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From Straitjackets to Jumpsuits: America's Mental Healthcare Crisis

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Introduction

Mental health and crime are all too often equated in the media. With every mass shooting and every violent tragedy, people look for answers to explain the seemingly inexplicable. In most cases, that explanation is mental illness, even though the majority of mentally ill people do not commit crimes (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009). However, while this flippant conclusion may be too quick a judgment in the case of mass tragedies, there is admittedly a very real connection between mental illness and crime in the United States. Around the country, states report their proportion of mentally ill inmates at anywhere from one in 10 to one in two (Dlugacz, 2014). Unfortunately, when mentally ill people are not being used as a scapegoat for tragedy, their entanglement in crime is quickly forgotten and any suggestion of criminal justice reform readily dismissed. For the past half a century, these issues have plagued the United States mental health and criminal justice systems, but research emerging in the past few decades shines light on the links between mental illness and criminality. Increasingly, experts are generating and implementing new methods to help take mentally ill people out of prisons and return them to their communities. Based on these growing developments, this paper explores the origins of criminal behavior and its connection to mental illness, the experiences of mentally ill people in the criminal justice system, and possible reforms to help the system better confront the struggles of mentally ill offenders.

Understanding Criminal Behavior

Criminality, like most of human behavior, is relatively complex and has long been little understood. While the topic has been extensively researched, criminologists have focused almost exclusively on the social factors that promote criminal activity (Wilson & Scarpa, 2012). In recent years, the field of criminology has expanded to consider the biological correlates that may

underlie the behaviors commonly associated with criminality (Wilson & Scarpa). This new development in criminology provides a more comprehensive view on criminal behavior. Many researchers now believe that antisocial behavior--a frequent precipitate of criminality--emerges through a combination of biological, social and biosocial factors (DeLisi, Beaver, Wright, & Vaughn, 2008). While biological and social influences can work independently to produce criminal behavior, most modern research suggests that a more complete understanding of criminality looks at interactions between biological and social elements (Wilson & Scarpa). The synthesis of heritable and environmental variables serves as the new foundation for emerging views on criminal behavior.

Environmental Risk Factors

The social contributions to criminality are extensive, and their influence can begin in early childhood. Child abuse serves as one of the earliest predictors of future criminal behavior. Abuse increases a child's risk of developing a number of problems, including physical and mental health issues, behavioral issues, and difficulties in school (Van Wert, Mishna, Trocme, & Fallon, 2017). Studies have repeatedly shown that many adolescents who become young offenders experience high levels of physical and emotional abuse during childhood, with one Australian study identifying 46 percent of the country's incarcerated adolescents as having a history of neglect or abuse (Shepherd & Purcell, 2015). Abuse marked as more severe, longer lasting, or recurring further increases the risk for criminality, as does experiencing multiple forms of abuse (Van Wert et al.). The link between child abuse and future criminality proves quite strong.

This connection between childhood abuse and criminal behavior might be partially explained by the behaviors that abused children commonly develop. Victims of abuse are at

significantly greater risk of exhibiting conduct problems (DeLisi et al., 2008). Conduct problems appear during childhood or adolescence, but they are usually chronic. These problems include a consistent tendency to break rules, to behave aggressively and destructively, and to lie--all behaviors that are associated with criminal behavior (Wilson & Scarpa, 2012). In examining specific types of abuse, researchers have found further support for the link between early abuse and criminality. Physical abuse can lead to the development of antisocial or criminal behaviors, while emotional abuse can increase risk for aggression and crime (Van Wert et al., 2017). This finding is especially problematic, since antisocial behaviors like these that appear prior to adolescence typically persist into adulthood (DeLisi et al.). Child abuse encourages children to develop attitudes and conduct that later become closely associated with criminal behavior.

Yet, not all abused children engage in crime as adolescents and adults. Researchers propose that child abuse might only foster the development of aggression and criminality when other risk factors are simultaneously present. These risks could include poverty, social problems with peers, depression or anxiety, or having parents with mental health issues (Van Wert et al., 2017). In support of this theory, abused children with a lower socioeconomic status are found to be at greater risk for criminality than abused children with a high socioeconomic position (Van Wert et al.). In fact, racial minorities face greater risk of engaging in criminal behavior because of the increased likelihood that they are growing up in disadvantaged communities (Matejkowski, Conrad, & Ostermann, 2017). The interaction of multiple environmental risk factors help to cultivate criminality, not the presence of child abuse or any one factor alone.

Additional evidence suggests that it is not only the combination of environmental factors that foster criminal behavior, but also their interaction with genetic and other biological vulnerabilities. For instance, while all child abuse victims are at significantly greater risk of

developing conduct problems, children with certain genetic risk factors are shown to be 12 times more likely to develop these problems than abused children without this genetic vulnerability (DeLisi et al., 2008). In addition, children with preexisting behavioral issues may face an increased risk for abuse and neglect, as some research has indicated that aggressive children are more likely to be physically abused (Van Wert et al., 2017). Physical abuse often prompts victims to develop assumptions that others always have bad intentions, to become inattentive to social cues, and to have worse problem-solving skills; these consequences of physical abuse only perpetuate the cycle of aggressive behavior (Van Wert et al.). Aggressive abused children are thus six times more likely to be abandoned than their non-aggressive counterparts, which bears relevance to the emergence of criminality given that children who are in the criminal justice system are five times more likely to have been victims of abandonment than those not in the system (Van Wert et al.). Abandonment heightens risk for criminality by amplifying the emotional, mental, and developmental issues that these children are already experiencing while also increasing their likelihood of ending up in high-risk situations, like becoming homeless or joining the sex trade (Van Wert et al.) The interplay between the biological tendency toward aggression and environmental risk of abuse demonstrates how biology and environment interact to promote the development of criminal behavior.

Biological Risk Factors

Other biological influences have also been connected to criminal behavior. These factors have not been as thoroughly studied as the social contributors to criminality for a number of reasons. Primarily, researchers and policymakers alike tend to view biological factors as less immediate risks and thus less significant, while many also hold the belief that biological vulnerabilities cannot be modified, making study of them virtually irrelevant (Newsome &

Cullen, 2017). This assumption has led the field of criminology to its focus on the social and environmental predictors of criminality, while neglecting the biological influences that might play a role. Emerging research, however, suggests that biology might help predict criminal behavior through genetic, neurological, and even physiological differences.

Research on the genetic contributions to criminality has issued from the fields of both behavioral and molecular genetics. Behavioral genetics attempts to determine the relative contributions of genes and environment to a given phenotype (Newsome & Cullen, 2017). Twin studies are a common way to assess these contributions. These studies suggest that about 71 percent of the variance in the development of conduct disorder and about 82 percent of the variance in the development of antisocial behaviors are due to genetic factors (DeLisi et al., 2008). Even the more conservative estimates still approximate genes to account for at least half of the variance in antisocial behavior, and studies have also identified other factors that lead to problematic behaviors to be at least partially heritable (Newsome & Cullen). Genetic variability can increase susceptibility to criminality in the right environment.

Molecular genetics research provides additional support to the argument that genes influence criminality. Molecular geneticists examine the effects of specific genes on behavior development and have identified multiple genes that appear to be related to antisocial behavior (Newsome & Cullen, 2017). DRD2 and DRD4, two genes that encode for dopamine receptors, have been connected to involvement in the criminal justice system. While it did not have a direct effect on an individual's likelihood of coming into contact with the police, DRD2 did significantly increase the likelihood of police contact among those with low environmental risk for criminality, (DeLisi et al., 2008). DRD4 also played a role in criminal behavior, having a significant direct effect on the age of someone's first arrest. However, these two genes only

showed significant effects on criminal behavior among people in low-risk environments, indicating that genes are interacting with the environment to affect criminal risk (DeLisi et al). Genes alone are not responsible for criminality, but certain genetic variants can increase a person's risk in select environments.

Because most traits are developed through highly complex interactions, a specific genotype only predicts the development of a criminal phenotype in certain environments (Newsome & Cullen, 2017). There are two popular theories that attempt to explain this relationship between genotype and phenotype. The Dual-Risk Theory suggests that specific variants of a gene can make people more vulnerable to the effects of negative life events (Newsome & Cullen). More recently, Differential Susceptibility Theory has gained traction by suggesting that certain genotypes could be characterized by high plasticity, allowing them to serve as risk factors or protective factors depending on the environment. These malleable genes would allow individuals to benefit more than other people from healthy environments, but they would be more negatively affected by harmful environments as well (Newsome & Cullen). Both of these theories stress that the environment largely dictates the effects of genotype on phenotype.

Genes can indirectly influence criminal behavior as well through their effects on neurological and physiological functioning. For instance, people with a gene variant that leads to low expression of MAOA--an enzyme that degrades a number of neurotransmitters--exhibit a number of neurological abnormalities: decreased gray matter in the limbic system, amygdalar hyperactivity during emotional processing, and decreased activity in the prefrontal cortex (Newsome & Cullen, 2017). All of these abnormalities are associated with problems in emotional regulation and self-control (Newsome & Cullen). Among psychopathic individuals,

decreases in gray matter volume remained significant even after controlling for numerous social risk factors (Wilson & Scarpa, 2012). A number of additional brain structures seem to be impaired in people who exhibit antisocial behaviors, and many of these areas are those that are known to be involved in moral thinking and emotionality (Wilson & Scarpa). In general, people who exhibit antisocial behaviors appear to have structural, functional, and neural connectivity abnormalities throughout their brains (Newsome & Cullen). A number of neurological irregularities can be linked to emotional and behavioral dysfunction associated with criminality.

Neurotransmission represent another arena in which genes affect behavior through neurological mediators. An excess or deficiency of neurotransmitters, or of the enzymes that degrade them, can impair communication within the brain and lead to cognitive, emotional, or behavioral problems (Newsome & Cullen, 2017). As evidence of this relationship, antisocial offenders consistently exhibit lower levels of serotonin metabolites, regardless of the nature of their crime (Wilson & Scarpa, 2012). In general, the genes that underlie neurotransmission processes are frequently connected to antisocial behavior and to other risk factors for criminality (Newsome & Cullen). Alterations in neural communication can affect cognition and behavior in ways that promote criminality.

Physiological characteristics can also increase risk for criminal behavior. Low resting heart rate and low resting skin conductance are consistently associated with aggression, psychopathy, conduct problems, and criminality (Wilson & Scarpa, 2012). These physiological factors signal general underarousal of the autonomic system, which can inhibit a person's ability to learn from negative events or from fearful experiences (Newsome & Cullen, 2017). Autonomic underarousal can promote criminal behavior by lowering physiological responses that usually alert people to avoid dangerous or harmful situations.

Hormonal imbalances are another physiological contributor to criminality arises. For a long time, testosterone has been viewed as the primary hormonal culprit involved in violent behavior. High levels of testosterone are frequently linked to aggression and criminality, but it seems that this correlation may be moderated by other biological and environmental risks (Newsome & Cullen, 2017). It is becoming increasingly evident that it is not a single hormone that promotes aggressive or criminal behavior, but rather the interactions between multiple hormones. Some studies have proposed that high levels of testosterone are only predictive of aggression and criminality when they appear in conjunction with low cortisol levels (Wilson & Scarpa, 2012). Cortisol is released by the HPA axis, which is the body system responsible for physiological responses to stressors. Thus, low levels of cortisol indicate a hypoactive HPA axis, suggesting a weak bodily response to stress (Newsome & Cullen). Like autonomic underarousal, reduced HPA responsivity likely makes people less sensitive to the potential dangers or consequences of a situation (Newsome & Cullen). Cortisol and testosterone could increase criminality by combining decreased sensitivity to danger combined increased aggressive tendencies. In general, lowered physiological responsivity can increase the likelihood of aggressive or criminal behavior by reducing a person's perception of the danger or severity of their actions.

Mental Illness as a Risk Factor

Mental illness is arguably the most complex of the risk factors for criminal behavior. About 4.1 percent of adults in the United States--equal to about 9.8 million people--have a severe mental illness, seriously impairing their daily functioning and ability to carry out essential life activities (Matejkowski et al., 2017). Within the correctional system, the proportions of people with mental illness are even higher. According to a 2009 estimate by the Bureau of Justice

Statistics, approximately 14 to 16 percent of people in the correctional system suffer from a serious mental illness, which amounts to about one million offenders (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014). While these numbers appear to reflect a direct correlation between mental illness and criminal behavior, the body of research on this issue suggests that the relationship is not quite so simple. In general, most people with a mental illness do not commit crimes (Shepherd & Purcell, 2015). Still, much research shows a significantly higher risk for criminal behavior among mentally ill offenders compared to their mentally healthy counterparts, which implies that these illnesses are somehow related to an increase in criminal offending and possibly in violations of parole or probation as well (Matejkowski et al.). Even so, other experts argue that psychiatric symptoms are not strong, independent predictors of recidivism (Peterson et al.). These conflicting findings make the link between mental illness and criminality difficult to define.

One way to understand the relationship between mental illness and criminal behavior is to differentiate between early onset and late onset offenders. Early onset offenders begin to exhibit antisocial or criminal behaviors as children before ever being diagnosed with a mental illness, whereas late onset offenders only begin to display these behaviors after their mental illness presents. (Matejkowski et al., 2017). Late onset offenders are more likely to be committing crimes as a direct result of their mental illness, but early onset offenders are probably more representative of the offender population in general, suggesting that the direct effects of mental illness on criminality are likely very small (Matejkowski et al.). Early onset offenders probably make up the majority of offenders because they have high recidivism rates and are two to three times more likely than late onset offenders to commit serious or violent crimes in

adulthood (Matejkowski et al.) The greater prevalence of early onset compared to late onset offenders presumably refutes the supposed influence of mental illness on criminality.

However, the theory of early and late onset offenders relies on an important distinction that clarifies the influence of mental illness on criminal behavior: the difference between direct and indirect effects. Research repeatedly shows that severely mentally ill individuals are in the criminal justice system at a higher rate than those without a severe mental illness, but this prevalence could be due to behaviors directly precipitated by their psychiatric symptoms or due to indirect consequences of the environment and experiences to which severely mentally ill people are more likely to be exposed (Matejkowski et al., 2017). Mental illness can directly or indirectly influence criminal behavior. Direct connections between mental illness and criminal behavior are often defined in terms of psychosis, but studies have found that psychotic episodes likely only explain about 5-12 percent of the crimes that mentally ill people commit (Peterson et al., 2014). Among mentally ill offenders, Peterson et al. found that only about 7.5 percent of crimes were directly influenced by their diagnoses, while about 27.9 percent of the crimes were believed to be partially influenced by symptoms. The direct effects of mental illness, at least through this lens, are relatively small.

Narrowly defining the direct relationship between mental illness and crime in terms of crimes immediately precipitated by psychosis neglects the many other ways in which mental illness can affect criminal behavior. Assessing whether or not a crime is the consequence of psychiatric symptoms depends on how one defines symptoms of mental illness. The common definition restricts these symptoms to hallucinations and delusions, indicating lower frequencies of symptom influence. Expanding the definition to include other symptoms like anger, irritability, confusion, disordered thinking, or impulsivity are likely to uncover a higher

frequency of correlations between psychiatric symptoms and crime (Peterson et al., 2014). Some researchers fear that, if symptoms outside of psychosis are included, it will be hard to differentiate between normal risk factors for criminal behavior and the psychiatric symptoms. For instance, symptoms like anger and impulsivity are strongly associated with multiple mental illnesses, but they are also considered to be personality traits (Peterson et al.). There is concern about how to assess whether or not the crime is truly related to a psychiatric disturbance.

Regardless of disagreement over its direct effects, mental illness can still indirectly correlate with criminal behavior through many other avenues. High levels of child abuse are common among young offenders, and many studies have also indicated that there is a link between this abuse and mental illness among these offenders (Shepherd & Purcell, 2015). In addition, comorbidity often helps explain the relationship between mental illness and crime. For example, substance abuse is considered a strong risk factor of criminality, sometimes being referred to as a "criminogenic need" (Newsome & Cullen, 2017). When combined with mental illness, substance abuse can serve as a strong mediator between the illness and criminal behavior (Shepherd & Purcell). In fact, research indicates that about 70 percent of inmates with severe mental illness also have a substance use disorder (Kesten, Leavitt-Smitt, Rau, et al., 2012). Severe mental illness exhibits an indirect relationship to recidivism mediated by the co-presence of criminal risk factors like substance abuse (Matejkowski et al., 2017).

Strikingly, individuals with severe mental illness also possess heightened levels of general criminal risk. Higher levels of risk are associated not only with first-time offending, but also with likelihood of recidivism and violation of parole (Matejkowski et al., 2017). Finally, mental illness is frequently linked to a longer duration of time spent stuck in the criminal justice system. Few of the people on parole have a psychiatric disorder because offenders with these

disorders usually must enter into specific treatments and housing as conditions of their release, and these services are not always available. They are also frequently accused of misbehavior during incarceration, reducing their chances of being granted parole even though this behavior is often provoked by symptoms (Baillargeon, Williams, Mellow et al., 2009). Mental illness indirectly influences criminal behavior through a wide array of factors.

The defining link between mental illness and criminal behavior may not be transparent, but the existence of a relationship is virtually undeniable. Ultimately, criminal behavior does not stem from any one factor, but rather from a constellation of social and biological factors that are often interconnected or comorbid with mental illness. Regardless of whether or not these factors are explicitly related to the ill-defined construct, "mental illness," they are still contributions to criminality that can be altered through treatment, which supports the efficacy of rehabilitative justice as a viable correctional policy (Newsome & Cullen, 2017). As Newsome and Cullen aptly recognize in their paper on offender rehabilitation, "It is clear that the causes of criminal behavior are complex and not simply a matter of free will--an assumption that underlies more punitive strategies" (1043). Comprehensive mental health care is a critical and primary component in rehabilitative justice. As the United States adapts to address its criminal justice crisis, rehabilitative strategies like mental health treatment will prove far more effective--and surely more ethical--than the punishment-focused approach that has dominated for too long.

The History of Mentally Ill People in the United States

Deinstitutionalization

Mentally ill people have not always been such a significant presence in the criminal system. The initiation of the deinstitutionalization movement in the late 1950s--when state mental hospitals were virtually emptied to return mentally ill individuals to their communities--

marks the beginning of the toxic relationship between the mental health and criminal justice systems. Before deinstitutionalization, there were about 339 people in psychiatric hospitals for every 100,000 people in the population; these facilities had lots of available space and could take in any individuals who were sent for treatment (Lamb & Weinberger, 2014). The Civil Rights movements of the 1960s created concern over the abuse and insufficient treatment occurring in state mental hospitals, and people became invested in improving the treatment of mentally ill people (Blevins & Soderstrom, 2015). The development of antipsychotic medications in the 1960s paralleled the emergence of these concerns about mental patient rights. The advent of psychotropics helped quicken the move toward deinstitutionalization because it seemed more feasible that severely mentally ill people could be managed in the community under the influence of these powerful medications (Baillargeon, Binswanger et al., 2009).

People who supported deinstitutionalization did so with differing motivations. Some people wanted to deinstitutionalize because they did not want criminals to get out of prison time by going to mental hospitals, but many people were motivated by the belief that mentally ill people would truly be better off receiving treatment from within their communities, where their individual needs could be better accommodated at a lower cost (Blevins & Soderstrom, 2015). The expense of mental institutions prompted governments to consider the return of mentally ill people to their communities as the more fiscally reasonably choice, which generated systemic support for the movement (Lamb & Weinberger, 2014).

With increasing support, deinstitutionalization gained momentum, but the results did not unfold as proponents of the movement had anticipated. The Community Mental Health Centers Construction Act of 1963 promised a plan to provide community mental health services to mentally ill people following their release from institutions (Hartwell, 2003). The closing of

mental hospitals was supposed to be replaced by community health centers, but not nearly enough of these facilities were established (Baillargeon, Binswanger et al., 2009). Communities either did not have the financial capacity to open these facilities or were simply unwilling to provide them. Instead, most of the mentally ill population ended up with no treatment options--and sometimes no home--after being released from state mental hospitals (Blevins & Soderstrom, 2015).

Deinstitutionalization proved largely unsuccessful due to insufficient planning and the failure to allocate adequate funding before the process began, which left communities unable to properly care for released individuals (Lamb & Weinberger, 2014). Without satisfactory care, people with severe mental illness struggled to thrive within the public sphere. Although the environment of state mental hospitals was problematic, these facilities at least provided severely mentally ill people with much-needed structure; when communities took over the care of these individuals, they did not implement alternative forms of structure to help mentally ill people function effectively in society (Lamb & Weinberger).

Instead, the emptying of mental hospitals begot a significant spike in prison populations, where former mental patients often found themselves soon after being discharged from state institutions (Dlugacz, 2014). In the decades following deinstitutionalization, it became even harder for mentally ill people to get needed treatment. Insurance companies increasingly limited their coverage of mental health treatment, hospitals only accepted small numbers of psychotic patients, and the well-intended new restrictions on involuntary commitment made this treatment route increasingly impractical (Baillargeon, Binswanger et al., 2009). By 2010, there were only 14 people in psychiatric hospitals for every 100,000 people in the population; these facilities no

longer have enough room to accept most of the candidates seeking admission (Lamb & Weinberger, 2014).

While the decline in the number of people committed to psychiatric hospitals is a seemingly positive trend, mental hospitals have, in many instances, simply been replaced by a new social problem. The majority of the people who used to be hospitalized in institutions are now arrested and imprisoned instead (Lamb & Weinberger, 2014). This shift has led to a modern crisis, where mentally ill individuals move interminably between homelessness, emergency hospitalization, and prison (Baillargeon, Binswanger et al., 2009). In the absence of affordable community mental health facilities, the prison system stands as one of the only ways for some mentally ill people to get any treatment at all, either because of the prohibitive cost of privatized treatment or because they develop a criminal record and are thus denied participation in many treatment opportunities in the public sphere (Blevins & Soderstrom, 2015). Deinstitutionalization aimed to improve mental health care for the severely mentally ill, but when governments did not arrange for alternative systems of care within the community, these individuals found themselves recycled from one restrictive institution to another.

Legal History of Prisoners

With the diversion of mentally ill people to the prison system, prisoner rights to health care became an increasingly pressing issue. The rights allotted to inmates in United States prisons have transformed dramatically over the past century. Until about 1960, prisoners did not even have the right to participate in litigation over their improper treatment in prison (Yanofski, 2010). Prior to the 1960s and 70s, the public expressed almost no interest in prison conditions, demonstrating little empathy toward the criminal populations (Felthous, 2009). It was not until the civil rights movements erupted in the 1960s that support began to build for improved

treatment of criminal offenders. In 1964, an inmate successfully sued a prison for the first time in *Cooper v. Pate*, establishing what came to be known as the "1983 precedent" (Yanofski). The title refers to Section 1983 of the Civil Rights Act of 1871, which permits legal action to be taken against a person who acts with the authority of the law behind them and violates someone's constitutional rights in the process. Usually, the violated rights that appear in correctional litigation involve the 1st, 8th, or 14th amendment (Yanofski). Following this landmark case, a number of other legal filings issued forth to advance prisoner rights.

Throughout the 1970s and beyond, cases like *Newman v. Alabama* (1972), *Wolff v. McDonnell* (1974), *Estelle v. Gamble* (1976), and *Balla v. Idaho State Board of Correction* (1984) issued forth to address legal rights to healthcare in prison. *Newman v. Alabama* became the first of these cases by prohibiting the intentional delay of medical care and requiring that prisons provide needed healthcare in a timely manner (The Harvard Law Review Association, 1981). Several years later, *Estelle v. Gamble* reaffirmed this right of incarcerated persons to receive medical care (Simon, 2013). The Eighth Amendment protects these rights through the prohibition of "cruel and unusual punishment," a category under which healthcare deprivation is argued to fall (Dlugacz, 2014). Some people debated over the appropriateness of using law-abiding citizens' taxes to finance correctional mental healthcare. In 1977, *Bowring v. Godwin* addressed this issue, declaring that offenders had a right to mental healthcare, although the level of care might differ across facilities (Blevins & Soderstrom, 2015). While legal cases like this one took steps to advance inmate rights to healthcare, political backlash quickly followed.

Nixon's "War on Drugs," launched in 1971, became one of the first of these retaliatory movements. As litigation promoted advances in prisoner rights, President Nixon combatted this progress with a process to lengthen sentences and increase the severity of convictions (Nesmith,

2014). Ironically, Nixon's original political platform promoted treatment and rehabilitation as solutions to issues like substance abuse. However, his position shifted in response to the increase in drug use following the 1960s liberation movements and the return of heroin-addict soldiers from the Vietnam War (Nesmith). Prior to Nixon's War on Drugs, judges possessed a great deal of discretion during sentencing, practicing an individualized approach that focused on rehabilitation, not punishment. Nixon established stringent mandatory minimum sentences for drug convictions that were, in many cases, much longer than the existing norm (Nesmith). He simultaneously increased the size and budgets of drug monitoring agencies in order to expand government surveillance of drug use throughout the country (Nesmith). Not only did the War on Drugs ignore the substance abuse issues at the root of the drug crisis, but it also likely targeted mentally ill offenders disproportionately, considering that the large majority of these people have a comorbid substance use disorder (Kesten et al., 2012).

Under Reagan's presidency, the state of American criminal justice worsened. Even though illegal drug use rates had dropped significantly since 1979, Reagan continued Nixon's drug crackdown with his "Tough on Crime" agenda, passing legislation that applied mandatory minimums to many other offenses (Nesmith, 2014). The United States Sentencing Commission (USSC), established in 1984 through the Sentencing Reform Act, was tasked with creating sentencing guidelines for judges and with conducting research to assess which forms of punishment were most effective for different types of offenses (Nesmith). The USSC increased sentences, but no research was conducted to justify this and other actions taken by the Commission. The USSC also reduced the opportunities for discretion among judges by implementing objective measures that were used to determine sentence severity (Nesmith). These measures gave no consideration to the accused person's social circumstances or

psychological well-being. As might be expected, incarceration rates increased dramatically (Nesmith).

While offenders were being attacked in the political realm, litigation began to turn on them too. Formerly a source of advancement for prisoner rights, a series of court cases soon arose that counteracted much of the progress made through the legal battles of the 1970s. In 1987, *Turner v. Safley* ruled that prisoner rights had to be balanced with the safety needs of the prison (Hudson, 2001). Three years later, *Harper v. Washington* decided that psychiatric medication could be administered to inmates involuntarily (Yanofski, 2010). The most dramatic affront to prisoners' rights came in 1996 through the Prison Litigation Reform Act, which asserted that correctional facilities were only obligated to do the "bare minimum" to correct any claimed violations of constitutional rights (Yanofski). Another damaging legal assault, particularly detrimental to mentally ill offenders, came in the declaration by U.S. Sentencing Guidelines that mental issues were irrelevant to sentencing (Dlugacz, 2014). Responding to the 1960s emphasis on individual liberties and civil rights, the following decades saw political and legal retaliation that heightened institutional power and removed much of the subjectivity from the criminal justice process.

In recent years, the tide has slowly turned back toward the protection of prisoner rights. *States v. Booker*, in 2005, returned some allowances to judges for subjectivity during sentencing (Dlugacz, 2014). The USSC enacted the "all drugs minus two" policy, reducing sentences ex post facto for many low-level drug offenses (Nesmith, 2014). The greatest improvement, however, has been a change in the general ideology governing political and social thought. Former U.S. Attorney General Eric Holder exemplified this shift with his stance, "Smart on Crime," a counterpoint to Reagan's popularized "Tough on Crime." This revised criminal justice

perspective promotes alternatives to traditional prison sentences that better reduce recidivism rates, advocates for the implementation of systems that prevent crime and facilitate offenders' reentry into the community, and emphasizes the importance of conducting research that analyzes the cost and efficacy of criminal justice policies (Nesmith). All of these proposals are encouraging steps toward narrowing the scope and dominion of the criminal justice system in the United States and moving in a more rehabilitative direction. Even so, until ideological stances are transformed into legislation, the support for these ideas will be subject to changes in political control. These agendas are impotent without the support of the law--and the government funding that these laws generate--to bring them to fruition.

Interactions with Law Enforcement

Police Responsibility for Mentally Ill Citizens

Despite the frequent interactions between police officers and mentally ill citizens, the majority of research on mentally ill people in the criminal justice system has been conducted in prisons (Ogloff, Thomas, Luebbers et al., 2013). Without research to identify the problems, it is nearly impossible to generate relevant and effective reform. Yet, emerging evidence indicates that encounters between law enforcement and mentally ill persons are a key area for intervention and improvement.

Deinstitutionalization led to a sharp increase of mentally ill people living in the community, creating the need for a simultaneous expansion of community care (Lamb, Weinberger, & DeCuir, 2002). With community mental health services perpetually underfunded, the burden of caring for these individuals has instead fallen to law enforcement (Ogloff et al., 2013). Because police officers are obligated both to protect the public and to protect individuals

who cannot protect themselves, they have become the first responders to psychiatric crises--the de facto psychiatrists for the community (Lamb et al.).

A variety of circumstances bring law enforcement into contact with mentally ill citizens. Police officers may be responding to a domestic or public disturbance, a psychiatric crisis, criminal behavior, disorderly conduct, or to a number of other domestic, public, or legal matters (Watson, Swartz, Bohrman, Kriegel, & Draine, 2014). In a study of law enforcement officials in Australia, half of the officers reported having one to two interactions per week with mentally ill individuals, and one third of the officers reported as many as three to 10 interactions per week (Ogloff et al., 2013). Although their role is less recognized in talks of criminal justice reform, law enforcement frequently engages with the mentally ill population, serving as a critical link between the mental health and criminal justice systems.

Police response to disturbances involving mentally ill individuals is often a necessary precaution. Mentally ill people who are experiencing psychosis, skipping their medication, or abusing other substances have been shown to be more dangerous than the general population, and many psychiatric crises thus hold the potential for violence (Lamb et al., 2002). Because law enforcement has a responsibility to keep citizens safe, their presence may be obligatory. However, most police officers do not receive sufficient training to be able to handle these mental crises appropriately (Ogloff et al., 2013). To determine whether a person is mentally ill, law enforcement relies on informal information gathered from dispatch, provided by health services, or simply gathered through their own observations during their interaction with the person (Ogloff et al.). The majority of police officers' mental illness knowledge is gained through experience on and off the job, and one study indicated that officers' methods for identifying mental illness misclassified almost half of detainees (Ogloff et al.). As a result, sometimes police

officers arrest individuals for minor crimes instead of diverting them to services because they do not recognize the symptoms of mental illness that a mental health professional might. Instead, they may think that the erratic or unusual behavior is a consequence of drugs or alcohol (Lamb et al.). Law enforcement sometimes mishandles their interactions with mentally ill individuals because their knowledge about mental illness is limited, and they often lack the appropriate training to know how to approach these situations effectively.

Approaches to Interactions with Mentally Ill Persons

Police officers have a number of options for handling encounters with mentally ill individuals. All states give law enforcement the authority to submit individuals for psychiatric evaluation and treatment if they have reason to believe that they might be a threat to themselves (Lamb et al., 2002). However, police officers handle the majority--more than 75 percent--of mental illness encounters informally, usually by attempting to compose the distressed person and then taking them home (Lamb et al.). Involuntary commitment is time-intensive, and police officers usually only resort to this option for a limited scope of cases, as when the individual has attempted suicide, has engaged in violent acts, or is visibly unable to care for themselves (Watson et al., 2014). The outcomes of a police interaction with a mentally ill person may also be affected by the community in which it occurs, the offending individual's personal characteristics, the responding officer's attitudes toward mental illness, and the nature of the scene. For example, if the encounter occurs in a public area, police officers are more likely to refer an individual for evaluation or to mental health services, whereas people of color, young people, and hostile individuals are all at increased risk of being arrested (Watson et al.). Not all interactions between law enforcement and mentally ill citizens are handled in the same way, and the results of these interactions are not unilateral.

This variation in outcomes becomes especially meaningful in encounters that involve violence or the potential for use of fatal force by an officer. Although only about 25 percent of mentally ill offenders threaten violence with a weapon, those who do threaten such violence are two times more likely than the general population to actually follow through with the act (Ogloff et al., 2013). Traditional police strategies of de-escalation may not be as effective with individuals in the midst of a psychiatric crisis, as they might be experiencing irrational thoughts that make them more resistant to the officer's usual tactics (Ogloff et al).. The repercussions of the individual's noncompliance could be deadly, since police officers are most likely to use fatal force in situations where the individual provokes or escalates aggression toward the police (Ogloff et al.). Because people in psychiatric crisis may be less responsive to an officer's demands, and officers are not trained on how to react appropriately, these situations can easily escalate. In an analysis of the occasions when an officer used fatal force, the individual had a diagnosed mental illness in more than half of these cases, and in more than a third of the cases, the individual had multiple diagnoses (Ogloff et al.). Interactions between law enforcement and mentally ill people are not only challenging, but also dangerous and occasionally lethal.

In most cases, though, the mentally ill person eventually ends up in police custody. However, the decision to detain these individuals is not always because law enforcement views them as a significant threat to others (Lamb et al., 2002). Often, police officers resort to "mercy booking," where they arrest mentally ill individuals because they believe there are no other good alternative resources available. This solution is a significant cause of the criminalization of mentally ill people (Lamb et al.). Officers often cite a lack of support from mental health services as one of their most common challenges in responding to mental illness crises (Ogloff et al., 2013). Thus, many police officers believe that psychiatric treatment will be more accessible to

the individuals in jail, and it is not illegal in most states to detain a mentally ill person in jail, even if they have not committed a crime (Lamb et al.).

Another factor that encourages law enforcement to choose arrest over mental health intervention is the hassle that officers face in diverting individuals to the mental health system. Waiting for psychiatric services takes a significant amount of the officers' time and prevents them from moving on to other tasks (Lamb et al., 2002). When officers do access the mental health system, mental health professionals and other hospital staff do not always trust the informal diagnoses made by law enforcement, and they may refuse to admit the individual or immediately release them from the hospital (Lamb et al.) To many officers, diversion seems like a waste of time because it takes so long to access these services and then the individual often ends up right back in the situation in which law enforcement found them.

Court Systems

Problem-Solving Courts

For people who are arrested and formally charged with a crime, the court process becomes the next opportunity for diversion from the standard criminal justice system. Overzealous criminalization in the United States has left criminal courts burdened by more cases than they can handle; most of these courts do not have sufficient resources to take on all these cases and are unable to appropriately address the wide variety of problems that offenders have when they enter the courtroom (Frailing, 2010). The first problem-solving court was developed in 1989 to better address offenders' unique constellation of needs, specifically in reaction to the crack crisis and War on Drugs that had led to a dramatic increase in drug charges (Landess & Holoyda, 2017). Problem-solving courts are diversionary courts that require offenders to participate in treatment and to be subject to court supervision as an alternative to being

prosecuted and incarcerated; these courts attempt to reduce recidivism rates by addressing the issues that lead people to offend in the first place (Landess & Holoyda).

Problem-solving courts, including mental health courts--are governed by the principle of therapeutic jurisprudence, a legal theory that focuses on the extent to which laws and related practices are therapeutic for offenders (Frailing, 2010). There are a variety of types of problem-solving courts, including drug courts, mental health courts, and domestic violence courts, but all of them operate under the assumption that the legal system should address the underlying precipitates of offenders' criminal behavior (Landess & Holoyda, 2017). In 2012, the Bureau of Justice Statistics reported that there were about 3,000 problem-solving courts in the United States, about 40 percent of which were drug courts (Landess & Holoyda).

Drug courts served as the model for the development of most other problem-solving courts, eventually leading up to the establishment of the first mental health court in Broward County, Florida in 1997 (Landess & Holoyda, 2017). Mental health courts attempt to divert mentally ill individuals to treatment and other forms of support in lieu of entering the criminal justice system (Frailing, 2010). Crime statistics reflect the need for diversionary mental health courts: mentally ill people have a high frequency of arrest, a greater likelihood of being denied bond, and a longer duration of time spent in prison (Landess & Holoyda). In spite of the conspicuous need for these programs, mental health courts have developed slowly across the United States. Even though the first of these courts opened its doors back in 1997, that number only grew to 347 mental health courts across the entire United States by 2013 (Landess & Holoyda). The continued growth of such programs is a critical component in combatting jail overcrowding, lowering recidivism rates, and improving offenders' lives and general well-being (Frailing). Currently, the growth rate of these courts fails to meet the level of need.

Over the past decade and a half, Congress has made some legislative steps to support mental health court development. In 2002, Congress passed Public Law Number 107-77, which allocated $4 million to fund the establishment of mental health courts around the country (Landess & Holoyda, 2017). In some cases, Congress has crossed party lines to address the increasingly dire situation in the U.S. justice system. The 21st Century Cures Act represented one such bipartisan effort in Congress--it provided funding to support lowered criminalization of the mentally ill in favor of diversionary programs (Landess & Holoyda).

Mental Health Courts

With increased support and funding over the past few decades, the use of mental health courts as a viable alternative to the traditional criminal justice process has finally begun to grow. However, the data on their effectiveness remains unclear. The research on mental health courts lags significantly behind the rate of their development (Kopelovich, Yanos, Pratt, & Koerner, 2013). Even with the research that has been conducted, it is hard to compare these courts because of the inconsistency in practices across mental health courts nationwide. Courts differ in their criteria for acceptance into their program, the types of sanctions issued for non-adherence, and the criteria that must be met to complete the program (Frailing, 2010). Research showing the efficacy of one mental health court does not validate the efficacy of other mental health courts that may operate differently.

Despite the variability across mental health courts, there are a few components that appear with relative constancy in most of the programs. In general, people can be diverted to mental health courts for misdemeanor or felony charges, with about 60 percent of mental health courts accepting felony cases and some even accepting select violent felonies (Landess & Holoyda, 2017). In most mental health courts, participants are required to plead guilty to the

offense in order to enter the program, with the possibility that the offense will be removed from the person's permanent record if they successfully complete the program (Landess & Holoyda). Andrea Kohlmann & Erica Villiesse, two probation officers in a mental health court, note that most offenders are referred to the court by their lawyer. This informal recommendation process can overlook some people if their lawyer is not familiar with the mental health court or does not recognize their client's symptoms (personal communication, January 26, 2018). Consequently, not all offenders have an equal chance of being diverted to a mental health court.

For those accepted into the mental health court, the program usually requires engaging in mental health and substance abuse treatment, maintaining sobriety, adhering to medication regimens, attending regular court hearings, and complying with mandated court supervision (Landess & Holoyda, 2017). Typically, the treatment plans are developed by health professionals, court officials, or through a collaborative effort by both teams. If participants fail to comply with their treatment plan, the court may issue a variety of sanctions, including increasing the participant's treatment, issuing community service, or even temporarily sending the participant to jail (Landess & Holoyda). While these elements are common across mental health courts, the specifics of their implementation still vary by program. Because mental health courts are not uniform in their practices, it is hard to determine which of the factors present in these courts are most important to recovery (Kopelovich et al., 2013). The inconsistency poses a challenge for researchers who try to comprehensively analyze these programs.

Although it is difficult to conduct research that reflects the diversity of practices at work in mental health courts, preliminary data seems to support the efficacy of these programs. While some studies have found no differences in reoffending, most studies suggest that participation in a mental health court leads to significantly lower rates of recidivism (Landess & Holoyda, 2017).

One study compared offenders in the mental health court with offenders undergoing the conventional criminal court process but who would have had a similar likelihood of being accepted into the mental health court program. After eighteen months in the mental health court program, participants were 39 percent less likely to reoffend and 55 percent less likely to violently reoffend than the matched offenders going through the criminal court process (Frailing, 2010). Compared to their own prior arrest history, participants were also 50 percent less likely to be arrested after entering the program and 62 percent less likely to violate their probation. People who completed the program were almost four times less likely to be rearrested than people who dropped out of the program--participants who successfully graduated from the program demonstrated a 400 percent drop in their overall offending rate (Frailing). These statistics indicate considerable decreases in recidivism for individuals participating in the mental health court program.

In addition to lowering participant crime rates, mental health courts appear to have other beneficial effects. The study by Frailing (2010) found that participants in the mental health court were also hospitalized for significantly fewer days compared to the year preceding their entry into the program. Routine drug and alcohol tests conducted by the court revealed that the program lowered participants' rates of substance abuse as well. Only 17.4 percent of participant drug tests and only 2.1 percent of alcohol tests were positive, and more than half of these positive results appeared within the first four months of the program--almost 70 percent of them occurred in the first six months (Frailing). These data are especially propitious because of the strong correlation between substance abuse and criminal behavior.

Other research has attempted to decipher factors that may be critical to successful completion of the mental health court program. An emphasis on procedural justice is considered

especially important to participants' success. Procedural justice stresses that offenders should be treated with respect, which means including them in decisions and ensuring that the process is perceived as fair and not coercive (Kopelovich et al., 2013). This theory suggests that it is the participant's experience of the process, not the actual outcome, that is the most important in determining their satisfaction with the services, and it is believed that groups who frequently experience stigma--like mentally ill people--may find procedural justice particularly important (Kopelovich et al.). Procedural justice couples well with therapeutic jurisprudence, the other guiding tenet of problem-solving courts, because it emphasizes working with the participant on recovery and highlights their ability to take on normal roles within the community (Kopelovich et al.). Participants in mental health courts who experience higher levels of procedural justice are not only likely to have more positive feelings toward the experience, but they also are likely to feel more capable and hopeful (Kopelovich et al.). This attitude toward the program may help facilitate their adherence to treatments and successful return to the community.

Not many studies have analyzed the influence of the judge on the mental health court experience, but most professionals believe that the judge plays a pivotal role in participants' perceptions of the program experience. In fact, some research has shown that participants' relationships with court officials influence the likelihood that the individual will complete the program (Kopelovich et al., 2013). Judges tend to be more closely involved with offenders in problem-solving courts, continually overseeing the individual's progress and adherence to the program and getting them connected to community services (Landess & Holoyda, 2017). However, one study found that there was significant variability across mental health courts in the amount of time judges spent with participants: while interactions lasted an average of 2.39 minutes, the range spanned from as brief as 0.04 minutes up to as long as 23.15 minutes

(Kopelovich et al.). Even so, participants in these programs tended to rate their experience with the judge as positive overall.

Unlike the typical approach in a criminal court, judges in mental health courts are more likely to emphasize respect, understanding, and positive reinforcement (Kopelovich et al., 2013). The way in which mental health court judges communicate and work with participants is drastically different from the average criminal court. For example, a study that observed a mental health court for ten days found that the judge made 87 comments of praise and 62 comments of encouragement, while only making 19 sanctioning comments (Kopelovich et al.). The positive nature of these interactions between the judge and participants is likely a key factor in determining offenders' receptivity to the program.

These studies suggest that mental health courts are a superior alternative to the traditional criminal justice route, at least for mentally ill individuals. However, researchers have also uncovered some significant issues embedded in this process. It is unclear whether or not the mental health court program is actually responsible for the success of the participants, since the people accepted into mental health courts are already the people most likely to succeed in the program, and high dropout rates mean that only the people who are successful in the program are available for study (Frailing, 2010). Further research is needed that compares similar individuals in criminal and mental health courts and that tracks participants after they exit the system. Because the eligibility criteria are not clearly defined in many mental health courts, certain individuals are disproportionately involved in these programs: middle-aged white males are overrepresented among mental health court participants, whereas young minority males are more likely to be incarcerated (Landess & Holoyda, 2017). Mental health courts are also limited by the services available in the surrounding community. The courts can only connect offenders with

services that are actually available, and the available treatment may not always be the ideal treatment (Landess & Holoyda). Thus, while mental health courts show demonstrable promise, their success and reliability is currently impaired by the lack of research and the inconsistency in program practices.

Incarceration

Psychological Consequences of Imprisonment

If mentally ill offenders are not diverted from the criminal justice system by law enforcement or representatives of the court, they are likely to be forced into a correctional facility. The conditions of incarceration can precipitate or worsen psychiatric symptoms in mentally healthy and mentally ill offenders alike. The environment of incarceration leads to higher levels of mental illness than offenders would have if they remained in the community, and the stress of the restrictions and isolation can have additional health consequences as well (Yi, Turney, & Wildeman, 2017). These issues may persist even after individuals reenter the community. One study found that, compared to fathers with no history of incarceration, fathers with a history of incarceration were twice as likely to be depressed (16.4 percent versus 8.2 percent), almost three times more likely to report life dissatisfaction (20.7 percent versus 7.8 percent), and more than three times as likely to report illegal drug use (15.5 percent versus 5.0 percent); (Yi et al.). The attitudes and behaviors adopted to survive prison life are counterproductive to effective reentry into the community. Incarceration fosters a dependency on the prison and an inability to make personal decisions. It can also encourage individuals to become hyper-alert, distrusting, and emotionally inexpressive, often provoking social withdrawal (Nesmith, 2014). The longer that people remain in prison, the more time these behaviors have to develop and the greater likelihood that they will become entrenched in the person's identity

(Nesmith). The very nature of the correctional environment is an inherent threat to psychological well-being, regardless of whether or not offenders have preexisting mental health issues.

For mentally ill individuals, the correctional environment can significantly aggravate symptoms. Mentally ill offenders are more likely to be physically or sexually abused by other inmates, which can worsen symptoms or create new mental health problems (Blevins & Soderstrom, 2015). Drug offenders are also more likely to face abuse from more violent criminals who are higher up in the prison hierarchy (Nesmith, 2014). Although drug use alone does not indicate mental health status, there is a strong correlation between substance use and bad mental health (Yi et al., 2017). Additionally, when these individuals face the threat of abuse from violent inmates, they may engage in emotional suppression to avoid appearing weak. This defense mechanism can further degrade their mental health, and it promotes the adoption of aggressive behavior that can continue after release from prison and lead to recidivism (Nesmith).

Offenders with severe mental illness may engage in misbehavior as a consequence of their symptoms, and the correctional response typically augments these symptoms rather than ameliorating them. Misbehavior by mentally ill inmates is usually interpreted as punishable misconduct in prison. As a consequence, mentally ill offenders may be put in solitary confinement, which aggravates symptoms (Blevins & Soderstrom, 2015). Recently, policies on restrictive housing for mentally ill inmates has changed as a result of a lawsuit about the deleterious effects of confinement on inmate well-being. Severely mentally ill offenders can now only be held in solitary confinement for a maximum of thirty days (M. Gipson, personal communication, November 16, 2017). Still, even thirty days may be too long, as research shows that solitary confinement negatively affects the mental health even in non-mentally ill offenders, indicating that its consequences are significantly drastic (Blevins & Soderstrom).

In addition to this relatively short-term punishment, mentally ill individuals may experience long-term ramifications for their misbehavior. Many mentally ill people find their prison stay lengthened because parole boards do not understand or acknowledge the influence of mental illness on their behavior (Blevins & Soderstrom, 2015). Research shows that mentally ill offenders tend to serve longer prison sentences for each conviction compared to their mentally healthy counterparts (Baillargeon, Binswanger et al., 2009). Incarceration leads to deterioration in offenders' well-being, and these effects may be especially salient for mentally ill inmates, who are more vulnerable to attacks on their mental health and who are more likely to experience the worst that prison has to offer.

Prison Suicide

Prior to the 1960s, the public took little interest in the quality of prison conditions. Even as effective mental health treatments began to take shape in the general community, the therapies were rarely applied to correctional populations, for whom the public showed little compassion (Felthous, 2009). The 1960s civil rights movements fostered more concern for the rights of people in prison, but it was not until the 1970s and 1980s that the true horror of conditions came to light (Felthous). Public interest in these issues rose as the many court cases and lawsuits filed in response to inmate suicides drew attention to the crisis. During this time, research conducted by Lindsay Hayes came into the public view, shining a spotlight on the suicide crisis in correctional facilities (Felthous). Exposing the mental health plight of prisoners prompted mental health professionals to begin considering the needs of these individuals. In spite of the increased investment in inmates' well-being, large prison populations and few resources meant that mental health care was usually reduced to addressing the primary concern at the time: suicide prevention (Felthous).

Although suicide prevention efforts have increased over the past few decades, the correctional environment by its very nature still increases suicidal risk, especially among mentally ill offenders. Suicide remains one of the top three leading causes of prison deaths, and prevalence rates are even higher among those with a mental illness (Blevins & Soderstrom, 2015). The circumstances of imprisonment often exacerbate symptoms. In general, mentally ill offenders are more likely to be victimized--physically or sexually--by their fellow inmates. This trauma can worsen symptoms or create new sources of mental distress (Blevins & Soderstrom). Symptom elevation poses an increased risk for the development of suicidal ideation.

To successfully combat suicide rates, correctional facilities need to establish solid lines of communication between correctional and clinical staff, conduct continuous risk screenings, and not dismiss inmate behavior that is deemed to be merely "manipulative," as it may still be a sign of suicidal risk. Staff should be thoroughly trained on suicide prevention and on appropriate response measures to suicide attempts (Dlugacz, 2014). Prison suicide can only be effectively reduced if all of these measures are implemented.

Correctional and Clinical Priorities

Still, implementing mental healthcare measures in correctional facilities is far from simple. Prison staff are faced with the unique challenge of navigating both the protocol of the correctional facility and the clinical needs of offenders. Correctional staff must "learn to balance patient needs with availability of resources and organizational goals" (B. Wolfe, personal communication, September 07, 2017). Correctional facilities are challenged with maintaining a difficult balance between inmates' mental healthcare needs and the safety concerns or financial burdens of the prison (Tamburello, Kaldany, & Dickert, 2017). In a correctional environment, even a simple process like transporting offenders from their cells to treatment is a strenuous

undertaking. Many of these individuals need to be restrained and require an escort by correctional officers, in addition to undergoing time-consuming security searches and safety protocols that must be performed before offenders can enter clinical areas (Wolfe). Many mentally ill inmates must also be kept in protective custody away from the general prison population, a necessary safety precaution that regrettably limits clinical access to these individuals (Wolfe). Providing offenders with adequate treatment poses complications that do not exist in the public sphere.

Differences in the priorities of correctional and clinical staff can lead to conflict within the facility. Correctional officers view offenders as inmates first, while clinical staff tend to view them as patients first (Collins, Avondoglio, & Terry, 2017). In many cases, correctional and clinical professionals have opposing viewpoints on the function that incarceration should serve: correctional officers may view the goal of prison as punishment, while clinicians view the objective as rehabilitation (Tamburello et al., 2017). These opposing perspectives can promote disagreement and conflict between the two groups. Yet, clinicians depend on productive coordination and cooperation with correctional officers in order to successfully treat offenders. Officers assist clinicians in dispensing medications, and more importantly, they engage in personal interaction with offenders on a daily basis and therefore have the most direct knowledge about the offender's well-being and day-to-day behavior (Collins et al.).

Clinical staff depend on this information in order to make well-informed decisions about appropriate treatment for their patients. However, some correctional staff are skeptical of mental health concerns because they view these complaints as excuses used to avoid punishment (Collins et al., 2017). Even if these officers do value the importance of mental health treatment, they are challenged with reconciling an authoritative, security-enforcing role with a treatment

and care-providing role (Martin, Hynes, Hatcher, & Colman, 2016). Maintaining their authority purportedly keeps the facility under control, and this responsibility can feel incompatible with the compassionate role of a care provider. Yet, if offenders do not have a positive relationship with correctional officers, they may withhold relevant mental health information from the officers, making the clinicians' diagnostic and treatment duties more difficult and less effective (Martin et al.).

Distrust of the mental health processes can be yet another barrier to correctional officers cooperating with clinicians. Lack of knowledge about mental health and mental illness includes even many correctional mental health administrators, who often possess far more legal than medical education (Tamburello et al., 2017). Administrators may tend to prioritize the criminal justice issues in the prison over medical issues simply because they lack the appropriate knowledge of the offenders' treatment needs. In addition to administrative misunderstandings, mental health professionals are also placed in a problematic position when offenders engage in disruptive behavior, due to the misplaced assumption by correctional officers that mental illness is the root of violent behavior. Because violent offenders are difficult for correctional officers to control, they may place pressure on mental health clinicians to "fix it," forcing clinicians into overdiagnosis and over-prescription of medications (Collins et al., 2017). The objectives and perspectives of correctional and clinical staff are not always compatible; this conflict is problematic for mentally ill offenders because cooperation between correctional and clinical professionals is essential to the delivery of quality treatment.

Psychopharmacology in Prison

Regulating the distribution and consumption of psychopharmacological agents yields a new set of challenges in a correctional setting. Correctional psychiatrists must address legitimate

concerns about diversion or abuse of medications when they prescribe psychotropic drugs to an inmate. As prisons expand the medications available in their facilities to reflect the level of care present in the general community, there are increasing opportunities for substance abuse or diversion of medication (Felthous, 2009). Yet, even though anywhere from 17 to 60 percent of inmates are dealing with some type of mental health issue, correctional experience is not always a mandatory part of training to become a psychiatrist (Collins et al., 2017). Psychiatrists are thus unprepared to handle the unique challenges of treating patients in a correctional environment.

A variety of motivations underlie inmates' decisions to abuse or divert psychotropic medications. In correctional facilities, the prevalence of drug abuse tends to be much higher than in the general community, with 10 percent to 48 percent of men and 30 percent to 60 percent of women reporting some form of drug abuse (Pilkinton & Pilkinton, 2014). Among mental health patients, the prevalence skyrockets. Some estimates suggest that up to 75 percent of mentally ill inmates could have a comorbid substance use disorder (Collins et al., 2017). With such high rates of abuse, concerns about misuse of psychotropic drugs are warranted, especially considering that medication use has increased over the past few decades and remains the most common form of treatment for inmates (James & Glaze, 2006).

Some individuals seek psychotropics because they can mimic or enhance the effects produced by illegal drugs, to which inmates have less access in corrections. Other inmates may seek these medications because being on them can relieve them from certain unpleasant jobs in the facility (Pilkinton & Pilkinton, 2014). For some inmates, narcotics and other sedatives are highly prized because they can help "ease the boredom of existence" during incarceration (B. Wolfe, personal communication, September 07, 2017). Still others try to overdose on strong psychotropic drugs in order to be transferred out of corrections and into a hospital, sometimes to

facilitate an escape plan. Inmates may also try to sell or trade medication in exchange for other services or amenities (Pilkinton & Pilkinton). Even severely mentally ill inmates who genuinely need their medications may be at risk for medication diversion. Many mentally ill offenders depend on their medication as currency in prison because they do not have outside connections or finances on which they can depend. Other individuals are threatened into diverting their medications by other inmates (Pilkinton & Pilkinton). One of the biggest challenges in correctional psychiatry lies in minimizing abuse and diversion of psychotropic drugs while still ensuring that mentally ill inmates get the medications they need.

Correctional facilities take numerous precautions to lower the likelihood of medication abuse and diversion. To determine whether an inmate is trying to acquire certain medications for non-clinical purposes, some psychiatrists try to communicate with the inmate's family or with correctional staff to clarify the patient's actual needs (Collins et al., 2017). However, identifying the patient's symptom profile depends significantly on cooperation from correctional staff, many of whom are skeptical about mental illness diagnoses because of their assumption that mental health concerns help offenders escape punishment (Collins et al.).

Psychiatrists can lower the potential for abuse or diversion by conducting more extensive and thorough diagnostic assessments. These assessments should include questions about the patient's past or current substance abuse, their motivations for seeking treatment, and investigation of their compliance with medications which they are already taking or have taken (Pilkinton & Pilkinton, 2014). Ideally, psychiatrists should supplement these findings with information from officer reports, arrest and court records, family members, and other medical professionals. This extensive process takes longer initially and may delay decisions or treatment, but it may provide critical information that saves time in the long-term by helping clinicians

avoid ineffective treatment plans (Pilkinton & Pilkinton). Still, while comprehensive assessment may be the ideal, it may not always practical in the correctional environment.

Facilities have different methods of dispensing medication to help lower the associated risks too. Medication administered in liquid or injectable form can prevent individuals from storing the medication in their cheeks and can help identify inmates who are simply malingering for these purposes (Collins et al., 2017). Some correctional facilities currently crush medications and mix them with food to promote adherence, but there is minimal evidence to suggest that this actually decreases diversion rates, and it can also affect the absorption or effectiveness of the medication (Pilkinton & Pilkinton, 2014). Other facilities try to administer medications that are harder to alter into abusable forms, but this method may be too expensive for some institutions. A more effective measure seems to be "directly observed therapy," where a nurse gives the inmate the medication and then an officer inspects their mouth to make sure they have ingested it. The inmate must wait at least fifteen minutes after receiving the medication to ensure that they do not immediately vomit it up (Pilkinton & Pilkinton).

Urinary drug tests may be run to detect whether the patient is actually ingesting and metabolizing the medication, but this testing is flawed because many psychotropic medications can go undetected by urine tests (Collins et al., 2017). Newer serum level tests are more effective in identifying the presence or absence of a medication, but these can be expensive. Still, although the laboratory tests are costly, they likely pay for themselves in the end by limiting the consequences of medication diversion and limiting the prescription of expensive medications when they are unneeded or not used. For example, on-brand antipsychotic medications cost about $500-$2000 a month, while a serum test only costs $100-$200 per sample by comparison (Pilkinton & Pilkinton, 2014).

Psychiatrists may be able to detect risk for medication diversion or abuse by uncovering the patient's motivations for seeking treatment. A patient who reports symptoms that do not align with their actual presentation, that are inconsistent, or that are too "textbook" should raise a red flag about the possibility that they are malingering for the purposes of medication abuse or diversion (Pilkinton & Pilkinton, 2014). Patients who request specific medications and refuse alternatives may also be trying to obtain the medication for inappropriate use (Pilkinton & Pilkinton). Being attuned to these signals helps psychiatrists lessen the likelihood that they will prescribe medication unnecessarily that might be misused by the patient.

Clinical and correctional staff engage in these initiatives to reduce abuse and diversion, but there are certain features of the correctional environment that serve to counteract some of these efforts. Clinicians frequently face pressure from correctional staff to ameliorate inmate behavioral issues through medication; psychiatrists may be motivated to over-diagnose and over-prescribe to satisfy the demands of correctional staff (Collins et al., 2017). Psychiatrists may also succumb to over-prescription out of a genuine desire to help their patients or because they are not sufficiently aware of the risks associated with pharmacology in a correctional facility (Pilkinton & Pilkinton, 2014).

Timing the distribution of medication poses a challenge as well, since it must be organized around the correctional schedule--the clinical staff administering the medication do not have continuous access to most inmates. Working around correctional staff schedules or availability may force clinical staff to dispense medications at non-optimal times for ingestion, such as taking a sleeping pill during the middle of the night (Collins et al., 2017). Lack of continuous access to inmates can also increase opportunities for use and abuse. The marked absence of substance abuse treatment programs only maintains and exacerbates these issues

(Pilkinton & Pilkinton, 2014). The simplest approach to reducing medication diversion and abuse would be to reduce or eliminate the market for these drugs, which requires correctional facilities to address the exorbitant rates of substance abuse among offenders.

The ramifications stemming from psychotropic misuse highlight the importance of reducing abuse and diversion. These issues breed financial consequences: the facility wastes money on medications that are not actually being used by the patient to improve their symptoms, and the facility spends money on additional staff to manage individuals experiencing the health and behavioral effects that arise when they miss their medication (Pilkinton & Pilkinton, 2014). Skipping medication may increase the frequency of emergencies and hospitalization, which is both costly and a potential threat to security. Diversion of medication can be dangerous to the patient and to other inmates or staff in the event that the patient suffers from erratic behavioral symptoms in the absence of their medication (Pilkinton & Pilkinton). Psychiatric patients in prison not only have a constitutional right to proper medication and treatment, but also the financial and practical risks associated with medication abuse and diversion hold negative consequences for staff, inmates, and the facility as a whole.

Mental Health Treatments and Resources in Prison

Despite evidence of significant need among offenders, the available mental health resources in corrections remain highly limited. Although services vary greatly by state, one statistic shows that there is only about one psychiatrist for every 1,528 inmates and only one psychologist for every 932 inmates in corrections (Blevins & Soderstrom, 2015). According to the medical director of the Indiana Department of Corrections, "the large number of offenders with mental health needs easily outpaces the available mental health staff capacity, and more staff and treatment space is always needed" (B. Wolfe, personal communication, September 07,

2017). While state prisoners have the highest treatment percentages, the Bureau of Justice reported in 2006 that only one third of state inmates with mental health issues received treatment upon entry into a correctional facility (James & Glaze, 2006).

Diagnostic error is one of the first obstacles that limits access to treatment in prison. Screening upon entry into the correctional facility determines initial treatment access, but the inordinate number of patients that clinicians must evaluate during a short period of time creates challenges in conducting an accurate and comprehensive assessment of each offender (Martin et al., 2016). The APA states that anybody who is not a licensed psychologist or psychiatrist should be supervised by one if they are conducting diagnostic mental health assessments, but many states let professionals other than psychiatrists and psychologists conduct diagnostic screenings without supervision (Blevins & Soderstrom, 2015). Because these people do not have extensive training in mental health diagnosis, this process may increase the possibility for diagnostic error. Communication problems between patient and clinician can also affect diagnosis. Many inmates distrust correctional staff, including the clinicians, and they may be unwilling to disclose their symptoms (Martin et al.). Other times, inmates may fear retribution or victimization by other inmates if they admit to their symptoms, or they may wish to avoid the interventions that might result from expressing symptoms, like being assigned to protective custody for having suicidal thoughts (Martin et al.).

Undiagnosed mental illness can remain that way for a long time. Mental illnesses can change quickly, but follow-up screenings at most facilities occur only every three months at their most frequent, and sometimes they do not take place until up to a year after the initial screening (Blevins & Soderstrom, 2015). If an inmate does not receive a diagnosis for their mental illness in the initial screening, they may go a significant amount of time before their symptoms are

noted and addressed by staff. The delay in treatment onset can generate a number of negative consequences for the ill inmate and for the facility as a whole: early intervention leads to better prognosis, fewer disciplinary infractions, and lowered levels of security needed to manage the offender (Martin et al., 2016). Thus, delayed intervention can be assumed to have the opposite effects. Conducting effective diagnostic screenings is one of the first steps to providing adequate and effective treatment for individuals in corrections.

Even when inmates receive a diagnosis, they are still largely undertreated. Although medication use has increased significantly in recent decades, there has been virtually no change in the number of inmates receiving therapy (James & Glaze, 2006). Most of the existing research on mental illness in prisons focuses only on prevalence rates, which does little to provide information on how to implement effective treatments for offenders (Felthous, 2009). Only in the past few years have mental health resources begun to increase in correctional facilities in response to mandates from the federal court system, a regulatory body that plays a significant role in the improvement of mental health care in correctional facilities (B. Wolfe, personal communication, September 07, 2017).

While resources may be increasing in the prison system, almost all of the states that participated in a study on correctional mental health acknowledged that treating mental illness is one of the hardest tasks faced by the correctional facility. They attributed the root of this problem to the failure of legislatures to pass legislation that would adequately provide for mental health treatments (Blevins & Soderstrom, 2015). While all of the participating states in the study had some type of suicide prevention program in place, only 14 states provided sex offender treatment and only 16 states provided substance abuse treatment with a mental health professional present (Blevins & Soderstrom). Substance abuse shows high comorbidity with severe mental illness, so

the absence of these substance treatment programs neglects one of the most significant offender needs in the rehabilitation process (Kesten et al., 2012).

Substance Abuse

Many studies have found substance abuse to much higher within the criminal population compared to the general population (Shepherd & Purcell, 2015). Among offenders with severe mental illness, recent estimates suggest that approximately 70 to 75 percent also suffer from a substance use disorder (Collins et al., 2017; Kesten et al., 2012). Substance abuse problems may be most easily identified and treated during incarceration, but they play a significant role in every stage of the criminal justice system.

The high comorbidity of mental illness and substance abuse can have dangerous consequences during police interactions. Police are already more likely to respond with force in encounters with mentally ill individuals, and when police officers believe an individual is on drugs, they are even more likely to use force. The combination of mental illness and intoxication can escalate many police interactions with these individuals (Watson et al., 2014). Comorbidity heightens the tension already common in interactions between law enforcement and mentally ill people.

The co-occurrence of substance abuse and mental disorder also puts offenders at increased risk of homelessness, probation violation, and recidivism--often for crimes related to their substance use (Kesten et al., 2012). Even though this group is at increased risk for a number of legal issues, they are also largely underserved by treatment programs in prison, and studies show that people who do not receive proper treatment during incarceration are more at risk of recidivism after release (Kesten et al.). People with concurrent mental and substance use

disorders are more at risk for recidivism, yet they are less likely to receive the treatments necessary to reduce this risk.

When mentally ill offenders with substance abuse issues reenter the community, they rarely remain there for long. Typically, a condition of parole for comorbid offenders is adherence to a community treatment program (Baillargeon, Williams et al., 2009). Unfortunately, these offenders are still about two times more likely to have their parole revoked because of a parole violation and three times more likely to have parole revoked because they commit a new crime than those without mental illness or substance abuse issues (Baillargeon, Williams et al.). These statistics speak to the increased risk of recidivism that mentally ill offenders face when they have accompanying substance abuse problems.

In fact, recent studies suggest that substance abuse may serve as a significant mediator between mental illness and criminality (Shepherd & Purcell, 2015). There are a number of reasons why these offenders may face an increased likelihood of recidivism. Many of them are less likely to adhere to their mandatory treatment, are more likely to experience difficulty finding housing and employment, and are more likely to have difficulty rebuilding family relationships (Baillargeon, Williams et al., 2009). Without treatments that recognize these additional challenges, these offenders are less likely to be successful in reintegrating into the community. To fully manage the needs of most mentally ill offenders, substance abuse intervention must be a component in the treatment plan.

Reentry Services

Predictors of Recidivism

For all offenders, the threat of recidivism remains one of the central dilemmas in criminal justice. Over one third of offenders recidivate (Hartwell, 2003). Mentally ill offenders are far

more prone to reoffend than their mentally healthy counterparts, with one estimate suggesting that up to 78 percent of mentally ill offenders recidivate (Serowik & Yanos, 2013). Some studies suggest that mental illness alone is not a reliable predictor of recidivism, citing evidence that shows more similar recidivism rates between people with and without these illnesses (Baillargeon, Williams et al., 2009). However, these statistics may be misleading. Mentally ill people typically receive longer sentences for their crimes and are more likely than healthy offenders to serve the full sentence (Hartwell). Thus, data that shows similar recidivism rates between mentally ill and healthy offenders might be skewed by the fact that mentally ill offenders are less likely to be released from prison in the first place and therefore do not have as many opportunities to recidivate (Baillargeon, Williams et al.). In the general population, there are a few factors that consistently predict recidivism: being male, young, African American, and violent (Serowik & Yanos). Among mentally ill offenders, the factors associated with recidivism in the general population have not always held up. Instead, some of the factors that appear to increase the likelihood of reoffending among mentally ill people are youth, a history of violence or victimization, and substance abuse (Serowik & Yanos).

Comorbidity of substance abuse and mental illness may be one of the most important factors promoting recidivism. Substance abuse is correlated with criminal behavior in general and with a lower likelihood of successfully reintegrating into the community among severely mentally ill people (Hartwell, 2003). Substance abuse increases the likelihood of parole revocation and reincarceration for mentally ill offenders through a number of different avenues. Substance abuse issues can exacerbate the social and economic problems that offenders face upon reentry into the community, like finding housing and employment, which in turn can affect financial stability and the ability to afford healthcare (Baillargeon, Williams et al., 2009). These

challenges may be due to heightened discrimination against these offenders as well as the greater challenge that comorbidity creates for individuals in fulfilling their basic obligations (Baillargeon, Williams et al.). Regardless of the reason, it is evident that substance abuse impairs offenders' ability to reintegrate effectively back into the community.

Substance abuse also increases the likelihood of recidivism by impairing relationships. Social support, and family support in particular, is critical to successful reentry into the community--offenders without good family relationships are more likely to recidivate (Shinkfield & Graffam, 2010). Sadly, many offenders have few healthy relationships remaining after release from prison, and they are often ostracized (Shinkfield & Graffam). Substance abuse comorbidity is associated with increased social isolation and greater difficulty rebuilding family relationships, and the lack of social support increases the likelihood of recidivism in this subgroup (Baillargeon, Williams et al., 2009). Offenders with substance use disorders already find it more difficult to reintegrate into the public sphere, and the lack of social support only worsens their struggle.

Homelessness is another consequential contributor to recidivism. Homeless offenders have been shown to be significantly more likely to recidivate than those with housing accommodations, and they are more likely to recidivate sooner (Serowik & Yanos, 2013). Homelessness may encourage recidivism partly by reducing offenders' engagement with community services, given that insufficient community services are believed to be key in increasing reoffending rates (Serowik & Yanos). For mentally ill people, homelessness is an especially pertinent concern because the housing options for these individuals are more limited (Baillargeon, Williams et al., 2009). The effects of homelessness on recidivism are compounded by its frequent association with mental illness and substance use (Shinkfield & Graffam, 2010).

Even though substance use and homelessness are two of the most significant predictors of recidivism and are often coexistent, these problems are rarely addressed adequately upon reentry into the community. In fact, even though violent mentally ill offenders with comorbid substance abuse show increased risk for homelessness, rearrest, and reincarceration, this group is one of the most underserved by current treatment programs (Kesten et al., 2012). Housing is a frequently overlooked factor in recidivism, but it may be one of the most effective preventative measures.

Reducing Recidivism

Strategies to reduce recidivism rates among mentally ill offenders begin before they are even released from prison. Reentry programs should begin early enough before release from prison that correctional officials can communicate with services in the offender's community and ensure that they get connected to these services, which frequently have long waitlists (Kesten et al., 2012). Research indicates that mentally ill offenders released back into the community are more likely to thrive if a plan is created that is both rigorous and tailored to their specific needs (Hartwell, 2003). In the year prior to release, correctional and clinical staff need to establish a specialized reentry plan for offenders and help them develop skills to function effectively in the community (Kesten et al.). By establishing a plan for offenders to access services upon reentry, correctional officials help promote a smooth transition from incarceration back to the community.

In many places, few offenders are subjected to required supervision upon release from prison, making it voluntary for these individuals to participate in community services (Hartwell, 2003). This strategy appears to be largely ineffective. Instead, continued contact with offenders after reentry is crucial to making sure they actually connect with the proposed services and that these connections are maintained (Kesten et al., 2012). Having an official diagnosis may be

almost indispensable for mentally ill offenders trying to develop consistent connections to community services. Individuals with a confirmed diagnosis have the greatest access to healthcare because they qualify for benefits, like Medicaid and Social Security (Marlow, White, & Chesla, 2010). A condition of parole for offenders with a diagnosed mental illness or substance use disorder is usually adherence to a community treatment program, which increases the likelihood of gaining and maintaining access to necessary services after release from prison (Baillargeon, Williams et al., 2009). This condition is crucial because parole supervision without accompanying treatment or rehabilitative programs has been ineffective in helping mentally ill individuals stay out of the criminal justice system (Hartwell, 2003). Most recidivism--about 77 percent of reoffending--occurs in the first year after release, so continuity of care during this time is especially critical (Kesten et al.). Supervised release, where offenders are assisted in accessing services, can help reduce the risk of recidivism.

Unfortunately, these supposed guarantees of treatment access for mentally ill offenders may be an empty promise. At least one study found that the majority of individuals with mental illness and substance use disorder comorbidity had not received treatment for either disorder within the past year, and those who did participate in treatment were not very compliant over time (Baillargeon, Williams et al., 2009). Inadequate community mental health services are partly to blame for the lack of treatment. Community mental health services need to coordinate with correctional officials to be better equipped to cope with the unique needs of an offending population (Kesten et al., 2012). Treatment programs in the community often fail offenders because they rarely use an integrative approach that would address both mental illness and substance use issues. Because these substance and mental health treatment programs remain separate, it is difficult to create treatment plans for offenders that fit the specific needs associated

with comorbidity (Baillargeon, Williams et al.). An integrative approach to community services would even extend beyond mental health and substance abuse treatment. Reentry programs should address other risk factors, such as housing, that are known to be closely related to recidivism (Kesten et al.).

Improvements to reentry assistance should not only focus on the provision of material services, but also it should address the emotional components associated with prison release. Emotional and relationship issues regularly promote recidivism (Shinkfield & Graffam, 2010). Depression and anxiety are also significantly higher among prisoners than among the general population, and these symptoms often increase under the stress of reentry (Shinkfield & Graffam). Most of the support provided to inmates before reentry focuses on information and material services, without providing assistance for coping with the emotional challenges of incarceration and reentry; more attention should be given to lessening this psychological distress so that offenders are empowered upon their release (Shinkfield & Graffam). Integration into the community will be facilitated if offenders leave corrections with lower levels of psychological distress. Mentally ill offenders face the compounded stigma upon release of having both a mental illness and a criminal record (Hartwell, 2003). Social barriers like stigmatization lead parolees to become discouraged from seeking care at all (Marlow et al., 2010). Thus, clinical health professionals should engage in motivational interviewing, nonviolent communication, and other compassionate and encouraging treatment styles to promote adherence among these emotionally fragile individuals (Marlow et al.). Coupling improved services with quality emotional care is a comprehensive reentry strategy to help reduce recidivism among mentally ill offenders.

Proposed Reforms

Community Mental Health Services

The first critical step to reducing the involvement of mentally ill people in the criminal justice system actually begins by addressing flaws in the community mental health system. Developing a system that effectively diverts mentally ill people from the criminal justice system and into community mental health services is the ultimate goal (Baillargeon, Binswanger et al., 2009). It has been over fifty years since the deinstitutionalization movement, yet most areas in the United States still suffer from serious deficits in available mental health services within their communities (Baillargeon, Binswanger et al.). Without services to assist mentally ill people in the general community, these individuals are at increased risk for falling into the criminal justice system.

State legislators need to allocate more funding for community mental health programs to increase the availability of these services and to make it easier to enter the mental health system (Thompson, Reuland, & Souweine, 2003). Inteased of investing in social institutions and supportive networks that might decrease crime rates, the state diverts the majority of its funding to prisons, only increasing incarceration rates (Dlugacz, 2014). The increase of government spending on social programs often meets strong resistance, especially for those who fear tax increases as a consequence of these programs. However, in the current setup of the United States criminal justice system, it costs about $9 billion a year to imprison mentally ill offenders (Blevins & Soderstrom, 2015). By providing adequate treatment as an alternative to incarceration, communities ultimately minimize costs and use of resources (Collins et al., 2017).

In addition to increasing the general availability of mental health services, communities must restructure the nature of these services. Community treatment programs focus almost

exclusively on the treatment of psychiatric symptoms, rather than employing a more integrative approach that would address the unique constellation of needs faced by those with severe mental illness (Baillargeon, Williams et al., 2009). Many mentally ill clients who enter the mental health system have weak social support systems, lack vocational skills, and do not have sufficient housing options. If these obstacles are not addressed, most mentally ill patients will benefit little from the psychiatric help their clinicians try to provide (Lamb & Weinberger, 2014). Community mental health treatment should incorporate social services that assist mentally ill people with finding stable housing, employment, and social support in addition to providing them with psychiatric care.

Some might argue that enhanced mental health services alone will not significantly reduce recidivism rates among mentally ill people because they do not manage the many other criminal risk factors that promote criminal behavior among mentally ill and mentally health people alike. Partly, this concern is addressed by incorporating assistance with housing, employment, and other salient criminal risk factors into mental health services. Moreover, some therapeutic interventions do more than simply reduce psychiatric symptoms--these therapies create neural and physiological changes that could mitigate criminal risk (Newsome & Cullen, 2017).

Cognitive Behavioral Therapy (CBT), one of the most highly-valued modern psychological treatments, produces such changes. A 2014 review showed that CBT was linked to actual alterations in neurobiology. Children who underwent CBT exhibited decreased activation of the ventral prefrontal cortex, which is linked to improved emotional regulation and decreases in behavioral problems. Another study indicated similar decreases in the prefrontal cortex and the anterior medial temporal lobe among children who showed increased self-regulation after

CBT (Newsome & Cullen, 2017). CBT has also been linked to physiological changes, including changes in resting cortisol levels, heart rate, and skin conductance (Newsome & Cullen). Especially when clinicians use CBT to focus on adapting people's criminal thinking and attitudes, it can help reduce recidivism rates in mentally ill and mentally healthy offenders alike (Peterson et al., 2014). CBT can reduce psychiatric symptoms while simultaneously reworking criminal tendencies in mentally ill people who are at risk for criminality.

Growing empirical evidence also supports the efficacy of Mindfulness-Based Treatment (MBT) for individuals with criminal risk. This therapeutic approach helps people to increase their self-awareness, attention, and self-regulation (Newsome & Cullen, 2017). Although the treatment needs to be further researched, there are indications that it improves functioning in emotional regions like the limbic system and in executive decision-making regions like the prefrontal cortex (Newsome & Cullen). Thus, mental health treatments like CBT and MBT may help reduce recidivism by concurrently treating both psychiatric symptoms and criminal risks. Through the delivery of these treatments, mental health services do appear capable of reducing recidivism rates.

Finally, an integrative mental health treatment program should simultaneously address both mental illness and substance use issues. When these programs remain separate, it is difficult to develop treatment plans that meet the specific needs of those who suffer from the common comorbidity of mental illness and substance abuse (Baillargeon, Williams et al., 2009). Treatment should address substance abuse problems in order to be more valuable and effective. By increasing the availability of community mental health services overall and widening the scope of the treatments that are provided, the mental health system will reduce the likelihood of mentally ill people becoming entangled in the criminal justice system.

Interactions with Law Enforcement

The reforms for community law enforcement are three-fold. The first necessary adjustment is to build better relationships and communication between police officers and mental health professionals. Many police officers are unaware of the mental health services that might be available to mentally ill people, so they are more likely to arrest these people than to divert them to more effective community resources (Ogloff et al., 2013). To take the most beneficial course of action, law enforcement needs to be aware of the mental health resources in their area and of how to connect citizens to these services (Thompson et al., 2003). Communication between community mental health systems and law enforcement can help ensure that police officers divert mentally ill people to appropriate resources instead of resorting to arrest. To make this communication effective, mental health professionals and law enforcement also need to cooperate to build more mutually respectful relationships. When police officers do divert people to mental health resources, the wait for psychiatric services takes a significant amount of time, and clinicians do not always trust officers' judgment,often turning away or quickly releasing the individuals who the officers bring to them for help (Lamb et al., 2002). Fostering healthy relationships between mental health services and law enforcement will increase the likelihood that people will be diverted to proper treatment instead of entering the criminal justice system.

The second important reform involves increased mental health training for law enforcement. Despite their frequent interactions with mentally ill people, most police officers cannot accurately recognize mental illness symptoms. Police methods for identifying mental illness have been shown to misclassify almost half of police detainees (Ogloff et al., 2013). As a result, sometimes officers arrest people for minor crimes instead of diverting them to services because they mislabel mental illness symptoms as being the product of illegal substances or as

simply disruptive behavior (Lamb et al., 2002). Officers need to receive more extensive training on how to recognize signs of mental illness, how to respond effectively to these symptoms, and how to respond to symptom-driven threats of violence or suicide (Lamb et al.). Providing law enforcement with mental health training will give them greater confidence to make the right decisions during interactions with mentally ill people, which should lead to better responses in situations involving mental illness.

The most significant reform will be to actually incorporate clinicians into law enforcement responses to psychiatric crises. While there is concern about the monetary costs attached to this reform, crisis teams may actually help reduce costs by resolving psychiatric crises without having to refer people to hospitals or jails and instead connecting them to mental health services (Lamb et al., 2002). The ideal crisis teams include mental health professionals--either at the scene or over the phone--who can provide assistance to officers in real time as the crisis progresses (Lamb et al.). This reform relieves some of the burden typically placed on law enforcement to serve as lay psychologists in addition to their other responsibilities, and it also helps officers to respond more appropriately to the needs of mentally ill people in distress.

Court Systems

Reforms in the court system will require expanded development of mental health and drug courts so that they are more widely available, particularly in low-income areas. The limited development of problem-solving courts up to this point has translated to an overrepresentation of middle-aged white males in these diversionary programs, whereas young minority males are still far more likely to be incarcerated instead (Landess & Holoyda, 2017). Everyone should have equal access to these programs. All problem-solving courts should also be governed by more uniform, evidence-based strategies so that participation in the program is equally advantageous

regardless of location. Right now, there are great discrepancies in the processes and methods used in mental health courts (Kopelovich et al., 2013). Increased research on what works in mental health courts will help them to become even more effective and streamlined in reducing recidivism (Kopelovich et al.). Identifying the best practices will make these diversionary programs more productive and efficient.

Most importantly, the process through which people enter mental health courts needs to be revised. Probation officers in one mental health court note that people who are eligible for or who would benefit from the program are frequently missed. This omission arises because not everyone undergoes a clinical evaluation prior to entering the traditional court system. Instead, attorneys typically use their own judgment to refer their clients to programs in the problem-solving courts, and not all attorneys are equally familiar with diversionary opportunities or equally adept at recognizing pertinent mental illness symptoms (A. Kohlmann & E. Villiesse, personal communication, January 26, 2018). This informal process leads to an inequality of opportunity to participate in these programs. Everyone should receive a psychiatric evaluation by a qualified professional upon arrest, and people should be given the opportunity to enter diversionary programs based on the outcome of these assessments, not based on their attorney's judgment. These reforms will make diversionary opportunities more readily available to anyone who legitimately qualifies for these programs.

Incarceration

Opportunities for reform in correctional facilities emerge from the moment an offender becomes incarcerated. One of the first ways to increase offender access to essential treatments is through more accurate diagnostic assessment. In accordance with APA recommendations, mental health screenings should be conducted by a psychologist or psychiatrist--or conducted

under their supervision--using a standardized instrument (Blevins & Soderstrom, 2015). These screenings are critical because they determine whether or not the offender gets access to treatment, and earlier intervention is always better (Martin et al., 2016). In addition to the initial screenings, follow-up screenings should be implemented with relative frequency. Although studies have not identified a specific interval after which people should be reassessed, follow-ups should likely occur at least every few months to accommodate the quick rate at which mental illnesses can change (Blevins & Soderstrom). Screening early and often is the best initial course of action to make sure offenders' treatment needs are being met.

In order to meet diagnostic and treatment needs, correctional facilities need to hire more clinicians. The current averages--about one psychiatrist for every 1,528 inmates and one psychologist for every 932 inmates--are not nearly adequate for providing quality treatment to all the incarcerated people who need it (Blevins & Soderstrom, 2015). Increasing the number of clinicians on staff will better address the substantial treatment needs in these facilities, and it will allow these treatments to become more individualized. A greater clinical presence also promotes a more rehabilitative focus within the institution. Currently, about half of the states in America cite insufficient staff and resources as one of the key obstacles to providing effective treatment. Only 16 states report that they provide substance abuse treatment with a mental health professional present, in spite of the exorbitant rates of substance abuse among offenders (Blevins & Soderstrom). More mental health staff means increased availability and quality of treatments for incarcerated offenders.

Providing better substance abuse treatment in corrections may also lessen the risk of medication diversion among offenders who require psychotropics. Reducing problems of substance abuse in the facility will lessen the demand for these medications and thus lower rates

of diversion and misuse. With more clinical staff, the administration of medications can also be more closely monitored, and serum drug tests can be more readily issued to track adherence to medication regimens (Pilkinton & Pilkinton, 2014). While the additional staff and drug testing are costly, these improvements facilitate declines in medication diversion and recidivism that make them less financially draining to the institution in the long term (Pilkinton & Pilkinton). Clinicians are worth the expense.

Above all, correctional institutions need to prioritize reciprocal communication and support between correctional officers and clinical staff. Mental health staff need to help correctional officials to understand mental illness because many of these offers are likely to interpret signs and symptoms as simply attempts to avoid punishment (Collins et al., 2017). Officers who hold this view are less likely to recognize and share relevant information with clinicians about an offender's well-being. Officer skepticism about mental illness is highly problematic because mental health staff rely on insights from correctional officers about offenders' daily behavior in order to develop and carry out effective rehabilitation plans (Lavoie, Connolly, & Roesch, 2006). Mutual understanding is the key to promoting productive communication between clinical and correctional staff. Mental health staff need to be aware of the security measures that correctional officers must uphold to keep the facility running smoothly, and correctional officers need to receive training that provides education on mental illness. Reciprocal understanding, coupled with a commitment to personal communication and mutual respect, will foster cooperation between correctional and mental health staff. This collaboration benefits offenders by prompting earlier interventions and better treatment plans.

Reentry Services

The final major domain for reform is the services that are provided to offenders immediately prior to and immediately following their release from a correctional facility. When surveyed, about half of state correctional institutions reported having insufficient reentry resources for offenders (Blevins & Soderstrom, 2015). Because most recidivism occurs in the year after an individual is released from corrections, connecting offenders to services that will allow them to continue their treatment is of the utmost importance (Kesten et al., 2012). In addition to providing offenders with medication for the first few months after release and connecting them to community mental health services, reentry preparation should involve assistance in acquiring insurance, housing, and employment.

Prior to release, correctional facilities should also institute programs that prepare offenders for the emotional challenges of reentry into the community (Shinkfield & Graffam, 2010). The ability to cope with life outside of prison is perhaps equally important to the material services that offenders need after they are released. When offenders are reenter the community, they should remain under supervision for a period of time to assist them with the transition and to help them adhere to necessary treatments. Research has found that recidivism rates are lower among those who are placed under supervision after their release from corrections (Serowik & Yanos, 2013). The transition back into public life is a critical time for reducing the likelihood that someone will recidivate and for helping people to get their lives back on track, so a detailed reentry plan is essential.

Conclusion

The United States criminal justice system requires sweeping reforms that are not limited to increased mental health treatment. However, providing offenders with adequate and

comprehensive mental health care not only significantly reduces initial offending and recidivism rates, but also it represents a colossal shift in the American justice perspective from a punitive to a rehabilitative approach. A look into the treatment of mentally ill people in the criminal justice system reveals the larger ethical dilemma in the way the United States treats those who break the law. It uncovers the many failings in the punitive philosophy: principally, that punitive practices have been proven time and again to be ineffectual, while a striking amount of research supports the countless benefits of rehabilitation. To move away from punishment and toward rehabilitation, legislators will need to pass the necessary bills to reallocate funding and create systemic reform (Thompson et al., 2003). Gaining legislative support will likely only come as a consequence of public support or outrage, meaning that the real first step toward reform begins at the grassroots level. Mental health workers, advocacy groups, and independent activists must educate the public in order to alter their perceptions of mental illness, criminal behavior, and the role of the justice system (Thompson et al.). Widespread reform may be slow to materialize, but many small steps toward an improved justice system have already begun. Now is the time to capitalize on this momentum to transform the antiquated system and develop an approach to justice that is grounded in compassion and reason.

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