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The Benefits of Shifting from a Punitive Justice System to One that is Mental Health Aware

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Honors Thesis

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Abstract

Since the 1950's there has been an increasingly large population of individuals suffering from psychological disorders within the United States criminal justice system. Many psychiatrists and psychologists attribute this rising population to deinstitutionalization, a period in which psychiatric hospitals drastically reduced the number of patients they would serve. As a result, a larger amount of persons suffering from psychological disorders were released into society, where their symptoms are sometimes misinterpreted and criminalized, thus involving the criminal justice system. In response to this growing population the criminal justice system has begun to implement several methods for handling individuals suffering from psychological disorders. In this paper, I will assess the benefits of the criminal justice system shifting away from a purely punitive approach towards one that is mentally health aware. In order to accomplish this I will be examining the various methods the criminal justice system has begun to apply, such as mental health courts, treatment programs within the prison system, jail diversion programs, and the array treatment referral programs for post incarceration. This analysis involves the perceived success from the vantage points of the criminal justice system, the mental health experts involved, and the individual participants, as well as statistical evidence such as recidivism rates, improvement in behavior and symptoms, and improvements in quality of life. Finally, I propose a combination of the presented programs that provide the most beneficial care and outcomes, in the hopes that federal policy will make the necessary changes to beneficially serve individuals suffering from psychological disorders.

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Introduction

Extensive research suggests there is a large population of persons suffering from psychological disorders within the criminal justice system. For the purposes of this thesis the terms psychological disorder and mental illness are interchangeable; however, only psychological disorder will be used due to the stigmatizing nature of the term mental illness. The criminal justice system, for the purposes of this thesis, refers to police departments, court systems, and both the prison and jail systems. The National Commission on Correctional Health Care found that roughly 10 to 19 percent of people in city and county jails, 18 to 27 percent of people in state prisons, and 16 to 21 percent of people in federal prisons suffer from psychological disorder(s) (Lamb, Weinberger, Marsh, & Gross, 2007). Some common psychological disorders present in the criminal justice system are schizophrenia, major depression, bipolar disorder, mania, manic-depressive disorder, post-traumatic stress disorder, and co-occurring substance abuse disorders (Lamb & Weinberger, 1998; Dunnegan, 1997; Gordon, Barnes, & VanBenschoten, 2006). Due to the disproportionate amount of persons in the criminal justice system who are suffering from psychological disorders, this thesis discusses the benefits of shifting from a punitive justice system to one that is mental health aware.

Many psychologists and psychiatrists have perceived the tremendous amount of individuals with psychological disorders within the criminal justice system as the result of “deinstitutionalization” (Lamb & Weinberger, 1998). Deinstitutionalization refers to the period roughly between 1955 and 2000 when psychiatric hospitals decreased the amounts of beds and patients they would provide (Prins, 2011). For example, treatment occurrence in psychiatric state hospitals dropped from 77 to 28 percent, while the number of beds in psychiatric state hospitals dropped from 339 per 100,000 to 22 per 100,000 (Prins, 2011). The tremendous decrease of

hospitalization of individuals suffering from severe psychological disorders led to an increase of this population within society.

Due to the transinstitutionalization, or the interdependency of each system on the other, the criminal justice system and the Psychiatric Hospitalization system, many believe that decreasing one system's involvement with the persons suffering from psychological disorders increases the other system's involvement (Lamb & Weinberger, 1998). Following this logic, as the treatment and hospitalization opportunities decreased over time, the persons suffering from psychological disorders became increasingly criminalized as the criminal justice system's involvement inversely increased. It also leads many to the solution of increasing treatment opportunities as a means to remove and avert the individuals with psychological disorders from becoming further involved with the criminal justice system (Prins, 2011).

While this relationship may not seem so direct, many within the psychology fields believe that the period of deinstitutionalization provided the groundwork for the criminalization of individuals suffering from psychological disorders (Lamb & Weinberger, 1998; Prins, 2011). While many argue over the definition of criminalization, for the purposes of this paper it refers to the phenomenon of those suffering from psychological disorders being arrested for minor offenses, rather than being placed into treatment (Lamb & Weinberger, 1998). The decrease in long-term treatment for individuals suffering from psychological disorders led to society being exposed to the possibly deviant behavior of these individuals with psychological disorders. Deviant behavior refers to any behavior that contradicts society's perceived acceptable behaviors, including those behaviors that are considered illegal. Society as a whole has a limited range of tolerance of such deviant behavior and it is believed that if this behavior is not remedied, by placing the individuals suffering from psychological disorders in the mental health

system, then society will put pressure on the criminal justice system to respond (Lamb & Weinberger, 1998). During the period of deinstitutionalization, the criminalization of persons suffering from psychological disorders increased drastically.

There are others within the psychology field that argue that deinstitutionalization is not responsible for the large shift in the amount of persons suffering from psychological disorders within the criminal justice system. One main argument is that deinstitutionalization did not cause a rush of individuals suffering from psychological disorders to the streets because many were placed in general hospitals or nursing homes as a result of the introduction of programs like Medicaid (Prins, 2011). Further, studies have found that those suffering from psychological disorders who are incarcerated and those individuals suffering from psychological disorders within psychiatric hospitals have different characteristics, suggesting that the two populations are inherently different (Prins, 2011). However, the evidence for this argument is mixed, with some studies finding great difference between the two populations and others finding very little difference (Lamb & Weinberger, 1998). Finally, the last core argument against deinstitutionalization is the fact that community based treatment is effective (Prins, 2011). This is an argument that deinstitutionalization is not a real phenomenon because those who believe in deinstitutionalization argue that the individuals suffering from psychological disorders did not have as reliable or effective treatment options after the psychiatric hospitals closed (Prins, 2011). Therefore, if community-based treatment, which has remained available, is determined to be effective then the argument that there were not adequate treatment options is unsupported. While there are effective community-based treatment options available, funding for these programs is often limited and prevents service to the many individuals who need it. The argument that community-based treatment is effective matters little if the existence of community-based

treatment is lacking in areas of need.

Regardless of which side of the argument mental health professionals fall on, it is agreed that there are an overwhelming number of individuals suffering from psychological disorders within the criminal justice system and the criminal justice system cannot provide the ideal treatment for this population (Prins, 2011). The argument itself is important in that it shapes professionals' mindsets on solutions to the problem of individuals suffering from psychological disorders within the criminal justice system. For example, those that believe that deinstitutionalization is responsible may argue for more funding for psychiatric hospitalization and community-based treatment. They argue that decrease in this treatment caused an increase in individuals suffering from psychological disorders within the criminal justice system because they did not have proper treatment options available to them (Prins, 2011). On the other hand, those that do not believe in the reality of deinstitutionalization may deem funding for psychiatric hospitals as a waste of money (Prins, 2011). This is because they would argue that community based treatment helps most individuals suffering from psychological disorders and putting large amounts of money into psychiatric treatment would only service a small group of individuals with psychological disorders. These theorists argue that funding would be better spent on other factors that predispose the individuals suffering from psychological disorders to become involved with the criminal justice system, such as providing housing and aiding in job placement (Prins, 2011). The various solutions and methods will be reviewed further on in this work; however, it is important to first understand how someone suffering from psychological disorders could become involved with the criminal justice system.

There are many factors that put the individuals suffering from psychological disorders at an increased risk of arrest, and the intolerance of their deviant behavior is one. The community's

level of tolerance for behavior of the individual suffering from psychological disorders largely determines whether or not the person will be arrested. If the community has low tolerance, then the community will exert informal social control in such a way that the police will respond to the individual suffering from psychological disorders, involving them with the criminal justice system (Lamb & Weinberger, 1998). The community's level of tolerance and the criminalization of the individuals suffering from psychological disorders are inversely related: as one increases the other decreases (Lamb & Weinberger, 1998). As the community becomes less tolerant, the behavior of the individuals suffering from psychological disorders becomes more criminalized and the individuals suffering from psychological disorders become targets for the criminal justice system.

The lack of treatment opportunities for one suffering from psychological disorders further exacerbates this phenomenon. As Penrose theorized in 1939, there is an inverse relationship between prison populations and psychiatric hospital populations (Lamb & Weinberger, 1998). Reduced treatment opportunities could result in a lack of control over the deviant behaviors that are simply a symptom or indicator of their disorder (Lamb & Weinberger, 1998). These deviant behaviors have the possibility of causing the untreated individual suffering from psychological disorders to be arrested usually for minor offenses, thus representing the criminalization of psychological disorders. There are those suffering from psychological disorders that commit serious offenses and many believe that they should be processed through the criminal justice system (Lamb & Weinberger, 1998). However, many claim that these persons may never have committed these serious crimes had they been receiving sufficient treatment, which has been scarcer since the deinstitutionalization period (Lamb & Weinberger, 1998).

Dierkhising, Ko, Jaeger, Briggs, Lee, and Pynoos help provide a more specific picture of

how someone suffering from psychological disorders could become involved with the criminal justice system. Within their study of juvenile justice involved youth, they analyzed how these youth develop Post Traumatic Stress Disorder and how this leads to more involvement within the justice system (Dierkhising et al., 2013). This study found that ninety percent of the juvenile justice involved youth experienced multiple traumas before their involvement with the juvenile justice system. This trauma exposure led 23.6 percent to meet the clinical diagnosis for Post Traumatic Stress Disorder, with more reaching the clinical range on one symptom cluster. Two-thirds of the sample reported the externalization of problems using methods such as rule-breaking and aggressive behavior. In addition, roughly forty-five percent of the sample population reported the use of substances or alcohol as a form of coping (Dierkhising et al., 2013). Behaviors such as rule-breaking, aggressive behavior, and alcohol and substance use increase youths' risks of becoming involved with the juvenile justice system, despite these behaviors being symptoms of psychological disorders. From this study, it is easier to see how symptoms could be construed as deviant behavior that results in the involvement of the criminal justice system.

In addition, there has been an emerging correlation between violence and psychological disorders that could easily contribute to the criminal justice system's involvement with the individuals suffering from psychological disorders (Lamb & Weinberger, 1998). Previous experience of violent victimization or trauma, such as those suffering from Post Traumatic Stress Disorder, alters how one perceives violence in social interactions (Dunnegan, 1997). Dunnegan, who works with violent offenders suffering from psychological disorders in the Jail Psychiatric Services in San Francisco, argues, "in situations of powerlessness [...] humans can develop patterns of defiant violent reactions" (1997, p. 348). These violent reactions can be traced back to

shame, which Dunnegan suggests results from many things, but in particular knowing one has broken the rules of society (1997). In this regard shame refers to “the pain associated with some perceived deficiency in the self” (Dunnegan, 1997, p. 348). She stresses the importance of recognizing signs that the individual feels shame, which is often disguised by aggression, defiance, or depression (Dunnegan, 1997). Addressing the underlying shame is crucial to relieving the pain and ending the violent outbursts, as Dunnegan argues (1997).

This distinction hints at the presence of a subpopulation of individuals suffering from psychological disorders who are more violent than the general population of individuals suffering from psychological disorders (Lamb & Weinberger, 1998). Theorists generally believe that the violent behavior of this subgroup creates a negative stigma that is generalized to the entire individuals suffering from psychological disorders (Lamb & Weinberger, 1998). As James Gilligan, the former Director of Mental Health for Massachusetts prison system and the director of the Center for the Study of Violence at Harvard Medical School, once said,

“ Punishing requires much less effort than does understanding the many different forms of violence: learning what variety and interaction of biological, psychological, and social forces cause the different forms of violence. It is easier and less threatening to condemn violence so that we can punish it, rather than seeking its causes and working to prevent it” (Dunnegan, 1997, p. 346). The spread of this stigma increases the amount of criminal justice contact that the individuals suffering from psychological disorders faces because there is a common belief that they have strong potential to become violent and a danger to the populace. In this regard, it is important to note that not all psychological disorders are the same or require the same level of treatment. It is extremely likely that this small subpopulation requires intensive treatment within a secure facility, which would be unnecessary for other individuals suffering from psychological

disorders.

Substance abuse and improper or nonexistent self-administration of medications have been shown to exacerbate this correlation between violence and psychological disorders (Lamb & Weinberger, 1998). Dunnegan (1997) explains the many reasons why substance abuse and psychological disorders often correlate. She explains that drugs allow one to escape the rules of society, to separate oneself from the current situation, allowing one to hurt another and deny responsibility for the act (Dunnegan, 1997). In particular, individuals suffering from Post Traumatic Stress Disorder often have the additional incentive to use substances to self-medicate (Dunnegan, 1997). Dunnegan (1997) asserts that substances aid the individual in dissociation from the pain of the trauma they faced. In addition, the combination of trauma, which occurs in more cases than the individuals suffering from Post Traumatic Stress Disorder, and substance use can lead to violence as a pathway to reenact the trauma from a point of power rather than helplessness (Dunnegan, 1997). This combination suggests a need for a specific treatment model that recognizes that the individuals suffering from psychological disorders perceive violence as a healing tool with drugs being a catalyst.

Seventy-two percent of the individuals with psychological disorders within the criminal justice system are diagnosed with a co-occurring substance abuse disorder (Gordon, Barnes, & VanBenschoten, 2006). This co-occurrence is so prevalent that numerous programs, several of which will be explored later on, have been developed that solely focus on the co-occurring diagnosis (Gordon, Barnes, & VanBenschoten, 2006; Peters, LeVasseur, & Chandler, 2004). While the prevalence is high, the co-occurring disorder is often missed when the individual becomes involved with the criminal justice system (Peters, LeVasseur, Chandler, 2004). This is often due to a lack of or poor screening methods and leads to considerable consequences, such as

misdiagnosis, and a lack of or inadequate treatment options (Peters, LeVasseur, Chandler, 2004). Since the co-disorder is difficult to diagnose before arrest, the reasoning for arrest is often similar to the previously mentioned factors. However, this population is different from those diagnosed solely with psychological disorders, in that they have more substantial psychosocial problems, and larger cognitive and functional deficits (Peters, LeVasseur, Chandler, 2004). These issues likely exaggerate the symptoms of their psychological disorders and contribute to their contact with the criminal justice system.

However, there are factors other than the psychological disorders itself that increase the person's chances of involvement with the criminal justice system. One of the most predominant and devastating co-occurring factors that increases their risk is homelessness. Studies have found astounding numbers of criminal justice involved individuals suffering from psychological disorders who were homeless at the time of their arrest (Lamb & Weinberger, 1998). For example, one study found that within a random sample of 102 jail inmates who had been referred to psychiatric services more than half of those charged with misdemeanors had been homeless and eighty-eight percent were unemployed (Lamb & Weinberger, 1998). This trend is common and well documented: another study in New York City found that defendants suffering from psychological disorders were twenty-one times more likely to be homeless than the population of individuals suffering from psychological disorders within the city (Lamb & Weinberger, 1998). This trend suggests that the co-occurrence of homelessness and psychological disorders place individuals suffering from psychological disorders at an increased risk for criminal justice involvement.

The individual suffering from psychological disorders' presence in the public space allows for all of their behaviors and actions to be exposed to society. Individuals suffering from

psychological disorders who are homeless are unlikely to be in adequate treatment, which may result in improper management of their disorder (Lamb & Weinberger, 1998). Improper management of their disorder could lead to deviant behaviors that are simply symptoms of their disorder. Some suggest that those who commit misdemeanor offenses, that are relatively minor, are asking for help (Lamb & Weinberger, 1998). These deviant behaviors are on full display for the public, due to the individual's status as a homeless person. Depending on the tolerance of the community for both psychological disorders and homeless persons, the criminal justice system responds to the public's discomfort.

Police Interaction

It is clear that many factors lead to the involvement of the individuals suffering from psychological disorders with the criminal justice system. Therefore, unless there are drastic changes to the level of the involvement of the criminal justice system, then the criminal justice system needs to be appropriately prepared for such involvement. Police Officers are almost always the first point of contact for the criminal justice system. It is imperative that police officers are trained in proper methods of response to their calls for service, whether they are order maintenance or crime control oriented. Responding to situations that involve the individuals suffering from psychological disorders require even more careful finesse and awareness. Several aspects of this point of contact make it difficult for police officers to respond in a way that benefits both the officer and the individual suffering from psychological disorders.

The first issue may be that it is difficult for the officer to determine that the individual is suffering from a psychological disorder and exhibiting symptomatic behavior at that time (Lamb & Weinberger, 1998). If the individual has a coexisting substance abuse disorder this further disguises any symptomatic behavior (Lamb & Weinberger, 1998). Further, any symptoms that

are displayed may mislead the police officer into believing that the individual is intoxicated rather than suffering from psychological disorders, whether they actually are or not (Lamb & Weinberger, 1998). This detection issue suggests that it is crucial that police officers are trained in how to recognize signs of psychological disorders as well as techniques for managing the situations.

However, if the police officer does recognize the individual as suffering from psychological disorders then the officer faces a variety of other complications. The police officer may choose to take the individual to the hospital, which usually results in a short stay before they are released back onto the street (Lamb & Weinberger, 1998). This is another complication because the police officer may be called to the same situation a few days later; this will cause the officer to become discouraged with this method of aid. It is this particular situation that often leads officers to perform what are known as “mercy bookings”, where the officer’s best hope of providing any form of treatment services is to arrest the individual (Lamb & Weinberger, 1998). Arresting someone who is suffering from psychological disorders provides the individual with the opportunity to be evaluated by a mental health professional who is connected to the criminal justice system, which may lead to recommendations for treatment (Lamb & Weinberger, 1998). Police officers choose this route because they believe it will provide the best outcome; however, it is probable that if there were another viable option available to the police that did not result in the mass incarceration of the individuals suffering from psychological disorders they would take it.

The Worcester Police Department is an excellent example of a police department experimenting with other methods for handling situations involving individuals suffering from psychological disorders. To achieve this development the Worcester Police Department has been

collaborating with the Worcester Diversion Consortium with the mission “to identify service strengths and gaps in delivering effective, integrated services to persons suffering with psychological disorders, substance abuse, and/or homelessness issues” (Grudzinskas, Clayfield, Roy-Bujnowski, Fisher & Richardson, 2005, p. 288). The Worcester Diversion Consortium is itself collaboration between the Massachusetts Mental Health Diversion and Integration Program and law enforcement, treatment or service providers, research professionals and consumer advocates. It is clear from the mission statement that Worcester is attempting to provide a dedicated effort to the best aid for their individuals suffering from psychological disorders. In addition, these groups meet regularly to discuss and assess solutions for the issues individuals suffering from psychological disorders are facing, interagency cooperation and communication, and ensure the sharing of resources (Grudzinskas et al., 2005).

The Worcester Police Department broached two concerns with the Worcester Diversion Consortium (Grudzinskas et al., 2005). One was the desire for the entire police department to receive adequate training in how to handle situations involving the individuals suffering from psychological disorders. The other was to provide adequate solutions and opportunities for the police officers to turn the individuals suffering from psychological disorders into places of treatment. The Worcester Police Department was very familiar with the previously mentioned issues of difficulties checking the individual into the hospital and the individual being released quickly and returning to the streets (Grudzinskas et al., 2005). Therefore, the Worcester Diversion Consortium was eager to collaborate with the Worcester Police Department on ways to improve intake as well as treatment referral options.

The Worcester Diversion Consortium utilized its composition of treatment and service providers and advocates, law enforcement, and research professionals to combine resources and

services to develop solutions to the chronic arresting of individuals suffering from psychological disorders (Grudzinskas et al., 2005). Through constant communication they discovered several difficulties with obtaining services, many of which can most likely be generalized to other towns and cities. The main difficulties presented were

“a lack of health insurance for our target population, which limits treatment options; the stigma of being involved with the criminal justice system and how it limits access for our target population to programs and housing; poor communication between agencies in regards to referrals and feedback to help ensure our target population does not fall through the cracks; the lack of familiarity with (and faith in) other organizations of the WDC and the services they provide; and restrictive eligibility criteria. (Grudzinskas et al., 2005, p. 289-90)

The Worcester Diversion Consortium approached these problems the same way they approached the larger issue of the criminalization of their target population: with open communication and sharing of resources between agencies.

The efforts of the Worcester Diversion Consortium are currently ongoing; therefore, it is too early to evaluate all of their solutions. However, there are some clear successes from the collaboration between the Worcester Diversion Consortium and the Worcester Police Department. The Worcester Diversion Consortium’s commitment to constant open communication between the service agencies, law enforcement, research professionals, and mental health consumer advocates is a rarity that has allowed them to form solutions and strategies for meeting the needs of the individuals suffering from psychological disorders. One essential feature they have developed is the monthly meetings between agencies to discuss improvements for service integration (Grudzinskas et al., 2005). Similar teams of mental health

professionals and police officers in other locations have proven quite successful responding to situations involving individuals suffering from psychological disorders and diverting them to treatment rather than incarceration (Lamb & Weinberger, 1998). In addition to the successful interagency collaboration, the Massachusetts Mental Health Diversion and Integration Program focuses on alternative solutions for individuals suffering from psychological disorders, especially those that are criminally justice involved (Grudzinskas et al., 2005). However, the network of services between agencies that the Worcester Diversion Consortium is tasked with forming needs to be in place before diversion can be useful.

Mental Health Courts

The mental health courts in particular are a recent development in an attempt to offer alternative solutions to incarceration for criminally justice involved individuals suffering from psychological disorders (Grudzinskas et al., 2005). As Penrose's hydraulic model suggests, the correctional individuals suffering from psychological disorders and the psychiatric facility population are inversely related, meaning as one increases the other decreases (Grudzinskas et al., 2005). Following this model, diverting non-violent individuals and individuals with minor offenses into treatment rather than incarceration increases the psychiatric facility population and decreases the correctional population. This is the ultimate goal of mental health courts, to ensure that the maximum amounts of individuals suffering from psychological disorders are receiving treatment rather than incarceration. It is important to note that psychological disorders should not be the only qualifier for diversion; there are individuals suffering from psychological disorders who may be too dangerous to divert to a psychiatric institution. In these instances a more secure treatment facility or a high security treatment unit within a correctional facility would be a more useful service modality. With that said, mental health courts provide an essential opportunity to

receive community-based treatment for those that need it.

Mental health courts are a form of specialty court that has developed out of a shift in thought of the role of the courts in society (Grudzinskas et al., 2005). Traditionally, courts have served as a way to resolve situations where there are disagreements over whether or not laws were broken (Grudzinskas et al., 2005). On the other hand, specialty courts revolve around determining and resolving the underlying cause of the disagreement, providing a solution that deters the further involvement of the court system (Grudzinskas et al., 2005). In the case of mental health courts the underlying cause of the dispute is usually the untreated symptoms of a psychological disorder that the perpetrator is suffering from and the logical resulting solution is usually to place the individual into treatment (Grudzinskas et al., 2005). In general, there are two forms of jail diversion programs; those that divert before arrest, known as pre-booking programs, and those that divert after arrest but before sentencing, known as post-booking programs (Gordon, Barnes & VanBenschoten, 2006). Mental health courts, similarly to all specialty courts, employ judges who have a mental health specialization in the handling of legal matters (Grudzinskas et al., 2005).

Due to the subjectivity of sentencing in mental health courts, judges have a lot of flexibility when determining the best sentence for each individual case (Grudzinskas et al., 2005). For example, in a county of Florida, a judge sentences individuals suffering from psychological disorders to treatment under probation supervision, where any violation bears the possibility of incarceration (Grudzinskas et al., 2005). Meanwhile, in the district courts of Massachusetts, both the defendant and the judge agree on a treatment plan, which will be served over a probationary period and upon its completion the case will be dismissed (Grudzinskas et al., 2005). The Massachusetts approach recognizes the necessity of the individual's willingness

to enter treatment, however, both Florida and Massachusetts utilize the authoritative power of the courts to encourage fulfillment of the treatment plans (Grudzinskas et al., 2005). Many debate the benefits and ethics of involuntary treatment enrollment; however, it is crucial to recognize that some cases that come before the mental health court require more intensive treatment structure than the individual may desire (Lamb & Weinberger, 1998).

There are two key issues that need to be addressed and assessed before cases can proceed: competency to stand trial and criminal responsibility (Grudzinskas et al., 2005). These two sectors become particularly important and difficult to assess within the mental health courts. Competency to stand trial refers to whether or not the individual has adequate comprehension of the court proceedings, charges, and consultation with his or her counsel (Grudzinskas et al., 2005). To assess the level of understanding the accused possesses, the courts usually rely on the occurrence of *actus rea* and *mens rea*, meaning “evil act” and “guilty mind” respectively (Grudzinskas et al., 2005, p. 284). While the *actus rea* is not difficult to determine, in the cases involving individuals suffering from psychological disorders the *mens rea*, or guilty mind, can be more complex to determine, thus making it hard to decide how accountable the accused is for his or her actions (Grudzinskas et al., 2005).

This leads to the other sector that is assessed before court cases can proceed, criminal responsibility. This is most likely the crux of the issue upon which methods of criminalizing psychological disorders and focusing on rehabilitation precariously balance. For the mental health courts the difficulty lies in determining whether the criminal conduct was due to symptoms of a psychological disorder or whether the actions were unrelated (Grudzinskas et al., 2005). Further, it involves the assessment of the individual’s judgment and perception of the illegality of their actions, determining whether or not there is an understanding that the

individual committed a crime (Grudzinskas et al., 2005). If this is lacking, then the accused may not be responsible, meaning in full control, of his or her actions (Grudzinskas et al., 2005). On the other hand, if the accused is determined to be fully aware and comprehending of his or her actions, then the court asserts them as having criminal responsibility (Grudzinskas et al., 2005). This does not necessarily mean that those who are criminally responsible are sent to prison while those who are not receive treatment. The courts still reserve the right to assign individuals to treatment when they believe it is the most reasonable and effective sentence, even if the individual was determined to be criminally responsible (Grudzinskas et al., 2005). These assessments, while considered within the mental health court under a specialized judge, require collaboration between the court systems and clinicians (Grudzinskas et al., 2005).

As the number of mental health courts has risen, they have drawn the scrutiny of the public eye, whose concern led to the development of the “Ten Tenets of Fair and Effective Problem Solving Courts” by the National Legal Aid & Defender Association (Grudzinskas et al., 2005). These tenets apply to all specialty courts and include: voluntary entrance into the specialty court, guilty pleas cannot be requirements for entrance into the specialty court, individuals must be allowed to assess the program options and requirements with their designated counsel, program plans should not be unnecessarily restrictive, and finally when the programs are completed the cases are dismissed and expunged, if possible (Grudzinskas et al., 2005). In addition to these tenets of specialty courts, the National Mental Health Association has developed the “Policy, Principles, Concerns, and Guidelines for dealing with mental health courts” (Grudzinskas et al., 2005). These guidelines state that individuals suffering from psychological disorders should be diverted from the criminal justice system when voluntary treatment is an effective option and any referrals should occur before the arraignment hearing

(Grudzinskas et al., 2005). These guidelines are important for limiting the amount of time the individual suffering from psychological disorders is involved with the criminal justice system. Similarly to the National Legal Aid & Defender Association, the guidelines request that the actions of the individual suffering from psychological disorders are completely voluntary, whether this involves accepting or refusing treatment, and that the treatment options available to the individual are the least restrictive (Grudzinskas et al., 2005). This ties back to the previous point that some cases require more intensive treatment than the individual is willing to participate in. For this reason, deciding what level of treatment to assign the individual becomes a complex issue when considering their willingness. Sometimes individuals who need it most are unwilling to enroll into treatment and the ethics of involuntarily enrolling them into treatment that would be beneficial is constantly debated. Finally, the guidelines urge integrated treatment for those suffering from a co-occurring disorder such as substance abuse, meaning that the individual would receive a combination of treatment methods targeted at substance abuse and psychological disorders (Grudzinskas et al., 2005).

These guidelines and tenets are a crucial protection for the individuals suffering from psychological disorders within the specialty courts. They help to limit the grievances committed against an already targeted population and provide the individual suffering from psychological disorders with as many resource opportunities as possible to make the most informed and involved decision about their own sentencing options. Criminal justice diversion programs allow this population to receive the necessary community-based treatment while avoiding the detrimental effects that being involved in the criminal justice system could have on such a susceptible population. Mental health courts are often responsible for this diversion, by sentencing the individual to a community-based jail diversion treatment program.

Jail Diversion Programs

As previously mentioned there are typically two forms of jail diversion programs: pre-booking and post-booking. Pre-booking refers to programs that divert the individual to treatment before charges are brought whereas post-booking refers to programs that divert individuals once the individual has been arrested (Steadman & Naples, 2005). In general, jail diversion programs have two main goals: reasonably the first is to divert individuals suffering from psychological disorders away from the criminal system, the second is to create the most effective long term and individualized treatment plans for the individuals through a dedication to constant open interagency communication, particularly between the criminal justice system and the mental health and service providers (Grudzinskas et al., 2005).

A national study of six jail diversion programs, three pre-booking and three post-booking, in the Substance Abuse and Mental Health Services Administration (SAMHSA) Jail Diversion Initiative, revealed many benefits to jail diversion programs (Steadman & Naples, 2005). By comparing diverted individuals to non-diverted individuals it was discovered that diverted individuals spent less time in jail, on average by two months. Additionally, the re-arrest rates for the diverted and non-diverted individuals were similar which suggests that diversion programs are not a public safety risk. Individuals who are diverted are more likely to be matched with community-based services than those who are not diverted. Accordingly, jail diversion programs decrease the criminal justice costs and increase the treatment costs, however, more individuals receive treatment with the jail diversion programs (Steadman & Naples, 2005).

There are also hybrid versions of the jail diversion programs that combine an outpatient model with the jail diversion model to create a program where patients are housed in jail but

receive community-based treatment outside of jail (Gordon, Barnes & VanBenschoten, 2006).

An example of this hybrid jail diversion program is the Chesterfield County Dual Track Treatment Model, in Virginia (Gordon et al., 2006). This program originated from the collaboration between the local mental health clinic and the local criminal justice system to form the Day Reporting Center. In this novel model, clinicians and criminal justice personnel, such as probation officers, prosecutors, judges, and corrections officers, work together to develop treatment plans and establish clear policies for the program. The Day Reporting Center had great success reducing substance use and criminal behavior, however, it became clear that the Center's target population was suffering from a co-occurring disorder of substance abuse and psychological disorder (Gordon et al., 2006).

Due to this success, the Day Reporting Center Model was adapted to create the Dual Track Treatment Program, which is a post-booking jail diversion program for those suffering from a co-occurring psychological disorders and substance abuse problem (Gordon et al., 2006). Similarly to the Day Reporting Center, the Dual Track Treatment Program only offered its services to the nonviolent offenders within the jail. The Dual Track Treatment Program offered the following services to their target population: "immediate evaluation by a psychiatrist, medication management, entry into intensive outpatient services, drug testing, and pretrial supervision" (Gordon et al., 2006, p. 11). The program functioned on a level system, meaning as the individual showed success with the treatment, the level or amount of services necessary diminished, beginning with each participant receiving services five to six days a week for four hours each day. This modality recognizes that the needs of individuals suffering from psychological disorders differ and treatment needs to have varying levels of intensity to meet these needs. The treatment services offered consist of a blend of substance abuse and mental

health treatment, including Moral Reconciliation Therapy, cognitive behavioral program, process group, medical and symptom management groups and individual counseling (Gordon et al., 2006). Reconciliation is derived from the term conciliation, which refers to “the process of making deliberate, conscious moral decisions” (Ferguson & Wormith, 2012, p. 1077). Moral Reconciliation Therapy is a cognitive-behavioral approach that attempts to elevate offenders’ moral reasoning to the point where they value social rules (Ferguson & Wormith, 2012). These combined services and collaboration amongst the agencies led to great success for the Dual Track Treatment Model (Gordon et al., 2006).

This combination of treatment methodologies led to the psychological health improvement of the participants, with sixty percent of the participants reporting that they deal with daily problems in a more effective manner, that they feel more in control and have stronger social bonds (Gordon et al., 2006). The program can be attributed with reducing the prevalence of substance amongst the participants, with the percentage of alcohol use reducing by forty-three percent, consumption of alcohol to the point of intoxication reduced by thirty-seven percent, and illegal drug use reduced by a drastic seventy-two percent. These reductions and changes in mental health occurred and were evaluated over a six-month period after beginning the Dual Track Treatment Model. These data suggest that the Dual Treatment Track Model was successful in providing their target population, those with a co-occurring psychological disorder and substance abuse problem, effective treatment for reducing substance abuse and improving mental health and quality of life (Gordon et al., 2006).

Not only did the Dual Track Treatment Model offer improvements for the target population, it served the general public as well. While an important component of jail diversion programs is providing individuals suffering from psychological disorders with effective

treatment, public safety needs should also be considered (Gordon et al., 2006). The number and types of offenses and contacts with the criminal justice system were reduced and were less serious offenses, signifying an increase in public safety. The length of stay in the Dual Track Treatment Model further enhanced this decreased recidivism rate and increased public safety effect. The continuous collaborative efforts of the court systems, criminal justice personnel, clinicians and treatment service personnel led to the success of the Dual Track Treatment Model, both the public safety and treatment participants' aspects (Gordon et al., 2006). The Dual Track Treatment Model of Chesterfield County provides an excellent example of the possible achievements that can occur when there is a collaborative effort to ensure the proper responses and care to a susceptible population.

Correctional Treatment Programs

The Dual Track Treatment is an exceptional example of a combination of outpatient and jail diversion models. However, there are treatment programs provided within the correctional system for individuals suffering from psychological disorders who are not diverted out of the criminal justice system. These programs often vary widely between different correctional institutions because they are usually based on the needs of the target population, which may vary. This makes evaluating correctional treatment programs as a whole rather difficult. With that said, there are often common components and methods for these treatment programs, upon which success can be evaluated.

Trauma Incident Reduction Therapy is a powerful example of a successful correctional Treatment Program for those suffering from Post Traumatic Stress Disorder, anxiety, and/or depression (Valentine & Smith, 2001). Pamela Valentine and Thomas Smith evaluated the success of Trauma Incident Reduction Therapy within a federal prison, assessing the progress of

123 female inmates (2001). Trauma Incident Reduction Therapy has its foundations in what is referred to as a client respectful technique, where the client determines the way the traumatic event is perceived, and the therapist does not counter or alter this perception. Trauma Incident Reduction Therapy is a therapist-directed memory-based treatment program, which targets the reduction of symptoms of Post Traumatic Stress Disorder, anxiety, and or depression. Ultimately this means that the therapist directs the session so that it maintains structure, but the evaluation comes solely from the client. The memory-based portion of the treatment model reflects the concept that current symptoms are related to past events, which must be recalled and resolved in order to relieve the symptoms (Valentine & Smith, 2001).

At the time of this study, the symptoms of Post Traumatic Stress Disorder were categorized into three categories: intrusion, avoidance, and arousal (Valentine & Smith, 2001). Intrusion is represented by symptoms such as flashbacks, nightmares, and/or intrusive or recurring thoughts. Avoidance symptoms refer to numbness or lack of emotion, avoiding the event, both in terms of thought process and physical location. Finally, arousal is typically embodied by hypervigilance or an intense startle response. Low self-esteem and a sensing a lack of control are additional symptoms that often co-occur with Post Traumatic Stress Disorder, but are not part of the Post Traumatic Stress Disorder diagnosis. Post Traumatic Stress Disorder is diagnosed when the participant shows symptoms for four weeks or longer after the event. For the participants involved in this study, the 123 female inmates, the traumatic event was the occurrence of interpersonal violence (Valentine & Smith, 2001).

The success of the Trauma Incident Reduction Therapy was assessed using the Beck Depression Inventory, the Clinical Anxiety Scale, the PTSD Symptom Scale, and the Generalized Expectancy for Success Scale (Valentine & Smith, 2001). Both the treatment group

and the control group were assessed pretest, post-test, and at a three-month follow up appointment. For the participants who had received treatment, the scores for Post Traumatic Stress Disorder, anxiety, and depression all decreased over the treatment period and remained decreasing during the three-month follow up. In addition, the expectancy for success scores rose over the treatment period and continued to rise during the three-month follow up period; alternatively, all scores of those that were in the control group remained stable throughout the entire study. This provides evidence that Trauma Incident Reduction Therapy is effective at reducing the symptoms of Post Traumatic Stress Disorder, anxiety, and depression as well as increasing the individual's outlook on life and success (Valentine & Smith, 2001).

In addition to being a successful correctional treatment model, the Trauma Incident Reduction Therapy model was welcomed by the female inmates due to the client respectful techniques of therapy. The participants reported appreciating the client respectful techniques of the Trauma Incident Reduction Therapy Model in the three-month follow up. Approval from the clients is important for maintaining participation in treatment; therefore, this treatment model is likely to be successful in that aspect as well. Due to the simple design and structured treatment protocol, Trauma Incident Reduction Therapy is both cost-effective and easily accessible for treatment professionals to learn (Valentine & Smith, 2001). The Trauma Incident Reduction Therapy model is an excellent example of treatment that can be offered both within the correctional setting and in community-based treatment.

While the Trauma Incident Reduction Therapy model is an excellent treatment program for Post Traumatic Stress disorder, anxiety, and depression, there are other treatment programs that are necessary for the correctional system to implement. Peters, LeVasseur, and Chandler analyzed twenty different treatment programs across the nation for another very important

treatment model, co-occurring substance use disorders (2004). These programs were typically either their own distinct treatment unit or they were a part of a larger mental health or substance use treatment center within the correctional institution. These prisons ranged from minimum to maximum security facilities and these programs had been in existence for an average of five years, with the longest operating program being around for thirteen years. Nine of these programs employed voluntary participation, whereas the other eleven relied on court orders or referrals. In addition, the average length of treatment was ten months, with programs ranging from three months to twenty-four months. However, most of the programs' length of stay was determined by the participant's progress and funding (Peters, LeVasseur, & Chandler, 2004).

To examine the differences in treatment models and methods, it is important to first recognize the differences amongst the participant populations. Ten of the twenty co-occurring disorders treatment programs solely served males, seven only served women, and the last three served both, however, these populations were mostly male (Peters, LeVasseur, & Chandler, 2004). The racial diversity across these twenty programs turned out to be fifty-two percent White, one third African American, eleven percent Hispanic, and four percent were other races/ethnicities. Perhaps one of the most important statistical breakdowns was the diagnosis of the participants. For mental health disorders, twenty six percent suffered from major depression, nineteen percent suffered from Post Traumatic Stress Disorder, fifteen percent suffered from bipolar disorder, thirteen percent suffered from anxiety disorders, fifteen percent suffered from schizophrenia, and six percent suffered from schizoaffective disorder. The substance disorders, a subset of mental health disorders, were recorded as: forty-eight percent suffered from alcohol dependence, thirty-eight percent from alcohol abuse, thirty-two percent from polysubstance dependence, thirty-eight percent from polysubstance abuse, thirty-four percent from cocaine

dependence, and other various substance use disorders were reported. The substance use diagnoses were determined to be an integral part of the individual's overall diagnosis; therefore, the co-treatment factor of the co-occurring disorders treatment programs is an extremely crucial element (Peters, LeVasseur, & Chandler, 2004).

Overall, the co-occurring disorders treatment programs were adapted from therapeutic community programs with the goal of treating inmates with co-occurring substance disorders, decreasing confrontation from the staff, and increasing the coordination of the service professionals (Peters, LeVasseur, & Chandler, 2004). The first key component was drug testing, thirteen out of the twenty programs included drug testing the participants on a regular basis. Another important service was the availability of crisis intervention programs; sixteen of the programs had in-house short-term crisis intervention programs and long-term crisis intervention programs, meanwhile, three other programs had short-term crisis intervention opportunities, but not long-term crisis intervention programs. In addition to the clinical services provided by the co-occurring disorders treatment programs, most programs also offered occupational services such as educational programs, vocational programs, work programs, and religious services.

The clinical services for all of the participants of the twenty programs included group therapy, individual therapy, relapse prevention programming, and psychiatric consultation (Peters, LeVasseur, & Chandler, 2004). The majority of the co-occurring disorders treatment programs provided services seven days a week for the participants. Most of the co-occurring disorders treatment programs also invested in providing programming to encourage the participants to make it through the initial stages of treatment. This is a critical stage in treatment where retention can become an issue; therefore, many of the programs recognized the need for such programming. In addition, peer support groups were implemented in a large majority of the

co-occurring disorders treatment programs. These peer support groups include programs such as Alcoholics Anonymous, Narcotics Anonymous, drug education, and criminal thinking groups. Case management, re-entry programming, anger management programming, and health education programs were also provided for participants in a large majority of the co-occurring disorders treatment programs (Peters, LeVasseur, & Chandler, 2004). These clinical elements and programs were common to most of the co-occurring disorders treatment programs, providing a clearer depiction of the typical co-occurring disorders treatment program implemented in correctional facilities.

There are other important elements that were not implemented in all twenty of the co-occurring disorders treatment programs, but it is important to recognize their merit as components of this style of treatment (Peters, LeVasseur, & Chandler, 2004). For example, approximately half of the programs offered medication management groups, which typically involve learning about proper dosage and retaining medication use. Roughly half of the programs also offered vocational counseling, extending their occupational services for release preparation. Some programs that were less common amongst the co-occurring disorders treatment programs were family counseling, parenting skills training, domestic violence groups, education/GED preparation classes, literacy services, aftercare groups, and involvement in work-release programs. These additional programs suggest an awareness of aspects other than psychological disorders that affect the lives of the participants and provide the necessary tools for these individuals to succeed in these aspects as well as treating their co-occurring disorder.

Overall, the average weekly treatment hours for the co-occurring disorders treatment programs was twenty-five hours (Peters, LeVasseur, & Chandler, 2004). This is comprised of, on average, five hours a week devoted to engagement and motivational activities, group therapy,

and psychoeducational groups, one hour a week for individual level therapy, and one and a half hours a week for medication management. The group treatment programs, for example the group therapy or the peer support groups, had an average of fifteen participants. This small number is due to two main factors that are common in correctional treatment programs: a shortage of staff and exclusionary eligibility requirements.

On average the co-occurring disorders treatment programs had seven full time staff, with four programs having a psychiatrist on the staff and five programs including a psychologist on the staff (Peters, LeVasseur, & Chandler, 2004). In addition, only six programs included at least one social worker on the staff and only fourteen of the twenty programs had substance abuse counselors on staff. The programs indicated that they had some complications in obtaining staff, due to factors such as state licensing statutes. This limited the number of licensed psychologists that were available for hiring, making it difficult to have a large number of psychologists on the staff. The amount of funding varied greatly across programs, affecting the number of staff. These programs receive money from several sources, most commonly: federal grants, state correctional department budget, and state trust funds. The budgets for the co-occurring disorders treatment programs varied from 50,000 dollars a year to almost one million dollars a year, leaving the average budget for the programs at 365,000 dollars a year. That means there is a range of roughly 950,000 dollars a year spent on these programs, which affects the programs in many ways. It limits the number of staff that can be retained; for example, several of the smaller, less funded programs could only support one or more staff (Peters, LeVasseur, & Chandler, 2004). It also affects how much programming and services that the participants can receive, with well-funded programs being able to accomplish more.

The other factor that typically limits the participant population size is the exclusionary

eligibility requirements. The first and most simple eligibility requirement was that the participant was diagnosed with both an Axis I psychological disorder and a substance use disorder (Peters, LeVasseur, & Chandler, 2004). While this is not exclusionary in any sense other than limiting the population to the treatment target population, the other eligibility requirements are exclusionary. Most of the programs required that the participants were already stabilized on and compliant with their medication. This is a difficult task for someone suffering from psychological disorders to do on his or her own, presumably this is why the majority of the co-occurring disorders treatment programs included medication management in their programming. By excluding those that cannot already manage their medication it is arguable that these programs are excluding the individuals that require their programming the most, especially the medication management programming.

Another requirement created by most of the programs was that the individual must be able to operate well in group treatment settings (Peters, LeVasseur, & Chandler, 2004). While this is likely due to the many group sessions within the programs, it denies the person individual therapy that is also included in the program and could be effective treatment. The programs chose individuals in minimum security with no recent suicide attempts, violence, escape attempts, or recent discipline in the correctional facility (Peters, LeVasseur, & Chandler, 2004). These requirements are probably intended to provide protection for the treatment staff by excluding individuals who have more violent and aggressive records. While the insurance of the safety of the staff and other participants is a necessity, it would be beneficial to see programs that are geared towards serving this more aggressive group. It can be argued that this group is in dire need of critical intervention strategies and would benefit from intensive treatment in a facility and manner that also provides safety for the service provider.

The last common eligibility requirement amongst the twenty co-occurring disorders treatment programs was that the individual must have a certain amount of time left in their sentence, with programs ranging from a requirement of six to twenty-four months (Peters, LeVasseur, & Chandler, 2004). This is usually because of the duration of the treatment programs - the program should be completed before the sentence is over. It is always the most beneficial if an individual can complete a treatment program, however, this requirement denies individuals who have shorter sentences treatment that would be useful, even if incomplete. Perhaps the requirement should instead be the ability to complete a certain portion of the treatment program, such as being able to complete half of the treatment. As for the co-occurring disorders treatment programs, the length of the treatment program determined most of the sentences; therefore, it was unlikely that this eligibility requirement limited any individuals in this case (Peters, LeVasseur, & Chandler, 2004).

There will always be necessary adjustments to correctional treatment programs, such as addressing these factors of staffing, funding, and eligibility requirements; however, there are certain departments of corrections that have done well adjusting over the years. For example, New York has changed their implementation of correctional treatment programs over the years until settling on a system of outpatient services from their Central New York Psychiatric Center (Smith, Sawyer, & Way, 2004). The reach of the Central New York Psychiatric Center is broad, with specific units in twenty-three correctional facilities and a “clinical presence” in fifty New York State Prisons, providing services to a grand total of 7,400 patients (Smith, Sawyer, & Way, 2004, p. 29). This is a rather large presence, especially considering there are only seventy New York State Prisons (Smith, Sawyer, & Way, 2004).

Upon intake, the individual is assessed to determine which correctional facility will best

meet their needs and they are given a rating level, which determines the amount of services necessary (Smith, Sawyer, & Way, 2004). This level is susceptible to change as the patients' needs are reassessed. Those that are ranked a level one are sent to a facility with a Mental Health Satellite Unit, which houses inpatient admissions as well as those in the Residential Crisis Treatment Program. The Residential Crisis Treatment Program is comprised of observation cells and dormitory beds that are crucial in the stabilization of these patients. The goal of the Residential Crisis Treatment Program is usually to prevent suicide and stabilize the patient so that they can return to another facility for treatment.

In addition to the Residential Crisis Treatment Program, most of the Satellite Units have an Intermediate Care Program, which provides a separate housing area for the patients suffering from psychological disorders, away from the general population (Smith, Sawyer, & Way, 2004). Mental health programs are implemented by a Senior Correctional Counselor in the Intermediate Care Program with the eventual goal of returning the individual to the general population. This type of programming has proved to be rather successful, with patients displaying reductions in rule breaking, suicide attempts, disciplinary actions, and admission to both the Crisis Units and the inpatient programs (Smith, Sawyer, & Way, 2004).

The Central New York Psychiatric Center model provides an excellent example for other states on how to coordinate and standardize their treatment programs across the state's facilities. Further, the Central New York Psychiatric Center model is prepared to deal with individuals suffering from psychological disorders with varying levels of aggressive behaviors and intensive needs, as seen by the level rating method and the Residential Crisis Treatment Program. It is important to include a multitude of programs in each correctional facility due to the corresponding variety of psychological disorders and co-occurring disorders. It is also critical to

include re-entry programs in all correctional facilities, to provide the best preparation for returning to the community.

Re-entry/Transitional Programs

The importance of re-entry is a matter that is often overlooked in the general correctional field, but it is particularly important to recognize within this field. There are, however, correctional facilities that realize the importance of preparing individuals suffering from psychological disorders in correctional institutions for all of the complexities of returning to the community, both with a psychological disorder and as a former inmate. The previously mentioned Central New York Psychiatric Center, for example, releases 3,000 patients each year, providing all with the minimum service of pre-release coordination with a designated Pre-Release Coordinator (Smith, Sawyer, & Way, 2004). This Coordinator helps the individual familiarize themselves with the services and resources that are provided within the state.

In addition to this overall measure, several facilities have implemented more rigorous re-entry programs within their walls. Sing Sing Correctional Facility implements the Community Orientation and Re-Entry Program, which serves thirty inmates at a time for a period of four months before release (Smith, Sawyer, & Way, 2004). The Community Orientation and Re-Entry Program provides community preparation, vocational assessment, peer support, linkage to community, discharge planning, orientation to Parole supervision, and access to a new Medication Grant Program. One important feature for aiding in the transition is that the community service providers actually join with the Sing Sing Correctional Facility and come in to meet with the individuals that will be using their services within the community (Smith, Sawyer, & Way, 2004). This encourages a sense of familiarity with the future treatment program and relieves the anxiety of searching for programming upon release. The Community Orientation

and Re-Entry Program aims to resolve all of the overarching issues with re-entering society by improving community living skills, aiding the individual in a goal not to recidivate, and ensuring that the individual stays as long as possible in the community (Smith, Sawyer, & Way, 2004).

Re-entry Programs are not always separate from the treatment programs that the individual is receiving. For example, the twenty co-occurring disorders treatment programs reported in the study performed by Peters, LeVasseur, and Chandler had re-entry programs present or were under development at the time of the study (2004). In the majority of programs the co-occurring disorders treatment staff were responsible for matching the patients with community-based treatment. More specifically, the staff member contacts community based treatment facilities to set up appointments upon release as well as arrange for medication monitoring. To aid with aspects other than treatment, the staff member also helps the individual find long-term housing, job opportunities, and other financial or vocational services. Beyond these services the co-occurring disorders treatment programs displayed variance in additional services, however, the above services reflect an understanding of the most critical components of re-entry: treatment, medication management, housing and employment options (Peters, LeVasseur, & Chandler, 2004).

There are also re-entry programs that cover the same difficulties, but maintain a mindset of preventing recidivism as much as possible (Angell, Matthews, Barrenger, Watson, & Draine, 2014). The Critical Time Intervention and Forensic Assertive Community Treatment programs are two examples of treatment programs for individuals suffering from psychological disorders that are modified to aid in community reentry and decrease the chance for recidivism (Angell et al., 2014). The Critical Time Intervention is a short term, only nine months, program that assigns the individual a case manager who helps the individual build connections with treatment

programs, the community and family, and other resources such as housing programs. The end goal of Critical Time Intervention is for the individual to successfully rely on the referred programs by the end of the nine months: it is purely a transitional program. On the other hand, the Forensic Assertive Community Treatment program is time unlimited, meaning that the case manager will continue to work with the individual as long as they need to help maintain treatment, housing, family connections, and more. Funding and staffing likely limit the duration of the Critical Time Intervention program, but both short-term and long-term programs have their place in effective treatment models. Some individuals may need the constant availability of a case manager, while others may only need a case manager to help them obtain the necessary services and get on their feet. This again leads back to the idea that individuals suffering from psychological disorders face different challenges and to varying degrees; therefore, treatment needs to be able to meet this variation.

Both programs have the client meet them before their release from prison or jail to establish a relationship with the client and encourage them to utilize the program upon release (Angell et al., 2014). Developing a bond with the case manager and other staff is crucial for success, it encourages the client to put as much effort in as possible if they believe their case manager is doing the same. The initial goal of both programs is to obtain basic services for the client such as housing, welfare, and employment. This goal is especially important because no one released from prison or jail is given anything, so securing these basic needs build the foundation upon which the individual can pursue other services. Both of the programs offered financial help to their clients, however, they managed this in different ways. The Forensic Assertive Community Treatment program featured a “revolving loan fund” where a grant funded loans for the clients to obtain basic needs, which they were expected to pay back later (Angell et

al., 2014, p. 495). While this is a loan, it provided clients with the funding necessary to get back on their feet and it encouraged them to be more involved in the program. On the other hand, Critical Time Intervention had case managers obtain financial deals for them, such as free medications and housing vouchers, provided by other services (Angell et al., 2014). Ultimately, both programs are successful in recognizing and attempting to meet all of the various needs of their clients, posing a promising example for other re-entry programs.

Conclusions

Based on the current state of our society, the criminal justice system and the mental health system will be intertwined for the foreseeable future. This does not have to be the disjointed and contradictory relationship that we have seen so far. While there has been progress towards a positive symbiotic relationship, more still needs to be done. The primary problem resides in the lack of funding invested in the positive aspects of this relationship, such as community-based treatment, mental health courts, jail diversion programs, correctional treatment programs, and reentry programs. Many researchers argue that the beneficial programs they have analyzed are cost effective and would likely raise mental health costs and lower criminal justice costs (Valentine & Smith, 2001; Steadman & Naples, 2005).

The first priority for funding should be increasing community-based treatment in areas of need. According to Penrose's theory, greater involvement of the mental health system will decrease the involvement of the criminal justice system (Lamb & Weinberger, 1998). The criminal justice system should not be the main avenue for treatment; it is crucial that the mental health system is capable of meeting the treatment needs of individuals suffering from psychological disorders. One complaint of the President's New Freedom Commission on Mental Health is that treatment programs that have been proven successful in research are not

immediately implemented in practice (Hogan, 2003). Increased funding initiatives should focus on increasing the availability of these successful programs. Increased funding to community-based treatment should focus on decreasing the variability of treatment from one area to another, ensuring that certain programs are present everywhere. For example, the overwhelming rate of individuals suffering from the co-occurring disorder of psychological disorders and substance abuse speaks to the necessity of treatment programs tailored to this co-occurring disorder. Community-based treatment that focuses on aiding individuals suffering from psychological disorders with the other risk factors, such as homelessness, and unemployment should be implemented in all communities. In addition, funding will increase staffing to meet the needs of clients as well as reduce the waiting lists for treatment. These two factors would play a heavy role in reducing the number of clients that can receive treatment, both in community-based and correctional treatment.

Correctional treatment programs and reentry programs face the same issues as community-based treatment from lack of funding. While the correctional treatment programs should not be the main service for individuals suffering from psychological disorders, there is still a need to invest adequate resources into these programs so that they can meet the needs of their populations as well as have a uniform set of treatment program options. Reentry programs are an integral part of preparing for the return to society, with case management strategies of various durations proving to be the most successful at preparation and recidivism (Angell, Matthews, Barringer, Watson, & Draine, 2014). This style of programming should receive more funding with the recognition that these individuals will return to society and require connections to treatment, housing services, medication management, and employment opportunities. Currently, the Substance Abuse and Mental Health Services Administration provides funding to

various initiatives, which support these programs, through various grants (Grants; Steadman & Naples, 2005). In addition, the U.S. Department of Justice and the Bureau of Justice Assistance have funded several programs and initiatives in an attempt to broaden the reach of mental health treatment programs (Steadman & Naples, 2005; Peters, LeVasseur, & Chandler, 2004). These initiatives are imperative to the current successes within the mental health and criminal justice fields, but more is necessary to meet the needs of the individuals suffering from psychological disorders.

The criminal justice system and mental health system face other issues in providing effective treatment to all of those in need. One of these issues is the restrictive nature of eligibility requirements that are used in community-based treatment, correctional treatment, reentry programs, mental health courts and jail diversion programs. Often participants are excluded on the basis of poor medication management, violent offenses, and inadequate time to complete the treatment program (Peters, LeVasseur, & Chandler, 2004). Excluding on the basis of poor medication management or noncompliance with medication only suggests that one is excluding a population that requires the rigorous structure of treatment and monitoring. As previously mentioned, this is a difficult task for someone suffering from psychological disorders to do on his or her own, presumably this is why the majority of the co-occurring disorders treatment programs included medication management in their programming. It is understandable that treatment programs desire individuals finish the program before they are released, but placing a time restriction prevents the treatment of individuals who need it, regardless of the duration. Finally, violent offenses are often excluded due to the desire to keep psychiatric staff and other participants safe. While this is understandable, there should be alternative programs in high security facilities that are prepared to provide treatment for this small group of aggressive

individuals suffering from psychological disorders. Ultimately, the eligibility requirements of treatment programs should be heavily reviewed to ensure that no one in need is being restricted and if they are then ensure that there are treatment options accessible to them.

As previously stated, the current relationship between the criminal justice system and the mental health system is disjointed and uncommunicative, causing many individuals to fall through the cracks. In an effort to improve this relationship, mental health courts and jail diversion programs should increase. Mental health courts will help bridge the gap between the systems by specializing in mental health cases and intending to help the individual suffering from a psychological disorder, as opposed to the purely punitive response of traditional courts. Further, jail diversion programs should be supported, as sentences will divert more individuals in need to community-based treatment. An increase in mental health courts and jail diversion programs will help remove the barriers to treatment and will increase the communication between the two fields. In conjunction with this effort, police departments need to be trained in how to deal with situations involving individuals suffering from psychological disorders so that they can recognize these instances and respond appropriately. In addition, police officers need to be provided with effective options for referring and dropping an individual off at treatment centers so that they are not encouraged to make mercy bookings. This requires constant communication between community-based treatment centers and police departments, but there are examples of communities that are attempting to bridge the gap (Grudzinskas, Clayfield, Roy-Bujnowski, Fisher, & Richardson, 2005).

The criminal justice system and the mental health system face many challenges in the attempt to serve the individuals suffering from psychological disorders. The recent awareness of mental health within the criminal justice system and the increase in the treatment perspective

rather than the punitive response is encouraging. This relationship between the mental health system and the criminal justice system needs to be strengthened through open communication, sharing of resources, and increased funding. Once this happens, there is no doubt that we will see the benefits of shifting from a punitive justice system to one that is mental health aware.

References

- Angell, B., Matthews, E., Barrenger, S., Watson, A. C., & Draine, J. (2014). Engagement processes in model programs for community reentry from prison for people with serious mental illness. *International Journal Of Law And Psychiatry*, 37(5), 490-500.
doi:10.1016/j.ijlp.2014.02.022
- Dierkhising, C. B., Ko, S. J., Woods-Jaeger, B., Briggs, E. C., Lee, R., & Pynoos, R. S. (2013). Trauma histories among justice-involved youth: Findings from the National Child Traumatic Stress Network. *European Journal Of Psychotraumatology*, 4
- Dunnegan, S. W. (1997). Violence, trauma and substance abuse. *Journal Of Psychoactive Drugs*, 29(4), 345-351. doi:10.1080/02791072.1997.10400561
- Ferguson, L. M., & Wormith, J. S. (2012). A Meta-Analysis of Moral Reconciliation Therapy. *International Journal of Offender Therapy and Comparative Criminology*, 57(9), 1076-1106. doi:10.1177/0306624x12447771
- Gordon, J. A., Barnes, C. M., & VanBenschoten, S. W. (2006). The Dual Treatment Track Program: A Descriptive Assessment of a New 'In-House' Jail Diversion Program. *Federal Probation*, 70(3), 9-18.
- Grants. (n.d.). *Substance Abuse and Mental Health Services Administration*. Retrieved May 16, 2016, from <http://www.samhsa.gov/grants>
- Grudzinskas Jr., A. J., Clayfield, J. C., Roy-Bujnowski, K., Fisher, W. H., & Richardson, M. H. (2005). Integrating the Criminal Justice System into Mental Health Service Delivery: The Worcester Diversion Experience. *Behavioral Sciences & The Law*, 23(2), 277-293.
doi:10.1002/bsl.648

Hogan, M. (2003). *The President's New Commission on Mental Health*. The President's New Commission on Mental Health. Retrieved from

<http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf>

Lamb, H., & Weinberger, L. (1998). Persons With Severe Mental Illness in Jails and Prisons: A Review. *PS Psychiatric Services*, 49(4), 483-492. Retrieved October 5, 2015, from PsychINFO.

Lamb, H., Weinberger, L., Marsh, J., & Gross, B. (2007). Treatment prospects for persons with severe mental illness in an urban county jail. *Psychiatric Services*, 58(6), 782-786
5p.

Peters, R. H., LeVasseur, M. E., & Chandler, R. K. (2004). Correctional treatment for co-occurring disorders: results of a national survey. *Behavioral Sciences & The Law*, 22(4), 563-584.

Prins, S. J. (2011). Does transinstitutionalization explain the overrepresentation of people with serious mental illnesses in the criminal justice system?. *Community Mental Health Journal*, 47(6), 716-722. doi:10.1007/s10597-011-9420-y

Smith, H., Sawyer, D. A., & Way, B. B. (2004). Correctional mental health services in New York: ~~then and now~~. *The Psychiatric Quarterly*, 75

Steadman, H. J., & Naples, M. (2005). Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders. *Behavioral Sciences & The Law*, 23(2), 163-170. doi:10.1002/bsl.640

Valentine, P., & Smith, T. (2001). Evaluating traumatic incident reduction therapy with female inmates: a randomized controlled clinical trial. *Research On Social Work Practice*, 11(1),

40-52 13p.