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Decriminalizing Mental Illness: The Need for Treatment Over Incarceration Before Prisons Become the New Asylums for the Mentally Ill

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Decriminalizing Mental Illness: The Need for Treatment over Incarceration before Prisons

Become the New Asylums for the Mentally Ill

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Abstract

Currently, US prisons are home to 10 times more mentally ill individuals than state psychiatric hospitals. Instead of treating those with mental illness, an extremely vulnerable population is being thrown behind bars. Mental illness is often exacerbated during incarceration, leaving inmates much sicker than when they entered. Moreover, upon discharge mentally ill inmates have virtually no support, making recidivism almost inevitable. This lack of treatment has devastating consequences for the mentally ill as well as the community at large. Removing the mentally ill from jails and prisons would reduce recidivism, increase public safety and save money.

The current research explores the circumstances that led to a vast number of mentally ill recycling through our nation's correctional system. This paper also highlights current jail/prison practices in dealing with the mentally ill. Primary focus is on female inmate populations, who present unique circumstances, needs and concerns. My project has been inspired by 3 years of volunteer work educating inmates at Montgomery County Correctional Facility. This experience has been translated into a collection of vignettes. Stories about the women I have encountered provide concrete cases through which to consider various problems and solutions. My research and firsthand experience has been synthesized into one final piece: a draft for an intervention program for mentally ill female inmates. This program addresses the specific needs of women and introduces ideas for effective changes within our nation's correctional system.

Decriminalizing Mental Illness: The Need for Treatment over Incarceration before Prisons
Become the New Asylums for the Mentally Ill

Part I: Literature Review

Background

How did we get here?

In order to understand the present situation, it would be helpful to give some background on how so many mentally ill individuals have landed in jails and prisons. It wasn't always this way, in fact, at one point in history, most mentally ill individuals were housed in psychiatric hospitals. Since that time, there have been several shifts in the law and social welfare that have led to mass imprisonment of the mentally ill. Two movements in history are considered to be the main contributors to this issue: deinstitutionalization and the war on drugs.

Deinstitutionalization

Deinstitutionalization was a movement that began in the 1950s in effort to remove patients from large state psychiatric hospitals and into the community. The original intent behind deinstitutionalization was to give those with mental illness more freedom, dignity and autonomy. Unfortunately, many patients were discharged from hospitals, but they did not receive the community based treatment they were promised. This lack of treatment resources due to deinstitutionalization has had widespread negative effects that still persist today. In fact, an estimated 3.9 million Americans (1.5% of the population) with severe mental illness currently receive no psychiatric treatment (Smith, 2012).

One of the first efforts for psychiatric reform occurred in the 19th century by a woman named Dorothea Dix. In 1841 Dix began teaching Sunday school at East Cambridge Jail. During this time she was horrified by the way the mentally ill prisoners were treated. For instance, the insane prisoners did not have heated cells and when Dix asked an officer why he responded, “the insane need no heat.” From then on, Dix began to tour other jails and found the same inhumane conditions. By 1847, Dix had traveled to hundreds of jails and prisons across the country creating reports to present to state legislatures. Dix’s efforts were successful in convincing states to build psychiatric hospitals, which helped move the mentally ill out of prisons. Dix believed that in hospitals, as opposed to prisons, the mentally ill can heal and treat the root of their criminal behavior (Torrey, 2005).

Unfortunately, these psychiatric hospitals did little to improve treatment for the mentally ill. Many asylums were notorious for subjecting the mentally ill to deplorable conditions such as chains, corporal punishment, malnutrition, and isolation in filthy, small cells. Some patients were beaten so badly or so malnourished that they died. Periods of war and economic decline frequently resulted in funding cuts for these facilities resulting in overcrowding and poor treatment. Eventually, in the 1940s mental health professionals began to speak out against these deplorable conditions. During this time, the media were extremely influential in exposing the brutality of these asylums. Newspaper articles, magazines, books and even movies shared stories like those of a mentally ill man who died and had his face eaten off by rats in the Asylum’s morgue. As this movement continued to gain momentum, new treatment approaches began to emerge. One of the most influential developments was the creation of Thorazine, the first effective antipsychotic medication. Thorazine, also called chlorpromazine, was considered a pharmaceutical breakthrough. Previous treatments for the severely mentally ill included

electroconvulsive shock therapy and even lobotomy. For the first time, clinicians were now hopeful that the mentally ill could be sent home and function with supportive services in the community.

In 1963, President John F. Kennedy signed the Community Mental Health Centers Construction Act. This law was established to allocate funds to building community health centers throughout the country and to assisting those with mental illness as they reentered communities. Unfortunately, governors and legislators took this act as an opportunity to cut the mental health budget (Kupers, 1999). Also, residents in communities were often resistant to establishing centers that would bring inmates and mentally ill individuals into their neighborhoods. As a result, many psychiatric hospitals closed, but states did not follow through with using this extra money to create community resources like half-way houses, outpatient clinics, and in home psychiatric providers. This movement threw thousands of people suffering from mental illness out into the streets with virtually no support. Many were homeless, arrested, or died (Slate & Johnson, 2008).

Moreover, in the 1960s, the implementation of Medicare and Medicaid caused the federal government to be more responsible for covering the cost of mental health care. Later, in the 1980s and 1990s managed care systems began to sweep the health care industry. The fee-for-service model for insurance meant financial incentives to admitting fewer patients to hospitals and decreasing length of stay. Both of these changes in American healthcare motivated the government to accelerate deinstitutionalization. In fact, by 1994, the number of patients in public psychiatric hospitals dropped from 558,239 in 1955 to 71,619 (Smith, 2012).

Currently, mental health budgets still prevent development of adequate mental health services. While the number of mentally ill in psychiatric facilities has decreased significantly,

there is still a lack of outpatient services for the mentally ill. This shortage of services means many instances of mental illness go untreated. In fact, studies indicate that 40-50% of those with schizophrenia or bipolar disorder are receiving no treatment (Treatment Advocacy Center, 2014). In addition to mental health services, the severely mentally ill need support such as vocational training, employment assistance and housing. Due to this lack of support, many mentally ill find it difficult to stay out of trouble and often find themselves homeless or incarcerated. Overall, the efficacy of deinstitutionalization continues to raise debate. While deinstitutionalization benefited many Americans with intellectual and development disabilities, it was far less beneficial for those with severe mental illness. Unfortunately the idealistic vision of giving the mentally ill autonomy and dignity never came to fruition.

The War on Drugs

Widely considered to be a massive failure, the war on drugs movement, which began in the 1970s, resulted in skyrocketing incarceration rates. Instead of receiving treatment, thousands of drug addicts were thrown behind bars. This caused prisons to become overcrowded and made no significant decreases in drug abuse rates. Today this problem still persists. In fact, The National Center on Addiction and Substance Abuse found that 65% of all US inmates meet medical criteria for substance abuse addiction (CASA Report, 2010). Moreover, many individuals with mental illness self-medicate with illicit drugs. For this reason a significant number of inmates incarcerated for drug charges have comorbid mental illness. The war on drugs is thought to be a major factor leading to the incarceration of a large number of mentally ill.

In the 1960s recreational drug use gained popularity among young Americans during times of protests and rebellion. Hippies used hallucinogens like LSD and many soldiers

returning from the Vietnam War turned to heroin and marijuana. It was not until about a decade later that attention was given to the safety of these drugs. On June 18, 1971 President Nixon declared a “war on drugs” at a press conference, stating that drug abuse was “public enemy number one.” In order to combat drug use, Nixon increased federal drug control agencies, encouraged mandatory sentencing and no-knock warrants, and initiated treatment programs for addicts (“Drug War”, 2014).

In the 1980s the presidency of Ronald Reagan focused on “getting tough” on drugs. Reagan adopted a zero tolerance policy that imposed harsh sentences for possession of drugs. Instead of targeting drug transporters and suppliers, the government decided to penalize drug users in an attempt to reduce demand. During this time, the media portrayed disturbing images of people addicted to crack cocaine causing increasing public alarm. Furthermore, Nancy Reagan launched the “Just Say No” drug campaign. Nationwide hysteria surrounding the war on drugs continued to gain momentum into the late 1980s. In fact, in 1989, 64% of Americans polled considered drug abuse to be the country’s “number one problem,” compared to just 2-6% in 1985.

Today, more than half of America’s federal inmates are in prison for drug convictions (Engel, 2014). Our country spends \$50 billion every year to fight the war on drugs. However, according to DEA estimates, less than 10 percent of all illicit drugs are captured (US War on Drugs, 2014). Not only is our country wasting billions of dollars on a “war” that is clearly being lost, but strict drug policies are actually counterproductive. Drug trade often provokes violent neighborhood crime, drug addicts are confined to prisons, and the children of drug users are abandoned. Moreover, the war on drugs has had no effect on decreasing the availability of drugs. Fortunately, in recent years, America is slowly beginning to move away from these tough on

drugs laws. Many states are lowering penalties for possession of drugs and decreasing mandatory minimum sentences (Engel, 2014).

In the last few months of his term, President Obama has made a priority of addressing mass incarceration in the United States. On July 13, 2015 Obama announced that he would be cutting short the prison sentences for 46 federal inmates convicted of nonviolent drug crimes. Days later, President Obama made a passionate speech at the NAACP convention addressing this issue. He described the United States' astounding incarceration rates and how we spend \$80 billion every year on locking up prisoners. Furthermore, he highlighted the majority of these inmates are nonviolent drug offenders whose, "punishment does not fit the crime." Obama mentioned possible solutions such as investing in community resources, lowering mandatory minimum sentences, providing prison alternatives, advocating for treatment, and creating more drug courts. He even made the bold statement that ex-felons who have served their time should be able to vote and encouraged employers to stop asking job applicants if they have a criminal record (Gosztola, 2015).

Overall, President Obama's efforts are an important step in addressing this issue. If the United States ever wants to win this war on drugs serious reform is necessary. Drug addicts need treatment and rehabilitation, not punishment.

Mental Health Treatment in Jails and Prisons

In 2012, there were an estimated 356,268 inmates with severe mental illness in US prisons and jails, that is 10 times more mentally ill individuals than in state psychiatric facilities

(Torrey et al., 2014). This burgeoning population is transforming jails and prisons into the new asylums for the mentally ill. Now more than ever, there is an urgent need for correctional facilities to provide psychiatric care to this vulnerable population. In fact, 20 percent of inmates in jails and 15 percent of inmates in state prisons have a serious mental illness (Torrey et al., 2014). Some studies suggest an even greater prevalence of mental illness in correctional settings. For instance, a study by the US Department of Justice's Bureau of Statistics found that 64% of local jail inmates, 56% of state prisoners, and 45% of federal prisoners have symptoms of serious mental illness (Fitzpatrick, 2006).

Medical treatment in jails and prisons is a right affirmed by the US Supreme Court. Mental illness is a serious medical condition, just like as diabetes or hypertension, and should be treated as so. However, current mental health services in jails and prisons are grossly inadequate. In fact, stressful conditions such as overcrowding, lack of privacy, lack of meaningful activity and isolation tend to exacerbate mental illness. Many inmates leave jails and prisons much sicker than when they entered. The bottom line is that jails and prisons are not intended or equipped to deal with mentally ill individuals.

What is serious mental illness?

The federal definition serious of mental illness was created in 1992 by the Secretary of Health and Human Services. During this time, Congress requested a formal definition of serious mental illness (SMI) in order to aid in the allocation of mental health funds and the approximation of SMI prevalence rates. According to the Secretary of Health and Human Services, adults with serious mental illness are persons who currently or at any time over the past year, (1) have a diagnosable mental, behavioral, or emotional disorder to meet specific criteria

within the Diagnostic and Statistical Manual of Mental Disorders, (2) have experienced functional impairment that interferes with or limits one of more major life activities (Insel, 2013).

Types of Mental Illness Encountered in Jails and Prisons

There are several mental illnesses frequently encountered in jails and prisons. Below are explanations of common mental illnesses found in inmates as well as information on the specific issues each illness presents in jails/prisons.

Psychotic Disorders

Psychotic disorders include schizophrenia, schizoaffective disorder and delusional disorder. People with psychotic disorders are so impaired in their thoughts and emotions that they lose touch with reality. They often experience hallucinations or delusions. Hallucinations are false sensory perceptions such as hearing voices or seeing things that are not there. Delusions are false beliefs held despite strong evidence against the belief, such as thinking someone is trying to kill you. Psychotic disorders result in severe impairments like disorganized behavior, bad hygiene, and poor interpersonal skills (Fagan & Ax, 2003).

Psychotic inmates present many complications within jails and prisons. They do not function well in the restrictive environment. They often have difficulty complying with routine procedures such as showering and eating. Correctional staff may misinterpret this as disrespect and punish these individuals often with the consequence of solitary confinement. Additionally, their bizarre behavior frequently results in conflicts with other inmates. Other prisoners may take advantage of these inmates for being weak and unaware. Paranoid psychotic inmates often isolate themselves from others, putting them at an increased risk of suicide. Psychotic inmates often do not receive treatment until they are called to the attention of staff after a disciplinary

infraction. Even then, treatment for psychotic inmates is usually limited to psychotropic medications. Proper treatment for psychotic disorders includes social skills training, cognitive-behavioral alteration of delusional beliefs and individual therapy. Unfortunately, this quality of care is practically unheard of in correctional facilities.

Mood Disorders

Mood disorders are mental illnesses characterized by mania or depression. Mania or hypomania is an elevation of mood, whereas depression is characterized by lowering in mood. One of the most common mood disorders inmates suffer from is major depressive disorder (MDD) or clinical depression. Those with MDD experience intense sadness, feelings of hopelessness, worthlessness, loss of interest in daily activities, and fatigue. Many inmates with MDD are so depressed they miss out on meaningful activities such as work, educational, or vocational programming. They may be irritable and thus may come into conflict with staff and other inmates. Depressed inmates are often suicidal.

Another common mood disorder found amongst inmates is bipolar disorder which is characterized by unstable mood, fluctuating from depressive to manic states. Manic episodes include racing thoughts, increased self-esteem, feelings of wakefulness, and psychomotor agitation. In jails and prisons, inmates undergoing a manic episode may become noncompliant to rules of conduct or engage in hypersexual behavior (Fagan & Ax, 2003). Some mood disorders are so severe that they may involve psychosis.

Treatment for mood disorders in correctional settings is generally limited to psychotropic medications. Jails and prisons often lack cognitive-behavioral interventions and proper suicide intervention needed to manage inmates with mood disorders.

Borderline Personality Disorder

Borderline personality disorder (BPD) is a serious mental illness characterized by instability in mood, self-esteem, and interpersonal relationships. Those with BPD are often impulsive, frantic, aggressive, fearful of abandonment and exhibit self-harming behavior. Sometimes severe BPD includes brief psychotic episodes. Due to difficulties in regulating emotions, patients with BPD are some of the most demanding on correctional staff. They will often create a crisis or break the rules just to get a reaction from officers. Many staff members become frustrated with their repeated attempts at self-mutilation and may not take these behaviors seriously. In addition, inmates with BPD often engage in “staff splitting”, in which they try to manipulate staff against one another. Inmates with BPD are frequently moved from institution to institution due to difficulties with staff members. Unfortunately, this simply worsens their already unstable condition.

Antisocial Personality Disorder

Antisocial personality disorder is characterized by a pattern of disregard for the feelings and rights of others. Those with antisocial personality disorder are often deceptive, impulsive, irritable, and reckless. They often manipulate others for their own personal gain and are extremely irresponsible with money and work obligations. A recent study found that 35% of male and female inmates met criteria for diagnosis of antisocial personality disorder (Black, Gunter, Loveless, Allen, & Sieleni, 2010). Similarly to those with BPD, inmates with antisocial personality disorder are extremely disruptive in correctional settings. They have difficulty complying with social norms and often conflict with authority.

Those with antisocial personality disorder should not be confused with psychopaths. Although, these terms are often used interchangeably, they are in fact two distinct diagnoses.

Most psychopaths meet the criteria for antisocial personality disorder, but only 1/3 of individuals with ASPD meet the criteria for psychopathy (Fagan & Ax, 2003). Psychopaths display many of the same behavioral characteristics of ASPD, like impulsivity, irresponsibility, and deceit, but are distinct in that they lack empathy. Psychopaths show no remorse or guilt for demonstrating antisocial behaviors.

Unfortunately, treatment for antisocial personality disorder or psychopaths is not very promising. Often treatment involves “resocialization” or empathy training. However, this type of therapy often makes these individuals even more skilled in manipulating others. In fact, one study found that treated psychopaths were more likely than untreated psychopaths to commit a crime after release (Fagan & Ax, 2003).

Substance Use Disorders

The DSM-V characterizes substance use disorder as dependence on alcohol or drugs. Substance use disorder ranges from mild to moderate to severe. Symptoms include uncontrollable cravings and continued use of substances despite clinical and functional impairment (Substance Use Disorders, 2014).

Substance abuse is a prevalent issue in jails and prisons. In fact a study by The National Center on Addiction and Substance Abuse (CASA) at Columbia University found that 65% of U.S. inmates meet medical criteria for substance abuse addiction (New CASA, 2010). Inmates with substance use disorder often create disciplinary problems because they continue to seek out and use substances while incarcerated. They may attempt to produce their own substances or bribe other inmates for their prescription medications. The supply and demand for substances within jails and prisons often contributes to violence (Fagan & Ax, 2003).

Post-traumatic Stress Disorder

One type of mental illness that is often underdiagnosed or misdiagnosed in jails and prisons is post-traumatic stress disorder. Post-traumatic stress disorder is a mental illness triggered by traumatic events. People with PTSD often experience flashbacks, nightmares, guilt, and persistent fear even when they are no longer in danger. PTSD is especially common in correctional settings because inmates often have a history of physical and sexual abuse. While in jails and prisons, inmates with PTSD often isolate themselves or act out. Those with PTSD need a safe place to work through previous trauma, however, living in jails and prisons creates additional trauma. The stress of living in a correctional setting may cause these individuals to have an emotional breakdown (Kupers, 1999).

Problems with Incarcerating the Mentally Ill

For any individual, living in a jail or a prison would be a stressful experience. Jails and prisons are frequently overcrowded, dirty, and poorly ventilated. They are extremely noisy, with rarely a moment of silence and lights are often left on all day and night. With skyrocketing incarceration rates, overcrowding in correctional facilities has become especially problematic. In fact, studies indicate that crowding increases violence, psychiatric disturbances and suicides in jail. Also, correctional staff members are more likely to become violent, anxious, and aggressive under crowded conditions (Kupers, 1999).

In addition, inmates deal with complete lack of privacy. They must share a living space with roommates and are subject to regular body and room searches. They are no longer able to make their own decisions and have no control over their environments. This lack of freedom and autonomy may cause inmates to feel powerless. Inmates are separated from their loved ones and

given very minimal contact. Additionally, jails and prisons have limited programming and productive activities for inmates. Many spend their days playing cards or sleeping.

Inmates with mental illness do not cope well with the sensory deprivation, social isolation, and lack of meaningful activity characteristic of jails and prisons. In fact, incarcerating mentally ill individuals presents a plethora of difficulties. For one, mentally ill offenders often remain in jail longer than normal prisoners, contributing to overcrowding and wasting tax dollars. This is due in part to the fact that many mentally ill offenders receive disciplinary infractions while incarcerated which extends their sentences. Also, the mentally ill are less likely to get bail. For instance, in Florida Orange County Jail, the average stay for all inmates is 42 days, compared to 215 days for mentally ill inmates (Torrey et al., 2014)

Mentally disordered prisoners are often called “dings” or “bugs” (Kupers, 1999). They are seen as weak and are taken advantage of or victimized by other prisoners. Most inmates find protection by joining a gang or group while in jail. However, mentally ill individuals often have trouble following prison code. They lack social skills to become part of a group so they are frequently isolated and vulnerable. For this reason, they are more likely to be abused, beaten, or raped.

Another problem with incarcerating the mentally ill is that their fragile mental conditions often deteriorate while incarcerated. Stressful living conditions coupled with grossly inadequate treatment, cause inmates to become sicker while in jail. This puts the mentally ill at risk for a total mental health crisis. One of the most difficult issues presented by mentally ill inmates is risk of suicide.

In addition, mentally ill inmates often cause behavioral problems. They have difficulty obeying authority and are often disruptive. For instance, psychotic prisoners may destroy their

rooms, throw feces at officers, or scream and chant. This puts them at a greater risk to be punished by correctional officers. In fact, mentally ill offenders are more likely to be placed in solitary confinement. Solitary confinement is typically called, “the hole,” supermax, disciplinary segregation, or security housing units. During this time, prisoners are kept alone in a cell for 23 hours a day and given just one hour for showering and exercise. The sensory and social deprivation of solitary confinement is even difficult for neurotypical inmates to endure. In fact, some experience SHU syndrome, which is characterized by unreality, disorientation, anxiety, confusion, difficulty concentrating, and even hallucinations after spending time in solitary confinement (Kupers, 1999). Solitary confinement is especially difficult on mentally ill offenders. Sensory deprivation often makes psychotic symptoms worse and isolation greatly worsens depression. Suicide attempts often occur when mentally ill inmates are in solitary confinement (Torrey et al., 1999).

Moreover, mentally ill inmates are more likely to return to jail after being released. This is due to the fact that most do not receive proper discharge planning. Instead of receiving mental health treatment, substance abuse treatment, education, vocational training and other forms of support, mentally ill individuals often return to the very same circumstances that landed them in jail in the first place. Without proper post-release support mentally ill inmates are very likely to be re-arrested.

One last problem with incarcerating the mentally ill is that they cost counties and states more than normal prisoners. For instance, in Washington State prisons in 2009, seriously mentally ill inmates cost \$101,000 a year to incarcerate, while other prisoners cost \$30,000 per year (Torrey et al., 2014). Much of these costs come from providing psychotropic medications.

The longer sentences served and high recidivism rates for the mentally ill also contribute to increased costs.

Women in Jails and Prisons

From 1980 to 2010 the number of women in US prisons increased 646%. Currently over 200,000 women are incarcerated in the United States (Incarcerated Women, 2012). In a male dominated system, the unique needs of women are often overlooked. Ultimately, women experience incarceration differently than men. They cope differently, have distinct emotional reactions to incarceration and present unique concerns such as motherhood and sexual harassment. In addition, since women's prisons are smaller and less common than men's, they often provide fewer programs and services.

Demographically, female inmates are very different than males. A typical female inmate is often a minority between the ages of 25-29. She most likely never finished high school and has only held low-wage jobs (Peter, 2011). Moreover, most females inmates are first-time offenders for nonviolent crimes such as drug and property offenses (Kupers, 1999). In fact, as of 2010, only 35.9% of female inmates committed a violent crime, compared to 54.4% of male inmates (Incarcerated Women, 2012). Of the women who do commit violent crimes, they are much more likely to assault or kill someone they know, whereas men are likely to harm strangers. Women in jails and prisons have often endured extremely hard lives, which experts call "lifetime trauma exposure" (Peter, 2011). They are also more likely to enter prison with serious preexisting issues like mental illness, substance abuse, and medical conditions.

Due to female inmates' psychological, social, and medical needs, they tend to adapt to prison life very differently than men. While many male inmates have a "do your own time code", female inmates often form relationships and bonds while incarcerated. They tend to protect one another and are less likely to victimize mentally ill inmates. Below is a list of issues unique to women. Unfortunately, current jails and prisons are built primarily with men in mind. In order to reform treatment of women in prisons, these specific issues must be addressed.

Issues Specific to Women

Motherhood

One especially important issue when considering women in jails and prisons is motherhood. Given the paper topic, this is an especially important focus because motherhood has complex psychological impacts starting from pregnancy and beyond. About 80% of female inmates are mothers (Peter, 2011) and pregnancy while incarcerated is not uncommon. In fact, some estimates suggest that as many as 1 in 12 female inmates are pregnant at the time of their incarceration (Fagan & Ax, 2003). This is problematic because prenatal care in jails and prisons is often subpar. In fact as of 2010, 43 states did not require medical visits for incarcerated women. Some states even allow women to be shackled while giving birth, which increases the risk of blood clots. When a pregnant inmate has her child she is only allowed to spend 24-48 hours with the baby. The child is usually given to a relative or placed in foster care if there are no other alternatives. Although uncommon in the United States, as of May 2013, 9 states had prison nurseries. These facilities provide separate areas where incarcerated mothers can live with their children. Although the cost of raising a child in jail is estimated at \$24,000 a year, this can be offset by reductions in recidivism. In fact, a study by the Nebraska Correctional Center found

that only 9% of women who were allowed to raise their children in jail were re-arrested, compared to 33% of women who had been separated from their children (Lee, 2012).

Female inmates who already have children must leave them behind during incarceration. Many children with parents in prison act out during this time. They may get involved in drugs or crime while a parent is away. These mothers feel guilty and struggle greatly with this separation. In fact, women are actually less likely than men to see their children while incarcerated because the mother is usually the one to bring children to visit their father, not vice a versa (Kuper, 1999). Also, there are fewer women's prisons than men's prisons. This makes visitation difficult because women are often housed in correctional facilities very far from home. In fact, over 50% of mothers reported never seeing their children during incarceration (Fagan & Ax, 2003). Maintaining family bonds is important for any prisoner. Visits with loved ones are a privilege, something for inmates to look forward to. This can actually motivate inmates to stay out of trouble and improve their wellbeing. In fact, research shows that contact with family members throughout incarceration reduces rates of recidivism (Kuper, 1999).

Nutrition

Most correctional facilities provide meals based on the nutritional needs of much larger, physically active male inmates. For this reason, the level of carbohydrates, fats, and sodium of food in correctional facilities is much too high for women. This can lead to health problems like obesity, hypertension, and Type II Diabetes. In fact, female inmates incarcerated for over 18 months reported an average weight gain of 20 pounds (Fagan & Ax, 2003).

Appearance and Self-Esteem

During incarceration, women are more likely than men to suffer from issues of self-esteem. For many females, their appearance is a large component of their identity and self-

esteem. The austere restrictions placed on their clothing, make-up and appearance take away from women something that once made them feel good about themselves. Female prisoners often feel unattractive and masculine in uniforms. On top of this, the weight gain experienced by female inmates also greatly reduces self-esteem.

History of Trauma

As previously stated, a large number of female inmates have very traumatic pasts. In fact, 80% of female inmates reported a history of physical, sexual, or domestic abuse. About 19-40% report that abuse began during their childhood and 20-80% report abuse during adulthood (Fagan & Ax, 2003). In addition to previous abuse, while in jails and prisons sexual abuse from correctional staff is not uncommon.

These traumatic histories contribute to many other complications female inmates face, like addiction and mental illness. For instance, these women may turn to drugs and alcohol to deal with the pain of abuse. In fact, women who are abused are 4 times more likely to abuse drugs than those with no history of abuse. These traumatic pasts are also related to increased incidence of anxiety, mood, sleep, eating and identity disorders among incarcerated women (Fagan & Ax, 2003). In general, jails and prisons lack the supportive services needed to help these women. In fact, the stress of incarceration often introduces additional trauma.

Discipline and Sexual Harassment

In terms of discipline, women's prisons tend to have more rules than men's prisons. The rules are often petty and nitpicky addressing things like how to act at the dinner table and keeping cells clean (Kuper, 1999). In addition, officers often use unnecessary physical force or sexually harass the women. This is especially problematic for these women because female inmates often have a history of physical or sexual abuse. Sexual harassment from a correctional

officer may evoke painful memories for female inmates who are all too familiar with abusive treatment from men. In addition, women are under constant watch by correctional officers even when they are showering, going to the bathroom or undressing. They are also subject to cell and body searches from officers. This lack of privacy and strict monitoring is often especially difficult for women.

Mental Health

The harsh conditions in jails and prisons can greatly exacerbate or contribute to the onset of mental illness. In fact, 73% of female inmates reported mental health problems, compared to 55% of men (Incarcerated Women, 2012). Men are more likely to become angry and aggressive during incarceration, whereas females are likely to internalize and become depressed (Kuper, 1999). In addition to depression, another common mental health illness encountered in female inmates is PTSD. This is due to the fact that many were physically or sexually abused. Women are more likely than men to seek out services to get help for their mental illness, but treatment programs in women's prisons are scarce and inadequate.

The Law and Mental Illness

The purpose of this section is to provide legal framework on how criminal law handles cases involving the mentally ill. When the mentally ill commit a crime whether or not they should be held accountable is often called into question. First, the judge must determine if an individual is competent to stand trial. Competency means that the defendant has the intellectual capacity and rationality to understand the legal proceedings. Generally, standards for competency are very low. Insanity, on the other hand, refers to the individual's mental state at the time of the crime. By definition, insanity describes a mental illness that is so severe an

individual cannot distinguish reality from fantasy and demonstrates uncontrollable, impulsive behavior.

A common dilemma encountered in courts is that mental illness does not always mean an individual is insane or incompetent to stand trial. In fact, many individuals with mental illness do not have impaired intelligence at all. Some are very intelligent and can proficiently understand the legal proceedings against them. For example, some people with disorders like schizophrenia have extremely high IQ's, but are so entirely consumed by delusions and hallucinations that they are not rational (Slate & Johnson, 2008). Determining whether or not a severely mentally ill individual is competent to stand trial and sane enough to be held accountable for his/her actions is a fine, often blurred line.

If a criminal is found to be not guilty by reason of insanity they typically receive involuntary civil commitment. This means that these individuals are removed from society and must undergo court-ordered treatment in a psychiatric facility. Another complication that arises is when severely mentally ill offenders do not meet the criteria for insanity, yet mental illness was a factor in their criminal behavior. In order to deal with this dilemma, the "guilty but mentally ill" sentence was adopted. A guilty but mentally ill conviction allows offenders to receive psychiatric treatment and then after they have been discharged from hospitals serve the remainder of their sentence in prison (Borum & Fulero, 1999). Unfortunately, a guilty but mentally ill verdict isn't much of an improvement from simply being found "guilty." In fact, this verdict does not guarantee mental health treatment. Some research even suggests that guilty but mentally ill defendants actually serve longer sentences than the average guilty defendant (Slate & Johnson, 2008).

The Right to Mental Health Treatment during Incarceration

The Eighth Amendment of the US Constitution, which prohibits cruel and unusual punishment, guarantees prisoners the right to treatment while incarcerated. This right was originally affirmed by *Estelle v. Gamble* in 1976. Years later, subsequent court cases confirmed that this right to treatment extends not only to physical ailments, but mental illness as well. In a famous case in 1980, known as *Ruiz v. Estelle*, a group of inmates evoked a lawsuit against Texas correctional facilities for overcrowding, inadequate medical care, and inhumane conditions. Judge William Wayne Justice settled this case by mandating several terms for minimally adequate mental health treatment in jails and prisons. These terms were as follows: a system of screening for mental illness, treatment that involves more than simply segregating and supervising mentally ill inmates, employment of mental health professionals, maintenance of mental health treatment records, appropriate and safe prescription of psychotropic medication, and a basic program for addressing suicide (Slate & Johnson, 2008).

While this lawsuit was settled in 1980, many of these guidelines provide the framework for mental health treatment standards in jails and prisons today. Currently, minimum standards for correctional health care have been published by the National Commission on Correctional Health Care, the American Psychiatric Association, and the American Public Health Association. Jails and prisons can apply for inspection to receive accreditation from these organizations, but these standards tend to be ambiguous. In fact, many correctional facilities with accreditation still provide grossly inadequate mental health services (Kupers, 1999). One major step to improving mental health treatment is revising these standards and requiring all correctional facilities to achieve accreditation.

Current Laws and Treatment Practices in Pennsylvania

Recently, Pennsylvania jails and prisons have been harshly criticized for their treatment of the mentally ill. Currently, the PA Department of Corrections does not allow involuntary administration of psychotropic medications unless the situation is an emergency. Many Pennsylvania prisons use Psychiatric Observation Cells (POCs) in which mentally ill are housed and controlled for problem behaviors until they can be evaluated and moved to a Mental Health Unit (Torrey, 2014).

In March 2013, the PA State Department of Corrections was sued by the Disability Rights Network of Pennsylvania for excessive use of solitary confinement. A civil rights investigation of the Pennsylvania prisons found that hundreds of mentally ill prisoners were being kept in solitary confinement for months and sometimes years. The Justice Department described these conditions saying, “They are routinely confined to their cells for 23 hours a day; denied adequate mental health care; and subjected to punitive behavior modification plans, forced idleness and loneliness, unsettling noise and stench, harassment by correctional officers, and the excessive use of full-body restraints” (Berman, 2015). Solitary confinement is harsh for all prisoners, but for the mentally ill it can lead to psychotic episodes, self-mutilation, depression, and suicide (Torrey, 2014).

This lawsuit was settled on January 6, 2015 mandating that mentally ill inmates must be sent to secure treatment units where they will receive up to 20 hours a week of mental health treatment outside of their cell. Additionally the settlement maintains that as of July 1, 2016 no severely mentally ill inmate may be placed in solitary confinement. Fortunately, the Pennsylvania Department of Corrections has already begun to implement changes. In fact, the number of people with severe mental illness in solitary confinement cells has decreased from 850

to 150 (Glazer, 2015). In addition, Pennsylvania jails and prisons are making efforts to develop new treatment units for the mentally ill, create peer support programs and provide mental health training for employees (Berman, 2015).

Mental Health Courts

Under the Americans with Disabilities Act, all courts have the responsibility to make accommodations for the mentally ill. However, with vast numbers of mentally ill being needlessly incarcerated, these accommodations are not feasible in traditional courts. Mental health courts are specialized judicial programs that focus on problem solving rather than punishment of the mentally ill. These courts strive to connect the mentally ill with treatment options in order to prevent unnecessary harm due to incarceration and future recycling back into the criminal justice system.

The first mental health court was established in Broward County Florida in 1997 after a civil lawsuit case against Florida's Department of Children and Families. The event that inspired the lawsuit surrounded a man, who had a traumatic head injury which caused him to have hallucinations. While at a grocery store, the man began to hear voices and ran into an old woman causing her to fall to the ground. Witnesses say the man tried to help the woman by picking up the fallen groceries. However, the woman died from injuries due to the fall. The man who accidentally ran into the woman was charged with manslaughter. However, his lawyer fought back, saying that his client was failed by the mental health and criminal justice system. Eventually, the client won the case, receiving a \$17 million award (Slate and Johnson, 2008). It was this lawsuit that inspired Broward County to reform traditional court practices for cases involving the mentally ill.

Broward County's mental health court employed a court clinician and a court monitor to assist the judge. The court clinician was a licensed clinical social worker from the Florida Department of Children and Families. The court monitor was from a local private mental health center and kept the judge up-to-date on the participants' treatment. The county also changed booking procedures so that officers could check off a box on a form if they noticed any signs of mental illness during the arrest. This ensured that mentally ill individuals were referred to mental health courts as opposed to traditional courts. In addition, when registering offenders, Broward County developed a computer system which allowed them to obtain one's history of mental illness from local mental health care providers. Lastly, Broward County created teams of specialized trained clinicians called mobile crisis stabilization units to help with transportation and treatment of the mentally ill (Slate & Johnson, 2008). This aided officers who often found it difficult and time consuming to handle the mentally ill. Overall, Broward County's mental health court was integral to reforming traditional courts and set an example for many others to follow.

Within ten years of the first mental health court, 150 mental health courts were opened in the United States (Wren, 2010). Currently, there is no best model for mental health courts; in fact these courts vary greatly from community to community on terms of eligibility, incentives, completion standards, etc. Most "first generation" mental health courts only accepted individuals with misdemeanors, "second generation" mental health courts are beginning to accept those with felonies. Additionally more mental health courts are accepting those charged with violent crimes as long as specific conditions are met. In order to be eligible for participation, mental health courts typically require a diagnosis of serious mental illness. Common diagnoses seen in mental health courts are schizophrenia, schizoaffective disorder, bipolar disorder, and depressive or

other mood disorders. Many participants have co-occurring substance use diagnosis. Some studies suggest as many as 83% (Almquist and Dodd, 2009).

Mental health courts are based on the principle of therapeutic jurisprudence. Therapeutic jurisprudence is the study of how legal systems impact one's emotions, behavior and mental health. The goal of this practice is to focus on repairing harm to victims and the community rather than punishing the offender. In order to accomplish these goals, mental health courts encourage participants to share their stories. The judge is empathetic and strives to individualize treatment. The court works with community mental health care providers to identify treatment options such as housing, case management, substance abuse programs and primary healthcare. This allows the courts to monitor and assess the efficacy of these community programs. Mental health courts encourage family members to be a part of the participants' treatment and recovery. Additionally, public safety increases because instead of just recycling through jails and prisons, the mentally ill are well supervised to make sure that they are functioning in the community. Participants are encouraged to comply with treatment through various incentives such as verbal praise, program completion certificates, reduced court appearances, and dismissal of charges. Jail time is rarely used as a punishment for noncompliance.

However, one issue with mental health courts is the delay between the initial arrest and subsequent court date. According to a 2005 study, of seven mental health courts, wait time between referral and entrance to mental health courts took between 0-45 days (Almquist and Dodd, 2009). This is a problem because many people with mental illness cannot afford bond amounts; therefore they have to wait in jail before potentially being placed into treatment facilities or outpatient programs. This time spent in jail can be very damaging for people with mental illness, exacerbating an already fragile condition. Minimizing these delays is crucial.

Incarcerating the mentally ill, even for a brief period of time is detrimental to their mental state and a waste of money.

Another issue with mental health courts is that they depend on existing community resources. Often, the quality of treatment services that judges are referring participants to is subpar. Mental health courts are not focused on creating mental health services within the community; they simply link participants to existing resources. In order for mental health courts to be effective the community needs to have adequate mental health services. Additionally, there tend to be delays in linking individuals to these services. For instance, a mentally ill individual may run out of medication before they begin seeing an outpatient clinician. Or delays in Medicaid funding may postpone treatment. Such delays put the mentally ill in a fragile position in which they are more likely to run into trouble with the law. These gaps in treatment need to be addressed to minimize encounters of the mentally ill with the criminal justice system and maximize efficacy of mental health courts.

Overall, despite these concerns, there have been many benefits since the implementation of mental health courts. The initial investment of resources to establish these courts has been shown to pay off in the long run by significantly reducing recidivism rates for the mentally ill. By keeping the mentally ill out of jails and prisons we are greatly improving the quality of life for the mentally ill and saving taxpayers money. In fact, according to a California Mental Health Court, it costs \$12,000 per year to house a prisoner in a county jail, compared to \$32,000-35,000 to house a mentally ill individual (Slate & Johnson, 2008). Thus it would make sense to invest in community resources to prevent the mentally ill from going to jail. In addition, mental health courts are improving services within the community by holding the providers accountable to provide satisfactory treatment. Moreover, outcome data suggests that participants in mental

health courts reported more positive interactions with the judge and felt as though they were treated with more respect and fairness than in traditional courts (Wren, 2010).

Law Enforcement Response to the Mentally Ill

When officers are called to a scene they expect obedience and compliance. However, when dealing with the mentally ill, often this is not the case. Mentally ill are sometimes confused, chaotic, and unable to obey commands. They are not purposefully trying to be defiant, but to an untrained officer it would appear so. One way to address the issue of mentally ill in jails and prisons is to prevent them from arrest in the first place. Officers need to be able to discern between true criminals and mentally ill. They need learn techniques to de-escalate confrontations and they need to be aware of alternatives to arrest.

The first few seconds of a police interaction with a person with mental illness are imperative. Often during these situations, there is fear and stress on both ends. Police officers may have preconceived notions that the mentally ill are violent and dangerous. However, in actuality less than 1% of people with mental illness ever exhibit violent behavior (Slate and Johnson, 2008). An overwhelmed and untrained officer may use force or immediately arrest the mentally ill individual, which will only worsen the situation. In fact, mentally ill individuals are 4 times more likely to be killed by the police (Cordner, 2006). Training officers to keep bystanders away, use negotiation skills, maintain a positive attitude, use anger management will prevent unnecessary escalation and arrests.

Across the US, many states have implemented mental illness training and specialized units of officers to deal with mental health crises. For instance, in Long Beach California, the police department has a Mental Evaluation Team (MET) consisting of an officer with a graduate education and a mental health professional. These pairs are called to the scene to respond to police encounters with mentally ill individuals. In Birmingham, Alabama specialized officers called Community Service Officers (CSOs) are employed. These are officers that have a degree in social work and are capable of providing social services to those with mental illness. CSOs even have their own vehicles so that they can arrive at the scene when they are needed.

A recent NPR report highlighted the Los Angeles Police Department for having “the nation’s largest mental health policing program of its kind.” The LAPD’s widely successful Mental Evaluation Unit partners officers with county mental health workers. Street police officers are required to call the triage desk of the Mental Evaluation Unit whenever mental illness seems to be a factor in the call. At this point, county mental health workers help police officers deal with the crisis. For more serious cases, the unit has 18 teams of cops and clinicians which can be sent to the scene for additional help. This system has been especially effective because police are able to discuss the criminal records of clients while the mental health workers have access to their medical records. Last year the LAPD’s Mental Evaluation Unit was able to assist police officers in 4,700 calls. Most of the time, these calls were able to divert mentally ill from jails and prisons and direct them to the treatment they need. In fact, last year only 8.5% of calls resulted in arrest. However, when this happens, the LAPD does not stop there. They actually follow up with these individuals throughout incarceration and reach out to them when they are discharged to ensure they seek treatment (O’Neill, 2015).

Mobile Crisis Teams

Another option is to employ specialized teams that are separate from law enforcement officials. For instance, Mobile Crisis Teams are interdisciplinary teams of mental health professionals that do not have the authority to make arrests, but can be called to help officers if needed. These teams can consist of social workers, nurses, psychiatrists, psychologists, addiction specialists, and peer counselors. MCTs are often sponsored by voluntary agencies or public hospitals. In response to a mental health crisis, MCTs would provide expertise in dealing with the mentally ill (Slate and Johnson, 2008).

Crisis Intervention Team Training

Crisis Intervention Team training is a training program aimed to teach officers how to respond in situations involving persons with mental illness or developmental disabilities. The CIT model has been successfully implemented in many states and is considered a “best practice” model in law enforcement. CIT trains officers on how to safely intervene with mentally ill individuals, connect them with mental health services, and divert them from jails and prisons when possible.

The CIT model was spearheaded by the Memphis Police Department. In fact, many states have subsequently based their own CIT programs after the Memphis CIT Model. The development of CIT was inspired by the death of 27 year-old Joseph Dewayne Robinson in 1987. Robinson had a history of mental illness and substance abuse. While high on cocaine, Robinson stabbed himself in the throat with a butcher knife. He then proceeded to lunge toward police officers who shot and killed him in response. After this incident, community members were furious and demanded change. Tragedies like this were not uncommon, in fact there were at least seven mentally ill people shot by police each year in Memphis (Sweeney, 1999).

After this tragic event, a group of law enforcement officials, clinicians, and mental health advocates came together to create the Memphis CIT Model. The primary focus of the model is 40 hours of specialized training provided by mental health clinicians, consumer and family advocates and police trainers. CIT trains officers on how to recognize the signs and symptoms of mental illness, identify community resources and alternatives, and de-escalate the confrontation. Training typically includes background on the mentally ill in the criminal justice system, types of mental illness, treatment, co-occurring disorders, suicide, and departmental policies. Training also includes information on developmental disabilities, substance abuse, dementia/Alzheimer's disease and cultural differences.

An integral component of CIT is creating partnerships between law enforcement and mental health providers in the community. Before CIT programs, police officers and mental health providers were often distrusting of one another. Police officers felt as though hospitals were not providing appropriate care to the individuals they brought in, while mental health providers believe police officers were unsympathetic to mental illness and would worsen crises. Often CIT training brings in clinicians from the local community to share their expertise.. Often officers are given tours of local resources such as mental health facilities, drop-in centers, emergency rooms, and assisted living facilities. The goal is to familiarize officers with these services in the community so that they can utilize them during future encounters with the mentally ill.

In addition, officers watch videos and engage in role-playing exercises to practice communication and de-escalation techniques (Slate and Johnson, 2008). Some CIT training programs have even used audio headsets to simulate what it is like to have schizophrenia. These training modules ask officers to complete a variety of tasks while hearing voices in the headset.

Moreover, officers are trained to avoid using force with mentally ill individuals. Instead of using lethal weapons, CIT officers are trained on using things like tasers, stun guns, and pepper spray if they need to gain control. CIT training also emphasizes a systematic approach which encourages family involvement. Family members of the mentally ill are often responsible for making the call to CIT officers and are vital to obtaining background information.

Call dispatchers are trained to recognize crises involving mental illness and will assign these calls to CIT officers. Upon arrival to the scene, CIT officers can be identified by a special pin worn on their uniforms. This is especially comforting to those with mental illness and family members of the mentally ill who can look for these pins when law enforcement is brought to the scene (Slate and Johnson, 2008).

As of 2011, there were over 1,000 CIT programs being implemented worldwide (Watson & Fulambarker, 2012). Not only have these programs been widely successful, but they are also relatively low cost. In fact, most instructors donate their time. The greatest cost would be allocating time to allow officers to attend the training sessions. The only supplies needed are training manuals and reference guides for local community resources. Outcome studies indicate that CIT has been effective in decreasing injuries to persons with mental illness, increasing transport to community mental health providers, and reducing jail suicides. In addition, CIT has reduced the number of arrests for those with mental illness. In fact, one study found that during police encounters with the mentally ill, CIT trained police had a 6.7% arrest rate, compared to 20% arrest rate for the national non-CIT average (Slate and Johnson, 2008).

Overall, implementing CIT training is essential to addressing the issue of mentally ill in jails and prisons. Currently, only half of US police departments have some form of specialized mental health training for police officers and only 10 percent require CIT training (Kindy, 2015).

Training law enforcement to help, rather than punish the mentally ill, has countless benefits. The mentally ill will be more likely to receive the treatment they need. Proper treatment will reduce mental health crises and increase public safety. Consequently, less mentally ill individuals will be entering jails and prisons. Less prisoners means taxpayers will save money. Additionally, by educating officers about mental illness, CIT training is crucial step to reducing the stigma against the mentally ill.

Discharge Planning

For recently discharged inmates, the highest risk of recidivism is within 6 months after release from prison (“Ill-Equipped,” 2003). Often, when inmates are discharged from correctional facilities, they are homeless, unemployed, lacking an education and are returning to strained relationships at home. This position is already difficult enough, but individuals with mental illness are in an even more vulnerable and complicated situation. Upon discharge, many of these individuals do not follow through with mental health treatment. They are often unaware of community based treatment options or they do not have the resources to utilize these programs. For instance, when inmates are released they are faced with delays in public benefits that would otherwise allow them to pay for treatment. Although not required by federal law, 90% of states terminate Medicaid benefits while inmates are incarcerated and require them to reapply when released. Additionally, federal law requires that Supplemental Security Income (SSI) benefits are ended if an individual is imprisoned for over a year. Also Social Security Disability Insurance (SSDI) is suspended when one is incarcerated. Without access to psychotropic drugs, many mentally ill inmates with co-occurring substance use disorders choose to self-medicate

when they are released (Slate & Johnson, 2008). Each of these factors contributes to increased likelihood of a mental health crisis and subsequent conflicts with the law. Without adequate connection to housing, vocational/employment opportunities, and treatment our criminal justice system is basically setting the mentally ill up for failure. With all the odds stacked against them, how can we expect these individuals to avoid recycling back into the criminal justice system?

In 1976, the US Supreme court case *Estelle v. Gamble* mandated that jails and prisons must provide mental health treatment during incarceration. However, for many years, mental health treatment post-incarceration was largely overlooked. In 2003, a lawsuit known as the Brad H. lawsuit addressed the lack of discharge planning for the mentally ill. Brad H. was a 44 year-old man from New York suffering from schizophrenia and homelessness. Out of the 26 times Brad was treated for mental illness in jail, he was never once referred to community-based treatment. In response, attorneys sued the Department of Correction against New York State's Mental Hygiene Law and argued cruel and unusual punishment. The class action suit proposed that when released from jails and prisons those with mental illness receive a proper supply of medication, shelter, linkage to mental health services, and immediate restoration of benefits such as Medicaid and food stamps. The case was settled in January 2003 upon agreement that New York would begin to provide discharge planning for those who received mental health treatment while incarcerated (Slate & Johnson, 2008).

Unfortunately, lack of discharge planning continues to be a problem across the United States. In fact, a study by the Bureau of Justice Statistics found that 34% of adult correctional facilities did link released inmates with mental health treatment in the community. Moreover, of the 66% of facilities that claim to provide discharge planning, the quality of treatment and whether or not prisoners actually obtain the care is unknown ("Ill-Equipped," 2003). The most

recent estimates of US recidivism rates suggest that 67.8% of inmates are re-arrested within 3 years of release and 76.6% are re-arrested within 5 years. These astounding recidivism rates clearly illustrate that discharge planning for released inmates is grossly inadequate.

Jail Diversion Programs

The goal of jail-diversion for the mentally ill is to divert individuals with mental illness from the criminal justice system by providing connections to community-based treatment and supportive services upon release (Slate & Johnson, 2008). Discharge planning involves creating a plan for treatment before the inmate is released. All too often, discharge planning is left in the hands of the inmate. In order for successful re-entry into the community, inmates need a mentor or case manager. They need someone who is knowledgeable of the supportive services within the community and a mentor to encourage them to comply with treatment. Additionally, the inmate's family and friends should also be involved. While there are many models of discharge planning in practice, the most basic plans for re-entry for the mentally ill should include: at least one month supply of medication, housing, immediate restoration of public benefits, and a case manager. After thorough mental health screening, treatment should focus on rehabilitation. The mental and physical health of participants should be addressed. They may need assistance finding education and employment opportunities. And lastly, involvement should be as least restrictive as possible so that participants feel as though they have a choice in their treatment.

In a study of 6 jail diversion programs, results indicated that jail diversion resulted in less time spent in jail (with no increased risk to public safety) and saved money for the correctional system (Slate & Johnson, 2008). Researchers made note that as a result of these savings, the mental health system acquired higher costs. However, with time, these costs would eventually be

offset by preventing future incarceration and expensive treatment interventions such as admission to psychiatric hospitals.

Examples of Diversion Programs

Bexar County Jail Diversion Program

One exemplar jail diversion program was created at Bexar County Jail in San Antonio, Texas in 2006. This program has been so successful that it received the American Psychiatric Association's "Gold Award" for Program Innovation and the National "Program Service Excellence Award" from the National Council of Behavioral Healthcare. The Bexar County Jail Diversion Program is separated into 3 phases to assist mentally ill offenders before, during, and post incarceration (Slate & Johnson, 2008).

One of the most impressive aspects of this program is its Restoration Center which offers a 48-hour inpatient psychiatric unit, outpatient psychiatric and primary care services, detox centers, a 90-day recovery program for addicts, housing for the mentally ill, and job training. One branch of the Restoration Center is the Crisis Care Center which functions as 24/7 receiving facility for police to drop off mentally ill individuals. This frees up time for the police and has been integral in preventing arrests and connecting the mentally ill to treatment and social service programs. Bexar County's strategy for jail diversion has saved the city more than \$10 million each year (Moser, 2014).

The Nathaniel Project

Another successful program is The Nathaniel Project, a two-year alternative to incarceration program developed in New York City in 2000. The program was named after a homeless man with mental illness who had been recycling through the criminal justice system for 15 years ("Nathaniel ACT," 2015). While most jail diversion programs

target offenders with low level misdemeanors, the Nathaniel Program addresses the needs of felons who face lengthy terms in jails and prisons. To be eligible, clients must meet criteria for Axis I psychiatric disability. Common diagnoses are schizophrenia (33%), schizoaffective disorder (21%), bipolar disorder (21%), and psychotic disorder (4%) (“The Nathaniel Project,” 2005). Participants are usually referred to the program by defensive attorneys, judges, or mental health clinicians. The goal of The Nathaniel Project is to help individuals with mental illness avoid dangerous behaviors and substance abuse. After two years, if participants successfully complete the program, their charges will be dropped or reduced. However, if the client does not successfully complete the program she/she will receive an extensive prison sentence.

Typically treatment plans involve supervised housing or a residential treatment program. This is because most participants are homeless (92%) and many have substance abuse disorders (88%). Other supportive services include clinical treatment, referrals to education, employment opportunities, vocation training, and help obtaining public assistance such as Medicaid and food stamps (“Nathaniel ACT,” 2015). Once a participant is permitted to live out in the community, they are still supervised carefully by “intrusive case management.” At minimum, participants must meet with case managers 3 times a week. In addition, case managers often accompany clients to appointments and court dates (“The Nathaniel Project,” 2005). Overall, the Nathaniel Project has produced many positive outcomes which can be measured by public safety, retention of participants, treatment and housing. For instance, in one study, clients made significant improvements in number of arrests, which dropped from 101 arrests to 7 arrests a year after intake. Retention rates remain at an impressive 80%, all participants received

treatment services, and after 1 year, 79% of clients had permanent housing (“The Nathaniel Project,” 2005).

Re-entry Programs

Another type of discharge planning involves re-entry programs, specifically aimed at aiding prisoners in their return to the community. In general, there is a stigma that prevents many mentally ill individuals from seeking treatment within the community. This stigma is even greater for mentally ill offenders because they are often seen as a threat to public safety. Re-entry plans not only need to connect the mentally ill to treatment services, but they must address the reservations community members and treatment providers may have toward this population (Slate & Johnson, 2008). Effective re-entry programs employ clinicians who are empathetic to recently released offenders. Treatment providers should be educated on inmate survival code and why some offenders are resistant to sharing information. Two examples of such programs are Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM) and Re-entry After Prison (RAP) (Slate & Johnson, 2008).

One program that has spearheaded many re-entry efforts is Assertive Community Treatment (ACT). ACT provides 24/7 support to the mentally ill who have been released from jails and prisons. ACT teams include clinicians trained in psychiatry, nursing, social work, substance abuse, and employment services. The goal of ACT is to prevent future incarceration, hospitalizations, and homelessness. ACT programs have proven to be effective in lowering re-arrests, decreasing hospital stays, increasing housing, and improving quality of life for mentally ill individuals. In fact, after implementing ACT programs, one study reported 85% fewer

hospitalizations, saving over \$900,000 a year. Additionally, the study reported an 83% reduction in jail stays (“Assertive Community Treatment,” 2007).

Parole

Another area of special concern for discharge planning is mentally ill offenders who are released on parole. Parole refers to offenders who are released from prison on good behavior and permitted to serve the remainder of their sentence in the community. Parolees are supervised by parole officers and must adhere to specific conditions while in the community. Unfortunately, very few parole programs address the needs of mentally ill offenders. In fact, in a survey of parole administrators, less than 25% reported offering any specialized programs for individuals with mental illness (Slate & Johnson, 2008). This is a serious problem because violation of parole conditions results in recycling of the mentally ill back into jails and prisons. Not surprisingly, a study of California parolees, found that mentally ill parolees were more likely to violate parole and return to custody (Louden & Skeem, 2011). Judges need to be considerate of mentally ill offenders when creating conditions of parole. Otherwise, judges risk setting unreasonable and unrealistic expectations. Without proper consideration of mentally ill parolees, we are basically setting them up for failure.

Probation

Probation refers to supervision within the community instead of incarceration. The difference between parole and probation is that parole occurs after incarceration (as early release), whereas probation occurs prior to incarceration. Therefore, probation is an essential component to preventing the mentally ill from entering jails and prisons. Unfortunately, the

majority of probation officers are not properly trained to deal with persons with mental illness. In fact, a nationwide study in 2000 found that only 15% of probation departments had specialized programs for mentally ill probationers (Slate & Johnson, 2008). While their primary concern is public safety, probation officers should also focus on rehabilitation. In fact, research indicates that establishing specialized mental illness caseloads improved functioning for mentally ill offenders and reduced the risk of parole violation (Slate & Johnson, 2008). Training probation officers to carefully address the needs of mentally ill individuals is just another step to preventing incarceration of the mentally ill.

Conclusion

Overall, jails and prisons are no place for the mentally ill. Incarcerating those with severe mental illness simply ignores, rather than treats the origin of the problem. Inmates suffering from mental illness are extremely vulnerable and often leave jail sicker than when they entered. This lack of treatment is inhumane and has devastating consequences for the mentally ill as well as the community at large.

Benefits of Removing the Mentally Ill from Jails and Prisons

Housing the mentally ill in jails and prisons is an ethical, safety, and financial issue. Removing the mentally ill from jails and prisons and providing proper treatment will provide countless benefits including:

- *Improved Quality of Life for the Mentally Ill*

During incarceration, the wellbeing of the mentally ill deteriorates dangerously. The trauma of incarceration can exacerbate existing mental health issues or create new ones. Removing the mentally ill from jails and prisons will finally provide this population with the treatment and rehabilitation they deserve. Proper treatment needs to address behavioral, drug and alcohol problems. Incarcerating the mentally ill has allowed our society to neglect this vulnerable population for far too long. Simply locking the mentally ill behind bars to keep them away from the rest of society will never solve these issues. Providing treatment to the mentally ill can help them become productive, positive members of society. This will reduce the stigma of mental illness and greatly improve the quality of life for the mentally ill.

- *Cost Benefits*

Each year, the US is spending billions of tax dollars to incarcerate hundreds of thousands of severely mentally ill inmates. It is evident that the cost of incarcerating a mentally ill offender is significantly more than other prisoners. Removing the mentally ill from jails and prisons will significantly reduce these costs. Cost studies indicate that investing in community resources such as outpatient treatment centers and alternative to incarceration programs pays off in the long run.

- *Reduction in Recidivism*

Due to the lack of community resources and support, mentally ill offenders are much more likely to return to jails and prisons. Thus contributes greatly to overcrowding and high recidivism rates. Providing treatment to the mentally ill prevent these individuals from recycling back into jails and prisons.

- *Increase in Public Safety*

Removing the mentally ill from jails and prisons can reduce crime and increase public safety. Many individuals with mental illness engage in criminal behavior as a result of their mental illness or coexisting substance abuse. Treating the mentally ill, as opposed to locking them up in jails and prisons, actually addresses this root of the criminal behavior.

Solutions

It seems most appropriate to end this paper with some recommendations for addressing the large number of mentally ill trapped in our nation's corrections system. Throughout the course of my research I have encountered many examples of jails and prisons taking steps to address this issue. However there are still thousands of mentally ill individuals suffering behind bars. The bottom line is that correctional facilities are no place for the mentally ill. The ultimate solution to this issue lies within community resources. Mental health treatment facilities in the community need to be strengthened. Providing adequate care to the mentally ill will prevent them from ending up behind bars. Below is a list of several solutions to accomplish the goal of providing treatment, rather than punishment to the mentally ill.

1. Provide accessible outpatient and inpatient mental health services within the community, including substance abuse treatment centers.
2. Establish supportive services to help the mentally ill become productive members of society including: housing assistance, transportation services, vocational training, and education.
3. Create more mental health courts.
4. Reform punitive drugs laws that contribute to unnecessary incarceration.

5. Use court-ordered outpatient treatment.
6. Utilize alternative to incarceration or jail diversion programs.
7. Implement mandatory discharge planning for the mentally ill.
8. Assign case managers to mentally ill offenders upon release.
9. Establish careful intake screening to identify mentally ill inmates.
10. Reform booking procedures so that records are kept of an inmate's mental health history.
11. Never place mentally ill inmates in solitary confinement (unless for emergency purposes)
12. Provide adequate mental health services during incarceration. This should extend beyond simply prescribing psychotropic medication.
13. Implement psychotherapy services in jails and prisons.
14. Develop suicide prevention programs within jails and prisons.
15. Carefully monitor dispensing psychotropic medications to inmates.
16. Require all judicial and legal employees (police, prison guards, probation officers, judges, etc) to complete at least 20 hours of mental health training.
17. Reform jails and prisons to address the unique needs of women.
18. Establish specialized teams of officers and clinicians to respond to mental health crises.
19. Create national standards for minimally adequate mental health treatment.
20. Require all jails and prisons to achieve accreditation for these minimum standards.

Part II: Vignettes

Preface

For the past three years, I have been volunteering at Montgomery County Correctional Facility. I began as an occasional volunteer and since that time I have become the coordinator of two educational programs at MCCF. On Tuesday and Thursday nights I teach a GED prep class to female inmates to help them gain high school equivalency skills needed to pass the GED exam. On Monday nights I coordinate an Adult Basic Education tutoring program for male inmates. My Summer Fellows project and passion for reforming mental health treatment in jails and prisons has been inspired by my volunteer work at MCCF.

These writings are a collection of vignettes based upon my experiences volunteering in a jail. I have chosen to focus solely on women, because I feel as though they present a unique set of issues and needs. Through volunteering I have encountered some of the most kind, strong, genuine and inspiring women I have ever meet. I have gotten to know many of the inmates on a deeply personal level. I have heard their heartbreaking stories and there is a clear cycle of physical and sexual abuse, poverty and addiction behind almost every woman I have encountered. Time and time again, there often seems to be one underlying thread: mental illness. These women are vulnerable, and mental illness is often exacerbated during incarceration, leaving them much sicker than when they entered. These girls have truly been through hell and back. Their traumatic histories tell a greater story, of the immense injustice women in jails and prisons face on a daily basis. Our male-dominated corrections system is grossly ill-equipped to dealing with women's unique needs.

Throughout my time at MCCF I was been put in some very interesting scenarios to say the least. There have been moments where I have laughed hysterically with these women and others where I have been a shoulder to cry on. I've had moments of extreme frustration and disappointment, but I've also had moments of incredible pride. I've had to break up fights between the women, but I've also watched them be incredibly supportive and kind to one another. Some of the women have been extremely guarded; others have shared with me some of their most personal stories.

My vignettes are told based upon my experiences as a volunteer. In order to maintain confidentiality all names have been replaced with pseudonyms. Some of these stories are heartbreaking and disturbing, others humorous and silly. Overall, through these vignettes I hope to draw attention to a group of intelligent and strong women that are consistently written off by society. Inmates are often seen as "social junk." Our society likes to ignore these members of society. By locking them up in jails and prisons we can almost pretend they do not exist. Ultimately I hope that these vignettes will convey one thing: the humanity behind the gates of MCCF. The women I work with are not terrifying criminals that need to be kept out of society. They have families, friends, and jobs outside of the prison, and whether we like it or not, chances are, they will eventually be released and will be sharing the same neighborhoods as the rest of us. Ultimately, these women are *human* and the lack of treatment in jails and prisons is inhumane.

Introduction

The first woman I ever worked with at Montgomery County Correctional Facility was exactly what you would expect when envisioning a stereotypical female inmate. She went by the name "E," which was tattooed elaborately on her forearm. She had short, masculine hair, was

covered head to toe in tattoos, and never cracked a smile. When I sat down next E, I introduced myself excitedly. Immediately, I realized this woman did not want anything to do with me. She barely acknowledged my presence, would not look me in the eye and only mumbled short phrases in response to my questions. For the next two hours I attempted to make conversation with E, but she was not interested. I kept telling myself to kill her with kindness and she would come around eventually. When the two hours were up, E left without much of a goodbye. I did not get the overwhelming gratitude that I was accustomed to receiving when I volunteer, or even a simple thank you.

When I think back to this first day, I am shocked that I ever wanted to go back to MCCF. Even though my first day was rocky, when I left MCCF I could not stop thinking out the women. Looking back, it is crazy to think how far I have come since this first experience. Throughout the past three years I have developed a close bond with these women. The girls love to ask me about college and my sorority. They remember when I have a big test or when I am going on a trip. They ask me about boys, my roommate, my family and career aspirations. Each class I am filled in on the latest happenings in jail. The girls share stories about their cellies, encounters with the correctional staff, and living on their pods. They often sneak in pictures to show me their children, friends, and family and they love to tell me stories about their lives back at home. The women have also opened up to me about their heartbreaking and often disturbing pasts.

When I am alone in the classroom working with these women it is easy to forget that I am in jail. Each night, when GED class ends at 9 o'clock, a correctional officer comes to the door to escort the girls out of the classroom. We walk down a short hall together and then the path opens in two directions. Each time we come to this point I am hit with a pang of guilt. The girls are escorted to the left and I walk to the right. At this point I'm typically mid-conversation with a

student. The officer behind usually seems annoyed as we try to wrap up the conversation. As I part ways with the group, the girls always shout out their last goodbyes. Theresa, one of my favorites, always reminds me to check my backseat before I drive away.

It is not until this moment, when class is over and we must go our separate ways, that I am hit with this stark disparity. When it is time for me to leave, I breeze through several locked gates, hop in my car, turn on my favorite radio station, and then drive comfortably back to school. I am completely free to do whatever and go wherever I please. The women at MCCF do not have this freedom.

While I try really hard to put myself in these women's shoes, it is moments like these that I realize how nearly impossible it would be for me to even come close to understanding what it feels like to be in their position. This makes me think, if I have such a difficult time putting myself in their shoes, can I really blame the rest of the world for being so entirely unaware and apathetic to these women's needs?

Vignettes

Ashley

By far the most memorable, emotional, and impactful interaction I have had with anyone at MCCF was my experience with a woman named Ashley. Ashley was a white woman in her late 20s. Ashley was an absolute pleasure in class; she was enthusiastic, polite, and participated frequently. Every week she would sneak in root beer candies to share with the class. This was not exactly allowed, but I let it go because it made the other girls happy. I became fond of Ashley very quickly. She always called me "Miss Becca" and would joke around that when she got out of jail she was dying to come to one of my sorority's parties.

Ashley quickly opened up to me about her past. She told me that she was suffering from several mental illnesses, including multiple personalities, bipolar disorder, depression, and borderline schizophrenia. She had been battling cervical cancer for 10 years and needed a surgery that the MCCF had denied her. On top of all this, Ashley was also addicted to heroin. She was clean for several months, but recently relapsed after hearing traumatic news about her eight year-old daughter, Jessica. Jessica was living in a different state with her father when Ashley got a phone call that the father became angry and hit Jessica. The hit was so bad that Jessica's eardrum popped. After hearing this news, Ashley had a complete emotional breakdown. It tore her apart that she could not be with her daughter to protect her. She felt completely helpless and no longer wanted to live. She tried to end her life by overdosing on heroin, but was unsuccessful.

According to Ashley, this event is what resulted in her incarceration. She was on probation at the time of her relapse and failed a routine drug test after this suicide attempt. When Ashley told me this story she said, "I am in jail because I tried to kill myself." As absolutely absurd as this statement sounds, Ashley is not lying. Instead of receiving the mental health and addiction treatment she so desperately needed, Ashley was thrown behind bars. When I asked her if she was receiving any treatment at MCCF she said that she was on tranquilizers that just made her sleep all day.

After several weeks of class, Ashley asked me to help her write a letter to her judge before her court hearing. Ashley's court hearing would determine whether or not she would be sentenced to a prison upstate. In the letter we composed, Ashley asked the judge to consider allowing her to obtain mental health treatment. Ashley was completely raw and honest with the judge. She explained her mental health issues, as well as her battle with cervical cancer. Ashley

was not asking for pity in the letter, nor was she asking for leniency. However, she was asking for help.

What broke my heart the most was Ashley's utter self-awareness. She cognizant of her deteriorating mental health and she knew that she needed treatment. She cried to me that day saying she wanted more than anything to just be "normal." Ashley kept saying over and over that she felt like she was crazy. She said with everything going on in her head she couldn't focus on functioning like a normal person. She told me that she feels like she will never be able to get an education or a job because she is so unstable.

We just barely finished the letter when our time together was up and the corrections officer had arrived to escort us out. The officers get annoyed if you make them wait so I quickly wished Ashley luck. She just kind of looked at me and then left quietly, which struck me as odd. However, just as Ashley stepped out of the classroom she abruptly turned around and asked the officer to wait one minute before the door swung shut. I was busy in the classroom packing up my things when Ashley rushed toward me. She was crying and kept thanking me and telling me how much my help meant to her. I gave Ashley a hug and then we walked out of the classroom together as I hastily reassured her and wished her luck at court.

About 48 hours later, I found out that Ashley had attempted to commit suicide. Her court hearing did not go well; she was sentenced upstate and denied rights to a custody hearing for her daughter. After court Ashley was devastated. She cut herself with a razor and bled for over an hour before anyone found her. Jade, one of the girls in class, told me this news with tears in her eyes. She had a custodial job at MCCF and was ordered to clean up the blood in Ashley's cell. Jade said there was so much blood in the cell they were sure Ashley had died.

For a several days, we had no idea whether or not Ashley had survived. It is hard to explain exactly how I felt during these few days. The news of Ashley's suicide attempt hit me harder than I would have ever expected. During those four days I felt physically ill. I could not stop thinking about Ashley. I felt nauseous, and even had dreams about her. It felt like that last image, of Ashley crying and thanking me as we parted ways, had been burned into my brain. I replayed the scene in my head about one thousand times wondering what I could have said or done to make a difference. The thought of failing someone who had been so vulnerable and had so recently reached out for help really tore me apart.

Thankfully, Ashley was immediately hospitalized and survived. Once stabilized, she was taken to Norristown State Hospital, a local psychiatric facility. Ashley stayed at the psychiatric hospital for less than a week before she was discharged back to MCCF. A few days later, she was moved to state prison.

It absolutely sickens me that a mentally ill inmate, whom I cared for deeply, was able to attempt suicide under supposed jail supervision. When entering MCCF, Ashley was clearly suicidal, yet absolutely no precautions were taken to protect her. Ashley practically begged for help and was blatantly denied. Unfortunately, her story is not uncommon. In fact, suicide is the leading cause of death among jail inmates, accounting for 33% of deaths. Correctional staff members are inadequately trained on recognizing and responding to suicidal inmates. Often, officers disregard suicide threats because they think the inmate is simply trying to get attention or be moved to a more comfortable psychiatric facility. Some facilities even punish inmates for self-destructive behaviors.

Miranda

Miranda was a young white woman in her early 20s who had graduated high school and was interested in continuing her education. She didn't need to take the GED, but she took the class very seriously and loved learning. She was confident and quick to participate in class. Miranda always was the first to volunteer if I asked someone to read aloud or do a math problem on the whiteboard. While I appreciated the enthusiasm, I began to notice annoyance from the other students because Miranda consistently shouted out answers before the other girls had a chance. I tried speaking to her a few times, but nothing changed. Miranda was simply excited about the progress she was making in class and was completely oblivious to how this made the other girls feel.

One day, I was teaching adding and subtracting integers and some girls in the class were really struggling. Miranda, as usual, picked up this material very quickly. I could feel the tension in the room building as the other girls started to mumble angry remarks under their breath. Suddenly, Elaine, a woman who was struggling with the lesson, snapped at Miranda. She shouted something like, "Why are you even in this class, Miranda? You graduated high school. Why don't you just shut up and give everyone else a try?" Miranda snapped back, and suddenly the girls were both shouting back and forth at each other. I tried to calm them down, but the bickering continued until Elaine got up and stormed out of the classroom.

When Elaine left Miranda completely broke down. She began crying and shouting that she couldn't take it anymore. Miranda was completely hysterical. With her dark eye makeup dripping down her face she kept shouting, "You do not understand. There is something wrong with me. I am mentally retarded." She was no longer the strong and confident student I came to

know. She was vulnerable and to be honest a complete mess. This moment was a breaking point for Miranda. She said she had enough and wanted to give up on everything.

The next class, Miranda came in with a short story and a poem. Sometimes I assign the girls writing assignments and other times they write freely and ask me to edit their work. I was surprised and a bit nervous, when Miranda asked to share the short story with the class, but I agreed reluctantly. At this point, Miranda was definitely not well-liked in the class, so I reminded the other girls to be respectful while Miranda shared her story. Once Miranda started reading, the eye-rolling and snickering from the other girls in the class stopped almost immediately. The room fell completely silent. Miranda shared the heartbreaking story of a girl who was born to a mother addicted to crack cocaine. The character in the story spent years being shuffled to and from different foster homes, and eventually ended up with an abusive family. In one of the foster homes, she was sexually abused by her “brother.” When the character was eighteen she met a boy and fell in love. Eventually this relationship became physically abusive. She eventually turned to drugs to deal with her depression. Later, she got pregnant and had her child taken away. When Miranda was done reading she revealed that the character in the story was actually herself. She told the class that she wanted to share this with the class so that they could maybe understand her. After sharing her story, Miranda was very emotional. She shared that her biggest disappointment was becoming the kind of mother she never wanted her child to have. Miranda said she felt like a failure because so many people doubted her as a mother and she proved them right.

What happened within the next few minutes completely astounded me. One by one, nearly each and every woman in the class began to comfort Miranda. At first this began very slowly. Many of the girls did not like Miranda and were not completely ready to forgive her for

weeks of annoyance. However, slowly but surely, the women began to speak up. For the next hour and a half I witnessed a complete outpouring of support. The women began to share their own stories. Similar to Miranda, these women also shared a history of physical and sexual abuse. Many had also had their children taken away from them and suffered from addiction. One girl shared her story of being sexually molested by her grandfather. Another shared that one of her children was being raised by her cousin and that the child had no idea she was her biological mother. Another confessed how she turned to prostitution because she needed to feed her children. Countless heartbreaking stories continued for the rest of the class while I watched in amazement, chiming in here and there, but allowing the women to lead. During this time, I heard these women not only share sensitive information, but give incredibly sincerely and thoughtful advice. They could help Miranda because they could truly empathize with her situation. It was truly amazing to watch these women bond together to help Miranda.

Price

Throughout my entire experience at MCCF I can honestly say I have encountered very few women who I genuinely did not like. I am not saying that every woman greets with me with open arms, in fact it often takes some time before the new girls warm up to me. However, I have found that if I treat the women with respect and kindness, I almost always receive this in return. Keyword: almost.

Price was a 30-something, African American woman exploding with personality. Price was loud, abrasive, unpredictable, and brutally honest. When she walked into class one day in November, she took one look at me and said something like, “Oh no, you again? I remember you.” This was certainly not the warm introduction I was planning. I was a bit taken aback. Price

continued, “Last time I was here you didn’t have anything for me. Are you actually going to have something for me to do this time?”

Suddenly I remembered Price. My memory of her was vague, but I did recall meeting her about a year and a half prior. Girls come and go from MCCF all the time as they are moved to prisons or released, so I am used to getting random new students. I always spend a few minutes chatting with the new student to learn about her background, to familiarize her with the class, and give some background information on the GED exam. I try not to overwhelm the new student, but the first day of class can be hectic as I am usually trying play catch up on with what the rest of the class has been learning. I remembered that on Price’s first day she was having a hard time keeping up with the math lesson and was visibly frustrated. She left class early that day and I never saw her again.

With this in mind, I tried to be as accommodating as possible with Price. I was very pleased that she decided to give GED class a second try and I vowed to do my best to ensure that she stuck with it this time. However, Price had returned to class with guns blazing. From her perspective, the last time around I had completely abandoned and neglected her needs. When I asked Price to fill out a brief survey that I always give to new students to get an idea of their educational background and needs she was noncompliant. She kept repeating that I did not understand and that I did not have material that was “on her level.” I tried many times to get Price to explain what exactly her level was, but I did not receive straight answers. Price could not even tell me what grade she had gotten up to in school.

Once again, Price left class early out of frustration. Before she left, I stopped her at the door and promised that if she came back to class I would spend the whole time working individually with her so that we could figure out a plan to meet her needs. Price agreed

reluctantly. The next class I brought very basic lessons to work on with Price, things like simple adding and subtracting and 6th grade reading level passages. Within minutes, I became aware of Price's problem. She could not read or write. I was shocked. Now it made sense why Price refused to fill out my survey and why she was so frustrated. I had never encountered this problem with a student before. The class was focused on high school equivalency, so I always felt safe to assume that I could at least expect middle school reading and math level students. Suddenly, I could understand why Price was so abrasive and overwhelmed. The material that I was working on with the rest of the class was far beyond her level.

From then on I promised Price that each class I would bring an individual tutor for her to work with her. Tutoring Price was certainly a challenge and I felt kind of guilty pushing this off onto the other volunteers. However, I knew I had to focus on helping the rest of the class. Price was very easily distracted and impulsive. She would turn around and poke the other girls in class, randomly break out in song, and loved using my colored highlighters to doodle on her worksheets. In many ways, her behavior reminded me of a young child. In fact, Price was especially attached to one of the other students in class who she called her "dad." Price's "dad" was a masculine woman who was well-respected and liked amongst the others. I asked Price's "dad" about their relationship, and she explained that she looked out for Price like her child. She made sure that Price always had goods from commissary and that no one picked on her. In fact, she revealed that she actually had a high school diploma and that the only reason she decided to sign up for class was to keep an eye on Price.

One day during class Price asked if I would act as a scribe to write for her as she spoke aloud. I agreed with apprehension and confusion, but when she began speaking everything began to make sense. Price was speaking poetry that she had created, but was unable to write herself.

Not only was Price able to create poems, but they poems were actually really good! I was truly shocked that such beautiful and profound thoughts could come from a woman who struggled to read at the most basic level. Price's situation is a heartbreaking paradox. She creates incredible poetry, but her illiteracy prevents her from capturing these thoughts. She wants more than anything to be able to write poems, but until she learns to read, her beautiful words are essentially trapped in her head.

Price made a habit of asking the tutors she worked with to be a scribe for her poetry. Price was extremely particular about how her poems were written and only allowed volunteers with very neat handwriting to write for her. Things were going well with Price, she seemed to be getting along with the tutors and she was making progress. One day I could not make it to MCCF so I arranged for three other volunteers to go so that I wouldn't have to cancel class. Right when I was meeting the group in the parking lot to give them materials for the night, two of the volunteers called and told me they were not able to make it. I quickly scrambled to find at least one other volunteer to go, but I was frustrated because one of the girls who canceled was supposed to tutor Price. I immediately felt a lump in my stomach. I warned the two volunteers that Price was going to be angry. She was expecting this particular student to tutor her today I and knew she would not be happy that she was not there.

I was right about Price. The following week when she came into class she was furious. She walked in the room and immediately started yelling at me. She kept repeating that I had promised her a tutor and that I had lied. She said she trusted that I would bring help and that I had let her down. As much as I was expecting this reaction from Price, her words hurt more than I anticipated. I tried to explain to Price that the situation was completely out of my hands, that

the tutor canceled minutes before the volunteers were going to leave, and that if I could have been there that night I would have in a heartbeat. It didn't matter what I said, Price was stubborn.

When I was about to start class I asked Price to go sit at a different table to work with her tutor and she refused. She said that she did not want to work with the tutor today. There was no point in arguing with Price so I began class. Just as I was about to start, Price called out, "I actually have a poem that I would like to share with the class." I was reluctant and had a bad feeling about this, but I let Price share anyway after she promised it was appropriate. The poem Price shared was about betrayal and others letting you down. The whole time Price was reciting the poem to the class she maintained cold, angry eye contact with me. It was clear this poem was directed at me.

For the next few weeks I felt like I was being bullied by Price. She made it very clear that she did not like me. Many classes she refused to work with her tutor, which was frustrating because I hated wasting the volunteers' time. However, I didn't dare to not bring a tutor after what happened last time. When Price worked with her tutors they told me that she would make fun of me while I was teaching the rest of the class. Often I would overhear Price mimicking me as I was speaking. Sometimes she would insult my clothing; in fact one time she even told me my shoes were ugly. And she constantly harassed me about the time which was difficult because the classroom did not have a clock. Eventually I went out and bought a watch because I was sick of her complaining.

As much as I tried not to take this personally, each class I would secretly pray that Price wouldn't show up. I knew this was wrong, but the class was so much less stressful without an enemy present. What shocked me was that the other girls in class seemed to genuinely like Price. They said she was funny and that she had a good heart.

If anything, working with Price was a definite test of my patience. Looking back, I cannot really blame Price for the way she treated me. I certainly did not appreciate this at the time, but Price was clearly defensive and abrasive for a reason. I never did find out about Price's history, but it was clear that she did not have an easy life. The last I heard, Price was released from jail. I hope that one day she finally learns to read and write, because it would truly be a shame for all of her poems to go unrecognized.

Jane

Jane is a young, biracial woman serving her first (and from what she says, her last) sentence in jail. She says she comes from a very loving family who always supports her. Jane's mother actually works as a correctional officer at a prison in Philadelphia. Jane has struggled with mental illness since she was sixteen years old. She describes how she has been forcibly committed to psychiatric institutions at least 5 or 6 times in her life. She said she eventually turned to alcohol to self-medicate which quickly spiraled into an addiction. Jane wants so badly to join the Alcoholics Anonymous group at MCCF, but she says she has been waiting for weeks to be put on the list. Jane has not yet been sentenced, but is facing 6-20 years in prison for attempted murder of two individuals after an incident she describes as a "black out situation." Jane feels remorse for what she did and makes no excuses. She says wants to serve her time so the people she hurt can feel as though she is making reparations for what she did.

Jane lights up whenever I wear my sorority letters to class. She tells me how she had plans to go to Widener University to study business. She had been matched with a roommate and everything, but at the last minute, her financial aid fell through and she was unable to attend.

When Jane was first admitted to MCCF she was placed on “medical.” From what I have gathered, medical is where inmates are sent if they are sick or having a mental health crisis. Jane was admitted to medical because she was considered suicidal when she was admitted. Jane described her time in medical to me. She said that she had to sit in a room all day alone and with absolutely nothing to do. She was forced to wear a “dignity suit” which is made from heavy, plastic-like material. Otherwise, she had to be completely naked underneath. The worst part for Jane was that she had her period but was not allowed to wear tampons or pads. She would beg the officers for a pad, but no one ever helped. She said that while in medical she would cry all day long. Occasionally, an officer would stop by, see that she was crying, and simply ask, “Are you okay?” Every time, Jane would say no, but the officers did absolutely nothing to help.

Theresa

Theresa is a Caucasian woman in her sixties who has been attending GED class for almost a year now. Theresa is sassy and opinionated. She has a thick Long Island accent and never hesitates to speak her mind. Despite having a high school diploma, Theresa is by far one of the most dedicated students in class. She always does her homework, participates frequently and encourages the other women. Theresa says she is too old for the silly drama amongst the women at MCCF. Even though she tries to keep to herself, it is evident that the others adore her. Theresa has one of those charismatic personalities you cannot help but love.

Despite the less than ideal circumstances, Theresa always has a positive attitude. She told me that the only thing she has left at MCCF is her personality and that no matter what she is, “never going to let this place bring her down.” Whenever Theresa comes to class she full of energy and thrilled to see me. She asks me all about my classes, friends, and family. Theresa

doesn't have kids, but there is something so nurturing about her. When I talk to Theresa I feel like I'm with one of my aunts or something. What I love most about Theresa is that she always makes me laugh. She often comes to class with crazy stories about her "bunkies" at MCCF, like the one young woman who put Vaseline on the bars of her bed so that Theresa would slip when she climbed up to the top bunk. Theresa wears two pairs of glasses stacked on top of each other during class. One pair is for distance, the other for reading, Theresa jokes that they're her makeshift bifocals. The one pair of glasses always had one arm missing. Recently Theresa lost the other arm too. Since MCCF would not allow her to buy another pair of glasses she taped two plastic knives onto each side of the glasses to function as arms. Sometimes I joke that I can't take Theresa seriously when she is wearing two pairs of glasses and plastic knives on her face.

Theresa is serving an 18 month sentence for her third DUI. She says that the third time she received a DUI she actually wasn't driving, but was a passenger with a driver who was under the influence. Nonetheless, Theresa admits to being an alcoholic. One day she told me how she battled with depression all throughout her life. She said she would drink to make the pain go away. Eventually her drinking problem became so destructive that she would drink two fifths of alcohol every day. Since being incarcerated, Theresa has been sober for almost 12 months. She says that this time she is going to quit drinking for good; she says she won't let herself relapse after not drinking for an entire year.

Even though Theresa said that she would never let MCCF bring her down, recently, I cannot help but notice changes in her. Lately, when Theresa comes to class she is solemn and quiet. She looks completely drained and exhausted at all times. The other day I got a chance to talk with Theresa privately to see what was going on. She confessed that Edwin, her boyfriend who she always raved about, had broken up with her. For almost a full year, Edwin stayed by her

side while she was in jail, but recently stopped coming to visit. When Theresa called to see what was going on and he told her he had met another woman. Now Theresa has no home to go back to when she is released. She tells me how Edwin was the only one she had in Pennsylvania. The rest of her family is estranged except for her two sisters in Florida.

There is absolutely nothing about Theresa that is indicative of a criminal. She is so genuine, kind and full of life. Theresa is often protective of me. She will reprimand the other girls if they are speaking over me or scold them for not coming to class. No matter what Theresa makes sure she attends every single GED class. Even if she is having a terrible day she says she comes to see me because she knows I am taking time out of my day to volunteer. It absolutely breaks my heart that such as an amazing woman with so much to offer is sitting in a jail. Theresa has several months of her sentence left at MCCF. As time goes by I can see Theresa's depression is getting significantly worse. Recently, she looks like the life has been sucked out of her. I worry that when Theresa is released, with no significant other, no family, no job, and no home she will turn to alcohol again.

Hannah

Hannah is a 24 year old, white woman who was arrested on her birthday for possession of K2, which is synthetic marijuana. She describes the drug with disgust and regret, recounting how it has had devastating effects on her brain. She says that the drug is extremely addictive, that she felt like she needed to smoke every 25 minutes. Hannah has holes in her brain, fluid in her brain, and now suffers from epilepsy due to smoking K2. Hannah describes how this drug has completely changed her personality. She says that she used to be so sweet and calm. Now she is angry and impulsive. She told me how she will snap in a minute, which keeps getting her in

trouble and placed in the hole. In fact, when I first met Hannah she had just gotten out of the hole after 3 months due to fighting with another inmate. At this point Hannah has received 8 violations at MCCF, which are adding time to her sentence.

Hannah has 4 young boys between the ages of kindergarten and third grade. Hannah tells me that she was on the right track, that she could have been a “cute college girl” like me. That she was really smart, and always wanted to go to college and join a sorority. One day she cried to me and admitted that it was difficult for her to come to class and see me because it reminds her of what she could have been.

Hannah turned to drugs due to many traumatic experiences in her life. As a child Hannah’s mother was drug addict and she was often left alone to care for her younger siblings. She told me she was raped at a young age. Hannah had her first child when she was just fifteen years old. She says she loves being a mother more than anything. She didn’t grow up with much so she wanted to give her kids the world. Selling drugs allowed her to do just that. Once she got a taste of the easy money, Hannah says greed got the best of her. She was bringing in thousands and thousands of dollars and it was obvious and suspicious to members of her small community. Hannah struggles greatly with being away from her children. She says her son was almost murdered after being beaten by her sister’s husband who had molested him. She felt extreme guilt and always blamed herself for letting her son go over her sister’s.

Hannah has bipolar disorder. When I asked if she was receiving treatment she rattled off a list of antidepressants and benzodiazepines that she is prescribed. Hannah says she hates taking the medications because they make her sleep all day. In fact, this is not uncommon at MCCF. Hannah says she has never seen a jail with so many people on “benzos”. She said the inmates are so drugged up they all walk around like zombies. According to the women in my GED class

there are two psychiatrists at MCCF and all they do is prescribe medication. Talk therapy is never provided.

I have witnessed firsthand, what Hannah describes. Sometimes girls receive their medications right before class. They may sleep through class or by the time I see them they are so sedated that they can barely function. The other day, one of the girls in my class could barely keep her eyes open. She was so out of it she looked like she was going to fall asleep at any second. Thankfully most of the women receive their medication after class. Some choose not to take their medications. This is a problem too. Although I agree that most of the women's dosages are way too high, taking medications inconsistently will just further complicate things. If the psychiatrists are not receiving honest feedback from the women about their medications it is very difficult to make adjustments.

Part III

Invention Program for Mentally Ill Female Inmates

Introduction:

According to a study conducted in 2012, 73% of female inmates report mental health issues (Incarcerated Women, 2012). These women are trapped in correctional facilities that are not only ill-equipped to treat mental illness, but fail to address women's issues. The typical female inmate is probably a minority between the ages of 25-29, a single parent of one to three children, a victim of sexual, physical or domestic abuse, a high school drop-out, an addict, and convicted of a nonviolent crime (Bloom & Convington, 1998). In our male-dominated corrections system, women's unique concerns such as pregnancy, motherhood, nutrition, self-esteem, and traumatic pasts are often overlooked. This lack of treatment is inhumane and unjust. Mental health treatment during incarceration is a right affirmed by the US Supreme Court. Despite this right, jails and prisons continue to disregard mentally ill inmates, allowing their mental wellbeing to further deteriorate during incarceration.

The section below is a sketch for an intervention program for mentally ill female inmates. In an ideal world, the mentally ill would not even be in prisons. However, until drastic changes are made to legislation, something must be done with the vast number of mentally ill female inmates who are currently incarcerated. These ideas have been inspired by three years of volunteer work educating inmates at Montgomery County Correctional Facility. During this time I have encountered countless instances of heartbreaking mental illness and a criminal justice system that has become apathetic to these women's needs.

Intervention should occur at 3 levels: pre-incarceration, during incarceration, and post-incarceration. The current model strives to foster growth, mental health, sobriety, positive

relationships, and education for female inmates. The goal of this program is to make incarceration as productive as possible. Time spent in jails and prisons should focus on treatment and rehabilitation. Days should be structured and productive with educational, parenting, vocational, and therapeutic programming. Treatment should be individualized and intervention as least restrictive as possible. The women should be able to take pride in having an active, influential role in the treatment process. Each woman will be assigned a case manager who will monitor and support them during incarceration and for at least 1 year after release.

Overall, this intervention program strives to make time spent during incarceration meaningful and productive. Women in jails and prisons should emerge as overall better people upon release. They should emerge with new skills and knowledge, a solid plan for the future, and improved mental well-being.

Objectives

- Provide adequate mental health services to mentally ill female inmates.
- Implement gender-specific programs to address women's unique needs (motherhood, pregnancy, nutrition, self-esteem, etc.)
- Encourage sobriety
- Promote meaningful, structured and productive days while incarcerated
- Develop positive, external relationships with family and friends
- Promote education
- Treatment that is least restrictive as possible
- Foster empowerment

Pre-Incarceration

- Prevention of incarceration
- Jail diversion programs
- CIT training
- Alternatives to incarceration
- Community mental health treatment

During Incarceration

- Careful intake screening, thorough evaluation of mental illness
- Immediate assignment to a case manager
 - Must meet with case manager 2-3 times a week
 - Case manager will help create a schedule of programs and activities to get involved in, monitor medication, monitor psychotherapy, speak to doctor if need be, speak to family and friends of the inmate, and develop a discharge plan
 - Set measureable goals
- Proper psychiatric care
 - Careful monitoring/adjustment of medication
 - Monitor compliance
 - Talk therapy (psychotherapy)- at least once a week of a one-on-one session with a therapist
 - Group therapy (for mental illness, addiction, parenting, victims of abuse, etc)
- Careful, sensitive consideration when assigning housing
 - Housing accommodations

- Be careful of pairs of cellmates (maybe place with older cellmates, avoid putting two unstable women together, avoid placing in cells with more than one cellmate)
- NEVER place in max security or solitary confinement
- Visitation with family and friends
- Involvement of family and friends in treatment plan
- Day should be structured and productive
 - Jobs in jail
 - Educational programing
 - Therapy
 - Vocational assistance
 - Physical activity
- Proper nutrition (meals should meet dietary needs for a woman, not a man)
- Prevention of sexual abuse from staff
- Increased flexibility in appearance, clothing
- No petty rules
- Proper prenatal care for pregnant inmates

Programs for Mentally Ill Female Inmates

- Parenting classes
- Education (GED, college prep)
- Addiction services
- Group therapy
- Programs for victims of abuse

- Vocational training
- Religious services
- Decision making skills

Post Incarceration

- Case manager monitors client for 1 year after release, for the first 3 months weekly check-ins, then monthly.
 - Case manager can accompany client to appointments/court dates/etc
 - Case manager should meet the client on her own turf
- At least a one month supply of medication
- Referral to supportive services within the community
- Mandatory outpatient treatment for at least 6 months
- Immediate re-instatement of Medicaid, food stamps, SSI
 - Paperwork should be started before discharge so that there is no delay
- Transportation services
- Housing
- Job connection
- Education
- Childcare
- Regain custody of children

Outcome

- Successful model of adequate mental health services to female inmates
- Reform of female inmates' daily experience

- Gradual removal of mental ill from jails and prisons
- Reduced stigmatization of mental illness
- Increase in community mental health services
- Mental health training for all judicial and legal employees
- Acknowledgement of women's unique concerns
- Increase in positive relationships
- Feelings of dignity, empowerment
- Reduced recidivism
- Reduced incarceration costs
- Increased public safety

Conclusion

Overall, it is my hope that this paper has conveyed the urgency of removing the vast number of mentally ill from jails and prisons. The lack of treatment for the mentally ill is entirely inhumane. While current legislation seems to be moving in a positive direction, there is still a tremendous amount of work that needs to be done. The vignettes of the women I have encountered at MCCF barely even begin to convey the severity of this issue. Vast numbers of mentally ill inmates are deteriorating in jail and prisons. Without a voice to express these issues, thousands of inmates are suffering unnecessarily at the expense of taxpayers. My sketch for an intervention program for female inmates takes into account gender specific concerns and introduces ideas for effective change. Mental illness is not a choice, and it is certainly not a crime. Ultimately, change lies within strengthening community resources and reforming treatment practices in jails and prisons. The women I have worked with at MCCF and the 356,268 inmates with severe mental illness in US prisons and jails deserve this care.

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