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LEGITIMACY OF CORRECTIONS AS A MENTAL HEALTH CARE PROVIDER: PERSPECTIVES FROM U.S. AND EUROPEAN SYSTEMS

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Large numbers of seriously mentally ill persons are being incarcerated because their disturbed behavior is criminalized. The criminal justice system is struggling to manage the needs of these mentally ill persons in correctional settings. This article examines the problem of the incarcerated mentally ill in terms of whether or not the correctional setting is an ethically legitimate place to house and treat these persons. First, it briefly summarizes how we arrived at this problem in the U.S. Then, it examines the problem today in the U.S. and comparatively in European nations. Finally, it closes with recommendations for establishing treatment outside correctional settings and how to best address the issue of mental illness within correctional settings.

The public system for responding to serious mental illness in the United States is in a state of dysfunction. The largest psychiatric institutions in the nation are not hospitals, but instead correctional facilities (Torrey, 2008). This is not a new state of affairs in America. Some one hundred and seventy-five years ago the United States was faced with a similar situation, as the majority of poor mentally ill persons found themselves confined to poor houses at best, and to jails or prisons at worst (Grob, 1966, 1973). The situation seemingly has come full circle today. In the intervening time the United States witnessed the development and widespread establishment of large public psychiatric

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institutions for mental health care. More than a century of medical and social change led to the disbandment and deinstitutionalization of these large institutions in favor of community-based mental health services, and subsequent implementation problems led to the failure of these community-based services to meet the demands placed on them. After both past successes and failures, the seriously mentally ill are once again frequently confined to jails and prisons. In order to understand how we arrived at the present situation, it is necessary to review what led us here. The following is a short historical description of American mental health care and is not intended to be a comprehensive study of it. Elaborate discussions can be found in the works of Grob (1973, 1983, 1994) and Torrey (1997, 2008, 2014), among others. Subsequently this paper will look at mentally ill inmate populations in U.S. prisons and jails by introducing estimates on this particular inmate group and how correctional facilities deal with them. Then a comparative analysis of mentally inmates in European penal institution will follow before concluding with a discussion of findings and formulation of possible solutions.

A Brief Review of U.S. Public Mental Health Care

Mental illness in colonial American society was not a substantial problem. As the overall population of the colonies was relatively small, the numbers of the population with mental illness was similarly small (Grob, 1966). People with financial means often took advantage of care in private settings or their own homes when mental illness occurred, while the poor and indigent mentally ill needed to seek out public care (Grob, 1973). In the seventeenth and early eighteenth century those persons with mental illness who could not provide for their own care were most often placed in households subsidized by the government to provide care, as there were few institutions of any kind. Although many existed in Europe, it was not until 1773 that colonial America saw its first public psychiatric institution when the Virginia Colony opened one in Williamsburg that year because the presence of the mentally ill in communities was becoming a social problem (Dain, 1971). The hospital at Williamsburg represented only the most rudimentary beginning of institutionalized psychiatric care in America, and it was usually the local almshouses and jails that confined disturbing persons away from society (Grob, 1973). Not until the 1840s would the development of model public institutions for the care of the mentally ill take place.

The nineteenth century was a period of significant development and change in care for the mentally ill in the United States. Moral management became the cutting edge mental health treatment, encouraging productive activity and structured living situations among those afflicted with mental illness as means to promote recovery (Fellin, 1996; Grob, 1966; Whitaker, 2002). Public psychiatric institutions were few and far between during the early 1800s and most poor or indigent mentally ill persons were confined to poor houses and jails. It was not until Dorothea Dix, in collaboration with Horace Mann, began a historic investigation of the conditions mentally ill persons experienced in jails and poor houses throughout Massachusetts that a true mental health care movement would begin.

Heavily influenced by the promising philosophy behind moral management and motivated by witnessing the inhumane conditions that mentally ill persons were being subjected to while confined in jails, Dix used her investigation of jail and poor house conditions to initiate what would become the state hospital movement in American mental health care, eventually establishing systems of public psychiatric hospitals in each state (Grob, 1973). The state hospital and its accompanying use of moral management to bring about recovery from episodes of mental illness would replace the correctional institution and its use of confinement as the setting where the mentally ill received care. The state hospital movement, influenced by the notion of moral management, was based on the assumption that the mentally ill person required care, understanding, and active, structured living to recover. Mental illness was seen as an acute condition that could be effectively cured (Fellin, 1996). The apparent success of state hospitals during the mid-nineteenth century led to widespread adoption of such systems as the best practice for treatment of mental illness (Grob, 1973). When the nineteenth century came to a close, however, our ability to offer treatment through moral management in the state hospital setting became increasingly impractical and ineffective.

During the 1890s it was becoming evident that moral management was impractical and most cases of mental illness were chronic rather than curable. State hospital populations grew rapidly while the number of trained staff did not correspondingly increase (Grob, 1983). Furthermore, early claims of overwhelming success at cure through moral management were demonstrated to be the consequence of inaccurate statistical methods rather than treatment protocol. A series of studies published by the noted physician and state hospital superintendent Pliny Earle (1887) indicated that not only were cures by moral management far less frequent than those being reported, but that all claims of its efficacy were suspect. The orientation toward treatment and recovery was replaced by custodial care. With the view of mental illness as a condition characterized by chronicity, state hospitals focused on the confinement and maintenance of disturbed persons. These institutions became overpopulated by very long term residents, with conditions in them gradually turning increasingly impersonal and, ultimately, inhumane (Fellin, 1996).

By mid-twentieth century state hospital care for the mentally ill was largely seen as a failure, but a revolution in treatment was about to begin. Psychotropic medications, starting with Thorazine to manage psychotic symptoms, were introduced during the 1950s (Grob, 1994). These medications benefited many long-term patients. Although their introduction did not immediately change the use of large institutions to confine the mentally ill (Whitaker, 2002), it was now possible to see mental illness as treatable. During the 1960s, pivotal legislation, such as President Kennedy's Community Mental Health Centers Act of 1963, slowly began a process of moving well-functioning patients out of psychiatric institutions to community living settings (Torrey, 2014). Ultimately, such legislation led to a radical change in how mental health care would be delivered in the United States. Together with the introduction of psychotropic medications, such legislation for policy for community-based care set the stage for deinstitutionalization. In the early 1970s a psychiatric survivors movement made up of former psychiatric institution patients became active. This movement was a civil rights movement for the mentally ill and worked successfully to change laws governing involuntary commitment and treatment (Rosenthal, 2011; Torrey, 2008).

Combined with advances in treatment and federal policy, the deinstitutionalization of psychiatric hospitals began. No longer would long-term commitment to state hospitals be an option for treating mental illness. The movement to deinstitutionalize persons with serious mental illness would move thousands out of public hospitals and become controversial throughout the end of the twentieth century as a disastrously implemented policy. Inadequately developed community-based services fiscally strangled in their infancy, a lack of options for long-term inpatient care, and public responses to mental illness focusing on criminal aspects of disturbed behavior have led large numbers of seriously mentally ill persons to be incarcerated rather than hospitalized because of their illness (Torrey, 2008, 2014).

As state hospitals closed in quantity, a question emerged: where would the mentally ill go if they needed the level of care formerly provided by state hospitals? It has been hypothesized since the 1930s that a reduction in the number of public psychiatric beds led to a corresponding increase in demand for beds in correctional settings (Penrose, 1939). The end of the twentieth century and beginning of the twenty-first tested this hypothesis with disheartening results. As the number of state hospital beds dwindled, the demand for beds in jails and state prisons correspondingly increased. It is not that the population who were formerly housed in state hospitals was now being put into correctional facilities. Rather, without the availability of public psychiatric beds, persons' whose behavior would have resulted in their placement in a public mental health care setting are now placed in a correctional setting because their behavior is viewed treated as criminal activity (Raphael & Stoll, 2013). Thus, in the first decades of the twenty-first century, the mentally ill can once again be found confined to the cells of correctional settings.

Mentally Ill Inmates in U.S. Prisons and Jails

As most state mental hospitals have closed their doors or dramatically decreased the number of available beds, more and more mentally ill offenders end up in the correctional system, which in many instances serves as the only place that can provide secure twenty-four hour supervision (Vitiello, 2010). Incarceration occurs because of a lack of community programs and adequate housing for mentally ill, which all too often leaves them homeless. Engagement in petty crimes and illegal drug use, a common way to self medicate for the mentally ill, ultimately drives them into the criminal justice system (Lamb & Bachrach, 2001).

As those individuals eventually enter the correctional system, a system that was created to punish, incapacitate and/or rehabilitate individuals who are held accountable for their actions, one must ask the question whether such placement for a mentally ill individual is ethically justifiable. This question before all else, must therefore consider whether correctional institutions are used with the primary purpose to punish or incapacitate convicted criminals versus providing them with rehabilitative services. From the early colonial times to today, correctional goals have changed several times, but many scholars agree that

incapacitation and retribution appear to be the primary goals of corrections today (Cullen at al., 1990; Garland 2001; Kifer at al., 2003).

With such underlying correctional goals at play, institutions today demand inmates to follow strict rules and regulations at all times and they assume that everyone understands those, while punishing individuals who do not comply. Many mentally ill inmates, however, struggle with the expectations of that particular environment due to "illogical thinking, delusions, or auditory hallucinations" (Turner, 2007, p. 52).

Depending on which source is consulted, the numbers of individuals with mental illness in the correctional system (including jails and prisons) vary. Maruschak (2004) for instance estimates the number to be as low as 5%, while Lamberti (2007) estimates the number to more around 25%. In a special Bureau of Justice Statistics report, James and Glaze (2006) suggest that as of midyear 2005, 45% of Federal prisoners, 56% of State prisoners, and 64% of jail inmates suffered from a mental health problem, which they defined as a recent history or current symptoms of a mental health problem, with symptoms being based on criteria specified in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The most frequently identified symptoms include mania, major depression and psychotic disorders. While jails appear to have the highest rate of inmates with mental health issues, it must be understood that those facilities may only hold those individuals for a short time before they are transported to a more appropriate health care treatment facility. It must be noted at this point, however, that one factor for the disparity in estimated numbers of inmates with mental health problems, is a lack of common definitions of mental illness among those studies.

While males are more likely to be incarcerated than women, female inmates show higher rates of mental health problems in all correctional settings (Ditto, 1999; Maruschak, 2004; Soderstrom, 2007; Steadman et. al, 2009). James and Glaze (2006) also report that an estimated 73% of females in State prisons (55% of males), 61% in Federal prisons (44% of males) and 75% in jails (63% of males), had a mental health problem. Mental health problems also seem to be more prevalent among white inmates age 24 or younger. Unfortunately current data on inmates with mental health problems are only scarcely available, however, the number is expected to have increased due to the economic crisis, which resulted in budget cuts of community mental health programs and further closures of mental hospitals (Coffey, 2012).

Today many correctional facilities operate as de facto mental health treatment facilities even though they were never designed as such, which creates many issues related to this specific inmate group. The treatment vs. custody debate is not particularly new, as Adams and Ferrandino (2008) point out, being recognized as early as 1940 by Clemmer, who already realized that there is no simple solution to resolve this debate. More recent publications on this matter (Faiver, 1998; Fellner, 2006; Clements et. al., 2007) all acknowledge the tension between the security mission of prisons and the specific treatment needs of inmates with mental health problems.

This tension translates into several specific problem areas regarding the custody of mentally ill inmates. O'Keefe and Schnell (2007) identify inadequate mental health screening

processes at intake as particularly challenging. Overlooking or misdiagnosing certain disorders can result in problematic and sometimes dangerous situations for the inmate, the prison population in general and staff, as those individuals may harm themselves or others due to non-treatment of a psychiatric disorder.

If inmates are diagnosed correctly, correctional facilities are often not able to provide the necessary resources that mentally ill inmates need (O'Keefe & Schnell, 2007). One significant problem pertains to the fact that the most common form of treatment is that of medicating the mentally ill inmates even though it is a known fact that medication should always be offered alongside therapy and counseling (Brandt, 2012). Furthermore, a 2011 study by Bewley and Morgan revealed, that the majority of mental health providers in correctional settings had no specific training in correctional or forensic psychology. Similarly, correctional staff, which regularly interact with mentally ill inmates, often lack training on supervising these types of offenders (Fellner, 2006; Geiman, 2007; Adams & Ferrandino, 2008). Due to these treatment shortfalls, mentally ill inmates are particularly affected by the particular prison environment, which can worsen illnesses, lead to aggressive behavior against other inmates, staff or themselves, and increase suicide risk (Vitiello, 2010; Brandt, 2012; Felson et. al., 2012). Blitz et. al. (2008) also found evidence that "mental disorder is a significant marker for victimization inside prison" (p. 392). As a result, it is not uncommon to find overrepresented numbers of mentally ill inmates in segregation units, where they usually end up as a result of being unable to follow institutional rules (Adams & Ferrandino, 2008; Spencer, 2012).

Given the problematic nature of dealing with this inmate population, it is not surprising that those inmates often are faced with longer incarceration times due to time added for "bad behavior" and that they recidivate more often than released inmates without mental health problems. The biggest obstacles for successful reentry seem to be a lack of mental health services upon release, a lack of treatment efforts focusing on vocational training during incarceration, both which more frequently drive released offenders into homelessness, an unhealthy environment often plagued by criminogenic behavior and substance abuse as a form of self medication (Lurigio et. al., 2004; James & Glaze, 2006; Soderstrom, 2007; Greenberg & Rosenheck, 2008; Baillargeon et. al., 2009; Torrey et. al., 2010; Bewley & Morgan, 2011).

It is evident that the situation of mentally ill individuals in the U.S. correctional system is highly problematic and continuously challenging. Surprisingly the United States is not the only country with this issue, as the following section on mentally ill inmates in European correctional facilities will show.

Mentally Ill Inmates in European Penal Institutions

Mental and behavioral disorders affect an estimated 450 million people worldwide, with disproportionately high rates of such disorders in prison systems around the world.

Based on current research, the World Health Organization (WHO) estimates "that about 40–60% of all prisoners have some form of mental health problem, and prisoners are up to seven times more likely to commit suicide than people in the community" (WHO, 2013). Taking into account that, according to the World Prison Population List (Walmsley, 2011), more than 10.1 million people are held in penal institutions worldwide, mental health problems among inmates simply cannot be ignored. A systematic review and meta-regression analysis on severe mental illness in 33,588 prisoners in 24 different countries by Fazela and Seewald (2012), found an overall prevalence for psychotic illness in 3.7% and for major depression in 11.4% of male and female inmates. Further research has also shown that "89% of all prisoners have depressive symptoms and 74% have stress-related somatic symptoms" (Health in Prisons, 2007, p. 133), which clearly shows an association between imprisonment and mental health problems.

While European countries have not seen the same extent of deinstitutionalization as was witnessed in the United States, the WHO reports (Services and Deinstitutionalization, n.d.), that more recently, strategies to support community-based services are becoming more prominent across Europe. As a result bed numbers have been reduced and several institutions have been closed. Taking these developments into account, recent research studies have found similar problems with mentally ill offenders in European correctional facilities to what US facilities are faced with. One study based on information obtained from 13 European countries by Blaauw et. al. (2000) reveals that none of the 13 countries had sufficient space available to ensure that the estimated 12% of inmates in need of psychiatric treatment could receive such. What must be noted at this point is that comparative research, particularly with respect to data from European Union (EU) countries, is available and much needed, however poses problems as well in a sense that common understanding must be reached in regards to terminology in and functionality of the various criminal justice systems involved (MacDonald et.al., 2012). Salize, Dressing, and Kief (2007) have contributed to this need by providing a systematic, comparative study funded by a grant from the public health program of the European Commission, analyzing concepts and routine practices of mental health services in penal institutions in 24 EU and EFTA countries, including: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, England & Wales, Finland, France, Germany, Greece, Hungray, Iceland, Ireland, Italy, Lithuania, Luxembourg, The Netherlands, Norway, Poland, Portugal, Slovenia, Spain, and Sweden.

Before any findings can be evaluated in terms of effectiveness, basic information on national prison systems must be reviewed to understand possible differences in outcomes. The best source for such statistics are the Council of Europe's Annual Penal Statistics, also known as SPACE (*Statistiques Penales Anuelles to Conseil de l'Europe*), which provides data, reported as SPACE I, on imprisonment and correctional intuitions in Council of Europe member states (Aebi & Delgrande, 2013). With a participation rate of 51 out of 52 prison administrations of the 47 Council member states, the 2011 survey of SPACE I, provides the most accurate comparative prison data for those 47 members, which also include all the above listed 24 EU and EFTA states surveyed on mentally disordered persons in the European prison systems.

The average prison population of penal institutions, including pretrial detainees,

juvenile offenders and inmates held in private facilities, reached 154.0 per 100,000 inhabitants on September 1st, 2011. Of those an average of 5.3% inmates per 100.000 are females and 20.6% are made up of foreign prisoners in the total prison population. The average length of imprisonment in 2012 based on total number of days spent in penal institution was 8.1 months, which could create problems for proper mental health services as those require time, which many inmates do not have due to fairly short incarceration times. Suicide rates for 2010 remained fairly low at an average of 6.7 per 10.000 inmates or 23.9 percent of overall reported deaths in penal institutions. SPACE I does not provide specific information on personnel for mental health services, however it lists personnel responsible for psychological assessment and psychologists employed directly by penal institutions to average at 1.6% of all correctional staff, compared to 37.7% of doctors and health care staff providing services to inmates that are employed by agencies outside the correctional facilities. For those 37.7% SPACE I does not distinguish between medical and mental health care services. Therefore it is unclear how many mental health care providers (whether employed by the correctional facility or an outside agency) are in fact providing services to inmates.

Given the much smaller average incarceration rate reported in SPACE I compared to the average incarceration rate in the United States of 743 per 100,000 as reported by the US Bureau of Justice Statistics (Walmsley, 2011), it is not surprising that European penal institution do not report a fully developed mental health crisis yet. This, however, can also be attributed to the fact that "prison or health administrators throughout Europe know neither how many nor what kind of mental disorders are prevalent in their national prison systems" (Salize et. al., 2007, p. 74). Salize et. al. found that none of the 24 countries in their study provide regular national statistics on mental disorders and treatment options in their penal institutions. This is also impacted by the fact that European countries do not share a common model on dealing with inmates also including the diagnosis and treatment of mentally disordered inmates. Prison mental health care follows many different organizational models, involving the Ministry of Justice, Health Department or Ministry of Health, while two basic models of mental health care prevail in the majority of European countries: in one model all care is provided by an external system of mental health care and in the other, prison mental health care alone is responsible for inmates in need of services.

Some of the key data collected by Salize et. al. (2007) include the following. Regarding mental health care capacities in prison, the study found that the number of psychiatric prison beds, without there being a common definition of what constitutes such, varies between 0 and 41.5 per 1,000 prison places. Variation also exists in the number of psychiatrists and psychologists in prison services ranging from 0 to 5.5 psychiatrists and 0 to 15.8 psychologists per 1,000 prison places. Numbers of psychiatric staff vary because of the above listed difference in prison mental healthcare models. Mental state screening and assessment immediately after prison entry, appears to be infrequently performed across Europe and often conducted by poorly trained staff, which can easily overlook prevalent mental disorders among new inmates. Furthermore it was found that no country surveyed, legally requires a mental health re-screening at a later point during imprisonment and as such inmates acquiring mental disorders during their imprisonment and possible mental health needs prior to release remain completely undetected. Likewise, only four countries in the

study could quantify the extent of psychopharmacologic drug use in penal institutions, which points to another shortcoming in data collection.

Due to the lack of reporting and research, the effectiveness of either system cannot be assessed (p. 73). In countries where prisoners are sent to outside facilities for treatment, treatment for inmates is equal to that of regular patients; however it is uncertain whether all inmates, who require treatment, are in fact referred to a mental health care provider outside the penal institution. Respectively, penal systems which provide care within their system, reported various treatment shortcomings, in particular for sexual offenders, suicide prevention, and inmates diagnosed with personality disorders. Overall, as Salize and Dressing (2008) note, the lack of systematic data collection and information on mental health needs and services in European penal institutions is inexcusable. Without further information, the extent of individual suffering due to non-treatment of mental health disorders and criminal recidivism based on lack of treatment will remain unknown.

Discussion and Possible Solutions

As was previously stated, it appears that we have moved through an entire cycle of trying out different approaches to deal with the mentally ill, who continue to fill our correctional facilities. Clearly this solution is not working nor should it be the desired approach for a modern society. Unfortunately, the United States does not seem to be alone with this problem as many European countries, while not to the same extent as American correctional institutions, face similar issues in dealing with this specific offender category. Overall, smaller incarceration rates and better funding for specialized treatment staff and treatment programs alleviate some of the problems in Europe, which are crippling the U.S. correctional system. It does appear though, that continued deinstitutionalization in many European countries will lead to increased problems with mentally ill inmates, unless increased funding is being made available for treatment.

The debate is ongoing and the question on whether to focus on treatment or punishment has no unequivocal solution. In 1957, even before deinstitutionalization had started, Legrand asked the ever important question whether the criminally insane should be housed in prison, as he found in a previous study, that "39 state hospitals housing criminally insane patients did not have the facilities to provide maximum secure custody" (p. 677). In a follow up survey he found only 2.6% of the criminally insane to be housed in federal and state prisons, a number that can nowadays only be dreamt of. It must be noted here, though, that his study exclusively looked at inmates detained under the legal concept of insanity, excluding all mentally ill inmates of state prisons that had not been classified as legally insane. Nonetheless it is quite interesting to see that nearly 70 years ago, the system already seemed to struggle with similar questions in regard to mentally ill/or legally declare insane offenders as we do today. Melamed (2010) asks the exact same question discussing the right of the patient to be treated versus the right of the public to be protected, concluding that there probably has to be a balance between the two.

If the punishment route is taken, more specific reforms would be necessary. These need to include the increased use of mental health courts, which allow offenders to choose between being incarcerated or receiving treatment in a community mental health care setting (Torrey et. al., 2010). If mentally ill offenders are sent to a correctional facility it is imperative to utilize extensive mental health screening at the beginning of and throughout imprisonment to assess existing and developing mental health problems and to establish a specific treatment plan. This could possibly include special accommodations for specific individuals. Once offenders with mental illness are identified, treatment, whether in form of medication and/or counseling, needs to be offered, however budgetary constraints have left minimal funding available to those mental health treatment programs. Torrey et. al (2010) suggest that states should shift savings of the Department of Mental Health from closing state-funded psychiatric facilities, to the Department of Corrections, another suggestion that, while it would only be fair, appears to be unrealistic. Ethical treatment also requires adequate staff, that is trained to deal with this particular inmate category, which not only includes actual mental health providers (psychiatrists, counselors, social workers etc.), but also correctional officers, who need specialized training on supervising mentally ill inmates, as they are significantly involved with those individuals on a daily basis. Lastly, discharge planning for successful reentry, seems to be one of the least frequently provided services for offenders with mental illness (O'Keefe & Schnell, 2007). Ideally, plans should be in place to link inmates with long-term, community based mental health care programs to help them manage their problems and to reduce risk of recidivism, substance abuse and homelessness, all which seem to be more prevalent among released inmates diagnosed with some form of mental illness (Baillargeon et al., 2009; Greenberg & Rosenheck, 2008).

Assuming that correctional settings were not legitimate locations for mental health treatment and the option exists to provide treatment completely outside of correctional settings, then a secure residential setting would be ideal. The secure residential setting operated as a psychiatric facility by psychiatric personnel and not as a correctional facility operated by correctional personnel is a potential solution to the incarceration of our seriously mentally ill. What is suggested is essentially a designated state hospital exclusively for those individuals picked up by the criminal justice system because of activities directly related to their mental illness. Unlike court monitored treatment that is the cornerstone of our mental health courts, these offenders should immediately be made wards of the public mental health system and not the correctional system. This would be true of involuntary inpatient commitment for the purposes of extended treatment for promoting recovery and enhanced social functioning as imagined by the mental health system's psychiatric rehabilitation and recovery models (e.g., Rosenthal, 2011) rather than the correctional system's offender rehabilitation for criminal activity. If one were to look critically at the problem, impairments in psychological and social functioning due to disabling mental illness coupled with the lack of supervised living is a set up for arrest due to mental illness. What is suggested here is not the mental health courts we have today, but an option to directly divert mentally ill offenders to intensive treatment and psychiatric rehabilitation. This would require change to existing commitment laws to accommodate some activities defined as criminal to be grounds for such commitment if they stemmed directly from mental illness. If such changes were made then a true treatment system for these persons could be created. Potential models for initiating such system development exist today.

Earley (2006) describes Passageway in Florida. Passageway is a model halfway house used to move mentally ill ex-offenders back to community living. Ex-offenders are provided with treatment and recovery services in a community residential care setting that emphasizes psychiatric rehabilitation. It is the psychiatric rehabilitation element that stands out. Persons finding themselves in the criminal justice system as a consequence of disturbed behavior stemming from their mental illness being criminalized require psychiatric rehabilitation rather than the correctional system's offender rehabilitation. It is psychiatric rehabilitation and appropriate psychiatric aftercare that is suggested as an ethical, legitimate alternative to incarceration that may well prevent recidivism among this population. Although not a secure residential treatment center as specifically envisioned above, Passageway provides an example that could be used to develop a community-based secure residential alternative to the correctional institution as the setting for care and treatment of mentally ill offenders. It is not suggested that those deemed criminally insane be afforded this option. What is suggested is that those persons whose disturbed behavior led to being arrested for nonviolent offenses (e.g., vagrancy, public urination, petty theft) be provided an exit from the correctional system directly to the mental health system via involuntary commitment and that such commitment be for the purpose of intensive psychiatric rehabilitation.

Drawing from the Passageway example, the following psychiatric rehabilitation alternative is briefly proposed. If an offender whose offending action was due to mental illness is brought to the court and severe, persistent mental illness is the reason for the offending action, the court would order involuntary commitment in custody of the public mental health system for inpatient treatment on an involuntary basis (with no use of a diversionary mental health court). He or she would then go to the secure residential treatment center, which would be operated as a miniature state hospital. An initial phase of acute stabilizing treatment would be provided if necessary, followed by subacute care directed toward recovery and psychiatric rehabilitation. This level of subacute care would continue until such time that the treatment team viewed the person as ready for discharge to a highly structured halfway house setting. This indicates a series of stepped down care settings that could end in an option such as assertive community treatment (e.g., Torrey, 2008) and eventual release when there was no longer a risk of reoffending. A benefit here is also discharge without a damaging and productivity impairing criminal record.

The most ideal solution would be to provide treatment options outside the correctional setting for those criminal individuals, who are afflicted with some form of mental illness. Given the ongoing demise of the mental health care system and continued budget crisis, this seems to be more of a utopian vision than something that could actually be realized. As such it appears that, at least in the near future, corrections will remain the primary mental health care provider, which would require significant changes in order to provide ethically sound and much needed care.

In conclusion, corrections today operate on the basis of incapacitation and retribution, which leaves little to no room for rehabilitative efforts. As such, mentally ill individuals are set up to fail right away, denying them the necessary treatment to cure or improve the root causes of their problems. Correctional facilities, therefore, should not be utilized as legitimate mental health care providers, even though that is happening exactly due to the failed mental

health system. If, however, the correctional sector is to be chosen to be the primary care provider for mentally ill offenders, another paradigm shift towards a more rehabilitative approach is crucial paired with funding for appropriate staffing, specialized housing, training of all correctional staff, specific treatment and transitional aftercare planning to treat those individuals humanely in an ethically sound institutional setting. Even though more specific data on the mentally ill inmate population in European penal institutions is needed, the analysis has shown that lower incarceration numbers and a less advanced deinstitutionalization process keeps overall numbers of mentally ill inmates at a lower level, which in turn probably allows for better treatment of those individuals who are incarcerated. More research, however, is needed before a true comparative analysis could be performed. One conclusion that can be made with certainty is that without investments to acknowledge and treat the current mentally ill inmate population properly, the U.S. is failing a substantial part of our society.

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