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Modern Approaches to Addressing the Mass Incarceration of America's Mentally Ill Population

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Abstract

Correctional facilities negatively affect individuals with pre-existing mental and behavioral health concerns while also creating an environment that manifests a future mental illness. Issues include facility overcrowding, restrictive housing practices, lack of accessible services, and ill-informed practices and procedures when working with individuals with mental

illness. Incarcerated individuals with mental illness also face disparities through (1) sentence length, (2) race/ethnicity and gender, and (3) increased risk of victimization. This paper draws attention to a long-standing, yet current critical issue in the American criminal justice system—the use of jails and prisons as modern-day psychiatric hospitals. The literature yields many options for disrupting this practice, including both proactive and reactive reforms that seek to reduce the mass incarceration of those with mental illness as well as improve correctional facility conditions for this incarcerated population.

Keywords: mental illness; corrections; mass incarceration

Modern Approaches to Addressing the Mass Incarceration of America's Mentally Ill Population

Roughly 25% of the world's population is housed within the United States prison system as the U.S. leads the world in rates of incarceration (The Sentencing Project, 2021). This is alarming considering the population of the U.S. only accounts for about 5% of the world's population. There are nearly 2 million people incarcerated in U.S. jails and prisons which is a 500% increase over the past 40 years (The Sentencing Project, 2021). Within the incarcerated population, a disproportionate representation of mental illness has been observed (Al-Rousan et al., 2017; Gottfried & Christopher, 2017). These rates show a drastic difference in comparison to the general U.S. population (Prins, 2014; Sugie & Turney, 2017). Jails and prisons house those with mental illness at a rate ten times that of state psychiatric hospitals (Al-Rousan et al., 2017; McCarthy, 2014). The increasing number of individuals showing signs of, and/or being diagnosed with, mental illness(es) places a burden not only on the person, their families, and the community but also on the specific correctional facility and the entire criminal justice system (Ben-Moshe, 2020).

Correctional facilities are required to offer mental and physical health services (Reingle-Gonzalez & Connell, 2014). Yet, many facilities lack adequate resources to provide proper treatment to those with mental illness (Franke et al., 2019). Services may include prescription medication(s), psychiatric care, individual and group therapy, pharmacotherapy, and so forth. More recently, some facilities have experimented with telepsychiatry (see Kaftarian, 2019). Lack of resources not only impacts those with pre-existing mental illness but also those experiencing acute symptoms or the progression of a serious and persistent mental illness. Some scholars

have identified incarceration as the most damaging consequence to one's physical and mental health within one's involvement in the criminal justice system (Schnittker et al., 2012).

Individuals diagnosed with serious mental illness may experience adverse effects from being housed within a correctional setting (Ben-Moshe, 2017; Franke et al., 2019). Correctional settings are overpopulated and rely on restrictive housing as well as the use of punishment as an effort to control behavior (Cochran et al., 2018; Reingle-Gonzalez & Connell, 2014). Poor facility management may result in increased rule violations and higher recidivism rates (Human Rights Watch, 2009; Reingle-Gonzalez & Connell, 2014). Mental health can also deteriorate for other reasons including financial familial strain (Porter & Novisky, 2017), increases in general stress, adaptation, and stereotypes associated with being an incarcerated person (Porter & DeMarco, 2019). Those with mental illness are also more vulnerable to victimization. These issues, and others, cause a greater risk of mental health decline in incarcerated individuals already experiencing mental illness as well as those with no current symptoms (Reingle-Gonzalez & Connell, 2014).

With the continued rising of correctional facility populations, it is imperative the U.S. consider both proactive and reactive approaches to addressing the mass incarceration of individuals with mental illness. The following literature review outlines the negative consequences surrounding the modern-day practice of warehousing those with mental illness in our jails and prisons. Preventatively, literature is provided that supports community-based interventions to disrupt the pathway from community to prison for those with mental illness. Reactively, programs are reviewed specific to correctional settings that can provide a safer and more rehabilitative focus for those with mental illness. In sum, this paper addresses a looming issue—the overrepresentation of people with mental illness at all criminal justice decision points.

Literature Review

Deinstitutionalization is a major contributing factor to the rapid increase in the incarceration of those with mental illness. The deinstitutionalization movement started in the 1950s and was sparked by the creation of antipsychotic drugs (Hector & Khey, 2018; Scull, 2021). Investigators documented the inhumane and deployable conditions of many psychiatric hospitals, sparking a knee-jerk decision to close these facilities. Yet, communities were not equipped to serve the influx of patients as community-based resources were still lacking (Hector & Khey, 2018; Novella, 2010). In 1955, state psychiatric hospitals recorded a population of over 550,000 individuals (Scull, 2021). This population significantly decreased by 1994 to a mere 71,619 (Hector & Khey, 2018).

Deinstitutionalization led to the “warehousing” of patients in correctional facilities also ill-prepared to respond to serious mental illness (Haney, 2017). Between 1970 and 2000, both the federal and state incarceration rate increased by almost five times from 98 per every 100,000 individuals (1970) to 476 per every 100,000 individuals (2000) (Greenberg & West, 2001). As of 2021, the U.S. now incarcerates 639 people per every 100,000 (The Sentencing Project, 2021). Deinstitutionalization created a direct path for individuals with mental illnesses into the criminal justice system—a system proven incapable of providing an appropriate environment and treatment for those with mental illness.

Brief Review of Police Encounters for those with Mental Illness

The U.S. has observed a disproportionate rate of arrest for people with mental illness (Reuland et al., 2010) while the research does not support the belief that those with mental illness are more violent and/or commit more crime than non-mentally ill populations (Pescosolido et al., 2019). Yet, public perceptions regarding mental illness and criminal involvement generally support the belief that those with mental illness commit more crimes, including acts of terrorism and mass shootings (Pescosolido et al., 2019). Research has shown that persons with mental illness typically encounter police contact because of non-criminal behaviors or minor misdemeanors (Borum et al., 1997; Watson & Wood, 2017). Failure to address underlying illness(es) within police encounters can exacerbate mental health problems (White et al., 2006).

Law enforcement remains in the role of first responders in most situations where a mental health crisis has occurred, and these instances are increasing in volume (Santos & Goode, 2014). Officers’ responses usually include either formally arresting the person, detaining them to transport for mental health services, or informally handling the situation. This role sometimes referred to as officers playing “street-corner psychiatrist” (Teplin, 1984), often results in law enforcement feeling ill-prepared to handle these instances (Franz & Borum, 2011). Tragically, some persons experiencing a mental health crisis or responding to mental illness, fail to comply with police commands, presenting a perceived threat to the law enforcement officer(s) which can result in injury or death (Santos & Goode, 2014).

Resisting the police is a top factor in use-of-force cases and research shows those with mental illness are more likely to resist their interactions with police (Morabito et al., 2017). “It is not that persons with serious mental illness have a higher propensity for criminality. It is that persons with untreated serious mental illness react to situations and stressors differently, and oftentimes irrationally, which can prompt aggressive and violent reactions (i.e., going into flight

or fight mode when expecting or perceiving imminent harm" (Hassell, 2020, p. 160). A 2016 study found 45% of the people killed by police in Minnesota since 2000 had a history of mental illness or were in a mental health crisis. One in four police shootings involves someone with serious mental illness (Peterson & Densley 2018). In yet another study, Fuller et al. (2015) found untreated people with mental illness were approximately 16 times more likely to be killed in a police-involved shooting than other community members. Evidence suggests that "frequent fliers," or those with mental illness encountering regular police contact, comprise a small population of the public, but more frequent contact with law enforcement. Individuals with mental health needs may require longer police presence with specially trained officers (Reuland et al., 2010). Fortunately, more attention has been given to police encounters and the use of force, including interactions with those with mental illness.

Brief Review of Court Responses to those with Mental Illness

In addition to disparities in policing, mental illness is also prevalent throughout the court system. Policies such as mandatory sentences for drug offenses, and restrictions on access to welfare services as a form of punishment, rather than problem-solving, have negatively influenced the criminalization of those with mental illness (Barrenger & Draine, 2013; The Sentencing Project, 2002). The research shows that crimes committed by those with mental illness generally fall under three categories including illegal acts as a product of mental illness (e.g., disorderly conduct and disturbing the peace), economic crimes to obtain money for subsistence (e.g., petty theft and shoplifting), and finally, more serious offenses such as burglary, assault, and robbery (The Sentencing Project, 2002). When individuals with psychiatric disorders present in court, they are more likely to engage in self-harm, use substances, and encounter victimization (Simonsson et al., 2020). Yet, the first two categories of criminal behavior could be prevented, or at least reduced, with stronger community resources. The Bureau of Justice Statistics has reported those with mental illness are twice as likely as others in jail to have been homeless, unemployed, and with substance use issues prior to their arrest (James & Glaze, 2006). Those with co-occurring disorders (more than one diagnosis occurring at the same time) are more likely to be sentenced to incarceration (The Sentencing Project, 2002).

***Sentence Lengths*.** Individuals incarcerated with a diagnosable mental illness typically serve sentences four months longer, on average, in comparison to incarcerated individuals without a mental illness (Hoke, 2015). It is not uncommon for those experiencing severe and persistent mental illness to act out while incarcerated. Due to these behavioral responses,

disciplinary actions are more likely (Clark, 2018). Hoke (2015) explains that the inability to abide by facility rules may lead to longer sentence lengths for individuals who are mentally ill. In one study, 53% of inmates with mental illness were charged with rule violations, while 43% of inmates without mental health issues were charged with rule violations (Hoke, 2015). Coupled with rule violations, Hoke (2015) explains parole boards also become hesitant to release individuals with diagnosed mental disorders because of the lack of community services available for continued rehabilitation and treatment.

Mental Illness Prevalence in Correctional Facilities

Individuals with mental illness are overrepresented within U.S. jails and prisons. Correctional facilities house individuals with serious mental illness at rates ten times that of state mental health hospitals (Al-Rousan et al., 2017; McCarthy, 2014). Estimates show approximately 64% of those incarcerated in jails, 56% in state prisons, and 45% in federal prisons, have experienced a form of mental illness (Smith et al., 2019). Timmer and Nowotny (2021) explained that at least one correctional facility in 44 states, individually, and the District of Columbia, holds more individuals with one or more mental illness(es) than the largest psychiatric hospital in each of those states. Felson et al. (2012) explained that incarcerated individuals experience mental illness(es) similar to those of the general population, but with greater frequency. Research shows that individuals within correctional facilities present with mental illness(es) at a rate of two to four times that of the general population (Al-Rousan et al., 2017).

For incarcerated populations, and especially for girls and women (Lynch et al., 2017), trauma can exacerbate already existing mental health concerns while also resulting in declines in general functioning predisposing individuals to mental illness (Gottfried & Christopher, 2017; Gueta et al., 2022). These histories are likely to include chronic poverty, deprivation of basic needs, severe forms of abuse (e.g., emotional, physical, and sexual), and neglect (Haney 2017). Approximately 21% of incarcerated women and 6% of incarcerated men meet the criteria for Post-Traumatic Stress Disorder (PTSD) (Baranyi et al., 2018). In addition to the trauma and mental illness, many incarcerated people have co-occurring disorders that may include substance use, personality disorders (Felson et al., 2012), and mood disorders (Fazel et al., 2016).

Gender. Incarcerated women have greater rates of reported mental illness than do their male counterparts. In one jail-based study, women reported serious mental illness at a rate twice that of men (30% and 15%, respectively) (Hall et al., 2019), while in a second study, 70%

met the criteria for the presence of mental illness within the last twelve months (Lynch et al., 2014). One correctional facility study found that 65.8% of women reported mental health issues upon intake which was twice that of their male counterparts (Porter et al., 2021). Green et al. (2016) found PTSD to be diagnosed in women at a rate of four to ten times more than in women in community samples. Studies also consistently find women have far greater abuse histories creating an abuse-to-prison pipeline. One study involving girls with single or multiple types of child maltreatment found the risk of engaging in violence increased by 2.24 times; and for those reporting three or more forms of child maltreatment, their risk of engaging in violence increased by 11.2 times (Brav, 2021). Experiencing multiple forms of abuse and/or maltreatment is termed poly-victimization; this, in conjunction with trauma, can negatively affect behavioral, emotional, and cognitive functions throughout an individual's life (Brav, 2021). "Results indicate that experiences of CPA [child physical abuse], CSA [child sexual abuse], and CEA [child emotional abuse] intersect with both criminal offending and mental health issues, amplifying the risk of recidivism for abused women who met criteria for current depression" (Tripodi et al. 2019, p. 1230).

Race/Ethnicity. Research suggests that incarcerated people of color are more likely to have a mental illness compared to their white counterparts (Appel et al., 2020; Prins et al., 2012). In one study in Los Angeles County jails, 41% of incarcerated people of color were found to have a mental illness, while 19% of incarcerated white individuals have a mental illness (Appel et al., 2020). At the time of intake, screening tools may also cause additional disparities in detecting mental illness for people of color. Administering screening tests may produce "unwarranted judgments" and/or "erroneous assumptions" by disregarding noticeable symptoms of mental illness or believing that specific groups of people are unaffected by the outcomes of mental health treatment (Prins et al., 2012, p. 636).

People of color are also less likely to be offered access to specialty courts such as mental health or drug courts. Specifically, one study found only 21% of drug court participants were African Americans, whereas they made up 44% of the prison population (Han & Redlich, 2018). Similarly, Hispanics comprised only 10% of drug court participants, but approximately 20% of the prison population (Han & Redlich, 2018). In another study, minority status was associated with a 101% increased risk of termination from a municipal mental health court (MHC), though receiving a new criminal charge while in the MHC was associated with an 1198% increased risk of termination (Dirks-Linhorst et al., 2013). While disparities may exist throughout specialty courts, the American public endorses problem-solving courts as an alternative to incarceration as it focuses on rehabilitation (Thielo et al., 2019).

Studies show increased stigma for help-seeking among incarcerated individuals. Porter et al. (2021) explained that incarcerated Black individuals find themselves stigmatized in two roles—first, being Black, and second, being incarcerated. Due to this, many avoid or delay treatment to not face a third stigma. Black individuals also hold a strong distrust for medical and mental health services, in general (Porter et al., 2021). Han and Redlich (2018) found minorities are significantly less likely to seek out, and benefit from, mental health and substance use treatment compared to their white counterparts. In comparison to white Americans, Black Americans tend to have fewer available resources with one of those resources being health insurance, leading to no record of previous use of mental health services or mental health diagnosis prior to incarceration (Porter et al., 2021). When compared to white incarcerated individuals, people of color, specifically African Americans and Asian Americans, were 5% and 10% (respectively) less likely to receive treatment while incarcerated (Hedden et al., 2021).

Isolation. It is not uncommon for those with mental illness to be segregated and/or separated from the general population and confinement can cause an increase in mental deterioration for those with and without current mental illness (Ben-Moshe, 2017). Facilities may justify this isolation by classifying it as protection; however, restrictive housing units often resemble the size and shape of a closet (Ben-Moshe, 2017). These individuals are usually confined for 23 hours a day (Ben-Moshe, 2017). Isolation, therefore, may be used to manage mental health symptoms as adequate treatment is lacking (Clark, 2018).

According to Beck (2015), around 17-20% of those incarcerated in jails and prisons will be confined to restrictive housing. Others estimate this number to be higher and closer to 20-30% of incarcerated persons with mental illness (McGill, 2016). In a study in Wisconsin, between 55-77% of those in restrictive housing placements had some form of mental illness (Clark, 2018). Yet, research does not show that restrictive housing results in later deterred behavioral issues, fewer assaults on staff, or overall improved behavior (Haney, 2018). Instead, isolation can cause psychological effects including insomnia, hallucinations, paranoia, anxiety, depression, and so forth, and may result in the exacerbation of preexisting mental health conditions (Clark, 2018).

Victimization. Individuals with mental illness are more likely to be victimized, both in their communities as well as when incarcerated. Research shows incarcerated individuals who have been diagnosed with a mental illness are more likely than individuals without mental illness to report being a victim of sexual and/or physical violence (Blitz et al., 2008; Canada et al., 2022; Daquin & Daigle, 2018; Jachimowski, 2018). In one study, Wolff et al. (2007) surveyed approximately 7,528 inmates (both men and women) and found approximately 1 in 12 men with

a mental illness experienced at least one sexual victimization by another incarcerated person over a period of six months, as opposed to 1 in 33 for incarcerated persons with no mental illness (Wolff et al., 2007).

Those with mental illness are more likely to be victimized by correctional staff when compared to their non-mentally ill counterparts (Blitz et al., 2008; Jachimowski, 2018). Research suggests that incarcerated men with mental illness(es) are more likely to be assaulted by correctional officers, whereas incarcerated women with mental illness(es) are more likely to be assaulted by inmates (Blitz et al., 2008; Wolff et al., 2007). One study found the rates of physical victimization amongst incarcerated men with mental illness(es) were 1.6 times (for inmate-on-inmate assault) and 1.2 times (for staff-on-inmate assault) higher than that of incarcerated men with no mental illness(es) (Blitz et al., 2008).

Mental Health Treatment. United States correctional facilities are known for being the largest mental health care providers within the country. Correctional facilities house up to ten times the number of individuals with mental illness compared to psychiatric facilities in the country (Al-Rousan et al., 2017; McCarthy, 2014). While correctional facilities are required to offer mental health care, access to mental health services while incarcerated has varied and is widely limited (Canada et al., 2022; Reingle-Gonzalez & Connell, 2014). Correctional facilities have accepted the use of pharmacotherapy as a form of treatment, in conjunction with individual and/or group counseling; however, correctional facilities often cannot afford to provide the necessary amounts of medication needed for the increasing rates of individuals with mental illness (Canada et al., 2022; Reingle-Gonzalez & Connell, 2014).

Additionally, mental health providers are also understaffed (Reingle-Gonzalez & Connell, 2014). This shortage could lead to poor inmate-staff relationships. The value of creating and maintaining positive inmate-staff rapport is crucial in establishing a safe environment needed to deliver adequate care to individuals with mental health problems (Morgan et al., 2007; Segal et al., 2018). Segal et al. (2018) explained there are multiple hierarchies and chains of command between floor staff, clinicians, and patients. This can hinder proper treatment as correctional staff can then prevent access to medical staff for treatment if they deem a situation unworthy of medical attention (Segal et al., 2018).

Summary of the Literature

Individuals with mental illness(es) are drastically overrepresented within United States jails and prisons (Al-Rousan et al., 2017; Gottfried & Christopher, 2017). Research suggests this overrepresentation as being a response to the rising rates of incarceration throughout recent

decades (Hector & Khey, 2018) and the shutting down of psychiatric facilities. The disproportionate rates of mental illness(es) within jails and prisons create problematic outcomes for the individual, their families, the correctional facility, and the entire criminal justice system (Ben-Moshe, 2020). Incarcerated individuals with and without signs of or diagnosed with mental illness(es) may face adverse effects from overpopulation, punishment as a form of behavioral control, poor adaptation to correctional housing, heightened risk of victimization, increased sentence lengths, and so much more. Not only are disparities noted within correctional facilities, but they are also prevalent in police encounters (Reuland et al., 2010) and court responses to those with mental illness(es) (Barrenger & Draine, 2013; The Sentencing Project, 2002).

While incarceration rates continue to rise, it is crucial the United States considers both proactive and reactive approaches to addressing mass incarceration of persons with mental illness(es). Further, we review proactive approaches to supporting community-based interventions consisting of collaboration between mental health providers and law enforcement agencies, additional funding for mental health programs, implementing CIT training throughout law enforcement agencies, specialty courts, and so forth. Reactively, we provide information on programs to be utilized within specific correctional environments designed to provide a more rehabilitative focus on individuals with mental illness(es) including physical activity and nature exposure.

Proactive Responses

While this paper focuses mostly on criminal-justice system responses to those with mental illness, we want to first suggest that these encounters are a product of poor community social support and services. To further this point, in one six-year study in Texas, nine patients made 2,678 visits to the emergency department (Associated Press, 2009). The need is high, but the number of those seeking and/or receiving community-based services is dismal and demonstrates a public health crisis. Broadly speaking, increased collaboration between law enforcement agencies and mental health providers is a fundamental step toward proactive reforms (Almquist & Dodd, 2009). This can serve more as a philosophy rather than a policy. Communities should allocate funding to community-based alternatives, with not only the mental health providers but also the consumers of services, including homeless populations (The Sentencing Project, 2002).

Research has shown the U.S. spends far less money on mental health services than on physical health. The average per capita spending on mental healthcare is less than $2.00 (Stuart, 2016). In addition to a lack of focus on mental health and the importance of self-care,

the U.S. also continues to harbor a stigma surrounding mental illness. Literacy programs to improve knowledge of the mental illness, the sharing of personal accounts of lived experiences, and overall increases in awareness, are broad sweeping suggestions. As one suggestion, stakeholders at all decision-making points can benefit from training such as Mental Health First Aid (MHFA). This training helps individuals assess for suicide risk and self-harm, and increase skills to listen nonjudgmentally while giving assurance, information, and encouragement for self-help and professional help. Completion of MHFA has been shown to increase knowledge about treatment, improve helping behaviors, decrease social distance and stigma, and provide confidence to those trained (Atanda et al., 2020; Morgan et al., 2018; Stuart, 2016).

Proactive Law Enforcement Responses

All law enforcement agencies should provide in-service training to enable officers to recognize the signs and symptoms of serious mental illness (The Sentencing Project, 2002). Crisis Intervention Teams (CIT) is a police-based approach where law enforcement officers receive extensive training to better provide a first-line response to people with mental illness (Morabito et al., 2017). The CIT program originated in Memphis and, accordingly, has become known as the “Memphis Model” (Hassell, 2020). Currently, around 10% of U.S. law enforcement officers are trained (Morabito et al., 2017).

CIT is a 40-hour training where officers either volunteer or are selected. The training intends to immediately influence officers’ perceptions of the dangerousness of the person with mental illness, increase understanding of emotional/behavioral issues, and help officers become better listeners and resort to fewer emergency detentions by using verbal de-escalation (Canada et al., 2021; Hassell, 2020; McNeeley & Donley, 2021). Research in recent decades has shown that officers CIT trained have proven to be more prepared to work with individuals suffering from mental illness(es) (Canada et al., 2021). Officers with CIT training conduct more thorough evaluations of the risks involved in mental health calls, exhibit a better understanding of why individuals display certain behaviors and contain more knowledge of dispositions outside of arrest (Canada et al., 2021; McNeeley & Donley, 2021).

Proactive Court Responses

At sentencing hearings, judges and others involved in the court process need to be aware of the role that serious mental illness may have played in a person’s current charges. To ensure this, the defense should be trained in mental health issues including interviewing techniques and the importance of utilizing social workers. They should understand their clients

need access to timely counsel, judges need information regarding their mental health status, medication status, and specific needs to help the client actively participate in the court process. Judges then should be permitted in diverting non-violent persons with mental illness away from incarceration to appropriate treatment. Judges could even defer entries of judgment until the successful completion of treatment programs, dismiss charges, or expunge records (The Sentencing Project, 2002).

Specialized mental health courts can be utilized for those with mental illness who have been charged criminally. These courts have specialized dockets with a main feature of collaborative and non-adversarial approaches. The specialized courts generally comprise a judge, prosecutor, defense attorneys, those from probation and/or parole, and representatives from a mental health agency (Almquist et al., 2009). The collaborating parties are likely to make referrals including those to mental health and substance use resources (Wolff, 2002).

Research on these specialty courts is promising but also mixed. Some studies find that participation in mental health courts reduces recidivism and reincarceration (Almquist & Dodd, 2009; DeMatteo et al., 2013) while having positive mental health consequences for participants (Almquist & Dodd, 2009; DeMatteo et al., 2013; Snedker et al., 2017). MHCs also help in monitoring and supporting community stability, treatment compliance, and progress to achieve treatment goals (Simonsson et al., 2020). The evidence is not definitive (Sarteschi et al., 2011; Sirotich, 2009) as some question the ability to assess given inclusion differences, treatment conditions, and lack of longitudinal data (Snedker et al., 2017) while some are critical of the added expenses. However, the costs would be offset by the savings of bypassing the traditional criminal justice system (Almquist & Dodd, 2009; Ridgely et al., 2007).

MHCs focus on therapeutic jurisprudence with a balance of rehabilitative ideas with a public safety model (Snedker et al., 2017). If jurisdictions were unable to offer MHCs, the court and jail systems could collaborate to reduce the time spent detained for those with mental illness. When arrested, someone with mental illness could engage in an early screening, classification, and referral process. Additionally, pretrial release programs can be effective at reducing incarceration while connecting community-based agencies to the individual (The Sentencing Project, 2002). Post-booking diversion programming can screen individuals who may be eligible for diversion in lieu of prosecution or reduction in charges (The Sentencing Project, 2002).

Reactive Correctional Responses

This section reviews different practices and/or policies that can address mental health care needs for incarcerated populations. These policies include only reactive approaches of increasing resources for those who are incarcerated while focusing on community-level interventions to help reduce the incarceration and reincarceration of those with mental illness.

Programs. Outside of traditional psychotherapy and medication management, physical activity and nature exposure can improve living conditions within the correctional environment. These approaches are inclusive of all incarcerated populations, including individuals of all races, religions, genders, and so forth—which assists in decreasing disparities that currently exist surrounding individuals with mental illness in correctional settings. The first step in implementing these programs would be to collect data within local correctional facilities and disseminate the findings to local representatives. Implementation at the state/local levels allows for the possibility of further studies and greater evidence to implement on a federal scale. Realistically, beginning at the state/local level should also be more cost-effective for researchers presenting policy suggestions, while more connections could be made for broader outreach.

Physical Activity. Many incarcerated persons with mental illness are confined to separate spaces such as restrictive housing and other forms of isolation (Clark, 2018). This type of confinement can have extreme effects on an individual's mental state, especially if that individual has already been diagnosed with mental illness or has been experiencing symptoms of mental illness (Ben-Moshe, 2017). Confinement measures may result in individuals receiving only one hour per day outside of their cells (Ben-Moshe, 2017). This isolation would leave incarcerated individuals with little to no time or resources for building and maintaining a healthy physical routine, while also drastically limiting socialization, hindering the creation of positive relationships.

Physical exercise can influence an individual's mood through physiological parameters (Battaglia et al., 2015). These parameters consist of factors such as body temperature regulation, adrenal activity, and the transmission of noradrenaline and dopamine through neural pathways (Battaglia et al., 2015). Physical activity can increase self-esteem and confidence, and decrease depression/hopelessness (Woods et al., 2017). Physical activity can also provide individuals with lessons on discipline, setting goals, reducing boredom, relieving tension, improving self-esteem, and much more (Battaglia et al., 2015). Woods et al. (2017) explain that regular involvement in any form of physical activity can have a beneficial effect on the social, physical, and psychological well-being of an individual. Small groups of individuals performing physical activity also provide opportunities for positive social interactions and relationship

building among incarcerated populations, potentially decreasing the divisive nature instilled within correctional facilities (Woods et al., 2017).

Exposure to Nature. As mentioned above, many incarcerated individuals with mental illness find themselves in isolation (Ben-Moshe, 2017) which limits their time outside (Timler et al., 2019). Restrictive housing practices are abusive, ineffective, and unethical, which decreases well-being and mental status (Reddon et al., 2019). Yet nature-based programs have consistently shown nature exposure improves both mental well-being and psychological health (Barnes et al., 2019; Devine-Wright et al., 2019). Mental health improvement through exposure to nature has a positive impact on a range of demographic groups (Barnes et al., 2019; Liu et al., 2021). Several studies have found that women are more likely to benefit from nature exposure than men; however, there are also opposite findings showing stronger beneficial effects in men (Liu et al., 2021).

Prison environments generally consist of cement walls, poor ventilation, and little to no lighting (Reddon et al., 2019) resulting in diminished positive effects achieved by nature exposure. Reddon et al. (2019) explained that both direct and indirect exposure to nature can increase blood flow to areas of the brain that are utilized for experiencing altruism and empathy. For example, hospitals and schools are full of brightly colored flowers, trees, blue skies, animals, and more—this is an example of indirect exposure (Reddon et al., 2019). Nature exposure also increases positive social behaviors, while decreasing aggression and rumination (Reddon et al., 2019).

Direct exposure to nature may include activities such as daily walks and gardening (Reddon et al., 2019). Gardening is especially beneficial in that it gives individuals an improved appreciation of nature and provides a source of physical activity, which also helps aid in the well-being of individuals' mental health (Reddon et al., 2019). Caring for a garden may give incarcerated individuals a sense of accomplishment and lead to a reduction in boredom (Reddon et al., 2019). Lee et al. (2021) explained that implementing a horticulture therapy program, like gardening, assists individuals with setting goals, making plans, and executing strategies. Such programs can lead to mental health improvements and social adaptations. These factors hold the potential in assisting in the reduction of facility violations for those with mental illness (Lee et al., 2021) while also providing a sustainable source of food (Reddon et al., 2019). Correctional facilities can profit from selling extra produce to gain a return on their investment in the program (Reddon et al., 2019) and compensate incarcerated people for their work. Other programs have even helped cultivate plants that pollinate in pursuit of attracting

monarch butterflies (Timler et al., 2019). These activities create a community connection for incarcerated individuals that could ultimately provide a path to employment post-release.

These programs provide opportunities for acquiring social skills, personal growth, constructive experiences, and positive relationships/influences (Timler et al., 2019). Horticulture therapy programs have been associated with reduced depression, along with increased self-esteem and life satisfaction (Lee et al., 2021). Having access to green spaces improves coping abilities and provides a means for reducing stress in a cost-effective way (Timler et al., 2019). Correctional agriculture has also been proven to reduce the rate of recidivism among incarcerated populations (Timler et al., 2019). This reduction is linked to spending time in nature, in turn, improving cognitive functioning and increasing restorative thought processes (Timler et al., 2019). Lee et al. (2021) explained that participating in the maintenance of a garden allows for incarcerated people to discover similarities between the human and plant life cycles, creating an opportunity for self-reflection and better emotional intelligence (Timler et al., 2019).

Currently, only one-third of U.S. prisons have implemented some variation of “green education” (Timler et al., 2019). Yet, to summarize these programs, they have a variety of positive impacts, including (1) an increase in positive socialization, (2) a decrease in boredom, (3) improvement in physical activity, (4) acquisition of skills to be utilized post-release, (5) a more nurturing correctional environment, and so on (Battaglia et al., 2015; Timler et al., 2019). This can also lead to reductions in victimization and recidivism, improvement in social relationships, and means for counteracting the mental deterioration experienced by living within a prison cell (Clark, 2018; Hoke, 2015; Jachimowski, 2018; Timler et al., 2019).

Conclusions

Individuals with mental health issues are overrepresented in jails and prisons (Prins, 2014). The United States currently houses 25% of the world’s prison population (Prins, 2014), with approximately 20% of incarcerated people experiencing mental illness. The deinstitutionalization of psychiatric facilities in the mid-1900s has been linked to the rise in incarcerating those with mental illness within correctional facilities (Hector & Khey, 2018). Correctional facilities were not designed to treat individuals with mental illness and remain unable to meet this demand (Ben-Moshe, 2017).

Incarcerated individuals face continued disparities while incarcerated, including oppression based on gender, race, and ethnicity, and risk of victimization (Hedden et al., 2021; Jachimoski, 2018; Porter et al., 2021; Prins, 2012). Correctional environments ultimately hinder

the mental state of incarcerated individuals, both with and without, current diagnosable mental illness. The current suggestions seek to find solutions for reducing and preventing system involvement while recognizing some individuals with mental illness will still do time behind bars. This paper has outlined the major issues for those with mental illness at the different criminal justice decision points from first police interaction to post-release from a correctional facility.

More proactive responses include increased training for all system players but especially for first responders. Training law enforcement on mental illness and the presentation of signs and symptoms is crucial for the safety of all involved. Law enforcement officers could complete a 40-hour CIT program. They could also partner with local courts to work on early screening processes and pre-trial and post-booking alternatives to reduce incarceration. The court system should also work towards collaborative efforts with law enforcement as well as local jails. When possible, jurisdictions should implement MHCs for non-violent individuals. While this approach is treatment-focused rather than punitive in nature, with each new hire and/or appointment, the momentum to change the narrative regarding mental illness and criminality may be lost. A long-term cultural commitment is necessary for sustained change.

Correctional facility programs do not provide “cures” for mental illnesses, but they can assist in limiting the onset of new mental illness among incarcerated populations, reducing the exacerbation of previously diagnosed mental illness(es), and providing acquired skills and routines to be carried over into life upon release (Timler et al., 2019). Yet, due to cultural and political barriers, improving the lives of incarcerated people does not tend to garner widespread support. Utilizing non-profit agencies or foundation funding could help provide and expand upon such correctional-based programs. This is especially important as research shows the transition from prison to the community is stressful, continuity of care is lacking, and suicidal risk is highest within the first month of post-release (Hopkin et al., 2018).

With the continued increase in correctional facility populations, both proactive and reactive approaches are crucial for addressing mass incarceration of mental illness(es). The warehousing of individuals with mental illness in correctional facilities is ill-informed, unethical, and possibly, cruel, and unusual punishment. The approaches reviewed throughout this paper did not explore *all* solutions to the mass incarceration of individuals with mental illness; rather, the current suggestions provide pertinent steps in reducing the harsh effects of correctional facilities and future criminalization of mental illness.

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