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## Preventing Reincarceration of Women with Mental Illness

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PREVENTING REINCARCERATION OF WOMEN WITH MENTAL  
ILLNESS

by

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A thesis submitted in partial fulfillment of the requirements  
for the Honors in the Major Program  
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## ABSTRACT

Since deinstitutionalization of state hospitals began almost 50 years ago, there has been an increase in the population with mental illness seen in the prison system. A combination of factors were looked at when studying causes behind incarceration, including active symptoms of mental illness, socioeconomic status, social support systems, history of trauma, history of drug abuse, police education on mental illness, and public perspective on mental illness. This study is a literature review focusing on people with mental illness in the prison system, with particular attention to women.

It is costly to house inmates for any extended period of time. Specialized housing, needed for people requiring greater supervision, including those with mental illness, is particularly expensive. These funds were intended to go into community programs supporting those with mental illness after release from the institutions of the past. Without this support, many people with mental illness wind up homeless and turning to substance abuse, which leads to opportunities for incarceration. While further research is needed, there is evidence of promise shown in the combined efforts of increased case management and social support systems along with increased education of law enforcement officers on the symptoms and handling of cases of people with serious mental illness.

## DEDICATION

This paper is dedicated to anyone living with mental illness. It is often a lonely fight, and while there is much to be improved, there is hope for the future.

## ACKNOWLEDGMENTS

I would like to acknowledge everyone who has helped me reach this point in my studies. To my parents, for fully supporting me throughout my entire life, in particular as I figured out my major and plans for the future. To my friends and other loved ones, thank you for always being there for me, no matter how crazy my schedule gets. Finally, a huge thank you to my Committee: Ms. Neubauer and Dr. Potter, and in particular my Chair: Ms. Dever. Thank you for making me feel as though I always had a handle on life, including convincing me I would be able to complete this undertaking.

## TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION.....	1
BACKGROUND .....	3
PROBLEM.....	6
PURPOSE .....	7
METHOD.....	9
CHAPTER 2: REVIEW OF LITERATURE .....	10
DISCUSSION .....	16
CHAPTER 3: RECOMMENDATIONS .....	23
NURSE PRACTICE .....	23
RESEARCH.....	24
CHAPTER 4: LIMITATIONS.....	25
CHAPTER 5: CONCLUSIONS .....	26
APPENDIX A: SELECTION METHOD OF LITERATURE.....	28
APPENDIX B: TABLES OF EVIDENCE.....	30
REFERENCES.....	44

## CHAPTER 1: INTRODUCTION

Over fifty percent of prison inmates in the United States have been diagnosed with mental illness (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009). Past research has revealed that a high proportion of people in Texas and New Jersey state prison systems have a history of mental illness (Barrenger & Draine, 2013; Baillargeon, et al., 2009). Additionally the percentage of people in the United States prison system with a history of mental illness, many of whom have co-occurring substance use disorders, is significantly higher than those in the general population. "The risk of incarceration for persons involved in the public mental health system or with a history of psychiatric hospitalization is estimated to be 2.5 to 25 times that of the general population" (Barrenger & Draine, 2013, p. 156). While research has been done, there is a negligible amount of information available as to why these rates are so much higher. More recently, research was done by Hawthorne et al. (2012) and Willging, Malcoe, Cyr, Zywiak, and Lapham (2013) to observe the risk factors, reincarceration rates, and possible interventions to be provided upon release. The studies focus on potential ways to reduce reincarceration rates for this population of incarcerated women with mental illness.

Public Health nursing can contribute to increased social services for women with mental illness leaving the prison system. People do not need to be in the particular role of social worker in order to make a difference in the opportunities available. Judge Steven Leifman was an example of someone who went outside his expected practice to

gain support for former prisoners returning to the community. His efforts have reduced the re-arrest rates in the Miami-Dade area from 70% to 19%, saving the county over \$2.5 million a year. Upon appointment, Judge Leifman noticed the difficulty for people with Serious Mental Illness (SMI) to return to the community after arrest. For various reasons, including inability to know how to bail out, or lack of resources on the outside, people with mental illness were being arrested and detained at an alarmingly high rate. They were also being detained far longer than those without SMI. Even after the extra time in jail, defendants were being released following evaluation with no additional care. It was at this time that Leifman discovered the link between mental illness and adults in the prison system (Heines, 2005).

It is only recently that studies have started to look at the connection between availability of follow-up care and percentage of recidivism. Thus, this information is in short supply. As of 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) had collaborated for four years on guidelines for what care should be available for prisoners, both in prison and after release. These recommendations include substance abuse and mental health services, including gender-g geared services. Most of the existing information is directed at men and their particular needs. Future research proposed by Johnson et al. includes qualitative studies aimed at asking the women themselves what their needs are when returning to the community from the prison system. This study can form the basis for what services and interventions are truly needed for this population (Johnson et al., 2015).

## BACKGROUND

In 1939, Penrose looked at census data from prisons and mental hospitals across 18 European countries. He found an inverse relationship between the populations of the two. His theory was that if either of these forms of recidivism were reduced, the other would increase. In 1841, Dorothea Dix began the movement toward establishing psychiatric hospitals in the US, creating large, pastoral asylums that reduced the mental illness presence in prisons to 0.7%. While the Royal Commission in Canada was the first to establish an asylum in 1836, it was not until the US started the move toward pastoral asylums that this trend was reflected in Canada. After awhile, overcrowding and underfunding led many to become undercared-for in the institutions. With the discovery of psychotropics in the 1950's, a push began to deinstitutionalize, claiming that the community funds previously used for the hospitals would create community support programs and allow reinstating of the patients into the population at large. Hospital psychiatrists were wary, but deinstitutionalization took effect. Lack of funding and appropriate programs resulted in many patients on the streets. Thus, Penrose was proven correct when by the 1970s, higher rates of mental illness began appearing in the prison system once again. This initiated the criminalization of mental illness, only to be heightened by the new ruling that people could claim Not Criminally Responsible which, while protecting people with mental illness from legal action, had the unintended backlash of implying mental illness drives criminal behavior. By criminalization of mental illness, it is understood that in public opinion and the media,

people with mental illness are viewed as dangerous and prone to violent or criminal behavior. Luckily this was improved in 1999 with the Supreme Court of Canada case, *Winko v. British Columbia (Forensic Psychiatric Institute)*. Following this case, it became the responsibility of the hospital, rather than the patient, to prove the patient was not a risk. This ruling had a large impact on the treatment of mental health in the criminal system in the United States. Following this ruling, it became necessary for a licensed mental health professional to declare someone mentally unfit if they are to use this defense in court of law. Now there is an emphasis on increasing validity of going into the psychiatric profession, decreasing the legal backlash for people with mental illness by better educating law enforcement, and looking for better ways to find treatment than accepting it through the judicial system (Chaimowitz, 2012).

Peterson (Peterson et al. 2010) decided to take this concept one step further in a study designed to further determine whether or not the criminalization of mental illness has validity. Here, the criminalization of mental illness means the assumption that the illness itself is behind most of the crimes landing this population in the prison system. Two hundred twenty-one participants were interviewed, all of whom had been released within the previous 14 weeks, and 112 of whom has serious mental illness. Based on the interviews, people were categorized by driving factors behind their criminal activity into: psychotic, disadvantaged, reactive, instrumental, or gang activity/drug abuse. By the criminalization theory, in which crimes by people with mental illness are considered a direct byproduct of their active symptoms, psychotic should be the highest group for

those with SMI. Due to the results obtained, this category had to be further broken into two categories: the first in which crimes were directly resulting from hallucinations or delusions, the other pertaining to minor crimes of survival. The first group comprised of five percent of the group (N=6), while the second consisted of five percent (N=2). Thus, only seven percent of people with SMI had a crime directly or indirectly related to their illness. Most of each group (90% with SMI, 68% without) fell into the reactive group, further supporting the idea that other factors are at play when people with SMI commit crimes. Further data from 608 violent incidents in the MacArthur Violence Risk Assessment study showed a mere 11% (N=67) of crimes occurred while patients were actively delusional or hallucinating.

In addition to concerns about the mental health population itself, and the community at large, there is a rise in the number of older adults with mental disorders winding up in prison. This was exhibited by Regan (2003), and raises economic concerns as the general population ages. The average cost per prisoner per year was \$16,700 in 2002, and has only increased exponentially since, with the most recent price cited between \$50,000 and \$100,000 per year, depending on location. Particularly expensive is specialized housing, such as for prisoners with mental illness, who require greater supervision. This expenditure lends to concern over the future costs for the taxpayer (Regan, Alderson, & Regan, 2003). This money could be spent in preventative and rehabilitation programs aimed at preventing incarceration of the elderly psychiatric

population. These programs would serve to treat not only the elderly population, but the entire mental health population.

## PROBLEM

In the year 2005-2006, per Hawthorne et al. (2012), 4,544 (11.5%) of the 39,463 patients in the public mental health system in the San Diego county were incarcerated. Incarceration risk factors include prior jailing, substance use, homelessness, psychiatric diagnoses, male gender, young age, lack of insurance, and being African American. While it would be simple to point to the rates of incarceration among women with mental illness and aim treatment at offering mental health services, it is quickly becoming clear this is not the entire story. As explained by Barrenger and Draine (2013), not only do these released individuals need to find basic necessities such as food and shelter, but they also need to care for their families, obtain health care, and acquire identification. All this must be done while often being denied employment or housing based both on criminal history, and a history of mental illness, due to preexisting social stigmas about the dangers of people in these categories.

Similar findings were discovered in a focused study by Willging et al. (2013) of 98 women in a New Mexico state prison. Not only did 100% of the women interviewed screen positive for having experienced previous trauma, but 85% were positive for substance abuse, 50% for mental illness, and 46% for both. The analyses showed a co-occurrence with bouts of homelessness, mental illness, and substance use as being a primary factor for recurring incarcerations (Willging et al., 2013). This brings to light

several factors that coincide with mental illness that may pertain to the incarceration and reincarceration rates. Mental illness itself is a factor, often leading to the increased rate of violent crimes as laid out by Regan et al. (2003). However, coinciding factors of history of abuse/trauma, homelessness, poverty, substance use, and lack of medical insurance often lead many released patients to wind up right back in prison (Hawthorne et al., 2012).

## PURPOSE

This review aims to propose a way to decrease the proportion of women with mental illness in the prison system. A review of systematic studies on which interventions are effective and which are non-effective is done in order to provide reasoning for further research. In a study by Hawthorne et al. (2012) of 4,544 mental health patients who were incarcerated between 2005 and 2006, those receiving outpatient mental health services or case management services following release were less likely to be reincarcerated within 90 days or require emergency services. Thus, further research has been proposed by Willging et al. (2013) in the reduction of prison rates through better housing and addiction/therapy programs.

Barrenger and Draine (2013) explained “preventing reincarceration is a complex task, made nearly futile if one does not examine the risk environment in which consumers of mental health services are living their daily lives” (p. 163). Studies need to be done on increasing immediate availability of adaptive services such as work programs or shelters, as well as focus on modifiable risk factors, including lack of

insurance, homelessness, and substance abuse (Hawthorne et al., 2012). Future research needs to focus on a cumulative effort to bring these former prisoners into society in a way that supports their emotional and physical needs. Thus new programs can be designed that cover all bases when it comes to the issue of high reincarceration rates among the mental health population.

For women in the criminal justice system, mental illness and substance abuse often go hand-in-hand. It is difficult for said women to get proper care, as they often do not serve as long of sentences as men, and are quickly returned to the community. In 2013 there were around 111,000 women in state and federal prisons, with 1.1 million on probation or parole (Johnson et al., 2015). For these women quickly returned to the community, it can be difficult to effectively plan the transition and make available all necessary services. As shown by Johnson et al. (2015), the revolving door of co-occurring substance abuse, mental illness, and incarceration are furthered when appropriate mental health, substance use, and criminal justice resources are not readily available. Statistically, only 30-50% of women leaving the prison system access mental health services, and less than one third access substance abuse help. This can be for a variety of reasons, including but not limited to: poor communication with the criminal justice system, lack of available mental health and substance abuse resources, low insurance, and low Medicaid enrollment. There also needs to be consideration given to the barriers for the individual women to accessing care, from their disorders themselves, to lack of transportation (Johnson et al., 2015).

## METHOD

This is a review of literature corresponding to studies of women in the prison system with history of mental illness. Individual peer reviewed studies of interviews or data collection, as well as meta-analyses, found through CINAHL, EBSCOhost, Psychinfo, and MEDline, will be compared to determine patterns in the incarceration and reincarceration rates of women with mental illness, as well as to study success rates of various interventions aimed at decreasing said rates. Search terms included psych\* OR mental illness AND women AND prison OR jail. Inclusion criteria included English, 2000 to present, nursing subset, and findings categorized by sex. Focus will also be given to the future research necessary in this topic area, and how best to go about collecting this research.

## CHAPTER 2: REVIEW OF LITERATURE

As of 2005, according to the National Institute of Corrections, an estimated 300,000 to 400,000 adults in the prison system had some form of mental illness. Meanwhile, 540,000 people on probation had mental illness. As noticed by Leifman, this high number was attributed to the deinstitutionalization. The 560,000 people with mental illness in state hospitals at the time of deinstitutionalization have decreased to fewer than 40,000 while the numbers in the prison system have gone up dramatically. As Leifman explained, it is not so much that deinstitutionalization occurred, as that reinstitutionalization did. Instead of terrible conditions in a state hospital, people ended up in terrible conditions of the local prison system. There were still not proper treatments and community integration at play, but rather a new place to warehouse the mental health population. In this vein, a summit was held in order to determine better ways for law enforcement and the correctional system to handle people with mental illness (Heines, 2005).

As previously shown, there is an unusually high percentage of people in the prison system with mental illness when compared to the general population (Baillargeon et al., 2009). One population particularly affected is women. When women at several prison sites were interviewed, it was discovered by Nowotny, Belknap, Lynch, and DeHart (2014) that one in five qualified as having both a mental illness and a substance use disorder. The women with multiple disorders had higher history of violence, 87% physically abused by family, 81% sexually assaulted, and 78% experienced Intimate

Partner Violence. They were also more likely than other women to be in jail for a violent offense. The group was racially and ethnically diverse, with findings indicating the negative effects on incarceration of women with traumatic pasts, substance use, and mental illness (Nowotny, Belknap, Lynch, & DeHart, 2014).

In a study by Baillargeon et al. (2009) of 79,211 inmates who began sentences between Sept. 1, 2006 and Aug. 31, 2007, ones diagnosed with psychiatric disorders were more likely to have history of multiple incarcerations than those without. Additionally, a disproportionate selection of inmates with psychiatric disorders were women. In Baillargeon et al.'s (2009) study, the racial and ethnic groups were represented equally. However, women were overrepresented in the depressive and bipolar categories. This supports the point to be discussed that many women wind up in the prison system due to substance abuse for self-treatment, when better treatments are not made available in the community. In comparison, people with history of schizophrenia and nonschizophrenic psychotic disorders were most often jailed for violent offenses. Were there to be proper interventions at the time of psychotic break, many of these crimes could be prevented, which Crisis Intervention Teams, to be further discussed (Baillargeon et al., 2009).

On the other hand, in a study by Regan et al. (2003) of 671 inmates over age 55 in Tennessee's state Prison System, no statistical significance was found for correlation between gender and type of illness, except when dementia and depression were studied alone. Overall, 109 of the 671 inmates were diagnosed with mental illness.

While the general prison population consisted of twelve percent women, among the mental health population in prison, women comprised thirteen percent. Thus, while people with mental illness are overrepresented in the prison system as compared to the community in general, women are even more so overrepresented proportionally than men. Most research to date focuses on males in the prison system. This points to a need and a co-occurring deficit in the research available on the subject. Overall, depression is most highly correlated to murders in women while dementia is the most correlated to sex crimes in men in this study. This imbalance points to a further need for research among sex, type of mental illness, and crimes committed, in order to draw any definitive correlations (Regan et al., 2003).

One intervention already in place is the training of Crisis Intervention Teams (CIT) to determine whether a person is currently affected by mental illness at the time of committing a crime, and how to handle the situation, rather than immediate incarceration. Within the past 30 years (since implementation in Memphis in 1988), focus has turned to decreasing the criminalization of mental illness through use of better responses by law enforcement officers (LEOs) to incidents involving people with active symptoms of mental illness. These teams of LEOs have received special training in how to respond to people in mental health crises. They are trained in recognizing and responding to various disorders, medication side effects, and therapeutic communication. They also are more willing to bring patients to hospital settings with the creation of mental healthcare facilities with no-refusal policies that have a sped-up

process for officers involved in the admission process for people in mental health crises. This process also allows for greater follow-up in care than is possible once someone is released from prison, further reducing the likelihood of winding up in the revolving door of incarceration and reincarceration. Through a combination of education and availability to the CIT, officers are more likely to reach out for mental health assistance, rather than taking people with mental illness straight to jail, as often happened previously. This lends largely to decreased criminalization of mental illness, as percentages of people being sent to prison are reduced. This also frees up resources previously used to house prisoners, which can lend toward further implementation of programs, as only 11% of major police departments in the US were cited as using such programs as of 2003 (Browning et al. 2011).

In a similar effort to the CITs, an effort was made by Judge Leifman's team to train law enforcement officers how to handle people with mental illness, and where to direct them for comprehensive care resources. Should the individual be arrested, upon release it was arranged that those with mental illness have a meeting with psychiatry within 24 hours. At that time, the psychiatrist would determine what level of care is required for their safety. By providing other avenues for safe detainment of individuals with mental illness, as well as follow-up care to prevent reincarceration, Judge Leifman was able to greatly reduce the proportion of people with mental illness in the misdemeanor area of his local jail (Heines, 2005).

Morabito (2007) took a different stance on police's involvement in the incarceration of people with mental illness. While agreeing that large proportions of the prison population have mental illness, this article looked to decrease the blame placed on police interaction in the criminalization of mental illness by focusing on the social and environmental factors behind arrest of people with mental illness. Correlations are drawn between available resources in the area, general opinion of the community toward people with mental illness, and potential for actions to harm selves or others that are leading factors in high proportions of arrests. One study focused on the lack of police education and the correlation to higher arrest rates and fear, which was described as largely baseless. The article also serves to warn the difficulties in being too restrained in treatment of criminals with mental illness. By using mental illness as a way to avoid penance for one's crimes, this in fact supports the criminalization theory that the illness itself causes the crime, rather than a myriad of factors unique to the individual (Morabito, 2007).

An article by Pinals (2015) further supports this idea. This article brings together studies from the past two years (2012-2014) to point out the multiple factors that lead to the high population of people with mental illness in the prison system. While attributing a mere 3-4% of crimes by people with mental illness to symptoms of the illness itself, this article goes on to show a myriad of causes that are mirrored in the general population when committing crimes. While some of these factors often go hand-in-hand with mental illness, such as substance abuse, poverty, inactivity, social disruptions, and prior

physical/ sexual victimization, they are not a direct effect of the mental illness. In the study by Pinals (2015), an analysis was done in the public mental health services of people with schizophrenia and psychotic disorders who had been arrested. It was found that people with co-occurring antisocial personality disorder or substance use disorders were significantly more likely to be arrested. Meanwhile, those with co-occurring anxiety disorders or post-traumatic stress disorder were more likely to have committed violent crimes. The article goes on to suggest ways to improve the system. Starting with CIT and specialized courts for everything from veterans, to mental illness, to substance abuse, greater education for LEO regarding mental health is a huge step toward preventing unnecessary incarcerations. While a small proportion of the actual crimes, this separation of mental health issues from the criminal activity will potentially go a long way toward improving the name of mental illness. This change will hopefully improve opportunities in the community, garner support, and increase resources (Pinals, 2015).

## DISCUSSION

Future interventions, according to Willging et al. (2013), need to focus on “harm reduction, treatment engagement, housing, and other support services” (p. 590). It is important to focus not only on the individual, through reducing risk factors that may lead to imprisonment, but also on the environment, for instance reducing social disadvantage such as low socioeconomic status (Barrenger, & Draine, 2013). It is not enough to treat the illness alone especially if desperate living situations have driven people to make the same mistakes that landed them in prison in the first place. Financial difficulties may be a concern, as payment or insurance are often required for the treatment, and this may impede a person’s ability to pay for basic needs such as food, medication, and housing. New interventions combine the use of case management, previously used to keep people out of homeless shelters and psychiatric hospitals, with a residential component, in which housing and basic needs are provided. This allows patients to focus on rehabilitation without the social concerns of lacking resources to support themselves (Barrenger, & Draine, 2013). By focusing on the presence of women with mental illness in the prison system, the study by Barrenger and Draine (2013) looks to find patterns of reincarceration, and how to best target the risk factors in order to implement superior interventions.

Upon leaving prison, it can be difficult for women not to fall back to old ways of substance abuse, petty crime, or even merely interacting with people of poor influence. This can be due to a combination of factors, including negative relationships, family

upbringing and responsibilities, trauma, or discontinuation of psychiatric meds when they are no longer available. For these and so many other reasons, it is easy for women, particularly those with mental illness, to fall prey to the revolving door of the prison system.

Johnson et al. (2015) have recommendations for how to prevent this occurrence. These include continuity of care, sober support, role models, and peer support, mental health treatment, and healthy substance use for mental health. When interviewed, both providers and former prisoners described the process of jumping through hoops as a major deterrent to receiving treatment after release. By this, they mean the overwhelming job of coordinating services and finding funds, such as insurance, are often not worth the effort when these women often have major issues to worry about, including where to live. As a result, case management and coordination of post-release services are major needs for women leaving the prison system. Were it easier to find care, more women would be likely to seek services (Johnson et al., 2015).

As of 2003, an estimated one million prisoners had a history of mental illness evident in the year leading up to their arrest. Among the prisoners with mental illness, women are significantly more represented than men, with rates of 73% and 55% respectively. In a study done on prisoners released from a Utah State Prison from 1998 to 2002, researchers looked at recidivism, community tenure, and illness severity for people with SMI. After acknowledging a prior deficit in sex-specific statistics, this study looked at the co-occurring factors of sex and mental illness to show the risk of repeat

incarceration for women with mental illness. This increased risk in reincarceration is made especially apparent when overall statistics are looked at. While men without SMI have a significantly higher rate of reincarceration than women without SMI, when factoring in SMI, women have the higher rate. This emphasizes the need for further research on how women in particular are impacted by mental illness in the prison system. Without addressing needs specific to women, it is difficult to provide proper community support necessary to prevent further incarcerations (Cloyes, Wong, Latimer, & Abarca, 2010).

Lack of services for women returning to the community can be broken down into three categories: lack of resources, lack of motivation, and competence in using available services, according to Johnson's (2015) interviews with providers. The first is that oftentimes resources are not made available to these women. The second is that both the women and the services must be motivated to work toward supporting these women. Finally, they have to be competent in utilization of resources when made available. When it comes down to it, there are several systemic issues in place preventing these women from seeking necessary care. The parole system has its own demands, in addition to the stressors of finding housing and employment with a criminal record, supporting a family, often avoiding negative or abusive relationships, not having transportation, and lack of economic support. With numerous physiological and safety issues at hand, it is unsurprising these women are often unable to move up Maslow's hierarchy to meet the esteem needs required to find treatment for mental health. Other

barriers include the fact that many support programs are not available to those with criminal records, and that prison treatments often gave women a skewed vision of how available treatment would be in the community, leading them to feel as though they had failed somehow when they were unable to find proper treatment. This makes it that much harder for women to have the motivation to continue seeking treatment options. While it is important for the women to be proactive in seeking their own treatment upon community reentry, recovery and treatment deficits within the community are significant barriers, which will be discussed further (Johnson et al., 2015).

Throughout the interview process, providers suggested a few ways women could receive the support they need to manage numerous services and providers. A few of these suggestions included case management, wraparound services, mentors, life coaches, supportive housing, or reentry specialists who work with the probation officers already on the case. The primary focus of these support positions would be that women would have daily contact with them, allowing constant support, guidance, and service provision. This need was agreed upon by all providers in the study. Other topics with unanimous support included occurrence of relapse triggers in the community and treatment needs. These needs also matched up one hundred percent with needs expressed by female prisoners in a similar study done at about the same time as Johnson's. For example, when given a list of common potential relapse triggers for women with substance abuse disorders leaving the prison system, both providers and prisoners identified "being with the wrong people" as the most common cause.

Additionally, service needs identified by both included those for substance use, mental health, family, housing, and employment issues (Johnson et al., 2015).

In many cases, it is not necessarily that these services are not available, but that they are not accessible. Between coordinating the numerous aspects of care and lack of knowledge about how to proceed, both providers and prisoners described accessibility as a process of “jumping through hoops,” indicating a need for one particular person to manage service needs. Once arranged, there is still a need for women to have the motivation and confidence to follow through with their care. However, standing in the way of these services are enormous barriers in the form of lack of resources in the mental health and substance abuse treatment fields. Systemic issues surrounding provision of treatment include insufficient discharge planning and services, few community mental health programs, and programs that do not center on the need of former prisoners, or worse do not provide to former prisoners (Johnson et al., 2015).

To begin his research, Johnson (2015) interviewed 14 prison and post-release or “after-care” providers about the in-house treatment and community post-release services available for women in the prison system. As services are provided by a wide variety of individuals, including substance use providers, mental health providers, discharge planners, employment and reentry specialists, parole and probation officers, and community providers, various positions were interviewed at this time (Johnson et al., 2015).

Difficulties are especially apparent for women with co-occurring mental illness and substance abuse disorders. When interviewed, providers related that compared to women with substance abuse alone, women with mental illness are not as emotionally capable of handling issues in their personal life, such as lack of finances or support systems. Compared to men with co-occurring disorders, women were more likely to fall prey to negative relationships that hindered them from getting necessary treatment. Therefore, despite women with mental illness being more open to the concept of treatment, other factors often stood in their way of actually receiving the help they needed. It is also found that women with these disorders are likely to have fewer vocational skills, lower rates of education, high rates of depressions, poor health, and families/friends that abuse substances. The factors keeping these women in poverty and out of treatment are present in every aspect of their lives. It is thus unsurprising that once in the cycle of the prison revolving door, it can be nearly impossible to escape for so many (Johnson et al., 2015).

For women with mental illness in these situations, co-occurring substance abuse comes into play as a readily available way to self-treat. As previously discussed, treatments can be difficult to coordinate or pay for, while many of these women have family members or friends who abuse substances. As opposed to male prisoners who often use substances for enjoyment, Johnson's study into the experiences of providers in and following prison time showed that female prisoners are more likely to abuse substances as a way of treating physical or emotional pain. Therefore, top priorities for

women reentering the community after prison are continuity of care and good support systems. Women need positive relationships in their lives and people they can depend on if they are going to be empowered to improve their circumstances. This includes a relationship with at least one provider in prison who continues to play a role after release, someone to call in emergency situations immediately following release (first 24-72 hour critical period), and someone with whom to continue follow-up long-term (Johnson et al., 2015).

## CHAPTER 3: RECOMMENDATIONS

### NURSE PRACTICE

Research on the various factors leading to incarceration of women with mental illness points to the necessity of continuity of care. For nurses, it is important to ensure proper connections with Case Management and that follow-up appointments with providers are arranged. A major aspect of the discharge process is education. Between education about medications, medication administration, and importance of treatment, nurses play a major role in the care process for women with mental illness. Nurses also ensure that the primary needs are addressed by Case Management. By screening each patient upon admission for financial and security needs, nurses are able to identify where further support is needed. Nurses play a vital role in the assessment and referral to appropriate resources. The nurse needs to be aware of the importance this role plays. Admission and discharge in particular are times in which nurses must be aware of the importance of proper screening and referral, and focused on helping patients seek appropriate treatment.

Through better support, financial assistance, and education on the importance of following up, women in these situations may be better able to focus on improving their circumstances, and be able to stay away from the factors causing reincarceration, such as substance abuse, life stressors, and poor influences (Johnson et al., 2015). Therefore, it is important for nurses to be educated on these issues and how they lead to women ending up behind bars.

## RESEARCH

While the role of nurses is important in the improvement of situations for women with mental illness, necessity of improving these situations has yet to be fully evidenced by the intellectual and influential communities. Herein lies the importance of further research. Additional studies on the variety of factors leading to incarceration of women with mental illness are necessary in order to show where the need is greatest. Research is also needed to show how to provide necessary support, such as implementation of programs including CITs or Case Management expansion. Through research, evidence is provided in support of such programs, garnering further resources and basis for future programs to be implemented.

Although a more lengthy process than merely reminding nurses to be more attentive to situational issues in the lives of patients, it is the research that will provide long-term solutions for the criminalization of mental illness issue and eventually decrease the numbers of women with mental illness winding up in the prison system. Recommendations for future research include a multifaceted approach, investigating all of the following in women with mental illness: living conditions, reincarceration rates, new and existing programs to decrease incarceration rates, funding options for these programs, and, importantly, the role of nurses and other providers.

## CHAPTER 4: LIMITATIONS

First and foremost, little research has taken place into the factors leading to incarceration and reincarceration of women with mental illness. Of the research that has been done, much of it has taken place in Europe. More research has also focused on men, due to the higher numbers of men in the prison system. For women in the United States, studies have been primarily qualitative in nature, and frequently have a small sample size. Even where research has been done, there often have not been implemented programs for support. Where programs such as CITs have been implemented, little research has been done on the efficacy of this program.

Additionally, most studies focus on a multitude of social, cultural, economic, and environmental factors, making it difficult to differentiate influence of mental illness in and of itself in the incarceration of women. Among these factors, it is important to differentiate mental illness from mental illness with co-occurring substance abuse. Of the articles studied, only six directly looked at interviewing/ reviewing records of women with mental illness in the prison system. Of these, two contained patient populations smaller than  $n=100$ , lending toward lack of validity toward patient populations as a whole. Despite positive initial findings, there remains a poverty of research done directly for women with mental illness in the prison system.

## CHAPTER 5: CONCLUSIONS

The high proportion of women with mental illness in the prison system is due to a number of reasons. First, deinstitutionalization of mental health state hospitals led to a rise in the number of people with mental illness in the community. A deficit of coinciding community support programs left a gap in care for many. This lack, coupled with stressors of everyday life, and compounded by the illness itself, results in many of these women ending up in desperate situations that lead to incarceration. Lack of insurance, difficulty holding down a job, lack of motivation in treatment, and high occurrence of coinciding substance abuse all contribute to a high rate of incarceration (Barrenger, & Draine, 2013). While further research needs to be done, it seems that merely treating the symptoms of SMI would not have the large impact on decreasing the number of people with SMI in prisons as hoped. This is due to the fact that criminalization of mental illness is not as accurate or conclusive a theory as much of society seems to think.

Further research is necessary in order to devise a way to improve conditions for women with mental illness, so that incarcerations cease to be a common occurrence. Programs such as CITs are being implemented in order to decrease arrest rates for people with mental illness in crisis. However, greater emphasis needs to be placed on availability of mental health treatments, in order to prevent escalation to crisis in the first place. Overall, it is more cost effective to provide the community resources intended at the time of state hospital closure than the current cost of maintaining the number of

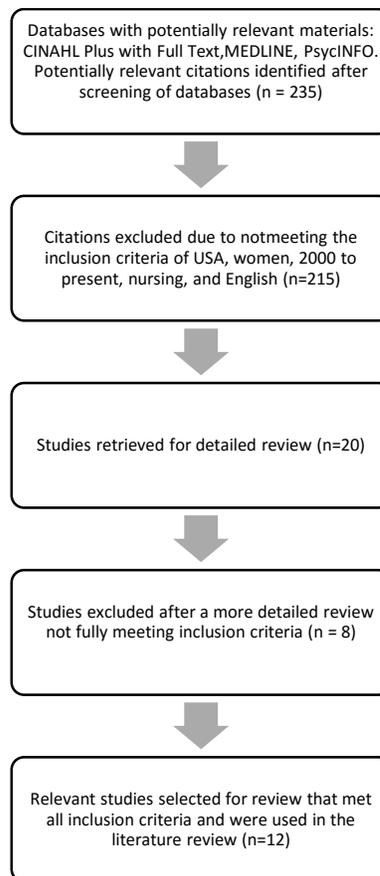
people in the prison system. Therefore, a combination of further research backing the necessity of such community support and the importance of mental health resources with research into the efficacy of support programs are necessary in improving this situation.

For women in particular, focus needs to be placed on securing and continuing positive relationships. No matter the difficulty of the situation, the effects of positive relationships versus negative relationships is a major factor in where a woman ends up. Many of those arrested have been negatively impacted by the violent or drug-seeking activities of friends and/or family members.

## APPENDIX A: SELECTION METHOD OF LITERATURE

Search terms included psych\* OR mental illness AND women AND prison OR jail.

Inclusion criteria included English, 2000 to present, nursing subset, and findings categorized by sex.



## APPENDIX B: TABLES OF EVIDENCE

	<b><i>Behavioral Health and Social Correlates of Reincarceration Among Hispanic, Native American, and White Rural Women</i></b>	<b><i>Psychiatric disorders and repeat incarcerations: the revolving prison door</i></b>	<b><i>Psychiatric Disorders in Aging Prisoners</i></b>	<b><i>Incarceration among adults who are in the public mental health system: rates, risk factors, and short-term outcomes.</i></b>
<i>Article citation</i>	Willging, C., Malcoe, L., Cyr, S., Zywiak, W., & Lapham, S. (2013). Behavioral Health and Social Correlates of Reincarceration Among Hispanic, Native American, and White Rural Women. <i>PS Psychiatric Services</i> , 64(6), 590-593. Retrieved June 11, 2015, from <a href="http://resolver.flvc.org/ucf?ID=pmid:23728602&amp;genre=article&amp;atitle=Behavioral%20health%20and%20social%20correlates%20of%20reincarceration%20among%20Hispanic,%20native%20american,%20and%20white%20rural%20women.&amp;title=Psychiatric%20Services&amp;issn=10752730&amp;is">http://resolver.flvc.org/ucf?ID=pmid:23728602&amp;genre=article&amp;atitle=Behavioral health and social correlates of reincarceration among Hispanic, native american, and white rural women.&amp;title=Psychiatric Services&amp;issn=10752730&amp;is</a>	Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: the revolving prison door. <i>American Journal of Psychiatry</i> , 166(1), 103-109. doi: 10.1176/appi.ajp.2008.08030416	Regan, J. J., Alderson, A., & Regan, W. M. (2003). Psychiatric disorders in aging prisoners. <i>Clinical Gerontologist</i> , 26(1/2), 117-124.	Hawthorne, W. B., Folsom, D. P., Sommerfeld, D. H., Lanouette, N. M., Lewis, M., Aarons, G. A., . . . Jeste, D. V. (2012). Incarceration among adults who are in the public mental health system: rates, risk factors, and short-term outcomes. <i>Psychiatric Services</i> , 63(1), 26-32.
<i>Hypothesis/purpose</i>	The purpose of this study was to identify the needs of ethnically diverse, rural women following reentry into the community from the prison	The purpose of this study was a retroactive study of the percentage of Texas inmates with psychiatric disorders compared with	The purpose of this study is to compare the percentage of prisoners with mental illness diagnoses in the TN	The purpose of this study is to look at the proportion of patients in the public mental health

	system. These included factors linked to re-incarceration, including mental illness, substance dependence, and other factors.	a history of previous incarcerations, in order to discover a correlation between the two. Results were to be further studied with regards to demographics.	prison system with those without diagnoses.	system who are incarcerated.
<i>Population</i>	The population consisted of 98 women residing in New Mexico in prison. The women used were randomly selected from a list of inmates and asked to participate in the study.	All inmates at TDCJ's 116 prison facilities (N=79,211), whose sentences started between September 1, 2006, and August 31, 2007, were used in this study.	The population consisted of 671 inmates in the TN prison system over 55 years old. They were divided into those with mental illness, and those without, as well as into male and female.	Public mental health records for 39, 463 patients were compared with county prison records from 2005-2006 to find 4,544 matching inmates.
<i>Methods</i>	Via interview, information was collected from a random cross section of prisoners to collect information about history of mental illness, substance abuse, trauma, and socioeconomic status, which was then analyzed for correlations with repeat occurrence of incarceration.	Interview was used to determine inmates' demographic information. Meanwhile, electronic records were used to determine previous incarcerations in TDCJ's system. Incarcerations due to parole violations were not included. Medical and psych evaluations were performed by mental health nurses or professionals, who screened for display of symptoms of psychiatric disease, history of mental	The prison provided data on information such as incidence of reincarceration, length of sentencing, mental illness and offenses committed for use in comparisons. Demographic data was also provided. Categories of mental illness used were adjustment disorders, substance abuse, antisocial behavior, mood disorders (including various forms of anxiety, depressive disorders, and bipolar), catatonic disorder,	Records for the patients were compared with 4,544 county prison records for incarceration from 2005 to 2006. Logistic regression studied incarceration and reincarceration with potential risk factors. Time until health services were received following release was studied with survival analysis.

		<p>health treatment, current suicidal ideation, prior suicidal gestures, display of unusual behavior, affective distress, and unusual nature of criminal offense. Positive results warranted referral to formal mental health evaluation, which was conducted by master's-level mental health professionals using a DSM-IV-guided interview. Positive interviews determined placement for treatment, and disorders were categorized in four ways: major depressive disorder, bipolar disorders, schizophrenia, and nonschizophrenic psychotic disorders. Data on inmates with these disorders was then compared with that on previous incarcerations to look for correlation.</p>	<p>dementia, schizophrenia/delusional disorders, and pedophilia.</p>	
<i>Results</i>	<p>100% of the women interviewed screened positive for prior trauma. Additionally, 85% were positive for substance abuse, 50% for</p>	<p>As far as inmates in this study go, ones diagnosed with psych disorders were more likely to have history of multiple</p>	<p>109 of the 671 inmates were diagnosed with mental illness. 13% were women, as compared to 12% women in the non-</p>	<p>In the year studied, 4,544 (11.5%) of patients were incarcerated. Incarceration risk</p>

	<p>mental illness, and 46% for both. The analyses showed co-occurring homelessness, mental illness, and substance use as being primary factors for recurring incarcerations. Thus, further research has been proposed in the reduction of prison rates through better housing and addiction/therapy programs.</p>	<p>incarcerations than those without. Additionally, a disproportionate selection of inmates with psych disorders were women. Racial/ ethnic groups of non-Hispanic Caucasian, Hispanic, and African American were equally represented in the sample. 7,878 inmates were diagnosed. For inmates with major depressive disorder and/or bipolar disorders, females and non-Hispanic Caucasians were overrepresented and Hispanics and African Americans were underrepresented. For schizophrenia and nonschizophrenic psychotic disorders, African Americans, 50 or older, and with violent offense records were overrepresented.</p>	<p>psych population. This study found no statistical significance in gender and type of illness, except for dementia and depression alone. Of the psych population, 43% were incarcerated for murder 28% for sex crimes, 4% kidnapping, and 3% substance violations. No notable correlation between type of disorder and specific crime. 77% of women with psych disorders (majority with depression) committed murder. Meanwhile, 28% of the men, and 4 of 5 with dementia, committed sex crimes.</p>	<p>factors include prior jailing, substance use, homelessness, psychiatric diagnoses, male gender, young age, lack of insurance, and being African American. Those receiving outpatient or case management services following release were less likely to be reincarcerated within 90 days or require emergency services.</p>
<i>Analysis</i>	<p>So far, both studies have compared the re-incarceration rates of women with mental illness and substance use with those without disorders. The</p>	<p>The re-incarceration rate for inmates with psychiatric disorders have been shown to be higher than for those</p>	<p>The numbers of men incarcerated with mental illness are higher in this study, however the percentage of women in</p>	<p>This study shows potential for studying how to prevent reincarceration for patients with mental</p>

studies span a diverse population and point to the idea of lack of treatment causing greater risk of re-incarceration.

without disorders across the board. However, the rates for Women with disorders, as well as those with disorders who have been re-incarcerated are higher than those for men.

prison with mental illness are higher than the percentage of women overall in prison. Thus, the trend continues for women with SMI being over-represented in the prison system.

disorders. It also showed greater likelihood for men with mental illness to be incarcerated than for women, which was different than previous studies.

	<b>“You Don’t Get No Help”: The Role of Community Context in Effectiveness of Evidence-Based Treatments for People with Mental Illness Leaving Prison for High Risk Environments</b>	<b>Analyzing Offense Patterns as a Function of Mental Illness to Test the Criminalization Hypothesis</b>	<b>Women, Serious Mental Illness and Recidivism: A Gender-based Analysis of Recidivism Risk for Women with SMI Released from Prison</b>	<b>Speaking Out to Improve the Health of Inmates</b>	<b>Horizons of Context: Understanding the Police Decision to Arrest People With Mental Illness</b>
<i>Article citation</i>	Barrenger, S. L., & Draine, J. (2013). “You Don’t Get No Help”: The role of community context in effectiveness of evidence-based treatments for people with mental illness leaving prison for high risk environments. <i>American Journal of Psychiatric Rehabilitation, 16</i> (2), 154-178. doi: 10.1080/15487768.2013.789709	Peterson, J., Skeem, J. L., Hart, E., Vidal, S., & Keith, F. (2010). Analyzing offense patterns as a function of mental illness to test the criminalization hypothesis. <i>Psychiatric Services, 61</i> (12), 1217-1222. doi: 10.1176/appi.ps.61.12.1217	Cloyes, K. G., Wong, B., Latimer, S., & Abarca, J. (2010). Women, serious mental illness and recidivism: a gender-based analysis of recidivism risk for women with SMI released from prison. <i>Journal of Forensic Nursing, 6</i> (1), 3-14 12p. doi: 10.1111/j.1939-3938.2009.01060.x	Heines, V. (2005). Faces of public health. Speaking out to improve the health of inmates. <i>American Journal of Public Health, 95</i> (10), 1685-1688 1684p. doi: 10.2105/AJPH.2005.068502	Morabito, M. S. (2007). Horizons of context: understanding the police decision to arrest people with mental illness. <i>Psychiatric Services, 58</i> (12), 1582-1587.
<i>Hypothesis/purpose</i>	The purpose of this study is to look at the impact of initiating individual help models in preventing incarceration. It looks at the impact of each of mental health services, housing, criminogenic factors, and substance use as improvements to reduce incarceration.	The purpose of this study was to look at factors contributing to recidivism of parolees, from low socioeconomic status, to active symptoms of serious mental illness.	The purpose of this article is to compare recidivism rates for men and women with mental illness in Utah State Prison. It looks at severity of illness and clinical history as factors in recidivism.	The purpose of this article is to profile two unlikely leaders in the field of public health, in order to study how individuals can make a difference in the health of America’s prison population.	The purpose of this article is to look at factors that contribute to high rates of arrest for people with mental illness. It also seeks to decrease blame on police lack of education as a major reason for increased rates.

<i>Population</i>	Literature on parolees from 1995 to 2011 to whom different methods of help were provided.	220 parolees, 111 of whom had serious mental illness were interviewed.	Past research by said authors is analyzed here, with the population being prisoners released between 1998 and 2002 from Utah State Prison. The study sample included 9,245 cases, with 14,621 releases from prison.	The population studied here includes Dr. Melanie Spector focused on women's health, and Judge Steven Leifman on mental health in the judicial system.	This article looks at police involvement, views of the community at large, and factors surrounding arrest, as reasons for incarceration of people with mental illness.
<i>Methods</i>	A review of literature from 1995 to 2011. This study focused on factors that contribute to incarceration of individuals with mental illness, by focusing on effectiveness of various help programs, including housing and linkage to health services.	A combination of interview and data collections was used to look at the connections between mental illness symptoms and crimes committed, in order to look at the validity behind the "criminalization hypothesis."	This is a literature and past research review, with focus on the fact that past research primarily focuses on mental illness or gender influences alone, but not both. Research was done through data collected from the Utah State Department of Corrections Bureaus of Research and Planning, as well as access to their Offender Tracking System.	Interview was used to gather first-hand experience about the differences each made in their community. Research was then done into the community itself, so as to explore extent of impact.	This review of literature provides a look at the history of incarceration of people with mental illness, as well as factors surrounding arrests.
<i>Results</i>	Each of the services provided: mental health, housing, substance use, criminogenic help, and support systems, are individually insufficient to effectively help those with mental health stay out of the	While only 5% of offenders with SMI committed crimes as a direct result of their psychosis, another 2% were due to survival crimes, common among the homeless population with MI. Additionally, crime among those with	A primary result is that women were more likely to have recidivism risk based on SMI and resources available. It supports the need for further research on gender-specific risks associated with mental illness, as the populations at large had different risk	Relevant results are those provided by Judge Leifman. Upon finding the percentage of people in his county jail with mental illness to be disproportionately high, Leifman initiated pre and post-arrest diversion programs to	This article breaks down the context of arrest into three context, here referred to as the manipulative, temporal, and scenic. These can be explained as the views of the

<p>prison system on their own.</p>	<p>MI often had a major contribution of substance abuse leading up to the crime.</p>	<p>factors and needs than the women alone.</p>	<p>decrease arrests, and increase speed of access of care following release. Among other changes, these programs reduced recidivism from 70 to 19% in one year, saving the county \$2.5 million.</p>	<p>community about mental illness, the person doing the arrest as an individual including police knowledge about the incident, and the instances surrounding the time of arrest including any safety concerns to the officer or community.</p>	
<p><i>Analysis</i></p>	<p>This is a literature review for itself, in which the various factors behind recidivism of people with SMI are explored.</p>	<p>While serious mental illness can contribute to criminal activity in a minority of cases, treatment for the greatest number overall would be aimed at “hostility, disinhibition, and emotional reactivity.”</p>	<p>This study was able to directly compare recidivism rates between men and women for a large prison system over a 5 year span. It showed the contributing factors of both mental illness and sex on recidivism rates.</p>	<p>This study provided evidence for efficacy of wraparound services for people with mental illness having run-ins with the legal system. For Dade County in Miami, reducing arrests through redirection to proper care centers, and increasing follow-up care for prisoners upon release were quite effective in reducing the rates of prisoners with mental illness and recidivism.</p>	<p>This article further supports the idea that each case is individual and arrest is often determined by surrounding circumstances. However, it looks to decrease the role of police education or lack thereof as a factor in high incarceration rates.</p>

	<b><i>Provider Experiences with Prison Care and Aftercare for Women with Co-occurring Mental Health and Substance Use Disorders</i></b>	<b><i>The Criminalization of People With Mental Illness</i></b>	<b><i>Dealing with individuals who have mental illness: the Crisis Intervention Team (CIT) in law enforcement</i></b>	<b><i>Risk Profile and Treatment Needs of Women in Jail with Co-Occurring Serious Mental Illness and Substance Use Disorders</i></b>	<b><i>Crime, violence, and behavioral health: collaborative community strategies for risk mitigation</i></b>
<i>Article citation</i>	Johnson, J. E., Schonbrun, Y. C., Peabody, M. E., Shefner, R. T., Fernandes, K. M., & Rosen, R. K. (2015). Provider Experiences with Prison Care and Aftercare for Women with Co-occurring Mental Health and Substance Use Disorders: Treatment, Resource, and Systems Integration Challenges. <i>Journal of Behavioral Health Services &amp; Research, 42</i> (4), 417-436 420p. doi: 10.1007/s11414-014-9397-8	Chaimowitz, G. (2012). The criminalization of people with mental illness. <i>Canadian Journal of Psychiatry, 57</i> (2), 1.	Browning, S. L., Van Hasselt, V. B., Tucker, A. S., & Vecchi, G. M. (2011). Dealing with individuals who have mental illness: the Crisis Intervention Team (CIT) in law enforcement. <i>British Journal of Forensic Practice, 13</i> (4), 235-243.	Nowotny, K. M., Belknap, J., Lynch, S., & DeHart, D. (2014). Risk Profile and Treatment Needs of Women in Jail with Co-Occurring Serious Mental Illness and Substance Use Disorders. <i>Women &amp; Health, 54</i> (8), 781-795. doi: 10.1080/03630242.2014.932892	Pinals, D. A. (2015). Crime, violence, and behavioral health: collaborative community strategies for risk mitigation. <i>CNS Spectrums: The International Journal of Neuropsychiatric Medicine, 20</i> (3), 241-249. doi: 10.1017/S1092852915000164

<i>Hypothesis/ purpose</i>	This article looked into first-hand experiences of mental health providers and prisoners to discover what the specific needs of prisoners are during reentry to the community, and what obstacles most often stand in the way of securing these needs.	This article looked at the comparative histories of the mental health systems in the US and Canada, starting with the pastoral movement by Dorothea Dix (US) and the Royal Commission (Canada). With overcrowding and underfunding for such programs coinciding with the use of psychotropics in the 1950s and 60s, these state hospitals began emptying into the community. This increased community base is looked at in this article as a reason for the rise in mental health populations in the prison system.	The purpose of this article is to discuss the creation and relative effectiveness of Crisis Intervention teams developed in law enforcement agencies. These teams are implemented to recognize people in crisis and utilize de-escalation, contacting proper mental health facilities rather than automatically arresting people for public disturbance or petty crimes.	The purpose of this article is to study the incidence of women with SMI and SUD in the prison system in conjunction with the factors that led to their arrest, namely past abuse or underage drug use.	The purpose of this study is to look at the correlation between mental illness and criminal activity. This correlation is predicted to be due to societal and environmental factors common in the lives of people with mental illness, as well as in the lives of those committing crimes.
<i>Population</i>	The population at hand were 14 prison and aftercare providers who had worked closely with a number of women as they were leaving the	This article looks at the movement of the mental health population from state mental health hospitals, to the	The population looked at here is the law enforcement officers themselves who are being trained in recognition/	491 incarcerated women were chosen randomly from prison rosters in 9 counties across Idaho, Colorado, South	This article looks at the role of police, courts, and reentry programs in

	prison system and returning to the community.	community, to the prison system, from the 1950's to current times.	de-escalation, as well as its effect on the prison population.	Carolina, and Maryland/Virginia, in order to include a variety of urban and rural areas. 10 women were excluded due to acute distress and possible violence, in addition to general exclusion of inmates charged with felony sex charges, homicide, or first degree assault, which dropped another five. 142 declined to participate, thus bringing the initial number of 633 to the 491 involved in the study.	determining the outcome for prisoners with mental illness across the country.
<i>Methods</i>	Interview was used to put together a qualitative study on the needs formerly expressed by prisoners, and evaluated by the providers at hand.	By looking at the history of mental health treatments in the US and Canada, the author is able to provide a timeline of mental health treatments and social views of mental health. This is a literature review.	This study combinations qualitative information about what the Crisis Intervention teams do and how they are trained, with a brief quantitative study on the relative results of such programs in Memphis, Tennessee	Following informed consent, an interview with each woman was held privately to collect information on socio-demographic status, incarceration history, substance abuse, mental illness, and use of treatment. Each interview was approximately two	This is a review of literature that looks at the relationship between violence and mental illness, the role of police officers and courts, community involvement,

<i>Results</i>	<p>Ideal care described by said providers included continuity of care with the same provider prior to and following release, services accessed within 72 hours, case management services, relationship support, and long-term care. It also supports allocation of resources to provide for better care resources upon release.</p>	<p>Results of the review include recommendations for the future of mental health treatment. These include redistribution of resources to provide proper treatment in the community, improving treatments in the prison system, new legislation supporting people with mental illness, and further research on the matter.</p>	<p>after 12 years implemented, Albuquerque, New Mexico, and Akron, Ohio after two years. It also utilized discussion by officers of first-hand experience with the interventions. In the case of Memphis, statistics about special weapons and tactics (SWAT) team call-outs, officer injury rates, length of time on mental health crisis calls, and arrest rates of individuals with mental illness decreased after implementation of crisis intervention. Meanwhile, arrest rates for people with mental illness dropped to about 2%, far lower than the national average. Recidivism dropped below 15%. For</p>	<p>hours long and the women were compensated for their time. One in five women in this study qualified as having both a mental illness and a substance use disorder. The women with multiple disorders had higher history of violence, with 87% physically abused by family, 81% sexual assault, and 78% IPV. They were also more likely than the other women to be in jail for a violent offense. The group was racially and ethnically diverse, with findings indicating the negative effects on incarceration of women with traumatic</p>	<p>and recovery programs. This article looks to police diversion programs and specialty courts as a way to redirect people with mental illness out of the criminal justice system. It emphasizes looking at the risks and needs of the individual, with special emphasis on trauma services.</p>
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			Albuquerque, findings were similar, if not as dramatic, with arrests dropping below 10%. Meanwhile, Akron showed no statistically significant improvement.	pasts, substance use, and mental illness.	
<i>Analysis</i>	.This article further supports the necessity of continuity of care and management of care resources for women upon return to the community following release from prison.	This article not only explains the history of mental health, but also sets up where the future is heading and offers suggestions for how to ensure improvement in the future.	While great success was shown in TN, lack of results elsewhere may be due to short time implemented, improper training, or insufficiencies in the program itself. Additionally, among officers interviewed about the program, many still felt unfit to handle mental health crisis situations following training. This study is greatly limited in that only 3% of law enforcement agencies in the States utilized such programs at the time.	This article sets up the correlation between women with mental illness, women with substance use disorders, and incarceration.	This article further supports the idea that factors beyond the mental illness contribute to high rates of incarceration, and goes on to offer suggestions for reduction.

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