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# The Effects of Mental Health Treatment in Correctional Facilities

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**Abstract**

The purpose of this study is to investigate the effect of mental healthcare in the criminal justice system on post-release recidivism of people with serious mental illness (PSMI). It can be noted that mental illness is not the cause of criminal behavior, but there is a significant negative relationship between mental health services available while incarcerated and successful community reentry. A review of previous research on this topic was used to develop the hypotheses and questions tested in this study. The review provides evidence that PSMI who have been involved with more community based outpatient services have been more susceptible to treatment and will more consistently seek psychiatric or rehabilitative care for a longer period of time post-release. Specifically, the analyses conducted will focus on the effect that mental health care received while incarcerated has on re-arrest rates at 3 months post-release. The findings of the study will be interpreted and used to discuss possible treatment implications or programs that could lower rates of re-arrest in the future. A focus on enhancing outpatient services, such as mental health courts or other intensive community treatment programs (ICTP), could lead to a more successful reintegration and reduce the risk of rearrests for individuals who have previously been involved in the criminal justice system.

## Introduction

There are multiple theories that people develop when asked to explain the current overrepresentation of people with serious mental illness (PSMI) in the criminal justice system. To many, it is the result of deinstitutionalization in the United States, the criminalization of PSMI, or the violent tendencies that PSMI display. Though these may contribute to the incarceration of individuals with mental illness, none of the above are causal factors. According to a report by Arthur J. Lurigio (2011), the predicting factors of criminal involvement do not differ from individuals who do and do not have a mental illness. The idea that mental health treatment will prevent crime before an individual enters the system is irrational. The majority of focus needs to go to enhancing mental health recognition, attention, and treatment in correctional facilities. This report will focus on the prevalence of PSMI in correctional facilities, their involvement with the criminal justice system, and the benefits of receiving mental health treatment from the time of arrest to a period of time post-release. This information has been considered when developing this study, which tests the credibility of previously developed reports exhibiting the benefit of mental health care that inmates receive while incarcerated. If mental health care is proven to successfully reduce re-arrest rates after an individual is released, the importance of mental health care can be emphasized and used to formulate more in depth treatment programs for inmates. This review will also touch on community diversion programs, such as mental health courts or reintegration programs that have shown success in community reentry, along with lower rates of recidivism and the discontinuous involvement with the criminal justice system. If mental health treatment in prisons results in a decrease in re-arrest and community treatment options have proved to be more successful in reintegrating ex-offenders back into society, the conclusions of this study can be used to implement transition based

treatment options that are more accessible to inmates who are anticipating release and rebuilding their life outside of prison.

## Profile: People with Serious Mental Illness

This review primarily focuses on adults ages 18 and older who have been detained and are currently in or have been released from a jail or prison. The participants in this study also demonstrate symptoms of having a serious mental illness. People with serious mental illness are generally categorized as individuals who are diagnosed with a "major thought or mood disorder" that causes an individual distress, hinders their lifestyle, and requires treatment (Thuerer & Lovell, 2008, p.391). The most common diagnoses seen across the population of these studies tends to be bipolar disorder, major depressive disorder, and schizophrenia (Broner, Maryl, & Landsberg, 2005; Lurigio, 2011). A report by Baillargeon et al. (2009) includes nonschizophrenic diagnoses into the category of serious mental illness, stating that in a sample population from the Texas Department of Criminal Justice (TDCJ), the largest state run correctional facility in the country, there were a total of 7,878 individuals who were diagnosed with a serious mental illness. According to the *Diagnostic and Statistical Manual* (4$^{th}$ edition), "these brain diseases are among the most distressing, debilitating, and persistent of all psychiatric disorders (American Psychological Association, 2000; as cited in Lurigio, 2011). The report focuses on this population due to the inability to adhere to the regulations of the criminal justice system in a way that individuals without serious mental illness have the capacity to do.

The majority of individuals diagnosed with serious mental illness in these studies also show signs of a co-occurring substance abuse disorder. Alcohol and illicit substance use is prevalent among PSMI. The populations across studies have emphasized the prevalence of these co-occurring disorders, claiming that anywhere from 50-75% of PSMI also have been positively

diagnosed with an addictive substance abuse disorder (Regier D, Farmer M, Rae D, et al., 1990; as cited in Lamberti, 2007; Skeem et al., 2010). The recognition of substance abuse disorders in this population is not caused solely by serious mental illness, nor are either of the categories the primary cause of criminal behavior.

There is no significant variance for differences in race or gender throughout the populations across studies. It can be noted that females typically report symptoms and seek mental health treatment more frequently than males, but this could be due to confounding variables, such as the stigma of femininity behind mental illness. Though overall arrest populations are weighted differently, individuals incarcerated with serious mental illness do not show any dominance in race.

## PSMI in the Criminal Justice System

### *Incarceration*

Over the past few decades, people with serious mental illness have been increasingly represented in the criminal justice system, while especially demonstrating a significant rise of incarceration rates. For the purpose of this review, we will investigate offenders under the United States Bureau of Justice Statistics (2014) definition of incarceration as follows: the population of inmates confined in a prison or a jail. The number of inmates who meet criteria for serious mental illness varies depending on the population studied, but all populations tend to represent a consistently high rate of incarceration for PSMI. According to the Bureau of Justice Statistics, over half of the inmates in state prisons, over 1 million individuals, were considered qualified for a mental health diagnosis (Baillargeon et al., 2009;James & Glaze, 2006; as cited in Fisher et al., 2014). Lamberti (2007) claims that the high numbers of PSMI represents about 15% of prison

and 24% of jail inmates. Another report by Vogel, Stephens and Siebels (2014) states that individuals with a history of mental illness compose 20% of state prisoners and 21% of inmates in jail. Although these percentages do not seem high, or the numbers may not represent the majority of the United States population, these are just the PSMI that are accounted for, or are incarcerated in residential facilities.

Many of these statistics are also compiled off of self-report surveys or diagnoses from criminal justice officials who may not be trained to properly identify symptoms of serious mental illness. When relying on self-report methods, the participants may alter their responses due to stigmatization or differences in treatment from other prisoners or facility officials. For example, individuals who reported receiving mental health treatment during the time they took the survey were more frequently females (73%) than males (55%), which could demonstrate a female's tendency to over-report symptoms or diagnoses, and a male's lack of accurately reporting the diagnoses or treatment received (Fisher et al., 2014). An increase of openness from the community and criminal justice system could enhance the likelihood of an individual, specifically male, to speak up about symptoms of mental illness and trust that he will receive the help that he needs to successfully function in the community after release.

The deinstitutionalization of mental health facilities is not the cause of the rapid influx of PSMI entering prisons or jails, but the criminalization of deviant behavior resulting from mental illness plays a huge roll. The symptoms displayed by PSMI, namely auditory hallucinations and mood changes, make an individual more inclined to act in a deviant manor which may lead to a criminally driven punishment; this process is sometimes referred to as the "criminalization" of mental illness (Skeem et al., 2010). Deviance is known as a behavior that is not necessarily illegal, but violates a level of social normalcy. This sort of behavior is seen as abnormal or

inappropriate, and can be treated in various ways. Skeem, Machak, and Peterson (2011) explain that deviance used to be handled with psychiatric based treatment methods; this approach was the appropriate way to avoid criminal justice involvement. This was seen to decrease as mental health facilities have been slimming down. Often times, the responding officer may not be trained to identify mental illness, thus is unable to determine whether the individual needs psychiatric treatment (Voegel, Stephens & Siebels, 2014). If the officer is unable to identify symptoms of mental illness, they may interpret the symptomatic behavior as criminal, which results in arrest, and begins that individual's involvement in the criminal justice system. Police officers frequently respond to disturbance calls involving people with serious mental illness, but it is now more common to react with punishments that are framed by the criminal justice system. If mental health services in the community are limited, the officer is more inclined to use arrest than to advise the individual to seek any sort of outpatient treatment on their own (Vogel et al., 2014). Individuals are being arrested for minor offenses that typically would not earn entry into prisons or jails due to the lack of mental health service availability in the community, and the inability for police officers and other public safety officials to identify the difference between deviance stemming from serious mental illness and criminal behavior.

*Substance Abuse*

Substance abuse disorders are often seen to coincide with serious mental illness in the population of individuals with criminal justice involvement. Drug use alone can enhance symptoms of serious mental illness and increase the likelihood of criminal behavior, leading to arrest. According to Fisher et al. (2014), 63% of the PSMI in state prisons reported simultaneous drug abuse in the months preceding the arrest. Many individuals struggling with mental illness result to drug or alcohol abuse in hopes that their symptoms would subside. Substance abuse

disorders, like other serious mental illness, can escalate if gone untreated. Due to the high co-morbidity with other disorders, substance abuse disorders serve as an easier gateway for the entrance of PSMI into the criminal justice system. With this, substance abuse issues can lead to involvement with the criminal justice system, but also result from incarceration. Psychoactive drugs used to treat mental illness can be distributed improperly, resulting in a drug dependence while imprisoned (Oxelson, 2009). If a jail or prison is not careful when distributing medication, or are not adequately trained to medically treat psychotic disorders, the prisoners receiving treatment are susceptible to begin abusing these drugs, even if they were not medically necessary before being prescribed.

Substance abuse is directly related to drug possession, which is also strong predictor of criminal justice involvement. Since the early 1980's, law enforcement officials have been fighting off illegal distribution and use of drugs, or what is commonly referred to as "the war on drugs" (Lurigio, 2011). As the criminal justice system got tougher on enforcing drug laws and sentenced harsher punishments for illegal sales and possession, jail and prison population began to increase. Since there is an existing correlation between serious mental illness and substance abuse problems, PSMI were entering the criminal justice system on drug based offenses. Baillargeon, Binswanger, Penn et al. (2009) noted from their study of PSMI with involvement in the Texas Department of Criminal Justice that drug possession charges were more prevalent among inmates who were previously diagnosed with schizophrenia or a nonschizophrenic psychotic disorder. Not all PSMI who are arrested for drug possession are at risk of incarceration. Imprisonment often depends on the number of previous interactions with the justice system. Since it is common for PSMI to cross paths with law enforcement due to disturbance calls from the public, but to also intercept with officials due to drug possession or

distribution, these individuals tend to end up in prisons or jails. More times than not, PSMI will enter the criminal justice system solely on drug offenses due to the lack of accessible services and the will to continue drug use (Lurigio, 2011).

*Homelessness*

Along with deviant behavior and substance abuse, homelessness ties into the involvement PSMI have with the criminal justice system. There are many factors that influence how a person with serious mental illness will enter the system, but the preceding two, along with the current factor being discussed, pose the most determinant risks. Individuals with serious mental illness who may not seek treatment, or do not have access to psychiatric assistance, have a high risk of becoming unemployed and living in areas of low income. These areas, poverty stricken and prone to criminal activity, make PSMI more likely to engage in criminal activity. PSMI residing in deprived areas of lower income are also more likely to commit property offenses, such as loitering, squatting, or breaking and entering. The TDCJ study concluded that inmates with major psychiatric disorders of all categories showed higher rates of offenses against properties (Baillargeon, Binswanger, Penn, et al.,2009).

A lack of community stability can easily lead to target area-specific policing and an increase in criminal behavior demonstrated by the individuals residing in that area. This is not to be interpreted as a causal relationship between mental illness and homelessness, or homelessness and criminal justice involvement. When collectively investigated, these three factors predict a higher risk for increased rates of recidivism after an individual is released from a correctional facility. A study by Broner, Lang, and Behler (2009) on homeless individuals involved with the criminal justice system concluded that out of all homeless individual who are incarcerated in jail, 30% have positive mental illness diagnoses, and 78% of the described individuals also have a

reported substance abuse issue (McNiel, Binder, & Robinson, 2005; as cited in Broner et al., 2009). The primary risk factors for recurring interactions with law enforcement listed above all contribute to the heightened recidivism rates of PSMI post-release.

### *Violent Crimes*

Violent crimes are not significantly committed by PSMI in comparison to the entire population of criminal offenders. Serious mental illness does not predict violent behavior, nor does increase the likelihood of violence within PSMI. Many theories claim that violent behavior is a result of untreated psychotic disorders, but most violent offenders are not those possessing any mental illness at all. Skeem, Manchak, and Peterson (2011) display a week link between psychosis and violent criminal behavior, but also psychosis and violence in general. It must be noted that PSMI are not less likely to commit violent crimes, but are just as likely as individual without serious mental illness. In addition, a weak correlation does not mean that people with serious mental illness do not commit crime, or that it should go unattended. Inmates specifically studied by Baillargeon et al. (2009) disproved the above frequency; 20%-25% of the inmates in the mentioned study were violent offenders with a mental illness. Again, it is worth being said that although these offenders need to be offered treatment that assesses their criminal activity and mental illness, there is no statistically significant evidence that proves serious mental illness is a causal factor of violent criminal activity.

## Mental Health Treatment

### *Learning to Identify Symptoms of Mental Illness*

Although there are currently successful programs that treat serious mental illness, correctional facilities and the justice system as a whole must first consider improving psychotic

or depressive symptoms while PSMI are filtering through jails and prisons. In his review, Lamberti (2016) concluded that in order to address recidivism, and hopefully prevent it, criminal justice officials and mental health professionals must collaborate and find a common ground where both treatment methods are respected and incorporated into the case plan of an individual. Once an individual, specifically one with serious mental illness, enters the criminal justice system, they could get lost in the shuffle. With over 1.25 million individuals with mental illness incarcerated in the United States (Van Dorn et al.,2013), it can be difficult to tend to the specific needs of each individual. It is also important to consider that the criminal justice system was not developed on a mental illness treatment based foundation, therefore, facilities are not fully qualified to treat PSMI and often lack effective services attending to those symptoms (Vogels, Stephens, & Siebels, 2014). With the development of cross training individuals who provide both mental health and criminal justice services, the ability to properly identify and treat risk factors of individuals with serious mental illness in correctional facilities will increase, along with the potential decrease in criminal recidivism seen in PSMI.

Teaching criminal justice officials to recognize the symptoms of serious mental illness will not only enhance the knowledge of how to properly attend to PSMI, but it will also decrease the prevalence of criminalizing the actions of these individuals. In jails and prisons, PSMI are often punished for their inability to obey by specific regulations mandated by the facility. Lurigio's (2011) report concluded the importance of evaluating an individual's treatment plan if they are unable to abide by the rules mandated by their incarceration; he suggests that it is important to place the individual in a hospitalized treatment setting while reevaluating the psychotropic medicines the individual is receiving, as opposed to punishing the individual with personal restrictions, such as solitaire confinement. Improperly punishing PSMI due to the lack

of conforming to correctional implications could enhance existing psychotic or depressive symptoms, or surface symptoms that the individual did not previously display.

*Mental Illness Specific Treatment in Correctional Facilities*

Research illustrates that only 1 of every 8 PSMI in correctional facilities receive psychiatric treatment (Beck & Maruschak, 2001; as cited in Theurer & Lovell, 2008). As previously stated above, correctional facilities and the criminal justice system are not specialized in treating serious mental illness, nor is it often their primary focus. The focus of the justice system is justice itself, typically grounded on philosophies such as retribution and incapacitation as opposed to rehabilitation. Since mental illness does not necessarily cause crime, eliminating psychiatric symptoms will not directly reduce rates of recidivism. Though, the effect of psychiatric treatment in correctional facilities does indirectly reduce criminal activity and community instability in PSMI. Lurigio (2011) states that the increase in treating serious mental illness in correctional facilities could help alleviate symptoms of the specific disorder, in turn, making it easier for the individual to adhere to other types of treatments used to directly affect criminal behavior and recidivism. Treating symptoms of serious mental illness while incarcerated could also lead the individual to obtain a more stable life in the community after their release. Psychiatric care in correctional facilities could enhance an individual's ability to remain sober once they are back in the community, seek steady employment, and continuously engage in forms of outpatient treatments to subside symptoms of serious mental illness (Lurigio, 2011). Psychiatric treatment can be used to enhance the success of other treatment methods. Skeem, Manchak, and Peterson (2010) discuss the use of psychiatric treatment to enhance the effectiveness of cognitive behavioral therapy, or CBT. The use of psychiatric treatment, in this case, could help reduce the impeding symptoms, such as intolerable hallucinations. The relief of

the primary symptoms that accompany the serious mental illness could make the CBT more effective in reducing criminal thinking in the individual. In this instance, the psychiatric service offered by the correctional facility has an indirect, but pertinent effect on risk factors that could reduce criminal recidivism.

Though many correctional facilities implement psychiatric care for PSMI, this is not true throughout the entire system. Another study indicates that half of all inmates with serious mental illness are being treated, but for the majority, medication is the only means of treatment the individuals are receiving (Ditton, 1999; as cited in Lamberti, 2007). Fisher et al. (2014) discussed the difficulty of reintegration for individuals who were leaving the prison system due to the lack of psychiatric treatment they received while incarcerated. If treatment while incarcerated is not as effective as it should be, an individual will not fully adhere to the implications of the criminal justice system, resulting in longer prison sentences. On average, individuals with mental illness serve sentences over one year longer than individuals without mental illness (Ditton, 1999; as cited in Baillargeon et al., 2009). This could represent the lack of effective psychiatric care in correctional facilities, but also the inability for individuals to seek out treatment services that are offered to them, but not necessarily required. The criminal justice system is taking on the responsibility of providing psychiatric care to inmates who have serious mental illness, and although it is not necessarily their strong suit, policy changes must be made to enhance susceptibility to treatment and result in successful community reentry.

## Community Treatment Services

### *Medicaid and Treatment Accessibility*

Lamberti (2007) states that “even the most competent care is not effective if it is inaccessible.” Making mental health treatment options more accessible to inmates for whom treatment is not mandated is also extremely important for successful community reintegration, in turn, reducing recidivism. For many, inmates being released from jail or prison do not receive psychiatric outpatient treatment due to a lack of income or unstable living situations. In the United States, Medicaid services are offered to individuals with disabilities, including PSMI. If an individual is incarcerated, their additional Medicaid services come to a halt, and service is provided through the correctional facility. When an inmate is released back into the community, very seldom are their Medicaid benefits immediately renewed. Without Medicaid insurance, no immediate method of treatment is accessible upon release (Morrissey et al., 2007). The period immediately after release, throughout the first year back in the community, is understood to be the most vulnerable time for an individual who was previously incarcerated (Lovell, Gagliardi, & Peterson, 2002). This poses an even greater risk for PSMI who also have criminal tendencies. Morrissey et al. (2007) concluded that a combination of Medicaid benefits and accessible behavioral health services offered to an individual during the most crucial post-release period led to a 16% decrease in detentions, on average, compared to individuals who did not obtain Medicaid benefits during this time. Medicaid benefits offer a variety of services, but for the purpose of this review, it is important to focus on the increased engagement in mental health services that Medicaid offers, which in turn helps prevent post-release recidivism. Though the advantages discovered by Morrissey et al. (2007) were relatively small, there was evidence that supported a negative correlation between Medicaid benefits at the time of release and reincarceration rates among PSMI.

*Diversion Programs*

Jail diversion programs were created to keep PSMI out of correctional facilities and actively involved with mental health treatment while remaining in the community. One of the most influential methods of jail diversion is the Mental Health Court. Anestis and Carbonell's (2014) study first defines MHC as "criminal courts with a specialized docket for mentally ill offenders, who typically voluntarily consent to enrollment." In other words, MHC are programs that give an individual with serious mental illness the opportunity to enroll in a court monitored therapeutic based treatment instead of entering the criminal justice system. Mental health courts are typically alternatives for PSMI who committed felony offenses, and was found to more successful to this group. Anestis and Carbonell (2014) found that individual involved in MHC who committed misdemeanor offenses had a higher rate of rearrest and were less likely to successfully complete the program. Another study monitoring MHC effect at the time of enrollment and after a six month period concluded that it is not necessarily the treatment received that is reducing arrests, but it is the impact of the treatment along with being monitored by the court systems that decreases the risk of reoffending, concluding that mandated treatment options result in a greater decrease in recidivism among offenders with serious mental illness (Han & Redlich, 2016).

Using legal leverage to ensure adherence and successful completion of mental health court programs may be a factor that demonstrates greater reduction in recidivism, but implementing this could also reduce the feeling of procedural justice that comes with the voluntary will to enroll in the program. Munetz et al. (2014) discussed the results of their comparison between individual enrolled in mental health courts and assisted outpatient treatment, or AOT. AOT programs are involuntarily mandated by civil courts to individuals who have committed a lesser offense, but are still considered to have serious mental illness and are

not willing to actively seek treatment. This study concluded that individuals who chose to enroll in mental health courts had a more positive view of the program and felt that they had more control of their treatment, as opposed to AOT treatment participants, who felt higher levels of coercion and, in turn, resulted in lesser success rates and greater chance of rearrest (Munetz et al., 2014). An individual who feels more respected in the criminal justice system, such as those cooperating in mental health courts, will result in more positive adherence to the treatment methods and end up more likely to remain involved in the program for a longer period of time. This reduces recidivism and criminal activity due to the extended period of time the individual is willing to commit to monitoring symptoms, maintaining sobriety, and abiding by social and civil norms in society.

## Summary

This literature review focused mainly on the involvement of PSMI in the criminal justice system and a variety of facility based or community outpatient psychiatric treatments. According to Wilson and Draine (2006), about 600,000 individuals are released from prisons each year, along with 7 million individuals released from jails. The studies included in the report demonstrate the decrease in rearrest among individuals who seek out and or receive appropriate psychiatric treatment. Treatment implications must not only treat psychotic or depressive symptoms, but also acknowledge substance abuse disorders, assist in reintegrative methods, and provide the individual with positive reinforcement and respect. Criminal justice officials must collaborate with mental health services to offer optimal treatment for PSMI who are incarcerated or are being released from correctional facilities in order to expect a reduction in criminal recidivism from people already involved with the system. As previously stated in this report and all studies reviewed, serious mental illness is not a causal factor of criminal involvement.

Treating only symptoms of mental illness and anticipating lower rates of recidivism is not feasible, but treating contributing factors (substance abuse, psychotic symptoms, and treatment accessibility) will result in a decrease in reincarceration of PSMI who have been stuck in the revolving door of the criminal justice system.

## Methods

The data set used in this study was collected between 2004 and 2008 as a part of the Serious and Violent Offender Reentry Initiative, or SVORI. The initial 1,697 participants evaluated were all males who were interviewed for the SVORI under four "waves." All males completed the first pre-release interview. This wave one interview occurred 30 days before prison release, and interviews for wave two, three, and four were conducted at three, nine, and fifteen months post-release. Due to attrition, approximately 80% of initial participants completed at least one of the post-release interview sessions. (see Lattimore and Steffey, 2009; Lattimore and Visher, 2009; 2011 for more on the SVORI data set).

The data will be analyzed and interpreted to understanding the range of influence that in-prison mental health care has on serious and violent offenders post-release. Specifically, we will address research questions such as:

Q1A: Do individuals who reported receiving mental health counseling in prison at wave one have decrease in re-arrest rates after 3 months post-release?

Q1B: Do individual mental health counseling and group mental health counseling have different effects on these rates of re-arrest at 3 months post-release?

H1A: Individuals who reported receiving mental health counseling while incarcerated will have a lower rate of re-arrest at the 3 month post-release period.

$H1_B$: Individuals who reported receiving group mental health counseling at wave one while incarcerated will demonstrate significantly lower rates of re-arrest at the 3 month post-release period, compared to those who reported receiving individual mental health counseling at wave one.

This study will evaluate the effect that in-prison mental health counseling has on an individual's ability to successfully reenter the community without being rearrested. Since it is predicted that mental health counseling will reduce the rate of re-arrest at the 3 month post-release mark, the study will be expanded by looking into whether group therapy or individual therapy sessions were more successful at treating mental health symptoms that could lead to re-arrest after the individual is released.

The self-reported symptoms categorizing Serious Mental Illness (SMI), and other factors associated with mental health or treatment will be evaluated individually. For the purpose of this study, the primary SMI that will be focused on include bipolar disorder, major depressive disorder, and schizophrenia. Post-Traumatic Stress Disorder treatments will also be considered due to the significant amount of individuals who receive PTSD treatment while incarcerated. Specific factors such as treatment types, such as group or individual counseling, , and documented re-arrests will also be analyzed and used to identify patterns in post-release recidivism. This information will further be used to determine how counseling impacts the susceptibility to utilizing treatment after the individual is released, and whether or not the counseling decreases the chance of reoffending. After describing the statistical value of each independent variable, the variables will be used in multiple analyses to determine whether any factors hold a significant influence on the dependent variable, re-arrest occurring at wave two, 3 months post-release.

*Measures*

The data analyzed were collected during the interview by using a self-report survey method. Inmates were asked to identify their age and race as general demographic data. At wave one (30 days before release), participants were asked to rate their emotional or mental health conditions on a scale of 1 being "excellent" to 5 being "poor," which constitutes the *condition of mental health* variable. Through wave two (3 months after release) the conditions of questioning remained constant for this variable, which was categorized as *current emotional or mental health* after the first wave. Statistics for this group of variables are listed in the table below. It should be noted that although the numbers of participants in each wave of questioning fluctuate, there are 981 valid participants that participated in both interview sessions at wave one and wave two.

**Mental and Emotional Health Conditions**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Condition of Emotional or Mental Health (W1) | 1693 | 1 | 5 | 2.46 | 1.109 |
| Current Emotional or Mental Health (W2) | 983 | 1 | 5 | 2.39 | 1.158 |

The next group of variables that hold a great deal of importance to the analyses in this study pertain to the individual's perceived need for mental health treatment. *Need for mental health treatment* was measured in all four waves of interviews on a scale of 1 (a lot), 2 (a little), and 3 (not at all). Descriptions of the results are as follows:

**Perceived Need for Mental Health Treatment**

| | **N** | **Minimum** | **Maximum** | **Mean** | **Std. Deviation** |
|---|---|---|---|---|---|
| Need Mental Health Treatment (W1) | 1693 | 1 | 3 | 2.67 | 0.618 |
| Need Mental Health Treatment (W2) | 982 | 1 | 3 | 2.73 | 0.593 |

The need for mental health treatment at wave two indicates whether or not the individual feels the need to receive mental health treatment at 3 months post-release.

*Received mental health treatment for emotional problems, received individual counsel for mental health problems, received group counsel for mental health problems, and received treatment for mental health problems before incarceration* were all measured once at wave one as "yes" or "no" questions. Responses to these questions were measured as either 0, meaning "no" or 1 meaning "yes." *Helpfulness of care for emotional problems* was only measured based on whether the individual received treatment, of which the individual rated on a similar scale of 1 (very helpful), 2 (somewhat helpful), 3 (a little helpful), or 4 (not at all helpful). Descriptions for variables are listed below:

**Mental Health Treatment**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Received Mental Health Treatment Before Incarcerated (W1) | 1693 | 0 | 1 | 0.25 | 0.433 |
| Received Mental Health Treatment While Incarcerated (W2) | 1675 | 0 | 1 | 0.18 | 0.382 |
| Received Individual Counsel for Mental Problems | 296 | 0 | 1 | 0.57 | 0.495 |
| Received Group Counsel for Mental Problems | 295 | 0 | 1 | 0.22 | 0.415 |
| Helpfulness of Care for Emotional Problems | 296 | 0 | 4 | 2.22 | 1.126 |

The survey administered required individuals to rate *PTSD Symptoms* on a scale from 1-51, 51 being the worst symptoms endured by the individual. This method was similarly used to measure symptoms for depression, on a *depression scale* ranging from 5-25, 25 being the worst. These symptoms were measured during all four waves of interviews, but the results of the first two waves will be the focus of this study.

**Post-Traumatic Stress Disorder**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| PTSD Symptoms (W1) | 1689 | 0 | 51 | 10.31 | 10.023 |
| PTSD Symptoms (W2) | 977 | 0 | 49 | 7.81 | 9.298 |

**Depression Symptoms**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Depression Symptoms (W1) | 1696 | 5 | 25 | 8.38 | 3.893 |
| Depression Symptoms (W2) | 983 | 5 | 25 | 7.39 | 3.507 |

Since the interviews did not include symptom data regarding the other two categories of SMI considered, whether or not an individual received care for schizophrenia or bipolar disorder at wave 1 and 2 were analyzed based on "yes" or "no" responses from participants. Information on whether or not the individual received treatment for these two disorders acted as a positive measure of symptomology, so receiving care for SMI was weighed more heavily than solely experiencing symptoms. Statistics for the variables described above are listed in the following table.

**Schizophrenia and Bipolar Mental Health Care**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Received Care for Schizophrenia (W1) | 925 | 0 | 1 | 0.05 | 0.208 |
| Received Care for Schizophrenia (W2) | 217 | 0 | 1 | 0.06 | 0.238 |
| Received Care for Bipolar (Manic Depression) (W1) | 925 | 0 | 1 | 0.11 | 0.315 |
| Received Care for Bipolar (Manic Depression) (W2) | 217 | 0 | 1 | 0.11 | 0.309 |

The dependent variable, re-arrest after 3 months post-release, is measured by incarceration data recorded by the National Crime Information Center. Descriptive data for this variable is shown in the table below:

**Re-Arrest at 3 Month Post-Release**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Re-Arrest 3 Months Post-Release (W1) | 1581 | 0 | 1 | 0.17 | 0.377 |

2-tailed bivariate analyses and linear regression models were conducted to determine how influential the different independent variables were on the dependent variable, which in this study is primarily re-arrest after 3 months post-release. The first correlation worth analyzing displayed whether or not re-arrest rates at 3 months post-release were correlated with receiving mental health treatment while incarcerated. Individual and group mental health treatment correlations were also conducted to determine whether or not there was an effect on re-arrest rates at 3 months post-release. The models for each independent variable were developed while controlling for predictors or re-arrest, such as the reported mental health condition of the individual and the perceived need for mental health treatment reported by the individual.

## Results

At wave two, 3 months post-release, there was a total of 1560 individuals who participated in this interview. This interview was broken down into whether or not the individual received mental health treatment in prison and whether or not they were re-arrested at the 3 month mark.

**Received Mental Health Treatment in Prison and Re-Arrest at 3 Months**

| | | Re-Arrest at 3 Months Post Release | | |
|---|---|---|---|---|
| | | No | Yes | Total |
| Received Mental Health Treatment in Prison (W1) | No | 1088 | 211 | 1299 |
| | Yes | 202 | 59 | 261 |
| Total | | 1290 | 270 | 1560 |

A crosstab correlation was conducted to determine any relation between receiving mental health treatment in prison and re-arrest rates 3 months post-release. The results of this correlation between receiving mental health treatment while incarcerated and re-arrest at wave two, or 3 months post-release, are shown below:

**Receiving Mental Health Treatment in Prison and Re-Arrest at 3 Months Post-Release**

| Re-Arrest at 3 Months Post Release | | Value | Approximate Significance |
|---|---|---|---|
| | Phi | .063 | .013 |
| | Cramer's V | .063 | .013 |

A t-test was conducted to analyze the average population of those who received mental health treatment while incarcerated based on the re-arrest data recorded by the NCIC.

**Received Mental Health Care and Re-Arrest at 3 Months Post-Release**

| Received Mental Health Treatment While Incarcerated (W1) | | F | Sig. | t | df | Sig. (2-tailed) | Mean Difference | Std. Error Difference |
|---|---|---|---|---|---|---|---|---|
| | Equal Variances Assumed | 21.94 | 0.000 | -2.483 | 1558 | .013 | -.062 | .025 |
| | Equal Variance Not Assumed | | | -2.281 | 360.877 | .023 | -.062 | .027 |

The assumption of equal variances does not significantly represent the means of individuals who received mental health treatment while incarcerated, so we can reject the null hypothesis and conclude that receiving mental health care while incarcerated does in fact influence rates of re-arrest at wave 1. According to the results of the analysis, only 6.2% of individuals who received mental health treatment in prison were re-arrested at 3 months post-release. The chance of finding this or a larger difference is about 2.3%, so although mental health while incarcerated does have a significant effect on re-arrest at wave 1, a larger sample must be tested to determine whether the chance of finding a larger difference in means would dramatically increase. It is concluded that individuals who receive mental health care in prison do exhibit a decrease in re-arrest rates at 3 months post-release compared to those who do not receive mental health treatment; t (360.887)= -2.281, p=.023.

Individuals who reported receiving individual counseling in prison (at wave 1) and individuals who have been re-arrested at the 3 month post-release mark (wave 2) were broken down according to whether or not treatment was received and whether or not they were re-arrested.

**Received Individual Counseling and Re-Arrest at 3 Months Post-Release**

| | | Re-Arrest at 3 Months Post Release | | |
|---|---|---|---|---|
| | | No | Yes | Total |
| Received Individual Counseling in Prison (W1) | No | 79 | 31 | 110 |
| | Yes | 123 | 28 | 151 |
| Total | | 202 | 59 | 261 |

The correlations between individual mental health treatment in prison and the rates of re-arrest at 3 months post-release were further reviewed. In order to analyze results to confirm our hypothesis, we must first establish proof of a correlation between individual counseling and re-arrest at 3 months post-release. Results are listed below:

**Received Individual Counseling and Re-Arrest at 3 Months Post-Release**

| Re-Arrest at 3 Months Post Release | | Value | Approximate Significance |
|---|---|---|---|
| | Phi | -0.114 | 0.066 |
| | Cramer's V | 0.114 | 0.066 |

Although there was a distinguishable difference in the number of re-arrests at 3 months post-release seen above, the analysis did not display a significant association between individual mental health counseling and re-arrest rates. A t-test was conducted to determine whether or not there was a significant difference in the effects of receiving individual mental health counseling.

**Received Individual Counseling and Re-Arrest at 3 Months Post-Release**

| | | F | Sig. | t | df | Sig. (2-tailed) | Mean Difference | Std. Error Difference |
|---|---|---|---|---|---|---|---|---|
| Received Individual Counseling | Equal Variances Assumed | 2.564 | .111 | 1.843 | 259 | .066 | .134 | .073 |
| | Equal Variance Not Assumed | | | 1.814 | 92.348 | .073 | .134 | .074 |

The analysis for the effect of individual counseling on re-arrest in the table shown significantly assumes equal variances of the means, so we conclude that there was a 13.4% difference in re-arrest rates at 3 months post-release when comparing individual who received individual counseling to those who did not. Receiving individual counseling did impact re-arrest while assuming equal variables in this model, and this impact was significantly represented by the sample; t(259)= 1.843, p=.066

Next, the relationship between group mental health counseling and re-arrest at 3 months post-release was evaluated.

**Received Group Counseling and Re-Arrest at 3 Months Post Release**

| | | Re-Arrest at 3 Months Post Release | | |
|---|---|---|---|---|
| | | No | Yes | Total |
| Received Group Counseling in Prison (W1) | No | 146 | 53 | 199 |
| | Yes | 56 | 5 | 61 |
| Total | | 202 | 58 | 250 |

The correlation results are as follows:

**Received Group Counseling and Re-Arrest at 3 Months Post Release**

| Re-Arrest at 3 Months Post Release | | Value | Approximate Significance |
|---|---|---|---|
| | Phi | -.188 | .002 |
| | Cramer's V | .188 | .002 |

Upon finding a significant correlation between treatment method and re-arrest rates at 3 months post-release, a model of the difference in receiving group counseling and not receiving group counseling is exhibited below:

**Received Group Counseling and Re-Arrest at 3 Months Post-Release**

| | | F | Sig. | t | df | Sig. (2-tailed) | Mean Difference | Std. Error Difference |
|---|---|---|---|---|---|---|---|---|
| Received Group Counseling | Equal Variances Assumed | 61.590 | .000 | 3.069 | 258 | .002 | .191 | .062 |
| | Equal Variance Not Assumed | | | 3.916 | 147.172 | .000 | .191 | .049 |

Although there was a significant association between receiving group mental health counseling and re-arrest at 3 months post-release, we could not reliably use this model to assume equal variances. Group counseling exhibited a difference of 19.1% in re-arrest compared to those who did not receive group counseling. This model displays that group counseling has an impact on re-arrest at 3 months post-release if equal variances are not assumed; $t(147.172)= 3.916$, $p= .000$. A larger model of individuals who received group counseling would have to be evaluated in order to determine whether or not group counseling can significantly reduce re-arrest rates of individuals at 3 months post-release.

In order to determine why group or individual counseling truly bears success in decreasing levels of re-arrest, further data analyses must be completed. There is an importance in analyzing the effects of the independent variable while controlling for other predictors of re-arrest, such as self-reported condition of mental health and the perceived need for mental health treatment. A hierarchical regression was conducted to determine how valuable the two mentioned variables to the model used to predict rates of re-arrest at 3 months post-release.

**Coefficients**

| | Unstandardized Coefficients | | Standardized Coefficients | | |
|---|---|---|---|---|---|
| Model | B | Std. Error | Beta | t | Sig. |
| 1 (Constant) | 0.239 | 0.148 | | 1.616 | 0.107 |
| Condition of Emotional or Mental Health | 0.011 | 0.023 | 0.031 | 0.455 | 0.65 |
| Need Mental Health Treatment | -0.035 | 0.042 | -0.058 | -0.84 | 0.402 |
| | | | | | |
| 2 (Constant) | 0.347 | 0.15 | | 2.321 | 0.021 |
| Condition of Emotional or Mental Health | 0.007 | 0.023 | 0.021 | 0.306 | 0.76 |
| Need Mental Health Treatment | -0.044 | 0.041 | -0.072 | -1.069 | 0.286 |
| Received Individual Counseling | -0.071 | 0.047 | -0.094 | -1.51 | 0.132 |
| Received Group Counseling | -0.156 | 0.056 | -0.172 | -2.77 | 0.006 |

The only variable shown above to bear any statistical significance on the model predicting re-arrest is whether the individual received group mental health counseling. The standardized beta value of the received group counseling variable shows that group counseling reduces the likelihood of re-arrest at 3 months post-release by 83%. Receiving group counseling while

incarcerated has the strongest impact on rates of re-arrest at 3 months post-release. The model summary below indicates how the set of variables as a whole accounts for any variance in the predicted outcome of re-arrests.

**Re-Arrest at 3 Months Post-Release Model**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | R Square Change | F Change | df1 | df2 | Sig. F Change |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 0.007 | 0.006 | -0.002 | 0.377 | 0.006 | 0.76 | 2 | 257 | 0.469 |
| 2 | 0.222 | 0.049 | 0.034 | 0.37 | 0.043 | 5.821 | 2 | 255 | 0.003 |

While controlling for the individual's reported emotional or mental health conditions and their need for mental health treatment, and incorporating those variables into the model above, we can conclude that the two variables only account for approximately .6% of variance, or change, in the outcome. The whole model, with confounding variables included, explains 4.9% of the predicted outcome. The predictor variables, in this situation being received group, individual, or overall mental health treatment during the period of incarceration, explain an additional 4.3% of variance, even after the condition of emotional or mental health and need for mental health treatment variables have been statistically controlled for. With a significance level of .012, we can conclude that the model, as a whole, is a statistically significant predictor of re-arrest at 3 months post-release, but the confounding variables, in this situation, had little impact on the model.

## Discussion

The results of this study provide valuable information that offers a specific focus on the impact of mental health care offered in prisons and how effective treatment is to reducing re-arrest, specifically three months after release. Our original hypotheses were as follows:

$H1_A$: Individuals who reported receiving mental health counseling while incarcerated will have a lower rate of re-arrest rates after 3 months post-release.

$H1_B$: Individuals who reported receiving group mental health counseling at wave one while incarcerated will demonstrate significantly lower rates of re-arrest at the 3 months post-release period, compared to those who reported receiving individual mental health counseling at wave one.

Rejecting the null hypothesis of $H1_A$ leads us to conclude that receiving mental health counseling while incarcerated does, in fact, predict a decrease in re-arrest rates after 3 months post-release. Our analysis showed that after accounting for mental health care received while incarcerated, 6.2% of those individuals were re-arrested at by the 3 month post-release mark. With results such as these, we can say with certainty that mental health counseling does have an overall effect on re-arrest at 3 months post-release. Of course, it is important to further the analyses to determine how controlling for variables, such as one's mental health condition and their perceived need for mental health treatment, can impact the results of re-arrest data. By doing this in our study, we were able to determine whether they could be included to accurately predict the effects on mental health counseling, more specifically individual counseling versus group counseling.

Since we saw that group counseling was more effective at reducing re-arrest rates at 3 months in our sample population, we come to a few different conclusions. We can reject the null for $H1_B$ which lets us conclude that receiving group counseling while incarcerated showed a significant decrease in re-arrest as opposed to receiving individual counseling while incarcerated. We reviewed the analysis that controlled for the variables discussed above, *condition of emotional or mental health* and *need mental health treatment*, and determined that only group mental health counseling could accurately predict a reduce in re-arrest at 3 months post-release.

This condition, while controlling for the variables discussed throughout the study, had the strongest influence on decreasing re-arrest rates and was declared the most significant means of treatment, according to this study.

These results can be interpreted in a variety of ways. First, we point our attention to a more general statement: mental health treatment received in prison can reduce the rates of re-arrest when evaluating the standing of individuals at 3 months post-release. This is significant because it is understood that not all individuals who feel that they need mental health treatment receive that while incarcerated. Mental health services in prisons are accessible, for the most part, but are sometimes limited and not always used when they should be. Although mandated mental health screening and treatment, if executed efficiently, would be more costly and time consuming, the influence this treatment would have on the individuals themselves and keeping them out of prison after release could be very beneficial to the "revolving door" issue we see in our prison system. While implementing mandatory mental health treatment, at least for individuals with serious mental illness, has been put on the back burner as our prisons got more populated, it is something that must be evaluated and acted upon. Our prisons will continue to populate with more individuals who may have a serious mental illness that is not being properly treated, and because of the lack of care, they will continue to filter through the system.

While we do recognize the prisons that have effective mental healthcare systems and are actively involved with offering mental health treatment where it is needed, we can next evaluate which treatment types prove to be more beneficial to the individual's community standing. The results of this study conclude that group mental health counseling has proved to be more effective when reducing re-arrest at 3 months post release. When comparing individual mental

health counseling to group mental health counseling, group counseling reduced the likelihood of re-arrest by 83%, while individual counseling was not a significant predictor at all.

When considering the fact that group counseling is more effective than mental health counseling, we take many possible factors into consideration. Since our study was conducted of a sample of all males, we consider the effects of the stigma on males with mental illness. Males have been known to be tougher, and mental illness has always been seen as a weakness or a problem. Males are less likely to reach out for help and receive treatment due to the immasculinity of receiving counseling. Although this could be seen as a limitation of our study, we could also use this idea to interpret the effectiveness of group counseling. If males are treated in a group setting with other males, they could potentially feel more included and may not feel as "different" because of their mental illness. While individual treatment would be expected to produce better one on one results, group counseling works to build a healthy community between the counselor and the other individuals who are suffering with a serious mental illness. Togetherness and inclusion could play into the effectiveness of group counseling, which is not necessarily the case with individual treatment.

We can use the idea of building a connection with others during treatment to explain why group counseling has a specific effect on decreasing re-arrest while the individual is back in the community. Although our study only extends to the 3 month mark, this time period is upon the most difficult periods of successful reintegration. Once an individual is released back into the community, they are typically reentering a high risk area that may have triggered their initial arrest. Re-arrest is commonly seen during this time period, especially upon individuals with serious mental illness, because being back in the environment that originally led to the arrest is dangerous. The individual may not have proper coping mechanisms or know how to stay out of

the system, so they usually end up back in prison. Group treatment in prison helps the individual to build a rapport between others, so interacting with individuals outside of the prison system will be easier than it would be if an individual relied solely on his counselor for help. Building a stable support system is important in group counseling, and these traits and mechanisms could travel outside of the prison walls when the individual is released.

While group counseling seems to hold a significant importance to an individual's community standings and successful reentry, post-release counseling should be a larger focus. It is so common to see individuals successfully manage symptoms of mental illness while in prison, but when that community relation ends upon release, the individual may not feel as strong and able to lead a normal life. Community re-entry is a huge transition, especially considering the social environment they are being released back into and the duration of their incarceration. It is not easy to jump back into the place with the people who originally led to your arrest. Whether involvement in others was the reason an individual entered the system, or the lack of social support while trying to function with the symptoms of a serious mental illness was what got the individual arrested, community stability plays a huge role in successful reintegration.

Since in prison treatment reduces re-arrest at 3 months, initiating community treatment programs immediately upon release is crucial before the effects of the received treatment wear off. The implication of mandatory mental health counseling upon release has been debated for years, especially after the influx of PSMI in the prison systems. This would require the criminal justice system to focus more on financial assistance upon release, whether that be ensuring that the individual has health insurance (most likely under Medicaid) or providing funding for treatment up to a certain period of time. The 6 month period after release has been recognized as

the most difficult time for an individual who has been incarcerated, but mandating group counseling or support groups could ease the stresses of symptomology and encourage the individual to develop a more stable support system back in the community.

Unfortunately, due to the belief that mental illness is weak, or a feminine issue, many males do not seek counseling after they are released because they are nervous that they will be judged while trying to fit back into where they came from. This is another reason that mandating treatment, as opposed to just offering it, would be more beneficial to individuals who feel that they do not want to express their mental illness and reach out for help. An overall increase in openness from the community and the criminal justice system could enhance the likelihood of an individual, specifically male, to speak up about symptoms of mental illness and trust that he will receive the help that he needs to successfully function in the community after release. This could be a period of time where an individual is feeling helpless and alone, but with the guarantee of community assistance and treatment necessary to thrive outside of the criminal justice system, we can ensure that the individual does not feel as if he is not the only individual attempting to settle back into society while managing symptoms of a mental illness.

Although much of the discussion has been geared towards implementing treatment programs to help the individual as they reenter society, it is also important to use the results of this study to change staff policies in the criminal justice system. The criminalization of mental illness is the process of treating symptomology and lack of social normalcy as a criminal act. While symptoms of serious mental illness sometimes result in inappropriate behaviors or behavioral outburst, society is forced to respond to these individuals in a way that separates them from society. Police officers are usually the first officials to respond to an individual with serious mental illness, and today, they are not all qualified to deal with these individuals. As previously

discussed in this study, officers who typically do not know how to identify or properly react to an individual with mental illness will interact with the individual in the same ways that they would interact with others. This is an ineffective strategy which typically results in the arrest of an individual, which begins their time in the criminal justice system. Although many officers are cross trained to identify and treat symptoms of mental illness properly, majority of officers are not. With the development of cross training individuals who provide both mental health and criminal justice services, the ability to properly identify and treat risk factors of individuals with serious mental illness will increase. This will result in better knowledge of how to treat mental illness both inside and outside of the prison system, and could potentially decrease criminal recidivism prevalent in PSMI.

While it is important that street police officers are aware of the signs and symptoms of mental illness, the correctional officers and prison staff must also properly identify these characteristics in order to successfully treat and release inmates with a serious mental illness. It is common that individuals will be screened for mental illness and other health conditions upon entry, but this does not cater to the individuals who may develop a mental illness while incarcerated or not have visible symptoms. The need for mental or emotional health treatment can stem from more than the diagnosis of a mental illness. If an individual is in prison for a long period of time, their seclusion from society and the different lifestyle they are now living could alter their sense of being, and could result in the desire, or need, for mental health care. Many correctional officers interact with the inmates daily, and if they are unable to respond to or identify the symptoms of a mental illness, they will not be able to tend to the individual or refer them to the necessary treatments available.

This is often the cause of the lack of parole offered to individuals with serious mental illness in the prison system. Since there is often more of an issue conforming to others and obeying strict prison rules, they are not eligible for parole as quickly as others are. Symptoms and characteristics of mental illness could be perceived as not obeying by prison rules or behavioral infractions, so their standing while in prison is lower than individuals who do not have an issue abiding by the rules. There are many individuals in the prison system who are qualified to treat and assess individuals with mental illness, but this type of training should be mandated for all individuals working in the criminal justice system.

## Conclusion

The reviews of previous research and the overall study conducted focused mainly on the involvement of PSMI in the criminal justice system and a variety of facility based or community outpatient psychiatric treatments. According to Wilson and Draine (2006), about 600,000 individuals are released from prisons each year, along with 7 million individuals released from jails. The studies included in the report demonstrate the decrease in rearrest among individuals who seek out and or receive appropriate psychiatric treatment. Treatment implications must not only treat psychotic or depressive symptoms, but also acknowledge substance abuse disorders, assist in reintegrative methods, and provide the individual with positive reinforcement and respect. Criminal justice officials must collaborate with mental health services to offer optimal treatment for PSMI who are incarcerated or are being released from correctional facilities in order to expect a reduction in criminal recidivism from people already involved with the system. As previously stated in this report and all studies reviewed, serious mental illness is not a causal factor of criminal involvement. Treating only symptoms of mental illness and anticipating lower rates of recidivism is not feasible, but treating contributing factors (psychotic symptoms,

perceived need for mental health counseling and treatment accessibility) in a community based group setting will result in a decrease in reincarceration of PSMI who have been stuck in the revolving door of the criminal justice system.

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