

MENTAL ILLNESS IN THE PRISON SYSTEM: EXPLORING THE ISSUES
AND POSSIBLE SOLUTIONS

by

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ABSTRACT

The purpose of this research was to explore the issue of mental health in the prison system. A large portion of the prison population is mentally ill. The prison environment poses special challenges to these individuals. Treating mental illness in a prison environment can be difficult as there are many factors that must be considered in deciding the best way to handle mentally ill offenders. Mental health courts show promise in dealing with these issues, but methods vary quite significantly from region to region. A literature review was conducted to provide an overview of the types of mental illnesses seen in prison populations, the types of crimes committed by those with a mental illness, treatment options, efficacy of treatment, and recidivism of mentally ill offenders.

Data from a 2000 California Department of Corrections and Rehabilitation report on California prisoners and parolees and data from the California Department of Mental Health were used to run a Pearson R correlation matrix. It was predicted that there would be a higher correlation between mental illness in the general population and incarceration than socioeconomic class, in this case individuals below the poverty level, and incarceration. The results supported the hypothesis which highlights the prevalence of the issue of mental illness in the prison system. It is important to ensure that those with mental disorders are receiving appropriate treatment while incarcerated. Effective treatment may have the potential to help the individual better adapt to prison life and possibly have a better outlook upon release into the community and more research should be done to explore this possibility.

DEDICATION

For my loving husband Mike who has been there to encourage and support me through my college career and every other aspect of my life. I could not have done this without you.

For all of those suffering from mental illness, I hope to dedicate my career to finding the best ways to help you through your struggles.

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INTRODUCTION

Society is slowly moving towards having more understanding and more compassion for those with mental illnesses. Awareness seems to be improving; community programs now exist to help those with mental illness and their families, and the stigma once associated with mental disorders has also begun to fade (Angermeyer & Dietrich, 2005, p. 163). However, when it comes to mental illness in prison, public attitudes are less clear. Public forum comments on news articles regarding crimes committed by the mentally ill show many opinions that convey anger and fear, sometimes to the extent of wishing harm upon criminals regardless of their mental state. This is seen in an article by Dylan Stableford regarding Jared Loughner's plea (Stableford, 2012). Similar public comments are found in an article regarding James Holmes by Connor Simpson (Simpson, 2013). Even in high-profile cases such as these, there seem to be many varying opinions on how to handle these types of criminals. Violent crimes committed by mentally ill individuals usually receive a lot of publicity which has an effect on public opinion. When fear increases among the public, stigmatization can result (Stuart & Arboleda-Florez, 2001, p. 654). In a 2012 study, Anumba pointed out that the general public looks at the criminal justice system as overly lenient towards offenders (Anumba, 2012).

The issue of mental illness in the prison system is one that raises many questions. I will explore some of these issues with a literature review which will provide an overview of the various issues of mental illness in the prison system such as how those with mental illness are treated during their time in prisons or jails, the types of mental health programs that exist in prisons, and the efficacy of these programs. I will perform a data analysis using publicly available data to compare the instances of incarceration of the mentally ill to the instances of

incarceration of people below the poverty line. Using another population variable, in this case socioeconomic class, specifically populations below the poverty line, provides a point of comparison to explore the prevalence of mental illness in the prison system. I predict that there will be a higher correlation between mental illness and incarceration than socioeconomic class and incarceration. This information will contribute to the fields of psychology, sociology, criminal justice, and the health professions as well as encourage discussion about the ethical dilemmas that these issues pose.

TYPES OF MENTAL ILLNESSES SEEN IN THE PRISON POPULATION

Estimates vary on exactly how many of the people who currently are incarcerated are also mentally ill. A 2008 article by Adams and Ferrandino estimated that approximately 16% of inmates have mental illnesses. Ditton had similar estimates in 1998, reporting survey results that indicated about 16% of the inmate population in state and local jails and about 7% of federal inmates were mentally ill. Watson, Hanrahan, Luchins, and Lurigio estimated about 10-15% of inmates have a serious mental illness. These rates are higher than average as the incidence of serious mental illness in the general population is about 2% (Watson, Hanrahan, Luchins, & Lurigio, 2001, p. 477). Reports also suggest that the number of mentally ill individuals who are incarcerated may be increasing. In Florida for example, the number of inmates who could be classified as having a moderate mental disorder increased from 8,053 to 10,553 in a four year period and those who could be classified as having a severe mental disorder increased from 402 to 812 in the same four year timeframe (Adams & Ferrandino, 2008, p. 915). Steadman, Osher, Robbins, Case, and Samuels found in 2009 that there were possibly as many as 2,161,705 annual bookings of individuals with serious mental disorders in the United States. These reports are somewhat startling, and they highlight the fact that this is an important issue that affects a large number of inmates.

The types of disorders seen in incarcerated people are similar to those seen in the general unincarcerated population. Even so, what studies have found is that these disorders are seen in greater frequency in the prison system. In 2002, Fazel and Danesh found that prisoners have two to four times more diagnoses of psychotic illnesses and major depression and about ten times more instances of antisocial personality disorder. To elaborate, psychotic illnesses and major

depression are seen in about one in seven prisoners in western countries (Fazel & Danesh, 2002, p. 548). Schizophrenia and bipolar disorder are frequently seen, and approximately 45% of inmates also have a comorbid substance abuse disorder (Adams & Ferrandino, 2008, p. 915). Again, these are above the norm as in the general population about 1.1 percent of people are schizophrenic, about 2.6 percent are bipolar, 1 percent have anti-social personality disorder, and 6.7 percent have major depressive disorder according to the National Institute of Mental Health.

CRIMES COMMITTED BY MENTALLY ILL INDIVIDUALS

The types of crimes committed by mentally ill patients vary. In 1999, Ditton examined these occurrences and frequencies. Mentally ill people are somewhat more likely to be incarcerated for a violent crime than those without a mental illness. For example, Ditton (1999) found that 53% of mentally ill state prisoners were serving time for a violent crime whereas only 46% of those without mental illness were serving time for a violent crime. More specifically, of the state prisoners with a mental illness, about 13% were incarcerated for murder, 12% for sexual assault, 13% for robbery, and 11% for assault. In the Federal system, 33% of mentally ill people were incarcerated for violent crimes versus 13% of other inmates. In local jails, it was 30% versus 26%. Looked at in the reverse, about one in five violent offenders were determined to be mentally ill (Ditton, 1999, p. 5).

With these figures, we can begin to see some of the potential issues surrounding mentally ill inmates. The numbers indicated that mental illness in the prison system is a widespread issue that affects not only the prisoners, but also is also likely to affect staff members in prisons and jails who must assess and treat these patients.

THE PSYCHOLOGICAL TOLL OF INCARCERATION

There is evidence to show that being incarcerated has psychological effects on most inmates, not just those with preexisting mental illnesses. A 2001 article by Craig Haney examined this issue in depth. The prison environment itself can be one in which adaptation is difficult. People who are incarcerated must learn to follow new sets of rules that apply to things such as daily routines of life and social interaction. Inmates often feel a sense of isolation. Prisons can be a dangerous environment and inmates must learn to adapt to this as well. Inmates may have to learn to take special caution to avoid hazardous situations within the prison walls. This can lead to general mistrust of others which can have a lasting effect on the person upon release. Haney found that people who are incarcerated when younger sometimes learn to adapt better to prison because they do not necessarily have routines and norms of their own as autonomous adults. These inmates pose more of a challenge upon release because of the fact that they had to adjust to life in prison and have difficulty transitioning to normal life once released. Many inmates grow dependent on the control and routine of prison and this can become a challenge when released back into society (Haney, 2001.)

In addition to these issues, inmates may experience social withdrawal, a lack of self-esteem and self-worth, post-traumatic stress, and emotional numbness. Although the evidence is not suggesting that prison causes psychological disorders, it does highlight the fact that there are many psychological stressors that can affect inmates. Mentally ill offenders and developmentally disabled offenders often have an even harder time adapting to institution life and their needs are not always addressed properly (Haney, 2001). Although prison must have a structure to ensure safety and adequate control over individuals who may be dangerous, the

psychological toll should be addressed and considered when looking at the general issue of mental illness in prison.

TREATMENT

It is a constitutional right that prisoners be provided health care which includes care for psychological disorders (Steadman et al., 2009, p. 761). Thus, regardless of whether inmates were mentally ill when they came to prison or whether their mental state deteriorated while in prison, treatment is important. With numbers this large, however, the question becomes whether or not these inmates are receiving proper care; if they are, what kind of burden is this placing on an already strained prison system? Lack of staff and resources may limit the care that these patients are receiving. Additionally, some disorders require more thorough treatment than others. For example, schizophrenia typically requires lifelong treatment involving medication, therapy, and sometimes hospitalization. Comparatively, depression can sometimes be treated successfully with just therapy or medication and is usually managed more easily than a disorder such as schizophrenia (Mayo Clinic, 2012).

Screening

Prisons and jails have variable methods of determining mental illness in their prisoners. State prisons use intake screenings about 70% of the time. This approach may utilize clinical interviews or assessments. The goal is to identify whether or not the inmate has a mental disorder and if so, identify which type of treatment may be appropriate. Additionally, the staff attempts to assess whether the person is a danger to him or herself or others. There is debate about which methods are the most appropriate. Clinical interviews have the risk of bias depending on the clinician, plus one clinician's assessment may be quite different than that of another clinician which can affect reliability. Assessments can give reliable results and they can also be beneficial when it comes to gathering statistics of a population, but certain things may be

missed (Adams & Ferrandino, 2008, p. 916). Some believe that moving to a combination of these approaches may yield more accurate results, but this creates an issue of time and resources.

Types of Treatment

A 2009 report by the Federal Bureau of Prisons outlines the types of treatments used in prisons that fall under the jurisdiction of the Bureau. Many of these are similar to treatments used for unincarcerated individuals suffering from mental illness such as cognitive behavioral therapy and trauma therapy. The report focuses on evidence based treatments, which use current research as a guideline to determine appropriate treatment methods, drug abuse programs, resolve programs which focus largely on trauma programs for female inmates, challenge programs which are designed for high-security inmates, and mental health treatment programs.

For evidence based treatments, the Bureau favors cognitive behavioral therapy (CBT). This is because it has shown effectiveness with inmates (U.S. Department of Justice, 2009, p. 9). Like CBT used in the general population, the goal of this treatment is to change errors in thinking. With prisoners, it is believed that these errors can be a cause of criminal behavior and the treatment goal is to change thinking patterns that may be deviant to be more in line with society and its laws. Residential treatment programs also are used. This method creates a community within the prison and attempts to teach values and skills that will be beneficial when the inmate is released. This program aims to reduce inmate recidivism and has been shown to be effective according to the Bureau of Prisons report.

All institutions that fall under the Bureau of Prison's jurisdiction employ a drug treatment specialist who works with inmates with substance abuse disorders. Several different types of

programs are available to inmates including a drug abuse education course which is approximately fifteen hours in duration, non-residential and residential treatment programs, follow up treatment in the general population, and community transitional drug abuse treatment. Each treatment option has different screening protocols. Inmates who are not required to participate in a program have the option of volunteering to do so (U.S. Department of Justice, 2009, p. 15).

Female institutions that fall under the Bureau of Prisons have a trauma treatment program known as the Resolve Program. This program is designed to help inmates with trauma-related disorders using psycho-educational workshops and a non-residential program. Cognitive behavioral therapy, group therapy, and skills training are utilized to try to treat inmates who report experiencing a traumatic life event or who have an Axis I or Axis II disorder that is related to a traumatic life event. This program exists because women are more likely to be victims of trauma (U.S. Department of Justice, 2009, p. 41).

The Bureau Rehabilitation and Values Enhancement (BRAVE) Program is designed for inmates who are believed to be likely to cause or engage in disturbances in prison. Inmates who participate in the BRAVE program are under 32 years of age. The participants are housed together and are separate from the general prison population. This minimizes peer pressure from the prison environment and helps foster pro-social attitudes. The program lasts six months and includes an orientation phase, a core treatment phase, and a transition phase (U.S. Department of Justice, 2009, p. 44).

The Challenge Program is another residential treatment program that aims to help inmates conquer addictions and work towards managing mental illnesses. The goal is to help inmates adjust to life in prison and also to have more success when released back into the community (U.S. Department of Justice, 2009, p. 51).

In addition to the programs above, there are also several other programs for mental health treatment including the Habilitation Program designed for inmates having difficulty adjusting to life in prison, the Skills Program which is designed for those with cognitive limitations, the Axis II Program for those with Axis II disorders such as personality disorders, and programs designed specifically for men or for women (U.S. Department of Justice, 2009, p. 58).

Mental Health Courts

Mental health courts attempt act as an intervention rather than a treatment program. The mental health courts are trying to address the issues of mental illness in the criminal justice system. Mental health courts attempt to address issues associated with mental illness during the trial period. Jail sentences may be reduced or deferred and in some cases the charges against the defendant may be dropped. Mental health courts only deal with offenders that have mental disorders and the court officials are typically trained to handle these types of cases. These courts can differ in how they handle cases involving mentally ill defendants. In general, the mental health court tries to assess competency, find appropriate resources for the client, arrange treatment during incarceration if the defendant is sentenced, and link the individual with resources upon release (Watson, Hanrahan, Luchins, & Lurigio, 2001, p. 478).

These are examples of the types of programs and treatments available to inmates. How effective are these treatments? Do inmates that participate in these programs do better while in prison and when released? The following section will examine some of the existing research on the efficacy of these programs.

Efficacy of Treatment

Several studies examine the efficacy of treatment for inmates with mental illness. A 1997 study by Edens, Peters, and Hills looked at programs designed to treat prisoners with co-occurring disorders. They found that although treatments such as skill training tended to show promise and efficacy, the barriers involved in treating inmate populations were numerous. Some of these difficulties included a lack of resources such as halfway houses and outpatient treatment programs, reluctance to treat those with criminal backgrounds from community agencies, a lack of follow-up monitoring within community based programs, lack of proper training among staff, and resistance to continue treatment on the part of released offenders (Edens, Peters, & Hills, 1997, p. 15). The researchers determined that more research was needed to assess treatment programs.

Another 1997 study by Steadman and Veysey under the United States Department of Justice looked at 100 different jails who rated their mental health services as “very effective”. Unfortunately, not much data was collected on the outcome of the patients, but Steadman and Veysey found many of the same issues with treatment that Edens and colleagues did. Additionally, they found that services varied widely depending on the size of the facility. Small jails typically did not have programs of their own. An initial screening of inmates may be done, but after that they relied heavily on community resources to treat mentally ill inmates. Larger

facilities typically had more in house resources, but the efficacy of the programs was not clear in this study. It did highlight some of the challenges of organizing treatment which can be a potential roadblock in truly assessing the effectiveness of treatment for incarcerated individuals. This is a point that should be considered further.

A 1999 study by Morgan, Winterowd, and Fuqua examined group psychotherapy using cognitive behavioral based treatment. They compared two groups of inmates. One group received no treatment and the others were in a treatment group. They found that there was no statistically significant difference between the two groups based on psychological assessments. Traits such as behavior while incarcerated, empathy, and defensiveness were assessed and the results showed that the inmates receiving treatment had very little change in their assessment scores that measured these traits. Interestingly, the self-reports of both inmates receiving treatment and the therapists did indicate that treatment had helped. The inmates that participated in treatment felt that the treatment had been beneficial and also would be willing to participate in similar treatment in the future. The therapists reported that they saw improvement in their patients. The researchers noted that the inmates participating in the treatment did not score particularly low in empathy or high in defensiveness or poor institutional behavior so that may have been a factor (Morgan, Winterowd, & Fuqua, 1999). This study is interesting because although no statistical significance was found supporting the efficacy of this type of treatment, the self-reports indicated that treatment may still support the overall well-being of mentally ill inmates.

In 2005, Cosden, Ellens, Schnell, and Yamini-Diouf examined the efficacy of a mental health court. Although the mental health court did not show as much efficacy with inmates who

suffered from drug or alcohol addictions, there was a decrease in jail time served and improvement in psychological functioning for those who went through the mental health court. One challenge that the study presented was that some released inmates were impossible to track once they were released because researchers were unable to locate them. This is an issue in general when assessing how well treatment in the prison system works. Overall, the study showed that the mental health court appears to be a promising option to address the issue of mentally ill convicts.

These varying results demonstrate some of the challenges in determining how effective treatment options available in the prison system are. There are many variables involved with these patients, which makes it more difficult to assess whether treatment is working and will have a long-term effect.

Issues with Treatment

While incarcerated, treatment can become a complicated issue for inmates. There is conflict that often exists between clinicians and prison administrators. The goal of a psychologist is usually to obtain a proper diagnosis and administer appropriate treatment to a patient. Prison administrators often have a goal that focuses more on control and safety within the facility. Sometimes these ideals can clash. One can see both sides of this dilemma. For example, if an inmate is acting out due to their mental disorder, this can be hard on prison staff. Even if it is not the inmate's intention, prisons and jails need to maintain control so sometimes an inmate may be disciplined for something that is not being done purposefully or even sometimes something that they cannot understand. This is not often conducive to proper treatment of many disorders. However, a clinician may only wish to treat the disorder and if some behaviors are

allowed, this could compromise the safety of staff and other inmates or create a perceived double standard for those with disorders as opposed to those without. These are significant challenges and it can be difficult to try to determine approaches that have good success rates and that satisfy the needs of the patient, clinician, and prison staff (Adams & Ferrandino, 2008, p. 918).

A 1999 book by Kuper found that often offenders with mental disorders do not get needed attention by prison clinical staff and that their treatment is sometimes lacking. The prison environment also takes a toll on these inmates which can lead to further deterioration of their mental condition as well as suicide. Rates of suicide in prison are up to nine times higher than rates seen in the general population (Kuper, 1999). This raises concerns for the welfare of mentally ill offenders while they are incarcerated as well as worries for their rehabilitation.

Additional issues arise when those with mental illness have served their time and are released back into the community. Recidivism rates are a concern, both for the offender and the community. Unfortunately, Adams and Ferrandino found that mentally ill inmates are more likely to reoffend than those without mental illness. Additionally, this population is more likely to serve longer sentences. The average is about one year longer than non-mentally ill prisoners. Parole also is not granted as often to mentally ill offenders. This situation can cause a vicious cycle in which those with mental illness end up caught in the criminal justice system. If their issues are not being addressed properly, this can make it much harder for this population to succeed once released from jail or prison which are factors that contribute to further criminal activity.

One possible solution to this problem is case management. A 1998 study by Ventura, Cassel, Jacoby, and Huang examined the effect of case management on recidivism. Results are

encouraging, but difficult to fully interpret as a complete solution. Often, it is those with the most severe disorder that receive more thorough case management, so it is hard to see how it would affect those with more moderate disorders. It was found that case management does reduce recidivism, but it is possible that other factors are involved in this reduction as well. In 2005, Lamb and Weinberger talked about initiatives such as more intensive community mental health services and incentives to encourage mentally ill patients to participate. This is another option that has hope for improving the situation.

METHOD

Materials

Publicly available data provided by the state of California were used for this analysis. A 2000 report on prisoners and parolees in California and 2000 data on prevalence of mental disorders from the California Department of Mental Health were the data sets used to gather information.

Procedure

Research was done to find publicly accessible data that showed the percentage of the population that were mentally ill and the percentage of the population that were below the poverty line in 2000 in fifteen counties in California. Both sets of data were from the year 2000 to account for differences that may occur from year to year. The counties analyzed were Alameda, Contra Costa, Fresno, Kern, Los Angeles, Medocino, Monterey, Orange, Riverside, Sacramento, San Bernadino, San Diego, San Francisco, Sonoma, and Ventura ($N = 15$). These counties were used because data on both variables for the year 2000 was available and different regions of the state were represented. Data on the percent of people incarcerated were gathered from the report on parolees in California and data on prevalence of mental illness and socioeconomic status were obtained from the California Department of Mental Health.

SPSS software was used to run a Pearson-R correlation coefficient matrix. Data were entered as percentages to account for population differences between the counties. The percentage of mentally ill people and the percentage of people below the poverty line in each

county were used. These numbers were compared to the percentage of the population in each county incarcerated. Data collected are displayed in the table below.

Table 1 Population Percentages for California Counties

County	% of Population w/Mental Health Disorders	% of Population Incarcerated	% of Population Below Poverty Line
Alameda	5.763477	0.465492	9.952909
Contra Costa	5.420489	0.320793	6.591471
Fresno	6.963767	0.889532	17.99986
Kern	7.144497	0.878933	11.436419
Los Angeles	6.579713	0.579832	11.051525
Medocino	6.545636	0.479557	13.466509
Monterey	6.903084	0.515446	10.97104
Orange	5.855323	0.404405	8.982083
Riverside	6.47165	0.818058	11.590365
Sacramento	6.473213	0.795239	11.456411
San Bernadino	6.687564	0.919658	12.862076
San Diego	6.062181	0.626695	10.44139
San Franscisco	5.30522	0.347777	10.398671
Sonoma	5.961999	0.353287	7.604896
Ventura	5.788816	0.381109	7.915347

RESULTS

The Pearson-R correlation matrix showed that there was a positive correlation between mental illness and incarceration and a positive correlation between populations below the poverty line and incarceration indicating that as these percentages increased so did the percentage of the incarcerated population. There was a higher correlation between mental illness and incarceration ($r = .785$) than socioeconomic class and incarceration ($r = .717$) which supported the hypothesis. The results were found to be statistically significant. Data is displayed in table. Interestingly, there was also a positive correlation between populations below the poverty line and mental illness ($r = .698$).

Table 2 Correlations

		% of Population w/Mental Health Disorders	% of Population Incarcerated	% of Population Below Poverty Line
% of Population w/Mental Health Disorders	Pearson Correlation	1	.785**	.698**
	Sig. (2-tailed)		.001	.004
	N	15	15	15
% of Population Incarcerated	Pearson Correlation	.785**	1	.717**
	Sig. (2-tailed)	.001		.003
	N	15	15	15
% of Population Below Poverty Line	Pearson Correlation	.698**	.717**	1
	Sig. (2-tailed)	.004	.003	
	N	15	15	15
**. Correlation is significant at the 0.01 level (2-tailed).				

DISCUSSION

The data did support my hypothesis that there would be a higher positive correlation between percentage of mentally ill in a population and incarceration that percentage of population below the poverty line and incarceration. Although there was a higher percentage of people below the poverty line than people diagnosed with mental illness in each county, the data suggests that mental illness may play a larger role in incarceration. The data gathered in the literature review shows that mental illness is prevalent in the prison system and this data reinforces that. Possible implications could be that mental illness may be a contributing factor in criminal behavior. It could also imply that the mentally ill end up convicted and sentenced to prison time more often than people without mental illness. Further research is needed to explore these possibilities and learn more about the connections between mental illness and incarceration.

There are limitations when researching the topic of mental illness in the prison system. It can be difficult to access data on mentally ill in a population versus the mentally ill in prison. While other population variables such as gender, race, education, socioeconomic class, and employment status may be available, it is not always broken down within the mentally ill prison population or mentally ill in general population so the data analysis can be challenging. There are many factors involved in incarceration in general, not just incarceration of mentally ill. More research should be done regarding mentally ill inmates to attempt to assess why the mentally ill commit crimes and end up in the prison system. An in-depth analysis on a specific prison should

be done in the future to gain more information and contribute to the research focus of mentally ill in the prison system. I plan to explore this in future research.

CONCLUSION

The issue of mental illness in the prison system is extremely complex and there are many factors to be considered. It is clear that there is evidence to support the idea that it is a significant issue that affects many people, but the solutions to the problems are not as clear. As discussed, there are differences in treatment methods, varying evidence on the efficacy of these methods, and extreme variation in how mentally ill offenders are handled and treated from prison to prison. It is important to continue to try to tackle this issue. It would be ideal to be able to predict which mentally ill individuals have a higher risk of offending in the first place and try to intervene before it happens, but this poses many challenges, some of which are ethical. Currently, it is important to focus on how we handle mentally ill offenders, both while they are incarcerated and upon their release. Prisons are a social institution and they are necessary at this time to ensure the safety of the general population and enforce laws and societal standards. However, we also have a social responsibility to ensure that people that are incarcerated are receiving a proper standard of care while in prison. This is not always the case when it comes to mentally ill offenders.

The possible criminalization of mental disorders and the challenges faced by mentally ill inmates are concerns. We must examine causal factors, population trends, treatment options, risks to society, and plausible solutions. The issue is complex and there are many challenges in finding a perfect solution, if one does in fact exist. Social policy may need to adapt in order to improve the circumstances of mentally ill inmates. There is concern for the safety of members of society and also concerns about where funding and training would come from if a plausible solution were to be implemented. I believe there is a need for this type of research in order to

improve the welfare of mentally ill offenders as well as ensure that they can coexist with the community as productive members of society upon release. If we can continue this type of research, we can not only improve the lives of mentally ill individuals who end up in the criminal justice system, but we can also improve society if mentally ill people are able to improve and be properly treated for their disorders upon release because then they will be able to become functioning members of communities.

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