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Perceived Effectiveness of Mental Health Rehabilitation on Recidivism

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Abstract

As the American criminal justice system moves towards rehabilitation over punishment it is important to see if rehabilitation of mental illness reduces recidivism rates on a large scale. As established by previous research (Gonzalez & Connell, 2014; see also, Osher, et al, 2003), people with mental health issues are notoriously ignored or not provided the proper treatment during incarceration and it is necessary to examine this connection so new policies can be implemented to help incarcerated Americans. By reducing recidivism the amount of people incarcerated is lowered, because most people incarcerated are repeat offenders (Bureau of Justice Statistics), saving America millions of dollars most of which come from American taxpayers. However, to enact the changes needed in the incarceration system we will need the support of the American people. This study aims to measure how willing people are to work with, socialize, and interact with treated offenders versus untreated offenders. It was hypothesized that people will be more willing to associate with individuals who received treatment and that individuals who received treatment will have a perceived more successful reentry to society. A hypothetical prisoner with mental illness was perceived more positively when he was described as receiving treatment than when he did not have a mental illness at all and those who received no treatment, supporting the hypothesis that Americans are more willing to associate with treated offenders than not.

Perceived Perception Of Mental Health Rehabilitation On Recidivism

The government of the United States of America spends approximately 85 billion dollars annually on private and public incarceration facilities (Prison Policy Initiative). This astronomical number fails to include the amount of money spent annually, by the families of those incarcerated, on phone calls and prison commissary accounts. If the United States could lower its incarceration rate it would save Americans billions of dollars. At least two million Americans, on average, are currently incarcerated on any given day (Hammett et al., 2001). The vast majority (95%) of inmates are eventually released from prison (Lurgio, et al., 2004), with 68% of people released in 2005 being rearrested within three years (Prison Policy Initiative). If hundreds of thousands of Americans are stuck in a constant loop in the criminal justice system, what can be done to tackle this problem? The United States has a problem with an incarceration system that only holds people in the system rather than rehabilitating them. Given these statistics, America could benefit from a rehabilitation-focused criminal justice system that emphasizes the reduction of recidivism.

Recidivism and mental health issues

People with mental illness are highly overrepresented in the prison population compared to the communities in which they live (Canada et al., 2022; Gonzalez & Connell, 2014; Lurgio et al., 2004). Studies have found that between 13% and 20% of inmates have a serious mental illness while only 10% of the population has a serious mental illness (Theurer & Lovell, 2008). They are also more likely to serve their entire sentence and not be given parole or early release than prisoners without mental illness (Canada et al., 2022). It has also been recorded that more than 60% of mentally ill inmates are rearrested within 18 months of release (Theurer & Lovell, 2008). With many individuals incarcerated suffering from mental illness, incarceration facilities

need to provide focus on mental health. This focus needs to begin during the intake process for individuals to be identified early and receive proper treatment as quickly as possible.

Early detection and treatment of a mental illness are imperative to lowering suicide attempts and mental health relapses (McKenna et al., 2018). Yet, the vast majority of prisoners report having a negative experience with prison staff in and out of mental health treatment (Canada et al., 2022). Mentally ill inmates, on average, spend more time with incarceration staff due to behavioral problems, trips to the infirmary, and counseling centers. With mentally ill inmates spending more time with incarceration staff, it is easy to see how dependent this relationship is on successful rehabilitation and reintegration for individuals. These experiences are concerning given that individuals with symptoms of many mental health disorders were less likely to be identified by the prison staff interacting with these individuals (Gonzalez & Connell, 2014). This leads to a large portion of the prison population not receiving any type of treatment or minimal treatment. As the prison population increases, the less likely inmates are to receive necessary prison mental health treatment and post-release mental health treatment plans (Osher et al., 2003).

Unmet needs for mental health treatment are common in prisons and have adverse consequences for both the inmates and the criminal justice system, including increased recidivism (Jakobowitz et al., 2017; Gonzalez & Connell, 2014). Access to mental health services is sporadic and unregulated in the United States but when inmates receive proper treatment, both therapy and medication, their likelihood of reoffending is greatly decreased (Canada et al., 2022; Gonzalez & Connell, 2014; Lurgio et al., 2004; Martin et al., 2018; Warren, 2007). While studies have varied on exactly how many people with a mental illness receive treatment, ranging from 40-60%, it is clear that a large portion of individuals are not receiving

the treatment they need. Not only are individuals not being allowed access to treatment that could help them, but they are also being denied medications they were already taking before entering an incarceration facility (Gonzalez & Connell, 2014).

Gonzalez and Connell (2014) reported that between 40% and 50% of inmates who were on mental health-related medications when entering prison did not receive their medication while incarcerated. Consistent with these findings Jakubowitz et al., (2017) found that 40% of inmates who needed medication received medication while incarcerated. Half of the people who were on medication before entering prison were denied access to that medication, despite this not being legal. It is not entirely known how this occurs: perhaps a lack of communication between inmates and prison staff or lack of resources or negligence by the prison staff. However, it occurs, being taken off of medication while in a stressful situation, such as prison, has negative consequences for the inmates. Coming off medication, especially so abruptly as being incarcerated, has numerous withdrawal symptoms that may affect how people behave. These withdrawal symptoms, such as irritation and anxiety, coupled with the return of an individual's mental illness symptoms are a recipe for disaster in this high-stress situation. Individuals with diagnosed mental health disorders are significantly more likely to have negative interactions with other inmates and prison staff, leading to more punishments during their sentence such as isolation (Canada et al., 2022; Gonzalez & Connell, 2014). Isolation has been found to make mental health disorders worse in not only inmates but also in people who are not incarcerated (Canada et al., 2022; Gonzalez & Connell, 2014). These issues are further exacerbated by the gender of the individual needing treatment.

When it comes to gender differences there is a discrepancy between who receives treatment with female inmates receiving treatment 53% of the time compared to 36% of males

(Jakobowitz et al., 2017). Due to societal standards, men who have mental health issues seldom seek treatment because of the stigmatization of men needing or wanting treatment. Therefore, it makes sense that males were denied or seen as not needing treatment significantly less than females. It has also been reported that when males ask to be seen by a mental health professional they are more likely to not be taken seriously by prison staff (Jakobowitz et al., 2017).

Prison Approaches to mental health treatment

Before exploring the future of mental health treatment in prisons in the United States it is important to understand what is happening in prisons successfully and unsuccessfully around the world. McKenna et al., (2018) compared five prisons and their approach to mental health treatment in New Zealand. It does need to be noted that treatment can only be effective if people choose to receive treatment, this can hinder studies on the effectiveness of treatment types by lowering the number of participants available to researchers. McKenna et al., (2018) found that despite the high need for drug and alcohol treatment, identified based on diagnosis, across five prisons the services were greatly underused compared to those who had a diagnosis of a drug or alcohol addiction. This lower usage can be attributed to numerous factors, most of which can be attributed to the mental health stigma, which is why eliminating this stigma and providing judgment-free treatment is important. McKenna implemented changes to who could have access to treatment and medication by expanding it past just psychosis and allowing for people not previously diagnosed to be diagnosed and receive treatment. When the approach to mental health treatment was changed in the prisons, Mckenna (2018) noticed an increased usage of treatment without any addition of new resources to the prisons.

Warren (2017) has researched civil rights in prison systems around the world. He outlined ten policy initiatives that should be introduced to prisons to reduce recidivism, with many of

these not requiring the addition of new resources. The first of these policies is for legislators to emphasize the treatment in penal sentences rather than punishment because such a small number of repeat offenders commit most crimes it is imperative to rehabilitate these individuals to lower recidivism and crime rate. The next several policies are related to this previous sentiment. Warren addresses how to use assessments for sentencing focused on treatment and creating databases for judges to use as "precedents". Warren's study is a unique example of how American citizens can get politicians to move for new legislation that will begin to tackle the recidivism problem facing America. While Warren is working to get these policies implemented through his work with the Civil Rights Commission, more support is needed to enact these reforms.

Coupler and Olver (2020) implemented an intensive non-prison treatment, instead of incarceration, that lasted for eight months and then followed up with the violent offenders after ten years, well after the average recidivism risk period. They found that a cooperation approach of everyone on the patient's "team" was highly effective in reducing recidivism in those patients. This was because there was no stigma anywhere in the facility rather than in prison where other inmates and guards are judging those trying to receive treatment. The protective scores were much higher at release from the program than after the ten years, although for most it did not matter as they did not commit another crime. Similarly, Osher et al., (2003), found that getting the correctional staff, treatment staff, and criminal justice system to work together greatly increases the chance of a positive outcome for inmates.

McKenna (2015) implemented an in-prison policy known as the assertive prison model, which focuses on a cohesive collaboration among correctional staff and treatment professionals, similar to Coupler and Olver. Again, this was an approach to reducing recidivism that needed no

additional resources but focused on the reorganization of staff and education of inmates. Inmates who were placed under this assertive prison model were provided more pre-release knowledge of community resources/services and treatment options that could be used after their release from prison. Because of this, the inmates were able to create post-release plans with their care providers in the prison before being released. Creating post-release plans is important and offers many benefits to inmates who receive them. However, the larger the prison the more likely inmates will not receive a post-release plan (Osher, 2003). In some cases, inmates were able to visit those treatment facilities and receive treatment in the weeks leading up to release allowing them to begin the adjustment phase before being released. This led to a significant increase in the use of community resources post-release and in turn a significant decrease in recidivism among those who participated in the assertive prison model. When compared to those who received no post-treatment planning there was a significant difference in people who used post-release resources, with participants in the assertive prison model using more post-release resources. Perhaps with better mental health options while in prison, and upon release, recidivism could be reduced.

Specific Populations with Mental Illness

While it is important to get an overview of recidivism rates and how mental illness is treated it is equally important to observe these relationships in specific populations. Teplin et al., (1997) saw the disparity in research on women's mental health treatment in prison compared to their male counterparts. While gender can affect the diagnosis and treatment of mental health disorders, these differences have not been examined in incarceration facilities. Despite the United States Supreme Court establishing that the eighth amendment against cruel and unusual punishment requires that inmates receive mental health treatment and that the treatment should

be equal regardless of gender, female facilities receive substantially less funding for mental health treatment (Gonzalez & Connell, 2014; see also, Osher, et al, 2003). Teplin, et al., (1997) observed that only 25% of inmates who were flagged as needing mental health resources received any type of treatment. Treatment likelihood was affected by the diagnosis the inmate had received with inmates diagnosed with more severe mental illness more likely to receive treatment. Yet the numbers were still not great, with only 47% of people diagnosed with schizophrenia receiving treatment compared to the 15% of inmates diagnosed with depression who received treatment.

Arsonists, another specific population, have been researched by Ducat et al., (2015) to see if arsonists have a higher recidivism rate than other types of criminals Pure firestarters are people who have only been charged with fire-related crimes while versatile offenders are people who have fire-related charges but have also been charged with other crimes not related to arson. To do this, firestarters were put into two groups, either pure firestarters or versatile offenders. While pure firestarters only had a 5% recidivism rate, versatile offenders had a 94% recidivism rate (Ducat, et al., 2015). Despite pure firestarters having such a low recidivism rate, intake officials need to review an inmate's entire criminal history to see if any arson-related crimes have been committed because the jump to 91% in recidivism is more significant and should be taken seriously. It also needs to be noted that 73% of all versatile offenders had either a diagnosed severe mental illness or received some type of psychiatric treatment in their lifetime. The intake process in various studies has been found to significantly affect the treatment process an inmate receives in prison and this is another step that should be taken during that process to ensure the best outcome for inmates. These individuals need to be flagged by intake so forensic clinicians can meet with the inmate and future steps can be taken to minimize the risk of recidivism.

Davis et al., (2015) focused on the age group with the highest recidivism rates, emerging adults, 17 to 21-year-olds. These are the peak years of offending for not only the general population but those with serious mental health conditions (SMHC) as well. This study implemented multisystemic therapy (MST), a manualized, community- and family-based intervention with proven effectiveness for reducing recidivism in delinquent youth aged 12–17. The standard MST model had not been used with emerging adults or with individuals experiencing significant mental health concerns until then (Davis et al., 2015). The modified MST was shown to reduce recidivism in those among the study population. With further research, this could be implemented on a larger scale for all emerging adult inmates. If society can begin to reduce recidivism effectively earlier in life there will be fewer people incarcerated and save money and resources for those who need them most.

These three studies are excellent examples of how treatment can be effective when given to specific populations. Although these studies might seem highly specific, there are women and emerging adults in almost every prison. These various treatments and intake measures can be implemented across the United States of America to lower not only recidivism but incarceration rates. Mental health affects these groups particularly hard and tackling these populations may help thousands of Americans. If these studies can be replicated or further expanded over other populations within the incarceration system then the United States can begin to tackle its incarceration problem on a large scale. Lowering the recidivism rate will begin the shift in incarceration rates and could eventually lower the United States' incarceration rate enough to be comparable to other countries.

Public Opinions on Recidivism-Related Issues

Zimmerman, et al., (1988), observed how public opinion is influential on criminal justice policy changes in the United States but that much research had yet to be done on public opinion on punishment. While this research provides great insight into the public views on current punishment policies or laws in the United States it gives little to no attention to reducing crime through rehabilitation. People were getting frustrated with crime rates increasing and wanted harsher, in terms of length, punishments in hopes of reducing crime and recidivism (Zimmerman, et al., 1988). Yet, the participants were only asked about the severity of punishments they desired and were not given alternatives to punishment. Given the time period this study was done, it is no surprise that rehabilitation was omitted from the discussion. Still, research is lacking in this area of public opinion despite how much time has elapsed since the original study. However, two years before this a study was done that aligns closely with the research of the current study.

Robert & White (1986), conducted three studies examining public estimates of recidivism and the actual rate of recidivism at the time. In the first study, the public was asked about what they perceived the recidivism rate for three separate crimes was and how that changed with each re-offense. Overall, people highly overestimated the recidivism rate of each crime for the first offense but for the 2nd and 3rd offense, the public estimate aligned with the true recidivism rates. This suggests that people give criminals a stable recidivism rate regardless of the number of offenses (Robert & White, 1986). This suggests that the public perception of criminals is that they will repeat in our current system, yet the public has never been offered alternative solutions to the issue of recidivism. This is why the current study aims to provide the public with an alternative approach to reducing recidivism.

Current Study

As the American criminal justice system moves towards rehabilitation over punishment it is important to see if rehabilitation of mental illness reduces recidivism rates on a large scale. As established by previous research (Gonzalez & Connell, 2014; see also, Osher, et al, 2003), people with mental health issues are notoriously ignored or not provided the proper treatment during their incarceration and it is necessary to examine this connection so new policies can be implemented to help Americans who are incarcerated. By reducing recidivism the amount of people incarcerated is lowered, because most people incarcerated are repeat offenders (Bureau of Justice Statistics), saving the United States millions of dollars most of which come from American taxpayers. However, to enact the changes needed in the incarceration system we will need the support of the American people. This study aims to measure how willing people are to work with, socialize, and all around interact with treated offenders versus untreated offenders.

The independent variable was mental illness status and treatment status, with three levels; mental illness with treatments, mental illness with no treatment, and as a control no mental illness. The dependent variable was the participants' perceptions of the hypothetical inmate's likelihood to repeat a crime, continue treatment, occupational competence, and social competence.

Method

Participants

Participants were recruited through one of two methods, firstly through an introductory psychology course offered at a small private university and a campus-wide email at the University of Lynchburg. A total of 121 people responded to the survey. The average age of the participants was 22 with a standard deviation of 8.499. Gender identity demographics included

38 males (31.4%), 76 females (62.8%), 1 transgender (0.8%) 5 non-binary (4.1%), and 1 “other” (0.8%).

The racial demographics of the participants included; 82.6% white or Caucasian, 9.9% African American, 3.3% Hispanic or Latino, 0.8% American Indian or Alaska Native, 0.8% Native Hawaiian or other pacific islanders, and 2.5% answered “other”.

Regarding class year, 32.2% were freshmen, 14.9% were sophomores, 14% were juniors, 22.3% were seniors, and 16.5% were graduate students. Participation in this study was free of any incentives and was completely voluntary. Students in the introductory psychology course were offered class credit but students who did not want to participate in the introductory class were offered alternative assignments.

Materials and Procedures

This study was conducted over several weeks through an online survey using Survey Monkey. Participants read an informed consent to reflect the nature of this experiment and possible minimal risks. Participants first read an informed consent form and had to choose “agree” to participate in the study. If after reading the informed consent they no longer wished to participate they were instructed to close the survey. Participants were then asked to answer demographic questions (Appendix A), which included age, race, college year, and gender identity. After the demographic question participants were randomly assigned to one of three groups.

Each group was provided with a different scenario (Appendix B) about a hypothetical criminal named Bryan who had been imprisoned for the past three years and was about to be released. In the first scenario Bryan had a mental health illness and received treatment while incarcerated, in the second scenario Bryan had a mental illness but did not receive treatment

while incarcerated, and the last scenario was the control with Bryan having no mental illness while being incarcerated. Once the scenario was read each of the participants answered several scales all based on a 5-point Likert scale (Appendix C).

The first scale was the Occupational Competence and Identity Scale (Zhen, et al., 2020), which consisted of 10 items and a Coronbach's alpha of .919. Each of the items were modified to be in future tense and included the name of the hypothetical criminal in order to apply more effectively to the current study. Of these items, 6 were performance items, 3 were habituation items, and 1 was a volition item. The questions were answered based on the statement "after being released Bryan will do the following within a year of release". Answers are based on a 5-point likert scale with 1 being "very unlikely" and 5 being "very likely". No items were reversed scored and a higher score on these items indicates a perceived less successful reentry to society with the highest possible score being 50 and the lowest score being 10.

The second scale was a modified version of the Cognitive Subscale and Behavior Subscale of the Multidimensional Attitude Scale Towards Individuals with Disabilities (Findler et al., 2007). The scale was modified to include the name of the hypothetical criminal as well as the items being changed to present tense (Appendix D). This was a 9 item scale used to measure the participants likelihood to engage socially with the hypothetical criminal and had a Cronbach's alpha score of 0.703.. Answers were based on a 5-point likert scale with 1 being "very unlikely" and 5 being "very likely". The higher the score the more likely the participant was to engage socially with the hypothetical criminal with 45 being the highest possible score and 9 being the lowest possible score.

The third scale was a section of the Social Dysfunction Rating Scale (Linn, et al.,1969) with a Cronbach's alpha score of .694. No items were modified on this scale but the instructions

were changed to apply to the hypothetical criminal with the following statement, “Bryan will experience these emotions” (Appendix E). Answers are based on a 5-point likert scale with 1 being “very unlikely” and 5 being “very likely”. The higher the score the more likely the participant was to engage socially with the hypothetical criminal with 50 being the highest possible score and 10 being the lowest possible score.

The final scale was created specifically for this study and asked questions about the hypothetical criminal’s behaviors directly related to mental health treatment and recidivism behaviors (Appendix F). These items ranged from asking about Bryan’s likelihood to continue medication and treatment or continue to meet with his parole officer. Two items were reversed scored, with a total of seven items and had a Cronbach’s alpha score of 0.906. The questions were answered based on the statement “after being released Bryan will do the following within a year of release”. Answers are based on a 5-point likert scale with 1 being “very unlikely” and 5 being “very likely”. A higher score shows a belief that Bryan will succeed in re-entry into society.

Once the survey was completed the participant submitted the electronic survey. Participation in this study took between fifteen to twenty minutes. The survey was taken with no researcher in the room. After a few weeks data was no longer accepted and the analysis of the data began.

Results

It was hypothesized that higher scores on the Occupational Competence and Identity Scale would come from the mentally ill who received treatment and the non-mentally ill. A one-way analysis of variance (ANOVA) was used to analyze the data. The hypothesis was supported by demonstrating a statistically significant difference between at least two of the means, $F(2,114)= 32.50$, $p< .0001$, $\eta^2 = .36$ (see table 1). Post hoc tests showed the mentally ill

who did not receive treatment significantly differed from the mentally ill who received treatment and the non-mentally ill, however, this was not the case.

It was hypothesized that higher scores on the modified Cognitive Subscale and Behavior Subscale of the Multidimensional Attitude Scale Towards Individuals with Disabilities would come from the mentally ill who received treatment and the non-mentally ill. A one-way analysis of variance (ANOVA) was used to analyze the data. The hypothesis was supported by demonstrating a statistically significant difference between at least two of the means, $F(2,117)= 6.950$, $p< .001$, $\eta^2 = .106$ (see table 1). Post hoc tests showed that being diagnosed with a mental illness but not receiving treatment significantly differed from being diagnosed with a mental illness and getting treatment and not having a mental illness at all.

It was hypothesized that higher scores on the modified Social Dysfunction Rating Scale would come from the mentally ill who received treatment and the non-mentally ill. A one-way analysis of variance (ANOVA) was used to analyze the data. The hypothesis was supported by demonstrating a statistically significant difference between at least two of the means, $F(2,117)= 1.542$, $p< .218$, $\eta^2 = .026$ (see table 1). Post hoc tests showed that being diagnosed with a mental illness but not receiving treatment significantly differed from being diagnosed with a mental illness and getting treatment and not having a mental illness at all.

It was hypothesized that higher scores on the Recidivism scale would come from the mentally ill who received treatment and the non-mentally ill. A one-way analysis of variance (ANOVA) was used to analyze the data. The hypothesis was supported by demonstrating a statistically significant difference between at least two of the means, $F(2,117)= 14.066$, $p< .0001$, $\eta^2 = .194$ (see table 1). Post hoc tests showed that being diagnosed with a mental illness but not

receiving treatment significantly differed from being diagnosed with a mental illness and getting treatment and not having a mental illness at all.

After examination of the data through One-Way-ANOVAs, exploratory analyses were conducted, comparing only the two groups in which the hypothetical criminal had a mental illness, to determine whether there was a difference in perceptions based on whether or not treatment was given. An independent samples t-test was used to analyze the exploratory data. In the OSA total (N=117), the hypothetical criminal with a mental illness who received treatment had a mean of 33.6 (SD=6.42), the hypothetical criminal with a mental illness who did not receive treatment had a mean of 22.8 (SD=6.74), and the hypothetical criminal with no mental illness had a mean of 30.9 (SD=5.52). Results demonstrated a significant difference between the means, t (80)= 7.44, p=.0001.

In this study, an independent samples t-test was used to analyze the exploratory data. In the Cognitive total (N=120), the hypothetical criminal with a mental illness who received treatment had a mean of 26.22 (SD=3.45), the hypothetical criminal with a mental illness who did not receive treatment had a mean of 23.32 (SD=4.02), and the hypothetical criminal with no mental illness had a mean of 25.25 (SD=3.79). Results demonstrated a significant difference between the means, t (83)= 3.56, p=.001.

In this study, an independent samples t-test was used to analyze the exploratory data. In the Emotion total (N=120), the hypothetical criminal with a mental illness who received treatment had a mean of 21.02 (SD=3.67), the hypothetical criminal with a mental illness who did not receive treatment had a mean of 22.17 (SD=3.53), and the hypothetical criminal with no mental illness had a mean of 25.25 (SD=3.29). Results demonstrated no significant difference between the means, t (82)= -1.46, p=.147.

In this study, an independent samples t-test was used to analyze the exploratory data. In the Recidivism total (*N*=120), the hypothetical criminal with a mental illness who received treatment had a mean of 24.68 (*SD*=4.90), the hypothetical criminal with a mental illness who did not receive treatment had a mean of 18.83 (*SD*=5.64), and the hypothetical criminal with no mental illness had a mean of 22.30 (*SD*=5.59). Results demonstrated a significant difference between the means, *t* (82)= 5.08, *p*=.0001.

Table 1

Descriptive statistics

	With treatment		Without treatment		No mental illness	
Predictor	M	*SD*	M	SD	M	SD
OSA	33.6	6.4	22.8	6.7	30.9	5.5
Cognitive	26.2	3.4	23.3	4.0	25.2	3.2
Emotion	21.0	3.6	22.1	3.5	21.4	2.1
Recidivism	24.6	4.9	18.8	5.6	22.3	5.5

Discussion

It was hypothesized that people would perceive a hypothetical criminal with mental illness who did not receive treatment as less occupationally competent than a criminal with mental illness who did receive treatment and/or a criminal with no mental illness. It was also hypothesized that a hypothetical criminal with mental illness who did receive treatment would be perceived less occupationally competent than a hypothetical criminal with no mental illness. The results of this study supported both of these hypotheses with individuals receiving a hypothetical criminal with no mental illness as the most occupationally competent and a hypothetical criminal

with mental illness but no treatment as the least occupationally competent. The results show that individuals perceive a hypothetical criminal with no mental illness as being most capable to complete work responsibilities, manage finances, and work towards goals.

It was hypothesized that people would perceive a hypothetical criminal with mental illness who did not receive treatment as less cognitively and socially competent. It was also hypothesized that a hypothetical criminal with mental illness who did receive treatment would be perceived as less cognitively and socially competent than a hypothetical criminal with no mental illness. The results show that individuals perceive a hypothetical criminal with no mental illness as being most capable of making people feel comfortable, being able to start a conversation, and being pleasant person.

It was hypothesized that people would perceive a hypothetical criminal with mental illness who did not receive treatment as less emotionally competent. It was also hypothesized that a hypothetical criminal with mental illness who did receive treatment would be perceived as less emotionally competent than a hypothetical criminal with no mental illness. The results show that individuals perceived no difference between a hypothetical criminal with no mental illness, with a mental illness but having treatment, or with a mental illness but no treatment when it comes to things like being emotionally withdrawn, hostile, anxious, and depressed. It would be expected that someone with a mental illness would be considered less emotionally stable than someone without. One could see that possibly someone who received treatment for a mental illness might be more emotionally intelligent than someone who did not receive treatment or someone with no mental illness because they learned new skills in treatment. Still one would expect there to be some difference between the hypothetical scenarios but there is none.

It would be interesting to see if these numbers fluctuate depending on the age of the participants. Younger generations tend to be more emotionally aware and may perceive others as more emotionally intelligent. While older generations tend to be more reserved when discussing emotions and might perceive people differently this study primarily had college-age participants that cannot be examined at this time.If society believes that emotional intelligence is even across all walks of life then support for mental health treatment is more likely to be supported. More research would need to be done in this area specifically because this study primarily had college students as participants and younger generations seem to have more emotional intelligence and comfortability talking about emotions. If an older age group was the primary participant these results would likely change to reflect the original hypothesis.

It was hypothesized that people would perceive a hypothetical criminal with mental illness who did not receive treatment as more likely to recidivate. It was also hypothesized that a hypothetical criminal with mental illness who did receive treatment would be perceived more likely to recidivate than a hypothetical criminal with no mental illness. The results supported the first hypothesis as participants perceived a hypothetical criminal with mental illness who did not receive treatment as the most likely to recidivate. However, it was the hypothetical criminal with a mental illness who received treatment who was perceived least likely to recidivate instead of the hypothetical criminal with no mental illness as hypothesized. This could be because people perceive the extra assistance someone gets in treatment as aiding in their likelihood of recidivating. People perceive extra tools and time spent on people as a way to help with recidivism. This would be backed by research previously discussed and give even more reason for the public to push for more treatment in incarceration facilities if they already believe it works.

The exploratory tests done for this study compared the hypothetical criminals with mental illness who did and did not receive treatment. Participants perceived the hypothetical criminal with a mental illness who received treatment as more occupationally and cognitively/socially competent, as well as, less likely to recidivate than a hypothetical criminal with a mental illness who did not receive treatment. Meaning that a hypothetical criminal with a mental illness who receives treatment is perceived to be better at things like staying on task, working towards goals, communicating with coworkers, being friendly, being able to hold a conversation, following post-release plans, and staying in contact with parole officers than a hypothetical criminal with a mental illness who did not receive treatment. This aligns with past research on mental illness treatment lowering recidivism rates (Canada et al., 2022; Gonzalez & Connell, 2014; Lurgio et al., 2004; Martin et al., 2018; Warren, 2007). With both past research and public opinion seeing the importance of treatment in lowering recidivism rates it is time for the American criminal justice system to get on the same page.

The exploratory tests also found there to be no perceived difference between the hypothetical criminal with a mental illness who received treatment and one who did not receive treatment in regards to emotional competence. Again, this would be interesting to examine different generations of participants to see if these changes depend on the age of the participants. It is important to note that there was a larger gap between the perceived emotional competence of the two groups but it is still not large enough to be considered at this time. This could be a precursor to a larger difference between groups when the sample size is bigger and spans across more generations.

Since previous studies related to the topic of the current study were completed in the 1980s (Zimmerman, et al., 1988; Robert & White 1986), the current study provides a needed

update to data on public opinion on recidivism rates. With updated data on a small scale, the need for more data can be further argued as the current data reflects the public will and want for change regarding high recidivism rates. The current study also took a new, and much-needed approach, to public opinions on mental health treatments affecting recidivism rates. This allows activists to have data showing the support the public has for these changes to be made when going to advocate for legislative changes to be made. This also gives possible politicians or lawmakers a platform that the American people care about because in America for legal change to be made public support and pressure are needed. The current study can serve as a solid foundation for future studies with more resources to build upon. That does not mean that the current study is without flaws and limitations.

When it comes to limitations a larger sample size is always wanted when trying to get an accurate representation of the American population. A more diverse sample that reflects the population more accurately would also be an important alteration to the current study. The current study had a limited pool of participants and an even more limited pool of diverse participants. It could also be interesting to have the sample of participants match the incarceration demographics to see how their beliefs on recidivism differ from the white perspective that the majority non-incarcerated population consists of. Since minorities are overwhelmingly overrepresented in incarceration facilities compared to the general population it would be interesting to view a sample from that perspective and see if there is a racial difference when it comes to treatment and recidivism.

Another limitation is that the current study only included three different scenarios that participants were randomly assigned to, however, the addition of a fourth scenario in which the hypothetical “Bryan” is not a criminal at all could be a simple expansion that allows for more

variables to be viewed. The new fourth scenario would allow for more exploratory tests between those incarcerated and those not. This could show how biased people are to those who have been incarcerated despite serving their time and getting the proper treatment and/or resources needed to be successful and productive members of society.

This new scenario could be expanded to where "Bryan" the non-criminal has a mental illness and either does or does not receive treatment. This addition would provide an extra variable to examine and provide a more direct comparison to the general population. If people view individuals with a mental illness who have received treatment, regardless of criminal status, as being more competent than those who do not receive treatment it may strengthen the argument for not only treatment in incarceration facilities but cheaper, and easier access to treatment for the general population. Cheaper and easier access to mental health treatments outside of incarceration facilities can aid in lowering those who are incarcerated due to drug or other mental health issue crimes.

The current study could also be adapted to focus on racial biases when it comes to receiving treatment. Instead of having only three scenarios have two sets of the original scenarios but the first set use a more commonly African American name and the second use a more typically white name or a simple image of a white person or African American person is attached to each scenario. The researchers could then screen for biases against the African American despite there being no differences in the scenarios. This addition would dive more into systemic racial inequalities in our justice system that are known to exist but can be pushed aside by unaware racial biases the public has. This could provide a more accurate representation of the incarcerated population compared to the original study. These changes can also be adapted to examine for gender differences by changing the name or image to that of a female, as well as

socio-economic status differences by showing a mugshot of a homeless person versus a higher to middle-class person just arrested. Both of these changes would allow for more data to be collected on specific populations affected by incarceration and treatment needs that could push for attention to be placed on more affected populations within incarceration facilities.

While this study provides a lot of insight into what the population may believe regarding criminal reentry there is very little past research to compare these findings. What is available around a similar subject, such as Robert & White (1986), still provides no direct comparisons. This lack of knowledge in the area of re-entry and public opinion requires more attention immediately and positive changes to the current study have already been laid out for future researchers. If America wants to save millions of dollars a year and lower recidivism rates to match other first-world countries then improvements to dealing with mental illness treatment in incarceration facilities need to be made.

Exploration of Policy Changes

With the need for change in the incarceration system laid out throughout this paper, as well as, the support shown by the public through the current study, it is now time to explore what changes can and should be made in the incarceration system. For this particular portion, we will be focusing on various alternative treatments and punishments that have been successfully implemented in various places in America and other first-world countries.

Legislative Changes

Warren (2007) addressed, in the United States it is incredibly difficult, if not impossible, to enact nationwide policy changes due to the structure of power. In some states, it is the state who has the legislative power while in other states it is the local governments who have that power. This makes tackling legislative and policy changes harder compared to other countries

but not impossible. As with many past laws and changes once a few states begin making changes most states will quickly follow suit.

America gives judges discretion in many cases however even with judge discretion there are very few options to choose from. Discretion typically comes in the form of the length of an incarceration sentence rather than a choice between punishment or rehabilitation (Warren, 2007). Meaning, even if a judge is aware of the effectiveness of mental health rehabilitation, in many states they can not legally give mental health treatment as a "punishment" when scenting someone. Then as already outlined, when that person enters the incarceration system they are very unlikely to receive any mental health treatment. Then upon release, that person will more than likely recidivate and the cycle continues.

If we give judges the option to choose between punishment or mental health treatment we could have an increase in the use of treatment facilities right away. For this to happen legislation regarding the allowed types of punishment and minimum sentence statutes in some states will need to be revisited and modified. In many states, laws have very specific and strict punishments lined out that a judge can choose from. This can be the simple addition of a treatment option to still allow for judge discretion when scenting an individual. This could also be implemented in conjunction with a prison system. Mental health treatment is scarce for inmates, however, if given the resources to expand in-house treatment capabilities an individual could be sentenced to serve prison time while also required to undergo treatment options. These options could include one on one sessions with a psychologist or group sessions led by a psychologist.

Similar to changing the possible sentencing options we should promote using risk assessment instruments. These instruments would help judges determine whether an individual could safely be sentenced to a community-based treatment program or needs to be incarcerated

while receiving treatment. This is not a new idea, for example, the Commonwealth of Virginia created a state sentencing commission charged with developing an offender risk-assessment instrument designed to place 25 percent of its non-violent offenders who would otherwise be incarcerated in alternative sanctions programs (Warren, 2007). These alternative sanctions consisted of community service or house arrest and not mental health treatment options. Risk assessments would be used to determine if a person truly needed to be imprisoned or just needed mental health treatment which would free up more resources in the prisons. This would aid in overcrowding but also allow for more people who need to be incarcerated to receive treatment as treatment inside will be less strained (Manjunath et. al., 2018).

Just as with any punishment, these new sanctions should be given out using offender-based data. Meaning new and updated data on these topics needs to be provided consistently to not only measure the effectiveness of these interventions but also allow judges to make informed decisions backed by data rather than emotion. Similarly, just as with probation, if an individual does not meet the requirements of their community-based treatment sentence they can serve incarceration time. Many people will see these changes as an excuse to let people off "easy" but this could not be farther from the truth. These proposed changes are simply an alternate form of probation. Instead of being on probation with forty hours of community service, a person will be on probation with six months of community-based treatment (Hall et. al, 2016). Allowing these people a true shot at rehabilitation compared to what they would receive in prison or jail.

Community-Based Treatment Sentences

Manjunath et. al, 2018 conducted a series of interviews with people from England who served a community sentence with a mental health treatment requirement. These interviews give

us the perspective of individuals who have gone through something similar to the proposed model in a country that has the closest criminal justice system to America. These inmates who were interviewed before entering the community-based treatment sentence all had similar complaints and worries. Across all mental health issues from paranoia, suicidal ideation, and substance abuse most inmates expressed desperation for help but not having the resources or being believed as an inmate. After serving the community sentence these same people said things like " It helps people… giving the extra help; I get my medication now; It's good to talk to people" (Manjunath et. al., 2018). The difference between the participants' mental states before and after experiencing this type of punishment is significantly more positive than with any prison sentence they had served in the past.

In life, any person does better when they are happy and healthy, and it is our responsibility to make sure people who qualify for this type of treatment get it. If we want to lower the mass amount of repeat offenders we have to create a new solution. The data shows how helpful mental health treatment works in reducing recidivism and the people who have experienced this type of punishment felt it helped way more than any prison time. Also, the public realizes that our current system is not working to curb recidivism and shows they are more willing to associate with someone who receives mental health treatment in prison. So, if society is not willing to begin community-based treatment as sentences then we at least have to give more focus to treatment in incarceration facilities.

In Prison Treatment Options

With the vast majority of inmates not receiving mental health treatment while incarcerated, more focus is needed to rectify this discrepancy (Canada et al., 2022; Gonzalez & Connell, 2014; Lurgio et al., 2004; Martin et al., 2018; Warren, 2007). McKenna (2015)

implemented an in-prison policy called the “assertive prison model”, which focused on a cohesive collaboration among correctional staff and treatment professionals. This assertive community treatment (ACT) was specifically developed for people with serious mental illnesses (SMI). ACT included education about their illness, continuity of care, motivational interviewing, and integrated substance misuse treatment. There were also psychiatrists available 24/7 with small caseloads in order to provide proper treatment. This model reduced reoffending by almost 30% of the small population in the short time it ran.

The main positive of this model is that it requires very few additional resources to be successfully implemented. It focuses more on providing individual and group sessions with relevant information for the inmates. As well as, changing the focus of the correctional staff and treatment professionals. If the focus of prisons and everyone in the prisons is to help the inmates get better rather than punishing them we will get better outcomes, as the data shows. The more correctional staff treat the inmates as human beings needing assistance there will be a more positive interaction between inmates and staff and better outcomes for the inmates. This would require upper management to make this positive environment and interactions a priority of its facility. Holding new training and information sessions for incarceration staff using the data and previous successful models, such as McKenna (2015), can help inform staff about the importance of these changes. As well as give incarceration staff a model to follow when trying to implement these changes into their daily interactions with inmates.

Another way this can be achieved is through a more inclusive work study/release program in prisons in addition to the outlined changes above. Currently, many prisons disqualify inmates with mental health illness from work study programs (Hall et. al, 2016). This only further ostracizes the mentally ill inmate population and strips them of the opportunity to develop

occupational skills. Skills that they could use to get a job post-incarceration and be able to support themselves in order to avoid recidivating. By creating more workers who are trained in modern technology based skills we can simultaneously fill the hole in our workforce and provide people with the opportunity to successfully reenter society.

Conclusion

` The current study provides lawmakers and advocates with research on the importance of mental health treatment in lowering recidivism. This research should be used to draft new laws and legislation, as well as, get existing laws and regulations to be taken more seriously. This study shows that Americans believe in their fellow Americans to be successful in society once given the proper tools and therefore access to those tools needs to be the focus of the government. More research should be funded to capture the true support of the American people to pressure the government to make the necessary changes. Future research that uses the suggestions previously stated can aid in getting support for various minority groups that will need more help in the future as mental health treatment becomes more available. Society should try and focus on assisting the people who are more likely to be incarcerated, which is minority populations. Overall, this study can be used as a foundation for future research and advocacy for more mental health treatment in incarceration facilities.

Possible policy changes have been proposed within various different settings. Proposed legislative change included more mental health care options to be provided to judges to use when sentencing. This would still provide judges with judicial discretion but give them more options when sentencing someone. Judges should also be provided with risk assessment tools to determine if an individual should be considered for a community-based treatment option.

Community-based treatment options are an alternative to prison time or probation that allows for mentally ill individuals to receive care they would otherwise not be provided with

We also discussed the changes incarceration facilities can make in order to provide better in prison treatment for individuals with mental illness. This includes providing updating training for incarceration staff of all positions that focus on building a cohesive community throughout the prison. Management also needs to instill the importance of striving for positive interactions between staff and inmates. Incarceration facilities should also provide an inclusive work release program in order to provide more training for those incarcerated with mental illnesses.

Overall, a lot needs to be done in order to bridge the gap in mental health treatment for incarceration. This problem needs to be addressed if the United States wants to lower its recidivism rate and in turn its overall prison population. Lowering both of these factors would save America millions of dollars of year that comes from tax payer's wallets. The general population has been shown to be more willing to associate with people who have been incarcerated if they receive treatment. It is up to the American people to advocate for change to their respective legislators in order to begin the process of switching to a more rehabilitative criminal justice system.

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Appendix A

Participant Demographics

1. Gender Identity:
    a. Male
    b. Female
    c. Non-binary
    d. Transgender
    e. Other
2. Class year:
    a. Freshman
    b. Sophomore
    c. Junior
    d. Senior
    e. Graduate student
3. Age:
    a. _____
4. Race:
    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian or Other Pacific Islander
    e. White
    f. Other _____

Appendix B

Vignettes

Mental illness with treatment

Bryan has a diagnosed mental illness. Tom has received treatment for the past three years of his incarceration. He has been incarcerated on three previous occasions. He has received medication along with coping strategies and education on his diagnosis. He has also been given access to these resources once he is released and is excited to continue to use them.

Mental illness with no treatment

Bryan has a diagnosed mental illness. Bryan has received no treatment for the past three years of his incarceration. He has been incarcerated on three previous occasions He has spent a majority of his time in isolation because of his behavioral outbreaks related to his mental illness. He would like to receive treatment but will not be assisted in finding or securing treatment once he is released.

No mental illness (control)

Bryan has not been diagnosed with mental illness and has been incarcerated for the last three years. He has no mental or physical health issues. He has been incarcerated on three previous occasions. He will be using no re-entry resources upon his release.

Appendix C

Answer the following questions based on the statement “after being released Bryan will do the following within a year of release”. Answers are based on a 5-point likert scale.

Occupational Competency Scale:

No.	OSA Item
1	Bryan will manage his finances (P)
2	Bryan will concentrate on his tasks (P)
3	Bryan will take care of himself (P)
4	Bryan will identify and solve problems (P)
5	Bryan will work toward his goals (V)
6	Bryan will relax and enjoying himself (H)
7	Bryan will take care of the place where he lives (P)
8	Bryan will take care of others for whom he is responsible (P)
9	Bryan will have a satisfying routine (H)
10	Bryan will be involved as a student, worker, volunteer, and/or family member (H)

Appendix D

Cognition	Degree of Likelihood				
	Not at all				Very Much
1. Bryan seems like an interesting person	1	2	3	4	5
2. Bryan looks like an OK person	1	2	3	4	5
3. We would get along very well	1	2	3	4	5
4. Bryan looks friendly	1	2	3	4	5
5. Bryan enjoys meeting new people	1	2	3	4	5
6. Bryan will enjoy getting to know new people	1	2	3	4	5
7. Bryan can talk about things that interest him	1	2	3	4	5
8. I can make Bryan feel more comfortable	1	2	3	4	5
9. Bryan will start a conversation	1	2	3	4	5

Appendix E

Answer the following questions based on the statement “Bryan will experience these emotions”

Answers are made on a 5-point likert scale.

Interpersonal system

1. Emotional withdrawal (degree of deficiency in relating to others)
2. Hostility (degree of aggression toward others)
3. Manipulation (exploiting of environment, controlling at others expense)
4. Over-dependency (degree of parasitic attachment to others)
5. Anxiety (degree of feeling of uneasiness, impending doom)
6. Suspiciousness (degree of distrust or paranoid ideation)

Appendix F

Answer the following questions based on the statement “after being released Bryan will do the following within a year of release”. Answers are based on a 5-point likert scale.

1. Bryan will continue his treatment
2. Bryan will continue taking his medications
3. Bryan will continue to meet with his parole officer
4. Bryan will continue to follow his parole regulations
5. Bryan will commit another crime resulting in his reimprisonment
6. Bryan will stop his treatments
7. Bryan will not meet with his parole office