

THE NEXT STEP FOR THE JUSTICE REINVESTMENT INITIATIVE: MAKING
MENTAL HEALTH A PRIORITY

by

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THESIS ABSTRACT

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Title: The Next Step for the Justice Reinvestment Initiative: Making Mental Health a Priority

The criminal justice system in the United States was not created to treat mentally ill people. Despite this fact, the number of seriously mentally ill people in prisons and jails now exceeds the number in state psychiatric hospitals by tenfold.

At the same time, the epidemic of mass incarceration in the United States has become one of the most pressing economic and social problems our country has faced in the last three decades.

One novel approach to reducing prison populations and lowering costs to taxpayers has been justice reinvestment. However, for justice reinvestment to meet its ultimate goal of reducing incarceration rates, saving tax payer dollars, and creating safer communities, the Justice Reinvestment Initiative must begin to focus more attention and resources on how to better address the unique needs of the mentally ill in the criminal justice system.

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To my grandmother, mother and little sister; y'all are the reason for any good thing I do.
I take complete credit for the rest.

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CHAPTER I

INTRODUCTION

By the end of 2014, an estimated 6,851,000 people in the U.S., or 1 in every 36 adults, were under the supervision of the U.S. adult correctional systems (Crime Lab 2015). To put that into perspective, over the last 30 years, the number of people incarcerated in the U.S. has quadrupled (Crime Lab 2015). The almost 7 million people in our correctional system in 2014 were the fewest since 1996 (Kaeble 2015). Further exacerbating the problem of mass incarceration is the fact that the number of seriously mentally ill people in prisons and jails now exceeds the number in state psychiatric hospitals by tenfold (Torrey et al. 2014). In 2012, there were estimated to be 356,268 inmates with severe mental illness in prisons and jails, compared to approximately 35,000 patients with severe mental illness in state psychiatric hospitals (Torrey et al. 2014). Mentally ill prisoners remain in prison and jail longer than other prisoners because they are less likely to obtain bail and are more likely violate the rules while incarcerated, thus failing to get a reduction in their sentences for good behavior (Torrey et al. 2014). Since mentally ill prisoners stay longer and require more medical and psychiatric resources than other prisoners, it is not surprising that they also cost the correctional system significantly more than other prisoners.

The exponential increase in the prison population has led to States' corrections expenditures almost quadrupling over the past two decades (Henrichson 2012). The tremendous cost of the corrections system to taxpayers, and the fiscal challenges facing the country over the last decade created a perfect storm that forced the federal government and state legislatures around the country to start seriously considering ways to reverse the trend of mass incarceration.

One novel approach to reducing prison populations and lowering costs to taxpayers has been justice reinvestment. Justice reinvestment is the state's use of evidence-based practices (EBPs) and data-driven decision making to create savings by reducing incarceration levels; these savings can then be reinvested into neighborhoods and communities that generate significant criminal justice costs, hopefully resulting in further reductions in future incarcerations and additional savings to be reinvested (LaVigne et al. 2014). Federal support for justice reinvestment efforts through the Bureau of Justice Assistance (BJA) launched in 2010 with the formal introduction of the Justice Reinvestment Initiative (JRI). Since 2010, 31 states have worked on various JRI efforts.¹

¹ The following 31 states to have participated in JRI: Alabama, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Michigan, Missouri, Nevada, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, West Virginia, and Wisconsin.

Proponents of JRI claim that by reinvesting funds, funds that would otherwise be going to create new prisons, into evidence based community driven programs, states across the country can not only slow prison growth, but can also save money and create safer communities (Tucker and Cadora 2003).

The JRI is a new approach to criminal justice and is moving the conversation about mass incarceration in the right direction. However, while states are implementing JRI's in various ways, one area that has not received enough attention is the role that the mentally ill play in the growth and costs of correctional systems. For justice reinvestment to meet its ultimate goal of reducing incarceration rates, saving tax payer dollars, and creating safer communities, the JRI must begin to focus more attention and resources on how to better address the unique needs of the mentally ill in the criminal justice system.

In order to understand why the JRI has rapidly gained such widespread implementation, Section II of this paper begins with a brief overview of the historical origins of the prison, and the rapid growth of the prison population over the last 30 to 40 years. Next, it addresses how the deinstitutionalization of the mentally ill further exacerbated already overburdened correctional systems. Section III examines the origins and evolution of the JRI and uses Oregon's JRI to illustrate how the JRI is implemented in practice. Section IV argues that the mentally ill in the criminal justice system are directly tied to the fundamental

goals of the JRI: namely, reducing prison populations and saving tax payer dollars while simultaneously creating safer communities.

CHAPTER II

MASS INCARCERATION IN THE UNITED STATES

For 200 years everybody has been saying, "Prisons are failing; all they do is produce new criminals." I would say on the other hand, "They are a success, since that is what has been asked of them."

- Michel Foucault

A Brief History of Discipline and Punishment

The question of how best to control a population has inspired some of the cruelest and most unusual methods of punishment. Prior to the late eighteenth century, punishment was a public "spectacle," generally administered in a very brutal fashion (Foucault 1995). Punishment was retributive in nature; the point was to punish an individual for a crime. This type of punishment served many purposes besides retribution, including discouraging others in society from committing similar crimes. Such punishment also, and more importantly, established the rule of the sovereign over his subjects (Prado 1995). The threat, and use, of violence was seen as necessary in order for sovereignty to remain intact (Foucault 1995). In order for the sovereign to maintain the image of being all powerful, there was a need to publicly demonstrate that power and for it to be so extravagant that there was no questioning it. The penal system prior to the eighteenth century was primarily used as an extension of the sovereign to control his subjects.

Punishment began to change dramatically throughout the eighteenth century. The most notable change was the disappearance of punishment as a spectacle (Foucault 1995). Rather than having criminals punished in public spaces, punishment began taking place behind the closed doors of courtrooms and correctional institutions. At the end of the eighteenth-century punishment had become less a means of exacting the vengeance of the sovereign and more one of correcting and normalizing the deviant and society (Foucault 1995). Criminals began to be seen as threats to society rather than the sovereign. Disciplinary punishment became a means of rehabilitating criminals, attempting to make them like the rest of the “normal” society. When criminals began to be seen as threats to society rather than a threat simply to the sovereign, it became the responsibility of that society to regulate and maintain normalcy, and normalization became the priority of criminal justice (Foucault 1995). Thus, the criminal justice system has become tasked with recognizing and separating the criminal “other” from the rest of society and then correcting and “normalizing” them.

The early nineteenth century saw the rise of the prison system as a complete institution, and along with it, the idea of penitentiary reform (Morris 1998). The goal of incarceration became to correct the behavior of the lawbreaker so that they could rejoin society in a productive capacity, and the prison served as the

space where that transformation could occur. Unlike public displays of punishment, which focused on swiftly punishing the body, incarceration was designed to break and retrain the soul of the offender (Foucault 1995). Contrasting the swift corporeal punishment of the seventeenth and eighteenth centuries prisons were complete institutions where every minute of an inmate's life was regulated. Prisoners' identities were lost and replaced with those that "a whole army of technicians...warders, doctors, chaplains, psychiatrists, psychologists, educationalists" placed on them (Foucault 1995, 11).

Modern prisons have evolved in the 200 or so years since their inception, but many of the social functions compelling incarceration have largely been left in place. The comparatively low crime rates of the 1950's combined with economic prosperity following World War II gave rise to an emphasis on the rehabilitative aspect of prisons in the American criminal justice system (Morris 1998).

When in 1929 the Federal Bureau of Prisons had turned rehabilitation into a policy, its main concern was the development of an institutional network that would allow an effective classification system and individualized decisions regarding discipline and treatment. After World War II, classification was carried out by a team of professional psychologists, caseworkers, sociologists, vocational counselors, and psychiatrists, who all worked in creating the case history of the convict (Morris 1998, 169).

Since the 1950's the prison system has remained largely under the same basic organization. The most glaring difference in the criminal justice system today is the overwhelming number of individuals incarcerated and under correctional

supervision. The figurative explosion of the U.S. prison population began in the early 1970's. It was in 1973 that the imprisonment rate began to outgrow the population rate exponentially (Wagner 2014). The annual growth rate of imprisonment from 1972 through 2000 was nearly 15 percent per year compared to less than 1 percent annual growth before the mid-1970s (Wagner 2014). From 1976 to 2000 the imprisonment rate more than doubled twice, once between 1973 and 1982, and again between 1982 and 1992 (Wagner 2014). There is ongoing debate about what caused prison populations to increase at such an exceptional rate since the 70's, but that debate is outside of the scope of this paper. For our purposes, it suffices to say that for the last four decades the criminal justice system in the United States has operated with a central idea that "the best way to protect the public was to put more people in prison" (Pew 2015). As a result, since 1972, the prison population in this country has increased by over 700% (Pew 2015). At the end of 2014, just over 1.5 million people were physically incarcerated in U.S. prisons (Carson 2015). One aspect of the overburdened criminal justice system that is too often overlooked is the equally dramatic rise in the number of mentally ill individuals being housed in prisons and jails across the country over the last four decades.

*What Do You Get When You Cross the World's Largest Correctional System
With a Mental Institution?*

It sounds like the start to a bad joke, and it should be, but the sad reality is that in 2016 considerably more individuals with mental illness are incarcerated in U.S. prisons and jails than are in mental institutions (Ferrence 2015). While it is difficult to accurately determine the exact rates of mentally ill individuals incarcerated across the country (Toch 2007; Veysey & Bichler-Robertson 2002), as recently as 2009, researchers documented serious mental illnesses in 14.5 percent of male jail inmates and 31 percent of female jail inmates (Steadman 2009). So many people with mental illnesses being under the supervision of the correctional systems create an enormous challenge for our communities, federal and state correctional authorities, and, perhaps most importantly, for those with mental illnesses. To better understand how efforts like the JRI can reduce the number of mentally ill individuals in our correction systems we have to look at how prisons came to house so many mentally ill people in the first place.

A Brief History of Treating the Mentally Ill in America Before 1960

From 1770 until 1820 mentally ill persons were routinely confined in prisons and jails. In 1827 a report by the Reverend Louis Dwight, detailing the horrific conditions in which the mentally ill were being kept, led to an investigation by the Massachusetts legislature (Torrey et al. 2014). That investigation resulted in

the building of a state psychiatric hospital in 1833 (Torrey et al. 2014). More than half of the 120 patients first admitted were transferred from jails and prisons (Torrey et al. 2014). These initial efforts at reform are often overshadowed by the contributions made by Dorothea Dix.

Dix became appalled by the conditions of the mentally ill inmates in Massachusetts's jails when she began teaching Sunday school classes there in 1841 (Torrey et al. 2014). After witnessing the mentally ill being treated so poorly in jail Dix began investigating conditions in other Massachusetts jails (Torrey et al. 2014). After examining the conditions of every jail in Massachusetts, and other neighboring states, she began to lobby the states' legislatures to fund the creation of more state psychiatric hospitals (Torrey et al. 2014). Much like proponents of corrections reform today, Dix did not think the mentally ill could receive the treatment they needed in prisons and jails.

Jails and Houses of Correction *cannot* be so managed as to render them suitable places of confinement for that unfortunate class of persons, who are the subjects of your inquiries, and who, never having violated the law, should not be ranked with felons, or confined within the same walls with them. Jailors and Overseers of Houses of Correction, whenever well qualified for the management of criminals, do not usually possess those peculiar qualifications required in those to whom should be entrusted the care of lunatics (Torrey et al. 2014, 10).

Due in large part to Dix's determined efforts, "by 1880 there were 75 public psychiatric hospitals for the nation's population of 50 million, and most mentally

ill individuals who had previously been in prisons and jails had been transferred to the hospitals.” (Torrey et al. 2014, 11). Between 1880 and the mid-1960’s, the mentally ill in America were primarily treated as patients and were almost exclusively housed in mental hospitals.

Deinstitutionalization and the Beginnings of the Prison Asylum Complex

Deinstitutionalization refers to the 1960’s policy of moving mentally ill people out of large state institutions, and into the community for more individualized care. Deinstitutionalization also resulted in the closure of the majority of large state mental institutions. Despite the good intentions that motivated deinstitutionalization, it has been a major contributing factor to the mental illness crisis in the criminal justice system today (Grob 1991). Before the 1960s, the public psychiatric care system in the United States was almost entirely run by the states. However, once federal funds became available in the 1960’s, the public psychiatric care system became a convoluted network of programs funded by federal, state and local sources.

Deinstitutionalization began in 1961 when the Joint Commission on Mental Illness recommended the creation of a comprehensive network of community-based facilities designed to care for psychiatric patients who had formerly been treated in hospitals (Grob 1991). That recommendation led to the creation of the

Federal Community Mental Health Centers Act of 1964 and transferred part of the financial burden of care from states and local communities to the federal government (Grob 1991). President John Kennedy said the goal of moving mentally ill individuals out of large psychiatric hospitals and into community-based mental health treatment was at the heart of the new approach to the treatment of mental illness (Durham 1989). Theoretically, the individuals released from state hospitals should have been almost immediately taken into community facilities. However, due to an economic downturn triggered by the Vietnam War, the federal government failed to provide ongoing funding adequately, and states reduced their budgets for large mental hospitals but failed to increase funding proportionally for community-based mental health programs (Grob 1991). The inevitable wave of discharges that followed led to the release of thousands of mentally ill persons into communities that lacked the resources necessary to treat them. The deinstitutionalization movement started with a grand hope that the mentally ill would be able to live more independently with treatment provided by community mental health programs; this vision was never fully realized, however, and led to what Marc Abramson called the “criminalization” of mentally disordered behavior (Abramson 1972).

Abramson saw a rapid increase in mentally ill individuals in the San Mateo County jail and the California state prisons after deinstitutionalization, and he

anticipated that the release of so many mentally ill individuals would likely lead to pressure from society to use the criminal justice system to reinstitutionalize them (Abramson 1972). Abramson's prediction has proved to be correct. Studies show that, by 1980, deinstitutionalization was forcing a large number of previously psychiatric patients into the criminal justice system (Torrey et al. 2014). Because the federal government failed to fund the transition adequately from state institutions to comprehensive community-based treatment services, many mentally ill individuals ended up being *de facto* transferred from state psychiatric institutions to correctional institutions. The lack of state and federal funding had the harshest impact on people with limited, or no, financial resources or familial support (Shadish 1989).

During the 1980's and 1990's the problem only worsened. A survey conducted by Torrey et al. showed that many mentally ill individuals were arrested for minor offenses that were aggravated, if not caused entirely, by their untreated mental illness (Torrey et al. 1992). By 1999, there were approximately 600,000 to 900,000 mentally ill inmates in U.S. jail and prison facilities, 10%-15% of all prisoners (Roskes 1999). Between 1998 and 2002, 23% of all prisoners in Utah's prison system had a serious mental illness (Cloyes et al. 2010).

The continued rise in the number of mentally ill people incarcerated in the United States led Tom Moroney of Bloomberg Business Week to declare in 2014:

“It’s a forgone conclusion that U.S. prisons and jails serve as the nation’s de facto asylums for a majority of people with serious mental illness” (Moroney 2014).

Moroney made that claim after reading the latest figures produced by the Treatment Advocacy Center, which showed that “[t]en times as many people with schizophrenia, bipolar disorder, and other acute forms of brain disease reside in prisons and county jails than in state hospitals” (Moroney 2014).

Not only are there ten times as many people with mental illness in prisons as there are being treated in hospitals, in 44 states, the largest mental health institution *is* a prison or jail (Moroney 2014). For example, Oregon’s prison population in 2012 was 14,113 inmates, 12,953 men, and 1,160 women, of which an estimated 50 percent needed mental health treatments (Mentally Ill in Prisons and Jails 2012). Incarcerated women showed dramatically higher rates of mental illness. Of the 1,160 women in Oregon’s prisons in 2012, 80 percent needed mental health treatment (Mentally Ill in Prisons and Jails 2012). In that same year, there were only approximately 790 people receiving treatment at the Oregon State Hospital (Mentally Ill in Prisons and Jails 2012). In 2014, Bryan Denson reported that Oregon was housing 3,325 inmates with severe mental illness (Denson 2014). A year later in 2015, the Oregon State Hospital only admitted 920 individuals. The numbers in Oregon are reflective of the trend

across the country, and make a strong case for the notion that prisons have become the new asylum (Torrey et al. 2014).

How the Mentally Ill End-up in Prison, and Why It's Such a Problem

During the 1960's and 1970's, deinstitutionalization reduced money for state mental health services, and in the 1990's reductions in federal expenditures for social welfare programs left mentally ill individuals few treatment options or other social services for things like food, clothing, shelter, and medical attention (Thomas 1998). After the 1970s mentally ill individuals who eventually were hospitalized were more likely to have criminal histories and histories of substance abuse (Lurigio and Swartz 2000). The mentally ill fell victim to exactly what Abramson expected, and started to look like criminals to the rest of society.

Over one-third of the approximately 600,000 homeless individuals today suffer from schizophrenia or bipolar disorder, and nearly 300,000 individuals with schizophrenia or bipolar disorder are in jails and prisons (Torrey, Kennard, et al. 2010). The unfortunate result of so many individuals with a mental illness being homeless and lacking community resources is that arrests for minor offenses committed by mentally ill persons have become a way for law enforcement officials to get the mentally ill into a safe environment and provided with treatment (Hodulik 2001). As a result, when people who show signs of a mental illness have an encounter with the police, they are more likely to be

arrested than non-mentally ill individuals under the same circumstances (Durham 1989). While this may seem like a good option, most often it either starts or perpetuates a cycle of arrest, incarceration, release, and rearrest.

Parole board members and judges often see mentally ill offenders as greater threats to society than other offenders, and as a result, people with mental illnesses are more often sentenced to, and serve, the maximum sentence allowed by law (Council of State Governments Justice Center 2002). Once incarcerated, the mentally ill typically stay incarcerated for longer periods of time than other individuals with comparable sentences and as a result cost more to house (Torrey et al. 2014).

Prisons and Jails Are Not Designed to Treat the Mentally Ill

The criminal justice system in the United States was not created to treat mentally ill people. By their very design prisons and jails are incompatible with treating mentally ill people. The mentally ill require a supportive and therapeutic environment for any sort of treatment to be effective, and that is incompatible with how prisons and jails operate with their strict programming and complete control over inmates. The discomforts of incarceration—restrictions on freedom, lack of activity, almost no personal privacy, constant danger and a perpetual state of fear and anxiety—are powerful psychological stressors for any inmate, but can have an especially adverse impact on a mentally ill prisoner.

Studies have also shown that overcrowding makes incarceration more stressful for mentally ill inmates, and that added anxiety and instability make them more likely to subsequently violate prison rules, which results in discipline or isolation (Steinberg 2015).

The violation of prison rules by mentally ill inmates creates a dilemma for corrections staff. In order to maintain the regulated environment necessary to keep the prison and jails safe, the mentally ill are punished like any other inmate would be when they break the rules (Steinberg 2015). This is true even if it is apparent that the individual's violation of the rules was due to his mental illness (Fellner 2006). In almost any other setting attempts would be made to accommodate for their mental illness. For example, in the workplace, individuals suffering from a mental illness are not punished because of their disability, instead under the ADA employers must make accommodations to increase and maintain the individuals job performance. However, while incarcerated if they continue to break the rules, and they often will due to their mental illness, the inmates are then either moved to higher security units in the prison, or are put in isolation or segregation, ultimately extending their incarceration and exacerbating their mental illness (Fellner 2006). A study by Torrey, Kennard and Eslinger showed that in the state of Washington mentally ill inmates only made up 19 percent of the inmate population, but they were

responsible for 41 percent of the documented infractions (Torrey et al. 2010).

Across the country there are also a disproportionate number of mentally ill inmates in segregation (Fellner 2006).

“In Florida’s Orange County Jail, the average stay for all inmates is 26 days; for mentally ill inmates, it is 51 days. In New York’s Riker’s Island Jail, the average stay for all inmates is 42 days; for mentally ill inmates, it is 215 days.” (Torrey et al. 2010)

Another reason the mentally ill cost more to incarcerate is that, while they are in custody, they require costly psychotropic medication and other treatment, and often the corrections system is not set up to accommodate that treatment. For instance, in 2009 a survey of Michigan prisons found that 65% of inmates who were showing signs of severe mental illness had not received treatment in the previous year (Fries 2010). In Texas, the annual cost to house a mentally ill inmate ranges from \$30,000 to \$50,000, which is between \$8,000-\$22,000 more expensive than non-mentally ill inmates (Torrey, Kennard and Eslinger 2010). In Washington the average prisoner costs \$30,000 a year, and the most seriously mentally ill cost the state \$101,000 per inmate (Torrey, Kennard and Eslinger 2010). Torrey, Kennard and Eslinger also found that, in 2002, prescription medication costs for mentally ill inmates in an Ohio prison had grown to exceed the cost of feeding all inmates (Torrey, Kennard and Eslinger 2010). Another large group of costs for correction systems are psychiatric evaluations and

examinations. In Palm Beach County for example, one individual cost the state more than \$98,000 over 40 months because he was required to have a \$2,000 psychiatric exam each time he was arrested (Torrey, Kennard and Eslinger 2010). The rising cost to incarcerate mentally ill individuals is further exacerbated by the fact that the mentally ill are more likely to violate their probation or parole on technical violations, or return to prison or jail because they have been rearrested for committing new crimes.

As discussed earlier, state and community mental health services tend to be underfunded, bureaucratic nightmares that are largely inaccessible to the poorest mentally ill persons. This is particularly the case for mentally ill people recently released from prison or jail (Torrey, Kennard and Eslinger 2010). As a result, the criminal justice system becomes a sort of revolving door for the mentally ill. A perfect example is in Florida where a jail defined “frequent fliers” as individuals who had at least ten prior incarcerations in a 5-year period. The staff of the jail mental health unit and mental health professionals in the local community knew almost 50 percent of the frequent fliers (Torrey et al. 2010). The same is true across most of the country, where surveys show that mentally ill individuals constitute at least half of all frequent flyers (Torrey et al. 2010).

For example, a study by Amy Wilson looked at 20,000 inmates after a 4-year period upon release from the Philadelphia County jail system and found that 54

percent of those with severe mental illness returned to jail while 68 percent of those with co-occurring issues did (Wilson 2011). Not only are the mentally ill more likely to get caught in the revolving door of the criminal justice system, but research also shows that individuals with co-occurring disorders are more likely to experience unemployment, poverty, homelessness, hospitalization and chronic health conditions upon their release (Kubek 2011).

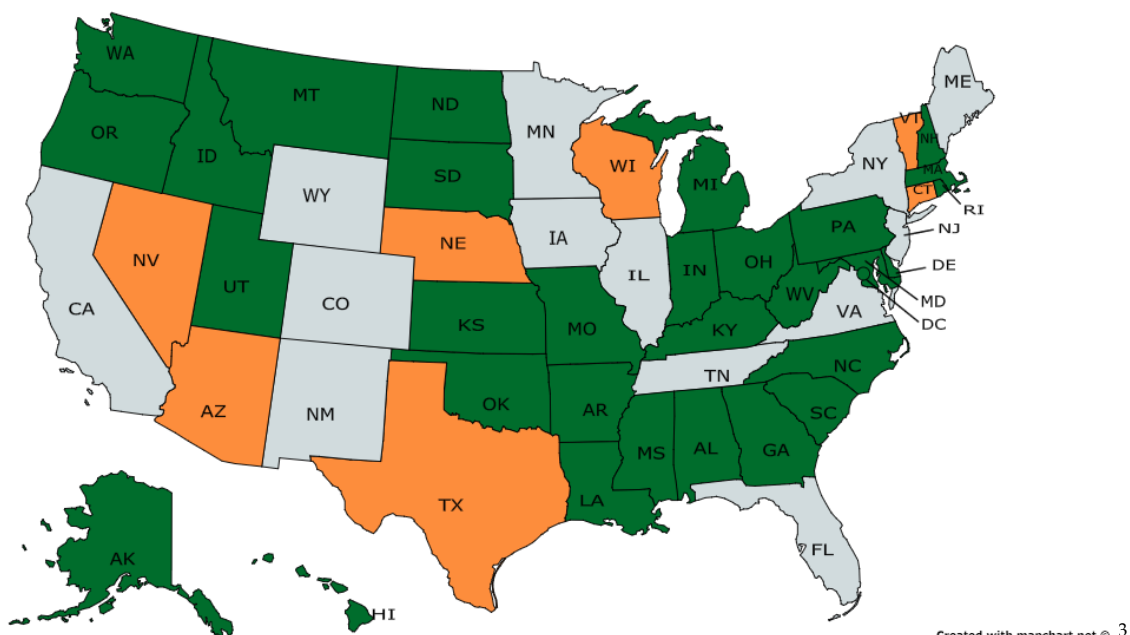
The epidemic of mass incarceration in the United States has become one of the most pressing economic and social problems our country has faced in the last three decades. During the 1960's and 1970's, deinstitutionalization reduced money for state mental health services while reductions in federal expenditures for social welfare programs in the 1990's left mentally ill individuals few treatment options or other social services. The result was a massive influx of mentally ill individuals into the criminal justice system (Thomas 1998). Justice reinvestment was born out of the mass incarceration crisis, with scholars arguing that the money spent on incarcerating such enormous numbers of people could be better spent investing in the communities that the corrections system was set up to protect in the first place (J. Burch 2011). This notion of investing in communities to prevent future prison growth is exactly what proponents of deinstitutionalization envisioned more than 40 years ago when they hoped to

shift mental health treatment from large state institutions to smaller more localized community health programs.

CHAPTER III

JUSTICE REINVESTMENT IN THE UNITED STATES

As of the end of 2015, 36 states have worked on various justice reinvestment efforts, including 31 states that are either currently part of the federal JRI or are actively working towards joining the JRI (JRI Sites 2016).²



The JRI is a public-private partnership between the BJA and the Pew Charitable Trusts (Pew) that gives technical assistance and financial support to states' criminal justice reform efforts (LaVigne et al. 2014). "Under the JRI model, a

² The following 36 states have participated in justice reinvestment efforts: Alabama, Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Missouri, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, West Virginia, and Wisconsin.

³ States in orange undertook justice reinvestment efforts prior to the 2010 launch of the JRI.

bipartisan working group comprising key policymakers uses comprehensive data analyses to identify the drivers of the local corrections population and costs and foster support for a set of cost-effective policy options addressing those drivers” (LaVigne et al. 2014).

The justice reinvestment movement had begun several years before the BJA funded the JRI, but from its earliest stages the ultimate goal has always been to reduce reliance on incarceration, and to promote safer communities and stimulate economic growth through reinvestment in neighborhoods with high concentrations of residents revolving through the criminal justice system.

The Origins of Justice Reinvestment

Tucker and Cadora first coined the term “justice reinvestment” in a paper written in 2003 for the Open Society Foundation (Brown 2012). Soon after Tucker and Cadora coined the phrase, the non-governmental organization (NGO) Council of State Governments (CSG) Justice Center took hold of the idea and, since 2006, has become the main body for justice reinvestment implementation in the United States (Brown 2012). Justice reinvestment efforts turn on the idea that the fundamental problem with the criminal justice system is resource allocation. To that end, justice reinvestment efforts seek to reduce crime, lower rates of recidivism and create safer communities in the most efficient and least costly way possible. Justice reinvestment is comprised of multiple strategies and is a

multi-stage process that assists local agencies in working together to reduce the underlying causes of criminal justice costs (LaVigne et al. 2014).

Justice reinvestment initiatives traditionally comprise four main phases: 1) “mapping:” an analysis of the corrections population and of relevant public spending in the communities to which people return from prison, 2) engagement of legislatures and policy-makers to generate a list of policy options to forecast financial savings and increase public safety, 3) implementation of the policies and reinvestment in high-risk populations, and 4) analysis of the implementation and evaluation of the impact (LaVigne et al. 2014). Justice reinvestment’s driving philosophy is that resources currently devoted to incarceration would likely be better spent on reducing the occurrence of crime at the source, the highest risk communities. This applies in particular where budgets are already limited, and the opportunity cost of incarceration is taking away funding from much-needed community resources.

Justice reinvestment efforts rely on economic and data-driven modeling for validity (Fox 2013). This rational and economically centered approach was one of the most appealing aspects of early justice reinvestment efforts and made bipartisan legislative support a reality (Fox 2013). For these reasons, justice reinvestment efforts were initially most concerned with so-called “million dollar blocks” where cycles of incarceration, release, and reincarceration had been most

pronounced, costing millions of dollars each year to incarcerate high proportions of working-age males (Tucker 2003). These neighborhood-based efforts set the stage for researching the trade-offs between locally concentrated incarceration spending policies, and alternative investment programs that could instead promote returns in public safety, strengthen community resources, and create safer neighborhoods (Austin 2013). When Tucker and Cadora first wrote about justice reinvestment, they made clear that the cyclical incarceration of people was a critical factor in the mass incarceration crisis facing the criminal justice system (Tucker and Cadora 2003).

98 percent of these persons will return to the community—630,000 annually—and two-thirds will end up back in prison. One-third of those released return to prison not because of new crimes but because of violations of their parole—missed office appointments, positive drug test results, or breaches of curfew. In California, 65 percent of new admissions are for parole violations, which cost the state \$1 billion annually (Tucker and Cadora 2003).

Tucker and Cadora based the justice reinvestment model on the idea that the prison, parole and probation systems were simply business failures (Tucker and Cadora 2003). If mass incarceration was supposed to be making communities safer, Tucker and Cadora claimed that not only was it failing, it was bankrupting communities at the same time (Tucker and Cadora 2003).

Recent research by criminologists Todd Clear and Dina Rose indicates that high levels of concentrated incarceration make a neighborhood less safe not more. The “coercive mobility” of cyclical imprisonment disrupts the fragile economic, social, and political bonds that are the basis for informal social

control in a community. The cumulative failure of three decades of prison fundamentalism stands out in sharp relief against the backdrop of today's huge deficits in state budgets (Tucker and Cadora 2003).

It was this idea, that justice reinvestment not only made economic sense but that it could also create safer communities, that helped spur the growth of the justice reinvestment movement over the course of the next decade.

Early Implementation of Justice Reinvestment

One of the earliest successful implementations of a justice reinvestment effort took place in Oregon in 1998.

In 1998, Oregon introduced an incentive-based justice reinvestment model for reducing juvenile incarceration. The experiment was based on state legislation that awarded a block grant to Deschutes County in the amount that the state was spending to incarcerate juveniles from the county each year. The County was free to spend the annual grant as it saw fit with the proviso that it would be 'charged-back' the cost of incarcerating juveniles who were sent back to the state. The charge-back system resulted in a 72 percent drop in juvenile incarceration from the county, redeployment of community supervision in the highest resettlement community, and leveraged new investments in civic service and neighborhood revitalization. Soon after, this model was emulated in Michigan and Ohio, which also saw substantial drops in the use of institutionalization of juveniles and the strengthening of local infrastructure (Cadora 2007, 12).

Following in the footsteps of successful juvenile programs in Oregon, Michigan and Ohio, in 2002 Connecticut used a justice reinvestment model for the first time on an adult population (Cadora 2007). Facing serious budget strains and a prison population crisis, public officials in Connecticut reached out to the CSG for technical support to analyze data about their prison growth and the places

from which people in their prison system were coming (Cadora 2007). CSG documented a trend in the Connecticut criminal justice system that was occurring across the country; the primary driver in prisoner population growth was probation and parole violations that were causing individuals to stay in the system longer and costing the state more money (Cadora 2007). Furthermore, much like in the rest of the country, almost half of the prison population in Connecticut came from a group of neighborhoods in three cities across the state, including one neighborhood that alone was costing the state \$20 million a year, \$6 million of which came from probation violators (Cadora 2007).

Local and state officials united around recommendations made by the CSG research team, and in 2004 passed the *Act Concerning Prison Overcrowding*, which created comprehensive community reentry plans, and reduced probation revocations (Cadora 2007). The passage of the Act diverted funds that would have gone to the state of Virginia to house 2,000 of Connecticut's inmates, and instead reduced the corrections budget by \$30 million, and reinvested \$13 million in community planning resources (Cadora 2007). The \$13 million supported increasing the capacity of the Department of Mental Health and Addiction Services, providing more community outreach and treatment, and implementing new probation programs that focused on prisoner reentry and better responses to technical probation and parole violators (Cadora 2007). The

funds also reduced probation officer caseloads by adding nearly 100 new officers (Cadora 2007).

As a result, Connecticut went from having one of the fastest growing prison systems in the country, to one of the fastest shrinking systems (Cadora 2007).

Not only did the state not have to ship prisoners out of state or open new prisons, but the prison population also shrank (Cadora 2007). These initial successes lead to other states becoming increasingly interested in justice reinvestment and eventually led to federal funding by the BJA in 2010.

The JRI Today

Following the success of earlier justice reinvestment initiatives, in 2010, the BJA, with funding appropriated by Congress and partnered with Pew, launched the JRI (What is JRI 2015). The JRI currently uses the following language to define “justice reinvestment:”

Justice reinvestment is a data-driven approach to improve public safety, reduce corrections and related criminal justice spending, and reinvest savings in strategies that can decrease crime and strengthen neighborhoods. The purpose of justice reinvestment is to manage and allocate criminal justice populations more cost-effectively, generating savings that can be reinvested in evidence-based strategies that increase public safety while holding offenders accountable. States and localities engaging in justice reinvestment collect and analyze data on drivers of criminal justice populations and costs, identify and implement changes to increase efficiencies, and measure both the fiscal and public safety impacts of those changes (LaVigne et al. 2014).

The number one priority for the JRI is to reduce spending on corrections and increase public safety (LaVigne et al. 2014). Secondly, JRI states should be reinvesting savings into programs that increase public safety, such as community-based treatment programs, prevention-oriented policing strategies and community-based recidivism reduction efforts (LaVigne et al. 2014). As of 2015, the expectations for the JRI are the following:

JR will (1) reduce costs, (2) increase the use of evidence-based programming, (3) expand the use of a broader range of correctional and other options to reduce crime and offending behaviors, and (4) reduce the harms associated with existing crime control and prevention policies. If these goals are to be achieved, improving the quality of correctional programming and reallocating resources to relevant social and community services needs to be a priority of JR practices (LaVigne et al. 2014).

For states to participate in the JRI and receive federal funding for their justice reinvestment programs, they must comply with the JRI's implementation process.

Becoming a JRI State

After a state expresses interest in the JRI, a JRI technical assistance (TA) provider conducts a preliminary assessment before recommending whether the state is selected as a JRI site (LaVigne et al. 2014). The TA provider makes site visits, speaking with key policymakers such as the governor's staff, attorneys general, corrections leaders, legislators, and members of the judiciary to familiarize them with JRI and assess the state's interest in participating. The TA

provider then decides whether the goals of state's leadership align with those of the JRI, specifically evaluating the suitability of potential JRI sites by six criteria:

(1) Commitment of state leadership to JRI, as evidenced by a letter of interest signed by key state leaders that includes a well-articulated and compelling problem statement addressing the state's need for justice reform; (2) commitment to information sharing and demonstration of sufficient data capacity to support analysis, including information on criminal justice populations and outcomes, such as arrests, average daily prison population, admissions and length of stay, and revocation rates; (3) participation of an influential leader or leaders to drive systems change and interagency collaboration; (4) existence of information, data, and personnel infrastructure to support the comprehensive data analysis and execution of JRI; (5) a system wide partnership in the form of an interbranch and bipartisan working group, or plans to develop such an entity; and (6) knowledge about and use of EBPs demonstrated through previous EBP implementation activities (LaVigne et al. 2014).

In addition, states are assessed for their overall need for JRI, with a particular focus on those states that have had significant increases in corrections populations and costs. After the BJA and Pew approve a state, they receive in-depth technical assistance for establishing a JRI working group, engaging stakeholders in JRI, analyzing data, and developing policy options.

The state begins the process by creating an interbranch and bipartisan working group comprising policy-makers and justice system leaders (LaVigne et al. 2014). The JRI heavily emphasizes the bipartisan and broad-based nature of the working groups. Working groups are formed through a variety of

mechanisms such as statute or appointment, or an established criminal justice committee or commission (LaVigne et al. 2014).

The state then works with its TA provider to conduct a comprehensive analysis of its criminal justice data, identifying corrections population and cost drivers (LaVigne et al. 2014). The state reviews 5 to 10 years of data from a wide variety of sources across the justice system to carry out this analysis (LaVigne et al. 2014). The analysis includes case-level data on arrests, convictions, attributes of offenders, jail and prison admissions, the length of stay and release data, probation and parole revocations and outcome measures from existing programs (LaVigne et al. 2014). After working through multiple rounds of analysis, the working group develops policy options.

The TA provider and working group members develop practical, data-driven policy options and review the projected impact of the choices on the justice system's population and costs (LaVigne et al. 2014). Working group members meet regularly during policy development to narrow the set of policies to best fit the state's specific criminal justice systems needs (LaVigne et al. 2014). State-specific frameworks are essential for addressing the unique challenges faced by each state and for garnering broad bipartisan support (LaVigne et al. 2014). Through this deliberative process, working groups arrive at a consensus

regarding the proposed policies and develop a set of recommendations for legislative consideration and enactment (LaVigne et al. 2014).

The passage of the proposed policies varies among JRI states, but throughout the codification process, states work with TA providers to educate policymakers, stakeholders, and the general public about the JRI process and any legislative proposals through briefings, presentations, and media outreach (LaVigne et al. 2014).

Passage of legislation, while a critical and significant step, is by no means the end of the justice reinvestment process. It is crucial that the legislated policy changes be implemented as intended, and to that end, as part of the JRI, the BJA also funds TA providers to assist states in implementation planning and provides supplemental awards for state implementation efforts (LaVigne et al. 2014). Once an implementation plan is in place, states prepare for implementation by identifying primary needs such as training and stakeholder education. In consultation with TA providers, states adopt tools like risk and needs assessment instruments and training modules, such as Effective Practices in Community Supervision, to support the implementation of JRI policies (LaVigne et al. 2014).

Finally, states reinvest in their justice systems by estimating the amount of cost savings generated by policy reforms and earmarking a portion of those

savings to invest in evidence-based public safety strategies and programs. States may opt to make an upfront investment before savings are realized or may reinvest actual savings (LaVigne et al. 2014). The upfront investment typically is appropriated in the same year that JRI legislation passes.

To support the accountability and sustainability of JRI policy efforts, states work with TA providers to develop a dashboard of justice system performance metrics. The dashboard is designed to help policymakers track the impact of enacted legislation on jail and prison populations, crime and incarceration rates, recidivism rates, parole and probation revocations, and justice system costs after technical assistance ends (LaVigne et al. 2014).

The JRI sets out parameters for implementation, but every state has almost complete autonomy to create the most appropriate justice reinvestment strategy for their state.

Oregon Opts into the JRI

“Between 2000 and 2012, Oregon's prison population increased nearly 50 percent, with a biennial corrections budget of more than \$1.3 billion in 2012” (Criminal Justice Commission Justice Reinvestment 2015). Without action, Oregon's prison population was projected to grow by 2,000 inmates in the next ten years, at a projected cost to taxpayers of an additional \$600 million (Pew Charitable Trusts 2013).

In May 2012, Oregon joined BJA's Justice Reinvestment Initiative (JRI) and the Commission on Public Safety was reconvened with an expanded membership. The PEW Center for the States provided technical assistance to the Commission and the CJC staffed it.

The work of the 2012 Commission on Public Safety culminated in a final report to the Governor. The report examined the key drivers of the state's growing corrections budget and resulted in several policy recommendations to the legislature (Oregon 2015).

With technical assistance provided by the JRI, it was determined that "the increased use of prison for less serious offenses or violations of community supervision, longer lengths of stay and gaps in evidence-based practices in community corrections were driving the growth of the prison population" (Oregon 2015).

During the 2013 legislative session, the Oregon legislature passed House Bill 3194 that created a Justice Reinvestment Grant Program with the goal of distributing savings from averted prison growth into community-based programs and increased funding for community-based victim services programs (Oregon 2015). The stated goals of HB 3194 are to reduce recidivism, decrease counties' utilization of incarceration in Department of Corrections institutions, protect the public, and increase offender accountability (Oregon 2015). The Justice Reinvestment Program is projected "to reduce Oregon's prison population by 870 inmates, saving \$326 million in averted costs by 2023" (Oregon 2015).

Following the passage of HB 3194, Oregon was accepted into Phase II of the JRI in December 2013. This phase of the JRI focuses on the implementation of HB

3194. Oregon was awarded a total of \$15 million in its first JRI grant fund allocation, and those funds were distributed to all 36 counties in the state by January of 2014 (Oregon 2015).

The only specific monetary requirement placed upon the counties that receive JRI funds is that they must spend 10% of their grant funds on community-based victim services. Outside of that requirement, counties applying for funds must only specify how they plan to address the four stated goals of HB 3194. Oregon, through its Criminal Justice Commission, does an excellent job of tracking counties' success with their implementation of JRI efforts. However, Oregon, like every other state that is currently participating with the JRI, does not place any specific emphasis on improving monitoring of mentally ill individuals in jail, prison, or on parole and probation, nor does it require counties to look at ways to improve how the mentally ill are handled by the corrections system. That is not to say that no money is going towards those goals because several counties in Oregon have made efforts to address mental health issues with their JRI funds.

Unfortunately, a piecemeal county-by-county approach to addressing the mentally ill in the criminal justice system will not suffice. There are currently no states participating in the JRI that place an explicit importance on the mentally ill, and the JRI programming does not specifically mention the mentally ill as a factor in the incarceration epidemic.

CHAPTER IV

TAKING THE NEXT STEP

One of the keystones of justice reinvestment efforts is the use of data mapping to determine communities that are most adversely affected by cycles of mass incarceration (Tucker and Cadora 2013). The “million dollar blocks” model that inspired Tucker and Cadora’s (2013) early justice reinvestment work has shifted the conversation about reducing mass incarceration in the right direction. However, if the ultimate goal is to create savings by lowering the incarceration rates of over-criminalized populations, reducing the lengths of sentences, slowing new arrests, and lowering recidivism rates, then focusing on “million dollar blocks” is too simplistic an approach, and is limiting the positive impact that the JRI could be having. In order to fully realize the potential of the JRI the BJA must begin addressing the impact that the mentally ill are having at every stage of the criminal justice system.

The BJS statistics about mentally ill prisoners are only rough estimates, because prisons and jails across the country are notoriously bad about agreeing about what constitutes mental illness and tracking the individuals that they determine are mentally ill (Toch 2007; Veysey & Bichler-Robertson 2002). The JRI cannot solve the mental health crisis in the criminal justice system, but it is in a perfect position to start creating the foundation that will lead to major criminal

justice reform in this area. The current JRI model is like a large ship in the ocean that left the harbor dragging its anchor. The ship is heading in the right direction, and might eventually reach its goal, but if the JRI pulls its anchor up and starts prioritizing the mental health crisis, it will reach its destination more quickly and efficiently.

Steps That Can Be Taken

The JRI has a finite budget, and cannot fund the overhaul of every state's criminal justice system, nor can it realistically be expected to improve mental health services in participating states. The following proposals however are well within the current framework of the JRI and should significantly improve our understanding of the impact of the mentally ill on the criminal justice system and how to better address their needs.

First, because it is currently so difficult to accurately determine the number of mentally ill individuals in the criminal justice system, the first step that the JRI should take is requiring participating states to adopt a set of uniform screening and assessment guidelines. This should not be overly difficult to implement. Incarcerated individuals are already going through intake screenings when they enter jails and prisons. By having a uniform set of screening and assessment guidelines, each state can start to more accurately track the number of mentally ill individuals in their correctional systems. The JRI is uniquely positioned to

make this a reality because every participating state already has in place a bipartisan working group consisting of legislatures and representatives of the corrections system. Those groups are critical, because they allow legislation to be more easily crafted that would implement the uniform screening requirements. This is a critical step for the JRI, because without uniform information, it is difficult to accurately determine the costs savings that mental health initiatives will provide.

Second, the traditional barriers between the criminal justice and mental health systems must be transcended through the creation of cross-disciplinary approaches for the case management and care of mentally ill individuals. The criminal justice and mental health systems must start proactively working together to break the incarceration cycle into which mentally ill individuals disproportionately fall. The creation of an interagency communication network would allow for better treatment of offenders both within the criminal justice system and upon their release to community service providers. States' representatives from the Department of Corrections (DoC) are already involved with the JRI, now representatives from the Department of Mental Health (DMH), and other community mental health providers must be brought into the JRI efforts. Mentally ill offenders will need transitional care upon their release from incarceration, but they and the system would also be better served if in the event

of reincarceration the agencies were communicating the needs of the mentally ill offender to one another.

Third, transitional continuing care for mentally ill individuals leaving incarceration must be improved. If the JRI is about investing in communities that are hardest hit by the mass incarceration crisis, then more funding must be focused on the mentally ill who have recently been released from prison and are homeless. A large number of mentally ill offenders are leaving incarceration and returning to a life either on the streets or living from shelter to shelter. These individuals are not only vulnerable to their mental illnesses, they are highly visible to the police and are likely to be rearrested just because they are homeless and mentally ill. The cycle of release and rearrest is costly to the criminal justice system, and detrimental to the mentally ill individual. The JRI is the perfect body to improve linkages between recently released mentally ill individuals, and the community mental health services they will require to keep from becoming recidivism statistics. The JRI should incentivize the DoC, DMH and community mental health providers to coordinate their efforts and provide a comprehensive transitional care system for mentally ill offenders.

Fourth, the JRI should incentivize law enforcement agencies cross training with mental health experts. Historically, law enforcement agencies have not worked closely with mental health experts and there has been little joint

planning or training across the fields (Munetz and Griffin 2006). Police officers have considerable discretion in resolving interactions with people who have mental disorders (Munetz and Griffin 2006) and so it is critical that the JRI incentivize law enforcement to become as well educated about mental illness as possible. While several strategies are being developed across the country in this area, I am less concerned with how law enforcement agencies ultimately implement their strategies to deal with mentally ill offenders, and more concerned with the JRI making it a prerequisite for state funding, or at least incentivizing these cross-agency trainings.

CHAPTER V

CONCLUSION

The epidemic of mass incarceration in the United States has become one of the most pressing economic and social problems our country has faced in the last three decades. Justice reinvestment was born out of the mass incarceration crisis, with scholars arguing that the money spent on incarcerating such enormous numbers of people could be better spent investing in the communities that the corrections system was set up to protect in the first place (Burch 2011). This notion of investing in communities to deter future prison growth is exactly what proponents of deinstitutionalization envisioned more than 40 years ago, when they hoped to shift mental health treatment from large state institutions, to smaller more localized community mental health programs.

The JRI is a new approach to criminal justice and is moving the conversation of mass incarceration in the right direction, but its failure to recognize the role that mental illness plays in incarceration and recidivism levels is unacceptable. In order for the JRI to continue moving states' correctional systems in the right direction, it must begin to address the role that mental illness plays in every facet of the criminal justice system. The role of the JRI is not to fix the mental health crisis facing our correctional systems, but it is in the perfect position to begin

investing in understanding and addressing the needs of the mentally ill in the criminal justice system, and that is a step that it must take.

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