The Importance of Eliminating the Dual Self-Stigma of Having a Criminal Record and Mental Illness

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On my honor as a University Student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments

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I. Introduction

According to a national survey conducted in 2016, 43% of state, and 23% of federal, prisoners reported a history of serious mental illness (SMI) (Maruschak et al., 2021). According to the National Institute of Mental Health, SMIs are a subset of conditions which have been defined as "diagnosable mental, behavioral, or emotional disorders that cause serious functional impairments and substantially interfere with one or more major life activities". If left untreated, SMIs may impair daily functioning, and individuals who participate in treatment interventions are less likely to return to custody than those who reject or discontinue these services (Martin et al., 2012). Further, according a study conducted by the Treatment Advocacy Center's Office of Research and Public Affairs, individuals with untreated mental illnesses are 16 times more likely to be killed during an encounter with law enforcement than other civilians (Fuller et al., 2015).

In addition to structural barriers, such as unavailability of services, that act as obstacles to receiving mental healthcare, there are many social barriers which deter criminally-involved individuals from seeking treatment in a correctional setting. Male prisoners tend to underreport emotional problems and often avoid seeking help until a psychological crisis forces them to (Kupers, 2005). There is also a limited level of confidentiality in correctional settings, as many facilities require counselors to report all disclosures of potential harm (Kupers, 2005). Despite the prevalence of SMIs in correctional settings, many treatment interventions are unsuccessful because their framework clashes with prison and jail "culture" (Martin et al., 2012).

II. Background Significance

Upon an individual's arrest at the Albemarle-Charlottesville Regional Jail (ACRJ), detainees take the Brief Jail Mental Health Screen (BJMHS): a booking tool developed by the Policy Research Advocates (PRA) that is used to identify individuals whose behavior may be attributed to a SMI. Depending on their BJMHS responses, detainees may be referred for further evaluation to receive counseling and/or medication. For many, the BJMHS is the first indicator of the presence of a SMI. According to the ACRJ leadership team, at least 30% of the facility's inmates are currently coping with a SMI; however, this figure is a known underestimate since many individuals have developed coping mechanisms which allow them to conceal their symptoms (Personal Communication, 2022).

Despite the fact that, as of Fall 2022, the costs of these services were covered by ACRJ, many individuals either reject, or discontinue, these free mental healthcare services (Personal Communication, 2022). A study in 2005 found that, despite the prevalence of SMIs within criminal justice settings, having a mental illness was an extremely stigmatized trait (Kupers, 2005). In order to supplement existing research on the structural barriers that can affect a person's ability to *access* mental healthcare, this paper seeks to investigate which social factors may influence an individual's *decision* to access mental healthcare.

Similar to individuals with a criminal record, the most prominent stereotypes surrounding individuals with mental illness are: dangerousness, unpredictability and unreliability (Rossler, 2016). In truth, there is no reliable way to directly link a mental health condition to acts of violence or criminal activity (Rueve & Welton, 2008). The public's understanding of individuals with these intersecting identities determines the survivability of mental healthcare initiatives in criminal justice settings. This fact magnifies the loss of control that is characteristic of a

correctional order. With this in mind, how can individuals with a mental illness and criminal record begin to eliminate self-predjudices? What resources would help this population become more resilient despite the discrimination they may face from the public?

III. Methodology

In order to answer these questions, I conducted an extensive literature review of the stigma research that is currently available. Literature reviews allow researchers to have a more conversational relationship with their sources, and I used these conversations to identify the recommendations that are most applicable to the population of interest. I analyzed the findings of these papers according to how applicable the recommendations are to people who have both a mental illness and a criminal record. I also focused on sources which address self-stigma, specifically. I then evaluated these sources and formulated an argument according to an Ethics of Care theoretical framework. The Ethics of Care moral theory acknowledges imbalances of power within a system and attempts to bring attention to individuals who have been made vulnerable by their condition(s) (Taylor, 2020). In contrast to utilitarianism, which often regards such vulnerable populations as “disposable”, the Ethics of Care theory asserts that the complexity of relationships between actors requires an additional level of understanding and empathy.

There is little information on how to address the intersectionality of these highly stigmatized identities. Individuals with a mental illness and history of criminal-involvement may benefit from a set of stigma-eliminating recommendations that are both actionable and non-patronizing. For example, although Rusch et al., and other existing sources, recommend “direct contact” as a method for gradually dissolving the public’s stigma of mental illness, the

population of interest (i.e. individuals with a criminal record) largely consists of individuals that have intentionally been separated from the rest of the general public (Rusch et al., 2005). Additionally, this recommendation focuses mainly on eliminating public stigma, so the autonomy of the "targeted" individual is never considered. Removing self-stigma is important for supporting rehabilitation and eliminating the "Why Try" phenomenon (Corrigan et al., 2009). Although it is true that internalized stigma emerges as a result of exposure to public stigma, engaging with methods of reducing self-stigma may have a more impactful effect on rebuilding an individual's sense of self-efficacy.

IV. Results

A. A History of Mental Illness Stigma

During the Middle Ages, individuals with mental illnesses were believed to be possessed by the Devil and were either killed, imprisoned, or tortured (Rossler, 2016). Although institutions were established to care for mentally ill patients during the Enlightenment, stigmatization and discrimination reached yet another peak during the Nazi reign in Germany when thousands of people with mental illnesses were either murdered or sterilized (Rossler, 2016).

Following World War II, the Deinstitutionalization Movement began shifting resources away from American psychiatric hospitals in an attempt to better support local community mental health centers (Lurigio, 2000). Although this effort succeeded in reducing the number of patients within psychiatric hospitals across the nation, alternative mental healthcare centers were never created (Torrey, 1997). Individuals in need of public mental healthcare services were

suddenly left without access to support networks that were valuable to help them cope with their conditions (Lurigio, 2000).

As a result, since law enforcement is often tasked with deescalating mental health crises, “mercy bookings” became common practice within the criminal justice system (Torrey, 1997). Charges are often based on behaviors, such as paranoia or grandiosity, that are directly related to untreated symptoms of certain mental illnesses (Rueve & Welton, 2008). Although some of these arrests are made in an attempt to protect the individual from further harm and connect them to mental healthcare resources, these arrests forever attach a criminal record to the detainee’s identity and may further isolate them from the supports that are key to their rehabilitation (Seltzer, 2005). Individuals with mental illnesses are frequently criminalized and are now currently overrepresented in the national inmate population (Torrey, 1997). What’s worse, highly-sensationalized portrayals of violence due to mental illness in the media often skews the public’s understanding of mental illness and further isolates the the population of interest (Rueve & Welton, 2008).

B. Conceptualizing Stigma

Link and Phelan’s conceptualization of stigma describes the process of developing, and internalizing, generalized stereotypes. This model also acknowledges the implications of discrimination and provides a useful guide to evaluate any future recommendations that attempt to remove stigma (Link & Phelan, 2001). According to their definition, stigma describes a labeled difference that a more powerful, privileged group associates with a negative attribute (Link & Phelan, 2001). Many social psychologists agree that stigma can be broken down into three general categories: public, systemic/institutional, and internalized/self (Vogel et al., 2013).

Public stigma describes negative attitudes held toward individuals who share a particular characteristic (Link & Phelan, 2001). Discriminatory, systemic stigma categorizes policies, or systems, which intentionally limit opportunities for individuals that share a specific characteristic (Rusch et al., 2005). Finally, self-stigma, which is best represented in terms of a process, describes negative thoughts, or internalized shame, about one's own identity (Vogel et. al, 2013).

The self-stigma process begins with stereotype awareness: the perception that others hold negative beliefs about one's identity status (Corrigan et al., 2009). If a person accepts stereotypes as being an accurate description of the group, stereotype agreement occurs (Corrigan et al., 2009). Perceived stigma and stereotype agreement can have negative consequences if stereotypes become internalized (Corrigan et al., 2009). Stereotype concurrence occurs if individuals then determine whether or not those stereotypes hold true for the self; accepting a negative stereotype as a true description of the self results in internalized stigma (Vogel et al., 2013). In summary, people who internalize stigma are thought to perceive stigma from the public, agree with negative stereotypes about their identity group, and believe these stereotypes accurately reflect the self (Corrigan et al., 2009). Therefore, even the mere anticipation of discrimination due to stigma can be harmful even when stereotypes are not internalized (Corrigan et al., 2009).

Criminal record stigma is associated with a lower quality of life, withdrawal from the public and secrecy of one's status as a coping mechanism (McWilliams & Hunter, 2021). Although McWilliams and Hunter's 2021 study found low levels of internalized criminal record stigma among participants, individuals with mental illnesses were found to have higher levels of self-stigma (Corrigan & Rao., 2012). Self-stigma is harmful because it may lead to the "Why Try" Effect and prevent an individual from attaining their goals (Corrigan et al., 2009).

Diminished self-esteem and self-efficacy can lead someone to believe they unworthy of opportunities and incapable of achieving goals and living independently (Corrigan et al, 2009). Following completion of a correctional program, the “Why Try” mentality may hinder someone’s ability to reenter society. However, recovering someone’s sense of self-efficacy and esteem has the potential to reduce the harmful effects of self-stigma (Corrigan et al., 2009).

Stigmatized groups are also at a greater risk of developing physical health problems than non-stigmatized groups (Major & O’Brien, 2005). Although this may be attributed to a stigmatized group’s limited access to quality healthcare services, heightened cortisol levels due to stress in anticipation of discrimination can have many negative physical effects over time (Major & O’Brien, 2005).

The public’s perception of criminally-involved people with mental illnesses can affect health outcomes in more ways than one. First, the public’s understanding of mental illness can indirectly impact the survival of mental healthcare programs in the criminal justice system via voting and funding directives (Rossler, 2016). Further, public perception of those with a criminal record has the potential to limit opportunities for reintegrating into society (McWilliams & Hunter, 2021). Second, the perceived stigma directed at an individual can affect their own self image, affecting both their physical and emotional wellbeing (Major & O’Brien, 2005). This is further demonstrated by the research focuses of the few publications that do acknowledge the intersectionality of criminal record and mental health status; most focus their attention on the destigmatization of individuals who have either been convicted of less serious crimes or diagnosed with more serious mental illnesses (Lurigio, 2000).

This dynamic brings the following questions to the forefront: are individuals coping with mental illnesses who commit serious/violent crimes less deserving of mental healthcare? How can the populations of interest address the double stigma of having a mental illness and criminal record? How can society begin to return autonomy to justice-involved individuals coping with a mental illness?

C. Empowerment: Group Identity & Education

Mittal et al.'s review of 14 different stigma reduction studies found that programs revolving around empowerment and self-acceptance seemed to be the most successful in removing self-stigma (Mittal et al., 2012). In order to avoid the "Why Try" Effect, Corrigan et al. also recommends interventions that focus on altering stigmatizing beliefs and attitudes of the individual (Corrigan et al., 2009). Examples of this include consumer-operated services such as peer mentoring and organized support groups (Corrigan et al., 2009). Participation in support groups aids with the formation of group identity and implies some level of "coming out". Although the physical proximity of in-person interaction provides contexts for experiences of empathy, various technologies, such as specialized mHealth apps, may be used as a tool for connection to overcome the circumstances that limit contact with others (Rao et al., 2015).

Educational programs, or self-paced modules, may allow individuals to better understand their condition and develop necessary coping skills (Corrigan et al., 2009). Since public stigma mainly develops as a result of fear, or lack of understanding, educational programs give individuals a chance to challenge these beliefs at their own pace (Lurigio, 2000). However, a study conducted in 2005 found that educational programs tended to be more effective for participants who already had some knowledge of mental illness prior to beginning (Rusch et al.,

2005). Designers of such programs should also take the audience into consideration before organizing the structure of content. In the 21st century, neurobiological causes of mental illness are predominantly used in educational programs developed by Western psychologists (Rusch et al., 2005). Although this approach is known to successfully reduce shame and self-blame, the focus on biological differences as a factor in mental illness could cause individuals with mental illnesses to be othered further by the public (Rusch et al., 2005).

D. Coping, Coming Out & Self-Esteem

Interventions that enhance skills for coping with self-stigma through improvements in self-esteem and help-seeking behavior are also successful in removing self-stigma (Corrigan et al., 2009). This could be done by forming some sort of group identity via support groups and advocacy work. Participants in these programs reported improvements in self-reliance, coping skills, and feelings of empowerment. (Corrigan et al. 2009). Broadcasting one's experience means educating people about mental illness and fosters a sense of power over the stigma of mental illness and the illness itself. However, openness may bring about discrimination by members of the public. Relapses may be more widely known than preferred, and therefore more stressful, so disclosure may become more isolating. (Corrigan et al., 2015)

V. Discussion

After several years of research on the nature of mental health care in a criminal justice context, Lurigio established several principles of care to guide effective treatment of criminally-involved individuals with SMIs. These principles of care also provide a reliable

framework which can be used to evaluate the recommendations in the previous section according to their applicability to ACRJ and relevance to the population of interest.

Lurigio asserts that criminal justice and mental health systems should coordinate services for criminally-involved individuals with SMIs (Lurigio, 2000). ACRJ is linked to multiple post-release organizations, such as Region Ten Community Services (locally known as "R10", a provider of mental health resources), Offender and Aid Restoration- Jefferson Area Community Corrections (OAR-JACC) and the Blue Ridge Area Coalition for the Homeless (BRACH). Although these organizations are already operating within close conjunction of each other, any changes that are made to the SMI healthcare mode in the future must be a united effort.

On a similar note, these organizations' collaboration has already satisfied another one of Lurigio's principle's: "aftercare planning and linkage must be available for individuals with SMIs released from jails and prisons" (Lurigio, 2000).

Finally, Lurigio also argues that continuous care models with single-point access to services should be implemented for individuals with SMIs–especially those with lengthy records of hospitalization and arrest (Lurigio, 2000). Although ACRJ's treatment plan for individuals with SMIs is well-aligned with the above principles, more work is needed to ensure released-individuals are reintegrated into society in the smoothest way possible.

Social distancing protocols of the COVID-19 pandemic forced many jurisdictions (including ACRJ's) to adopt tech-enabled alternatives to custodial incarceration and connecting to support networks (Reinhart & Chen, 2021). The opportunity to use technology, such as mHealth applications, could potentially increases the resilience of treatment programs in the event that structural barriers, such as lack of transportation or childcare, interfere with care. The

availability, cost, and convenience of eHealth technology indicates great promise for reducing stigma and ensuring individuals continue to engage in care (Rao et al., 2015). However, as society continues to rely on technology for interpersonal connection at an increasing rate, dependence on this technology may also foster increased feelings of loneliness and isolation (Rao et al., 2015).

Some may argue that self-stigma reduction methods make vulnerable populations responsible for taking action against stereotypes that were forced on them by society. However, correctional facilities are designed to take personal autonomy away from inmates; even Home Electronic Incarceration (HEI), which comparably allows some level of agency, still limits when and where an individual is allowed to move within a permitted boundary. With this in mind, it is understandable how these limitations may damage someone's sense of independence and self-efficacy. Ethics of Care theory defines responsiveness as a necessary element of proper care models due to its emphasis on empathizing with a patient's condition and acknowledging the potential of abuse (Tronto, 1993). In this case, being incarcerated can be regarded as the vulnerable trait. The potential for abuse of individuals with this trait has been demonstrated through extreme practices within mental health courts (Seltzer, 2005). While practical in theory, many individuals are coerced into treatment as a condition of release by these courts (Seltzer, 2005). For this reason, many incarcerated, or formally-incarcerated, individuals view all forms of mental healthcare as humiliating, distrust providers of care, and avoid it completely (Kupers, 2005). This example demonstrates how care as an oppressive act is ineffective. Individuals are more responsive to treatment when they feel they have an active role in their care.

VI. Conclusion

Individuals with mental illnesses are arrested at higher rates than that of the general public and often receive longer sentence lengths (Seltzer, 2005). Negative stereotypes which associate mental illness with violence often lead to the criminalization of these individuals. A study conducted in 2000 found that many correctional officers even admit to arresting individuals with mental illnesses as a method to either break the cycle of conflict or help the individual access local mental health resources (Seltzer, 2005).

According to a 2015 study conducted in the United Kingdom, out of 34 barrier scenarios, the top 17% of barriers to mental healthcare indicated by users of mental health services were later categorized as stigma-related treatment barriers (Dockery et al., 2015). Since the United States and the United Kingdom are regarded to be culturally similar, we may extend this finding to themes in the United States. This result was consistent with the findings of Kupers' 2005 study which identified similar themes during inmate interviews in American correctional facilities (Kupers, 2005). These individuals often cited their own self-stigma as a barrier to disclosing symptoms to law enforcement/medical professionals and consenting to treatment (Kupers, 2005). In addition to distrust, and/or lack, of access to healthcare as a result of economic, geographic, and racial factors, stigma is plays a significant role in inhibiting people from seeking/continuing care. Cultural and religious origins of mental illness stigma are still pervasive in our society and are now aided by extreme portrayals of mental health crises in the media (Rossler, 2016).

Although public, or perceived, stigma is usually the source of self-stigma, individuals coping with negative stereotypes should not have to wait for the public's opinion to change in

order to fully benefit from care. Providing criminally-involved individuals with mental illnesses with opportunities for empowerment (i.e. group identity via support groups and coming out) and education may help them begin to eliminate self-predjudices (Corrigan et al., 2009). When implemented under ethical codesign guidelines, technologies, such as mHealth applications, may provide an additional format with which stigma-challenging and treatment can take place (Becker et al, 2014).

According to an Ethics of Care theoretical framework, no one benefits from mental healthcare being purposely withheld from those who have committed violent crimes. How can the population of interest address the dual stigma of having a mental illness and criminal record? Empowering these individuals with the tools needed to eliminate self-stigma may reduce the risk of them avoiding, distrusting, and discontinuing treatment. Since internalized stigma often emerges as a result of stereotype concurrence with public stigma, it may seem more efficient to eliminate public stigma. However, because the size of the audience is larger, it may be more feasible and less time consuming to eliminate approach self-stigma.

Through my research, I have found that there are multiple levels of treatment access that do not solely rely on the medium through which treatment is conducted/received. Obstacles to treatment vary greatly and include both social and structural factors. When considering strategies to overcome these barriers, it is important to consider how care strategies may be percieved by the individual or group recieving treatment. My research on dual self-stigma may provide additional context as to why certain factors may discourage someone from continuing mental health treatment following release from custody. My hope is that these destigmatization

techniques reduce self-stigma and encourage more individuals to seek out mental health resources prior to a mental health crisis.

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