A Social Model of Mental Illness: The Key to Liberating Incarcerated Women From Ineffective Mental Health Treatment

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An assessment of public health literature suggests that correctional institutions have adverse effects on the mental health of prisoners, and this article responds to this issue by putting the current medical model of mental illness as it is applied in the criminal justice system under a critical lens, analyzing how it has proven insufficient in providing better mental health outcomes for inmates with mental illness. An expansion of the social model of mental health is proposed, one that is grounded in the belief that consideration of the social determinants of mental health is paramount to understanding why the mentally ill are disproportionately brought into the criminal justice system in the first place. Furthermore, federal studies have shown that incarcerated women experience mental health conditions at disproportionate rates, despite making up a smaller proportion of the prison population. Explaining this gender disparity has been an emerging area of research in criminal justice and mental health reform, and this article explores it by analyzing how the prison environment perpetuates it, investigating specific social circumstances that are particularly triggering to the mental health of incarcerated women, such as separation from children and increased exposure to sexual abuse and domestic violence. The article concludes with an examination of a case study of how the expanded social model is currently being applied to the specific context of incarcerated women's mental health, demonstrating its effectiveness and advocating for the widespread implementation of similar initiatives.

Keywords

incarceration • mental illness • mental health • criminal justice • social determinants of health • gender disparities • gender-based violence • prison systems

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Hospitals Are Not the Largest Mental Health Provider in the United States—Prisons Are

Dana was 22 years old, spoke in a soft voice with a bit of a country lisp, and stood at barely 5 feet tall. She was described as calm, relaxed, and extremely easy to talk to. She was also a mother and loved her children deeply. However, Dana was found to have taken her own life at the correctional facility she was imprisoned in. Her body was still warm when two correctional officers found her—and yet both of them failed to initiate a life-saving response (Davoren & Mustafa, 2018).

Unfortunately, Dana's story is only one instance of inmate mental health being overlooked, under-attended, and mistreated in the criminal justice system. According to a 2017 report by the Bureau of Justice Statistics, 37% of people in state and federal prisons and 44% of people in locally run jails have been diagnosed with a mental illness (Bronson & Berzofsky, 2017). As these numbers suggest, correctional institutions have essentially become "the largest provider of mental health services" in the United States (Gonzalez & Connell, 2014). However, prisons and jails are simply not suited to be psychiatric facilities. The prison environment has been shown to have negative impacts on the mental health of prisoners, regardless of whether they had a formal mental illness or not (Nurse, 2003). Moreover, a study conducted by a criminal justice reform nonprofit determined that despite the disproportionate mentally ill population in correctional institutions, 66% of people in federal prisons still reported not receiving any mental health care at all while incarcerated (Ring & Gill, 2017).

Given the large volume of evidence that exposure to correctional facilities seems to worsen mental health conditions, there has been a push for initiatives that mitigate this growing issue. Reforms such as crisis intervention teams and mental health courts have been implemented in an attempt to divert the mentally ill from the criminal justice system into community health services at the stage of arrest. Reentry programs have been developed to connect former inmates to social needs and support their reintegration into the community after their release. By the metrics of reduction of recidivism (relapse into criminal behavior) and success of connecting the mentally ill to mental health care, these reforms have proven to be extremely effective. One can observe, however, that these reforms occur at the stages of pre-incarceration and post-incarceration. This begs the question: what is being done to address the mental health needs of prisoners *during* incarceration?

Public health researchers and attorneys have found that most of the mental health treatments that people receive while in prison are primarily grounded in a medical model of mental illness, placing screening and medication at the forefront of care (*Inmates with Mental Illness Tell Their Stories*, 2015; Gonzalez & Connell, 2014). As such, the rising population of mentally ill inmates within the prison system has been attributed not only to the disproportionate rate at which people with psychiatric disabilities are arrested but also to the ineffective mental health treatments that lead to high rates of recidivism (Seltzer, 2005, p. 573; Gonzalez & Connell, 2014). I believe the reason for this effectiveness is that medical approaches to treatment, unlike successful divertive and reentry reforms, overlook a criterion that should be key for criminal justice reform: sufficient removal of an offender from the social circumstances that caused them to be arrested or incarcerated, to begin with.

This negligence of the social determinants of mental health during incarceration is especially prevalent in the treatment of a particular group of people who are often overlooked in conversations surrounding criminal justice, despite being the fastest-growing group of prisoners in the United States: women and girls (Santo, 2017). A study by the Bureau of Justice Statistics reported 66%

of women in prison having a history of a mental disorder—almost twice the percentage of men in prison—despite making up only 7% of the prison population; in local jails, 68% of women were reported to have been diagnosed with a mental health condition in comparison with 41% of men (Villa, 2017). These statistics have been a point of puzzlement for legal experts as they cannot quite explain why this gender disparity exists (Villa, 2017).

In an attempt to answer this question in an emerging area of research in criminal justice and mental health reform, this article argues that our current approach of basing in-prison mental health treatment primarily on a medical model of mental illness cannot sufficiently combat the rising populations of the mentally ill in correctional facilities. Instead, we need to expand our approach to mental health during the stage of incarceration to employ a social model of mental illness, focusing on addressing the social needs and environmental factors that directly contributed to the development and persistence of inmates' mental illnesses.

A Critique of Cure Culture: Analyzing the Application of the Medical Model of Mental Illness in Criminal Justice

Oxford Medicine defines the medical model of mental health as operating by "assessing a patient's problems and matching them to the diagnostic construct using pattern recognition of clinical features" (Huda, 2019). It is rooted in the belief that mental disorders are "a product of physiological factors" that are physical and organic, related to the structure and function of the brain; as such, there is a central focus on "curing" psychiatric disability by "identifying it from an in-depth clinical perspective, understanding it, and learning to control and/or alter its course," usually by way of diagnosis and prescription of medication (*Social and Medical Models of Disability: Paradigm Change*, 2014).

While the medical model is certainly important in treating mental illness, it is not the most holistic model of mental illness to apply, especially in the context of incarcerated populations, in part due to the number of systemic barriers that stand in the way of inmates receiving proper medical treatment. One of the most prevalent barriers is the mismanagement of psychiatric medications, which may take the form of lack of access, overmedication, or mis-prescription (*Inmates with Mental Illness Tell Their Stories*, 2015; Davis, 2021). One example of this can be found in the story of Kristine Flynn, an inmate with bipolar disorder, who attempted suicide six days after her eight psychiatric medications were "abruptly discontinued by prison staff" for unknown reasons (*Women at Wisconsin's Taycheedah Prison*, 2009). In addition, women incarcerated at the Correctional Institute—Framingham have described experiences of being prescribed medication without being informed about what exactly they were being given or being prescribed overly large doses of powerful psychoactive medications that induced seizures, depression, and suicidal ideation because the prison staff just wanted to "quiet [them] down" (Davis, 2021).

These women are not alone in their struggle to access proper psychiatric medication administration. A study conducted by public health researchers Jennifer Gonzalez and Nadine Connell at the University of Texas (2014), which analyzed survey data from a nationally representative sample of U.S. prisoners, found that 50% of those who were medicated for mental health conditions at admission did not receive pharmacotherapy in prison. This is partially due to underfunded public health systems resulting in a limited supply of psychiatrists and psychologists able to give proper diagnoses, as well as diminishing correctional budgets not having the resources to connect all inmates in need of treatment programs (Gonzalez & Connell, 2014). Moreover, the same study

also found that the screening tools employed by correctional facilities are not even used for the purpose of diagnosis but instead used "to gauge the security risk of a new inmate at the institution." As a result, a positive screening for mental illness still would not lead to an inmate receiving pharmaceutical treatment from a medical professional (Gonzalez & Connell, 2014). Thus, solely depending on medication to reduce symptoms cannot be sufficient if the path to receiving medication is not reliable in itself.

Even so, the medical model's view of mental illnesses as distinct sets of symptoms with which to heuristically make diagnoses is inherently dangerous, especially when applied to the unique environmental context of prison. The symptoms of mental illnesses are "dynamic" and thus may present themselves differently across a variety of individuals and circumstances (Gonzalez & Connell, 2014). Gonzalez and Connell (2014) have discussed the various implications of this: for instance, there may be cases in which prisoners with mental illnesses that are more difficult to identify based on outward presentation are misclassified or undetected even by the most validated and reliable screening tools, much less by correctional employees with no substantive mental health training. Additionally, the specific environmental conditions of correctional facilities, including "crowded living quarters, lack of privacy, increased risk of victimization, and solitary confinement" (Gonzalez & Connell, 2014), pose severe adaptation challenges that may uniquely influence the presentation and perception of mental health symptoms for different inmates. In other words, the environmental context of prison has the potential to further complicate its own diagnostic process—a process that was not even perfectly reliable to begin with.

Overall, public health researchers and attorneys alike seem to agree that there are concerning issues that surround current medical approaches to treatment. Underfunded public health systems, scarce amounts of mental health providers, limited access to psychiatric medication, unreliable mental health screening procedures—these barriers and oversights, stakeholders contend, help perpetuate the growing mentally ill population in correctional facilities by contributing to the high rates of recidivism post-incarceration. A study by the Department of Preventive Medicine and Community Health at the University of Texas found that former inmates who received a professional diagnosis of any mental health disorder were 70% more likely to return to prison at least once than inmates not given a diagnosis, and the rates of recidivism are between 50% and 230% higher for persons with mental health conditions than for those without any mental health conditions (Gonzalez & Connell, 2014). Also, 61% of those who relied on pharmacotherapy to treat a diagnosed mental illness while in prison used no other form of treatment (Gonzalez & Connell, 2014); in the case of female inmates, it has been reported by Amnesty International that even when women attempt to access mental health services, they are simply given medication with no opportunity to undergo psychotherapeutic treatment. As these findings suggest, diagnosis and medication of a mental illness are simply not enough on their own to protect against symptomatic relapse and recidivism.

The volume of evidence supports the notion that the medical model approach of diagnosis and prescription is not sufficient for combating the poor mental health among incarcerated populations due to systemic barriers that prevent it from being applied to its full effectiveness. Upon further inspection, many of these systemic barriers seem to be financial, stemming from a lack of funding being put toward improving the quality of and access to treatment. Keeping this in mind, we can then consider the fact that while the medical model prioritizes care by diagnosis and clinical treatment, its ultimate goal is to "cure" the mental illness at hand. These considerations then beg the questions: how can the criminal justice system achieve this goal if it does not have the finances or the resources to do so? Even more, is "curing" its mentally ill population necessarily

even a goal for the criminal justice system? After all, clinical interventions and services that are more involved (and potentially more effective) than screening and prescription, such as specialized housing and therapeutic treatment programs, are often very expensive, and as the number of mental health classifications assigned to prisoners increases, so too does the demand for these expensive services (Gonzalez & Connell, 2014). Studies have shown that this actually provides prison administrators with an incentive to "keep mental health classification levels low as a mechanism to save costs associated with health care and pharmacotherapy" (Gonzalez & Connell, 2014). In this sense, one could argue that the prison environment actually resists the medical model in that it not only lacks sufficient resources to adopt medical treatments beyond screening and prescription but also has a financial incentive to not seek out those resources at all. Thus, the medical model of mental health seems to be both incompatible with the fiscal interests of prison administration stakeholders and insufficient at improving mental health outcomes in prisoners during and after incarceration.

Herein lies the most pressing criticism of the medical model: the symptomatic lens from which it views mental illness is simply too narrow for it to be effective for prison populations. And for institutional administrators to be invested in mental health treatments for their inmates, they should, according to public health stakeholders, "result in a sharp decline in offender recidivism and, by extension, a long-term cost savings" (Gonzalez & Connell, 2014). Therefore, effectively improving mental health outcomes in inmates would have to rely on a more holistic approach to treatment—one that could be provided by a social model of mental health.

From Impairment to Social Creation: A Proposal to Expand the Social Model of Mental Illness

A key difference between the medical and social models of disability is their definition of disability itself. While the medical model defines disability as the "individual deficit" associated with physical impairment, the social model defines disability as a "social creation"—a relationship between people with impairment and a disabling society (Shakespeare, 2006). This distinction is important because it moves the responsibility of addressing disability from the shoulders of the individual to the shoulders of society. Individuals with impairments should not be expected to struggle in and conform to an able society that was not built for them; the able society should tear down and reconstruct itself to be accessible to individuals with impairments. "It is society which disables physically impaired people," wrote Tom Shakespeare (2006), professor of disability research, "[Impairment] is individual and private, [disability] is structural and public. While doctors and professions allied to medicine seek to remedy impairment, the real priority is to accept impairment and to remove disability." This is why it is imperative to turn our focus to government, policymakers, and other institutional stakeholders when discussing disability reform—holding them accountable for constructing a disabling society may pressure them to make top-level changes to how people with impairments are treated by the system. The social model thus becomes a powerful tool for creating this pressure, offering a new perspective on disabled bodies; it proposes that they are socially constructed, with "social attitudes and institutions determining far greater than biological facts" (Fogel et al., 1992).

Using this model, we can make the conjecture that mental illness itself is an impairment that places restrictions at the individual level, but that societal stigmas surrounding mental health and

the lack of structural support that comes with it are contributors to the disabling effects of mental illness. However, I would like to propose an expansion of the social model that more closely intertwines the relationship between individual impairment and societal disability: not only do societal and systemic factors pose disabling barriers to people with mental illnesses, they also contribute to the onset of mental illness as an impairment itself, acting as social determinants of mental health. This inclusion of the social determinants of mental health in the social model further emphasizes the placement of moral responsibility on the shoulders of society to remove these systemic burdens that influence both the development and perpetuation of disability (Shakespeare, 2006).

Having established this critical framework, I will now use this expanded social model as a lens through which to examine the disproportionate rates at which incarcerated women experience mental illness. According to a study published in the *Western Journal of Nursing Research* (1992), most female inmates come from "deprived environments fraught with social problems," with many of these problems being risk factors for poor mental health (Fogel et al., 1992). As such, this article aims to perceive and illuminate these social determinants of mental health that afflict women who become incarcerated as areas of focus in efforts to prevent incarceration, improve treatment during incarceration, and provide rehabilitation after incarceration. I focus on two specific social problems that are particularly salient to incarcerated women's mental health: (1) domestic violence and sexual assault, and (2) motherhood.

'I Just Learned to Stop Feeling': The Never-Ending Prison of Sexual Abuse and Domestic Violence

Women who are survivors of violence and abuse get funneled into the criminal justice system at inordinately high rates. The World Health Organization reports that female prisoners in the United States are three times more likely than male prisoners to have endured physical or sexual abuse prior to incarceration, with 60% of inmates in women's prisons nationwide and up to 94% in certain women's prisons having such a history (van den Bergh, Gatherer, Fraser, & Moller, 2011; *Fact Sheet on Domestic Violence & Criminalization*).

This victimization by domestic violence and sexual assault has been observed to be connected to a woman's reason for incarceration. "Violence perpetrated against women and girls can put them at risk for incarceration because their survival strategies are routinely criminalized," states Free Marrisa Now, an alliance of organizations and activists working to free a domestic violence survivor incarcerated for acting in self-defense. "From being [threatened and] coerced into criminal activity by their abusers to fighting back to defend their lives or their children's lives, survivors of domestic violence can find themselves trapped between the danger of sometimes life-threatening violence and the risk of spending the rest of their lives in prison." Reporters for the Marshall Project offer further support for this point, indicating that in cases where women are imprisoned on charges of violent crime, the attack oftentimes involves the woman committing an act of self-defense or retaliation against an abuser (Aspinwall, Blakinger, & Neff, 2020). Susan Ferrell, for instance, was a woman serving a life sentence in a Michigan prison before she died of COVID-19 in April 2020. She had been imprisoned for killing the husband she said had abused her for years (Aspinwall et al., 2020). Being at the mercy of institutions that criminalize acts committed under self-defense or coercion is demoralizing and destructive for survivors, for in their desperate attempts to either survive or break free from "climate[s] of terror and diminished, violated sense of self," they once

again find themselves in the shackles of yet another prison (*Fact Sheet on Domestic Violence & Criminalization*).

This cycle of trauma perpetuates poor mental and emotional health that already exists as a result of the abuse itself. Studies have shown that the rates of depression and anxiety disorders, as well as many other mental health problems, are higher in women who have experienced violence in comparison to women who have not (*Violence Against Women Prevalence Estimates*). In the case of women offenders, the National Institute of Corrections has found that their psychological trauma is often linked to their history of abuse, commonly manifesting in the psychiatric condition of post-traumatic stress disorder (PTSD) (Bloom et al., 2005).

The dire effect trauma has on mental health not only influences behavior leading up to incarceration but also follows incarcerated women into their cells long after the traumatic experience has passed. In an op-ed for the Marshall Project, Jennifer Toon, a former inmate in a Texas prison, recalled the night her cell block had discovered the news that a new inmate had just committed suicide (Toon, 2019). She remembered how the prisoners, usually wrapped up in their "jealousies, petty cliques and bitterness," instead banded together in solidarity against the prison chaplain's adamant denial of their request to hold a memorial service for the unknown young woman. She reminisced over the quiet prayers held in small groups, conversations that turned into confessions of their own mental health struggles.

> "Many of us had contemplated suicide before," Toon wrote, "One of the most intimidating women on our unit revealed that even she had wanted to die, many times. She said, 'Y'all, my stepdaddy used to put his hands on me. I would go to school and see all the nice families picking up they kids, and I was like, why can't I have that? . . . I learned to just stop feeling.' Another lady spoke up about her crime, which she told us she'd committed against her abuser: 'I've always thought that I should have killed myself instead,' she said. 'If he were alive, maybe he would have gotten his life right, and I wouldn't be trapped in this place. Sometimes I just want it all to end.'"
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> (Toon, 2019)

These women are victims of the injustice that plagues our criminal justice system. It punishes those who are survivors of traumatic crimes; instead of acknowledging their bravery in defending themselves, extending compassion, and connecting these women to effective mental health services, the system entraps them in an environment that instead worsens their mental health further. Therefore, this vicious cycle of gender-based violence, the influences of trauma on victim behavior, and criminalization is an explanation not only for the disproportionate rates at which women are incarcerated but also for the disproportionate rates of adverse mental health in these women.

Unfortunately, the threat of sexual assault doesn't end once women are imprisoned —in fact, incarcerated women are the victims of one-third of all sexual abuse cases committed by prison staff, 70% of whom in women's correctional facilities are male (Aspinwall et al., 2020; *Women in Prison: A Fact Sheet*). According to records by Amnesty International, correctional officers have subjected female inmates to rape, other sexual assault, sexual extortion, and groping during body searches, and have also watched female inmates undress while they were in the shower or the toilet. Oftentimes, these women feel as if they cannot even safely report these misdemeanors. Many states grant guards access to files on an inmate's personal history that includes records of complaint (*Women in Prison: A Fact Sheet*), allowing officers to monitor women who speak out and retaliate accordingly. Guards

also use tactics such as threatening the inmate's children and visitation rights, issuing tickets that extend an inmate's time in prison, and placing inmates in segregation as a means of silencing these women from ever speaking out (*Women in Prison: A Fact Sheet*). Even if a complaint does somehow end up going through, strict and proportionate disciplinary action is never inflicted on the perpetrator (*Women in Prison: A Fact Sheet*). The hopeless circumstances brought upon by this imbalance of power, in addition to the trauma inflicted by the sexual abuse, further contribute to the poor mental health conditions of incarcerated women.

Evidently, the higher rates at which incarcerated women are exposed to domestic violence and sexual abuse inside and out of the prison environment influence their higher rates of psychological trauma. However, in institutions that primarily offer diagnostic and pharmaceutical treatments for mental health, these social factors and their effect on inmates cannot be directly addressed. Giving these women the tools and resources they need to develop healthy coping mechanisms and embark on their recovery journeys would be instrumental in improving their mental health, both during and after incarceration.

"Being Ripped Apart All Over Again": An Exploration of the Emotional Toll Prison Takes on Mothers

In addition to domestic violence and sexual abuse, the prison experience of many incarcerated women is complicated by motherhood. The Prison Policy Initiative reports that of the 2.3 million women in the United States who will go to jail in a given year, 80% of them are mothers. And of all the women currently in state prisons, 60% of them have children younger than 18 (Santo, 2017). Given that many of these women are poor minorities with dependent children and a lack of adequate housing, they often have limited access to community-based health systems even prior to incarceration (Staton et al., 2003, p. 225). Additionally, these women are oftentimes single mothers before getting incarcerated; as such, being sent to prison is usually the first time they experience separation from their children (Friedman et al., 2020). This combination of lack of prior mental health support and departure from their children, on top of the stressful adjustment to a prison environment, maybe contributors to persisting separation anxiety, high distress, and overall poor mental health.

This effect has been demonstrated in a study published in the *Western Journal of Nursing Research* (1992), in which researchers compared the changes in the mental health of incarcerated mothers to that of incarcerated non-mothers over time. The study found that despite entering prison with about the same high levels of anxiety, the anxiety scores of the mothers remained high throughout the entire follow-up, whereas the anxiety scores of the non-mothers decreased over time (Fogel et al., 1992). The paper conjectured that separation from children as a source of severe anxiety, as well as a "fear that mother-child separation would result in dissolution of the child's bond with the mother," was a potent reason for this observed difference (Fogel et al., 1992). This fear is not unfounded: over half of mothers never had in-person contact with their children while incarcerated (Friedman et al., 2020). The bond between a mother and her children is one that is often very strong, with many mothers treasuring and being fiercely protective over their children. The strength of this bond may contribute to the intense separation anxiety that comes with incarceration. Furthermore, many children of incarcerated mothers are placed into kinship care or foster

care, commonly leading to the termination of the mother's parental rights and making it difficult for the mother to reunite with her child after release (Friedman et al., 2020). With children being the treasure of many mothers' lives, the knowledge that their identity as a mother may be stripped, and that they may never see their children again, would be very distressing. As such, it would make sense that many incarcerated mothers thus live in constant worry of the well-being of their children as well as in constant fear that their bond may be severed.

Even when incarcerated mothers are allowed to see their children, many barriers exist that make visitation and meaningful connection difficult. Ayana Thomas, for instance, "missed out" on being a mother to her children for the two and a half years she spent imprisoned (Santo, 2017). The geographic distance between her family's home in Virginia and her correctional facility's location in Connecticut made visits few and far between. This problem of great geographic distance between incarcerated women and their children is especially prevalent due to the lower number of women's prisons and the fact that the criminal justice system currently does not consider the location of the children when placing inmates who are mothers in correctional facilities (Friedman et al., 2020; *Parenting From Behind Bars with Senator Cory Booker,* 2017). Other barriers to visitation that mothers reported were financial constraints, lack of transportation, security procedures, and strict prison regulations (Fogel et al., 1992).

Furthermore, even when Thomas's children could come to see her, "they weren't allowed to embrace or hold hands for long before a guard would break them apart" (Santo, 2017). Other incarcerated mothers participating in qualitative studies expressed the same sentiments of how the prison's visiting environment "stifled meaningful emotional contact" by not granting privacy during visits, limiting the duration of phone calls and appointments, and restricting physical contact (Fogel et al., 1992; Friedman et al., 2020).

In particular, the security procedures mandated before the visit are itself dehumanizing and undignifying, emotionally taxing the mothers who have to endure it for the sake of seeing their children. Kyndia Riley, who grew up with both her parents being incarcerated, recalled how her mother had to deal with being stripped of her clothes and having a guard "fondle her while she was naked" before being allowed to see her visitors (*Parenting From Behind Bars with Senator Cory Booker,* 2017). Then, immediately after these invasive security checks, Riley's mother had to "go back to some happy place" and put on a brave face in order to hold a conversation with her daughter. "It was like her dignity had just been stripped," Riley said.

Additionally, for many mothers, going through the prison visitation process—enduring the security checks, seeing your loved ones for a short time under strict circumstances, saying goodbye for another extended amount of time—takes an extremely large mental and emotional toll. Ayana Thomas felt that the process was so "energy-draining" to the point of requesting her children not to visit her for the last nine months before her release as it would be easier to do her time without having to go through the vicious cycle of recovering from saying goodbye over and over again (*Parenting From Behind Bars with Senator Cory Booker,* 2017). "It would take me two days to recuperate from a visit," Thomas said. "From all the crying, from the whole . . . ripping you apart all over again."

All of these factors, from being separated from their children to enduring draining visitation procedures, are most likely contributors to the high rates of moderate-to-severe mental health problems experienced by incarcerated mothers (Stanton & Rose, 2020). Possible in-prison initiatives that address motherhood as a social determinant of mental health could prioritize maintaining familial connections and improving visitation procedures.

A Case Study: How One Law Center Is Advocating for Incarcerated Abuse Survivors and Mothers

The implementation of mental health treatments should be built around addressing the social needs of inmates during their incarceration. In the specific case of female inmates, in order to achieve improved mental health outcomes and thus reduced recidivism, effective approaches should focus on (1) giving domestic abuse survivors the support and tools they need to cope with their psychological trauma through counseling, education, and legal assistance, and (2) maintaining and improving the degree of meaningful interactions between incarcerated women and their children. It is important to note, though, that this is not an exhaustive list—the issue of mental health in the criminal justice system is an intricately woven network of countless socioeconomic and systemic factors, and it would be near impossible to integrate all of them into a singular treatment model.

Still, this method of narrowing the scope of what social determinants to address in treatment has proven effective in the case of the Harriet Buhai Center for Family Law, one of the largest providers of family law and domestic violence assistance to low-income persons in Los Angeles. Since 2019, the Center has embarked on multiple projects relevant to addressing the social issues of domestic violence and motherhood as they pertain to incarcerated women. The core aim of these initiatives is to advocate for "the creation of a more gender-responsive system for abused and incarcerated women that addresses their lifetimes of trauma" (*Helping Women Who Have Been Abused and Incarcerated,* 2019*)*.

One of these projects, the Community Legal Education Program, involves the Center's staff lawyers teaching interactive classes on child welfare, custody, domestic violence, support, and paternity to female inmates five days a week, granting them a certification at the end of the program that they can later present at court (*Helping Women Who Have Been Abused and Incarcerated,* 2019). The Center has stated:

> The theme throughout the series is to encourage healthy parenting and reunification with children, to present information to help them understand and address domestic violence in their lives, and to comprehend legal processes to better equip them to succeed with their court cases.

The program was piloted at the Century Regional Detention Facility (CRDF) in 2019, where more than 3,000 female inmates have participated in it every year since. Because the program was so well received, the Center has expanded its reach to various probation offices in the area and hopes to continue the expansion across the country (*Helping Women Who Have Been Abused and Incarcerated*, 2019).

Another project the Center has initiated is the Women's Gender-Responsive Jail Project, in which the Center's staff works closely with Los Angeles County and Sheriff Department personnel as well as members of the Gender Responsive Advisory Committee to advocate for the interests of families with incarcerated mothers. Most recently, the project has released a report that "aims to bring attention to the ways in which family visitation with incarcerated mothers promotes public safety and child welfare and to advocate for improving visitation policies and programs at CRDF" (*Helping Women Who Have Been Abused and Incarcerated,* 2019).

Of course, further research into the effectiveness of programs such as these must be conducted before their widespread implementation. Other complicating nuances such as the sexual assaults

women face from correctional officers and the effects the incarceration of mothers has on their children should continue to be thoroughly studied and factored into the implementation as well. Regardless, there is still potential for effectively executed in-prison social programs that improve mental health outcomes for inmates with mental illnesses.

Much More Than Their Condition

In a conversation with a correctional officer, Dana—the imprisoned woman mentioned at the beginning of this article—had confessed that she had been raped by a family member and had his children, and was now living in fear of returning home and facing him again. The reason why she hurt herself, she said, was because "the only way he would leave her alone was if she wasn't living anymore" (Davoren & Mustafa, 2018).

It is stories like this that serve as a reminder to pause, take a step back, and remember that behind the studies and statistics lie real people. A person with mental illnesses who is unjustly funneled into the criminal justice system is more than a psychiatric diagnosis. They are more than another faceless body in a sea of inmates that institutions would prefer not to spend more of their correctional budget on. Every inmate is much more than their condition—they are, most of the time, simply victims of a bad deal of societal factors that landed them where they are. This, above everything, is what makes the social model of mental illness so compelling to me.

Here, I would like to clarify that my intention with this article was not to encourage a complete overhaul of the medical model of mental illness and diminish the importance of viewing psychiatric disorders as real illnesses with genetic and biological factors. Instead, my aim was to advocate for a more holistic approach to treating prisoner mental health than the medical model is capable of providing, by turning to the social factors that contribute to mental illness both before and after its onset. The criminalization of mental illness is enabled by the belief that mental illness is an individual failure, but as Tom Shakespeare has expressed (2006), the power of the social model lies in its ability to change the way people with disabilities are perceived. "The problem of disability is relocated from the individual, to the barriers and attitudes which disable her," Shakespeare (2006) stated. "It is not the disabled person who is to blame, but society." So, by addressing both the negative impacts of the inmate's environment before incarceration and the negative influences of the prison environment itself, implementing socially focused mental health treatments during incarceration could combat the enabling effects of imprisonment on poor mental health and better equip inmates for when their time for release and reentry does come. Ultimately, the social model of mental health has incredible potential to help mitigate the prison system's self-perpetuation of a growing mentally ill population as a result of ineffective in-prison mental health treatments—liberating prisoners with psychiatric disabilities from a vicious cycle that has kept them in chains for far too long.

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