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Mental Illness Along the Criminal Justice Continuum

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Persons with mental illnesses are overrepresented along the criminal justice continuum (police, courts, parole and probation, incarceration, and reentry), which expose individuals to risk but can also serve at points of intervention. Two predominant explanations for this overrepresentation and the evidence surrounding interventions are examined. The most common interventions at each point on the continuum and their research evidence are examined, providing an overview of promising interventions, highlighting the need for more robust research or program development, and laying the groundwork for future systematic reviews at each point on the continuum. In general, interventions have not reduced the prevalence of persons with mental illnesses involved in the criminal justice system. Future interventions should address the individual, environmental, and structural factors exposing individuals to continued contact with the criminal justice system, requiring an interdisciplinary effort across the criminal justice and mental health workforce to address this complex problem.

Persons with mental illnesses are overrepresented among all aspects of the criminal justice system (Lurigio, Epperson, Canada, & Babchuk, 2012). The criminal justice continuum includes all points of interaction between individuals with mental illnesses and the criminal justice system. The continuum starts with police encounters and ends with community reentry from prison or jail. Other points along the continuum include courts, probation,

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and incarceration. Each point along the continuum poses risk for potential incarceration, exacerbation of symptoms, exposure to health risks, or other negative outcomes. However, each of these points are also a potential area of intervention to minimize the risk related to involvement in the criminal justice system and return or maintain individuals in the community.

Just over 4% of the United States population has a serious mental illness and 18.6% has any mental illness (Substance Abuse and Mental Health Services Administration, 2013). The prevalence of persons with mental illnesses along the criminal justice continuum ranges from 8% to 56% depending on what point along the continuum is being examined and how mental illnesses are being defined (James & Glaze, 2006; Steadman, Osher, Clark Robbins, Case, & Samuels, 2009; Theriot & Segal, 2005). Differences in how mental illness is defined (i.e., diagnostic criteria or contact with treatment providers), how mental illness is determined (i.e., through a standardized assessment or self report), and whether current or lifetime diagnoses are considered have contributed to discrepancies in prevalence rates of persons with mental illnesses along the criminal justice continuum. However, despite these discrepancies, prevalence studies consistently report higher rates of mental illness within the criminal justice continuum than are found in the population (see Prins, 2014, for a systematic review of the prevalence of mental illnesses in U.S. state prisons and thorough discussion of the difficulties in obtaining consistent findings). Clearly, persons with mental illness are overrepresented within the criminal justice system.

Two meta-analyses have been completed recently that have examined interventions for persons with mental illnesses in criminal justice settings (correctional institutions or forensic hospitals), one examined treatment outcomes (Morgan et al., 2011) and the other examined mental health and criminal justice outcomes (Martin, Dorken, Wamboldt, & Wootten, 2011). In addition, Skeem, Manchak, and Peterson (2011) examined model programs and research evidence on re-arrests across community-based correctional or mental health programs with a focus on the policy implications for developing effective interventions for this population. This article provides an overview of interventions along the entire continuum, both criminal justice settings and community settings, examining both the risks for individuals and the evidence for interventions at each point along the continuum. The purpose of this article is not to systematically review all interventions at each point along the continuum, rather common and promising interventions are examined, which provides both an overview of interventions across criminal justice continuum and provide a point of reference for further research and program development across the continuum. In addition, competing (or perhaps complementary) explanations for the overrepresentation of persons with mental illnesses within the criminal justice system are discussed, as well as the criminalization hypothesis and social disadvantage.

EXPLANATIONS FOR THE OVERREPRESENTATION OF PERSONS WITH MENTAL ILLNESSES IN THE CRIMINAL JUSTICE SYSTEM

Two explanations exist for the overrepresentation of persons with mental illnesses in the criminal justice system. For many years, the criminalization of persons with mental illnesses has been the prevailing explanation. This hypothesis posits that policies of deinstitutionalization, lack of community mental health services, and strict commitment laws have contributed to the overrepresentation of persons with mental illnesses within the criminal justice system (Lamb, Weinberger, & Gross, 2004; Torrey, 1997). These conditions create a scenario in which persons with mental illnesses attract the attention of police due to untreated mental illness and are arrested rather than provided mental health treatment. Lack of proper community care and less availability of state psychiatric hospital beds have made jails and prisons the de facto mental health providers (Lamb & Weinberger, 2005). This explanation guides the development of interventions within the criminal justice and mental health systems with the major goal of connecting individuals involved in the criminal justice system to mental health services.

The criminalization argument may be an inadequate hypothesis because of a lack of empirical support and continued high rates of criminal recidivism despite diversion programs and treatment (Draine, Salzer, Culhane, & Hadley, 2002; Fisher, Silver, & Wolff, 2006; Hiday & Burns, 2010). In an examination of arrest records and interviews with parolees, Peterson, Skeem, Hart, Vidal, and Keith (2010) found that only 7% of arrests were a direct result of an individual's mental illness or due to a survival crime. Similarly, Junginger and colleagues (2006) found that mental illness had a direct effect in less than 7% of arrests based on interview data and police records, but substance use indirectly accounted for 23% of offenses. Other studies have shown that risk factors for criminal behavior and criminal recidivism are similar between those with and without mental illnesses (Bonta, Law, & Hanson, 1998; Fisher et al., 2006).

The criminalization hypothesis also overlooks other policies that may have contributed to the overrepresentation of persons with mental illnesses within the criminal justice system: the retrenchment of social welfare policies and the expansion of criminal justice policies leading to more arrests and prolonged incarceration. In the 1960s and 1970s social welfare policies like the establishment of Medicaid, Medicare, Social Security Disability Income, and housing policies through Housing and Urban Development played an enormous role in transferring the care of many persons with mental illnesses from state psychiatric hospitals to the community by providing a means to pay for housing and treatment in the community (Clarke, 1979; Gronfein, 1985; Mechanic & Rochefort, 1990). But since the 1980s the benefits associated with these policies have been reduced through narrowing eligibility for entitlements, decreasing funding for programs, and eliminating programs

(Allard, 2009; Bachman, Brainoni, & Tobias, 2004; Frank & Glied, 2006). Just at the time that more people with mental illnesses were living in the community, criminal justice policies at every stage of criminal processing (arrests, arraignment, conviction, and sentencing) resulted in increases in arrest rates, prison admissions, and time served (Alexander, 2010; Western, 2006). Over the past 30 years, the United States incarceration rate has increased significantly, rising to 700 per 100,000 people currently from a low of 100 per 100,000 in the late 1960s (Gottschalk, 2006, pp. 1–5). Policy changes in the 1970s established sentencing guidelines and mandatory minimum sentences for judges (Alexander, 2010; Western, 2006). Three-strike laws and truth-in-sentencing laws in many states followed these policies during the 1990s (Western, 2006). These policy changes resulted in more people being arrested, being imprisoned, and staying in prison longer (Western, 2006). Lastly, the arrests related to the War on Drugs are responsible for two-thirds of rise in federal prison rates and half of the rise in state prisons (Alexander, 2010). These tough on crime policies, along with a disappearing social safety net, likely have contributed to the overrepresentation of persons with mental illnesses within the criminal justice system, but their impact on this marginalized population have largely been ignored.

An alternative, emerging argument regarding the overrepresentation of people with serious mental illnesses within the criminal justice system suggests people with mental illnesses come into contact with the law due to similar reasons as people without serious mental illnesses. In particular, social and environmental factors, or social disadvantage, pose risk for criminal justice involvement. Most prominent among these factors are unsuccessful life transitions, life circumstances, the physical environment, and lifestyle (see Draine et al., 2002; Fisher et al., 2006). Fisher and colleagues (2006) suggested that social and environmental risk factors are especially pertinent for people with mental illnesses because mental disorders may interfere with the life course, perpetuate social disadvantage, and create barriers to normative systems and regular activity. A growing body of empirical work supports this argument. For example, Ditton (1999) found that among detained individuals, homelessness and family history of criminal justice involvement were more prevalent among persons with mental illnesses in comparison to individuals without serious mental illnesses. Criminal justice involvement is more closely tied to poverty and living in high crime neighborhoods than the presence of a serious mental illness. Therefore, interventions to reduce criminal recidivism need to do more than merely provide treatment and services for psychiatric symptoms (Draine et al., 2002; Fisher et al., 2006; Skeem et al., 2011; Wolff, Epperson, & Fay, 2010). The overrepresentation of persons with mental illnesses within the criminal justice system is a complex problem requiring a complex solution. Below, we examine the unique challenges professionals face and the risks people with mental illnesses encounter at each point along the criminal justice continuum. In addition, we provide an overview of promi-

nent interventions used to divert people from, provide treatment within, and assist upon exiting the criminal justice system.

POLICE ENCOUNTERS

Approximately 45% of people seeking services through community mental health agencies had at least one previous contact (e.g., arrest, detention, or citation) with the criminal justice system (Theriot & Segal, 2005). Those contacts start with encounters with police officers who spend a sizable portion of their time responding to calls involving people with mental illnesses. Nationally, it is estimated that 7% of police encounters in urban areas (populations with 100,000 people or larger) involve people with mental illnesses (Deane, Steadman, Borum, Veysey, & Morrissey, 1999) with roughly 30% resolving in arrest or emergency hospitalization (Teplin, 1984). Of the people with mental illnesses who come into contact with the criminal justice system, most have subsequent encounters (Coleman & Cotton, 2010).

Managing calls involving persons with mental illnesses can present challenges for police officers. In general, calls involving persons with mental illnesses are perceived to be more time consuming, involve more resources, and require a specialized skill set (Lurigio & Watson, 2010). Police officers are not always trained to fully understand mental illness and how it can manifest in bizarre and unpredictable behaviors; mental illness and symptoms are often misunderstood, which can lead to arrest (Borum, Deane, Steadman, & Morrissey, 1998). Officers perceive that they have limited options when faced with decisions regarding encounter resolution (Lurigio & Watson, 2010). When responding to calls involving persons with mental illnesses, police officers in an urban jurisdiction perceived that there were few disposition options beyond involuntary hospitalization, and arrest (Canada, Angell, & Watson, 2011).

Police officers make urgent and critical decisions regarding response and use of force to resolve calls involving people with mental illnesses. One common stereotype is the belief that persons with mental illnesses pose a high risk for violence (Corrigan, 2000). The misperception that people with mental illnesses, particularly people with psychotic symptoms, are dangerous and violent has increased in the general population since the 1950s (Phelan, Link, Stueve, & Pescosolido, 2000). Actual predictors of violence and injury in police officer encounters with people with mental illnesses are similar to people without mental illnesses (Kerr, Morabito, & Watson, 2010). However, traditional policing tactics, such as command and control, use of force, and intimidation, may escalate a person who is agitated or experiencing other acute symptoms and heighten risk of injury to all parties involved in the encounter (Engel, Sobol, & Worden, 2000; Ruiz, 1993; Watson, Morabito, Draine, & Ottati, 2008). A lack of knowledge regarding psychiatric symptoms

and misperceptions of dangerousness coupled with a high-stress and injury-prone work environment creates risk for both officers and civilians.

Police officers come into contact with persons with mental illnesses as both perpetrators and victims of crime. People with mental illnesses are highly vulnerable to victimization (Lurigio, Canada, & Epperson, 2013) with rates at 2.3 to 140.4 times higher than victimization rates in the general population (Maniglio, 2009). Crime is often underreported within this population (Lurigio, Canada, & Epperson, 2013). Some officers may not believe reports of victimization because of the presence of psychiatric symptoms that may interfere with reporting. Other people with mental illnesses are victimized by relatives or caregivers and feel unable to report crime without retribution.

Interventions

Crisis intervention teams

One of the most widely used interventions for improving police officer interactions with persons with mental illnesses is crisis intervention teams (CIT). CIT is a community-based intervention for police officers to promote effective, respectful, and safe interactions between officers and people with mental illnesses. Since its inception in 1988, CIT has been nationally implemented in response to the challenges officers face with mental illness-related calls and the growing need for specialized procedures when working with persons with mental illnesses. In 1999, CIT was identified by the White House as a best practice in prebooking diversion (Center for Behavioral Health Services Criminal Justice Research, n.d.).

CIT is often tailored to fit the unique needs of the police department and community (Watson et al., 2008); however, all models contain two main components: specialized training and community partnerships between providers and police (Watson, 2010). The specialized training involves a 40-hr week-long curriculum that provides officers with knowledge about mental illness and response strategies through education about mental illnesses, substance use, medications, identifying symptoms, tools for effective intervention, and de-escalation skills to use in crisis (Watson et al., 2008). The CIT curriculum involves skill building role plays with families and consumers, site visits to community providers, and interactive exercises to improve understanding of how symptoms may interfere with daily tasks (Reuland, 2004). CIT establishes community partnerships with providers and crisis services that are available for emergency transport and/or service referral. Community partnerships allow for police officers to have additional resources to assist them when responding to a person in crisis, which also expands their knowledge of disposition options (i.e., beyond arrest or no action). CIT and related police-based interventions are aligned with the criminalization argument such that their underlying premise suggests that certain people with mental

illnesses should not be arrested but rather diverted into the mental health system to receive treatment as a means of addressing the symptoms that caused their contact with the law. The CIT curriculum provides officers with knowledge regarding mental illness, but it does not include a comprehensive discussion of how social disadvantage impacts people with mental illnesses and thus their contact with the criminal justice system.

The growing body of research on CIT demonstrates that CIT is an effective intervention for improving police responses to people with mental illnesses, increasing safety, and diverting some people from potential arrest to treatment. CIT officers demonstrate increased preparedness to work with persons with mental illnesses, improved disposition of mental health calls, and reduced use of force (Borum, Deane, Steadman, & Morrissey, 1998; Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Morabito, Kerr, Watson, Draine, & Angell, 2012; Skeem & Bibeau, 2008). Further, CIT officers in Chicago directed significantly more people into mental health services compared to their non-CIT peers (Watson et al., 2010). Although Watson and colleagues (2010) found that CIT-trained officers help people with mental illnesses access treatment, diversion to treatment did not translate into reductions in overall arrest rates during their study period. This finding, in particular, adds support to the role of social disadvantage in criminal justice contact among people with mental illnesses.

Research also shows improved officer attitudes and increased knowledge of mental illness and patience when working with people who are symptomatic (Compton et al., 2006; Hanafi, Bahora, Demir, & Compton, 2008). CIT has the potential to reduce stigma and alter beliefs about mental illness. Finally, CIT officers reported conducting a thorough assessment of risk in mental health calls; demonstrating understanding of why people may exhibit certain behaviors; using de-escalation and active listening in practice; allowing sufficient time to resolve issues; and having knowledge of myriad options for disposition (Canada et al., 2011).

Police academy curriculum

Although specific interventions are helpful to address the growing concerns police officers face when managing calls involving persons with mental illnesses, some stakeholders argue that the best approach to improving officer preparedness is to include specialized training in risk assessment and management of calls involving mental illness as a part of the police academy curriculum and the core trainings provided to officers on an ongoing basis (Kesic, Thomas, & Ogloff, 2013). CIT requires officers to participate in a 40-hr training that takes place over 1 week, which necessitates adequate resources for shift coverage. Some departments find they do not have enough resources, causing barriers to CIT implementation (Canada et al., 2010). Training in the academy alleviates some of the financial strain police departments face; however,

CIT-trained officers report that on-the-job experience with calls involving mental illness is needed to have a context for use of specialized skills.

Expanding police force

Finally, some departments are expanding by adding specialized positions like a community service officer (Borum, 2000). These specialized officers are sworn officers with mental health training that prepares them to respond to mental health crises. These officers could be CIT officers if the district adopted CIT. Departments are also employing mental health professionals who work for the police department and provide officers with on-sight and telephone consultation regarding intervention with a person who is symptomatic and in crisis. Mental health professionals may instruct officers on how to intervene, what to say to the individuals, and how to resolve the call. Department leaders would, however, be tasked with the duty to forge partnerships between police and mental health providers through mobile response teams or crisis call workers (Borum, 2000; Kesic et al., 2013).

COURTS

Although CIT and other police-based interventions help divert some persons with mental illnesses from being arrested (i.e., are prebooking diversion interventions), not everyone with a mental illness is or should be diverted from arrest. The prevalence of persons with mental illnesses within the court system is unknown; a portion of people may disclose their mental illness status to attorneys or judges while other people with mental illnesses go unnoticed by the courts. If people are held in jail prior to their court hearing, a brief jail screening for mental health issues may be conducted (Teplin & Swartz, 1989), but this practice is not universal across all counties. Although not routine practice in the United States, Australian courts employ official court-based personnel (e.g., psychiatric nurses, psychologists) to conduct assessments and screenings on people who enter the court system with the goal to identify people in need of services (Ogloff, Davis, Rivers, & Ross, 2007). Because there is no routine screening procedures across the United States, issues related to mental illness are often brought before the judge through attorneys or advocates (e.g., family members), if they are addressed at all.

Interventions

Mental health courts (MHCs) are one of the most common postbooking diversion programs for persons with mental illnesses. Since the inception of MHCs in the late 1990s, they have widely proliferated with approximately 400 courts nationally today (Goodale, Callahan, & Steadman, 2013). MHCs aim to move

beyond the traditional court approach to criminal activity in that they attempt to identify the causes of behaviors that led to criminal involvement and offer assistance to address those causes. MHCs were created on the premise that some people with mental illnesses are arrested because of their mental illness (i.e., the criminalization hypothesis); as a means of intervention, these individuals simply require treatment to reduce future contact with the criminal justice system. MHC models can vary considerably by judicial circuit. However, there are five common components that distinguish MHCs from traditional courts: (a) specialized docket for eligible persons with mental illnesses; (b) voluntary diversion to the specialized docket; (c) diversion from trial and possible incarceration to receiving monitored community-based treatment as a condition of program participation; (d) regular status hearings before a judge; and (e) use of rewards and sanctions to encourage compliance with court mandates (Council of State Governments Justice Center, 2008; Steadman, Davidson, & Brown, 2001).

One of the major criticisms of MHC is that people with mental illnesses are not being diverted away from the criminal justice, but rather remaining in it with intensive supervision. Depending on the court, some MHC graduates will exit the criminal justice system with a formal charge. More specifically, one of three plea models is generally followed in MHC: preadjudication, postadjudication, and probation-based (Griffin et al., 2002; Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). *Preadjudication* happens when legal proceedings are deferred and charges are dropped after successful completion of the MHC program. *Postadjudication* is when a formal judgment is made by a traditional court but the sentence is deferred; probation-based cases receive a conviction and, for some individuals, a deferred jail sentence (Griffin et al., 2002).

Among the people who choose to participate in MHC, the most well-documented outcome is the reduction of criminal recidivism (Christy et al., 2005; Council of State Governments Justice Center, 2008; Gurrera, 2005; Herinckx, Swart, Ama, Dolezal, & King, 2005; Hiday, Wales, & Ray, 2014; Trupin & Richards, 2003). In a recent study, Steadman and colleagues (2011) found MHC participants are less likely to be arrested in the 18-months following MHC participation in comparison to a matched treatment-as-usual group of individuals. Reduced criminal recidivism was especially prominent in graduates of the MHC. MHC graduates are 3.7 times less likely to be arrested than nongraduates of MHC (Herinckx et al., 2005). In addition to reduced recidivism there is also evidence that MHCs increase access to mental health treatment and related services. In one investigation, MHC participants used 62% more services, but fewer costly, crisis-oriented services, in the 8-month follow-up period in comparison to the eight months prior to MHC participation. Service use was also higher for MHC participants in comparison to traditional court participants with mental disorders (Boothroyd et al., 2003). Despite a growing body of research that touts the effectiveness of MHCs,

results should be interpreted with caution as some studies lack an adequate comparison group, include relatively short follow-up periods, focus heavily on criminal justice outcomes rather than psychosocial factors, and do not account for selection bias (i.e., recall MHCs are voluntary programs; therefore, people may opt in or opt out) that likely impacts outcomes in unknown ways.

Although many jurisdictions are developing MHCs, it is estimated that only about 10% to 12% of persons with mental illnesses who are arrested are diverted to MHCs. Judges often perceive that they have few sentencing alternatives for persons with mental illnesses who fall outside of the specific sentencing categories like "not guilty by reason of insanity." Some people with severe mental illnesses who are not fit to stand trial may be required to receive treatment in an inpatient psychiatric hospital until they have recovered enough to competently stand trial. Persons with mental illnesses may also be sentenced to probation where they are required to participate in community-based treatment.

PROBATION

National estimates suggest that approximately 20% of people on community supervision between the ages of 18 and 49 experiences psychological distress (measured by K6 standardized measures; Feucht & Gfroerer, 2011). The majority of persons with mental illnesses under community supervision also report co-occurring substance use disorders. Reports of mental illness, in general, are twice as high among people on probation or parole in comparison to the general public. Unmet mental health needs are also more likely among probationers and parolees, with estimates nearly twice that of the general population (Feucht & Gfroerer, 2011).

People with mental illnesses are at a high risk of probation and parole violation (Skeem & Eno Louden, 2006). People with serious mental illnesses on probation are empirically more likely to violate the terms of their probation, which can result in incarceration (Skeem, Emke-Francis, & Louden, 2006). In comparison to persons without mental illnesses under community supervision, persons with mental illnesses are twice as likely to have their community supervision revoked (Feucht & Gfroerer, 2011). Reasons for revoking supervision are similar for people with and without mental illness, but people with mental illnesses often face more risk factors (Feucht & Gfroerer, 2011) and have difficulty complying with court orders (e.g., adherence to treatment, paying fines, comprehension of court orders).

Working with persons with mental illnesses under community supervision can be a struggle for some probation officers (Babchuk, Lurigio, Canada, & Epperson, 2012). Monitoring and enforcing orders for treatment and general conditions can be challenging due to treatment shortages, wait times for treatment availability, and limited service options for people without

insurance. Locating and coordinating services can be time consuming and leave probationers and parolees with limited options. Further, probation officers must work with service providers to monitor treatment participation and adherence (Feucht & Gfroerer, 2011), which can be challenging when formal partnerships have not been established and/or the treatment ideals differ between officer and provider (Epperson, Canada, Thompson, & Lurigio, 2014). People under community supervision with mental illnesses may present with issues different than the general population of people on community supervision, which can leave officers feeling underprepared (Babchuk et al., 2012). For example, persons with mental illnesses may be too disabled to work, have difficulty applying for benefits like social security income, unable to pay court fees, and have little to no social support (i.e., high co-occurrence of social disadvantage).

Interventions

Specialized probation or parole

The size of the staff, volume of cases, and city population (i.e., rural vs. urban) are a few of the factors that are considered when probation and parole departments decide to adopt initiatives to address the growing prevalence of people with mental illnesses on community supervision. One model of supervision used in many urban settings is specialized probation units or, in smaller cities, having officers with specialized caseloads (Babchuk et al., 2012; Skeem & Eno Louden, 200). There are five core features that distinguish specialized probation models from traditional models of supervision. The core features include (a) exclusive caseloads of only people with mental illnesses or, more broadly, mental health needs; (b) reduced caseloads in order to allow officers more time to work with their clients; (c) officer trainings regarding mental illness and related resources (e.g., applying for disability, community resources); (d) resource integration through partnerships and building relationships with providers; and (e) compliance or adherence management to ensure clients are engaging in treatment and/or services. Although there is stakeholder support for specialized probation, the body of research on specialized probation faces some of the same criticisms as the MHC literature: few studies examining the effectiveness of specialized probation use appropriate comparison groups, include short follow-up periods, and generally examine criminal justice variables while excluding mental health and psychosocial factors (see discussion in Epperson et al., 2011).

Forensic assertive community treatment

Forensic assertive community treatment (FACT) is another intervention that is often used to assist people with mental illnesses on community supervision.

It is provided by mental health professionals, so a person on probation could be on a specialized probation caseload and work with a FACT team or vice versa. FACT, derived from the parent intervention assertive community treatment, is a team comprised of mental health professionals (e.g., case workers, social workers, psychiatric nurses) who provide intensive, comprehensive, coordinated, and integrated care in an effort to prevent arrest (Lamberti, Weisman, & Faden, 2004). Services provided include mental health and substance use treatment, medication management, educational or vocational support, housing assistance, and crisis services. Eligible individuals can be required to work with a FACT team as a condition of probation, within a MHC, or upon release from jail or prison. Although limited, there is some support for FACT's effectiveness at reducing criminal recidivism. In a randomized clinical trial, FACT participants had fewer bookings to jail and a higher probability of avoiding jail in comparison to participants receiving treatment as usual (i.e., provision of routine services through the county; Cusack, Morrissey, Cuddeback, Prins, & Williams, 2010). In addition, FACT participants also had fewer psychiatric hospitalizations and more contact with community treatment providers. Despite support for the FACT model, research also supports the elevated risk of recidivism for technical violations among probationers and parolees receiving intensive case management services (Solomon, Draine, & Marcus, 2002) and the potential for perceived coercion to negatively impact overall recovery when court-mandated (Link, Castille, & Stuber, 2008).

In sum, specialized probation and parole units/officers and FACT largely focus on preventing recidivism through the provision of mental health and substance use treatment. Probation and parole officers coordinate with the mental health system to obtain services for their clients and/or monitor adherence to treatment. It is much less common for specialized officers to address issues related to social disadvantage, particularly assistance with moving clients out of poverty. FACT teams', on the other hand, primary responsibility is to provide direct services like psychiatric medication management and therapy; however, they also coordinate resources and provide services that may help people with mental illnesses address social disadvantage like vocational services and supportive housing (Cusack et al., 2010).

INCARCERATION

A significant proportion of persons in jail and prison have mental illnesses. Steadman and colleagues (2009) found that 15% of men and 31% of women in jail have a mental illness. This corresponds with Teplin's (1984) seminal work of diagnosing men entering a county jail. A self-report of prisoners found that 56% in state prison and 45% in federal prison reported either having contact with mental health services or experiencing symptoms of mental illness in the year prior to their incarceration (James & Glaze, 2006).

In addition, a high percentage of incarcerated persons with mental illnesses also have a co-occurring substance use disorder. Proponents of the criminalization discourse see the decline in the number of persons in state psychiatric hospitals and the increase in the number of persons with symptoms of mental illness in prisons and jails as related events because they occurred during similar time periods (Lamb, Weinberger, & Gross, 2004; Prins, 2011). This view also assumes that the population of people needing inpatient services is the same as the population of persons with mental illnesses who end up in prisons and jails (Prins, 2011). The population of people who used to be institutionalized is White, middle-aged, and schizophrenic. The population of persons with mental illnesses in prison is more likely to be African American, under the age of 30, and have a wider range of diagnoses (Prins, 2011). Also the rate of persons with mental illnesses within the criminal justice system as a proportion of all people incarcerated has been fairly stable over the past 50 years, but the share of persons with serious mental illnesses in the criminal justice system varies with the overall incarceration rate (Frank & Glied, 2006). Since 1990, the share of persons with mental illnesses who are incarcerated has increased, but this more likely is a function of criminal justice policies and would have affected those with serious mental illnesses in the community even if deinstitutionalization had not occurred (Frank & Glied, 2006). This suggests two very different populations in two very different settings.

Medical care is mandated within prisons because withholding care is considered cruel and unusual punishment (Diamond, Wang, Holzer, Thomas, & des Anges, 2001). Likewise mental health treatment is considered part of comprehensive medical care within prisons and jails. Furthermore, mental health care should include screening to identify those needing mental health treatment, treatment by trained professionals including more than just supervision and segregation, sound medication practices, and a systematic way to identify and supervise those considering suicide (Diamond et al., 2001). Although these practices are mandated, prison administrators struggle to provide adequate treatment within the confines of tight budgets and within a system that was not designed to provide mental health treatment. Finally, staff working within prisons is not trained to recognize mental illness and to use de-escalation techniques with persons experiencing symptoms.

Both prisons and jails include people convicted of crimes and serving their sentences, but jails typically hold people sentenced to 1 or 2 years. The majority of persons in jails are those awaiting trial; those who have not been convicted of any crime. Stays in jails are much shorter than stays in prison and people pass in and out of jails with more fluidity and unpredictability than prisons, which makes it difficult to screen and provide adequate care because of the churning of people within that institution. Prisons hold individuals with longer sentences and have more opportunity to meet the mental health needs of those incarcerated. Despite the differences in jails and prisons, both are disruptive to individuals' lives. Loss of housing, jobs, and benefits can

be associated with incarceration in both jail and prison settings. In addition, incarceration can disrupt social connections with families and friends.

These structural, financing, and personnel issues within prisons and jails result in different experiences and outcomes for persons with mental illnesses than the general population. Persons with mental illnesses experience high rates of victimization while incarcerated; they are almost twice as likely to be the victims of physical assault (Blitz, Wolff, & Shi, 2008). Wolff, Blitz, and Shi (2007) found that one in 12 men with mental illnesses reported being sexually assaulted in the previous 6 months as compared to one in 33 men without mental illnesses. They also found that three times as many women (23.4%) than men reported being sexually victimized. In addition to victimization by others, they are dangerous to themselves. LeBrun (1990) found that 75% of people who attempted suicide in prison had a diagnosis of mental illness.

The structure and culture of jail and prison settings has the potential to exacerbate psychiatric symptoms (Jordan, 2011). An exacerbation of symptoms may put individuals at risk of acting out or not responding to instructions, which often results in administrative segregation (Adams, 1986). Persons with mental illness are more likely to be put in administrative segregation or solitary confinement for behaviors and incidents related to their mental illness (Metzner & Fellner, 2008). Once there, they are held for long periods, have relatively little contact with other people, and often experience more exacerbation of symptoms (Human Rights Watch, 2003). Perhaps related to these issues of limited treatment, violence and victimization, persons with mental illness spend between 5 to 15 months longer in prison (Ditton, 1999) and are less likely to be eligible for early release (Metreaux, 2008) than the general population.

Interventions

Alternatives to incarceration

One way to reduce the effects of incarceration on those with mental illnesses is to avoid sending them to jail or prison through programs created to divert those with certain charges (misdemeanors, non-violent, substance use) to treatment. These can include pre- or postbooking diversion practices that either keep individuals from entering jail or shorten jail stays by linking individuals to treatment (Draine & Solomon, 1999). Other postbooking interventions like mental health courts and specialized parole and probation are among the most notable and researched alternatives to incarceration programs, but these interventions can take many other forms as local jurisdictions attempt to keep persons with mental illnesses out of jails and prisons (Schaefer & Stefancic, 2003). These interventions range from the provision of case management services to supportive housing as alternatives to incarceration (Policy Research Associates, 2012; Stefanic et al., 2012).

Screening upon admission

Once individuals with mental illness are incarcerated, it is imperative they are identified and offered treatment. The Referral Decision Scale (Teplin & Swartz, 1989) was developed to be a brief screening tool to identify those who should be referred to a mental health professional for further assessment. Persons with mental illness may not want to self-identify as having a mental illness in order to remain within the general population, to avoid becoming a target for victimization, or to remain ensconced in their masculine stance (Kupers, 2005). Despite these attempts to not reveal their mental illnesses, correction staff needs to be trained to identify symptoms and signs in those who may not willingly admit to having a mental illness. In addition, correctional staff needs education on mental illnesses including training in de-escalation techniques.

Therapeutic communities

Therapeutic communities have been used within prisons with some success at addressing substance use and other psychological problems while in prison. Persons with mental illness can benefit from this prison intervention also. Therapeutic communities have shown to reduce recidivism for those with co-occurring disorders especially when coupled with modified version of a therapeutic community post-release (Sacks, Chaple, Sacks, McKendrick, & Cleland, 2012).

Health interventions

Incarceration in prisons and jails provide an opportunity for health interventions for a relatively transient yet poor health population (Draine, McTighe, & Bourgois, 2011). Even with their constraints jails can provide screening for infectious diseases needing treatment and provide information on continued health services once released. Jail in-reach programs in which community agencies have staff at the jail also allows for linkage or continuation of treatment despite individuals cycling in and out of the institution.

REENTRY

The process of reentry is different if one is being released from jail or being released from prison. Leaving prison is perceived to be a more complicated process than leaving jail. Jail stays are shorter and offer a narrow window to provide treatment or engage individuals into treatment postrelease. Jails are also housed in the communities in which people live so it is easier for individuals to stay connected to families. Conversely, prisons are geographically removed from the communities in which people live. During long sentences it

is difficult for families to keep in contact and community involvement from social service providers is rare. Leaving prison one may face an unfamiliar environment, fractured family ties, and few resources to aid in the transition. Leaving prison is a health risk; in the first 2 weeks postrelease individuals are at 13 times risk of dying from heart disease, overdose, suicide, or homicide then similarly situated individuals who were not in prison (Binswager et al. 2007).

In addition to a higher risk of death upon release, individuals need to find a place to stay, generate income, reconnect with family and friends, and access mental health or substance use services. Entitlements such as Social Security and Medicaid are often discontinued during a jail or prison stay. There are a number of federal and state policies that restrict or impact access to public assistance, housing, employment, driver's license, education, voting and jury duty, expunging of criminal records and parental rights for people with certain criminal convictions (Pogorzelski, Wolff, Pan, & Blitz, 2005). The risk environment comprised of multiple opportunities for criminal behavior or substance use, little opportunity for prosocial behavior, and heightened police scrutiny put men leaving prison at heightened risk for continued entanglement in the criminal justice system (Barrenger & Draine, 2013).

In comparison to a population of persons without mental illnesses, persons with mental illnesses have differential outcomes once released from prions. They are charged with new crimes at higher rates (Lovell, Gargliardi, & Peterson, 2002) and return to prison sooner. Cloyes, Wong, Latimer, and Abarca (2010) found that persons with mental illnesses returned to prison on average 358 days earlier than persons without mental illnesses (p. 182). This relationship was true for both parolees and nonparolees. Survival rates for committing a new felony offense show that 20% of persons with mental illnesses released committed a new offense within six months and by three years, 40% had committed a new felony offense (Lovell et al., 2002).

Reincarceration rates are high in the general population, but on average returns to jail or prison occur sooner for persons with mental illnesses and particularly if they also have co-occurring substance use (Hartwell, 2004; Baillargeon, Williams, et al., 2009b) and a previous criminal history (Case, Steadman, Dupuis, & Morris, 2009). Swartz and Lurigio (2007) found that persons with mental illnesses who also use substances have a higher risk of arrest for all types of offenses, except violent offenses. Persons with mental illness only stay out of jail longer than those with substance use only, those with co-occurring disorders, and those with no substance use or mental illness (Blank Wilson, Draine, Hadley, & Metraux, 2011; Blank Wilson, Draine, Barrenger, Hadley, & Evans, 2013).

Reincarceration is a common outcome indicator in intervention studies for persons with mental illnesses and studies on community reentry from prison and jail show little impact on reincarceration for this population (Draine, Blank Wilson, & Pogorzelski, 2007; Loveland & Boyle, 2007). In the few studies that have produced positive outcomes, lower rates of reincarceration are associated

with number of psychiatric visits (Rivas-Vazquez et al., 2009; Theurer & Lovell, 2008), access to housing (Case, Steadman, DuPuis, & Morris, 2009; Theurer & Lovell, 2008), and coordination between service systems (Theurer & Lovell, 2009; Vogel, Noether, & Steadman, 2007).

Interventions

In line with the criminalization hypothesis, interventions for persons with mental illnesses reentering the community from prison have built upon evidenced-based treatments (EBTs) that are successful in keeping people out psychiatric hospitals or homeless shelters. For instance, case management interventions, like assertive community treatment (ACT) that has shown to reduce psychiatric hospitalizations and decrease symptoms in many research trials (Morrissey, Meyer, & Cuddeback, 2007) or integrated dual disorders treatment (IDDT) that has been effective in treating persons with co-occurring disorders, are EBTs that have been adapted for persons with mental illnesses involved in the criminal justice system. These EBTs have had mixed results at preventing reincarceration (Chandler & Spicer, 2006; Morrissey et al., 2007). Successful jail reentry interventions have combined EBTs with a residential component (Smith, Jennings, & Cimino, 2001; Weisman, Lamberti, & Price, 2004), included integration among service systems (Richie, Freudenberg, & Page, 2001; Weisman, Lamberti, & Price, 2004), or operated in service rich environments (McCoy, Roberts, Hanrahan, & Luchins, 2004) boosting the effects of the intervention. Conversely, when EBT case managers saw their role as an extension of the legal system or lacked resources for obtaining treatment, higher monitoring led to increases in reincarceration (Solomon & Draine, 1995).

Several meta analyses have examined interventions for those with mental illnesses involved in the criminal justice system (Martin, Dorken, Wamfoldt, & Wooten, 2011; Morgan et al., 2011; Skeem, Manchak, & Peterson, 2011) and have found limited support for reductions in criminal or psychiatric recidivism. Martin and colleagues' (2011) meta analysis found small effect sizes for criminal justice outcomes of arrests, time to failure, and violent crime and small to moderate effect sizes for mental health outcomes of functioning and symptoms. Overall, they found variation in effect sizes for outcomes among studies and they also found that those studies that were more rigorous meaning that controlled for biases, were rated of higher quality, and used random sampling produced smaller effect sizes. In a review of both criminal justice system interventions and mental health system interventions, Skeem, Manchak, and Peterson (2011) found mixed evidence for a reduction in recidivism and mental health interventions had the weakest evidence. Developing more comprehensive interventions that take in to account both individual level factors, such as criminogenic risk, and environmental factors, such as social disadvantage, may produce better outcomes for individuals (Epperson et al., 2011).

One intervention that shows some promise in addressing the multiple needs of individuals with mental illnesses leaving prisons is critical time intervention (CTI). CTI is an EBT designed to aid in the transition from homeless shelters for people with mental illnesses by strengthening ties to service providers, families, and friends and by providing emotional and practical support during the transition (Draine & Herman, 2007). Research on CTI with homeless persons has shown it to be effective in reducing shelter bed days and in reducing negative psychiatric symptoms (Herman et al., 2000; Susser et al., 1997). CTI is a 9-month case-management intervention comprised of three phases: transition to the community, try-out, and transfer of care. The first stage of the intervention is the most intensive; case managers engage with and link consumers to needed services and supports. During the second two phases, CTI case management services taper off as consumers have been linked to services and supports to maintain their community tenure. CTI is unique in that it incorporates connecting individuals to existing social support in addition to needed mental health and social services. Preliminary analyses of a study using CTI for men with mental illnesses leaving prison shows that individuals felt more connected to services upon community reentry (Herman, 2013).

Reentry interventions for individuals with mental illnesses should include engagement within prisons and jails prior to release, linkage to entitlements and housing, strong practical and emotional support, address substance use and mental health issues along with criminally inclined behaviors, and incorporate peer providers who have also experienced incarceration. Interventions with these elements go beyond linking individuals with mental health services, but begin to address the social disadvantage that may also contribute to the overrepresentation of persons with mental illnesses in jails and prisons.

DISCUSSION

Persons with mental illnesses are overrepresented at all points along the criminal justice continuum. This interaction with the criminal justice system exposes individuals to a variety of risks and becomes another destabilizing aspect within a population that experiences much social disadvantage (Draine et al, 2002). Interventions focusing on linkage to mental health services have produced mixed results and even promising interventions have yet to accumulate strong evidence of effectiveness under rigorous research standards. Most interventions have also encountered difficulties with dissemination and implementation. As more specialized programs are developed, concerns about accessibility to services has arisen (Blank Wilson, Barrenger, Bohrman, & Draine, 2013).

Social work has a long tradition of combining individual level practice with policy and advocacy, which has become a major tenet of forensic social work practice (Maschi & Killian, 2011). As contact with the criminal justice

system becomes more ubiquitous among those with mental illnesses involved in the public mental health system, all programs and staff need to be aware of, sensitive to, accommodating of, and willing to advocate on behalf of individuals with criminal justice involvement. Knowledge of mass incarceration practices, effects of incarceration, the role of substance use on arrests and recidivism, and barriers to successful disentanglement with the criminal justice system is becoming more imperative to those working with persons with mental illnesses. Social workers provide a large percentage of mental health services in this country, yet there is a need for more comprehensive criminal justice curriculum among social work educational programs (Epperson, Roberts, Ivanoff, Tripodi, & Gilmer, 2013). Incorporating more criminal justice curriculum into social work programs could poise the next generation of social workers as leaders and boundary spanners in addressing the overrepresentation of persons with mental illnesses in the criminal justice system.

Implications

When considering the various points and interventions along the criminal justice continuum that persons with mental illnesses may encounter, there are a number of implications for practitioners and policy makers. One common component across interventions highlighted in this article is the collaborative efforts by both criminal justice-based professionals and mental health service providers. Novel and effective interventions will require individuals trained in different theories and embodied in disparate professional perspectives to develop a common language, mutually agreed upon guidelines, and respect for differing professional ethics. As mounting evidence demonstrates, it is essential for interventions aimed at reducing criminal justice involvement among persons with mental illnesses to bring together services that address aspects of the individual (e.g., symptom reduction and integrated substance use treatment), environment (e.g., participation in meaningful activity), and institutional structures (e.g., criminal justice policy that disproportionately impacts persons with mental illness). The success of these programs begins with interdisciplinary teams taking the time to invest in a shared vision of how to incorporate multisystem interventions into practice. Team members must be committed to all aspects of the program and work to establish mutually-agreed upon benchmarks of success.

Although team collaboration is one core component in establishing a successful intervention, it is also important to develop a standard of practice or core features that interventions for persons with mental illnesses within the criminal justice system should contain. Wolff and colleagues (2013) argued that first generation interventions have yet to reduce the prevalence of persons with mental illnesses in the criminal justice system. Through interviews with professionals working within these interventions, researchers conclude that people with mental illnesses in the criminal justice system have a number

of complex and co-occurring needs that cut across behavioral health, criminal justice, and social service systems. Many first generation interventions demonstrate expertise in one or two problem areas but are unable to manage the multitude of needs that clients possess. As new interventions are developed and first generation interventions evolve, it is important that practitioners can address either directly or through referral services the collective needs of individuals. Advocacy from providers as well as advocacy training for individuals is often important in order to address structural barriers inherent in state and institutional policy.

Increased collaborations between mental health, substance use, and criminal justice entities can bring innovations in addressing this complex problem and are long overdue (Osher, 2014). As states rethink their criminal justice polices and look to reduce the number of incarcerated individuals, community supervision, and community treatment will become more common, requiring innovation and change from mental health providers (Draine & Muñoz-Laboy, 2014). This complex problem will require a complex solution taking into account individual, environmental, and structural factors that interact to heighten the risk for contact with the criminal justice system along these points on the continuum. In addition to ensuring public safety, solutions have to address the multifaceted needs of persons with mental illnesses. Interventions will need to involve more than linking individuals to mental health services or address their criminal thinking; they will also have to address the social disadvantage that contributes to increased contact with the criminal justice system.

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