Criminal Justice: Promoting Public Health and Public Safety

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I am dismayed to be "forced to authorize the confinement of persons with mental illness in the Williamsburg jail, against both my conscience and the law" because of lack of appropriate services

(Deutsch 1937).

Introduction and Background

Persons with mental illnesses are vastly overrepresented in the criminal justice system—from arrest to reentry from jails and prisons. Researchers have documented serious mental illnesses in 14.5% of male jail inmates and 31% of female jail inmates (Steadman et al. 2009); rates in excess of 3–6 times those found in the general population (Kessler et al. 1996). Generalized to the findings that over 13 million jail admissions were reported in 2009 (Minton 2010), this implies that over two million bookings of a person with a serious mental illness occur annually. The presence of so many people with mental illnesses in criminal justice settings represent an enormous burden on federal and state corrections and behavioral health systems of care, our communities, families, and those with mental illnesses. There are multiple factors that contribute to this phenomenon, but none that can justify the tragic circumstance of imprisoning someone when effective treatment options are possible alternatives.

The majority of individuals with mental illnesses who wind up in jails have committed nonviolent misdemeanors, often as a result of their untreated mental illnesses. That said, it is important to be mindful that having a mental illness is not a "free pass" for criminal responsibility and people with mental illnesses will commit crimes for which legal remedies are appropriate and essential (JLI, Judges' Criminal Justice Mental Health Leadership Initiative 2010). Persons with mental illnesses who commit crimes must be held responsible for their actions, but the effect of the illness on behavior must be taken into account.

For individuals with mental illnesses, contact with the criminal justice system starts a cycle of arrest, incarceration, release, and rearrest that can pose nearly insurmountable challenges to recovery. With more serious charges, or failure to comply with conditions of probation and parole, prisons become the institutional home for these individuals. However, most criminal justice personnel agree with community-based treatment providers that jail and prison environments are not the best setting for individuals with mental illnesses.

This chapter focuses on the collaborative activities between mental health and criminal justice systems that are necessary to reduce the prevalence of persons with mental illnesses in the criminal justice system. As such, it is not a discussion of traditional forensic psychiatry with its rich history in civil law, criminal evaluations, and expert testimony. Rather the focus of this chapter is on the factors that increase risk of incarceration for persons with mental illnesses and the role of community psychiatry in achieving positive public health and public safety outcomes for these justice-involved individuals.

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The incarceration of high numbers of persons with mental illnesses is taking place in the context of expanding incarcerated populations in general. Over the past 25 years, the nation's prison and jail population has skyrocketed to an all-time high, with over two million people incarcerated and over five million on some form of correctional supervision. The United States reached the dubious landmark of having over one in every 100 adults in the nation behind bars (Pew Center on the States 2008). The United States has just 5% of the world's population, but accounts for 23% of the world's prisoners (Pew Center on the States 2008). Beyond the human cost, correctional spending has soared over the last 20 years to keep pace with rising prison populations. Annual state spending on corrections has grown 137% and is now over $50 billion (National Association of State Budget Officers 2009). Only Medicaid has grown faster than corrections as a proportion of state spending (National Association of State Budget Officers 2009). Reducing the number of persons with mental illnesses under correctional supervision will reduce costs and is a shared goal for behavioral health and criminal justice systems.

While these numbers cry out for new ways of doing business, it is imperative that community providers appreciate their role in enhancing public safety and commit to using behavioral health interventions to achieve positive public safety outcomes. Towards this end, the Group for the Advancement of Psychiatry Committee on Community (2010) has articulated the following principle:

> Public safety is part of the mission, priority, and concern of community psychiatrists and community behavioral health systems; community behavioral health and criminal justice service providers are partners in public safety and public health. Effective responses to justice-involved populations require collaboration and partnership with multiple systems.

It is also the case that involvement in the criminal justice system can be a public health opportunity. Jails and prisons are obligated to provide general and mental health care (Cohen 2003; New Freedom Commission on Mental Health 2004) in addition to meeting detainees' other needs. In fact, incarcerated individuals are the only U.S. citizens with constitutionally protected access to health care. The US Supreme Court, in *Estelle v. Gamble* [*429 U.S. 97* (*1976*)] found that deliberate indifference to prisoners with "serious medical needs" constitutes a violation of the eighth Amendment of the US Constitution. In *Estelle v. Ruiz* [503 F. Supp. 1265 (S.D. Tex. 1980)] and subsequent cases, "serious medical needs" were extended to include mental illness by the Fifth Circuit. The American Psychiatric Association (2000), the National Commission on Correctional Health Care (2008), and the National Institute of Correction (Hills et al. 2004) have all recommended that all jails provide at minimum: (a) mental health screening, referral, and evaluation; (b) crisis intervention and short-term treatment (most often medication); and (c) discharge and prerelease planning. Of note is that all of these standards include recommendations to assure connections to needed treatment and support services.

There have been concerted efforts by criminal justice systems to identify persons with mental illnesses at the earliest possible moments and to develop mechanisms to leverage legal authority to improve their connection to treatment. Innovative police-based responses, specialty courts, and jail, prison, and community corrections programs with a focus on persons with mental illness have been developed. The shared goal for all systems is to reduce the frequency of contacts and absolute numbers of justice-involved persons with mental illnesses in criminal justice settings. At the heart of all these strategies lies the delivery of, or linkage to, effective mental health services in the community. Police, judges, and corrections staffs that refer a person with mental illness to community-based care expect the delivery of comprehensive and effective services.

Why Are There So Many People With Mental Illnesses in Jail and Prison?

To develop appropriate responses to justice—involved persons with mental illnesses, it is important to understand the reasons why they

wind up in jail and prison. There are a number of contributing factors. First, people with mental illnesses are at increased risk of developing substance use disorders over the course of their lifetimes, and arrests for drug offenses have skyrocketed since 1980 (Mauer and King 2007). Rates of incarceration are generally higher for persons with co-occurring disorders compared with those with only mental illness (Mueser et al. 2001). Research has found that nearly three-quarters of men and women with mental illnesses in jails also have a co-occurring substance use disorder (Abram and Teplin 1991). High rates of illegal substance use leads to high arrest rates.

Second, incarcerated persons with mental illnesses are much more likely to have been homeless at the time of their arrest than those without mental illnesses (Ditton 1999). In jails, 30.3% of inmates with mental illnesses were homeless in the year prior to arrest compared to 17.3% of other inmates (Stephen 2001). Being homeless makes a person very visible in our communities and their panhandling or public intoxication frequently result in calls to law enforcement. In addition, not having a stable place to live severely complicates the reentry of a person with mental illness following release from prison.

A third contributing factor is the harsh conditions in many jails and prisons that can have a harmful effect on the mental health of all prisoners. Overcrowded, high-intensity interactions with regular threats to personal safety and limited access to treatment can make the experience of incarceration a prolonged traumatic event. The noise levels within jail and prison settings throughout the day and night are excessive and there is absolutely nothing the inmate can do about it. And yes, this is incarceration after all, but the deleterious effects of these circumstances on person with serious mental illnesses are predictable—despair, psychotic symptoms, and violent acting-out. These reactions are exacerbated by the use of special housing units which isolate the prisoner from contact and services.

Fourth, once in jail and prison, people with mental illnesses tend to stay longer and are less likely to be placed on probation or parole, than others charged with similar offenses. Parole board members may lack confidence in community resources for individuals with mental illnesses, have misconceptions about mental illnesses, or fear negative public reactions. As a result, people with mental illnesses have their release delayed and more often serve the maximum sentence allowed by law (Council of State Governments Justice Center 2002). Fifth, once released, without adequate treatment, supports, and supervision, prisoners with mental illnesses are more likely to recidivate. Compared to their relatively healthy counterparts, probationers and parolees with mental illness are significantly more likely to have their probation term suspended or revoked (Skeem et al. 2008). In a study of people released to parole in California during 2004 (more than 100,000 people), researchers found that people on parole with mental illnesses were more likely to return to prison for a parole violation within 1 year (33%), compared to people without mental illnesses (20%) (Skeem et al. 2011).

And finally, limited access to overburdened community-based treatments makes at-risk individuals with untreated symptoms more likely to be arrested. As such, cuts in mental health services have an impact on the prevalence of mental illnesses in jails and prisons insofar as they make it more difficult for treatment providers to dedicate resources, time, and treatment slots to this population. In combination, these factors account for the high prevalence rates of mental illnesses among justice-involved persons.

One public misconception about the reason for so many people with mental illnesses in jails and prisons is the belief that persons with mental illnesses are inherently violent. It is critical to iterate that most people with mental illnesses are not violent, and most people who commit violent crimes do not have mental illnesses. It is the case that those people with mental illnesses who are violent often have untreated symptoms of psychosis and/or co-occurring substance use disorders, with stimulant abuse being particularly problematic (Miles et al. 2003). It is also the case that people with mental illnesses are far more likely to be the victims of crime than perpetrators (Teplin et al. 2005).

What Can Be Done to Reduce the Likelihood That They'll End Up There?

There are programmatic responses that can identify persons with mental illnesses in the criminal justice system and divert them from jail and prison, or reduce the likelihood of their return to jail and prison after incarceration. All of these programmatic efforts are dependent upon collaboration between the mental health and criminal justice systems and require linkage to effective treatment and services in the community. In this next section, we discuss innovative program models and the types of individual evidence-based practices (EBPs) that are associated with public health and public safety positive outcomes. The Sequential Intercept Model (SIM) (Munetz and Griffin 2006) creates a framework for communities to organize responses to assist justice-involved individuals with mental illnesses. The model diagrams the various stages at which an individual may come in contact with the criminal justice system. The five intercept points identified in the model are: (1) law enforcement; (2) initial detention and hearings; (3) jails/courts; (4) reentry from jail or prison; and (5) community corrections (Fig. 34.1).

A sixth and "ultimate" intercept has been posited: access to comprehensive and effective community-based services. This intercept will be discussed in the context of EBPs that target risk factors for criminal justice involvement.

The broad set of responses to behavioral needs of citizens within a community is shaped by local, state, and federal regulations and policy. When this focus is narrowed to a specific target population defined by its participation in criminal activity, the need to incorporate the perspectives of law enforcement, courts, and local and state corrections personnel is imperative. Clarity in the goals and objectives for initiatives is critical to determine the range and intensity of collaborative partnerships. At the outset, stakeholders may be convened as a strategic planning committee, but additional collaborative partners will emerge as goals are explicitly stated. Additional partners may include health and hospital providers, housing officials, private funders, elected officials, crime victims, and community representatives. While concerns about issues related to the overrepresentation of persons with mental illness in the criminal justice system may be raised by any group, responses will need the committed leadership of mental health and substance abuse providers.

The SIM focuses on a series of intercepts where interventions can be set up in order to prevent individuals from penetrating further into the criminal justice system. At each of these intercept points on the SIM, there is an opportunity to develop programs that are tailored to the needs of persons with mental illnesses. The earlier in the SIM that a person can be redirected, the fewer legal consequences they will encounter that can block their path to recovery. At the first three intercepts, the processes are referred to as jail diversion which is defined as:

> A community-based, collaborative criminal justice-mental health response for justice-involved people with mental illnesses where jail time is reduced or avoided, and the individual is linked to comprehensive and appropriate services (JLI, Judges' Criminal Justice Mental Health Leadership Initiative 2010).

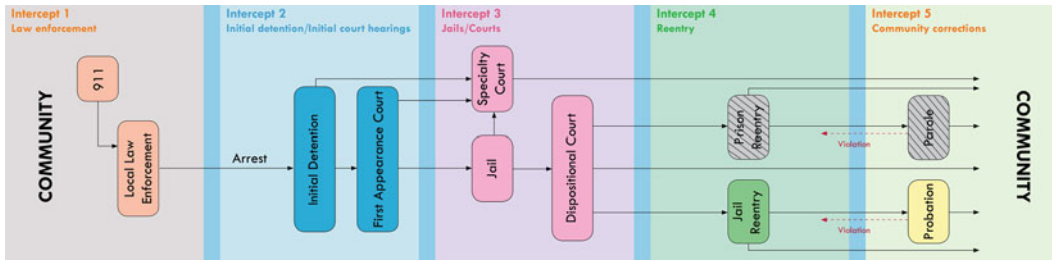

Fig. 34.1 Sequential intercept model (GAINS 2009)

Police-Based Responses

The earliest and most prevalent prebooking diversion programs rely on trained law enforcement officers who interact with people with mental illness in crisis. Law enforcement officers are the first-line, around-the-clock responders to deal with persons with mental health emergencies or criminal activity. How law enforcement personnel react to these individuals can have a huge impact on their outcomes and determine whether a person is linked to treatment or enter the criminal justice system. Specialized police-based responses (SPRs) have been developed around the country (Schwarzfeld et al. 2008). The most recognized SPR is the Crisis Intervention Team (CIT), as developed in Memphis, Tennessee, where officers receive extensive training in how to recognize behavioral disorders and deescalate the crisis on-site. Another type of SPR relies on mental health specialists who are hired to provide consultation to police officers. A third prebooking SPR approach is a specialized community mental health response, which includes a mental health mobile crisis team that responds upon request from law enforcement. SPRs have been associated with decreased injuries to officers (Reuland 2004) and increased linkage to mental health treatment (Steadman and Naples 2005).

Jail- and Court-Based Strategies

Postbooking diversion programs at Intercept 2 involve jail-based and court-based strategies. In these programs, individuals are screened and identified as having mental health needs and linked to treatment with conditions of release related to their charges. These interventions may consist of teams of mental health providers that operate within the jail and are available to assess individuals after arrest and advise the court or attorneys as to the appropriateness of deferred prosecutions, bond levels, and alternative dispositions in the community. Identification of arrested persons with mental illnesses in some communities has been improved by the matching of jail rosters to public mental health rosters. A one-way flow of information is then generated to the mental health provider informing them that their client is in custody. The mental health provider can then attempt to engage their client and coordinate care within the jail and promote alternatives to incarceration.

Mental Health Courts

At intercept 3, mental health courts have been developed in hundreds of jurisdictions around the country. These courts are defined as "a specialized court docket for certain defendants with mental illnesses that substitute a problem-solving model for traditional criminal court processing." Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, nonadherence may be sanctioned, and success or graduation is defined according to predetermined criteria (Thompson et al. 2008). Mental health courts have been associated with improved linkage to services, lower rates of criminal involvement, and the potential to produce cost savings (Almquist and Dodd 2009).

Transition Planning

With the constitutional obligation to provide health care within jails and prisons comes an opportunity to identify and begin treatment for mental illnesses within those settings. Despite chronic staffing shortages and limited formularies, critical treatment takes place behind the fences. Assuring continuity from the community, to the jail or prison, and back to community is a critical component of effective mental health care and consistent with all recovery principles. Thoughtful transition planning from jails and prisons can reduce the possibility of return to criminal justice systems. Almost all jail inmates, including those with mental illnesses, will leave correctional settings and return to the community.

At intercept 4, inadequate transition planning can put individuals who entered jail in a crisis state back on the street in the middle of the same crisis. This in turn puts jail inmates at risk for repeat offenses, increased psychiatric symptoms, hospitalization, homelessness, and rearrest (Daniel 2007). We follow the suggestion of the American Association of Community Psychiatrists (AACP) by using the term "transition planning," rather than "discharge planning" or "reentry planning" (American Association of Community Psychiatrists 2001). The AACP recommends "transition planning" as the preferred term because *transition* both implies bidirectional responsibilities and requires collaboration among providers. It is understood that some exoffenders will return to custody and as such reentry can be seen as part of a cycle of care. Transition planning is also discussed as a process and not an event. The APIC model—Assess, Plan, Identify, and Coordinate—describes elements of transition planning associated with successful integration back into community (Osher et al. 2002).

Specialized Community Supervision

At intercept 5, the opportunities to reduce the prevalence of persons with mental illnesses in jail and prison is very significant. The number of people with mental illnesses under correctional supervision has reached unprecedented levels and the vast majority is supervised in the community (Glaze and Bonczar 2007). With incredibly high caseloads and little access to community resources, probation and parole officers are often left with revocation to jail or prison as a punishment for failing to meet conditions of release. These "technical violations," where a new crime has not been committed, are the principle contributions to ballooning correctional populations. In this context, specialized community corrections caseloads have been developed to improve outcomes for persons with mental illnesses under community supervision. The key features of this programmatic response are smaller caseloads comprised exclusively of persons with mental illnesses, significant officer training on mental health issues, and extensive collaboration with community-based providers (Prins and Draper 2009). Studies support this model as effective in reducing recidivism rates among persons with mental illnesses under community corrections supervision (Roskes and Feldman 1999). However, with states facing the grim reality of enormous budget shortfalls, the resources to fund effective transition strategies like specialized community corrections supervision, effective mental health, and co-occurring substance abuse treatments are tough to identify.

Comprehensive, Effective Community-Based Care: The Ultimate Intercept

It has been said that any effort to keep people with mental illnesses out of the criminal justice system will only be as good as the community treatment and supports available—the ultimate intercept. Towards that end, this chapter now focuses on the linkage to community treatment. There are several EBPs that with adaptation have the potential to reduce jail days for persons with mental illnesses. In discussing justice-involved persons with mental illnesses, it is important to keep in mind the heterogeneity of this group. They differ in terms of the seriousness of their mental illnesses, charge levels, criminogenic risks, and access to community supports. Unfortunately, the criminal justice system rarely does an adequate job of screening, assessing, and individualizing responses to those identified as having a mental illness. And the mental health system rarely asks and details the nature of criminal justice involvement, or assesses for criminogenic risk. In fact, studies have found that almost one half of the clients seen for the first time at community mental health centers have had contact with the criminal justice system, and nearly one third of them had been sentenced to jail (Theriot and Segal 2005). Lumping justice-involved persons with mental illnesses into a single class does not allow for prioritization of scarce resources to those most in need. The need for valid and reliable screening and assessment

processes has never been greater. These processes will drive the development of effective integrated treatment and supervision plans. What follows are the services that should be available to reduce criminal justice involvement in persons with mental illnesses.

Integrated Mental Health and Substance Abuse Services

Since the majority of justice-involved persons with mental illnesses will have co-occurring addictive disorders, integrated treatments must be available. Effective interventions to reduce illicit and destabilizing substance abuse are critical. For nonjustice-involved persons with co-occurring disorders, integrated treatment has been identified as an evidence-based practice and its core components have been articulated (Center for Substance Abuse Treatment 2005; Drake et al. 2001). For justice-involved persons, the hypothesis underpinning effective co-occurring disorders interventions can be stated as:

> interventions (at the program or provider level) that reduce substance use (licit and illicit) and improve levels of functioning in persons with co-occurring disorders will reduce both the frequency of their involvement with the justice system and their time spent in justice settings or under correctional supervision.

Integrated treatment for justice-involved persons has been associated with reduced criminal activity (specifically the use of illegal drugs and violent behavior), fewer persons with co-occurring disorders at all points in the justice system, and improved reintegration of offenders with co-occurring disorders into community settings. Specific treatments within integrated programs include psychopharmacologic strategies (Noordsy and Green 2003), motivational interventions (Carey et al. 2002), and cognitive-behavioral interventions (Mueser et al. 2003). Several specific program models that use integrated treatments have been applied to justice-involved persons with co-occurring disorders. The Integrated Dual Disorder Treatment model is an EBP that combines program components and treatment elements to assure that persons with co-occurring disorders receive combined treatment for substance abuse and mental illness from the same team of providers (SAMHSA 2003) (see Chap. 23 for a detailed discussion). The evidence base for its effectiveness with justice-involved persons with serious mental illnesses is just beginning to accumulate (Mangrum et al. 2006; Osher 2007). The modified therapeutic community (MTC) is a residential treatment program for co-occurring disorders using integrated strategies that have been studied in justice-involved populations (DeLeon 1993). MTCs use the "community-as-method" as the basis for both its program and treatment integration. MTCs have been shown to significantly lower reincarceration rates and reduce harmful substance use for persons with co-occurring disorders, compared with groups receiving nonintegrated services (Sacks et al. 2008).

Supportive Housing

High rates of homelessness among justice-involved persons with mental illnesses have been previously discussed and must be considered in comprehensive treatment planning. Their housing needs range from owning their own homes or living in independent rental units to institutional care. Supportive housing can significantly decrease the chance of recidivism and is less costly on a daily basis than jail or prison. Supportive housing includes a variety of permanent housing settings coupled with on-site or easily accessible services. The service range includes case management, counseling, medical care, mental health and substance abuse treatment, vocational training, cognitive skills groups, and assistance in obtaining income supports and entitlements. Culhane et al. (2002) found that individuals with mental illness at risk for homelessness placed in supportive housing options in New York City had both reductions in shelter use and hospitalizations *and* spent fewer days in jail compared with the year before attaining housing. In addition, compared with a matched group of New York City residents without supportive

housing, they had fewer episodes of incarceration. Unfortunately, affordable housing is in short supply in many communities, and persons with criminal records often have trouble accessing public housing assistance. For greater detail, please refer to Chap. 33 concerning homelessness and Chap. 29 for a discussion of housing.

Trauma Interventions

Rates of physical and sexual abuse in jail and prison populations have been found to be at least twice as high as in the general population (Teplin et al. 1996). Among some criminal justice groups such as women with co-occurring mental and substance use disorders and histories of homelessness—histories of violent victimization are nearly universal. In response to this heightened recognition of the pervasiveness and profound consequences of trauma, many criminal justice systems programs have begun to incorporate an understanding of trauma and trauma recovery into all aspects of service delivery. This "trauma-informed" general strategy (see Chap. 12 for a detailed discussion) is often paired with trauma-specific interventions for persons meeting post-traumatic stress disorder (PTSD) criteria. Zlotnik et al. (2003) applied a well-established cognitive-behavioral model for the treatment of PTSD to a cohort of incarcerated women with PTSD and substance dependence and found positive outcomes consistent with its application in nonincarcerated women. While these studies suggest that trauma-specific interventions for justice-involved persons can positively affect trauma symptoms, no evidence exists that these interventions reduce rearrest and jail utilization.

Supported Employment

Assuming that some criminal activity is driven by the need for money, successful employment may mitigate subsequent contact with the criminal justice system. As detailed in Chap. 25, supported employment has emerged as an EBP over the past 15 years that can improve the success of persons with serious mental illnesses in competitive employment circumstances (Bond et al. 2008). There may need to be program modifications to accommodate to conditions of release which can require court or community correction monitoring concurrent with work hours. While there is limited data that suggest supported employment is as effective in improving work outcomes when the person with mental illness is justice-involved, there is no data on the impact of supported employment on criminal justice outcomes

Illness Management and Recovery

Illness management and recovery is actually a group of EBPs that teach persons with serious mental illnesses the required skills to manage their own illnesses in collaboration with health-care professionals and other natural supports (see Chap. 26 for details). The application of these EBPs has been demonstrated to prevent relapse and rehospitalization in addition to reducing the disabling effects of mental health symptoms (Mueser et al. 2002). There are several illness management and recovery program types (e.g., Wellness Recovery and Action Plan [WRAP] or social and independent living skills [SILS]) that share practice principles while employing different approaches. These programs have been implemented for persons with mental illnesses within correctional settings and appear to produce the expected social skill gains. There is no evidence concerning the impact of illness management and recovery on public safety outcomes. The common application of psychoeducational and cognitive components within illness management and recovery programs makes them well suited for adaptations that could address criminogenic thinking or anti-social tendencies.

Case Management and Forensic Assertive Community Treatment

Case management services are necessary for individuals with complex health and legal needs. Assertive community treatment (ACT) is a

well-documented EBP that combines treatment, rehabilitation, and support services within a multidisciplinary team (Dixon 2000). It is a high-intensity, high-cost service that is typically reserved for those most disabled by mental illness and persons who use multiple community acute and emergency services (see Chap. 24 for a detailed discussion). The ability of ACT to consistently reduce arrests and jail times among persons with serious mental illnesses has not been established (Morrissey et al. 2007). As a result, there has been a recent interest in augmenting ACT services by specifically focusing on justice-involved populations and training team members to be responsive to criminal justice partners (Weisman et al. 2004). These forensic ACT teams, or FACT teams, have been implemented in many communities around the country. Some demonstration studies have found significant reduction in jail days and arrests (Morrissey et al. 2007). The development of forensic intensive case management (FICM) teams is another effort to coordinate criminal justice supervision and treatment services. FICM focuses on the brokering of services rather than direct service provision. While brokered case management models are still a challenge for many communities with limited resources, they are sustainable in areas where services are more ample. The bottom line for many justice-involved persons with mental illnesses is that some form of case management is necessary and case management teams must have a sound understanding of legal issues. With their "criminal justice savvy" (Morrissey et al. 2007), case management teams can be expected to reduce recidivism and support client recovery in the community.

Cognitive-Behavioral Interventions

Critical to understanding how persons with mental illnesses end up in criminal justice settings are the concepts of "criminogenic risk and criminogenic needs." Criminogenic risks are factors associated with criminal conduct and arrest. Some of these individual characteristics are static factors that cannot be changed such as the early onset of criminal behavior (e.g., age of first arrest) or a family history of criminality (e.g., father is in prison). But some factors are dynamic such as criminal attitudes or values and cognitive emotional states (Andrews and Bonta 1994). Criminogenic needs are the dynamic factors most closely associated with criminal behavior and can be targeted for change strategies. Justice-involved persons with mental illnesses have been found to have more of these risks and needs than justice-involved persons without mental illnesses (Skeem et al. 2006). Most importantly, the dynamic factors can be mitigated with appropriate cognitive-behavioral treatment interventions. In addition, people who spend extended periods of time in custody are exposed to a different culture and experience stressful periods that include threats to their well-being and periods of isolation. In response to these circumstances, they may develop adaptive behavior that interferes with subsequent community adjustment (Rotter and Carr 2010). Cognitive-behavioral interventions targeted to criminogenic needs are promising practices with considerable face validity. With recognition of the high number of criminogenic needs in this population, interventions intended to change attitudes, values, and behaviors are likely to have an impact on recidivism. In fact, in general, the more criminogenic needs addressed by treatment and supports, the bigger the expected impact on return to jail and prison (Latessa and Lowenkamp 2005).

Accessible and Appropriate Medication

Treatment with psychopharmacologic medication can be critical to preventing an individual from entering the criminal justice system and for those who are incarcerated, continuing or initiating medication may be necessary. Having access to appropriate medication at appropriate doses, for sufficient lengths of time in jail or prison, and on release to the community is imperative. Research is inconclusive about specific medications and their impact on crime, but it is clear that effective psychopharmacologic strategies are a

prerequisite for full participation in other treatment, supervision, and supportive services. Like other persons with serious mental illnesses, access to prescribers, paying for medication, adherence, and continuity across systems are challenges for this population.

These programs and EBPs are components of a comprehensive strategy to reduce the overrepresentation of persons with mental illnesses in the justice system. Few communities have all components and none have sufficient capacity, yet inroads are being made. Financing these EBPs relies on a patchwork of block grant funding, public and private insurance, and uncompensated care. Advocacy for investments in these programs and services is essential. Passage of the Patient Protection and Affordable Care and Health Care and Education Reconciliation Acts in 2010 hold promise for increasing access to Medicaid-funded services for the vulnerable population of justice-involved persons with mental illnesses.

Conclusion

Community psychiatrists are working and will continue to work, with persons with criminal justice histories, and should develop expertise in the terminology of the criminal justice system. Recovery-oriented practices are as germane to justice-involved persons as those without criminal justice experience and must be integrated into treatment plans. Community psychiatrists must have a vision of what works, for whom, and under what circumstances. Gaining this expertise can be done formally by taking part in advanced training such as a forensic and/or community psychiatry fellowship programs. But effectively applying this knowledge requires active partnerships with criminal justice colleagues in law enforcement, courts, and corrections and justice-involved clients. If we are to avoid a return to a society where punishment inappropriately substitutes for care, a shared commitment to our communities' public health and public safety is of paramount importance.

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