

First-Episode Incarceration

Creating a Recovery-Informed Framework for Integrated Mental Health and Criminal Justice Responses

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FROM THE DIRECTOR

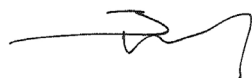
While there have been significant shifts in the understanding of mental health over the past 50 years, many of the responses to people with mental illness have changed very little. In the mid-1950s more than half a million people were held in U.S. psychiatric institutions for long periods and often in deplorable conditions. Sixty years later, an equivalent number of people with mental illness are held in the nation's prisons and jails on any given day.

During the 1960s and 1970s, endemic problems of involuntary confinement and abuse in psychiatric hospitals and a new generation of psychotropic medication that could be administered to people with mental health needs living in the community led to a dramatic shift away from residential, inpatient care. It was part of a movement that sought more compassionate care for patients in the context of their communities, based on a vision of people receiving the support they needed to lead stable, functional lives. However, the network of community-based mental health services that was necessary to realize this vision never materialized. In the absence of appropriate policies and practices to respond to people with mental illness, for many people the criminal justice system has become the provider of last resort.

Today there is a growing awareness that the justice system is no substitute for a well-functioning community mental health care system. Courts, public defender agencies, probation offices, and police departments around the country are increasingly adopting initiatives to connect people with mental health needs to treatment and other supportive services.

However, while initiatives to identify and divert people are desperately needed, their success depends on the existence of effective and accessible services. This report addresses fundamental questions about the effectiveness of services for people with mental illness who come into contact with the justice system. Drawing upon interviews with experts in the field, the authors address shortcomings in existing services and describe steps to reach people sooner with interventions that can help prevent future arrest and incarceration. Modeled on promising approaches in the mental health field to people experiencing a first psychotic episode, the report stresses early intervention, an understanding of the social determinants that underlie ill health and criminal justice involvement, and recovery-oriented treatment.

The United States has hundreds of thousands of people with mental illness languishing in the nation's jails and prisons. This is a crisis that demands a fundamental rethinking of how to serve people struggling with mental health disorders. Developing new approaches that can convert an initial contact with the justice system into the first step along a path toward long-term mental health and desistance from crime should be part of that goal.



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Contents

- 4 Introduction
- 5 The mental illness-criminal justice nexus:
Evaluating practice and theory
- 6 Planning for a new generation of interventions
- 7 Expanding the focus of intervention and the
metrics of success
- 13 Healthcare reform: Practice standards and
workforce development
- 15 Conclusion
- 17 Endnotes

Introduction

There is growing public recognition that the number of people diagnosed with serious mental illness in the U.S. criminal justice system has reached unprecedented levels. In 2007, there were more than 2 million jail bookings of people with serious mental illness.¹ Although prevalence estimates of serious mental illness in jails and prisons vary widely depending on methodology and setting (jail or prison), recent research estimates that approximately 15 percent of men and nearly one-third of women in jail settings have a serious mental illness and that rates of serious mental illness in state prison populations are at least two to four times higher than community populations.² This reality places a significant strain on institutional and community resources, including increased expenditures on incarceration. And it sheds light on why so many formerly incarcerated people face daunting prospects for successfully reintegrating into society. Seeking to mitigate these corrosive outcomes, local and state governments have developed a range of programs over the past two decades to serve people with serious mental illness in contact with the criminal justice system.³

The driving idea of interventions developed during the past 20 years is to keep people with serious mental illness out of jails and prisons when possible through prevention and diversion programs and to provide appropriate mental health services to those who need them during and after incarceration.⁴ Unfortunately, however well intentioned this first generation of interventions is, it has become increasingly clear that it has done little to reduce the number of incarcerated people with serious mental illness.⁵ Because of

METHODOLOGY

The analysis, observations, and recommendations in this report are based on an extensive review of the literature in both the mental health and criminal justice fields, as well as on interviews with 11 national and local practitioners, policymakers, academics, and others involved in responses to people with mental illness who are at risk of running afoul of the criminal justice system.^a The authors examined peer-reviewed journals, white papers, and reports from government, professional organizations, and nonprofits. After compiling information on national practices, they interviewed 11 stakeholders chosen for their leadership capacity at a variety of organizations that serve people with behavioral health needs affected by the justice system. Although the interviewees' specialties differed, they all answered questions about:

- > emerging practices or programs that merit more evaluation and attention;
- > opportunities for applying mental health service models to clients in criminal justice settings;
- > promising programs using peer counseling;
- > the potential application of mental health recovery frameworks to people in the criminal justice system; and
- > the promise of interventions attuned to environment-based and place-based frameworks.

The authors guaranteed the interviewees anonymity in exchange for candid responses about current programs and interventions in their fields.

^a While many of the examples in this report are based in New York, interviewees come from jurisdictions across the country.

the human toll and the staggering expense of incarcerating people with mental illness, policymakers and practitioners in both mental health and justice fields have begun to reevaluate existing policy and practice and to think creatively about what it will take to make meaningful change in how to respond to people with mental illness.⁶

This report outlines a new framework for designing and delivering integrated mental health and criminal justice interventions. It is predicated on creating mental health treatment programs that intervene consistently and productively at the outset of people's criminal justice involvement. After an evaluation of current practice and a discussion of the developing new generation of interventions, the report then draws upon interviews with 11 experts in the field to propose a "first-episode incarceration" framework (modeled on first-episode interventions in the treatment of psychosis) for people who have been diagnosed with mental illness and are in contact with the criminal justice system for the first time. Such a framework is rooted in prevention and early intervention, evidence-informed care, and recovery-oriented practice.⁷ The goal of the report is to seize the opportunity opened up by the current public debate about how to respond to the dearth of care for people with mental illness who come into the criminal justice system, thereby spurring creative thinking and cross-sector collaborations among mental health and justice system practitioners and policymakers.

The mental illness-criminal justice nexus: Evaluating practice and theory

People with mental health needs have staggeringly disproportionate involvement with the U.S. criminal justice system. This is not a new phenomenon; get-tough policies responding to people with serious mental illness who committed crimes prevailed for decades. Over the past 20 years, researchers and practitioners have developed a range of interventions to try to reduce the escalating levels of contact. The interventions, including criminal justice models such as crisis intervention teams, mental health courts, and specialty probation models, and mental health programs such as Forensic Assertive Community Treatment (FACT), were hailed as long overdue reforms to national practices and policies that have produced the world's highest rate of incarceration, strained the social and economic fabric of many communities, and reinforced racial and class inequalities.⁸

However, recent research on these interventions demonstrates that they have not succeeded in reducing the number of people with mental illness involved in the criminal justice system. The efficacy of interventions is typically

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assessed by their impact on recidivism. Careful reviews of program effectiveness, however, have found only mixed or modest evidence that existing programs reduce recidivism.⁹ Little research on program effectiveness has collected mental health outcome data, and studies that have drawn on this data have been unable to show that improved psychiatric symptoms and mental health status lead to improved criminal justice outcomes.¹⁰

A growing body of scholarly literature argues that prevailing interventions—or “first-generation” interventions—have not achieved their goals because they are based on a faulty premise: that people with serious mental illness engage in criminal behavior primarily because of their mental illness.¹¹ Much has been written about the criminalization of mentally disordered behavior in the wake of deinstitutionalization, a hypothesis suggesting that a decrease in the range of options for responding to people with mental illness led to an increase in the number of them in the criminal justice system.¹² Many analysts cite the criminalization hypothesis to argue that mental health disorders are causal factors for involvement in the criminal justice system, and that mental health treatment would therefore be a remedy for that involvement.¹³ Although this hypothesis is a key driver of policy, it fails to account for evidence that untreated symptoms generally do not explain criminal justice involvement; nor does it square with evidence that connecting people to mental health treatment often fails to prevent further involvement.¹⁴

Planning for a new generation of interventions

In response to doubts about the effectiveness of current interventions and evidence of their limitations, researchers across several fields have proposed alternative models that take a more nuanced approach to thinking about the relationship between mental illness and crime.¹⁵ These new models are sensitive to social context and to the myriad factors that may overlap with mental illness, but are also closely linked to the characteristics of socially disadvantaged communities. They thus share the perspective of a social determinants model—a focus on the circumstances in which people are born, grow up, live, work, and age, that is more focused on inequality than illness in affecting health.¹⁶

Indeed, scholars proposing next-generation interventions consistently turn attention to the fact that effective interventions cannot be limited to mental health services if the strongest predictors of recidivism (such as homelessness and criminal history) appear in people with and without mental illness. For example, one proposal calls for designing interventions guided by a person-place framework that accounts for individual factors including mental illness, addictions, trauma, and established risks for criminal behavior, including such traits as antisocial personality, as well as environmental

factors such as social and environmental disadvantage.¹⁷ This framework suggests that person (individual) and place (environment) risk factors interact to create stress that becomes a catalyst for criminal justice entanglement.¹⁸ A second alternative describes the link between mental illness and criminal justice as one of “moderated mediation,” in which the effect of mental illness on criminal behavior is indirect and mediated by more general criminal behavior risk factors such as antisocial history and “poorly structured leisure and recreation time.”¹⁹ People diagnosed with mental illness may have more of these risk factors than people without diagnoses, but general risk factors predict recidivism regardless of mental illness.

Both of these proposed interventions suggest that the focus of evidence-based practices must be expanded beyond linkage with mental health treatment to target other risk factors including antisocial thinking, addiction, and stress. In “Envisioning the Next Generation of Behavioral Health and Criminal Justice Interventions,” the authors identified the Monroe County, New York-based Project Link, and Changing Lives and Changing Outcomes, a holistic, manual-based treatment program for people with mental illness who are involved in the criminal justice system, as two interventions showing promise in targeting multiple issues.²⁰ An evaluation of Project Link—which comprises a mobile treatment team including a psychiatrist and nurse practitioner; a dual diagnosis treatment residence; and a team of case advocates (who engage clients and link them to mental health, primary care, residential and social services in the community)—demonstrated significant reductions in arrests, number of incarcerations and hospitalizations, and days spent in jail or the hospital.²¹ A preliminary evaluation of Changing Lives and Changing Outcomes, which includes nine therapeutic modules, showed significant reductions in mental health symptoms and distress as well as modest reductions in reactive criminal thinking among a group of incarcerated men.²²

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Expanding the focus of intervention and the metrics of success

The approaches discussed above take an important step in rethinking the relationship between mental illness and crime—namely, they demonstrate that for most people with mental illness, criminal justice involvement is not explained simply by a lack of mental health treatment. In so doing, they broaden the types of risks that put a person with serious mental illness at greater likelihood of running afoul of the criminal justice system. They are also valuable for their practice recommendations. For example, the treatment plan described in Changing Lives and Changing Outcomes addresses key risk factors for both ill-

FIRST-EPIISODE INCARCERATION

The experts interviewed for this report cited the need for holistic interventions for people who have both mental illness and early criminal justice system involvement—what one interviewee, borrowing from the mental health literature on first-episode psychosis, called a “first-episode incarceration.” Thinking about the intersection of mental illness and criminal justice involvement within this framework opens up new possibilities for how to develop effective approaches. In particular, it highlights the need for prevention and early intervention, for robust, evidence-informed care, and for recovery-informed practice.

None of the interviewees could identify any promising programs in the field that work with people who have been diagnosed with a mental illness but are still early in their involvement in the criminal justice system. Programs they identified as being successful were those that either worked with people during a period of prison incarceration (generally suggesting a conviction and sentence of at least one year) or worked with felony offenders before sentencing (for example, Nathaniel ACT) or upon release from prison.^a Both types of programs are labor and resource intensive, working with people over relatively long periods and addressing a wide variety of needs ranging from mental health treatment to material help in areas such as housing, employment, and education.

For people in jail, on the other hand, the interviewees described available services as being inadequate. For example, they cited the Brad H. settlement in New York City, which mandated that everyone who receives treatment for a mental illness while confined in a New York City jail also gets discharge planning and, in some cases, additional case management services upon release. Nevertheless, interviewees spoke of the settlement’s shortcomings. The settlement agreement cast too wide a net, making it impossible to provide adequate planning to so many people. Moreover, it failed to set standards for what good discharge planning and care should entail.^b

A recent fiscal brief by the New York City Independent Budget Office bears out the first observation. It reported that although the city Health Department delivered a greater variety of services in 2013 than in 2009, more than half of the 10 types of discharge services were reaching a

smaller share of eligible people in city jails. Thus, for example, more eligible people received comprehensive treatment plans and discharge plans but fewer got referrals or assistance with scheduling appointments upon release.^c At the very least, discharge planning remains uneven, and many people leave Rikers Island without adequate connections to care or community resources.

Some of the people with mental illness who are arrested and spend time in a New York City jail end up being able to take advantage of alternatives to incarceration, such as diversion through mental health courts or into specialty probation models. These options continue to be important elements on the continuum of interventions for people who become involved with the criminal justice system. For example, the Mayor's Task Force on Behavioral Health and the Criminal Justice System (established in June 2014) has identified emerging interventions in New York City to reduce the number of people who enter jail after arrest: developing diversion drop-off centers, expanding supervised release, and introducing strategies to reduce reliance on monetary bail.^d

^a The New York City-based nonprofit CASES launched the Nathaniel Assertive Community Treatment (ACT) team to help people with serious mental illness successfully make the transition from incarceration back to the community. perma.cc/BE64-J7DL.

^b Following a blistering report on the number, treatment, and follow-up for mentally ill inmates in New York's City's jail (Heather Barr, *Prisons and Jails: Hospitals of Last Resort*. New York: Urban Justice Center, 1999), the Urban Justice Center filed a class-action lawsuit in 1999 (*Brad H. v. City of New York*) challenging New York City's jail discharge planning activities. The case was settled in 2003 with an agreement that the city would provide discharge-planning services for people who receive psychiatric treatment in city jails. Services mandated under the Brad H. settlement include a supply of and prescription for medication, activation or reinstatement of Medicaid benefits (assuming the person qualifies), referral to or an appointment for mental health treatment, and, for those who are homeless, assistance in applying for supportive housing. Persons classified as having a serious and persistent mental illness receive additional case-management services. See Urban Justice Center. "*Brad H. v. City of New York*," (New York: Urban Justice Center, October 2015). perma.cc/9YWC-EYEJ.

^c New York City Independent Budget Office, *Has the City Met Its Obligation to Provide Mental Health and Discharge Services in the Jails?* (New York: NYC IBO, May 2015). perma.cc/73TA-K3Y9.

^d Mayor's Task Force on Behavioral Health and the Criminal Justice System, *Mayor's Task Force on Behavioral Health and the Criminal Justice System Action Plan*. (New York: City of New York, December 2014). perma.cc/E7SV-MLH9.

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ness recurrence and recidivism such as addiction, medication adherence, stress, trauma, and housing, education, and employment needs.²³

So far, however, there has been little analysis of how to design interventions at the intersection of criminal justice and behavioral health systems that both decrease recidivism and expand life opportunities for participants. This area calls for greater focus from practitioners, researchers, and policy-makers. The intense attention to reducing recidivism is understandable given the heavy social and economic costs of incarceration. But the fact that research on outcomes is rarely framed by an orientation to recovery—one that looks at opportunities for people with mental illness coming out of incarceration to renew possibilities, to regain competencies, or to reconnect socially—means that existing evaluation research tells us little about how an intervention succeeds in rebuilding lives.²⁴

What follows, then, is an attempt to think more broadly about the desirable outcomes of interventions for people involved in the mental health and criminal justice systems. The ultimate goals—desistance from crime and recovery from mental illness—can be slow processes. To show promise, emerging practices and programs must recognize this fact and help to change the life course of people seeking to stop criminal behavior and achieve mental health.²⁵ The ideas introduced here can help to lay the groundwork for further inquiry into what kinds of intervention can halt the progression from the need for mental health services to involvement in the criminal justice system, and what it will take to effect this result.

PREVENTION AND EARLY INTERVENTION

Mental health practitioners are making significant improvements in minimizing the disruption and negative life consequences for people experiencing first-episode psychosis. The rationale for early detection and intervention in mental health is straightforward: Psychotic disorders can derail a young person's social, academic, and vocational development, leading to cumulative disability and social marginalization.²⁶ Similarly, all interviewees stressed that the interventions for people with early criminal justice involvement and mental illness need to occur prior to incarceration to address their myriad needs.²⁷ Rather than perpetuating a system that rewards late-stage intervention as opposed to prevention, and rather than providing high-quality interventions to people only once they become hard to serve, interviewees said that the system needs to make a fundamental shift to front-end, early interventions.

A first-episode incarceration framework would thus take a more active approach to people who are diagnosed with a mental illness and also at risk for criminal justice involvement because of the person and place factors described above. The driving idea is a simple one: to invest in people early on to avert or halt a trajectory of interaction with the criminal justice system. Interviewees shared additional ideas such as the development of more crisis centers or crisis respite programs to serve as safe alternatives to emergency rooms; the creation of new neighborhood spaces people can access

when they are not yet in crisis but need a safe place; or the requirement that community mental health providers engage in root-cause analysis to determine the reasons for the outcome when clients come into contact with law enforcement. At a basic level, prevention and early intervention may be less about designing totally new programs than about integrating existing elements of effective practice into a comprehensive program.

COMPREHENSIVE CARE

Indeed, the experts interviewed agreed that if mental health programs are to be effective in preventing or disrupting a trajectory of criminal justice involvement, they need to deal with the factors that lead people to get arrested and rearrested—factors that are generally not related to their mental illness. Promising models such as Nathaniel ACT were cited because, as one interviewee reflected, they “deal with other things—the factors that lead people to getting rearrested—and actively work with people around those issues.”

More generally, mental health treatment must be reconfigured to include not only therapeutic intervention, but also strategies to address people’s material needs and the place-level factors that affect their lives and communities: homelessness, unemployment, high levels of violence, and other forms of social and economic disadvantage. Helping people with housing, for example, was commonly cited across interviews as something that makes a real difference in improving outcomes and keeping clients engaged in treatment and invested in their recovery. This is consistent with the literature cited above on next-generation interventions that target environmental as well as individual risk factors.²⁸

Individual risk factors were not discounted, however; in fact, several interviewees advocated for additional attention to substance use as a driver of criminal justice activity. They lamented the fact that substance abuse is often ignored and kept separate by community service and justice treatment agencies and professionals—something that is particularly problematic given the high co-occurrence of mental illness and substance use among people with criminal justice involvement. In turn, these interviewees stressed the need for integrated mental health and substance abuse interventions, suggesting that people should not have to go to separate treatment programs for these needs (nor receive a different type of care depending on whether their point of entry is the mental health system or the substance abuse treatment system).

An additional feature that emerged in discussions of more comprehensive care—and one that has not surfaced in the literature on this population—was the notion that mental health programs need to be designed to allow clients to pursue educational and vocational opportunities. As one interviewee observed, “One problem with a lot of mental health programs is that there is not a lot of flexibility for the people involved. A lot of times people involved in programs want to work, and that’s not necessarily an option. It’s an ongoing problem.”²⁹ Although some mandated mental health

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treatment programs likely allow time for pursuing work or training opportunities, a more thorough look at how existing programs support—or at least accommodate—clients’ other needs and desires is warranted. This is especially true because, as research on the coordinated specialty care model adopted by the National Institute of Mental Health’s RAISE Early Treatment and Connection Program has found, many clients value its supported employment and education services and feel motivated to fulfill the program’s other requirements.³⁰

RECOVERY-INFORMED PRACTICE

Another valuable observation from some interviewees was the importance of a recovery-oriented practice perspective when working with people with both mental illness and criminal justice involvement. Although definitions of “recovery” are varied and contested, the notion that people with a psychiatric disorder can reclaim a life of their own authorship regardless of their persistent difficulties has guided transformation in the mental health system since the 1990s.³¹

Nevertheless, some interviewees stressed that few programs based on principles of recovery exist at the intersection of behavioral health and criminal justice. One interviewee, an academic researcher and practitioner, said that many programs are still operating with a “disablement model—looking at deficits and not holding people to higher standards.” In contrast to those people who emphasized the need for material resources, she felt that too much work was “instrumental” and that more emphasis should be placed on building character and teaching the skills that foster empowerment such as grit, optimism, and conscientiousness. “How do you get that grit or zeal for another life? How do you rise again and again and again even though you keep seeing things that are negative?” This expert also noted that most people with whom she has worked and who have transitioned out of prison are uncomfortable with being on the receiving end of so much help without the opportunity to give back; part of being successful in avoiding additional criminal justice involvement is having the chance to identify with and take action as the new person you have become.

What, then, should recovery-informed practice look like for people with mental illness who are at an early stage of involvement in the criminal

justice system? It should include four central elements. First, policy and practice must be trauma-informed and trauma-specific. Researchers increasingly recognize the profound and enduring effects of trauma and its role in the development of subsequent health issues.³² The interviewees stated that there is much to be done to educate providers about the role and impact of trauma in people's lives (as well as its likelihood of increasing the risk of criminal justice involvement) and to integrate trauma-specific responses into the mental health and criminal justice systems. This involves a larger project of creating trauma-informed environments where people can access services—environments that are characterized by safety, trustworthiness, choice, collaboration, and empowerment.³³

Second, practitioners should strive to make mental health and criminal justice labels secondary and tertiary to their client's treatment. That is, they should focus on developing relationships with people that are person-centered and aim to understand and deliver on what people really need. Third, recovery-informed practice must go hand-in-hand with a wellness approach, focusing holistically on people, understanding the impact of social determinants on their quality of life, and empowering them to focus on self-care.³⁴

Finally, there is considerable room for improvement in integrating families and peers into this work. Several of the interviewees noted that families are often eager to be involved in caring for their loved ones but may be alienated or shut out by the system. Family members can be a key resource for identifying times when a person may need extra resources and can also provide essential support functions in a system that is under capacity.

The integration of peers in the mental health workforce has already been adopted as an important part of healthcare reform and should become a model for support at the intersection of mental health and criminal justice.³⁵ Peers have played an essential role in the public discourse about recovery and provide a powerful counterpoint to conventional notions of patient or inmate; they are increasingly recognized as having transformed their experience into expertise and serve as credible, embodied evidence of recovery.³⁶ The fact that so many people with a history of criminal justice involvement also have been diagnosed with a mental illness and the fact that the value of mental health peers is increasingly apparent should mean that peers are routinely involved in this field as a strategy for disrupting the cycle of criminal justice involvement.

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Healthcare reform: Practice standards and workforce development

Developing interventions that prevent people from moving on a trajectory from involvement in the mental health system to involvement in the criminal justice system requires scrutiny of mental health practice standards and workforce development.³⁷

The interviewees stressed that even if people with mental health problems receive more services, it is not always clear that the services measure up to best practice in the field. They cited case management as a good example of this inconsistency. Many interventions specify that clients should receive case management, but the programs lack standards that specify what good case management entails, or fail to grapple with such difficult questions as what effective participant recruitment looks like or what the core components are for successfully engaging clients. Interviewees also said that many existing programs do not follow particular models (such as evidence-based interventions), adding that the programs get little guidance and that available standards are not always applied in the field.

Workforce development among community health workers and mental health clinicians suffers from the same lack of rigor and consistency. Interviewees said that there are not enough staff trained to meet rising demand and that staff turnover will remain a widespread problem because of the intense experience of providing community mental health services.³⁸ Furthermore, they said that many staff in mental health programs resist working with people with criminal justice involvement (echoing Pope et al's research finding of stigma toward working with justice-involved people with mental illness).³⁹ One expert said that agencies must do more to become "justice sensitive" and to embed that sensitivity into their mission statement as well as their employee training, policies, procedures, and programming.

Finally, there was a sense among the interviewees that even with the implementation of effective, evidence-based models and the development of a skilled workforce, the success of particular programs is ultimately rooted in agencies and staff who "do what it takes" to work with and advocate on behalf of clients. Many of them described how the individual success stories heard in the field are almost invariably connected to the development of a strong relationship between a client and a staff member who recognizes that client as a person first. This is another reason why peers can play such a

vital role in the workforce—modeling for other staff how they connect with people and demonstrating to both staff and clients the possibility of a rich life beyond the criminal justice and mental health systems.

Not surprisingly, the people interviewed for this report were highly attuned to the potential of recent healthcare reforms such as the federal Affordable Care Act (ACA) and Medicaid redesign to drive change in this arena. In addition to focusing on the new funding streams available because of legislation and policy change—and the resulting ability to strengthen existing programs and develop innovations—experts highlighted the fact that healthcare reform is pushing entities to develop more rigorous accountability measures and produce better outcomes. Indeed, if care coordination and continuity are to be cornerstones of a reformed healthcare system, and if organizations are held to related metrics, then it seems inevitable that those who serve people at the intersection of the mental health and criminal justice systems will have far higher incentives to treat this population holistically. The interviewees were cautiously optimistic about the ability of healthcare reform to infuse new levels of accountability into the system and transform practice standards in turn.

Conclusion

After a period of unrelenting growth in the U.S. jail and prison populations and policies that have increased the disproportionate contact of people with mental illness with the criminal justice system, local and national momentum is building for reforms at the intersection of mental health and criminal justice. In this environment, the development of alternative approaches to thinking about the relationship between mental illness and crime is a welcome sign of change that could lead to real system reform. Experts have begun to map a broader range of risk factors that put someone with serious mental illness at greater likelihood of coming into contact with the criminal justice system. This understanding in turn points to the need for a more comprehensive response than that provided by standard mental health services alone.

This report's authors propose that the development and dissemination of next-generation interventions in the field accompany a more specific focus on people with a mental illness at the outset of their involvement in the criminal justice system. Adopting the lens of first-episode incarceration provides a way of imagining an integrated criminal justice and mental health system that is proactive about providing the necessary supports and services to people as soon as they enter either system and that aggressively commits to recovery-informed practices capable of generating expanded life opportunities.

Front-end, comprehensive, recovery-driven interventions have real potential to disrupt a path of criminal justice involvement by holding onto valued activities such as employment, schooling, and social connectedness that people pursue. Such interventions envision people as citizens and not only as justice-involved.

There is reason for optimism that change is on the horizon, given the unprecedented opportunities created by the ACA and the rollout of new local and national initiatives intended to transform how the criminal justice system interacts with people diagnosed with mental illness. But palpable, on-the-ground change will take time, committed work, and ongoing assessment of its effectiveness. An important next step will be to expand the capacity of the mental health workforce to deliver high-quality interventions that follow a recovery-oriented, full-service model and to recruit and train new staff who are deeply committed to working with justice-involved people with mental illness.

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ENDNOTES

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About *Justice Reform for Healthy Communities*

Mass incarceration has become one of the major public health challenges of our time. The millions of people who cycle through our nation's courts, jails, and prisons every year experience far higher rates of chronic health problems, infectious diseases, substance use, and serious mental illness than the general population. Justice Reform for Healthy Communities is a year-long initiative of the Vera Institute of Justice that aims to improve the health and well-being of individuals and communities most affected by mass incarceration. Guided by a national advisory board comprising public health and criminal justice policymakers, practitioners, researchers, and advocates, the initiative advances its mission through public education, coalition building, briefings, and publications.

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