

# Forensic Services, Public Mental Health Policy, and Financing: Charting the Course Ahead

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High-quality forensic evaluations can be critical for criminal cases brought before the court. In addition, forensic practitioners and mental health and forensic administrators have increasingly taken a broader view of the revolving door between the mental health and criminal justice systems. More attention is now paid to why individuals with mental disorders, including co-occurring substance use, come into the criminal justice system and the challenges that they face on re-entry into the community. In particular, individuals who receive care across civil, forensic, and correctional systems are at especially increased risk of disrupted health care access and coverage. With health care reform on the horizon, it is important to understand public financing and its impact on forensic services for this crossover population. This article is a review of historical and future trends in public mental health funding focused on Medicaid and other federal resources, the movement toward community-based services, and the impact of these areas on forensic practice and forensic systems. Tensions between recovery principles and legal mandates are also addressed as community services are emphasized, even in forensic contexts. This article calls forensic practitioners to action and offers suggested areas of focus for training to increase knowledge of public mental health funding, policy, and practice from a forensic perspective.

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The delivery of public forensic mental health services, traditionally rooted in providing individualized forensic evaluations and opinions and institutional care for defendants found incompetent to stand trial and not guilty by reason of insanity, represents an evolving landscape<sup>1–3</sup> with historically unique challenges.<sup>4</sup> Individual forensic assessments, approached with a goal of objectivity and honesty and crafted within a cultural framework with minimized bias,<sup>5</sup> provide a critical element to help the wheels of justice turn. Single-case forensic evaluations with the most advanced techniques help ascer-

tain clinical nuances,<sup>6</sup> and high-quality standards are necessary to inform the legal process optimally.<sup>7</sup> That said, individual forensic evaluators, treating clinicians, and public mental health and forensic administrators have over the past many years increasingly been asking questions about why many individuals get to the point of needing forensic evaluation in the first place. President Bush's 2002 New Freedom Commission on Mental Health recognized that some of the trends were based on the mental health delivery system, which was sighted as "fragmented and in disarray . . . lead[ing] to unnecessary and costly disability, homelessness, school failure and incarceration."<sup>8</sup>

Although similar to the general public sector mental health population, those who have criminal justice and forensic involvement have an increased risk of significantly fractured care<sup>3</sup> and a high risk of mortality and poor outcomes.<sup>9</sup> These individuals represent a crossover population, moving across three distinct public mental health systems (civil, forensic,

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and correctional) where they are evaluated and treated. Their transinstitutional existence and characteristics make treatment challenging and far more costly.<sup>10</sup> Barriers to uninterrupted care include multiple comorbidities associated with mental health, substance use, and medical illness. These are often treated in disjointed approaches at different community settings, across numerous hospitalizations, and through emergency room visits. Additional treatment challenges include nonadherence to medication, complex trauma histories, the potential for disproportionate minority representation, and the impact of culture and race on care access and care delivery.<sup>11</sup> Personality and criminogenic factors can further disrupt traditional engagement strategies<sup>12</sup> and continuity of care.

With that in mind, I will examine public mental health policy and the economic forces that have framed care for persons in forensic and criminal justice settings or at risk of ending up in those settings. I will also attempt to articulate the imperative that, with a broader systems understanding, forensic mental health professionals, who operate within legal and clinical frameworks, can provide more informed forensic evaluations and assist in developing service delivery models through unique perspectives.

### **How and Why: The Criminal Justice Door**

Although the phenomenon of deinstitutionalization of those in state mental health hospitals and the closing of some facilities have been commonly cited as the reasons for the increase in the number of persons with mental illness in the criminal justice system, the reasons for this increase are more numerous. The criminalization of drug offenses in the 1970s and the complex evolution of the civil commitment laws have been cited among other factors as contributing to the increase.<sup>3,13</sup>

Putting aside the reasons that persons with mental illness experience deeper penetration into the criminal justice system, over the years it has become common for police to be the first responders in crises involving such persons. The terms street corner psychiatrist<sup>14</sup> and frontline mental health worker<sup>15</sup> were used in the 1990s to characterize the role that law enforcement plays in individual communities. In these early studies, decisions to arrest were often found to have been based on workable and practical solutions that seemed more effective than did transfer into a health care system that had other chal-

lenges. Fisher and colleagues<sup>16</sup> found that 28 percent of state mental health consumers tracked over a 10-year period had experienced at least one arrest. Swanson *et al.*<sup>10</sup> found that one in four persons with schizophrenia or bipolar disorder in the public mental health and addiction services system in Connecticut had criminal justice involvement of some type during a two-year period. Other studies have found that most officers report having responded to a call involving someone with a mental illness in the past month.<sup>17,18</sup>

Correctional systems ultimately house inmates with high rates of substance use and mental health disorders. Baillergeon and colleagues<sup>19</sup> demonstrated that incarcerated individuals with psychiatric disorders had significantly increased histories of having had multiple prior incarcerations. Hoge *et al.*<sup>3</sup> highlighted the critical need for aftercare and re-entry services. Hartwell and colleagues<sup>20</sup> found that 61 percent of inmates who were identified while incarcerated as having mental health problems accessed substance use treatment services within 24 months of release from correctional settings.

Taken together, the studies clearly show that persons with mental health and substance use service needs are common both on the way into the criminal justice system and on the way out. Thus, policy level conversations are shifting from simple either/or solutions that only enhance treatment services or only build criminal justice approaches to reducing recidivism. Instead, public systems have been developing models that look at mutual problem-solving through emerging justice and behavioral health collaborations. However, in developing policies and practices that chart a path forward and in providing sustainable funding for these new models, we must understand certain aspects of funding for public mental health services.

### **Funding History and the Drive Toward Community-Based Care**

Traditional mental health services in the United States have incorporated a complex interplay of state and federal funding sources as well as a combination of private and public insurance to help individuals pay for care. State financing funded most mental health care through the 1950s.<sup>21</sup> The care and treatment of persons with mental illness was viewed as a state responsibility, and each state was allowed to determine how much of its budget to

allocate to mental health needs. State dollars were utilized largely to fund state institutions, where most individuals with mental disorders went for treatment at the time.<sup>22</sup>

Since the mid-1900s, several initiatives have directed the attention of the federal government toward those with mental illness. In 1946 came the passage of the National Mental Health Act, which established the National Institute of Mental Health, to enhance research and education. The 1963 Mental Retardation and Community Mental Health Centers (CMHC) Construction Act<sup>23</sup> provided grant funding to states to construct local centers for the delivery of mental health care. Although funding and the vision of enhancing community-based services were not fully realized through this initiative, other overarching broad reforms have continued to lead to certain, albeit insufficient, advances in community mental health care.<sup>24</sup> The creation of the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1992, under the U.S. Department of Health and Human Services, has further assisted states in system improvements through its distribution of block and competitive grants.<sup>25</sup>

In 1965, under the amendments to the Social Security Act,<sup>26</sup> Medicaid was established as a state-federal partnership, with the states eligible to receive funds from the federal government on the basis of *per capita* income. This calculation, called FMAP (Federal Matching of Assistance Percentage) generally allows states to receive one dollar for every dollar spent, with states with lower *per capita* incomes receiving a greater percentage of federal reimbursement for services delivered. Medicaid services are intended for parents of dependent children, children and pregnant women, and certain people with disabilities whose income is below the federal poverty level (FPL). Services traditionally covered by Medicaid include acute care hospitalization, with some exceptions (described later); medications; personal assistance; diagnostic and other clinical services; outpatient services; and certain types of community support services, such as targeted case management.

The Medicaid dollar for public services has become an increasingly important component of community-based care, with Medicaid spending surpassing state and local spending for mental health and substance use services for the first time in the early 2000s.<sup>21</sup> The Center for Medicare and Medicaid Services (CMS) administers the federal Medicaid

program and oversees the approvals of the states' activities. Waivers that allow home and community-based services to be covered through Medicaid for certain groups have been increasingly granted in recent years, such as those through § 1915, which help provide for individuals who might otherwise be institutionalized or who present with specific diagnostic criteria.<sup>27</sup>

With the initiation of the Supplemental Security Income (SSI), dating to the 1970s, and Social Security Disability Income (SSDI) passed in 1956, more individuals with mental illness were eligible to receive supported income that also assisted them in community living.<sup>21</sup> Medicare was also established as a federally funded insurance program for persons age 65 or older who had been in the workforce and for persons under age 65 with certain disabilities.<sup>28</sup>

With regard to Medicaid, when it was established, federal Medicaid reimbursement was prohibited for services rendered in Institutions for Mental Disease (IMDs).<sup>22</sup> IMDs include any facility with greater than 16 beds (except small community mental health centers, which fell under different provisions) that focus primarily on mental health care. From this exclusion came financial incentives to shift care of persons with mental illness to localities that were not subject to the IMD exclusion, such as psychiatric units in hospitals in which the number of medical beds exceeded that in mental health facilities (when psychiatric beds exceed medical beds, the hospital could be tipped toward emphasis on psychiatric care and come under the framework of the IMD exclusion), smaller community mental health centers, and other community treatment options.

Thus, the IMD exclusion has played a significant role in determining where care is delivered, as the lack of federal reimbursement for care in state mental health institutions places increased burdens on state budgets. As state budgets have tightened, state psychiatric beds have decreased, and the state institutions have been left with more difficult to discharge populations, such as those with complex behavioral challenges, those found incompetent to stand trial, those not guilty by reason of insanity, and those with criminal and risk-related histories. With fewer state hospital beds overall, forensic costs have represented increasing percentages of state hospital expenditures.<sup>29</sup>

CMS has additionally given recent guidance regarding prisoner services that Medicare may not

cover in specific circumstances, including services for those individuals “required to reside in mental health facilities,” and even those on “supervised release,” to name a few.<sup>30</sup> Procedures regarding labeling patients as prisoners trigger the Social Security Administration to terminate benefits for some forensically involved individuals. More complicated still is that federal reimbursement (e.g., via Medicaid and Medicare) and private payment, when they might be available for crossover populations, require determinations of medical necessity. Not all court-committed patients meet that threshold (e.g., certain defendants hospitalized for competence restoration services, insanity acquittees, or those hospitalized for forensic evaluations). Thus, attempts to recoup payments as billing is reviewed retrospectively and prohibitions on federal reimbursement for forensic patients place fiscal responsibility on state budgets that require adequate appropriations.

These budgetary forces are complex. Given many of the limitations on federal funding for forensic patients, state appropriations will also continue to play a role and state laws, policies, and practice will govern financing of these services. With that in mind, there is an ongoing need to balance limited resources at both the state and federal levels. More costly inpatient forensic services, as well as perhaps less costly but also financially complex community court-mandated services, will require ongoing analyses of viable long-term financing strategies and models of care that meet the unique needs of the crossover population.

### **Institutions Versus Community Placements: Civil, Forensic, and Correctional**

As alluded to already, a major driver of care delivery in mental health has been a shift from institutional to community-based care.<sup>24</sup> The premise that individuals with mental illness have the right to live full and meaningful lives in their communities is widely accepted. It is therefore important to understand the legal and fiscal forces that have moved services in that direction. During the period when state hospital beds were eliminated, persons with mental health disabilities gained increasing rights that have helped them move toward more community-based living. As noted, these rights were in part advanced through developments related to *Olmstead v. L.C.*,<sup>31</sup> the Americans with Disabilities Act of

1990,<sup>32</sup> and access to disability payments through the Social Security Administration. Advances in psychotropic medications have also had a major impact on increasing the number of people served in the community and on the cost of mental health services and health care in general, although this area of focus is beyond the scope of this article.

*Olmstead* claims and investigations under the purview of the Civil Rights of Institutionalized Persons Act (CRIPA)<sup>33</sup> have created a need for more robust discharge efforts in civil contexts. Leaving aside the sex offenders embedded in some state mental health forensic services, traditional forensic populations have also begun to receive similarly increased scrutiny with regard to whether an institutional level of care is reasonable for certain individuals. In Oregon, an investigation by the Department of Justice related to *Olmstead* under the provisions of CRIPA created a significant need to examine discharge planning from the Oregon State Hospital, whose patient population largely originated from criminal commitments,<sup>34</sup> creating additional challenges in discharge. Bloom<sup>34</sup> advised that the problems related to discharge of forensic patients in Oregon were likely to be relevant in other states as well.

Levitt and colleagues<sup>35</sup> made the interesting finding that incompetent unrestorable defendants were more likely to be admitted involuntarily, yet less likely to be dangerous, and they had longer hospital stays than did a matched community sample. Such findings raise further important questions regarding the utilization of hospital beds and the parallel forensic and civil systems with differing bases for admission (e.g., medical necessity and need for treatment versus involuntary court placement and need for containment). In the aftermath of *Jackson v. Indiana*,<sup>36</sup> Parker<sup>37</sup> identified the need to develop better approaches to unrestorable, incompetent inpatient defendants who become stuck between the public safety concerns of the prosecution and mental health treatment needs. Others have continued to write about the fairness and reasonableness of the length of time an individual can be held in a hospital as incompetent to stand trial.<sup>38</sup> Limited inpatient bed capacity has fostered greater front end demand for forensic services and treatment delivered in alternative settings (e.g., jail and community-based competence restoration services) and has increased pressures on discharge processes.

On the correctional side of the coin, the U.S. Supreme Court in 2011 affirmed the judgment of a lower three-judge panel, finding that because of overcrowding, the medical and mental health care that had been available in California's prisons had not met constitutional standards.<sup>39</sup> As a result, the Court ordered the state to develop a remedy of dramatically reducing the prison population through a variety of mechanisms, including transfers to county jails or outright release of inmates to community-based programs in certain cases. This ruling has created challenges for treatment of these individuals when released and balanced public safety concerns.<sup>40</sup>

If one follows these threads, higher costs of institutional care with fewer bed resources, risk of poor care in overcrowded settings, and other factors, it becomes clear that they point many of the traditionally forensic or correctional populations toward community services, with only the individuals who have committed very serious offenses or who pose the greatest risks remaining in state psychiatric hospitals or other institutions.

From a public health and public safety perspective, it would be prudent for forensic mental health professionals to be called on to assist in secondary and tertiary preventive approaches to help maintain at-risk individuals in the community. This can increasingly be done through well-informed risk assessment and risk management approaches in collaboration with criminal justice entities. As the forensic field has expanded to embrace correctional psychiatric practice, the current forces at play lead to the need to enlarge the embrace to include working with justice-involved individuals in community settings, thereby enhancing collaborations among mental health services, courts, probation, and parole.

### **Coexistence of Legal Mandates and Recovery Principles**

As these collaborative models evolve, in addition to funding, it is important to note the specific philosophical frameworks that have been increasingly emphasized. The public mental health care system has put forth principles related to recovery-oriented, person-centered, and family-driven care, that prioritize autonomy, freedom of choice, and hope. SAMHSA's working definition of recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."<sup>41</sup> These

themes were part of the New Freedom Commission's targeted goals.<sup>8</sup> Even within forensic systems, there have been efforts to incorporate these ideas to enhance outcomes.<sup>42</sup>

Individuals who travel through forensic settings, however, do so because of certain risk-related behavior, and they may at times lack decision-making capacity, which can signal additional concerns. These factors raise complex questions about recovery, personal responsibility, and clinical responses.<sup>43,44</sup> Psychiatrists in particular, along with certain other mental health professionals, have legal and clinical obligations to act to override self-directed decision-making by seeking care over an individual's objection under certain circumstances, especially when safety is a factor and when local laws further control aspects of forensic patients' autonomy.

Tensions related to the push and pull among individual rights, clinical obligations, prevailing laws, and public safety complicate management and disposition planning and must be attended to as services focused on crossover populations evolve. Forensic patients also must live with complex histories as part of their personal stories and challenges. With those caveats in mind, specific recovery principles can still be embraced to help justice-involved individuals in forensic and community-based settings find hope and meaning to make more positive choices to reduce their risks and reach their full potential when they are able to do so. Trauma-informed care, peer support, and strength-based treatment planning, to name a few, have been helpful for civil patients and have important roles in forensic contexts, as well. Forensic systems, however, are likely to continue to develop and to grapple with some of the more complex areas related to recovery-oriented policies and program models.<sup>42</sup> The integration of these concepts to enhance positive treatment engagement through support and guidance is an important direction of care delivery, but it should proceed with the recognition of the equal importance of navigating safety and mandated treatment to help individuals avoid more negative outcomes.<sup>44</sup> Appropriately balancing these approaches can help to establish mechanisms for the care of forensic patients in the least restrictive settings, with cost-effective programs that can help meet individualized needs while carefully attending to public safety.

## Health Care Reform: What Might It Mean for Crossover Populations?

Individuals with substance use, medical, and mental health challenges are at increased risk of receiving poorly coordinated care between the physical and behavioral health settings and can incur some of the highest costs in health care. Add criminal justice involvement, and the costs are even higher.<sup>10</sup> Successful health care outcomes and reduced recidivism with overarching reduced cost can be shared goals, and the promise of health care reform on the horizon may offer ways to help achieve improvements. The Patient Protection and Affordable Care Act (known as ACA), signed into law in 2010 and amended via the Health Care and Educational Reconciliation Act (2010), is the current major vehicle for changes to the health care landscape in the United States.<sup>45</sup> According to a white paper related to the ACA and criminal justice, produced by the Bureau of Justice Assistance, the ACA reform strategies also have “the potential to decrease crime, recidivism, and criminal justice costs, while simultaneously improving the health and safety of communities” (Ref. 46, p 3).

Expanded Medicaid coverage of individuals with low incomes represents a major shift in who is eligible for services that Medicaid provides. With the enactment of the ACA, it is estimated that up to 22.4 million more people will be eligible to enroll in Medicaid.<sup>46,47</sup> This expansion targets those whose incomes are at or below 133 to 138 percent of the federal poverty level (FPL), beginning in 2014. The federal government assumes 100 percent of the costs for newly eligible individuals for two years and will assume 90 percent of their costs thereafter. The ACA requires within the benefit packages for Medicaid-financed plans essential health benefits that include mental health and substance use disorder services.

Features of the ACA include providing additional subsidies to certain individuals and the development of health insurance exchanges to increase access to a broader network of health insurance plans available to consumers. The expansion of coverage includes mechanisms to cover health and wellness promotion in health care. Perhaps more important, it decreases discrimination against mental health care, extending the Mental Health Parity and Addiction Equity Act of 2008,<sup>48</sup> which mandates coverage for mental health and substance use disorder services on par with medical and surgical benefits, but only when

plans offer these benefits. The adoption of federal parity rules in the fall of 2013 marked a major achievement, but will require ongoing oversight, to ensure appropriate implementation.

## Even With Promises for Improvements, We Cannot Throw Caution to the Wind

More insurance and better access to care are positive developments. Disparate adoption of reform strategies by the states makes for a complicated landscape. Health care reform efforts are varied works in progress, as was seen with some of the start-up challenges with the Health Insurance Exchanges. Patience and thoughtful solution-based policies and implementation strategies will be critical to the success, not only of expanded coverage where it occurs, but of improved outcomes in all jurisdictions seeking better health care coverage designs.

As Medicaid expands in many states and plans develop for populations that are eligible for both Medicaid and Medicare, management of costs must inevitably be part of the discussion. Development of stratification schemes to distinguish higher risk (i.e., higher cost) plan participants from lower cost participants guide protocols in which the payer (Medicaid) and the provider (e.g., a community mental health center) share financial risk across populations.<sup>49</sup> The individuals who come to the attention of criminal justice or forensic mental health systems would most likely often be considered high financial risks, given their constellation of mental health, substance use, and physical health care needs.

Especially in the private payer market, many have cautioned about adverse selection, in that individuals in high-risk corridors may inadvertently be left with fewer choices for health care plans, since only certain plans will be able to accommodate their higher costs, leaving the health care plans to require higher payment premiums.<sup>50</sup> With the higher costs associated with a newly eligible Medicaid population, the need for increased cost containment and tight plan management could also yield unintended collateral consequences. Increased forensic involvement of plan participants, for example, was noted by Fisher *et al.*<sup>51</sup> who found that the addition of a managed-care Medicaid model increased the risk of forensic commitment<sup>52</sup> and that individuals under a Medicaid managed care plan were processed differently in court after an arrest. Even though certain tort reform protections are being contemplated, concerns about

emerging malpractice claims through new cost-containment-focused standards of care have also been raised.<sup>53</sup>

Given that justice-involved individuals with mental illness are at risk for a host of social and occupational challenges, including unemployment, homelessness, and arrest, their health care and health insurance coverage are at risk of repeated disruption. Limited access to health care for many individuals can be one of the challenges that contribute to symptom relapse and poor disease management. Insurance status may make a difference in both health and justice outcomes, as noted by McCabe *et al.*,<sup>54</sup> who found increased legal difficulties for individuals with mania who lacked health insurance during a period of social and occupational impairment.

On the hospital side of funding, there may be additional challenges ahead. For example, the Omnibus Reconciliation Act of 1987<sup>55</sup> provided for the further role of federal Disproportionate Share Payments (DSH payments) for safety net hospitals that disproportionately care for Medicaid and low-income patients. Over the years, provision of DSH payments to state funded psychiatric hospitals were reduced, but DSH expenditures have continued to include significant mental health-related costs,<sup>56</sup> including some care for the uninsured and other expenses. Individuals served in these safety net systems are often those who have cycled between justice and community care systems. With the ACA, DSH reductions are mandated, and it remains unclear whether the advances that the ACA provides will fully address the gap that the DSH payments have provided.<sup>57</sup>

### Roads to System Collaborations and the Interplay of Health Care Reform

With the aforementioned cautionary notes in mind, expanded coverage by the ACA offers promising opportunities. Protocol and policy developments leading to a transformed and improved system that attends to behavioral and physical health care at the boundary of the civil, forensic, and criminal justice arenas will require specialized considerations. Highlights of collaborative approaches focused on these areas should include the following broad themes (see Table 1).

**Table 1** Service Delivery Approaches to Improve Outcomes of Justice-Involved Individuals With Mental Illness

Screening and early intervention
Innovative coverage for care components beyond routine health care costs
Minimize breaks in entitlements and health insurance
Integrate behavioral and physical health care services that extend to collaborations with justice systems

#### Screening and Early Intervention

Mental illness, health disorders, and trauma exposure are highly prevalent among youth in the juvenile<sup>58</sup> and adults in the criminal justice systems.<sup>59</sup> Screening and referral for behavioral conditions and trauma at all ages and across settings can be a critical element toward health promotion, as well as prevention of decline and further justice involvement.

#### Innovative Models of Care Delivery

Innovative models supporting health and wellness have been developed, including coverage for nontraditional expenses that are related to well-being but not considered a health care service. Examples include coverage for air conditioning expenses to improve asthma outcomes<sup>60</sup> and for transportation or childcare services to facilitate attendance at Alcoholics Anonymous meetings as part of substance use recovery plans (e.g., Access to Recovery grants funded by SAMHSA).<sup>61</sup> Informed policy makers should examine innovations such as these that can decrease the likelihood of relapse and recidivism.

#### Minimized Breaks in Entitlements and Health Insurance

Developing seamless mechanisms to minimize disruptions in entitlements and health insurance is critically important to ensuring the continuity of care. Maintenance of benefits across forensic hospitals, jails, and other institutions can reduce the administrative burden of reactivating Medicaid and help facilitate access to treatment services on community re-entry.

Although Medicaid has traditionally not covered treatment services for incarcerated persons, the ACA specifically has a provision that states “. . . an individual shall not be treated as a qualified individual, if at the time of enrollment the individual is incarcerated, other than incarceration pending disposition of

charges.”<sup>62</sup> At the very least, this provision may mean that individuals who are pretrial may more easily be able to remain enrolled in Medicaid. Currently, many states terminate Medicaid benefits upon incarceration for both sentenced inmates and pretrial detainees. Several states have established mechanisms to suspend (rather than terminate) Medicaid benefits, which then makes it easier to reactivate them on release,<sup>63</sup> because an individual is not required to reapply for the benefit if it has only been suspended. Thus, pretrial defendants, including those who are considered incompetent to stand trial, but for whom a forensic status may mean termination of benefits (such as when they are deemed a prisoner by the Social Security Administration) may be eligible to maintain Medicaid benefits, at least in a suspended form that previously was not available. Many states have begun to look at these options as part of systems planning with state Medicaid authorities.

In addition, increasing information has become available related to the possibility that inpatient care for inmates may qualify for federal financial participation (FFP), even while an inmate is incarcerated under a specific exception to the Medicaid exclusions.<sup>63</sup> In theory, policies related to activating these options have the potential to generate cost savings elsewhere in state funding streams that could be redirected to additional community or other needed services.

### ***Integrated Behavioral and Physical Health Care Services and Financing That Extend Collaborations With Justice Systems***

Integrated behavioral and physical health care and “health home” modeling will be an important component of health care reform and, when appropriately planned, can help with the criminal justice population.<sup>64</sup> Munetz and Griffin<sup>65</sup> described the sequential intercept model, a framework from which to identify more accurately individuals with mental illness along intercept points of the criminal justice system (e.g., at pre-arrest, court, community re-entry, or community criminal justice supervision points). Once identified, these individuals can be diverted into needed treatment, thereby lessening the risk of deeper penetration into the criminal justice system. Many states have used this model to develop enhanced linkages to treatment and strategic planning for cross-training between justice stake-

holders and mental health professionals. The National GAINS Center of the Center for Mental Health Services of SAMHSA has used this model for system mapping across the country.<sup>66</sup>

Crisis Intervention Teams (CITs), which have grown exponentially in police departments across the United States, represent an example of an approach that targets an early point of intercept in criminal case processing. Preliminary research has shown positive outcomes in the ability of CITs to connect individuals with mental illness to needed services.<sup>67</sup> Programs like these at the police and mental health interface have been described and supported through the Bureau of Justice Assistance.<sup>68,69</sup>

The effectiveness of drug courts<sup>70</sup> has also inspired the evolution of new models of specialty courts. Mental health courts have begun to show promise as a vehicle for reducing recidivism and fostering participation in community-based treatment.<sup>71,72</sup> Studies showing this advancement are likely to be followed by data on the burgeoning veterans treatment courts, given the recent focus on veterans in the justice system.<sup>73</sup> Re-entry service planning frameworks are similarly expanding.<sup>3,12</sup>

Funds for specialized collaborative justice and treatment programs focused on mental illness and co-occurring substance use disorders through the Second Chance Act<sup>74</sup> and the Mentally Ill Offender Treatment and Crime Reduction Act,<sup>75</sup> managed by the Department of Justice, are helping to drive service enhancements. SAMHSA has identified trauma and justice as a strategic initiative and has for many years similarly provided jail diversion grant funds.

Innovative data evaluation and financing models for juvenile and criminal justice programs, such as Pay for Success and social innovations with private investment schemes, are currently being explored.<sup>76–78</sup> The Pew-MacArthur Results First Initiative is now working in several states to examine data on criminal recidivism and evidence-based treatment programs.<sup>79</sup> These initiatives aim to advance policy, reduce recidivism, and achieve cost savings with demonstrably better outcomes.

With the evolving landscape, public mental health forensic services have moved beyond providing traditional forensic evaluations and have additionally expanded to include programs across the justice continuum. With these innovative strategies to help crossover populations come new questions and refined understanding of the clinical effectiveness and

**Table 2** Suggested Training and Experience for Forensic Mental Health Professionals to Improve Outcomes of Justice-Involved Individuals With Mental Illness

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Enhanced training topics
Co-occurring mental health and substance use disorders
Trauma and its sequelae
Criminogenic factors contributing to recidivism
Behavioral and physical health care integration
Specialized justice and mental health collaborative services (e.g., mental health courts, CIT training, and re-entry programs)
Use of administrative data to inform treatment and enhance outcomes
Forensic, correctional, and public mental health administration and financing
Benefits for health care coverage and barriers to care across systems
Disability entitlements
Privacy protections and information-sharing across systems and with health information exchanges
Increased clinical exposure to justice and mental health collaborative services, such as specialty courts, re-entry programs, and others

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factors related to criminal recidivism. Additionally, there is a need to better understand how to ensure sufficient “treatment slots” for individuals who are legally mandated into treatment, as well as those seeking voluntary services.

### Forensic Roles in Emerging Community Services

Forensic mental health professionals must stay abreast of clinical and legal advances to provide high quality forensic evaluations. Forensic practitioners who also understand systems and services can better address a variety of concerns for individual defendants. For example, an integrated care system that maximizes treatment for co-occurring mental health and substance use conditions and uses peer support to optimize engagement may minimize a particular defendant’s risk of decompensation and subsequent criminal offenses. A forensic evaluator who opines on disposition options such as in an aid-in-sentencing evaluation would benefit from knowing what re-entry programs are available for a particular defendant after release from the jail, whether a specialty court might be available to help support the defendant’s sobriety, and whether the defendant could be eligible for entitlements such as case management and trauma-specific treatment to help him or her succeed.

Forensic practitioners should also be informed on interventions that target criminogenic factors that are likely to cause persons with mental illness to come in contact with the justice system,<sup>80</sup> which moves beyond simply thinking about the criminalization of mental illness. Successful models of justice and mental health collaboration are likely to be increas-

ingly informed by recidivism data and Risk-Need-Responsivity (R-N-R) models<sup>12,81</sup> and will need to focus on trauma and co-occurring disorders.<sup>12,59</sup> National models advancing the ability to look simultaneously at needs across these dimensions<sup>12</sup> will further drive treatment and justice supervision approaches (e.g., through probation and parole), and forensic mental health professionals should stay abreast of these approaches. Development of these service models is already under way.<sup>82</sup>

### Forensic Practitioners: Gearing Up and Stepping Up

The review provided in this article has aimed to help forensic professionals improve their understanding of mental health economics, policy, and service delivery systems that intersect with and impact public sector forensic work. Although it is only focused on the U.S. system, it is hoped that this article inspires a broader perspective of the health care landscape. Forensic mental health professionals may be particularly well-suited for administrative functions and policy development in this arena, given their training and experience in navigating across systems, laws, and clinical practice. Such roles require attention to both an overarching vision and the minutiae of operational details. For every policy that is advanced related to crossover populations, unintended challenging consequences and political push back may need to be addressed. Thus, there is an urgency to have strong clinicians and administrators who both understand the needs of these populations and can take on roles to help shape the future for patients, evaluatees, and the systems and professions that work with them.

Although there will likely always be a need for deep-end forensic services and forensic institutional care, many of the individuals with mental illness seen in the forensic and correctional systems can be better served, and collaborative care will be increasingly delivered, in community settings. As such, specific training and experiential goals should become part of a national standard for forensic specialists (Table 2). First, it will be important to expand the general training of forensic mental health clinicians in foundational areas related to co-occurring substance use disorders, trauma, criminogenic factors, and integrated justice and behavioral and physical health program models that use evidence-based approaches, while emphasizing the critical importance of basic psychiatric treatment as a mainstay of care.<sup>83</sup> In doing so, forensic mental health care can be brought under the aegis of the Institute for Healthcare Improvement's well established "Triple Aim" for better care, better health, and lower costs.<sup>84</sup> Quality measures for better mental health care are complex, and those in forensic settings are all the more complicated by local laws, regulations, and political forces, making improvements in care and discharge planning challenging. These are areas ripe for discussion and future research. Training should include an overview of administrative data and their use to inform quality improvement and service development. Seminars on public policy and psychiatric administration in forensic services should be incorporated into an educational effort that inspires future leaders to carry forward system improvements. Training on funding and economic factors behind forensic mental health care and the acquisition of entitlements (e.g., health insurance, housing, and disability) and barriers to these entitlements for certain offender categories will also help enhance the skills of forensic practitioners. Forensic training should include a focus on privacy protections and information-sharing across various systems of care, especially in light of emerging electronic data-sharing approaches.

Second, forensic mental health practitioners will likely find themselves increasingly involved in services that are relatively new, such as emerging specialty courts, expanded re-entry designs, or specialized probation or pretrial types of programs for persons with co-occurring disorders. Many states already offer an array of programs that are mandated by courts or local laws (e.g., conditional release and assisted outpatient treatment). These models of care

require thoughtful planning and risk management for those individuals with mental illness who may pose risks of harm to themselves or others and risk of recidivism. Early exposure to these programs will be increasingly important, with knowledgeable supervisors and peers who can provide education and broad perspectives.

Traditionally, state mental health agencies identify clinical standards related to many of these mandated services, although over time state Medicaid agencies may need to become more familiar with these legally complex models of care when and if treatment is funded through the Medicaid dollar. The expertise of forensic mental health professionals in legal and regulatory requirements, risk assessment, and risk management can be a helpful asset for providers and insurers that are managing care within these contexts.

## Conclusions

Although there is hope on the horizon for new models of integrated behavioral and physical health care through expanded insurance coverage, there will still be challenges across forensic, correctional, and civil mental health systems of care. We have seen purported improvements meet with disappointment as cracks in mental health care and loopholes in well-intended policies created gaps in services. With that in mind, it is increasingly critical that methods be developed to identify justice-involved individuals with behavioral health needs, beginning with at-risk youth. Once identified, efforts to link them to more effective treatments will need to increase.

If the fractured mental health system described by the New Freedom Commission is to be mended, policy makers must continue to construct models of care that can deliver treatments as seamlessly as possible and make continuous improvements in ethically balancing available resources with demands for services.<sup>85,86</sup> With the behavioral health system in transition, the time is ripe to take on these challenges. Forensic specialists are uniquely poised to develop knowledge and skills that can reduce treatment delivered through interchangeable revolving doors and chart a smoother course ahead.

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