American Journal of Psychiatric Rehabilitation, 16: 154–178, 2013

ISSN: 1548-7768 print/1548-7776 online
DOI: 10.1080/15487768.2013.789709

Routledge
Taylor & Francis Group

''You Don't Get No Help'': The Role of Community Context in Effectiveness of Evidence-Based Treatments for People with Mental Illness Leaving Prison for High Risk Environments

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Community reentry interventions for persons with serious mental illness leaving prison have operated under the tenet that linkage to mental health services is a paramount priority to achieving successful reentry. However, these interventions have produced mixed outcomes, especially related to psychiatric or criminal recidivism. As mental health evidence–based treatments are applied to this population, other environmental or community-level factors such as social disadvantage and poverty may enable or suppress the effectiveness of such intervention models. Such factors need to be considered as possible impediments to the effectiveness of these interventions as perhaps demonstrated in trials with other populations. Explicitly addressing these

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factors may help improve outcomes in some cases. In others, the impact of the risk environment may be stronger than what could be overcome with clinically focused intervention.

Keywords: *Criminal justice; Community context; Evidence-based practice; Mental illness; Prison reentry; Risk environment*

You don't get no help. Alright, I have a drug charge. I'm receiving food stamps now. I can't get medical care. I can't get money. So how in the hell am I supposed to live? You gotta pay bills where you live at. You gotta, you know .... Alright, well, I'll go get a nickel-ante job. I don't have a education. I wanna go to school but it's kinda hard when I wanna go to school but I gotta do this too in order to survive. So how long am I supposed to do this and then go back to school? It's hard and I got kids, too. It's hard. It's hard for me. It's not easy but I try to make the best of it and keep on moving. I try not to get myself in no trouble. I try. But when I came home this time I started selling drugs again. I started again. I didn't care because I said I'm not gonna starve. I tried to go get a job too. It's not like I didn't try to go get a job first. I tried to get a job. But the only job I had wasn't taking care of me like I need to be taken care of. Personal hygiene things, paying my bills, things that I need, not that I want; and I couldn't even get the things that I needed so I had to do what I had to do. (Tyrone, 40 years old, 7 months out of prison).

People leaving prison have multiple needs. They have to find a place to live, acquire a means of support, and secure basic necessities such as food and clothing. Many also need to obtain identification, reunite with family members, and access health care. These tasks are complicated when people are denied entitlements or jobs based on their criminal history. And especially difficult if one has limited education or work experience. All these tasks are further complicated when the person has a mental illness or co-occurring substance abuse disorder. Although the desire to not return to jail or prison may be high, this pales in comparison to the drive for basic needs for self or family, which can push one toward reoffending.

Interventions for this population have focused primarily on linking individuals to mental health services. However, this narrow focus has shown little effectiveness for keeping persons with mental illness out of the criminal justice system. Improving community

tenure for persons with mental illness leaving prison requires a comprehensive understanding of environmental risks contributing to reoffending and developing multiprong interventions that address more than the mental health needs of this population. Both persons with mental illness and those involved with the criminal justice system experience high rates of poverty and social disadvantage (see Baron, Draine, & Salzer in this issue). These conditions and other environmental risks can be described as pernicious and overwhelming for those with mental illness leaving prison.

Persons with mental illness are overrepresented in jails and prisons (Fazel & Danesh, 2002; James & Glaze, 2006; Teplin, 1990; Steadman, Osher, Robbins, Case, & Samuels, 2009) and most have a co-occurring substance abuse disorder (Drake, Mueser, Burnette, & McHugo, 2004). The risk of incarceration for persons involved in the public mental health system or with a history of psychiatric hospitalization is estimated to be 2.5 to 25 times that of the general population (Cox, Morschauser, Banks, & Stone, 2001). Once persons with serious mental illness (SMI) come into contact with the criminal justice system, they have different criminal justice outcomes than persons without mental illness: They have higher rates of return to prison (O'Keefe & Schnell, 2007), return to prison sooner (Cloyes, Wong, Latimer, & Abarca, 2010), are more likely to be charged for a crime or incarcerated compared with the general population (Cox et al., 2001). have less access to halfway houses and other programs to ease their transition to the community (O'Keefe & Schnell, 2007), and therefore are more likely to finish their entire sentence (Feder, 1994; Metraux, 2008). Yet, little is known about the factors that contribute to these differences; there are gaps in knowledge about how the environment and the processes contribute to these poor outcomes. This lack of understanding about the context and processes surrounding these differential outcomes may constrain high quality interventions for this population.

Recidivism rates among persons with mental illness remain high (Cloyes et al., 2010; Lovell, Gargliardi, & Peterson, 2002). Unfortunately, interventions for persons with mental illness in the criminal justice system have produced mixed results for both criminal recidivism and linkage to mental health or substance abuse services (Draine, Blank Wilson, & Pogorzelski, 2007; Loveland & Boyle, 2007; Martin, Dorken, Wamboldt, & Wootten, 2011; Morgan, Flora, Kroner, Mills, Varghese, & Steffan, 2011; Skeem, Manchak, &

Peterson, 2011). Most interventions for persons with SMI in the criminal justice system have operated under a criminalization framework, which postulates that psychiatric deinstitutionalization, changes in commitment laws, and lack of community mental health services have contributed to the criminalization of persons with SMI (Lamb & Bacharach, 2001; Lamb, Weinberger, & Gross, 2004; Torrey, 1997). However, this narrow conceptualization of mechanisms contributing to the large number of persons with SMI in the criminal justice system has constrained approaches to interventions for this population by focusing on individual behavior motivations and linkage to mental health services.

More recently, there has been a call to develop more comprehensive interventions by taking into account both individual-level factors, including criminogenic risk, and environmental-level factors such as social disadvantage (Epperson, Wolff, Morgan, Fisher, Frueh, & Huening, 2011) when planning interventions. Ignoring conditions such as poverty and social disadvantage, which may exacerbate mental illness or increase the risk of criminal offending or contact with the criminal justice system, almost guarantees that these singularly focused interventions will be ineffective for many. Effectively addressing environmental factors may be a missing link in producing effective interventions for persons with mental illness leaving prison.

INTERVENTIONS FOR PERSONS WITH SMI INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

Interventions for persons with SMI involved in the criminal justice system have produced mixed results and have overwhelmingly focused on the individual-level factors that pose risks for reincarceration, primarily focusing on linking individuals to existing mental health treatment without addressing social welfare needs such as housing and income (Martin et al., 2011; Morgan et al., 2011; Skeem et al., 2011; Smith, Jennings, & Cimino, 2010; Solomon & Draine, 1995; Weisman, Lamberti, & Price, 2004). In a meta-analysis, Morgan and colleagues (2011) found little evidence of reduction in psychiatric recidivism and criminal recidivism. Of note, one study showed reductions in both psychiatric and criminal recidivism; however, this study differed from most in that it provided integrated services across systems and included a treatment residence

(Lamberti et al., 2001). Another meta-analysis by Martin and colleagues (2011) found small effect sizes for criminal justice recidivism in general and the specific outcomes of arrests, time to failure, and violent crime; they did not find significant effects for mental health outcomes in general, but moderate to small effect sizes for the specific outcomes of functioning and symptoms. Further analysis by these authors also revealed that more rigorous studies (those that controlled for biases, were rated higher quality, and employed random sampling) had smaller effect sizes and that effect sizes varied considerably between studies. Skeem et al. (2011) reviewed program effectiveness among interventions located either within the criminal justice system or the mental health system. In general, they found mixed evidence for recidivism reduction, and mental health interventions produced the weakest evidence for a reduction in recidivism. Interventions, to date, have not been successful at reducing criminal and psychiatric recidivism or improving mental health outcomes for persons with mental illnesses involved in the criminal justice system.

Interventions for persons with SMI reentering the community from prison mirror the mixed outcomes observed in all interventions for this population. Reentry interventions have been built upon evidenced-based treatments (EBTs) that are successful in keeping people out psychiatric hospitals or homeless shelters. For instance, case management interventions, like assertive community treatment, which has shown to reduce psychiatric hospitalizations and decrease symptoms in many research trials (Morrissey, Meyer, & Cuddeback, 2007) or integrated dual disorders treatment, which has been effective in treating persons with co-occurring disorders, are EBTs that have been adapted for persons with SMI involved in the criminal justice system. But when extended to this population, these EBTs have had mixed results at preventing reincarceration (Chandler & Spicer, 2006; Morrissey et al., 2007). Successful jail reentry interventions have combined EBTs with a residential component (Smith et al., 2010; Weisman et al., 2004), included integration among service systems (Richie, Freudenberg, & Page, 2001; Weisman et al., 2004), or operated in service-rich environments (McCoy, Roberts, Hanharan, Clay, & Luchins, 2004), boosting the effects of the intervention. Conversely, when EBT case managers saw their role as an extension of the legal system or lacked resources for obtaining treatment, higher monitoring actually led to increases in reincarceration (Solomon & Draine, 1995).

Explanations for the limited effects of interventions for persons with mental illness involved in the criminal justice system have centered on critiquing the focus on linkage to mental health and not incorporating other individual-level factors such as criminogenic risk, substance use, and antisocial cognitions (Epperson et al., 2011; Skeem et al., 2011) into reentry interventions. More rigorous studies show smaller effect sizes for interventions (Martin et al., 2011), which suggest that other, unaccounted-for factors, may be important in reducing criminal or psychiatric recidivism. Developing more comprehensive interventions may help reduce recidivism within this population; however, the environments in which they operate may undermine even the most comprehensive interventions. Failure to understand the ways environmental context can impact interventions will contribute to continued mixed outcomes for people with mental illness leaving prison.

FUNDAMENTAL CAUSES AND RISK ENVIRONMENT AS FRAMEWORKS FOR CONTEXTUALIZING COMMUNITY REENTRY CHALLENGES

The fundamental causes and the risk environment frameworks are useful for exploring the contextual factors contributing to reincarceration and undermining interventions for persons with mental illness. The fundamental causes explanation in which Link and Phelan (1995) posit social conditions as fundamental causes for disease has been used primarily to explain disease or health outcomes in public health, but it is also a useful framework to examine a social process like incarceration or reincarceration. Clinical and services researchers tend to focus on the more proximal or intermediary causes of health outcomes and social processes, which are individual person-level factors that seem mutable and therefore worthy targets for intervention. Social conditions are more distal factors that can contribute to poor health outcomes and often are overlooked in health services research. These social conditions can include relationships with others, social or economic position in society, or a stressful event such as the death of a loved one. Distal factors also include access to resources that can help eliminate or minimize risks and allow one to deal with a disease when it does occur (Phelan, Link, & Tehranifar, 2010). Resources can be money, knowledge, power, or prestige, and they commonly operate within

social support and social networks. For example, people with lower socioeconomic status (SES) tend to have higher rates of obesity and diabetes. Interventions at the proximal level may focus on educating people about proper nutrition and diet. However, this approach overlooks the more distal causes that many people of low SES live in ''food deserts''—meaning that they have relatively little access to affordable, nutritious food. If interventions are focused only at the individual level in such environments, they will most likely fail. Food deserts are fundamental, social causes of poor health status.

Link and Phelan (1995) propose that keeping a focus on fundamental social causes instead of the more clinically oriented proximal causes starts with contextualizing the risk factors by taking into account people's life circumstances that shape their exposure to certain risk or protective factors. Contextualizing risk factors will help determine the social conditions that influence individual risks.

The fundamental-causes explanation can contribute to our understanding of the high incarceration rates of persons with SMI. Much of the research in this area has focused on proximal (or individual) causes of incarceration or reincarceration, such as disengagement with mental health treatment, substance use, or criminogenic factors. The current research overlooks the distal causes that contribute to these increased risks, such as environmental factors, like poverty and social disadvantage, that make it difficult for one to avoid drug use or get a job, as illustrated by Tyrone's comments that began this paper.

One way to contextualize the distal factors highlighted in the fundamental-causes explanation that might facilitate reincarceration for persons with SMI is to use the risk environment framework from public health research (Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). The risk environment framework has been successful in identifying public health policies that may negatively impact the health of persons who use IV drugs and promote HIV transmission. The factors examined under the risk environment framework are not individual traits, but political, economic, social, and physical aspects that operate at an individual or community level (Rhodes & Simic, 2005). Restrictions on eligibility for Medicaid or other benefits due to certain criminal offenses impair the individual's ability to gain stable housing or treatment (Nelson, Dees, & Allen, 1999). Employment norms screen out people with felony convictions, pushing individuals back to illegal activities for income generation. Peer and social norms may require that individuals

living with family members find a way to contribute to household income. All these factors have the potential to interfere with a smooth community transition.

The fundamental causes and risk-environment frameworks can highlight the ways poverty, social disadvantage, and other environmental structures contribute to the high rates of persons with SMI involved in the criminal justice system. These frameworks provide different ways of viewing the issue and lead to different practice and policy implications. Policies and practices to date tend to focus on connecting people to existing mental health services through interventions such as supervised reentry programs without taking into account how disparities such as lack of resources or an inability to access resources my contribute to negative outcomes and render these interventions ineffective. This is especially true for case management–based interventions and other interventions that rely on making connections to services and supports in the community. These services and supports are like the oxygen in the air that makes these interventions work. Take away these services and supports and the interventions do not get very far in reaching their valued outcome goals.

Because of the environments many people leaving jail return to, an appraisal of the risk environment needs to accompany any implementation of a reentry intervention for persons with mental illness leaving prison. The failure to understand how a particular environment could boost or restrict the effects of an intervention can lead to the wrong conclusions about the effectiveness of the intervention. In addition, by not fully understanding and addressing the complexities of community reentry, consumers like Tyrone ''don't get no help.''

As we use reentry interventions in attempting to apply evidence-based treatments that have been successful in the mental health or criminal justice systems, the focus of research and implementation in working services environments represents a switch from efficacy to effectiveness research (Hohmann & Shear, 2002). A primary concern of effectiveness research is to deal with the ''noise'' of real-world settings and understand how the noise ''affects the intervention, those providing the intervention, and the potency of its effect.'' (Hohmann & Shear, 2002, p. 202). Implementation research should serve as a guidepost for this transition from efficacy to effectiveness research, but very few implementation frameworks give suitable attention to the risk

environment in which interventions are implemented. Some implementation frameworks include the outer context that includes the sociopolitical context, funding, client advocacy, and interorganizational networks (Aarons, Hurlburt, & McCue Horwitz, 2010) or focus on implementation outcomes such as acceptability, adoption, appropriateness, costs, feasibility, fidelity, penetration, and sustainability (Proctor et al., 2010), but it is not clear what role, if any, the risk environment plays within these frameworks.

Community researchers who are clearly focused on implementation in real-world settings give priority to the potential mediating effects that community can have on implementation (Coulton, 2005). Mendel, Meredith, Schoenbaum, Sherbourne, and Wells (2008) developed an implementation framework that includes a multilevel perspective to implementation in community settings. In their framework, the macrosystem environment includes the culture/normative environment, the resource/economic environment, and the legal/policy environment, which fits nicely with the risk environment framework as the culture/normative environment encapsulates the physical, social, economic, and political types of the risk environment; the resource/economic environment corresponds with the physical, social, and environmental types of the risk environment; and the legal/policy environment matches the political and environmental types of the risk environment. Joining the macrosystem environment of Mendel and colleagues (2008) with the risk environment framework of Rhodes and colleagues (2005) can help elucidate the specific factors in the environment, or noise, that may have implications for effectiveness research (see Figure 1). This model provides a map of how to unpack the various ways the risk environment can interact with interventions and individuals. Including the community context as an integral part of implementation research can only help to expand the effectiveness of interventions, especially in high-risk environments.

EXPANDING THE FOCUS OF REENTRY INTERVENTIONS

Reentry interventions must operate within the social context of risk environments and the macrosocial environment, yet little research has contextualized the local environment in which these interventions operate. Contextualizing a risk environment can provide insight into the application of EBTs within community settings.

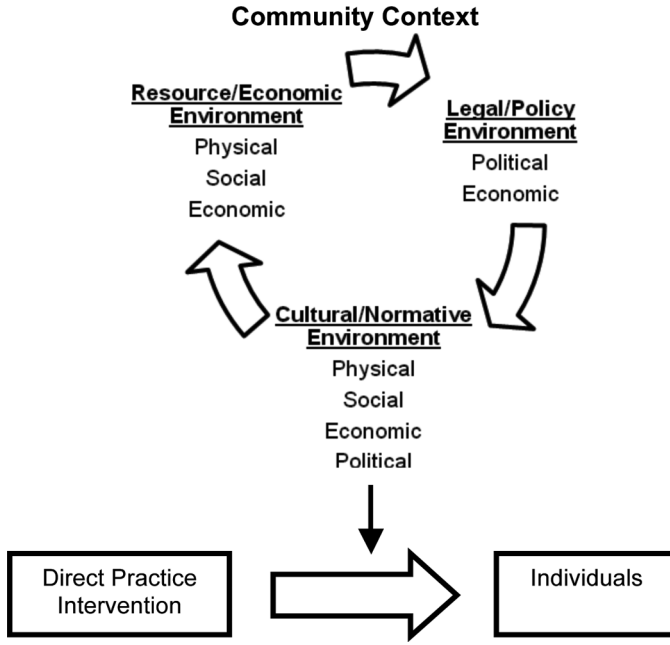

Figure 1 The community context as characterized by the three aspects of the macroenvironment (resource/economic, legal/policy, and culture/normative) and encapsulating the risk environment (physical, social, economic, and political) can interact with the effects of an intervention on individuals.

Knowledge of these factors can aid in developing and disseminating EBTs for persons with SMI leaving prison, especially as effectiveness may be helped or hindered by the community environment. The mixed results from previous research on specialized EBTs for persons involved in the criminal justice system reinforce the conclusion that that preventing reincarceration is a complex task, made nearly futile if one does not examine the risk environment in which consumers of mental health services are living their daily lives.

The categories within the risk environment—physical, social, economic, and political—are not mutually exclusive when real-world phenomena are examined, as some factors may occupy more than one type of risk environment. The macrosystem environment encapsulates these categories within its three environments: the resource/economic, culture/normative, and legal/policy. These

factors within the risk environment are an artifact of the interplay between the different types and level (Rhodes et al., 2005), and this is represented in Figure 1 as arrows between the environments, as each can have an effect on the other. These factors are also locally produced (Rhodes et al., 2005), meaning that although some factors are similar across environments, they may operate differently across communities. Consideration of factors that intersect the dimensions and types of risk environment and macrosystem environment for persons with mental illness leaving prison will be especially helpful at identifying the noise in the community setting impacting interventions: areas of concentrated poverty with limited housing stock and job opportunities, social disadvantage through complex or limited social support systems that can be beneficial and burdensome at the same time, communities fraught with social disorganization and coercive mobility, and federal and state policies that are locally interpreted and enforced.

CONCENTRATED POVERTY

The physical environments, to which many ex-prisoners return, are rife with challenges and obstacles. Many neighborhoods have high rates of poverty, unemployment, and single-headed households (La Vigne, Mamalian, Travis, & Visher, 2003; Travis, Solomon, & Waul, 2001); in other words, areas of concentrated poverty. In an examination of the neighborhoods to which formerly incarcerated persons return, the Urban Institute (Travis et al., 2001) found that people leaving prison return primarily to urban areas and are concentrated in a few neighborhoods within these cities. These communities are often lacking in the social services, treatment facilities, housing, or employment opportunities that people leaving prison desperately need (Pager, 2007). Undoubtedly these communities lack the resources to successfully reintegrate formerly incarcerated individuals and contribute to high rates of recidivism among this population.

Not only do formerly incarcerated persons return to areas of concentrated poverty, persons with SMI also live in concentrated areas of high poverty (Metraux, Caplan, Klugman, & Hadley, 2007). Although persons with SMI and formerly incarcerated persons are concentrated in high poverty areas, social service providers are not concentrated in these areas, as Allard (2009) found that

areas with high poverty have 30% fewer service providers than do areas with low poverty. These recent studies show that persons with SMI and formerly incarcerated persons are residing in high poverty areas with fewer social service providers available and, therefore, may be less able to access needed resources. These physical environment factors can contribute to increased exposure to risks leading to incarceration for this population.

Housing

Persons leaving prison end up in poor communities and have difficulty securing housing; there is a connection between homelessness and incarceration (Metraux, Roman, & Cho, 2008). Homelessness is found within the incarcerated population, and incarceration is found within the homeless population. A Bureau of Justice statistics report (James & Glaze, 2006) found that 19.5% of persons in state prisons were homeless prior to incarceration and 68% of those also had a mental health problem. Additionally, between 2% and 10.5% (Metraux et al., 2008) of persons released from prison did not have a place to stay and went directly to a shelter on release from prison. Among the homeless population, between 23% and 49% have had contact with the criminal justice system (Metraux et al., 2008). Metraux and Culhane (2006) found that 7.7% of the New York City homeless population had been incarcerated, and of those, 61.8% were staying in a homeless shelter within 30 days of leaving prison. Being homeless postincarceration increases the risk of returning to prison (Metraux & Culhane, 2004). These studies show a small but significant interplay between homelessness and incarceration.

Acquiring housing postincarceration is difficult due to lack of funding to pay rent, lack of affordable housing stock, and anticrime policies that make certain types of subsidized housing unavailable to persons convicted of certain crimes (Legal Action Center, 2004). The Housing Opportunity Program Extension Act of 1996 and the Quality Housing and Work Responsibility Act of 1998 created stricter admission policies and easier eviction policies against people convicted of drug or other crimes (Rubenstein & Mukamal, 2002) from living in public housing or obtaining Section 8 vouchers. Not only do these policies affect individuals accused, arrested, or convicted of certain crimes, but eviction policies could also extend

to the household in which the individual resides, putting extended families in jeopardy of losing housing due to one individual's past or current behavior. These tough-on-crime policies prevent some families who could provide shelter to a recently released family member from doing so, because having a family member with a certain criminal charge living in the household puts the entire family at risk of becoming homeless. For persons released on parole, living with family members may also be off limits if another family member has a criminal history, because parole terms often prohibit associating with other former inmates regardless of family connection.

Jobs and Income

Persons with SMI often have difficulty acquiring and maintaining employment and thus experience high unemployment rates. Salzer, Baron, Brusilovskiy, Lawer, and Mandell (2011) found that persons with psychotic and mood disorders had less access to vocational rehabilitation services and were less likely to be employed competitively. Not only does having a mental illness affect acquiring job skills and employment, but also having a criminal record affects access to employment (Peck & Theodore, 2008). Having a criminal background affects one's chances of getting called for an interview by 50% for white males and 75% for black males (Pager, 2007). In addition to informal restriction of job availability through employer scrutiny, there are formal restrictions at both the federal and state levels that bar people with criminal histories from particular occupations or from obtaining licenses for certain occupations (Pager, 2007; Pogorzelski, Wolff, Pan, & Blitz, 2005). Persons with mental illness leaving prison may have little access to developing skills that might lead to competitive employment, but even those who have skills to compete in the labor market may be excluded from employment through informal or formal sanctioning.

Social Support/Social Networks

In general, persons with SMI tend to have social networks composed mostly of family members, professionals or case managers, and peers with SMI (Angell, 2003). Hawkins and Abram (2007) found that marginally housed persons with SMI have small social

networks and people in their networks have little social capital, as they tend to have their own problems resulting from mental illness, substance use, or poor physical health. Yet with limited access to resources, individuals returning to the community from prison still must often rely on family or friends for support during this transition, even though they may have had limited contact with people on the outside while in prison. Reestablishing these ties can be difficult and stressful, and they provide little in the way of social support.

People leaving prison expect to have some social support from formal connections like social service providers and informal connections like family or peers on returning to the community, yet they are also concerned about the possible negative influence of some informal social supports (Pettus-Davis, Scheyett, Hailey, Golin, & Wohl, 2009). Martinez and Christian (2009) found a reciprocal relationship among family members and newly released inmates. Even though family members provided both informational and instrumental support, some family members and participants also expected the recently released inmate to reciprocate support. A majority of released prisoners either reside with family on returning to the community or rely on family for finding housing or meeting other financial or emotional needs (La Vigne et al., 2003; Nelson, Dees, & Allen, 1999). These arrangements can be beneficial when family support leads to positive outcomes (job, increased functioning, and outlook), but living with family can also have negative effects. Some former prisoners report an expectation to contribute financially to expenses and, without other opportunities, they return to illegal means to provide money to the family (Breese, Ra'el, & Grant, 2000). Others reported that high expectations from the family to find work or return to school created family conflict and pushed some to reconnect with drug-using or crime-committing peers (Breese, Ra'el, & Grant, 2000).

Whereas family or friends may be able to provide some type of support upon one's return to the community, this support may be limited in nature or kind either through a lack of resources or an expectation of reciprocity. These relationships can be a source of negative influence. Understanding the tenuous nature of these relationships is tantamount to knowing the resources available to individuals leaving prison. Intervention managers aimed at keeping persons with SMI in the community need to fully understand the complex nature of these relationships.

COMMUNITY OR NEIGHBORHOOD EFFECTS

Social Disorganization

Communities with social disorganization are characterized by little social integration and social control, which contributes to increases in delinquency and crime (Sampson & Groves, 1989). This produces an environment that weakens social ties between individuals and makes it difficult for neighborhoods to self-organize to provide protective factors, thus exposing residents to more negative consequences. Neighborhood characteristics such as socioeconomic factors like poverty, unemployment, percentage of persons receiving entitlements, percentage of female-headed households, and the amount of social disorganization characterized by residential instability, racial heterogeneity, and family disruption can contribute to the amount of mental illness, violence, or recidivism within a community. After controlling for individual-level factors, Silver, Mulvey, & Swanson (2002) found that residential mobility contributed to increased rates of schizophrenia, major depression, and substance abuse disorder and that neighborhood disadvantage contributed to increased rates of depression and substance abuse. Silver (2000) also found that individuals discharged from a psychiatric hospital to neighborhoods with high social disorganization committed more violent acts than individuals released to neighborhoods with low social disorganization. Social disorganization was accounted for by economic deprivation and other structural factors such as racial makeup and female-headed households. Controlling for individual-level characteristics contributing to rearrests, Kubrin and Stewart (2006) found higher rearrest rates for those returning to disadvantaged neighborhoods compared with those returning to more affluent areas. Neighborhoods with social and economic disadvantage can contribute to poor psychiatric health outcomes and rearrests for individuals with SMI leaving prison who live in these neighborhoods.

Communities and Coercive Mobility

Furthermore, criminal justice policies can have community level effects that further impact social networks. *Coercive mobility* (involuntary removal from a community through incarceration; Clear, Rose, Waring, & Scully, 2003) has a negative effect on communities

where incarceration rates are high by impacting social networks, thus destabilizing the community. According to the criminological literature, this destabilization results in increased social disorganization and an increase in crime at the community level. Increased formal social control as evidenced by increased police presence has a negative impact on informal social control and social networks. This phenomenon is captured in Goffman's (2009) research on the effects of arrest warrants on the relationships between wanted men and their families. Families were either subjected to increased attention from police as a way to get to the wanted male relatives or the families used the formal control of the police as a way to control the wanted male relatives (Goffman, 2009). This mirrors similar findings relating to the strategic use of restraining orders by family members seeking to manage the behavior of relatives with mental illness (Solomon, Draine, & Delany, 1995). When there is increased formal social control in these communities, little space is left for informal social control. This reduces the importance of informal relationships within these communities and limits the informal social support available to individuals. Families may be less willing or able to provide support at the crucial time of community reentry when individuals are in the most need of assistance.

FEDERAL AND STATE LEGISLATION

Federal tough-on-crime policies for the past 30 years have contributed to the rising rates of people in prison through the mid-2000s, including those with SMI. Since the late 1960s, the U.S. incarceration rate has increased significantly, rising to 700 per 100,000 people from a low of 100 per 100,000 (Gottschalk, 2006). Policy changes in the 1970s established sentencing guidelines and mandatory minimum sentences (Alexander, 2010; Western, 2006), and three-strike and truth-in-sentencing laws were passed in many states during the 1990s (Western, 2006). These policy changes resulted in higher percentages of people getting arrested, being imprisoned, and staying in prison for longer time periods (Western, 2006). Furthermore, arrests related to the War on Drugs are responsible for two thirds of the rise in federal prison rates and half the rise in state prison rates (Alexander, 2010). These tough-on-crime policies disproportionately affect poor, uneducated, black males (Western, 2006). The rate of incarceration for black males is eight

times that for white males (Western, p. 16). The incarceration rate for high school dropouts is high for both Whites (6.7%) and Blacks (32.4%; Western, p. 17). As the growth in incarceration rates levels off and even begins to decline, a significant portion of people under supervision in community corrections, through probation and parole as in an array of community corrections facilities, remains high, and the greater likelihood of persons with mental illness to fail on probation and parole means that they will continue to cycle in and out of incarceration as well as cycle through risk-laden communities (Skeem & Eno Louden, 2006).

PUBLIC POLICIES

Once people become ensnared in the criminal justice system, it is difficult to break free from the invisible punishment that follows (Mauer & Chesney-Lind, 2002). Public policy trends over the past 50 years meant to ensure that crime does not pay have the effect of making rehabilitation and reintegration into society particularly difficult for those coming out of prison. Restrictions on eligibility for food stamps or other benefits due to certain criminal offenses curb the individual's ability to access treatment or housing (Rubenstein & Mukamal, 2002). In New Jersey, a number of policies restrict or block access to public assistance, housing, employment, driver's license, education, voting and jury duty, expunging of criminal records, and parental rights for people with certain criminal convictions (Pogorzelski et al., 2005). Social service providers in Harlem identified policies in the areas of Medicaid, substance abuse treatment, and corrections as harmful to their clients and posed barriers to accessing treatment (Van Olphen and Fruedenberg, 2004). These policies limit access to important services and resources people with SMI leaving prison need in order to successfully reintegrate into society. When interventions do not address these issues, individuals are left feeling as though they are not receiving the help they need.

SOCIAL DISADVANTAGE

Persons with SMI involved in the criminal justice system share many characteristics with the general population of persons involved in the criminal justice system (poor, Black, and

uneducated) and share fewer characteristics of formerly psychiatrically institutionalized persons (Prins, 2011). In fact, the demographics of SMI within the criminal justice system more closely resemble the demographic profile of the general incarcerated population than the demographics of those who used to reside in state psychiatric institutions. Persons with SMI within the criminal justice system tend to be under 30 and Black and to have a range of psychiatric diagnoses (Teplin, 1990; Trestman, Ford, Zhang, & Wiesbrock, 2007). The inpatient psychiatric population tends to be over 30 and White and to have a diagnosis of schizophrenia (Erickson, Rosenheck, Trestman, Ford, & Desai, 2008; Fisher, Barreira, Geller, White, Lincoln, & Sudders, 2001; Manderscheid, Atay, & Crider, 2009). Clearly, the tough-on-crime policies that, in general, target the socially disadvantaged also target the socially disadvantaged with a mental illness (Draine, Salzer, Culhane, & Hadley, 2002). It is likely that tough crime policies have contributed to high rates of persons with SMI in the criminal justice system in a more profound way than the factors associated with the criminalization hypothesis. By overlooking the changes in crime policy and the role of social disadvantage that have contributed to the overrepresentation of persons with SMI in the criminal justice system, potential changes to reverse this trend are also overlooked.

Having a mental illness and a criminal history in addition to being poor, uneducated, and a minority contributes to a complex array of social disadvantages in which not only economic and employment opportunities are restricted, but opportunities for achieving and maintaining good mental health and accessing vital resources may be limited. Whether due to social causation or social selection (Saraceno & Barbui, 1997), persons with SMI are overrepresented among those with low socioeconomic status (SES). Although mental illness may contribute to diminishing income and movement to lower SES areas (social selection) for some, people living in low SES areas are subject to structural conditions, neighborhood disorder, and environmental stressors that can contribute to poor mental health outcomes (social causation; Aneshenshel & Sucoff, 1996; Wandersman & Nation, 1998). Additionally, there are racial disparities in access to mental health care (Chow, Jaffee, Snowden, 2003; Snowden, Catalano, & Shumway, 2009) that are persistent and not easily explained (Ault-Brutus, 2012). We know something about how risk operates for persons with mental illness and for those involved in the

criminal justice system, but we know little about how risk is operationalized for people who occupy both these statuses. Weaving together the ways in which poverty and social disadvantage operate for both those with mental illness and criminal histories through an examination of the risk environment is a critical step in developing effective interventions for those with mental illness leaving prison.

RISK ENVIRONMENT AS APPLIED TO COMMUNITY REENTRY

By accepting the criminalization of mental illness as the central contributing factor to the overrepresentation of persons with SMI involved in the criminal justice system, interventions have operated with the premise that connection to mental health services was the primary way to decrease or reverse this phenomenon. However, these interventions have not produced definitive decreases in criminal or psychiatric recidivism. Proposals to include other individual-level factors like criminogenic factors and substance use could help strengthen future interventions, but still might not be comprehensive enough. Interventions tend to focus on individual-level factors, which stems from concerns about targeting mutable behaviors, but for some complex social phenomena, we may also need to focus on structural or policy interventions to affect positive change. For example, Housing First models, a structural intervention that provides housing without first requiring treatment compliance, have produced favorable outcomes for persons with SMI, possible co-occurring substance use, and long histories of homelessness (Tsemberis, Gulcur, & Nakae, 2004).

The combination of the effects of poverty and social disadvantage (as evidenced by tenuous social support), homelessness (in the context of an urban environment with limited community resources), social disorganization, punitive public policies in an era of an eroding safety net, and expanding incarceration can profoundly inhibit the process of community reentry for persons with SMI leaving prison. To date, these factors have been examined mostly in isolation from each other, and the full impact of the complex risk environment on community reentry and reincarceration has been unexplored in clinical and services mental health research. Additionally, the risk environment may limit the effectiveness of conventional evidence-based treatments that focus on linkage to

and delivery of mental health services. Understanding how the risk environment operates for individuals with SMI leaving prison is important in understanding how the effectiveness of EBTs might be diluted and how conventional EBTs might be adapted to reduce reincarceration for this population. Research on EBTs can more explicitly describe the context in which the practices are tested. This would require greater on-the-ground work in understanding these settings and the interaction of poverty, violence, substance abuse, and criminal justice risks with the interventions and the anticipated outcomes.

Furthermore, intervention models can be developed that incorporate an understanding of the risk environment, with multilevel assessments of environment and resources. Fidelity studies of existing evidence-based practices can also be replicated in risk environments as ways of assessing the interaction of place-specific risks and the delivery or effectiveness of evidence-based practices (Matejkowski & Draine, 2009). This expands on the point made in the introduction of this special section that encourages researchers to begin to operationalize the specific mechanisms of how poverty interacts with mental illness to perpetuate social injustices in these communities. When clinical and services researchers earnestly focus on the mutable factor in explanatory models as targets for intervention, they tend to ignore a large number of social processes that also offer opportunities for intervention at different levels. The line between explanatory and change models is too often blurred as if they were the same thing. Using our social and clinical science skills to expand our repertoire of intervention targets could generate more ideas for strategies to target more mechanisms of change that are the focus of current interventions in these environments. Many of these mechanisms may not directly address clinical outcomes. However, what they lack in individual clinical impact may be made up in social justice objectives that address clinical outcomes over the longer term.

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