

Behavioral Health and the Justice System

The Missing Intercept: From Lived Experience to Lived Expertise - The Case for Justice Peers

By Helen “Skip” Skipper, CPS, MA
Executive Director,
NYC Justice Peer Initiative
Vice Chair, NYC Board of Correction

A behavioral health crisis can become a 911 call, which can then become police contact. Police contact can become arrest or, in some cases, death. Arrest can become detention, which interrupts medication, housing, employment, treatment, family connection, social supports, and recovery. When all is said and done, release can return a person to the same conditions that helped create the crisis in the first place.

We often describe behavioral health and the criminal legal system as two separate systems that sometimes intersect. For far too many people like me, they are not separate at all. They are experienced as one continuous revolving door – a hamster wheel if you will!

My work has placed me at this intersection from multiple vantage points—as a peer professional, criminologist, workforce developer, organizational leader, and participant in jail oversight and systems



change agent. Those perspectives have taught me something no flowchart can fully capture: when systems collide, people need more than another referral, another assessment, or another case file.

They need a credible human bridge. That

bridge now has a name: The Justice Peer.

We Have Mapped the Intercepts.
Now We Must Staff the Gaps.

The Substance Abuse and Mental

Health Services Administration’s (SAMHSA) Sequential Intercept Model maps six points at which people with mental health and substance use challenges can be diverted from deeper criminal legal system involvement—from community services and crisis response, through law enforcement, courts and jails, reentry, and community corrections (supervision) (SAMHSA, n.d.). The model uses communities as resource navigators identifying resources and gaps. I believe one of the most important gaps is relational.

A person may meet a crisis worker at Intercept 0, a police officer at Intercept 1, a court clinician at Intercept 2, correctional staff at Intercept 3, a reentry specialist at Intercept 4, and a probation or parole officer at Intercept 5. Each professional may be competent and mean well. Yet the person moving through those systems can still experience isolation, exclusion, fragmentation, distrust, repeated retelling of trauma, and the feeling that decisions are happening around them rather than with them.

Imagine instead that trained Justice Peers were intentionally embedded across

see Missing Intercept on [page 29](#)

Diversion Is Prevention: How New York Is Supporting Mental Health Around the Legal System

By Dr. Ann M. Sullivan
Commissioner
NY State Office of Mental Health (OMH)

We all deal with mental health challenges in our lives. In New York State, we are doing everything in our power to guarantee that nobody has to face these challenges alone by expanding community-based services, supporting individuals during all stages of life, and promoting sustained recovery. For those who are involved in the criminal legal system, such efforts are even more essential. Thanks to specialized intensive services and a variety of diversion initiatives, we can often address justice-involved individuals’ mental health needs in a safe and supportive setting.

Diverting individuals from the criminal justice system begins with ensuring access to a wide array of behavioral health treatment and services and the availability of targeted diversion services for those individuals who intersect with the legal system. This article will focus on our ef-



forts to expand the capacity of community-based services, strengthen diversion programs, and maintain the availability of forensic programs with a goal of assisting individuals in successfully maintaining

their community tenure. We have consistently seen that well-timed interventions, diversion initiatives, and ongoing links to tailored care can minimize the need for law enforcement interaction, arrest, and incar-

ceration when someone is experiencing mental health challenges.

Behavioral Health News readers are likely familiar with some of the OMH programs that offer flexible, individualized support and care to individuals navigating vulnerable periods in their recovery journey. Thanks to the tremendous investments of Governor Hochul, we continue to expand the capacity of these community-based services. One such program is Intensive and Sustained Engagement Teams (INSET), a voluntary, peer-led, community-based engagement approach designed to support adults who have been historically marginalized, underserved, or unserved by the traditional mental health system. This 24/7 program also supports people who are at risk of involuntary treatment, hospitalization, or involvement in the criminal legal system. Building on this foundation, the new Forensic INSET (F-INSET) program uses the INSET approach while adding critical enhancements to support people impacted by the forensic mental health or criminal legal system. Both INSET and

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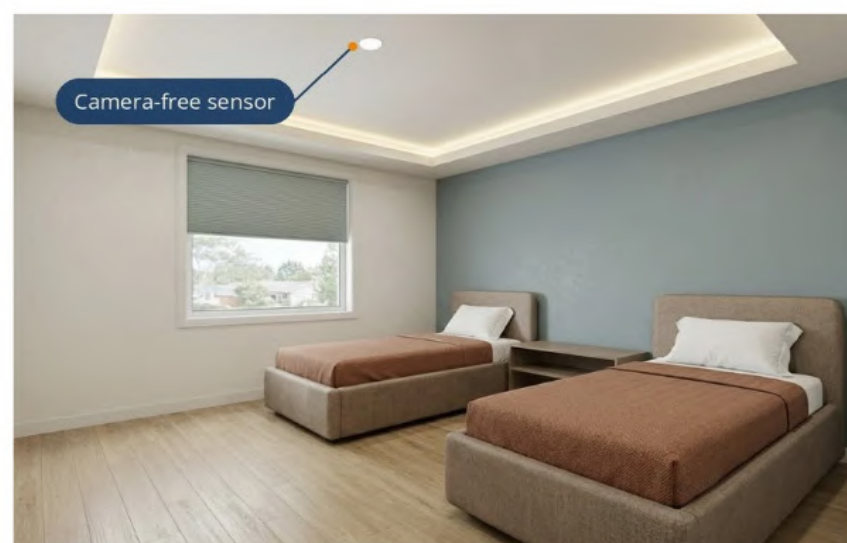


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Preventing Forensic Involvement Through Continuous Care

By Laura Savino, LCSW-R
Senior VP of Care Management
Institute for Community Living

When our behavioral health, housing, and social service systems are unable to adequately meet the needs of people with serious mental health challenges, those individuals too often find their way into the criminal justice system without the treatment and support they need.

The path to incarceration often begins with months or years of instability, repeated hospitalizations, difficulty engaging in traditional treatment, or gaps between levels of care. When the right support is not available at the right time, a behavioral health crisis can escalate into a 911 call, a police encounter, and, ultimately, an arrest.

In New York and other municipalities across the country, there is an ongoing effort to respond to 911 calls involving behavioral health crises with services instead of cuffs, but those efforts, I believe, come too late.

If we want to reduce the number of people with serious mental health challenges encountering law enforcement and the criminal justice system, we need to pay much more attention to what happens before that encounter. We also need to pay attention to what happens after someone becomes stable following a crisis.

At the [Institute for Community Living \(ICL\)](#), I oversee Assertive Community Treatment (ACT), Intensive Mobile Treatment (IMT), and Step-down Treatment Ensures Personal Success (STEPS), among other community-based programs. Overseeing these programs has given me a close view of the work our staff does every day and the importance of having different levels of care available as people's needs change.

No single program can prevent every crisis or instance of justice involvement. But when the continuum of care is strong, we have more opportunities to reach people before a crisis escalates, provide intensive treatment in the community, and help them maintain stability as their needs change.

Reaching People Others Cannot

For some people with the most complex behavioral health needs that have gone unaddressed for years, the first challenge is establishing a connection to care. Two intensive care models help reach this population in New York: the City's IMT program and the State's ACT program. Thousands of New Yorkers need this level of care.

Our 13 IMT and ACT teams bring multidisciplinary behavioral health care directly into the community, reducing the need for people with serious mental health challenges to navigate multiple offices, providers, and systems on their own.

The funding models for these programs allow us to provide ongoing support without an arbitrary cutoff date. IMT teams maintain smaller caseloads, allowing them to provide the most intensive level of community-based care and support, while ACT teams provide similarly comprehensive care at a lower level of intensity. Staff work with people wherever they are



Institute for Community Living staffers and participants inside ICL's East New York HUB. Photo courtesy of ICL.

— in hospitals, shelters, apartments, coffee shops, parks, or on the street — and can continue supporting them for years as their needs change. After hours, people can access their team via an emergency on-call phone for additional support. This flexibility helps connect people not only to behavioral health treatment and medication, but also to physical health care, food, family connections, public benefits, clothing, and other essential supports.

But one of the most important things we provide is time.

Many people we serve through IMT and ACT have experienced trauma and difficult interactions with institutions. Police encounters, incarceration, involuntary hospitalization, and years of difficult experiences navigating systems can make someone understandably reluctant to trust yet another person offering help.

IMT gives our teams the flexibility to start by building a relationship with the person in our care. Sometimes that process takes weeks. Sometimes it takes months or even years.

That persistence matters. Once we establish a relationship, we can provide the care a person needs and help them rebuild their lives. As a result, people in IMT and ACT experience greater stability, while IMT data also show reduced justice-system involvement.

According to New York City Department of Health and Mental Hygiene data from 2025, jail admissions among IMT participants declined from 18% in the year before enrollment to 13% in their most recent year in the program, while the percentage who were stably housed increased from 38% in their first year of IMT to 61% in their most recent year. ICL's 2025 data similarly show that 74% of ACT participants avoided recent psychiatric emergency room visits and 77% adhered to their medication.

But even effective programs like ACT and IMT cannot fulfill that role if people cannot access them. Today, approximately 1,300 New Yorkers are on waitlists for ACT or IMT services. At the same time, some people enrolled in these intensive programs have become stable enough that they no longer require the same level of support.

For years, there was nowhere appropri-

ate for many of them to go next.

The result was a bottleneck: people who had stabilized remained in intensive services because stepping down could mean losing too much support, while people with more acute needs remained on waitlists.

The Missing Step

ICL created STEPS in 2023 to fill that gap. STEPS supports people transitioning from ACT and IMT who have achieved greater stability but are not yet ready for traditional outpatient care. The level of support changes, but their connection to care does not.

That distinction is critical. Becoming more stable should not mean suddenly losing the services that helped someone get there.

We have seen promising results. During their time in STEPS, 97% of participants were housed, 89% were not hospitalized, and 86% did not visit an emergency room. And, remarkably, 100% avoided incarceration while participating in the program.

STEPS allows people who no longer need the intensity of ACT or IMT to move forward while creating capacity for others who urgently need those services. New York City recently invested \$4.5 million to expand the model citywide.

STEPS has allowed us to expand the behavioral health continuum so people have somewhere appropriate to go as their needs evolve.

STEPS is just one example. Because recovery is not linear, we need more types of "right-sized" interventions available to meet people's evolving needs and help them remain stable.

Before the Justice System Intervenes

Conversations about behavioral health and the criminal justice system often focus on moments of crisis: What happens when police respond to someone experiencing psychiatric distress? How can we divert people from jail? What services are available when someone returns to the community after incarceration?

Those questions are critical. But in my work, I have learned to ask another set of questions.

What happened in the weeks, months, or years before someone reached that point? Could they access intensive community treatment when they needed it? Was there a team willing to spend months building trust? Did someone help them maintain housing, connect with a doctor, or navigate benefits? And when they became more stable, was there somewhere for them to go without losing support altogether?

Community-based behavioral health care cannot eliminate every interaction with the criminal justice system.

But too often, jails become places where behavioral health needs are parked. That can be more disruptive and traumatic, further destabilizing someone in crisis.

We can do better by investing earlier and staying involved longer.

Our experience at ICL has shown me that this requires a continuum. IMT gives us the time and flexibility to build trust with people traditional systems have struggled to reach. ACT provides intensive treatment where people live their lives. And STEPS allows people who have achieved greater stability to move forward without asking them to navigate recovery alone.

These are different levels of support for different moments in a person's life. Together, they reinforce a larger lesson: reducing unnecessary justice involvement cannot be the responsibility of the justice system alone.

Sometimes, one of the most meaningful ways to keep someone from entering the criminal justice system is to make sure the behavioral health system never loses them in the first place.



Laura Savino, LCSW-R

Laura Savino, LCSW-R, is Senior Vice President of Care Management at Institute for Community Living (ICL). For more information, email laura.savino@iclinc.net or visit iclinc.org.

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New York City Department of Health and Mental Hygiene. (2025, December 17). *Testimony before the New York City Council Committee on Mental Health, Disabilities and Addiction: Evaluating and Measuring Outcomes and Equity in Mental Health.*



ICL's Step-down Treatment Ensures Personal Success (STEPS)



Institute for Community Living (ICL)'s STEPS offers a personalized, recovery-oriented model for individuals in Intensive Mobile Treatment (IMT) or Assertive Community Treatment (ACT) programs who have made significant progress in their recovery and no longer need a high level of care.

Services Include:

- Peer Recovery Support
- Psychiatric Evaluation
- Medication Management
- Health Monitoring
- Wellness Education
- Comprehensive Case Management & Advocacy
- Skills Development
- Social Engagement

STEPS focuses on individualized care rooted in each person's strengths, needs, and goals, with an emphasis on community connection, whole-health, and building a future that reflects what matters most to them.

Financial Stability: Building Practical Infrastructure for Reentry

By Wendy Molyneux, MSW
Certified Financial Social Worker
Whole Person Finance

James¹ completes a 90-day residential treatment program with a job interview set up for the coming week and a probation meeting he cannot miss. He also leaves with thousands of dollars in outstanding legal financial obligations (LFOs), a suspended driver's license related to unpaid fees, and no dependable way to get to the interview or the meeting. Clinically, he is doing everything right. Financially, he is already behind. That gap can place recovery and reentry at risk.

James's story reflects a widespread, systemic hurdle faced by individuals navigating behavioral health recovery alongside justice involvement. Reentry planning already addresses employment, transportation, housing, and legal and financial concerns, usually as separate areas of need. The opportunity is to go one practical step further: to recognize when the combined cost of legal obligations and basic reentry needs could destabilize someone's transition, and to connect them with appropriate support before a manageable problem becomes a crisis. Financial strain deserves recognition as a recovery and reentry risk in its own right, not as a downstream concern to clinical work. Financial stability is not adjacent to recovery. It is part of it.



The Weight of Legal Financial Obligations

Court costs, restitution, and fines, as well as fees for supervision, monitoring, or drug testing, can impose heavy burdens on people with limited income (Harper et al., 2021). LFOs may bear little relationship to someone's capacity to pay. In some jurisdictions, these obligations can accrue late penalties and interest. Yet depending on local law and the terms of super-

vision, failure to pay can bring enforcement actions, driver's license suspension, probation term extension, or even a new violation. What starts as a single financial obligation can spiral into a "poverty trap" (Lindenfeld & Rouhani, 2026) that follows a person long after the immediate behavioral health and legal issues have passed. An individual can complete every clinical requirement of their treatment plan and still face a fraught, vulnerable future.

The Cost of Coming Back

Reentry involves its own set of expenses that may not be fully anticipated in a treatment or discharge plan. Transportation for treatment and support sessions, court dates, and probation appointments is an ongoing expense that can derail an otherwise solid recovery. A skipped appointment because of a broken-down car or a lack of bus fare can trigger scrutiny, sanctions, or a violation process, depending on local practices and supervision conditions. Housing creates a similar bind. Affordable housing is hard to find for anyone, but many options exclude people with justice histories outright, further limiting the available supply. Renting also typically requires upfront costs, such as deposits and application fees, that many people leaving incarceration or residential treatment simply cannot afford.

Medical and treatment costs require financial means as well. Insurance coverage can lapse during incarceration, leaving a gap precisely when continuity of care matters most. Federal policy has moved toward requiring states to suspend rather than terminate Medicaid eligibility during incarceration (Congressional Research Service, 2024), but reactivation processes still vary and may be hard to navigate. For someone rebuilding a life with almost

see *Financial Stability* on [page 31](#)

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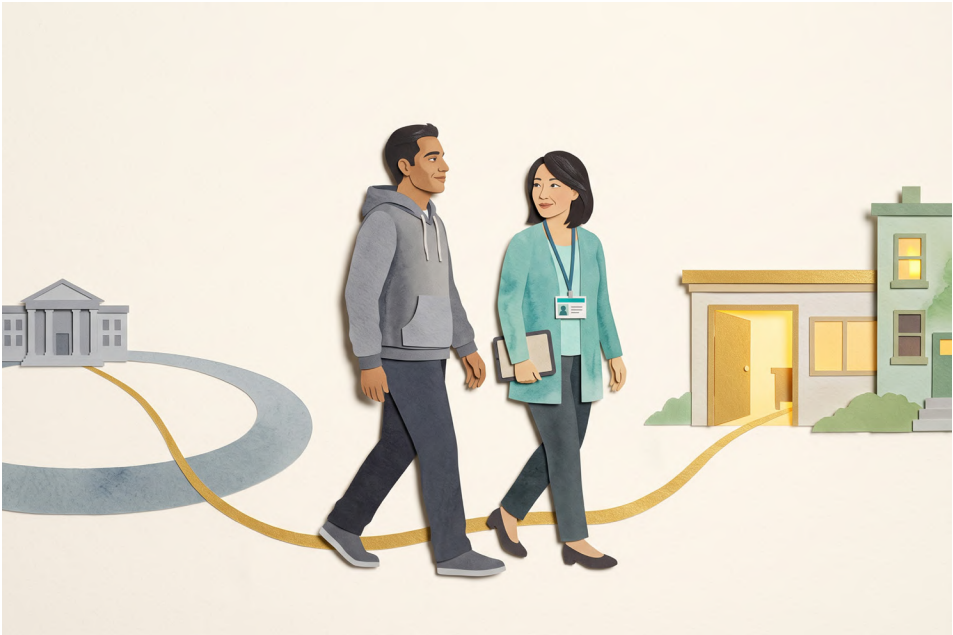
The Role of CCBHCs in Reducing Incarceration

Veronica Richardson, MHA, RHIA, CHPS, CHC,
Senior Compliance Consultant
First Class Solutions, Inc.

For decades, jails and prisons have functioned as the nation’s largest, and least appropriate, providers of mental health and substance use treatment. People with untreated serious mental illness (SMI) and substance use disorders (SUD) often move repeatedly through arrest, incarceration, release, and re-arrest — a cycle driven by the absence of consistent, community-based treatment that could interrupt this pattern. The Certified Community Behavioral Health Clinic (CCBHC) model was designed in part to change that trajectory, and a growing body of evidence suggests it is working.

What Is a CCBHC?

CCBHCs are community behavioral health organizations that receive enhanced, cost-based Medicaid reimbursement or federal grant funding in exchange for meeting rigorous federal standards. Unlike traditional community mental health centers, CCBHCs are required to provide a defined scope of nine core services — including 24/7 crisis services — to anyone who walks through the door, regardless of ability to pay, insurance status, or age.



That “no wrong door” mandate matters enormously for justice-involved populations, who are disproportionately uninsured, underinsured, or experiencing inconsistent coverage. The CCBHC model has grown rapidly, from an eight-state demonstration to more than 500 clinics across 46 states.¹ As the model expands, its accessibility and coordination requirements have become increasingly important for justice-system partners seeking alternatives to arrest and detention.

The Justice System Connection Is Built Into the Model

Justice system collaboration isn’t a peripheral benefit of the CCBHC model; it’s a structural requirement. CCBHCs are required to work with law enforcement agencies and other criminal justice partners specifically to help reduce incarceration, and the data on engagement reflects that mandate. Recent National Council for Mental Wellbeing impact reporting found

that CCBHCs frequently focus their outreach on people involved in, or at risk of entering, the criminal justice system; nearly 81 percent report specialized programming for this group. This emphasis reflects recognition of the substantial behavioral health needs within justice-involved populations and a deliberate effort to expand access, reduce barriers, and strengthen connections to care.¹

This engagement spans the full Sequential Intercept Model (SIM), the framework used across the justice field to map opportunities for diverting people with behavioral health needs away from deeper system involvement:²

- **Intercept 0 (Community Services):** CCBHCs participate in mobile crisis response or co-response with law enforcement, giving 911 systems and 988 crisis lines an alternative to a police-only response.
- **Intercept 1 (Law Enforcement):** CCBHCs can engage in co-response efforts with law enforcement and many train law enforcement and corrections officers in Mental Health First Aid, Crisis Intervention Team practices, or other behavioral health awareness curricula, building the skills officers need to de-escalate and redirect rather than arrest.

see Role of CCBHCs on page 32

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From Juvenile Hall to Clinical Care: De-Escalating Youth Trauma Through Deflection Pathways

By Joel K. Johnson, MEd
President and CEO
Treatment Alternatives for
Stronger Communities (TASC)

Communities increasingly seek preventive alternatives to juvenile detention. Seven in 10 justice-involved youths meet the criteria for a mental health disorder (Dirkhising et al., 2013). For these young people, juvenile detention centers too often act as traumatic accelerants rather than places of rehabilitation. Behavioral health professionals and justice system administrators must understand the critical difference between diversion and deflection — and why the latter is essential for de-escalating youth trauma.

- Traditional Diversion:** Occurs *after* the formal filing of charges and, in the case of youth, after the filing of a petition. It provides an alternative to incarceration, but still subjects a young person to an arrest and the initial stages of the legal process.
- Youth Deflection:** Occurs *before* charges are filed. It is an intervention designed for situations where an arrest might have otherwise occurred, allow-



ing the youth to bypass booking, processing, and an arrest record entirely. In deflection, an arrest might occur, but no charges or court petition are filed. The act of arrest itself, while not required for deflection, does not prevent Deflection from occurring.

By intervening earlier, we can connect youth to clinical services without wait-

ing for the court process, preventing them from reaching a crisis point or bearing the collateral damage of an arrest record.

The Traumatic Toll of the Justice System

Exposure to arrest, detention, and processing inherently adds trauma to a young person’s life. For adolescents with underlying behavioral health conditions, being

handcuffed and placed in a carceral setting — even temporarily — can cause severe anxiety, trigger manic episodes, and exacerbate existing symptomatology.

Deflection actively preserves mental well-being by engaging individuals in the community and de-escalating situations that might otherwise result in substance use or worsening mental health.

The evidence supporting this approach is compelling. For example, an R Street Institute policy paper (Seacrest, 2024) noted that even a short period of juvenile detention is associated with a 31% decrease in high school graduation rates and a 25% increase in adult arrests. Deflecting young people away from these encounters drastically increases their odds of stability and success.

“Deep End” Systems:
Coordinating Cross-System Youth Care

Adults often struggle within the baseline adult deflection handoff from law enforcement to a clinic. For minors, this framework is simply inappropriate. Legally or clinically, youths cannot be treated in isolation. Family dynamics are complex. Often, a young person is simultaneously involved with criminal courts, dependency

see *Youth Trauma* on [page 33](#)



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The Director Who Was Once the Intake: What Justice-Involved Clients Taught Me from Both Sides of the Desk

By Jeffrey T. Crick, MA-HSC, MMHC-BC, CpastC, CCLC
Founder
ReDefined Mission

I have occupied three chairs in the behavioral health system's relationship with justice-involved people: the client in the residential program with a record behind him, the counselor across the desk, and the director deciding who gets the bed. Most practitioners spend a career in one of those chairs. Having sat in all three, I have come to believe the system's biggest failures with this population are not clinical. They are relational — and they are correctable.

My road into the field was the long way. Addiction, homelessness, time behind bars, treatment. Then a rescue mission, where I assisted in the development and oversight of a high-capacity residential program in a homeless ministry capacity, and later directed a high-capacity, long-term residential recovery program. I am a master's-level human service counselor now, practicing in addiction treatment and teaching at the college level. In December 2024, the Governor of Tennessee signed a full pardon with my name on it. The record did not vanish — the pages are still on file — but the verdict is newer than the record.



That sentence, I have learned, is roughly how recovery works too.

The scale of the population we are discussing is not marginal. An estimated 65 percent of the United States prison population has an active substance use disorder (National Institute on Drug Abuse, 2020). These are not two systems with an overlap; they are, to a large degree, one population passing between two doors. What happens

at the seam between those doors is lethal: in the first two weeks after release, former inmates face a risk of drug overdose death many times that of the general population (Binswanger et al., 2007). The intake appointment a justice-involved client attends — or misses — in those first weeks is not an administrative event. It is frequently the highest-stakes clinical encounter that person will ever have.

What the client's chair taught me: shame suppresses engagement before treatment begins. When I sat in the intake chair, every form, every look, and every tone told me whether this program saw a person or a record. Research bears out what I felt: shame-proneness predicts worse substance use outcomes, while its cousin, guilt — responsibility for an act rather than condemnation of the self — predicts better ones (Dearing, Stuewig, & Tangney, 2005). Programs routinely confuse the two. An approach that leads with the record — the conditions, the violations, the “accountability” framing before any alliance exists — activates precisely the self-condemnation that drives concealment, and concealment is the enemy of every clinical goal we have. The practical correction costs nothing: sequence dignity before documentation. Learn the person's name and story before the file's. The file will still be there.

What the counselor's chair taught me: retention is relational before it is programmatic. In residential treatment, length of stay is among the most reliable predictors of post-treatment outcome, and what keeps a person in the building long enough to benefit is less the curriculum than the community and the alliance (De

see *Both Sides* on [page 35](#)

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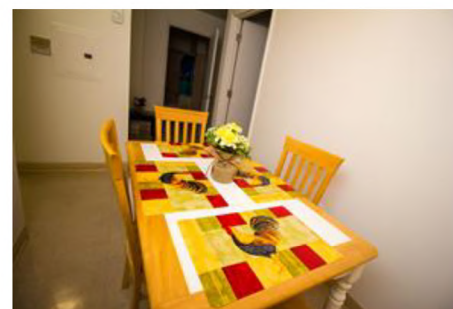
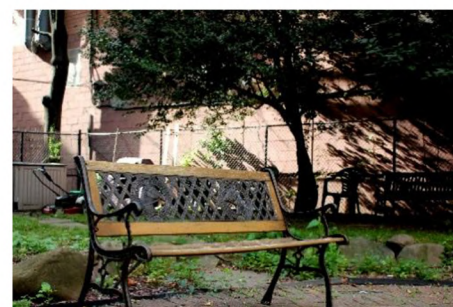
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A Trauma-Informed Approach to Justice-Involved Veterans

By Michael Conroy, LMSW
Team Leader, Supportive Services for
Veteran Families (SSVF) Program
Services for the UnderServed (S:US)

For many veterans, justice involvement does not happen in isolation from their life experiences. Trauma can shape how a person responds to stress, authority, relationships, and support, and for some veterans, those experiences may be connected to post-traumatic stress disorder (PTSD). PTSD can develop after a traumatic event and may include intrusion or re-experiencing, avoidance, negative changes in mood and thinking, and heightened arousal or reactivity. Among veterans, lifetime probable PTSD has been found in 8.0% of veterans, compared with an estimated 6.4%–6.8% of the general U.S. population.² These traumatic experiences may include combat, military sexual trauma (MST), physical injuries, loss, or challenges associated with the transition from military to civilian life. Research has also identified a strong association between justice involvement and PTSD, underscoring the importance of expanding behavioral health support for justice-involved veterans.^{3,4}

Why Trauma-Informed Care Matters

Trauma-informed care acknowledges the



impact trauma can have on behavior, relationships, engagement, and well-being by focusing on safety, trust, collaboration, empowerment, and freedom of choice.¹ Justice involvement, by contrast, often includes stress, authority, and circumstances that may feel threatening or unsafe. For professionals working with justice-involved veterans, trauma-informed care can be used as a universal precaution, meaning it assumes trauma may be present even when it has not been disclosed, to assist veterans who have experienced traumatic events.^{1,5}

Accountability and Trauma-Informed Care

Trauma-informed care does not excuse criminal behavior or eliminate accountability. Rather, it can provide a framework for approaching justice-involved veterans in a way that recognizes the impact of trauma while maintaining accountability. This approach can support pathways to resolution that include treatment, rehabilitation, and community inclusion.^{4,5}

Veterans Treatment Courts and VA Support

Veterans Treatment Court (VTC) is a court-based intervention established in 2008 to provide judicial oversight, accountability, treatment, and veteran-specific support to justice-involved veterans. VTCs assess veterans and connect them with mental health treatment, substance use treatment, medical care, housing, employment, peer support, and case management services. Their multidisciplinary structure, which may include judges, attorneys, treatment providers, Veterans Affairs (VA) personnel, and community-based organizations, allows VTCs to balance accountability with treatment and address behavioral health and social needs in ways that align with trauma-informed care.⁶

Veterans Justice Outreach (VJO), established in 2009, is a VA program designed to support justice-involved veterans by facilitating access to VA healthcare and other services. VJO staff coordinate with courts, jails, law enforcement, and community programs to engage veterans and assess their individual needs. Unlike VTCs, which provide court-based intervention and judicial oversight, VJO extends VA support across multiple stages of justice involvement, including interactions with courts, jails, and law enforcement.⁷

The work of VTCs, VJO, the VA, and community partners demonstrates the value of connecting justice-involved veterans with behavioral health and social services through a trauma-informed approach. Trauma-informed care can help establish trust, increase the likelihood of self-disclosure and openness, and bolster confidence and resilience among justice-involved veterans, potentially supporting stronger

treatment engagement and broader access to care.^{1,5} Research on VTC participants has also identified improvements in housing and receipt of VA benefits, while demonstrating the continued importance of addressing criminal justice outcomes alongside other areas of stability.⁸

Barriers to Access

However, not every justice-involved veteran will have access to VTC, VJO, or specialized behavioral health services. Availability can vary by location, individual circumstances, and the nature of the offense connected to their justice involvement.⁴ It can also be difficult to identify veterans who do not wish to self-disclose because of shame, guilt, or other stigmas associated with justice involvement. Veterans may not disclose a PTSD diagnosis or, in some cases, may never disclose their symptoms and remain undiagnosed.^{3,4}

These limitations highlight the importance of a broader trauma-informed approach that extends beyond specialized programs and individual points of contact within the justice system. Trauma-informed care is not a single treatment or intervention; it is an ongoing approach that can be applied across settings and adapted to the needs of the individuals being supported.¹ For justice-involved veterans, this creates an opportunity for community organizations working directly with veterans to recognize potential trauma-related needs, build trust, and connect veterans with appropriate behavioral health and community resources.

How S:US Supports Veterans

Community-based organizations also play a critical role in extending trauma-informed support beyond the courtroom and into the daily work of housing stability. At [Services for the UnderServed \(S:US\)](#), we help the most vulnerable New Yorkers build healthy, stable, and fulfilling lives — starting with a safe place to call home. Through our [Supportive Services for Veteran Families \(SSVF\)](#) program, we extend this mission to veterans and their families experiencing housing instability. S:US is among the largest providers of services to veterans, having served more than 7,500 veteran households across New York City and Long Island since the program's inception in 2012.

Our program is composed of a diverse group of highly specialized service coordinators, outreach specialists, housing specialists, and veteran peer navigators, allowing us to address the individual needs of veterans through a coordinated and comprehensive approach. Our staff work collaboratively to identify barriers to housing stability, connect veterans with appropriate resources, and help navigate systems that may otherwise be difficult to access. This individualized and collaborative approach is particularly important when working with veterans who may have experienced trauma.

At S:US, our commitment to trauma-informed care extends beyond individual

see Veterans on page 38

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Community Integration, Economic Security, and the Promise of Olmstead

By Nicole Willner
Executive Director
New York Integrated Network (NYIN)

T rue economic security for individuals with intellectual and developmental disabilities is shaped by whether individuals have meaningful opportunities to work, earn income, build relationships, make choices, and participate fully in their communities. Financial planning and economic security for individuals with developmental disabilities and their families extend far beyond benefits planning, special needs trusts, or long-term financial tools.

The [New York Integrated Network \(NYIN\)](#) is a regional network of not-for-profit organizations supporting individuals with intellectual and developmental disabilities and their families. Collectively, NYIN member organizations serve approximately 12% of New York State's developmental disability population, giving the network a significant perspective on the opportunities and challenges facing individuals, families, and providers. Every day, our members see the connection between meaningful community inclusion, greater independence, and long-term economic security.

For more than twenty-five years, the Supreme Court's decision in *Olmstead v. L.C.* has been a major affirmation of national disability rights policy. In its 1999 decision, the U.S. Supreme Court held that the unjustified segregation of individuals with disabilities can constitute discrimination under Title II of the Americans with Disabilities Act (ADA). The Court recognized that public entities are required to provide community-based services when such services are appropriate, individuals do not oppose community-based treatment, and the placement can be reasonably accommodated, considering available resources and the needs of others receiving disability services.

Recent developments at the federal level have renewed debate over the scope of that obligation. In a June 18, 2026, memorandum, the Department of Justice's Office of Legal Counsel (OLC), responding to a request from the White House Counsel's Office, concluded that neither Title II of the ADA nor Section 504 of the Rehabilitation Act imposes a broad integration mandate on states. The memorandum states that *Olmstead's* holding was narrow, acknowledges that its interpretation is "out of step with the common understanding" of the decision in federal courts, and argues that institutional treatment is not discriminatory when a state has a "nonarbitrary rationale" for choosing it. It further concludes that the existing Health & Human Services (HHS) and Department of Justice (DOJ) integration-mandate regulations exceed the agencies' statutory authority and states that the agencies can rescind those regulations and related guidance. These are not merely technical distinctions: they could lower the federal government's standard for challenging unnecessary segregation and weaken the enforcement framework that has supported community living for



decades. Importantly, however, *Olmstead* remains binding Supreme Court precedent, and a memorandum cannot itself rescind existing regulations or overturn the Court's decision.

For individuals with developmental disabilities and their families, the stakes extend well beyond legal interpretation. Community integration is not simply a location. It is a lived experience. A fully integrated life means having meaningful choice over where and with whom to live, opportunities for competitive integrated employment, relationships and natural supports beyond paid service systems, and the ability to participate and contribute as a member of the broader community.

These opportunities are also fundamental to economic security.

Community inclusion can create pathways to competitive employment; employment creates opportunities to earn income, develop skills, build financial independence, and establish long-term stability. Work also expands social networks and creates relationships and opportunities that extend beyond disability service systems. For families, greater independence can reduce some of the financial and caregiving pressures that affect parents' and caregivers' own employment, savings, and retirement planning.

The employment gap facing people with disabilities demonstrates why this connection deserves greater attention. In 2025, 38.1 percent of working-age people with disabilities, ages 16–64, were employed, compared with 74.8 percent of working-age people without disabilities. Among this same age group, the unemployment rate was 8.8 percent for people with disabilities, compared with 4.1 percent for people without disabilities. These disparities illustrate that closing the disability employment gap is not simply a workforce objective. It is an economic-security imperative for individuals and families.

Conversely, limited access to employment and meaningful community participation can reinforce dependence and restrict lifelong economic opportunities. This is why sustained investment in the direct support workforce, affordable and

connection. Competitive integrated employment should be considered a preferred outcome for New Yorkers with disabilities, with state policy supporting opportunities for people with disabilities to work alongside people without disabilities and participate meaningfully in the workforce.

NYIN strongly supports this direction because employment is one of the clearest ways that the promise of integration translates into greater independence and economic security.

Across the communities they serve, NYIN member organizations are demonstrating what a fully integrated life can look like in practice. Three areas are particularly important.

First, competitive integrated employment means more than placing someone in a job. NYIN members support career exploration, job development, coaching, and employer partnerships designed to help individuals obtain meaningful work and build toward long-term success and advancement. Employment provides wages, but it can also create professional relationships, confidence, skills, and a greater degree of financial independence.

Second, authentic relationships and community connections are essential measures of genuine inclusion. NYIN organizations help individuals participate in civic, recreational, volunteer, faith, and other

see Community Integration on page 34



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Beyond Either/Or: Where Assisted Outpatient Treatment Fits in Mental Health Care

By Nathan McLaughlin
Executive Director
NAMI New York State

Debates over Assisted Outpatient Treatment (AOT) too often ask us to choose a side. Either we respect autonomy and rely exclusively on voluntary treatment, or we accept coercion as necessary to ensure people receive care. Neither position adequately reflects the complexity of serious mental illness — or of human beings themselves.

Voluntary treatment should always be the preferred path. But there are people for whom even well-resourced voluntary services have not been enough to sustain recovery. AOT is intended to address that much narrower circumstance. This distinction matters when evaluating outcomes: the success of voluntary treatment for those able to remain engaged in it does not necessarily tell us what will work for someone who has repeatedly struggled to do so.

In June 2026, New York State released an [independent evaluation of its AOT program](#). The evaluation examined outcomes, implementation, participant experiences, and comparisons with intensive voluntary services. That comparison is particularly important: if voluntary treatment can



achieve the same outcomes for the same people, the justification for a court order becomes considerably harder to make.

The findings were more complicated. Across ten key outcome measures, people receiving AOT had significantly better outcomes than a voluntary Assertive Community Treatment (ACT) comparison group on four measures. The voluntary ACT group performed better on two, while

four showed no statistically significant difference. The evaluators viewed the strong results among voluntary ACT participants as evidence that New York has room to make greater use of voluntary intensive treatment where appropriate.

That strengthens the case for making robust voluntary services readily available and ensuring that people being considered for AOT understand those alternatives. But

it does not make the two approaches — or the people receiving them — interchangeable.

Earlier New York research has also found reductions in hospitalization and improvements in treatment engagement while individuals were receiving AOT. These findings should not be interpreted to mean that a court order alone produces recovery. Under [New York’s AOT program](#), court-ordered treatment includes care management or ACT services, along with other services identified in an individual treatment plan. These may include medication, therapy, substance use treatment, educational or vocational activities, and other supports. Separating the effect of these services from the mandate itself is difficult.

We should aggressively invest in intensive voluntary services and make them accessible long before court intervention is considered. But their success for many people should not lead us to assume they will be sufficient for everyone.

What do we owe a person when meaningful voluntary treatment is genuinely available, efforts at engagement have been made, and their illness nevertheless repeatedly prevents them from using those services successfully?

It is tempting to frame the answer entirely around individual autonomy. If each of

see AOT on [page 34](#)

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Why Caregiver Involvement Is a Cornerstone of Treatment for Adolescents with Problematic Sexual Behavior

By Suzanne Katz, LCSW, MBA
Assistant Director, Trager Lemp
Center for Trauma and Resilience
Westchester Jewish Community Services

Adolescents with Problematic Sexual Behavior – just the phrase conjures up stereotypes of these youth as “mini sex offenders.” For many years, treatment approaches for these youth were founded on a set of principles drawn from theories about adult pedophilia. Treatment protocols for youth were merely adult sex offender treatment models adapted “downward” for children and teens. These inaccurate assumptions often led to treatment practices that were mismatched and sometimes harmful, for this youthful population (Chaffin, 2008).

Fortunately, current research and best practices support treatment of this population as *youth* first, with their problematic sexual behavior (PSB) viewed as a possible function of their age and developmental stage. Unlike adult predators, adolescent PSB may be rooted in poor decision-making and impulse control, lack of knowledge of sex laws, and misdirected sexual curiosity. The prefrontal cortex (responsible for consequential thinking, impulse regulation, etc.) does not fully mature until a person’s



mid-20s, making adolescents highly vulnerable to short-sighted, impulsive sexual decision-making. In this context, it is easy to understand why caregiver involvement in treatment for adolescents with PSB is so important. With caregivers in joint treatment groups, the dynamic shifts from *fixing the teen* to *growing together as a team*. By learning the same impulse-control and decision-making skills as their teens, care-

givers can better model these skills at home in real time. They can reinforce new skills learned and address family dynamics that contribute to a teen’s behavior. Caregivers can also learn how to monitor and supervise their youth more appropriately. Active caregiver participation effectively bridges the gap between the clinical setting and the home environment, giving the adolescent a better chance of generalizing the skills

they learn in treatment to the real world in which they live.

My journey treating youth with problematic sexual behavior began last year, when I attended a learning collaborative at the [University of Oklahoma’s National Center on the Sexual Behavior of Youth \(NCSBY\)](#). A colleague and I were trained in the evidence-based treatment protocol of PSB-CBT-A: Problematic Sexual Behavior -- Cognitive Behavior Therapy Program for Adolescents. PSB-CBT-A was developed by Dr. Barbara Bonner in 1986 to treat youth who had been adjudicated for illegal sexual acts or had been otherwise identified as engaging in problematic sexual behavior. In the 40 years since its inception, the PSB-CBT-A program has built a robust evidence base for its effectiveness at reducing recidivism rates for adjudicated youth. Data indicates that over 97% of successful program completers were free of any sex offense arrests or reports at long-term (average of 10 years) follow-up. In other words, only 3% had a future offense or report. In contrast, approximately 15% of non-completing participants had a future sex offense arrest or report (University of Oklahoma Health Sciences Center, 2026). **Importantly, the strongest single**

see Adolescents on page 39



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The NYSPA Report - Treatment Before Arrest: Why Diversion Begins with Engagement

By Mardoche Sidor, MD
Chief Medical Officer
Urban Pathways

When psychiatrists discuss behavioral health diversion, we usually mean redirecting a person away from arrest, jail, or prosecution and toward treatment. Mental health courts, crisis-response programs, and alternatives to incarceration are essential; yet if diversion begins only after criminal-legal contact, it has begun too late. Before the police encounter or courtroom appearance, there may have been an unanswered outreach visit, an appointment that was never rescheduled, an escalating symptom interpreted only as misconduct, or a recurring crisis that never led to a sustained therapeutic relationship. At Intercept 0, engagement is what makes early diversion possible.

Making Intercept 0 Work

The Sequential Intercept Model correctly begins with Intercept 0: community services and crisis responses before law-enforcement involvement. It identifies additional opportunities for diversion throughout the criminal legal system and reentry (Substance Abuse and Mental



Health Services Administration [SAMHSA], 2024). The earliest opportunities for diversion therefore exist at Intercept 0. Yet services alone do not guarantee diversion. A referral, appointment, and clinically sound recommendation may all exist while the person remains disconnected from care. Intercept 0 succeeds only when people can be reached, relationships established, and services made acceptable and usable. In

other words, engagement does not precede Intercept 0; it is a clinical process that makes Intercept 0 effective. Behavioral health systems often assume a familiar sequence: a person recognizes a need, accepts a referral, attends an appointment, and follows a treatment plan. Those with the greatest needs, however, may be least able to move through that sequence. Some have experienced coercion, stig-

ma, institutionalization, discrimination, homelessness, or abandonment. Others live with paranoia, cognitive impairment, active substance use, trauma, or serious medical illness. From the clinician’s perspective, the person may appear resistant, unmotivated, or nonadherent. From the person’s perspective, refusal may be protective, avoidance may reflect fear, and anger may be an effort to preserve dignity. What appears to be a failure to engage may be a predictable response to how treatment or authority more broadly has previously been experienced. When this response is met with case closure, fragmented referrals, or escalating pressure, untreated needs do not disappear. They may instead reemerge as an emergency department visit, a 911 response, an involuntary intervention, or an arrest.

Engagement Is a Clinical Intervention

Psychiatry often treats engagement as a preliminary task: first persuade the person to enter treatment, then begin the real clinical work. Yet engagement is not merely the prelude to treatment; rather, it is part of treatment. Research identifies therapeutic alliance, accessibility, and confidence that treatment

see NYSPA Report on [page 36](#)

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The NYSPA Report - The Fifteen-Month Clock: Substance Use Disorder, Recovery Timelines, and the Law's Deadline for Parents

By Heidi Makhoul, MS-4
Case Western Reserve University
School of Medicine
and Elie G. Aoun, MD
Columbia University

The forensic dilemma at the intersection of substance use disorder (SUD) and family law appears at several junctures: pregnancy, child welfare, custody and divorce, juvenile justice, and education. Pregnancy is an especially telling case, a physical state that invites a future orientation toward the unborn child. How a clinician interacts with a patient seeking SUD treatment is colored by state and federal law, each shaped by its own precedent and political identity. This article follows one such path, from a mother's pregnancy through the child welfare system to the threat of losing her parental rights entirely.

Consider a 32-year-old woman with PTSD complicated by alcohol and opioid use disorders who learns she is pregnant at 12 weeks. She used intoxicating substances regularly before and after conceiving, but now wants to cut back and is motivated to deliver a healthy baby and raise the



child on her own. She previously attempted SUD treatment programs on several occasions unsuccessfully. Matters are further complicated by a previous delivery of a baby with neonatal abstinence syndrome: that child now lives with a paternal grandmother, while the patient herself is stay-

ing with a friend. She comes to the clinic seeking treatment. Whether her disclosure leads to treatment or triggers judicial prosecution will depend entirely on the state in which she lives.

The general features of this patient's case may lack nuance. However, parental

substance use is now a factor in a large and growing share of child welfare involvement nationally. Among children entering out-of-home care, alcohol or drug use by a parent was cited as a condition of removal in 18.5% of cases in 2000. By 2021, that figure had risen to 39.1%. Estimates of substance use problems among parents already involved in the child welfare system range from 50 to 80 percent. Roughly one in eight children in the United States lives with at least one parent who has a substance use disorder.

The complicated picture painted by these numbers is further complicated by how legal and treatment systems run on separate timelines. As anyone working in health care will attest, SUD treatment runs on relapse, re-engagement, and the slow accumulation of stability. Child welfare, by contrast, runs on deadlines, because indefinite uncertainty — a defining feature of SUD — is itself considered a harm to the child. Federal law starts the clock running and expects both the patient and her treatment to keep pace with it.

When the clock runs out, drastic measures can be taken, including termination

see *Fifteen-Month Clock* on [page 37](#)

Spotlight On: American Psychiatric Association Council on Psychiatry and Law

By Danielle Kushner, MD
Associate Chief of Mental Health,
NYC Health and Hospitals,
Correctional Health Services
Associate Program Director,
NYU Forensic Psychiatry Fellowship

The American Psychiatric Association (APA) Council on Psychiatry and Law is a national body responsible for evaluating key areas of legal and regulatory issues that influence the practice of psychiatry and offering expertise in specialized areas of forensic psychiatry. The Council

includes the Committee of Judicial Action, providing expertise for appellate cases and determining whether the APA should submit amicus curiae briefs, and the Carceral Psychiatry Workgroup, leading actions related to carceral (correctional) psychiatry. Recent Council work has included Resource Documents on Person Centered Language in Jails and Prisons and Role of Psychiatrists in the Post-Roe Era, along with Position Statements on a variety of topics including the legalization of cannabis, "excited delirium," civil commitment for substance use, and the insanity defense, among others.

Attention: Are you a local psychiatrist treating patients interfacing with legal and community psychiatry systems? Are you looking for like-minded colleagues to discuss challenges, support, and brainstorm solutions?

The Council has recently supported the initiation of the Justice Psychiatry Caucus to connect with other APA members about the important work of caring for and advocating for people involved in the criminal justice system.

The Justice Psychiatry Caucus held its first meeting during the APA Annual Meeting in May 2026 and started the discussion about ways we can advocate for patients,

improve the system, and support those working in this important but challenging area of psychiatry.

The first virtual meeting of the Justice Psychiatry Caucus will be held on Wednesday, **October 14th, 2026, at 5:00 pm ET**. Please reach out to contracts@psych.org for further information. All APA members are welcome to join!

Current and past members of the Council on Psychiatry and Law from New York (Area 2 of the APA) include: Jack Drescher, MD; Carl Fisher, MD; Elizabeth Ford, MD; Abhishek Jain, MD; Danielle Kushner, MD; and Gary Graca, MD. Thank you for your hard work and dedication!

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Justice-Impacted Older Adults: Supporting a Vulnerable Population

By Catherine Thurston, LCSW
Chief Executive Officer
Service Program for Older People (SPOP)

When we think about justice-impacted older adults, there are three facts we need to keep in mind:

- A post-incarceration transition is difficult under the best of circumstances.
- Justice-impacted older adults tend to have complex behavioral and physical health needs.
- Adults over age 60 are less likely than younger people to have a network of family or friends to provide practical or emotional support.

Given this scenario, one might expect communities to offer extra support for older adults. But that is not the case, and in fact the compounding bias of ageism + ableism + carceral history stigma often adds up to increased likelihood of homelessness, unemployment, and untreated mental illness.

SPOP is a community-based behavioral health provider for older adults (55+) based in New York City. We serve 1,000



clients annually through an outpatient clinic and a psychiatric rehabilitation day program (PROS) for adults with serious mental illness. We offer a full range of services including individual and group therapy, psychiatry, medication management, assessments, bereavement support, group-based psychiatric rehabilitation services, creative arts therapies, social healthcare, and linkages to support for housing, meals, and financial assistance. We have decades of experience supporting formerly incar-

cerated older adults, and we have seen how important behavioral healthcare, housing, and community are for successful re-entry.

We also offer training in aging and mental health that draws on our clinical expertise, with online and in-person workshops on various topics including best behavioral health practices for justice-impacted older adults. This particular workshop is designed to give staff the tools to recognize ageism and bias, understand the needs of this population, and connect older adults to appropriate services, housing, and social supports.

Recommendations for Better Supporting Older Adults in Re-Entry

I'd like to share a few recommendations on how we can all do a better job of supporting older adults as they re-enter society.

To start, we need to recognize that incarceration – together with the detrimental effects of racism, poverty, and limited access to healthcare – creates a dynamic of accelerated aging. These stressors literally erode the body by 10 years or more, so that a person leaving prison at age 50 is likely to have medical conditions and organ functions that mimic a much older person. This means that behavioral health programs that work with a justice-impacted population should pay particular attention to clients in their 50s, who may have acute needs but are too young to qualify for many aging-specific benefits and supports.

The mental health community must also confront ageism in behavioral health ser-

vices. Age bias is rampant, even among behavioral health professionals, and we need to focus on providing age-affirming care. Justice-impacted older adults are especially vulnerable: 30% have clinical depression, 20–40% have symptoms of Post-Traumatic Stress Disorder, and overall they are more likely to die by suicide than any other imprisoned age cohort.

We need to become familiar with age-related risk factors and signs of older adult anxiety and depression, and we need to resist the temptation to use “elderspeak” or other reductive language, such as high-pitched voices or speaking too loudly, which may undermine an older person's strengths and capacities. All agencies should screen older adults for substance use – and not wait until the client falls or develops a serious medical condition. Justice-impacted older adults should especially be supported with screening and healthy coping options.

Interventions can also focus on meeting social health needs such as stable housing, vocational or avocational support, transportation, food security, and safety. Social health includes frequent and consistent social contact — because loneliness and isolation can be a death sentence for older people. When older people who were formerly incarcerated are rebuilding an outside community, they need people, places, and things to sustain them.

Finally, behavioral health professionals can help justice-impacted older adults build positive identity and legacy. Incarceration disrupts the opportunity to generate a positive self-image, mastery of life skills, and a meaningful role in the community. Older adults emerging from the justice system benefit from professionals who value their contributions, encourage intergenerational activities, volunteerism, and community engagement, and give them the tools to live purposefully.

Catherine Thurston, LCSW, has served as Chief Executive Officer of [Service Program for Older People \(SPOP\)](#) since 2024, having previously served as Chief Program Officer. She has over 35 years of experience in gerontological social work. She has been a member of the Adjunct Faculty at the Silberman School of Social Work at Hunter College since 2016. She received her Master of Social Work from Hunter College School of Social Work.

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Beyond Deinstitutionalization: Unraveling the Complex Criminalization of Serious Mental Illness in America

By Ashley Brody, MPA, CPRP
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Search for Change, Inc.

Individuals with Serious Mental Illness (SMI) are disproportionately represented among the populations of the nation's correctional facilities. Some have dubbed jails and prisons the "New Asylums" as the criminal justice system has become the de facto service provider for individuals with severe psychiatric disorders. It is commonly believed this trend is a tragic byproduct of a deinstitutionalization movement that began in the 1950s with the advent of new psychotropic medications and emerging calls for reform. As the census of state-operated psychiatric facilities dwindled to a fraction of its peak in the mid-20th century, incarceration rates among individuals with SMI have exploded. Many cite this inverse correlation as evidence of a "transinstitutionalization" wherein former (or would-be) hospital patients are now relegated to carceral settings ill equipped to serve them. To attribute the prevalence of SMI in America's jails and prisons solely to the deinstitutionalization movement is an oversimplification, however, and it obscures other factors that underpin an exceedingly complex problem for which solutions of sufficient nuance and sophistication are warranted.

The widespread incarceration of individuals with SMI corresponds to rising rates of incarceration in general, as the U.S. now imprisons significantly more of its citizens than other industrialized nations. During the first half of the 20th century, incarceration rates remained relatively stable at approximately 110 prison inmates per 100,000 people (Schlosser, 1998). The 1970s marked an inflection point at which incarceration rates climbed sharply. Exponential increases followed in the ensuing decades, and the U.S. now incarcerates approximately 1.9 million people (541 per 100,000) within its state and federal prisons, county jails, and other detention centers (The Global Statistics, 2026). America's reliance on incarceration as a default corrective for crime and social disorder is a consequence of factors through which the modern "Prison Industrial Complex" has emerged to perpetuate the status quo. Politically driven imperatives to enact "tough-on-crime" legislation, perhaps most notoriously in the form of the Rockefeller Drug Laws enacted in the early 1970s, which imposed mandatory minimum prison sentences for convictions of even relatively minor drug-related offenses, produced a predictable spike in incarceration rates among the urban poor and other marginalized communities (Schlosser, 1998). A consequent crisis of overcrowding in the nation's correctional facilities became a boon to private prison operators eager to relieve state and federal governments of their administrative responsibilities. Moreover, the political climate for these operators could not have been more auspicious. A prevailing antipathy toward "Big Government" and corresponding devolution



of authority to the private sector provided fertile ground on which a new prison industry blossomed. What emerged is an inordinately complex web of actors whose economic interests are inextricably tied to the mass incarceration of the American people, including a disproportionate share of the most vulnerable among us.

Individuals with SMI are uniquely susceptible to involvement in the criminal justice system for reasons that underscore the failings of this system and of others on which they rely for essential healthcare and social support services. A subset of this population is prone to repeated episodes of arrest and incarceration for minor criminal offenses related to symptoms of untreated disorder or associated life challenges. Such "offenses" include loitering, panhandling, camping in public spaces, visibly erratic behavior, and other manifestations of mental illness or homelessness. Thus, the prevalence of homelessness among individuals with SMI is, in and of itself, a leading risk factor for encounters with law enforcement officials (Urban Institute, 2020). Once incarcerated, individuals with SMI often remain incarcerated longer than other inmates charged with comparable offenses (Ditton, 1999). The trauma of imprisonment is felt most acutely by individuals with preexisting disorders of thought, mood, and behavior, so it is unsurprising that many should experience profound difficulty in navigating its stressors in a manner that would expedite their release. For instance, individuals with SMI are more likely to be involved in (and victims of) assault while incarcerated (Blitz, Wolff, & Shi, 2008), and many are also unable to consistently abide by the strictures of carceral life (Halvorsen, 2018). These factors do not merely prolong the terms of imprisonment for those with SMI. They render them uniquely vulnerable to solitary confinement — a punishment deemed exceptionally traumatic for members of this population. A broad coalition of stakeholders now supports a prohibition on the use of solitary confinement, particularly among individuals with SMI, as it has been found to induce or to exacerbate mental illness and to undermine opportuni-

ties for rehabilitation that might otherwise interrupt cycles of arrest and incarceration (Karplus, 2023).

Life upon release from incarceration poses additional challenges for individuals with SMI that contribute to recidivism and deeper entrenchment in the criminal justice system. As it is not uncommon for inmates to lose community housing arrangements they might have maintained

prior to incarceration, homelessness is an all but inevitable consequence of confinement. An acute shortage of affordable and supportive housing leads to prolonged periods of homelessness and reexposure to the adverse conditions that preceded incarceration, ensnaring many in a seemingly endless "Homelessness-Jail" cycle (Urban Institute, 2020). Some research suggests individuals with SMI who receive community supervision through the Division of Parole are particularly susceptible to this cycle, as they are more likely than other parolees to be reincarcerated for violating the conditions of parole (Wood, 2011). An intervention designed to facilitate offenders' successful reentry and enduring community tenure may undermine these aims when applied to those too compromised to accommodate its terms.

In consideration of the multiplicity of factors implicated in the criminalization of serious mental illness, some researchers suggest strategies must be carefully calibrated to individuals' conditions and circumstances to successfully mitigate their risk of incarceration. Adherents of a Sequential Intercept model describe interventions that may be applied to effectively "capture" individuals at various stages of involvement in the criminal justice

see *Deinstitutionalization* on page 36



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Closing the Re-Entry Gap: Connecting Justice-Involved Individuals to Addiction Treatment

By Raven Manchester
Joshua Lynch, DO, FACEP
MATTERS Network
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Erie County Sheriff's Office

Individuals in incarcerated settings are found to have an increased risk of overdose and drug-related injury during community re-entry, with the first two weeks carrying the most risk (Hartung et al., 2023). Justice-involved individuals face significant barriers to accessing substance use services both while incarcerated and upon release. Lack of training around medication for addiction treatment (MAT), limited staffing capacity, and overcrowding are common challenges across correctional settings, including both jails and prisons (Farhoudian et al., 2022). The Correctional Association of New York State (CANY) found in 2019 that 78% of individuals with Opioid Use Disorder (OUD) were denied MAT, which contributed to a post-release overdose mortality rate 40 times higher than the general population (Correctional Association of New York, 2024). Since NYS implemented legislation mandating access to MAT (such as Law Article 22, 626) in state prisons, CANY reports a 552% increase in total active participants between



2022 and 2024, with an additional 19% increase between 2023 and 2024 (Correctional Association of New York, 2024). Aside from barriers within the justice system itself, individuals with system involvement experience compounded stigma, both for their substance use and their criminal history. Concerns about further legal repercussions, such as a fear of re-incarceration or loss of parental rights, can

deter individuals from seeking help. Connections between community-based treatment and correctional settings can often be fragmented, creating gaps in care during the re-entry process (Farhoudian et al., 2022). In Rhode Island, the introduction of their MAT program in jails and prisons was correlated with a 60% decrease in post-release overdose deaths. Participants who engaged in MAT had a decrease in opioid

use, HIV/Hep-C transmission, and return-to-use rates, and an easier transition to community re-entry. New York's own pilot programs in Sing Sing and Bedford Hills correctional facilities showed similar outcomes, with 72% of participants retaining treatment for at least six months post-release, compared to 22% in non-MAT cohorts (Substance Abuse and Mental Health Services Administration, 2019; The Council of State Governments Justice Center, 2024). Comprehensive re-entry programs are more than MAT; they are composed of supports for mental health, housing, employment, physical health, and other SUD services. Evidence shows these programs reduce recidivism and improve independence within the community (Department of Justice, 2024). MATTERS partners with jails, prisons, and other criminal justice organizations to facilitate rapid referrals to treatment for opioid use disorder. The program helps bridge gaps in care during re-entry, including delays in Medicaid reactivation or access to a community treatment provider. Understanding the diversity across correctional settings, our team has developed facility-specific workflows across NYS to address the complex needs of different facility types and provide seamless linkage

see Re-Entry on page 35

Continuity of Care Before and After Release

How MATTERS Supports Re-entry

Connecting people with opioid use disorder (OUD) to continued care and resources before and after release.

MATTERS works with correctional facilities, criminal justice organizations, treatment providers, and community partners to streamline referrals and help people maintain access to care.

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Decriminalization Alone Won't Fix Addiction - Infrastructure Will: A Comparative Look at Portugal, the Netherlands, and the U.S.

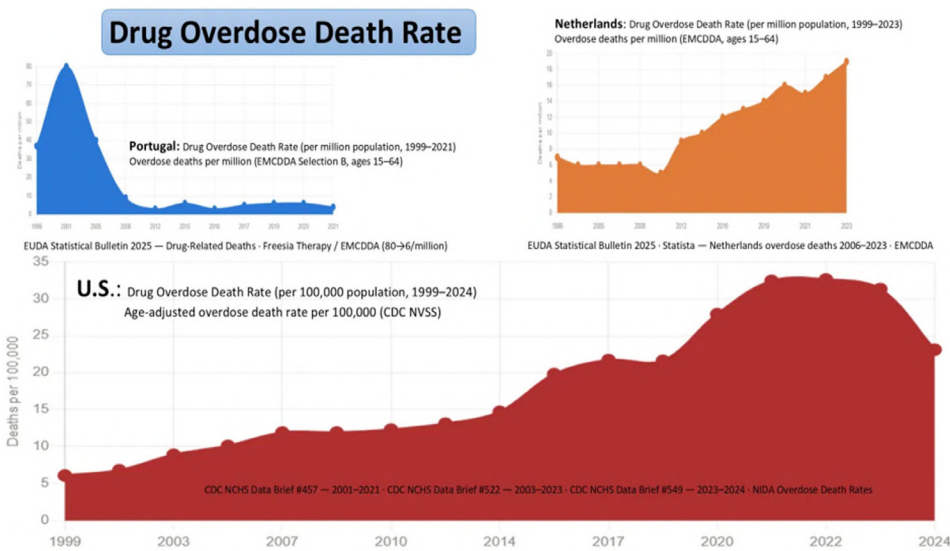
By Shawna Logue, CHW, PS
Mihwa Gassett, ST-LAC
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In *Chasing the Scream: The Search for the Truth About Addiction*, Johan Hari asks, “What if everything you think you know about addiction is wrong?” (Hari, 2015). Hari posits that addiction is driven by isolation more than chemicals. In a widely viewed TED Talk he states, “The opposite of addiction is not sobriety. The opposite of addiction is connection” (Hari, 2019).

This literature review examines the approaches of three different countries and their drug policies. The countries examined are Portugal, the Netherlands, and the United States, which have policies ranging from decriminalization of substances, public health, and approaches that combine harm reduction with criminalization.

With the rate of overdoses and overdose deaths around the world in the tens of thousands, a study of drug policies was needed to examine the strengths and weaknesses of each model.

For this review, we selected literature from government and scholarly sources.



Government statistics presumably gather information that reflects the success rates of different approaches for the purpose of driving the focus of interventions.

Data from the European Union Drug Agency (EUDA) and the Trimbos Institute (Formerly known as the Netherlands Institute of Mental Health and Addiction) was utilized for the Netherlands, and the EUDA data was also utilized for Portugal. Statistics from the Centers for Disease Control (CDC) were utilized to look at outcomes in the United States.

Research Questions:

- 1. Does a public health policy or a criminal justice-focused policy more effectively address substance use disorder as measured by overdose death rates?
- 2. Does a public health policy or a criminal justice-focused policy more effectively address substance use disorder as measured by the number of people incarcerated for substance use?

- 3. Does a public health policy or a criminal justice-focused policy more effectively address substance use disorder as measured by the costs associated with each approach?

Addiction as a Disease:
A Public Health Model – Portugal

In the 1990s, Portugal faced one of the most severe heroin crises in Europe (Moury & Escada, 2022), with approximately one percent of the population reported as heroin dependent and overdose deaths peaking at 369 in 1999 (McCarthy, 2020). Waters (2019) stated that treating drug use primarily as a criminal issue had failed to contain the crisis, prompting Prime Minister António Guterres to convene an expert panel of clinicians, psychiatrists, and legal experts under the leadership of Dr. João Goulão. Following the panel’s recommendations, Portugal adopted the National Drug Strategy in July 2001 (Soares, 2016). The law maintained the illegality of drug use and possession but reclassified personal possession of up to a ten-day supply as an administrative offense rather than a criminal one, while trafficking and supply remained criminal, punishable by one to twelve years in prison (Hughes & Stevens, 2010).

see *Infrastructure on page 40*

Still Arresting Our Way Out: Why New York Needs to Expand Its Diversion Courts

By James Norton, MCJ
Government & Community
Affairs Manager
National Alliance on Mental Illness
of New York State (NAMI-NYS)

For decades, New Yorkers dealing with mental health and substance use issues have been funneled into our jails and prisons and denied the treatment they need to get better. Far too often, local correctional facilities end up serving as the default mental health provider. New York is not alone in this issue. Nationwide, an estimated 44% of people in jails and 37% of people in prisons have a mental illness, and an estimated 65% of people in prisons have an underlying substance use disorder (SUD). In the veterans’ community, 55% of the nearly 50,000 veterans incarcerated in local jails report experiencing a mental illness.

Mental illness is not a crime, but untreated symptoms and limited access to care lead many people to get caught up in the criminal legal system. A number of organizations are leading the charge to divert mental health calls away from law enforcement and to expand treatment options that offer opportunities for intervention before mental health issues decompensate into crisis — including efforts to enforce men-



tal health parity and reduce delays in access to care. Still, instances of psychosis, crisis, substance use, and other behavioral health emergencies will inevitably arise. So the question remains: what happens when behavioral health and the justice system meet?

Mental Health Courts (MHCs) seek to improve safety, court operations, and the well-being of justice-involved individuals living with mental illness by linking them

with court-supervised, community-based treatment. They provide off-ramps from the revolving door of jail and prison for those who become involved in the criminal legal system because of underlying mental health and substance use issues. Specialty courts, like mental health treatment courts and veterans courts, are an evidence-based tool that can reduce the number of people with mental illness in our nation’s jails and prisons by focusing on treatment instead of

punishment. Yet almost half of all counties lack a mental health court, and many that do operate are limited by insufficient funding.

A New York State bill, the [Treatment Court Expansion Act \(TCEA\)](#), would look to address this disparity. Similar to the 2009 Drug Court Expansion, this bill would require mental health courts in every county, mandate state funding, and expand options for participation. Counties across the state used the opening created by the 2009 expansion to self-fund their own mental health courts, with 30 counties now operating some type of mental health court. Some have gone even further, standing up 35 veterans courts and 12 human trafficking courts. However, these remain ad hoc courts, operated using only county funds and grants. While recent legislation has opened courts to residents of adjacent counties, these courts still cover only half the counties in the state and only a fraction of eligible cases.

The TCEA would also change the requirements around guilty pleas for participation and around charge-based exclusions. Many people don’t participate in these courts because doing so would require them to plead to the top count and face the full sentence if they cannot complete the emotionally intensive treatment programs the courts often require. Faced with that

see *Diversion Courts on page 43*

Nobody Listened Until She Was in a Courtroom: Postpartum Illness and a Diagnosis That Runs Out

By Susie Branagan, BSN, RN
Founder and Chief Executive Officer
Susie Branagan Consulting LLC

Dana came onto our unit nineteen weeks after she delivered her son. Her husband got up at two that morning and found her side of the bed empty. She was in the baby's room, sitting straight up in the rocking chair, not rocking, looking at the wall. She did not lift her head when he came in, or when he said her name. Her robe was open. One flange of the pump still hung off her breast, the tubing in her lap, the bottle empty. She had been at it an hour and gotten nothing.

By the time I saw her on our unit, her hair had matted at the nape. She smelled like milk and old sweat. Her breasts were still hard, and she flinched when any piece of clothing brushed one.

She had not slept more than two hours at a stretch in eleven days, and none of it went anywhere deep. She lay down, which is what she told people who asked, then held just under the surface, listening through the wall for the baby while her husband slept an arm's length away. She told the intake nurse she was frightened to be alone with the baby, then said it again, slower, watching what would happen.

Her admitting diagnosis read major de-



pressive disorder, recurrent episode, severe, with psychotic features. Accurate as far as it went. Nothing in the diagnostic line indicated she had given birth four and a half months earlier. Nobody made a charting error. The manual worked as written.

A Four-Week Window
Inside a Twelve-Month Illness

The DSM-5-TR contains no diagno-

sis called postpartum depression. It has a specifier, "with peripartum onset," applied when symptoms begin during pregnancy or within four weeks of delivery (American Psychiatric Association, 2022). Past four weeks there is no modifier and it gets coded as ordinary depression.

Clinically we work in twelve months. Pediatrics screens the first year. Medicaid covers twelve months in most states. The manual stops at four.

The window was not arbitrary. Roughly half of episodes labeled postpartum are now understood to have begun during pregnancy, which is why it was broadened to peripartum. It left behind the woman who gets sick at three months.

Mothers Are Older Now and
the Window Never Moved

The window assumes a population that no longer exists. The mean age at first birth hit a record 27.6 in 2024, up from 21.4 in 1970, and in Massachusetts it is 30.0. Birth rates now fall for every group under 35 and rise only for women in their 40s (National Center for Health Statistics, 2026).

For Dana, maternity leave ended two weeks ago. The alarm is set for 5:10, but she is already up, because the baby was up at 2:00 and again at 4:15. She pumps in her car in the parking garage with a jacket over the window, because her building has no room for it. At 9:00 she sits in a meeting as the only person who did not sleep. At lunch she books the pediatric checkups, answers the school's email about her older child, and orders the school supplies. Her mother calls about her father's appointments, because he cannot keep them straight and she is the one they call. Pickup at 5:30, dinner,

see *Postpartum Illness* on [page 39](#)

Relationship-Driven Recovery: Reimagining Behavioral Health Support for Justice-Involved Individuals

By Alexander Frisina
Senior Director of Empowerment Services
Hands Across Long Island, Inc. (HALI)

For many people leaving jail or prison, release isn't just the end of a difficult journey; it's the beginning of an entirely new set of challenges. Returning to the community often means rebuilding nearly every aspect of daily life: obtaining identification, securing housing, finding employment, accessing transportation, restoring benefits, and reconnecting with family and friends. Many are also managing physical or behavioral health needs while trying to establish stability. Yet they're expected to accomplish all of this with little more than a list of appointments and referrals and very few trusted relationships.

The Missing Piece

Some people successfully navigate re-entry despite enormous obstacles. Many others do not.

This isn't because they lack motivation. More often, it's because they lack meaningful connections to community, support, and opportunity. Without those connections, people may find themselves cycling through emergency rooms, overusing crisis



services, becoming increasingly isolated, or, in some cases, returning to incarceration.

The individuals served through [Hands Across Long Island's \(HALI\) Forensic INSET program](#) often arrive with extensive system involvement. More than 80% have experienced psychiatric hospitalization, and many have experienced years of involvement with both the behavioral health and criminal justice systems. Their

challenges rarely exist in isolation. They are interconnected, requiring coordinated, relationship-based support rather than fragmented services.

Upon release, individuals are assigned a parole officer with whom they must attend frequent, in-person check-ins. Those with identified behavioral health issues are also referred to ongoing providers or programs. But engagement with these sys-

tems doesn't always feel like the answer when you're feeling intimidated, isolated, and hopeless, or if you've had negative past experiences with traditional support. Furthermore, those with undiagnosed challenges may not have access to the resources they need. Well-meaning parole officers are concerned with ensuring compliance with the conditions of release, not necessarily centered on the individual's own goals and priorities.

Why Traditional Models Miss the Mark

Traditional behavioral health often begins with a question:

"What problems need to be solved?"

While this can be effective for some people, others require a different approach. That's where peer support models offer great value to individuals recently released from prison or jail.

Peer support begins with a different question:

"What matters most to you right now?"

That answer is different for each person. For some, it may be getting their driver's license back. For others, it's reconnecting with a friend or family member. And for someone else, it may be navigating life back home with a parent after having been

see *Relationship-Driven* on [page 38](#)

A Qualitative Exploration of ADHD, Prosocial Bonds, and the School-to-Prison Pipeline

By Sarah Jalbert, PhD
Institute for Community Health
and Holly Swan, PhD
MA Office of the Child Advocate

Symptoms of Attention Deficit and Hyperactivity Disorder (ADHD) affect up to 11 percent of children (Visser et al., 2013). There is strong empirical evidence that an ADHD diagnosis puts children at higher risk for significant academic impairment, weaker ties to pro-social institutions, increased risk of delinquency, and negative impacts on social functioning and job attainment and retention as adults (Kent et al., 2011; Kuriyan et al., 2013; Sibley et al., 2011). For children who are already vulnerable to school discipline, poor education outcomes, and justice-system involvement due to their race or socio-economic status (Education, 2014), ADHD likely magnifies these risks. This study used qualitative interviews with 21 racially diverse, out-of-school, justice-system-involved young men to explore the ways ADHD shapes young people's prosocial bonds and school experiences.

Methods

In-depth interviews were conducted



with 21 young men (ages 18-24) enrolled in a program provided by a non-residential, non-profit organization devoted to serving young men with justice involvement who are disconnected from school and employment in Massachusetts. These young men are frequently referred to the program as an alternative to incarceration while under community supervision, and are at high risk for future incarceration.

The 21 young men identified as Latino (10), as Black (African-American, Afro-Caribbean, or Afro-Latino) (4), white (3), multi-racial (3), and Asian (1). Twelve had a diagnosis of ADHD and seven had a co-occurring learning or other disorder. Five did not have ADHD but had been diagnosed with other neurodevelopmental or mental health disorders. Four had no diagnosis.

Findings

School was a challenging place for most of the young men, but particularly those with ADHD. Young men without ADHD diagnoses seemed to have fewer disciplinary problems in school and were punished less severely. Most young men with ADHD reported having an individualized education program (IEP). Consistent with the literature, the young men had varying experiences with IEP implementation. None of them reported having any legal advocates in IEP meetings or negotiations, and for those who had been removed from their homes or involved with the Department of Children and Families (DCF), there was little continuity for their accommodations. Some young men felt singled out by the IEP process and felt it differentiated them from other students. Several expressed shame or stigma at having their IEP publicly revealed and expressed defensiveness about what having an IEP meant about their intelligence or abilities:

I used to hate those [IEP] meetings cause my mom had to come to school... I'm sitting in class and I'm getting called down out of a lot...nobody knew what an IEP was...I had special education written all over me.

see *School-to-Prison* on page 42

Dr. Isaac Mawuko Adusu Named 2026 Community Leader of the Year for Advancing Disability Inclusion

By David Minot
Publisher
Behavioral Health News

Dr. Isaac Mawuko Adusu, a health and human services executive, disability advocate, and frequent contributor to Behavioral Health News and Autism Spectrum News, has been named the **2026 Community Leader of the Year** by the Inclusive Leadership Impact Awards, recognizing his work to advance inclusion, strengthen community-based services, and expand opportunities for people with intellectual and developmental disabilities (IDD), including autistic individuals.

Dr. Adusu received the award during the 2026 Inclusive Leadership Impact Awards ceremony in Norwalk, Connecticut. The awards program honors leaders whose work has produced measurable and lasting impact within their organizations and communities.

According to Simone Morris Enterprises, the organization behind the awards, Dr. Adusu received the top votes in his category following a review of nominations from across the United States. The organization stated that judges carefully reviewed and discussed the nominations before identifying the highest-scoring recipient in each category.



The Community Leader of the Year Award recognizes an individual whose commitment to inclusive leadership has produced measurable community-level impact through programs launched, partnerships formed, coalitions built, or sustained advocacy. The award criteria emphasize documented and independently validated outcomes directly connected to the recipient's leadership.

For Dr. Adusu, that commitment has been closely tied to improving systems of care and expanding opportunities for people with disabilities. As Assistant Vice President of Adult Services at Seven Hills Rhode Island, he provides strategic leadership for community-based programs serving adults with complex needs.

His work has included developing specialized service approaches designed to

create more individualized and supportive residential options for people whose needs may be difficult to meet within conventional service models. His professional focus includes disability policy advocacy, community-based care, workforce development, inclusive leadership, and the development of innovative service models aimed at improving access, quality of care, and quality of life for underserved populations.

A significant area of his work has involved expanding residential opportunities for autistic young adults with complex and behavior-intensive support needs. According to the award announcement, Dr. Adusu designed a specialized residential program model and led the establishment of **three state-licensed specialized residential programs between 2021 and 2024**.

The initiative reflects a broader philosophy that inclusion must extend beyond participation in community life to ensuring that people with significant behavioral, clinical, and support needs have access to services capable of responding effectively to those needs.

Dr. Adusu's work has also extended to system-level advocacy. The award announcement highlighted the development of the **Adusu Advocacy Framework**, a

see *Leader of the Year* on page 44

Westchester's Behavioral Health Diversion Continuum: A Roadmap Through the Justice System

By Joseph A. Glazer, Esq.
and Michelle Hart, MA
Westchester County Department
of Community Mental Health

The intersection of the criminal justice and behavioral health systems is neither a point nor a straight line. Rather, the overlap of these systems is a continuum; one in which the inflection points of systemic cross-contact can be identified and potentially addressed.

The clearest tool for identification of these points is the Sequential Intercept Model (SqIM). The development of the SqIM dates back to the late 1990s, under the guidance of Dr. Henry Steadman and his team at Policy Research Associates, Inc. According to the materials explaining the SqIM, "With funding from the National Institute of Mental Health, PRA developed the linear version of the SIM [sic] as an applied strategic planning tool to improve cross-system collaborations to reduce involvement in the justice system by people with mental and substance use disorders... to assist cities and counties in determining how people with mental and substance use disorders flow from the community into the criminal justice system and eventually return to the community."¹



And this tool was developed none too soon. With the downsizing of the psychiatric hospital system, the population of people with mental health, addiction, and co-occurring disorders held in prisons and jails ballooned. "In 1970, nearly 400,000 adults with psychiatric illnesses were housed in state and county mental hospitals, while approximately 360,000 adults were incarcerated in prisons and

jails in the United States. Four decades later, by 2010, these numbers had moved dramatically in opposite directions; the census of public mental hospitals had dwindled to under 50,000 while the incarcerated population had risen steeply to more than 1.6 million on any given day. Evidence emerged that these trends could be intertwined; 44% of jail inmates and 37% of federal and state prisoners report-

ed that a mental health professional had told them they have a mental disorder, according to a national survey of inmates published by the Bureau of Justice Statistics (BJS)."²

Linking Westchester's Service Models to the SqIM Intercepts

In Westchester County, the SqIM is our road map. With six distinct intercept points along the justice continuum, models and tools can be, and have been, developed to connect with individuals with behavioral health needs at any point in the justice system.

Intercept 0 (Prior to Arrest): Intense behavioral health needs in the community frequently draw attention. These matters can initially be met with calls to crisis lines or calls to 911 which are diverted. In Westchester, more than 600 of the 911 call-takers have been trained in behavioral health identification and diversion. Three of the largest cities have police/clinician co-response staffing, and the county has developed both a crisis call network (an enhanced 988 phone system) and eight Mobile Crisis Response Teams, covering all of Westchester.

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It's 2026. Why Are Peers Not Front and Center in Our Mental Health Crisis Response System in NYC?

By Jim Mutton, LMSW
Associate Executive Director of NYC
Operations at Concern Housing

The movement toward non-police-based responses to mental health crises in our city has taken on many shapes and sizes. For years, efforts were made to train NYPD rookies, sergeants, and captains on appropriate crisis intervention techniques. Over three days of intensive training at the police academy in Queens, thousands of officers were trained by peers (those with lived mental health experience), paid actors, and non-profit professionals in real-life scenarios set in staged subway cars and delicatessens. Police received badges of recognition and special identifiable jackets, and were deployed to active crises in the community. The results, sadly, were not that successful. People in crisis still ended up seriously hurt, and in 24 cases alone since 2015, shot and killed by police during a mental health crisis encounter. In turn, the NYPD has made it clear that they did not feel comfortable being the first responders to mental health crises.

New York City has responded over the past decade with a flurry of new mobile crisis teams, co-response teams, peer-respite-based crisis centers, a 988 crisis number, and B-HEARD (Behavioral Health



Members of CCIT-NYC rally at City Hall in support of adding peers to the city's B-HEARD crisis response teams.

Emergency Assistance Response Division) teams employing social workers and emergency medical technicians (EMTs) to select high-need neighborhoods around the city for 16 hours per day. The program was recently shifted to oversight by NYC Health & Hospitals after complaints that EMTs were being taken away from other medical emergencies. One of B-HEARD's most critical defects is the failure to involve trained peers with lived experience who can be the first responders to most, if not all, mental health crises.

Since 2012, [Correct Crisis Intervention Today - NYC \(CCIT-NYC\)](#) has advocated

for a crisis response model that is peer-led in composition and expertise. CCIT-NYC is a broad-based coalition of organizations and individuals working to transform how New York City responds to mental health crisis calls. We advocate for a non-police response to mental health crises led by peers. Our model utilizes teams that would consist of one peer trained as a crisis counselor and one EMT independent of city government. It would operate citywide, 24/7. Our vision utilizes 988 — rather than the police-run 911 — as the primary contact method for dispatching responders. There would be interoperability between

all relevant three-digit numbers: 911, 988, and 311, and the crisis response teams dispatched via 988 would be able to request police assistance when needed. The coordinated crisis response system would include prevention, alternatives to hospitals, and robust follow-up from local service providers to avoid future crises.

So why is having a peer as part of a crisis response so important? A [2024 Bazelon Center report](#) found that peers are best suited for crisis response work because they are credible messengers, bring cultural responsiveness, are cost-effective in the long term via reduced emergency service use, and their emphasis is on recovery. The concept is also nothing new, having been part of successful crisis response models in Oregon, Colorado, and Toronto for many years. In addition, a [recent report](#) released in April 2026 by Human Rights Watch (HRW), New York Lawyers for the Public Interest (NYLPI), and the Center for Racial and Disability Justice (CRDJ) identified more than 150 non-police crisis response programs nationwide, many of which promote peer-involved solutions to their efforts.

What can New York do to address this remaining piece of the crisis response puzzle? The expertise is clearly out there. The peer training is available. Perhaps one

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Behavioral Health and the Justice System: Accreditation and Continuity-of-Care Standards for Justice-Involved Individuals Entering SUD Treatment

By A. Ant, CADC-II
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Men and women leaving jails or prison face some of the highest overdose risk of any population in the country. Typically, by the 3rd month of release, an estimated 75 percent of previously incarcerated people with an opioid use disorder (OUD) experience a return to opioid use, and formerly incarcerated individuals are between 10 to 40 times more likely to die of an opioid overdose than the general population, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) [1]. That gap is not the availability of treatment anymore but more of an accreditation and continuity-of-care problem: Are the systems that touch this population before, during, and after their incarceration, actually built to hand that person off to one another -- without losing them in the transition? This is a defining element which can spell success or failure.

The Accreditation Landscape

There are three accrediting bodies that shape how behavioral health providers



serve the general population, including previously incarcerated persons with substance use disorders (SUD), and each plays a distinct role in how behavioral healthcare programs are structured and standardized.

CARF International's Behavioral Health Standards Manual allows an accredited organization to add a Criminal Justice specific population designation on top of the core ASPIRE to Excellence and General

Program Standards that every accredited organization must meet [2]. CARF also separately accredits Court Treatment and Diversion/Intervention programs, giving drug courts, diversion programs, and jail-based treatment programs a defined accreditation pathway that is distinct from the standard outpatient or residential SUD programs. It's more specialized and population specific, giving special attention to

the needs of formerly incarcerated people.

The Joint Commission, which also accredits behavioral health organizations, including opioid treatment programs (OTPs), under its Comprehensive Accreditation Manual for Behavioral Health Care and Human Services, and many community providers that provide care to that population also hold Joint Commission accreditation for their broader SUD treatment operations.

The National Commission on Correctional Health Care (NCCHC) also occupies a narrower but important role: it's the only accrediting body authorized by SAMHSA to accredit opioid treatment programs (OTPs) operating inside correctional facilities [3]. This is important because federal law requires a methadone-dispensing OTP to be both certified by SAMHSA and accredited by a SAMHSA-approved body; a jail or prison seeking to operate methadone treatment on-site must generally go through NCCHC rather than the standard community accreditation route. It's a very difficult route. As of 2021, only 30 correctional facilities nationally had achieved NCCHC's OTP accreditation, illustrating how early-stage this specific segment of the field still is [4]. To put that into a broader context, of the thousands of correctional

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Beyond Punishment: Rethinking Behavioral Health Care in the Justice System

By Shriya Biswas
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University of Delaware

Correctional facilities in the United States have increasingly become major providers of mental health care (Cherson, 2025). One in every two to three people incarcerated in U.S. prisons is estimated to live with a mental illness, far higher than the general population (Dumont et al., 2012). Despite this, these facilities are mostly designed for custody, and there is less emphasis on caring for people with health conditions, with stigma and institutional practices making it harder for individuals to receive equitable healthcare (Reagan et al., 2024).

Even if individuals are on treatment regimens, it is hard for them to remain on them when incarcerated. More than 50% of individuals who were taking medications for mental health conditions at admission did not continue receiving their medications once in prison, despite court mandates (National Alliance on Mental Illness [NAMI], 2021). Increasingly, as prisons continue to serve as de facto mental health institutions (Alves et al., 2026; Preston et al., 2022), a critical question emerges: how can effective and compassionate care be delivered in environments primarily built around security and punishment? Prison



sentences should not become a sentence to untreated mental illness.

An important point to note is that correctional health is closely connected to community health. It not only affects individuals inside facilities but also families and communities after release (Macmadu & Rich, 2015). These populations also experience higher rates of substance use, traumatic brain injuries, infectious diseases, and social challenges such as unstable housing

and unemployment (Centers for Disease Control and Prevention [CDC], 2024). Thus, these vulnerabilities overlap, making correctional mental health a public health concern rather than an isolated issue (Dumont et al., 2012; Macmadu & Rich, 2015).

This shift toward deinstitutionalization has contributed extensively to the movement of many individuals with severe mental illness from psychiatric hospitals into community settings.

However, inadequate community-based mental health resources can leave individuals with undertreated mental health conditions, thus leading to involvement in the criminal legal system (Macmadu & Rich, 2015; Yohanna, 2013). Consequently, prisons and jails are increasingly encountering individuals with complex mental health issues (Kolodziejczak & Sinclair, 2018).

Along with elevated rates of mental illness among incarcerated populations, another issue that arises is the intensification of psychological stressors (Haney, 2021; Morin, 2026). Factors such as isolation, separation from family, loss of autonomy, and uncertainty about the future can create an environment where existing conditions are harder to manage (Quandt & Jones, 2021).

At the same time, there are also opportunities to connect individuals with healthcare services and professionals. Services such as screening, diagnosis, treatment, and linkage to community-based care might not have been easily accessible in the community (Macmadu & Rich, 2015). These essential interventions can provide important points of contact with care. As emphasized by the CDC, correctional health must extend across the entire period of justice-system involvement from entry into a facility through reentry into the community (CDC, 2024). This is important, as

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Florida's Youth Incarceration Problem Has a Proven Fix

By Jeanie Burton, MBA, JM
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Florida incarcerates more children than any other state in the country. Even while research shows harsh punishments and long sentences don't rehabilitate kids — they keep them coming back. There needs to be another way to hold kids accountable because, right now, we are manufacturing the outcomes we claim to be fighting against.

A child under 17 who spends time behind bars is 70% more likely to reoffend within three years, [according to research from the Department of Justice and The Sentencing Project](#). That statistic reinforces the belief held by many that Florida has invested in a “school-to-prison pipeline.” In fact, Florida's minimum age of incarceration and prosecution is seven years old, which is the youngest age among the states that have one.

Additionally, the use of the Baker Act, a law allowing law enforcement to involuntarily detain someone for mental health challenges, on children has increased 128% during the last two decades. These factors create a perfect storm for funneling kids into the system instead of out of it.

Nationally, [almost 32,000 children and teens are confined in facilities](#) on any given



day. So, while this problem presents itself at its worst in Florida, it's a nationwide challenge we all have the responsibility to address.

Why exactly does incarceration backfire? It's a combination of several factors: peer influence, brain development, and developmental disruptions. Prison is designed to punish adults, and exposing children to such conditions further sets back a brain that hasn't even finished developing.

Prison as a punishment doesn't have the same effect on adolescent brains, as the

prefrontal cortex isn't fully developed until the age of 25. This part of the brain is responsible for impulse control, weighing consequences, and regulating emotions. The Sentencing Project found that most youth age out of “lawbreaking” naturally as their brains develop, but incarceration introduces them to factors that otherwise break the normal coming-of-age process.

Time spent in confinement means more time spent around delinquent peers. We also know youth are more easily swayed by peer influence than adults. When they

spend time with others who committed more serious crimes, it normalizes and reinforces the behavior we're supposedly trying to correct.

Additionally, prison time disrupts important developmental milestones. Detention derails school enrollment, job prospects, and family stability. Normal experiences like school, work, and friendships — linked to brain maturation — are no longer part of their day-to-day. Instead, children are exposed to social environments that reward attention-seekers and impulsiveness. The very conditions that put them in the system are reinforced, not corrected.

It's also important to address that almost two-thirds of youth in correctional settings have a diagnosable mental health or substance use disorder, according to the Center for Health Care Strategies. It's another gap that sends youth deeper into the system.

Access to mental health care in correctional settings is a legal right in the United States, yet many states fail to provide it. A 16-year study of detained youth found fewer than 20% who needed mental health services ever received them in the last two decades, [according to a Journal of the American Academy of Child and Adolescent Psychiatry study](#). Untreated disorders lead to low educational achievement, difficulty maintaining employment, drug overdose, and death.

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The Justice System's New Role in Behavioral Health Compliance

By Casey Bright
Founder and CEO
Pure Life Behavioral Health

The relationship between behavioral health and the justice system has traditionally been characterized by courtroom interaction, diversion programs, and people moving through a system built to process them. Today, that relationship is changing rapidly as the justice system ramps up oversight of fraud, and many providers are ill-prepared for what that means operationally.

Ohio is a clear example. After investigators uncovered [more than \\$42 million in behavioral health Medicaid fraud](#), the state pursued the individuals responsible through federal indictments and asset seizures, and stood up a [formal federal-state partnership](#) linking the U.S. Department of Justice's (DOJ's) Fraud Division, U.S. Attorneys' offices, and state Medicaid fraud units. At the same time, the Ohio Department of Behavioral Health slowed to a near-standstill in processing new provider license applications.

The impact had direct and dire consequences for the operational sustainability of providers and access to care for patients, and it points to a clear question every behavioral health provider needs to answer: is your organization built to withstand this level of scrutiny or survive a major industry shift?



Why the Story Is Bigger Than Ohio

It's tempting to treat this as a single state's story, but trends suggest otherwise. The DOJ's [June 2026 National Health Care Fraud Takedown](#) charged 455 defendants across 56 federal districts and 45 states and territories, tied to more than \$6.5 billion in alleged false claims. While not centered on the behavioral health sector alone, this move represents the highest level of coordination in DOJ history. Notably, [behavioral health has surfaced](#) as a named priority

in that enforcement push. Once a coordinated model like Ohio's proves it can move fast and produce headlines, other states are likely to replicate it.

For Ohio providers already in the pipeline, the fallout from what happened was significant. Because the state requires national accreditation before licensing, new providers must spend real money on staff and operations, chasing a costly accreditation before they can apply for an operational license. This meant many Ohio providers who had already earned accreditation

got stuck holding it with nowhere to use it. In addition, managed care organizations simultaneously stopped contracting with new providers, leaving even accredited, licensed providers unable to get paid.

One example included a behavioral health organization in Oregon, Ohio that received Joint Commission accreditation the same day the freeze hit but was unable to get an operational license. They were the community's only behavioral health provider, and the nearest medication-assisted treatment (MAT) clinic was half an hour away — a non-starter for people without transportation since federal MAT regulations require in-person visits.

I worked with multiple providers in similar situations, structuring a path to keep services running in the interim by billing through individual practitioner National Provider Identifiers rather than waiting on the facility license. While this effort provided a much-needed short-term solution, the reality is that providers need strategies that truly put them in readiness mode.

How Providers Actually Get Ready

Looking ahead, behavioral health providers need to invest in infrastructure and adopt strategies that enable them to operate efficiently, comply with changing regulations, and adapt quickly to heavy scrutiny. Based on what I've seen helping operators

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those intercepts—not as an “extra service,” but as part of our behavioral health and public-safety strategy – building needed strong, unshakeable infrastructure.

Justice Peers Are Not Simply Peers Who Work in Justice Settings

Peer support is grounded in mutuality, recovery, shared experience, hope, and the belief that people are more than diagnoses or the worst moments of their lives. Justice Peer practice carries those principles into the highly specialized environment of carceral care.

Justice involvement creates its own language, trauma, stigma, barriers, and survival knowledge. Arrest, arraignment, incarceration, court mandates, probation, parole, reentry, collateral consequences, housing exclusions, employment barriers, and family disruption are not abstract concepts to people who have experienced them. Shared experience can create relational credibility—the kind of credibility that cannot be conferred by a job title alone (Hart, 2026; Skipper, H., & Ortiz, J. M., 2024).

A clinician may ask, What treatment might help? A District Attorney may ask, What does the law require? A case manager may ask, What services are available?

A Justice Peer can also ask: How did you get here? What is happening to you right now? What are you afraid of? What do you understand? What do you want to be your next step? And what do you need to make that next step possible?

That does not make the Justice Peer a clinician, attorney, or case manager. It makes the peer something different—and vitally necessary.

From Lived Experience to Lived Expertise

There is a very important distinction between lived experience and lived expertise. Lived experience is what happened to us.

Lived expertise is what we build from what happened to us through reflection, training, education, practice, ethical boundaries, and the ability to translate personal experience into service and systems change.

We should not romanticize lived experience. Experiencing incarceration does not automatically prepare someone to support another person through incarceration, just as receiving therapy does not make someone a therapist. Justice Peer work requires competencies: active listening, trauma-informed practice, behavioral health knowledge, recovery principles, system navigation, advocacy, professional boundaries, crisis awareness, cultural humility, and the ethical use of self.

A 2024 umbrella review encompassing 35 reviews of paid mental-health peer support found that successful implementation is associated with factors including adequate training and supervision, clear roles, supportive workplace culture, leadership, and effective collaboration. The review also identified role ambiguity, inadequate resources, low pay, and negative attitudes



Helen “Skip” Skipper, CPS, MA

from non-peer staff among persistent implementation barriers (Cooper et al., 2024).

Professionalization, however, must not become something that looks like sanitization.

We cannot credential Justice Peers so thoroughly that we erase the authenticity, candor, cultural knowledge, and critical perspective that make their lived expertise valuable in the first place.

Justice Peers Should Exist Before, During, and After Incarceration

The criminal legal system often locates peer support at reentry. Reentry is critical—but it is too late to begin thinking about peers only after incarceration has already occurred.

At Intercept 0, Justice Peers can work alongside community crisis teams, respite programs, outreach teams, shelters, and alternatives designed to resolve crises without arrest. SAMHSA specifically identifies peer-operated crisis response or respite as a strategy at this stage.

At Intercept 1, Justice Peers can strengthen crisis-intervention training, co-response efforts, post-crisis engagement, and diversion. At Intercepts 2 and 3, peers can help people understand what is happening, connect to care, maintain hope, and prepare for transition. At Intercept 4, peers can provide in-reach and reentry support before the gate opens—not merely a folder of brochures at discharge. SAMHSA expressly recognizes peer support as a reentry strategy, including assistance with planning, housing, treatment connections, and identifying triggers or circumstances that could lead to renewed justice involvement.

At Intercept 5, Justice Peers can help people navigate the complicated tension between supervision requirements, treatment, recovery, employment, housing, and family responsibilities (Policy Research Associates, 2020).

The evidence base is growing. A 2025 scoping review identified 49 peer-support programs across 66 studies focused on people with health-related needs returning to communities after incarceration. Shared lived experience, sustained engagement, participant-centered support, and cross-agency collaboration emerged as important implementation factors (Treitler

et al., 2025).

But I want us to imagine something larger than reentry. **“What if the peer relationship—not just the case file—could travel across the intercepts?”**

What Our Work Has Taught Us

At the NYC Justice Peer Initiative, our work developing, training, and supporting Justice Peers has reinforced several lessons.

First, justice-specific training matters. A generic peer credential cannot be expected to cover every complex issue and trajectory created by criminal legal system involvement.

Second, employment matters. We cannot celebrate certification while offering people only temporary, low-wage, or tokenized positions. A workforce is not truly professionalized until there are sustainable jobs, living wages, quality supervision, advancement opportunities, and leadership pathways.

Third, employers need preparation too. Hiring someone with lived experience does not automatically create an environment that values lived expertise. Organizations must examine job descriptions, background-check practices, disclosure expectations, supervision, workplace culture, compensation, and—perhaps most importantly—who is allowed to hold authority.

Finally, Justice Peers should not be limited to helping people survive systems. They should help redesign them.

From Representation to Power

For years, directly impacted communities have rightly insisted: “Nothing about us without us.” That remains essential. But the next stage of this work must go further.

We must move from referral to relationship. From representation to power. From isolated peer programs to peer infrastructure. From lived experience to lived expertise.

Justice Peers should be present in crisis services, hospitals, courts, jails, reentry programs, community supervision, policy offices, research teams, training institutions, and executive leadership. Their expertise should influence and live in budgets, program design, hiring, evaluation, policy, and accountability—not just advisory committees convened after the important decisions have been made.

Too often, people with lived experience are invited to a table built by someone else and told that inclusion has occurred because somebody added a chair.

The next evolution must be different. We are not simply asking for a seat at the table. **WE ARE THE TABLE!**

The Missing Infrastructure

National data points have long documented disproportionate behavioral health needs among incarcerated populations. In Bureau of Justice Statistics surveys conducted in 2011–2012, approximately one in four people held in local jails met the threshold for serious psychological distress during the previous 30 days, while 44 percent reported previously being told by

a mental health professional that they had a mental disorder (Bronson & Berzofsky, 2017). This data is unfortunately dated, but the system questions that are exposed remain urgent, factual, and up to date.

We cannot punish people into wellness. We cannot arrest our way out of unmet behavioral health needs. And we cannot build continuity of care solely through forms, referrals, and institutional handoffs.

The question is not whether people experiencing behavioral health challenges will encounter the justice system. Until we fundamentally change the pathways that lead there, unfortunately most of them will.

The more important question is: Who will be standing beside them when these systems collide? Justice Peers can stand at that intersection—not merely helping people navigate the road but helping us rebuild it.

If behavioral health and justice systems are serious about transformation, lived expertise cannot remain at the margins of either system. It must become part of the infrastructure of both.

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F-INSET programs are led by peer support workers who build trust and rapport with participants.

Another example of intensive supports is Assertive Community Treatment (ACT), which offers treatment and rehabilitation services in the community for individuals with Serious Mental Illness (SMI) whose needs have not been met in traditional service settings such as an outpatient clinic. ACT helps people gain independence, recover, and thrive in their communities.

Thanks to Governor Hochul's record investments in our mental health system, we have significantly grown the reach of ACT, with 32 new and expanded adult teams, increasing statewide capacity by more than 1,600 slots. We have also enhanced and expanded the availability of Forensic ACT, to a total of 16 teams, with another four in development. Forensic ACT adapts the traditional ACT model to serve those involved in the criminal legal system by addressing risk and protective factors associated with arrest and incarceration. Along with investments in transitional housing, programs like these offer a supportive level of engagement for individuals who otherwise may find themselves in jails or prisons.

For a small number of individuals, the legal system can also be utilized to ensure that individuals access treatment to support their recovery. A recent independent evaluation of the state's Assisted Outpatient Treatment (AOT) program was released, demonstrating that AOT can provide critical support for individuals who have not accessed needed services voluntarily. Individuals receiving AOT are at risk of further law enforcement interaction, incarceration, homelessness, hospitalization, and/or physical danger. AOT, when a judge orders mental health services to be provided to an individual who has not accessed them voluntarily, may be the necessary bridge between a need for intensive support and follow-through to recovery. The evaluation noted that court-ordered mental health services can improve outcomes for those who are at high risk of not being able to survive safely in their community otherwise. It also found that longer durations of participation in AOT were associated with better housing stability, stronger life skills, and reductions in hospitalization and further interaction with law enforcement. For individuals on an AOT order, a careful and intentional approach that supports individual autonomy and dignity, while also promoting personal and community safety, is needed. In this way, AOT, while employed



Dr. Ann M. Sullivan

rarely, can have a major positive impact on the lives of a select group of individuals.

OMH is also working in partnership with the Office of Addiction Services and Supports to strengthen the behavioral health crisis response system statewide, a priority for our state that has led to the establishment of new Crisis Stabilization Centers, Comprehensive Psychiatric Emergency Programs, further investments in the 988 Suicide & Crisis Lifeline, and the new Behavioral Health Technical Assistance Center (BHTAC). The BHTAC will develop and support the implementation of standardized protocols for a community-based, public health-led response to behavioral health emergencies and provide training and technical assistance to localities on their crisis plans.

Additionally, OMH is funding pilot programs in three communities across the state, with another four soon to follow, to ensure that crisis response systems prioritize a health-led response to behavioral health crises, providing safe, compassionate care. The funding supports multidisciplinary teams and requires peer support professionals to be deployed as part of their crisis response system. The resulting system will be trauma-informed, prioritizing racial equity, cultural humility, and harm reduction across the lifespan. By supporting a health-led response, we are reducing the reliance on law enforcement during a mental health crisis, enabling individuals to receive timely care and preventing unnecessary interactions with police and the criminal legal system.

Within OMH's Division of Forensic Services, the Diversion Center plays a critical role in supporting both localities and individuals who can benefit from access to appropriate mental health services instead of incarceration. The Diversion Center, formally established in 2020, facilitates, evaluates, and promotes local initiatives and programs to divert justice-involved in-

dividuals with serious mental illness from arrest, prosecution, and incarceration. Under the auspices of the Diversion Center, the Mental Health/Criminal Justice Collaboration Unit provides support and technical assistance, developing and training community and criminal justice professionals who interact with individuals experiencing emotional crisis or living with mental illness. When detention in county jails is unavoidable, the unit provides suicide prevention screening training for professionals working there.

Over the summer, the Office of Mental Health announced the awarding of \$2.4 million to help four upstate counties grow their capacity to divert individuals with behavioral health needs from the criminal legal system by connecting them with timely treatment and services. This funding is part of years of concerted effort to help individuals receive support and services outside of the criminal legal system, so they can remain engaged and thriving in their communities. And it represents only a small slice of the programs that share a similar goal.

With Diversion Center funding, counties across the state are utilizing peer support specialists, clinicians, care managers, community services coordinators, mobile response teams, and more — improving outcomes for individuals diagnosed with severe mental illness who are involved in the criminal legal system. These efforts are helping to address the fact that an increasing number of admissions to OMH civil psychiatric centers are individuals with legal system history and close to 10,000 adults in the state prison system are receiving OMH prison-based services. Unfortunately, this demonstrates the all too often coexistence of mental health challenges and legal system involvement.

Another important new initiative is Court-Based Mental Health Navigators, who support justice-involved individuals with mental health needs in the community, working with local systems to coordinate voluntary care and promote wellness and recovery. Based within county government, Navigators have a strong understanding of the local mental health, social services, and criminal legal systems. Navigators work at courthouses and coordinate closely with peer specialists, fostering rapid connection to support and encouraging engagement and participation with services. While this program is still in its early stages, 71 Navigators, who can be caseworkers, certified peer specialists, or licensed mental health professionals, will be working across 40 counties including New York City. Early data shows that

about three-quarters of those referred for Navigator services accepted them, remaining engaged for at least a month on average during a critical period.

Even given all of these efforts supporting diversion, we know that there are instances when law enforcement involvement is unavoidable. And it is during these times that the Mental Health/Criminal Justice Collaboration Unit is so vital. This unit oversees our Crisis Intervention Teams (CIT) training, which ensures officers understand how to use enhanced skills to interact appropriately with individuals experiencing emotional crisis. The CIT program also guides officers on how to effectively work with mental health programs and providers.

It is important to note that our services do not stop when an individual becomes incarcerated, as we continue our work to promote hope, wellness, and successful community integration through ready access to evidence-based mental health treatment. Mirroring the spectrum of services available in the community, prison-based services encompass both inpatient and on-site corrections-located treatment in programs staffed by OMH. This includes clinic services, residential programs for more vulnerable individuals, crisis treatment, and more. From telepsychiatry to gender-related therapeutic services, peer support to suicide prevention, incarcerated individuals take critical steps toward recovery and prepare for successful community reintegration by addressing mental health needs before release from prison and return to the community. These efforts are complemented by appropriate pre-release discharge planning, ensuring individuals are equipped for a successful reentry and are able to live safely and thrive once back home, in many cases working with the support of Forensic ACT or INSET teams and utilizing supportive housing.

Our goal for individuals living with mental health challenges who are involved in the criminal legal system is the same as our goal for all New Yorkers. We must provide the care, support, and services required to ensure that everyone can recover, maintain meaningful roots in their community, and lead fulfilling lives. Thanks to a broad array of intervention and diversion efforts, we are taking necessary steps to prevent individuals from entering the legal justice system while also providing the needed services and supports for those who unfortunately are justice-involved.

Dr. Ann M. Sullivan is Commissioner of the [New York State Office of Mental Health](https://www.omh.ny.gov)

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Financial Stability from page 8

no financial cushion, the ability to cover medical and treatment costs can make the difference between continuing in recovery and veering off track.

When Employment Is a Barrier Instead of a Bridge

Stable employment is often considered a key goal in successful reentry, a foundation for everything else. In practice, employment can be one of the hardest hurdles to clear. Criminal record disclosure requirements, licensing restrictions in certain fields, and gaps in work history can all make finding a job more challenging, regardless of a person's desire or ability to work.

Employment barriers create a cruel bind: LFOs may continue accruing at exactly the moment a person's earning capacity is most limited. An individual can be doing meaningful work in recovery and reentry, actively searching for employment, and still find that their income is insufficient to meet their LFOs and other expenses. The result is a widening gap between the financial demands of reentry and the resources available to meet them.

Financial Stress as a Recovery Risk, Not Just Background Noise

Taken together, LFOs, reentry expenses, and barriers to earning enough to cover them can become a considerable source of stress (Harris & Smith, 2022). Financial precarity also impacts key social determinants of health (SDoH) such as housing, economic stability, and family support, which are critical to recovery.

The effect of LFOs on mental health and substance use-related outcomes remains understudied, though Lindenfeld and Rouhani (2026) map the connection. They find that LFOs increase the risk of further justice involvement as well as financial destabilization such as debt and poverty, and that the resulting financial strain worsens SDoH and increases behavioral health risks such as "trauma, stress, [and] increased or riskier patterns of substance use..."

Financial stress in recovery and reen-



Wendy Molyneux, MSW

try is not simply an unpleasant backdrop to the "real" clinical work. A person can have strong clinical supports, a solid recovery community, and genuine motivation, and still be knocked off balance by a missed shift, an unpaid fine, or a housing deposit they cannot cover. Financial stabilization deserves consideration alongside other identified recovery factors because it shapes the ground recovery is built on (Lin et al., 2024).

What Practitioners, Families, and Support Networks Can Do

For practitioners: Addressing financial stability does not require providers to act as financial coaches or to duplicate existing assessments. The work begins with treating financial strain as a continuing recovery and reentry consideration. When legal, employment, housing, transportation, or benefits barriers are already identified, consider whether their combined costs or deadlines could interrupt treatment, supervision, or safe housing. Build and maintain referral pathways to legal aid, benefits navigators, reentry organizations, and employment programs before a financial crisis makes assistance urgent.

These referrals matter because navigat-

ing LFOs, benefits, and legal aid intake is itself cognitively demanding. For some people in early recovery, lingering effects of substance use or withdrawal, or co-occurring conditions, can interfere with executive functioning and make paperwork, deadlines, and multi-step intake processes especially difficult to manage. A warm handoff, rather than a phone number or address, may be what makes a referral usable.

For families and support networks: Help someone problem-solve a financial obligation without taking it over entirely. The goal is to build capacity and confidence while preserving the person's sense of agency. Financial stress may show up as irritability, withdrawal, or avoidance rather than an explicit request for help. Recognizing these signs can create an opportunity to offer support before a financial problem becomes a larger recovery challenge.

For reentry support programs: Build financial stabilization into the reentry process rather than treating it as a separate concern. Establish referral relationships with legal aid groups, employment programs experienced with justice-involved candidates, and benefits specialists. Pay particular attention to the transition from incarceration or residential treatment, when gaps in benefits or health coverage can disrupt continuity of care.

Recovery Infrastructure, Not Personal Finance

The financial consequences of justice involvement are not a personal finance problem in the conventional sense. They are a structural feature of how the justice and reentry systems are built, and they land straight in the middle of the reentry process whether care planning accounts for them or not. When financial stabilization is treated as a core pillar of reentry and actively supported, people are given a far more realistic chance at sustaining recovery. When financial stabilization is minimized, we are asking people to build a stable life on ground that keeps shifting underneath them. James has done the work of recovery. Ensuring that he has a realistic path to sustain it re-

quires recognizing financial stability as part of that work, not as a separate concern.

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Footnote

1. James is a composite character based on common experiences in behavioral health and reentry settings to illustrate systemic challenges; he does not depict a specific person.

Florida's Youth from page 28

Most recently, U.S. Sen. Jon Ossoff of Georgia and Rep. Jen Kiggans of Virginia launched a [bipartisan investigation](#) into the incarceration of children with mental health conditions in juvenile detention facilities. The investigation found that 75 facilities were incarcerating children who were eligible for release to mental health care programs. These children remained there because the care they needed was simply not available. Often, these facilities incarcerate children for at least a month before discharging them - some waited as long as a year.

The missteps in the system are evident, yet proven alternatives are sitting largely unfunded and underused — such as restorative justice diversion. This method is about reframing crime from "breaking the law" to "harm done to people and relationships." Restorative justice focuses on: who was harmed, what do they need, and whose obligation is it to make things right?

It's about accountability over punish-



Jeanie Burton, MBA, JM

ment, voice and participation, addressing root causes, and reintegration — never exile. [Studies show](#) higher victim satisfaction and perceptions of fairness, improved vic-

tim mental health, and higher rates of restitution compared with court processing. So why is it underused?

Restorative justice diversion isn't a blanket alternative to incarceration. It's specifically designed for non-violent, lower-level offenses, where the goal is repair rather than removal. Only seven states provide significant funding or support for these programs. Florida is notably not one, even though the evidence — victim satisfaction, cost, reduced severity of reoffending — favors this approach.

At The LJD Jewish Family & Community Services, our At Hope Youth program is a free, voluntary wraparound advocacy program for minors who've received civil citations or been referred to a diversion program for non-violent offenses through the Department of Juvenile Justice and Duval County Courts. We also serve kids and teens who are at a high risk of system involvement before any citation occurs.

At Hope assigns each child to a case manager who oversees their court sanctions. These are like community service

hours or check-ins tied to the terms of their diversion agreement. Beyond that, case managers provide coordinated wrap-around services such as additional mentoring, counseling referrals, school tutoring, and more. It starts with addressing the root causes and holding the child accountable. We focus on repairing the whole situation and not just punishing the incident — all while keeping them out of jail.

Restorative justice programs like ours work within the confines of an undeveloped brain. They keep children away from bad influence and ensure adolescents still meet developmental milestones.

Florida doesn't need to lock up more kids. It needs to fund alternatives that not only work but also better our community as a whole. Let's move the focus away from punishment and start funding second chances.

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Role of CCBHCs from page 9

- **Intercepts 2 & 3 (Courts and Jails):** CCBHCs collaborate with law enforcement, jails, and courts to divert people with behavioral health needs from the justice system. Through pre-booking screenings, data-driven identification, and partnerships with specialty courts and deferred prosecution programs, they connect individuals to treatment instead of further criminal justice involvement.
- **Intercepts 4 & 5 (Reentry and Community Corrections):** Continuity-of-care requirements mean CCBHCs are positioned to engage with individuals upon release, reducing the treatment gap that so often precedes reoffending.

These structured intercepts aren't theoretical; they translate into measurable reductions in recidivism with justice involvement.

The Positive Impact

The logic linking behavioral health access to incarceration rates is straightforward: police and sheriff's departments routinely absorb the cost of responding to and transporting people in behavioral health crises, a burden that falls on public safety budgets rather than health systems. At the individual level, a relatively small group of people drives a disproportionate share of these costs by cycling repeatedly through crisis, arrest, detention, and release.

Reducing incarceration is not primarily about diverting first-time or low-level offenders; it's about disrupting the revolving-door pattern within this high-utilization population through sustained, coordinated treatment. CCBHCs are designed to do exactly that. Their care coordination requirements create a single point of accountability that follows a client across settings — crisis stabilization, outpatient care, primary care, and social service referrals — rather than leaving coordination to chance or to already overextended public defenders or probation officers.

While many behavioral health organizations, outside of and prior to the CCBHC model, have had community partnerships for outreach, evidence suggests that the CCBHC model has pushed organizations to deepen those partnerships for stronger impact in their communities.³ This shows up concretely at the state level.

Some states, such as New York, stipulate within their policies that the CCBHC is required to secure partnerships and establish protocols with justice system agencies for both adult and youth populations.⁴

In Missouri, the Community Behavioral Health Liaison (CBHL) model has sub-



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stantially strengthened collaboration between behavioral health providers and justice-system partners. CBHLs function as a direct conduit to care for individuals with behavioral health needs who frequently interact with law enforcement and the courts, helping connect them to timely, community-based services that reduce repeated justice involvement.⁵

CCBHCs address housing instability, unemployment, chronic medical conditions, and other social determinants that increase the likelihood of justice involvement. Integrated care reduces risk factors for arrest and supports long-term stability. As these partnerships expand, the operational demands on clinics grow as well, requiring careful attention to the infrastructure that supports cross-system collaboration.

Compliance Considerations for CCBHCs Engaged in Justice-System Collaboration

Justice-system partnerships create real opportunities for CCBHCs, but they also introduce compliance exposure that clinics need to remain aware of. Cross-agency data flows, diversion-specific documentation, and justice-adjacent billing all raise the stakes for programs that may not have built these safeguards into their original compliance infrastructure.

Accurate Documentation of Crisis and Diversion Encounters - Clear, complete documentation is essential for capturing clinical decision-making, risk assessment, and diversion outcomes. Records must reflect the full scope of crisis services delivered, including stabilization efforts, safety planning, and referral pathways. This is particularly important where a diversion decision substitutes for an arrest or citation — documentation may later be reviewed by courts, oversight bodies, or auditors, and gaps can undermine both the clinical record and the defensibility of the diversion itself. Accurate documentation also

supports defensible coding, appropriate reimbursement, and transparent reporting of justice system partnership activities to state CCBHC programs and SAMHSA.

Data-Sharing and Privacy Compliance

- Cross-system collaboration requires strict adherence to HIPAA, 42 CFR Part 2, and minimum-necessary disclosure standards, and justice partners often operate under different confidentiality expectations than healthcare entities, which raises the risk of inadvertent overdisclosure. CCBHCs must maintain structured workflows for obtaining authorization and consent for disclosure, understanding that justice system partners are outside of defined treatment/payment/operations (TPO) pathways. Particular caution is warranted with SUD treatment records under Part 2, where consent and re-disclosure rules are more restrictive than general HIPAA requirements and where law enforcement partners may not be familiar with those distinctions.

Quality Metrics and Performance Reporting

- CCBHC quality measures directly influence justice-related outcomes and are increasingly scrutinized by states and SAMHSA as justice collaboration becomes a more visible part of the model. Accurate reporting allows CCBHCs to demonstrate the impact of diversion strategies, identify gaps, and support continuous improvement, but it also means these metrics are audit-relevant. Clinics should treat justice-related outcome data with the same rigor applied to clinical quality measures more broadly.

In my work supporting CCBHCs, documentation and data capture around crisis and diversion encounters are areas where strong clinical practice isn't always fully reflected in the record. Providers are doing the work, often at a high level, but the documentation, consent workflows, and reporting pathways don't always keep pace with the complexity of cross-system collaboration. Strengthening these processes is not only a compliance safeguard; it ensures clinics can demonstrate the full impact of their justice-system partnerships to state programs, SAMHSA, and community stakeholders.

Conclusion

CCBHCs were created to improve access to care and alleviate fractured infrastructures in behavioral health — one being a long-standing systems failure: the reliance on jails and prisons to absorb the consequences of untreated behavioral health conditions. By pairing comprehensive services with crisis response capacity and formalized justice-system partnerships, the model replaces reactive, enforce-

ment-driven responses with coordinated, accountable care. The evidence emerging from states and national reporting shows that this approach is not only feasible; it is shifting outcomes for people who have historically cycled repeatedly through crisis, arrest, and incarceration.

As CCBHC adoption continues to expand, and as states refine expectations around diversion and performance reporting, clinics are positioned to play an even more central role in reducing justice involvement and strengthening community-based treatment pathways. The model's core design offers a durable framework for interrupting the revolving-door pattern that has burdened individuals, families, and public safety systems for decades. Continued investment in these clinics, and in the infrastructure that supports their justice-system collaboration, will be essential to sustaining this progress and realizing the full potential of a community-driven alternative to incarceration.

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Youth Trauma from page 10

courts such as the Department of Children and Family Services (DCFS), and the school system. They may also be facing housing instability.

Youths are suddenly submerged in these “deep end” systems and must stay above water. Typically, none of these systems is connected. Success in youth deflection requires the cooperation, support, and buy-in of parents or guardians, as well as the broader “village” of adults in their world, such as coaches, choir instructors, and school personnel.

Deflection case managers must work among siloed institutions. Through clear written policies, memoranda of understanding (MOUs), and consent-for-release forms, we ensure that every entity that impacts a youth’s life is informed and coordinated.



Joel K. Johnson, MEd

The Power of Relentless Engagement

Because participation in deflection is voluntary, keeping youth and families engaged requires a mindset we call relentless engagement. We offer our support as many times as it takes for a person to say yes. Even if they initially decline, we return to discuss the virtues of deflection and the risks of unaddressed behaviors before they result in a formal sanction. The goal of relentless engagement is to meet them where they are but not leave them there.

Relentless engagement starts with meeting people as strangers and building deep trust and rapport with both the youth and their guardians. From there, our focus is on:

- Finding the right clinical provider for the individual’s specific needs and personality at that time.
- Eliminating barriers to care, such as a lack of transportation, so there are no excuses for non-engagement.
- Connecting youth to community supports like a Boys and Girls Club or YMCA, allowing them to express themselves through sports or classes outside of a clinical setting.
- Introducing therapies, restorative justice models, and peer groups to help youth define past trauma and develop positive coping mechanisms for high-risk behaviors.

Crucially, we also work closely with

schools. With appropriate consent, providers can share relevant information with school teams and help families request accommodations through an Individualized Education Program (IEP) or Section 504 process. Coordination with schools helps counselors understand whether the student is utilizing community resources. Instead of a knee-jerk reaction like in-school or out-of-school suspensions, students get a supportive educational pathway.

How to Fund Youth Deflection and Establish Community Protocols

To safely pivot a youth from a disciplinary track to a therapeutic one, schools and law enforcement must establish clear protocols. School resource officers and local police are heavily trained in enforcement. Providing them and other school personnel with crisis intervention training and behavioral health screening tools is an immediate step toward better engagement. To be clear, deflection is not a crisis response. Its purpose is not to wait for, nor to need, a crisis or an arrest (with charges) before taking action.

A true “warm handoff” protocol, whether through localized community interventions or the national 988 crisis system, allows responders to seamlessly connect youth to a curated portfolio of specialized resources.

For behavioral health executives, the immediate question is how to fund youth deflection programs. These initiatives can be supported by braided funding models, including:

- Billing for recurring revenue, clinical care management, and peer crisis services under the Medicaid fee schedule.
- Utilizing Section 1115 Medicaid waivers — a federal tool that grants states the flexibility to bypass standard rules to fund non-traditional care. In this context, 1115 waivers provide the necessary authority to pay for cross-system transition services and justice-related behavioral health infrastructure.
- Tapping into grants, philanthropy, opioid abatement funds, and marijuana tax revenues.

To sustain this funding, aggregate, de-identified data is essential to prove efficacy. By utilizing MOUs acceptable to all parties, stakeholders can securely track service engagement - such as attendance in individual therapy, substance use disorder treatment, or after-school mentoring - without violating HIPAA or a minor’s privacy.

Ultimately, this data demonstrates that deflection avoids the exorbitant costs of the traditional system. Juvenile court processing for a simple misdemeanor can cost taxpayers over \$1,500 per case (Washington State Institute for Public Policy, 2024), and youth detention averages \$588 per day per child (Justice Policy Institute, 2020). By redirecting these funds, we preserve taxpayer dollars while keeping youth engaged in their communities.

Building Your Community’s Framework

Deflection holds immense promise for transforming public safety and behavioral health. It engages individuals in need, avoids the trauma of an arrest, ensures accountability, and helps people contribute to the community.

For clinical directors and behavioral health CEOs looking to build a youth deflection framework, the first step is to identify the gaps in your region’s law enforcement and school contacts. In our technical assistance work at TASC’s Center for Health and Justice (CHJ), we have seen firsthand that these operational structures are the linchpin of a successful program. Reach out to law enforcement to discuss how front-end engagement strategies can make their jobs easier. Identify local youth-serving resources to build a supportive ecosystem.

This coordinated approach ensures that we are not waiting for a youth to be arrest-

ed and charged or to be in crisis before taking action. Youth deflection also means that when we take action, the youth is met with a clinical response, rather than a carceral one. By choosing a named policy of deflection over detention, communities can halt the traumatic cycle of the justice system and provide our youth with the clinical care and community support they deserve.

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Compliance from page 28

navigate challenges across five states, it comes down to three things:

1. **Make data part of every conversation, not just a monthly report** - If your staff’s first login of the day takes them to email or a schedule instead of a dashboard, they are already behind the power curve. Management meetings should run on the data you’re seeing — actual numbers that reflect outcomes, length of stay, and problem areas like AMA rates.
2. **Diversify your payer sources** - Programs that depend entirely on one funding stream, such as Medicaid, look successful right up until that funding

source changes or a payer pulls back reimbursement. Providers need to build a real mix of in-network, out-of-network, and Medicaid business so no single disruption can take the organization down.

3. **Invest in retaining staff instead of chasing hires** - It’s not uncommon in the behavioral health field to see people cycle through five or six jobs in a year. That instability shows up in care quality and institutional knowledge. Leadership development and staff retention strategies are a critical part of how an organization stays stable enough to respond to industry shifts.

Underneath all three of these is a technology partner that provides the data needed to improve decision-making. To help clients

position for the future, I rely on API-driven EHR platforms like Sunwave that provide real-time views of important KPIs and allow organizations to build custom workflows in weeks instead of over a year, as is the case with many implementations.

Ohio won’t be the last state to learn hard lessons about readiness within the current regulatory and oversight climate. Maintaining a sustainable path forward for both provider organizations and the communities they serve requires infrastructure investments and strategies that protect payer mix and improve overall staff retention.

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Casey Bright

Community Integration from page 15

community activities where relationships can develop outside paid service systems. True integration occurs when a person's connections include coworkers, friends, neighbors, and other community members, not only providers and support staff.

Third, choice over housing and community life allows individuals to define what independence means for them. Person-centered planning and self-advocacy help ensure that individuals have a meaningful voice in decisions about where and with whom they live, how they spend their time, the relationships they pursue, and the goals they set for their lives.

Imagine a young adult with an intellectual disability and anxiety who wants to work but has repeatedly been told they are not ready. Unfamiliar environments feel overwhelming, transportation is a barrier, and past experiences have weakened their confidence. With coordinated behavioral health support, travel training, job coaching, and an employer willing to provide reasonable accommodations, that person secures a competitive job in the community. Over time, they begin earning a paycheck, contributing to household expenses, forming relationships with coworkers, and making plans for their future. Their family, once uncertain whether employment was possible, can begin to imagine a future defined by greater independence rather than lifelong dependence. This is what meaningful integration can make possible



Nicole Willner

and what is at risk when community-based support is weakened.

These outcomes illustrate why the current federal debate matters. A policy framework that focuses primarily on physical placement risks setting the standard too low. Being in the community is not the same as belonging to it. Public policy should continue creating conditions that allow individuals to work, form relationships, exercise meaningful choices, and participate economically and socially in their communities.

NYIN firmly opposes federal policy or enforcement approaches that dimin-

ish meaningful community integration or make segregation easier to accept as an adequate outcome. Olmstead remains binding law, and the progress it helped advance should be strengthened rather than diminished.

For individuals with developmental disabilities and their families, community integration and economic security are inseparable. When people have meaningful opportunities to work, earn income, build relationships, make choices, and belong, they are better positioned to build greater independence and long-term stability. Their families, in turn, are better positioned to plan for their own economic future with confidence.

That is the promise Olmstead helped establish. It is also the standard to which we must continue to hold ourselves: not simply services delivered in the community but lives fully lived within it.

Nicole Willner is a human services leader with more than 30 years of experience in social work and behavioral health systems. She currently serves as Executive Director of the New York Integrated Network (NYIN), where she leads efforts to strengthen collaboration among providers and government agencies to improve service delivery and outcomes across New York. Her career spans executive leadership roles supporting individuals with developmental disabilities and behavioral health needs, with extensive experience in New York's OPWDD system overseeing

residential and community-based services. Through her work with an Independent Practice Association, she has also partnered with OMH and OASAS organizations to advance integrated, person-centered care. Nicole holds a degree in Social Work from Widener University and is committed to developing innovative, sustainable solutions that improve the lives of individuals and families in New York.

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AOT from page 16

us lived in a vacuum, perhaps the equation would be that simple. We do not. We live in families and communities, and the effects of serious illness that remains inadequately treated can extend beyond one individual.

Children deserve particular consideration. They have little control over their circumstances and often little ability to understand or change what is happening around them. I know this not only through my professional work, but through lived experience as a child in a family profoundly affected by serious mental illness. The effects of trauma do not necessarily disappear when a crisis ends. They can reverberate through families and across generations.

This does not give families an unlimited claim over another person's treatment decisions, nor does family hardship alone justify coercive treatment. But neither should our concern for one individual's autonomy make everyone else in the equation invisible.

Choosing not to intervene does not necessarily mean that coercion disappears. Sometimes it means waiting until circumstances deteriorate enough for another system to intervene — perhaps through emergency hospitalization, child protective services, or the justice system. Those interventions can be considerably more disruptive to the individual and their family.

The ethical question cannot be limited to the consequences of intervention. We also have to consider the consequences of choosing not to intervene when voluntary treatment has repeatedly been insufficient.

None of this means AOT should become an easy answer. Quite the opposite. Its narrow application is part of what makes it defensible. Gross expansion carries serious



Nathan McLaughlin

risks. AOT should never become a mechanism for criminalizing mental illness, an alternative to adequate voluntary services, or a convenient tool for managing people whom other systems find difficult to serve.

Nor should AOT be understood as protecting society from people with mental illness. We should aspire to communities that accept mental illness as part of the human experience, surround rather than isolate people experiencing it, support families, and understand recovery as something that occurs within relationships and communities.

For the relatively small number of people for whom AOT is appropriate, New York assumes responsibilities of its own. If the state uses its authority to require an individual to participate in treatment, it must be equally accountable for making that treatment available.

That principle is both simple and complicated. It means a properly funded and managed AOT program with access to clinicians, appropriate services, oversight, continuity, and good discharge planning. Recent [New York State Comptroller audits](#) identified shortcomings in AOT oversight, including delayed investigations, lapses in services, and weaknesses in monitoring. Accountability cannot run in only one direction. We should ask not only whether an individual complied with treatment, but whether the treatment system complied with its responsibilities to the individual.

AOT Should Be a Step Forward

If someone remains caught in a cycle of hospitalization, judicial involvement, poorly coordinated discharge, and renewed instability, simply adding a court order has accomplished very little. A functioning AOT system should provide the oversight, clinical access, and continuity necessary to interrupt that cycle and create a pathway toward recovery.

Success should not be measured by indefinite compliance with an AOT order. Success is a person thriving without AOT while retaining access to the services that helped them get there. That means continued access to appropriate voluntary treatment and supports rather than allowing services to disappear simply because the court order has ended. New York's use of [Enhanced Voluntary Agreements](#) also provides a less restrictive pathway for some people who might otherwise be considered for AOT.

Recovery can also create an opportunity to plan for the future. Someone who has regained stability may wish to consider a [psychiatric advance directive](#), documenting how they would want to be supported

and treated during a future period when they may be less able to communicate those wishes.

AOT should be a bridge, not a destination. Its ultimate purpose should be greater autonomy, not compliance for compliance's sake.

This cannot be an either/or debate because human beings do not exist in either/or categories. We exist across an infinite spectrum, and our needs and circumstances change throughout our lives.

Eliminating AOT would sell short the people for whom it may provide a necessary path toward recovery. Expanding it indiscriminately creates a different danger: abuse, entanglement with criminal justice, or use as a substitute for services people should have been able to access voluntarily.

The challenge is harder than choosing a side. New York must continue building robust voluntary services long before AOT becomes necessary. It must preserve AOT as a carefully limited tool for people whose needs cannot always be met through voluntary treatment alone. And when the state exercises the extraordinary authority to mandate treatment, it must accept an equally extraordinary responsibility to provide meaningful care.

Above all, we must never lose sight of the human being at the center. The measure of a humane system is not whether it can claim never to have used coercion. It is whether even its most difficult interventions remain directed toward recovery, dignity, connection, and ultimately the greatest possible return of autonomy to the person.

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upon release. For example, MATTERS program staff have worked closely with the Erie County Sheriff's Office Correctional Health Division (ECSD) to support their correctional health staff in the re-entry process. Prior to the implementation of the MAT program, individuals received little or no guidance related to reintegration into community MAT treatment programs, with discharge education focused on naloxone training and abstinence.

Stigma and lack of education related to the effectiveness of treatment with buprenorphine and methadone were the greatest barriers to implementation of effective comprehensive MAT programs. Today, while the individual is still incarcerated and beginning the release process, an RN at ECSD trained in substance use disorder (SUD) provides discharge education. This includes harm reduction supplies, an appointment with MATTERS telemedicine, if needed, and a referral to a community-based provider, facilitated via the referral platform. The ECSD Correctional Health Division has provided comprehensive care to more than 200 incarcerated individuals daily throughout the 2026 calendar year. This represents more than 25% of the average daily jail population receiving counseling, medication, and discharge planning.

MATTERS referrals can occur at multiple points across the criminal justice system, including in courts, jails, and prisons, as well as during community re-entry. The program provides a vital safety net during a high-risk period as individuals on MAT transition from incarceration back into the community. In a corrections landscape where time and resources are limited, MATTERS offers a timely and

**Raven Manchester**

effective tool that streamlines workflows and increases the likelihood of a successful connection to care. Linkage to treatment is supported through various wraparound services, including financial assistance for medication and transportation, peer connections, harm reduction resources, telemedicine, and more.

In 2026, MATTERS expanded to accommodate referrals to community HCV testing and treatment, in addition to OUD referrals, through a partnership with UBMD telemedicine. Studies have shown that recent incarceration has been linked to a 62% increase in the chance of contracting an HCV infection (Stone et al., 2018). In NYS jails, a recent study found that only 29% of facilities that were surveyed (46 out of 58 located in NYS, excluding the NYC region) initiated treatment for those who were newly diagnosed with HCV. Further, only half of these

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facilities (51%) had agreements with a community-based provider for post-release treatment and cited rapid test kits and HCV education resources as barriers (Riback et al., 2026).

Facilitating linkage to methadone treatment is a recent addition made to the program, including dose verification questions for certain referral partner categories (such as emergency departments). Individuals who are referred through MATTERS can filter for additional treatment needs while choosing an outpatient program, including mental health, additional SUD, and medical services. Care continuity is vital for those re-entering the community after a period of incarceration, especially for those with SUD. Evidence supports the utility of comprehensive MAT programs in jails and prisons that include robust re-entry support to improve outcomes for this population. Providers,

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policy makers, and communities must work together to create supportive environments for justice-involved individuals. MATTERS serves as a framework for other communities to develop partnerships with their local correctional institutions and improve connections to community-based care. To learn more about MATTERS' work supporting individuals with SUD and our work in communities in New York, Pennsylvania, and New Jersey, please reach out using the contact information below.

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Leon, 2000). Justice-involved clients arrive with finely tuned detectors for institutional insincerity; they have survived institutions. They do not disengage because the workbook is wrong. They disengage the first time the program behaves like the last institution that processed them. Every staff interaction is therefore either evidence for or against the proposition that this place is different. That is not a burden reserved for clinicians — the intake coordinator, the cook, and the night monitor are all delivering treatment, whether or not anyone told them so.

What the director's chair taught me: the system's impossible decisions land on the staff, and nobody screens for what that costs them. As a director I made capacity decisions — who got the bed, who waited, who was discharged for a violation I understood better than I could say aloud. Those decisions are the ordinary machinery of a constrained system, and they exact a specific occupational wound: moral injury, the damage done by perpetrating, failing to prevent, or witnessing acts that transgress one's own moral code (Litz et al., 2009). The concept emerged from military psychology, but any frontline supervisor in behavioral health will recognize it — the case manager who enforced a discharge she believed was wrong, the counselor who

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watched a waitlisted client return to jail. We screen our workforce for credentials and background. We do not screen for the accumulating weight of the decisions we require them to carry, and then we call their departure "turnover." Peer and lived-experience staff carry a compounded version of this load: they are maintaining their own recovery inside a building saturated with the thing they recovered from, and disclosure of strain can feel like an admission of

being the wrong hire.

Three practices follow from the three chairs, and none requires a budget line. First, audit the first hour of contact for shame: every question that can be asked after the alliance forms should be. Second, treat retention as everyone's job description and train the whole building accordingly — the evidence locates the therapeutic effect in the community, not only the counseling hour (De Leon, 2000). Third, give the staff the same honest check-in we ask of clients — leadership first, because no team answers honestly about a practice its director has not undergone. The people who carry everyone else are the least likely to check their own gauges, and the collapse, when it comes, is almost never loud.

The behavioral health system did not fail me; parts of it saved my life. But it saved my life at the points where individual people decided the record was not the final word about me. The task ahead is to make that decision structural rather than heroic — to build programs where the person who was once the intake can become, without exceptional luck, the counselor, and one day the director.

This article reflects the author's professional experience and the cited literature; it describes no specific client or facility.

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will address the person's goals as important influences on participation (Dixon et al., 2016). Street-outreach research similarly indicates that people experiencing homelessness and serious mental illness may require more time to engage than those reached in traditional settings (Lam & Rosenheck, 1999).

Disengagement should not automatically be treated as a final decision or fixed patient characteristic. It is clinical information about symptoms, cognition, trauma, survival needs, prior coercion, cultural difference, the therapeutic relationship, or service design.

Psychiatrists have a particular responsibility here. Diagnostic formulation should help us understand barriers to engagement without reducing the person to a diagnosis. Risk assessment should guide proportionate intervention without allowing every refusal to become evidence of dangerousness. Respect for autonomy should not mean abandoning a person whose capacity to trust or organize care develops slowly. Conversely, concern for safety should not become a rationale for unnecessary coercion.

The clinical question must shift from "How do we make this patient comply?" to "What is preventing this person from experiencing care as safe, relevant, and usable?" That shift does not minimize illness or risk. It makes our formulation more complete.

Match the Intervention to the Relationship

Even an appropriate intervention can fail when offered at the wrong stage of the relationship. A person who does not yet feel safe may experience problem-solving as pressure. Someone who does not feel heard may experience psychoeducation as dismissal. A treatment plan developed before trust exists may be clinically appropriate and relationally unusable.

A practical sequence is to:

1. **Establish safety:** reduce threat, preserve dignity, and clarify that the immediate purpose is neither punishment nor control.
2. **Listen:** understand the person's account of the problem, including what the person wants, fears, distrusts, or believes has gone wrong before.
3. **Convey empathy:** demonstrate that the person's experience has been understood before attempting to redirect it.



Mardoche Sidor, MD

4. **Collaborate:** identify the smallest next step the person is willing to take rather than insisting on the entire preferred treatment plan.

These functions are consistent with trauma-informed principles emphasizing safety, trustworthiness, peer support, collaboration, and empowerment (SAMHSA, 2023). They also apply beyond the consulting room. Research involving people with mental illness who experienced police contact suggests that perceived procedural justice, including voice, dignity, and fairness, can influence cooperation and resistance during those encounters (Watson & Angell, 2013).

Engagement is rarely linear. A person may collaborate one day and withdraw the next. A crisis may require returning to safety. A missed appointment may reflect ambivalence, cognitive difficulty, substance use, competing needs, or a rupture in trust. Sometimes the appropriate response is not discharge or another generic referral, but renewed engagement.

Treat Disengagement as an Early Warning

Behavioral health and criminal-legal systems typically measure events after engagement has deteriorated: hospitalizations, emergency calls, arrests, incarceration, missed appointments, or program discharge. These outcomes matter, but they are lagging indicators.

If engagement is an upstream component of diversion, we should also observe its trajectory. Is trust growing or shrinking? Are interactions becoming more or less re-

ciprocal? Is the person expressing needs, accepting small forms of support, or participating in decisions? Are clinicians, crisis teams, hospitals, shelters, and community programs communicating consistently? Where does continuity repeatedly break down?

Increasing avoidance, shorter interactions, missed visits, growing mistrust, escalating conflict, or withdrawal from previously accepted support should prompt clinical curiosity and coordinated action. The team might reconsider who conducts outreach, when and where contact occurs, what the person identifies as urgent, whether peer involvement would help, and whether previous interventions have inadvertently increased threat.

Needless to say, engagement alone cannot prevent every crisis or arrest. Persistent outreach cannot substitute for emergency intervention when imminent risk is present. Nor can relationships compensate for inadequate housing, unavailable treatment, workforce shortages, fragmented systems, or insufficient alternatives to incarceration.

Research on mental health courts and jail-diversion programs shows potential benefits, but outcomes vary, and referral into nominal treatment is not the same as sustained connection to effective care (Steadman et al., 2011; Broner et al., 2004). Diversion policy should therefore measure not only whether a referral was made, but whether the person was reached, remained connected, participated meaningfully, and received care matched to actual needs.

Engagement is the connective tissue that makes the rest of the diversion continuum usable.

The First Diversion Decision

The criminal legal system should not become the default behavioral health system for people whose needs are complex, whose trust is fragile, or whose acceptance of care develops slowly.

Psychiatry must remain centrally involved in crisis services, pre-arrest diversion, mental health courts, treatment alternatives to incarceration, and reentry planning. However, our contribution cannot begin only after the legal system has assumed responsibility. We must help build clinical systems capable of recognizing deteriorating engagement and responding before symptoms become crises, crises become public-safety events, and public-safety events become criminalization.

True diversion begins before the courtroom, before the police encounter, and of-

ten before the crisis call. It begins when we decide whether to interpret withdrawal as refusal, anger as dangerousness, ambivalence as failure, or mistrust as a reason to change our approach.

The first diversion decision is not made by a judge. It is made when a person begins to disengage and the behavioral health system decides whether to close the door or find another way to remain present.

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system and to redirect them to treatment and other support resources (Mulvey & Schubert, 2017). For such interventions to be successful, however, they must be readily available and accessible to those in greatest need. They must also target root causes of recidivism, foremost of which are the health-related social needs that often go unmet among individuals with SMI. To this end, some promising initiatives have emerged. Mental health courts offer alternative venues for the adjudication of non-violent offenses in which defendants may be remanded to behavioral healthcare in lieu of incarceration provided they ad-

here to certain court-imposed conditions. Forensic Assertive Community Treatment (FACT) Teams deliver mobile, multidisciplinary behavioral health and rehabilitation services to individuals with SMI and histories of criminal justice involvement who have failed to benefit from more conventional interventions. Most recently, New York State embarked on an ambitious demonstration project in partnership with the federal Centers for Medicare & Medicaid Services (CMS) that provides housing and nutritional assistance, transportation, and other vital services for vulnerable Medicaid recipients, many of whom experience mental illness and have been exposed to the criminal justice system. An authentic trans-

formation of our carceral system requires these and other approaches, including some yet to be conceived, to achieve consistent outcomes on a substantially larger scale. It also requires a radical reevaluation of the pecuniary pillars on which it stands. Proponents of the Prison Industrial Complex will not consent to its dissolution unless it proves economically expedient to do so.

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View the full list of references [here](#).

Fifteen-Month Clock from page 19

of parental rights, a permanent action that severs the legal relationship between parent and child entirely. Research on which parents with substance use disorders reach that endpoint identifies specific risk factors: having children at a younger age, parental incarceration, co-occurring mental illness, homelessness, parenting skill deficits, and domestic violence. These are the same factors associated with longer recovery times. Co-occurring psychiatric conditions require multidisciplinary care coordination that remains elusive in most systems, and housing instability is a strong predictor of treatment attrition. The clinical markers that foreshadow a protracted recovery path are, in many cases, the same markers associated with termination of parental rights.

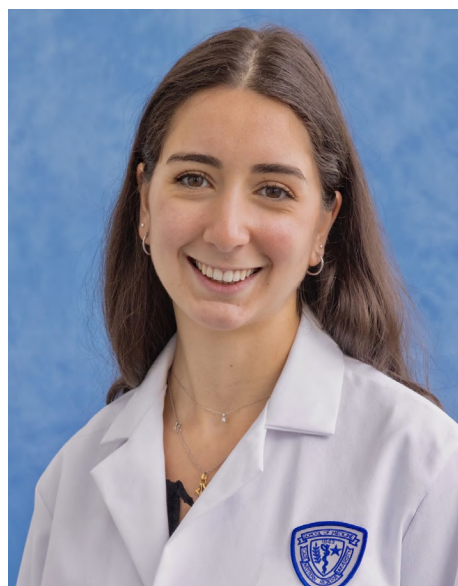
The federal Adoption and Safe Families Act of 1997 (“ASFA”) sets a strict timeline: states must move to terminate parental rights once a child has spent 15 of the preceding 22 months in out-of-home care. The clock is cumulative, not continuous, and starts running at the initial court finding of maltreatment or 60 days after removal, whichever comes first. Exceptions exist for kinship placements, documented compelling reasons, or a state’s own failure to provide services, but the federal mandate favors permanency through adoption, reinforced by financial incentives for completed adoptions. The result is an expectation of rapid recovery that often collides with the slower pace of clinical stabilization.

ASFA responded to children remaining in foster care for years while agencies waited for parents to stabilize, itself a form of harm from prolonged uncertainty. But the law raises a question it does not answer: does a fifteen-month window reflect any realistic understanding of how parents actually recover?

Recurrence of use does not signal clinical failure. It is a hallmark of the disease itself, one that requires measuring progress in years rather than months. A parent who achieves temporary stability, relapses, and then re-engages in treatment is following the expected course of recovery, not straying from it. A fifteen-month timeline barely allows for one such cycle. It is a narrow window for recovery to begin, be recognized, and hold, especially when compounded by familiar barriers to treatment: waiting lists, lack of transportation, and a persistent shortage of social support.

In *Santosky v. Kramer*, a 1982 Supreme Court case, the Court held that severing the parent-child bond, an irreversible act, requires proof by clear and convincing evidence. ASFA preserved that high standard of proof while shortening the time families have to meet it, in part because children faced such long waits for a permanency decision. Some argue that ASFA shifted the priority, in practice, from family reunification to permanent placement.

Returning to the patient from our open-



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ing case, what happens after she discloses her substance use to a physician diverges along three paths, depending on the state. In some jurisdictions, the disclosure triggers a referral to treatment and supportive services. In others, it opens a child welfare investigation that can proceed toward removal. In still others, it produces nothing immediate at all, only a notation in a protective services file that can later be introduced as evidence of abuse if other problems surface. This third outcome is the least visible to the clinician and the most consequential to the patient, because it turns a clinical encounter into a record that will be read years later by someone with a different purpose.

A physician who identifies substance use in a pregnant patient faces an obligation that changes at the state line. Twelve states and the District of Columbia treat substance use during pregnancy as child abuse under civil child welfare statutes. Seven states and the District require health care professionals to report suspected prenatal drug use without that classification. Three authorize civil commitment on the basis of substance use in pregnancy, and twenty-five fund or have created treatment programs directed at pregnant women. These categories overlap unevenly, so a physician may be reporting into a system built to deliver services, or into one built to build a case.

In addition to knowing one’s own state reporting laws, clinicians should also have an understanding of what happens once a report is filed. This understanding will allow for more honest and constructive dialogue between the clinician and their patients who might be subject to such a report. That conversation is better had in advance of the reporting. In the months that follow, attendance at doctor’s appointments, adherence with treatment, and toxicology testing accumulate into a record that a reunification proceeding will eventually read, making contemporaneous documentation the only advocacy available before anyone asks for it. None of that is possible if care is declined at the outset. Refusing care to a pregnant patient is prohibited outright in several



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states, though such laws alone have not improved access. Similarly, the legitimate use of medications for opioid use disorders may not be treated as disqualifying for custody.

Pregnancy invites a future orientation, an instinct to plan for a child not yet born. The law moves on its own timeline, one that does not always align with the pace of clinical recovery. Nothing that follows a disclosure resolves the forensic dilemma with which this article began: a mandated reporter cannot choose whether to become a participant in the legal process, only how well informed that participation is. Knowing which outcome a given state’s laws produce, documenting contemporaneously, and telling a patient what to expect are the tools available within a system the clinician did not design.

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interactions and is reflected in how we structure our services. We have revised our assessment processes to incorporate trauma-informed and motivational interviewing principles, with an emphasis on creating a safe, respectful, and collaborative experience for veterans. Under the leadership of Robin Smith, Director of Veteran Services and a U.S. Air Force Technical Sergeant (TSGT), S:US developed specialized veteran peer staff to engage veterans who may be especially vulnerable to housing instability. This includes veterans with disabilities and older veterans. Our service coordination team has also placed greater emphasis on proactively connecting veterans with VA services, community partners, and other resources that can address individual barriers to stability. These efforts reflect a broader commitment to meeting veterans where they are, respecting individual choice, and connecting veterans with the resources necessary to support their goals and stability.

A Path Toward
Stability and Recovery

Trauma-informed care can help identify behavioral health needs in justice-involved veterans while balancing accountability



Michael Conroy, LMSW

with opportunities for treatment and rehabilitation. The work of organizations serving veterans demonstrates that accountability and recovery do not have to be competing approaches. For justice-involved veterans, trauma-informed care offers a path forward: one that recognizes trauma, upholds accountability, and connects people to the support they need to build stability, wellness, and community.

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Relationship-Driven from page 24

incarcerated for several years. Whether it’s reconnecting with family, finding work, restoring a driver’s license, or simply rebuilding confidence, peer support begins with the individual’s unique goals, not the system’s expectations. By starting with the person’s priorities, peer support restores hope, builds confidence, and empowers individuals to move forward on their own terms.

Rather than focusing solely on what led to a person’s incarceration, peer specialists recognize the resilience it took to survive those experiences. Instead of asking, “What’s wrong with you?” they ask, “What has helped you survive everything you’ve been through?”

Relationships Before Referrals

Recovery begins with relationship, not compliance. Our goal isn’t to tell people who they should become. It’s to walk alongside them as they rediscover who they’ve always been capable of being. That approach is reflected in the program’s engagement. Nearly 80% of individuals referred to HALI’s Forensic INSET (Intensive and Sustained Engagement Team) remain engaged beyond their first three meetings — a critical milestone for people who have often experienced repeated disconnection from traditional systems.

Forensic INSET is a peer-led mental health program for individuals with complex conditions and criminal justice involvement. It bridges gaps left by traditional behavioral health services and supports people whose past involvement with the criminal justice system may impact their path back to community connection.

HALI’s Forensic INSET program demonstrates what a relationship-first model can look like in practice. At HALI, Forensic INSET is designed to reach indi-



Alexander Frisina

viduals who need more than conventional services can offer. It is a voluntary, community-based model that prioritizes trust, persistence, and choice over compliance.

Using a person-driven, peer-led approach, Forensic INSET is led by a multidisciplinary group of experienced professionals who work together to build trust and provide wraparound support. Certified Peer Specialists work alongside licensed clinicians and Family Peer Advocates to provide individualized, flexible services tailored to each person’s goals.

Recovery Is Bigger Than Treatment

Recovery cannot be mandated. While accountability has an important role in the justice system, healing happens through trust, autonomy, and meaningful relationships. When people are offered choice rather than coercion, they’re more likely to engage, remain connected, and build lives they value.

It can be tempting to point to data to prove outcomes, but it doesn’t usually tell

the whole story. Every person is different, and therefore success looks different for everyone. We recently had an individual come through our Forensic INSET program who decided to participate in a Department of Labor training opportunity soon after their release. They successfully completed the series only a short time after returning to the community. What mattered most wasn’t that they completed the program so quickly; it was that they invited members of our team to celebrate with them. That invitation reflected trust, connection, and the belief that they no longer had to navigate recovery alone. That moment says more than statistics ever will.

Success is measured not only in clinical outcomes, but in reconnecting with family, securing housing, obtaining employment, accessing recovery supports, and rediscovering meaningful roles in the community.

Recovery Doesn’t Happen
Through One Program

Recovery isn’t a single service. It’s a continuum of relationships, supports, and opportunities that evolve over time. Forensic INSET is just one aspect of a range of supports that help a justice-involved individual navigate life outside of jail or prison.

For many individuals, the journey begins before release with Forensic Bridging, which is a service that helps inmates successfully transition from prison to the community. Forensic peers facilitate groups within local jails and state prisons, sharing their own experiences with “bridging” to the community post-release, and answering questions about what to expect.

HALI’s forensic peer specialists meet individuals primarily from the Sing Sing Correctional Facility Community Orientation and Reentry Program (CORP), help them transition back into the community, and remain connected through one-on-one support and peer groups at the organization’s

recovery center in Suffolk County, New York, as well as its drop-in center in Manhattan. This model is designed to reduce recidivism while giving people the respect, connection, and opportunities they deserve.

Forensic INSET builds relationships and offers ongoing, flexible support to help them navigate the transition, reduce isolation, and move forward on their own terms. Ongoing community support allows them to form positive connections with individuals who are committed to staying on the right track.

Looking Ahead

Supporting successful reentry requires more than behavioral healthcare alone. It also requires addressing the practical conditions that make recovery sustainable. Without a safe place to live, it’s difficult to maintain employment, engage in treatment, reconnect with family, or build the stability that lasting recovery requires. Housing remains one of the greatest unmet needs for justice-involved individuals. Among individuals entering Forensic INSET, 64% are experiencing homelessness or housing instability, underscoring why safe, stable housing remains one of the most significant barriers to successful reentry. HALI’s forthcoming re-entry housing initiative reflects a commitment to addressing that need while creating lasting stability.

Justice involvement should not define a person’s future. People are people regardless of their past experiences or system involvement. If we meet people where they are and help them move toward the future they envision, we create the conditions for hope, empowerment, and lasting recovery.

People don’t reconnect with systems. They reconnect with people.

Alexander Frisina is Senior Director of Empowerment Services at *Hands Across Long Island, Inc. (HALI)*.

Postpartum Illness from page 24

bath, books. The laundry is from Tuesday and has to run again.

She is forty-one. She has mentioned the night sweats, the hot flashes, and the panic attacks in the grocery store parking lot to more than one person, and nothing came of it. So when someone asks how she is doing she says tired. She tried saying more and it went nowhere.

On Saturday she packs the beach bag. Towels, sunscreen, the cooler, snacks in separate bags because one of them will not eat anything that has touched anything else, shovels, a change of clothes for the baby. She gets everyone out the door and realizes in the parking lot that she never packed a suit for herself.

The water is fifty-eight degrees. She goes in anyway, in the jumper she put on that morning, and lets it dry on her after. Under the surface there is no sound except water in her ears, and for five seconds nobody needs anything from her. She comes up wanting to go back down. Then she is out, drying off, doing the sunscreen and the sandwiches and the sand in everybody’s eyes. Cold water is the one thing that resets her, and she will take it however she can get it.

This creates an overlap the diagnostic system has no words for. Perimenopause commonly begins in the mid-40s and can start earlier, producing insomnia, mood instability, anxiety, and fog through the same mechanism as postpartum illness: steep fluctuation in estradiol and progesterone. A woman who delivers her third child at 41 runs both at once and is screened for neither.

The Window Closes Before the Period of Highest Risk

A review across fourteen state maternal mortality review committees found 63 percent of deaths from mental health conditions happened between 43 and 365 days postpartum, against 18 percent from other causes. Most were suicides, all judged preventable (Trost et al., 2021). CDC data from 46 committees put mental health conditions behind 22.5 percent of pregnancy-related deaths (Policy Center for Maternal Mental Health, 2025). The window closes on day 28. Most of these deaths

come after day 43.

Postpartum Psychosis Has No Diagnosis at All

Postpartum psychosis has no codable entry in the DSM. It gets coded as brief psychotic disorder, bipolar disorder with psychotic features, or major depression with psychotic features, depending on the clinician in front of her. In 2025 an expert panel recommended making it a distinct DSM and ICD-11 category, since its onset, treatment response, and prognosis set it apart (Bergink et al., 2025).

Onset is fast and the presentation shifts hour to hour. A woman can be lucid at three and acutely psychotic by nine, and the note written at three follows her. That reads as inconsistency, and I have watched clinicians act on it, myself included.

Where the Courts Pick Up What Psychiatry Set Down

Criminal responsibility is decided on diagnosis. When a woman is charged after harm to her infant or herself, the case turns on whether a recognized condition took away her capacity to know what she did was wrong. The defense must name the illness. The prosecution can point out that it is not in the manual.

A trial in Massachusetts this summer (2026) put that in front of a jury, with a former labor and delivery nurse as the defendant and postpartum psychosis at the center of the defense. She was roughly eight months postpartum when her children died, well outside the four-week specifier and outside the typical onset window, and her diagnosis was contested from the start. Whether an illness emerging at eight months still counts as postpartum is unsettled in psychiatry, and it got argued to a jury for lack of anywhere else. Twenty-nine countries have adjusted the penalty for infanticide in recognition of the biology of childbirth (Spinelli, 2004). England and Wales cover the first year. Ours stops at four weeks.

She Told Them

The testimony, from witnesses on both

sides, laid out this sequence. Four months before her children died, she called psychiatric services and described intrusive thoughts. Her mother stayed with her for weeks that fall because she was frightened to sleep alone. In December she told her mother and husband she was having thoughts of harming her children. Her sister testified to daily suicidal thoughts for a month. She saw a nurse practitioner and a psychiatrist, went through partial hospitalization, and was admitted.

She said it out loud, repeatedly, to family and clinicians. She told her treatment team she was having intrusive thoughts about harming her children and went home.

Women here and abroad have followed this trial closely. They recognize the sequence, because they said something once too. Someone handed them a form, told them the first year is hard, or asked if they had support and wrote yes. Then they stopped.

Postpartum psychosis is rare. Missing it while a woman describes it out loud happens all the time. If the courts weigh criminal responsibility, they must weigh the record: what she reported, to whom, and what followed. A woman who told her team about intrusive thoughts and was sent home is in a different position from one who told nobody. The law can barely see that difference, because what she described is not in the manual. Until it is, screen past four weeks and act on what she tells you that week. If nothing follows the form, it only documents that she asked.

Dana

Dana stayed with us eleven days and went home. She came back six weeks later with the baby in a carrier and asked whether what happened to her had a name. I told her it did, then had to explain it was not in the book.

Her discharge summary never mentioned childbirth. There was no field for it. Mental health conditions underlie more than one in five deaths in the year after childbirth, and nearly all are preventable. Many of these women will never be diagnosed with anything, and what they carry is real all the same. Give clinicians a diagnosis that matches what they see and we will actually make progress in mothers’ mental health.

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Resources

National Maternal Mental Health Hotline: 1-833-852-6262 (1-833-TLC-MAMA)

Postpartum Support International Helpline: 1-800-944-4773

Suicide and Crisis Lifeline: 988

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predictor of successful program completion was parent or caregiver involvement.

PSB-CBT-A uses a modular, weekly group format (with one pass through the program lasting approximately five to six months), with participants attending separate caregiver and teen groups for the first hour each week, then coming together for a combined half-hour group. Modules include psychoeducation (sex laws, anatomy, principles of healthy sexual relationships), CBT-focused exercises (understanding thoughts and feelings that precede PSB and other problematic behaviors), and family-strengthening skills (supervision, rules in the home, caregiver/teen communication). The core tenets of PSB-CBT-A include its being developmentally focused -- teens are impulsive, not deviant; they have the capacity to learn and make healthier choices; strengths-based -- no shaming, focus on behavior and better decision-making; trauma-informed -- recognizing that many

of the youth and caregivers have experienced trauma themselves; and family systems oriented -- caregivers provide encouragement and enhance communication with and supervision of youth.

In the time I have been running PSB-CBT-A groups, I have seen caregivers go from reluctant, skeptical participants to enthusiastic, passionate contributors. Many caregivers come to group feeling defeated and hopeless, believing that there is “something wrong” with their child and that their parenting is wholly to blame. They may feel stigmatized, isolated from their usual social support networks, and may believe some of the myths and misconceptions about youth with PSB. The PSB-CBT-A group becomes a normalizing environment where caregivers meet others who are “in the same boat,” and caregiver shame and guilt about their predicament are reduced.

With shame and guilt reduced, the power of their participation in treatment with their teen becomes apparent. Caregivers begin to understand they are the therapist’s frontline extension in the home, translating

cognitive-behavioral strategies into techniques their teen can use to regulate themselves when they feel distressed or on the verge of engaging in negative behavior. The caregiver practices communication skills learned in treatment at home, contributing to more effective conflict resolution and less arguing. The caregiver feels more comfortable setting rules for their teen because they discussed behavioral expectations in group and their teen provided input on what rewards and consequences they believe are fair and motivating.

Perhaps most importantly, the teen’s view of the caregiver changes as a result of the caregiver’s involvement in treatment. The teen realizes the caregiver sees their pain, not just their bad behavior. The teen feels valued for who they are, not just judged for their worst behavior. Seeing a caregiver sit in a room and do hard emotional work proves to the teen that the adult is willing to change too. The vulnerability the caregiver shows in group makes them seem more human and relatable, which actually increases the teen’s respect for them. And with this

shared family journey, where judgment is replaced with partnership, the teen will feel he has the active, daily support he needs to sustain long-term change. The teen, and indeed the entire family, will be better for it!

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Central to this reform was the creation of the Commissions for the Dissuasion of Drug Addiction (CDT). The CDT system served as a structured diversion mechanism that redirected individuals away from criminal prosecution and toward assessment, voluntary treatment, and social support (Transform Drug Policy Foundation, 2021). Portuguese policymakers shifted the primary objective of drug policy from punishment to health promotion, prevention, recovery, and social inclusion (Justice Trends, 2018).

Over the first decade after reform, Portugal consolidated harm reduction programs and treatment services (Hughes & Stevens, 2010). The country experienced a drop in drug-related incarceration from 3,863 individuals in 1999 to 1,140 in 2017, representing a reduction of more than 70 percent (McCarthy, 2020; Transform Drug Policy Foundation, 2021). Overdose death rates declined from approximately 80 per million in 2001 to 6 per million by 2021, placing Portugal far below the EU average of 20.3 per million recorded in 2015 (Drug Policy Alliance, 2023; EUDA, 2026; Frayer, 2019). Rego et al. (2021) note that decriminalization allowed resources to be reallocated toward prevention, harm reduction, treatment, and social reintegration, and that lower stigma improved the reach of those services (Hughes & Stevens, 2010). The most important lesson from this period is that infrastructure came before law (Moury & Escada, 2022; Transform Drug Policy Foundation, 2021).

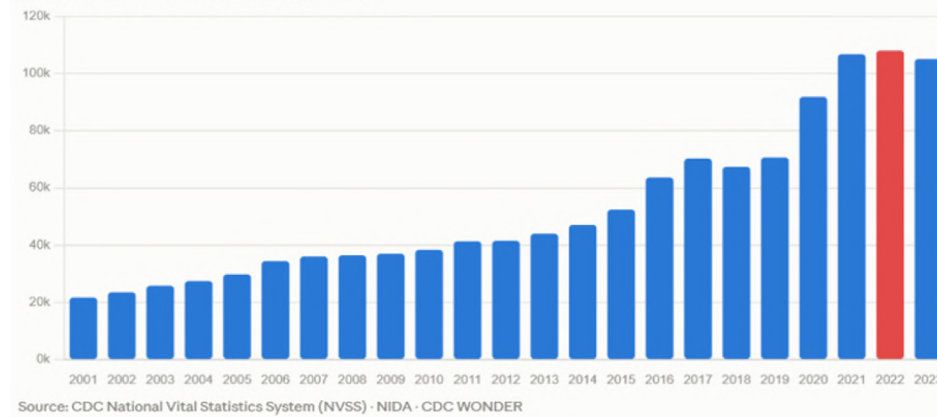
Portugal experienced a precipitous drop in overdose death rates (Kristof, 2017). The country went from having the highest rate in the European Union (EU) in 1999 to the lowest in 2021 (European Union Drugs Agency (EUDA), 2025). Portugal's 93% reduction in overdose death rates over two decades (1999–2021) was produced by decriminalization layered on top of a pre-existing, state-funded harm reduction infrastructure (Hughes & Stevens, 2010; Transform Drug Policy Foundation, 2021). Portugal's experience therefore demonstrates that successful drug policy depends less on changing criminal law than on building and maintaining a comprehensive public health system capable of supporting individuals throughout prevention, treatment, recovery, and long-term social reintegration.

Mixed Approaches with Differing Outcomes – The Netherlands

In 1976, the Netherlands, which pioneered harm reduction, moved to a harm reduction approach. The Opium Act created a distinction between drugs with unacceptable risks, such as heroin, LSD, cocaine, and amphetamines, and those that were under the heading of cannabis products, including hashish (Leuw, 1991). It was designed to make substance use by the public more manageable. Part of the benefit of this law was that it legalized less dangerous (i.e., “soft”) drug sales, so dealers (who now had to be licensed and follow regulations) were not lacing products, and customers knew what they requested was what they were getting (Henk & Ven Vliet, 1990). Due to cannabis now being a lawful substance, shops that sold drinks and food started selling cannabis products also (Henk & Ven Vliet, 1990).

In 2010 the Netherlands switched back to a more criminal justice approach due to the

Annual Deaths — United States, 2001–2023



side effects of “coffee shop ecstasy” (Van Ooyen-Houben & Kleemans, 2015), which is another name for soft drugs (those made with cannabis, sold in shops that also sell drinks and food). Dutch politicians wanted to demonstrate that they were tough on crime. There were still needle exchanges and supervised consumption rooms, but penalties were harsher (Busz et al., 2024).

In 2024, as overdose rates surged and international control efforts were increasingly seen as ineffective, the Netherlands reverted to a public-health-centered approach (Busz et al., 2024). That same year, the Office of the United Nations High Commissioner for Human Rights (OHCHR) issued a statement urging rights-based drug policies, reinforcing this broader shift (Busz et al., 2024). The Dutch experience illustrates how policy direction can directly shape outcomes. After the country moved away from harm reduction toward a criminal justice model, overdose mortality steadily increased — from roughly 5 deaths per million people in 2010 to 19 deaths per million in 2023 (EUDA, 2025) — underscoring the importance of stable, sustained public health investment and consistent policy implementation (EUDA, 2025).

Focus on Interdiction and Criminalization: With Treatment and Harm Reduction – United States

The so-called “War on Drugs” began in the 1970s, treating substance use primarily as a criminal issue (Hari, 2015). This approach coincided with increased substance use, overdose deaths, and the spread of illnesses (HIV, hepatitis) and infections due to the sharing of needles. Minimum sentencing and differential sentencing for different substances have disproportionately penalized minority communities (Pamplin et al., 2023). African Americans make up 14% of the total U.S. population and account for 38.5% of the total prison population (The Global Statistics, 2026; Federal Bureau of Prisons, 2026).

The sustained increases in overdose mortality documented by the CDC during 1999–2018 raise important questions about the effectiveness of a predominantly criminal-justice-oriented approach when it is not accompanied by comprehensive harm reduction and accessible treatment. The age-adjusted rate of drug overdose deaths increased from 6.1 deaths per 100,000 standard population in 1999 to 21.7 deaths per 100,000 in 2017, with the rate increasing by an average of 10% per year from 1999 through 2006, 2% per year from 2006 through 2013, and 14% per year from 2013 through 2016 (Hedegaard et al., 2018).

Another issue for the U.S. is the lack of access to substance abuse treatment. According to the Southwest Rural Health

Research Center (2025), only about 6% of those who wanted treatment, in rural areas, were able to obtain it. A study by Choi & Marti (2025) found that 75.46% of those who sought treatment could not get it due to inadequate insurance.

While the 2026 National Drug Control Strategy articulates important public health goals for the United States — making treatment more accessible than illegal drugs, expanding naloxone availability, and strengthening community-based recovery support (National Drug Control Strategy, 2026) — KFF Health News (Aneri Pattani, 2026) reports that accomplishing the strategy's goals “will be difficult in the face of the . . . mass layoffs of federal employees, cancellation of research and community grants, attacks on organizations and practices that serve people who use drugs, and cuts to Medicaid,” which is the largest payer for addiction and mental health care nationwide. Specifically, Medicaid work requirements in the administration's legislative agenda are projected to strip coverage from approximately 1.6 million people with substance use disorders, directly undermining the strategy's stated goal of expanding treatment access. When Medicaid rolls were previously reduced after COVID-era protections expired, many people receiving medication treatment for opioid addiction stopped it, and fewer people started treatment.

Treatment capacity in the United States remains uneven and often inadequate, especially when addiction intersects with mental illness, homelessness, and poverty. The U.S. system is fragmented across local, state, and federal agencies, making coordination between police, courts, treatment systems, and housing services difficult to sustain.

In addition, the current U.S. drug environment is dominated by fentanyl and other highly potent synthetic substances, which create a much faster and deadlier risk environment than the heroin epidemics that shaped many earlier European reforms. Political polarization and punitive public narratives make it difficult to sustain support for reforms when visible disorder or the perception of disorder increases.

The United States policy endorses harm reduction on the record (National Drug Control Strategy, 2026), while simultaneously reducing Medicaid coverage, SAMHSA grants, and community organization funding that deliver those services. The document is not the policy; the funding is the policy.

Why Treatment-Centered Policy Matters

The economic costs of addiction have steadily increased over time, with esti-

mates indicating that substance abuse costs the United States over \$740 billion annually (Lines, 2019). In 2015, the United Nations Office of Drugs and Crime and the World Health Organization established an Informal International Scientific Network. This committee was comprised of experts in SUD sciences. The members of the committee were appointed by Member States and represented widely diverse geographical regions, political systems, and cultures. As per Volkow, et al., (2016) they concluded that there was scientific evidence supporting the idea that, “. . . substance use disorders are brain disorders; that they can be treated; that people with even the most severe forms can recover with access to evidence-based treatment and social supports; and that criminal sanctions are ineffective at preventing or addressing these disorders.” (Emphasis added by authors). Bernard, et al., (2020) found that diversion programs decrease criminal justice costs while only moderately raising health care costs. If criminal justice interventions are ineffective at stemming the devastating impact of SUD, where is the best place to focus resources?

Portugal's model worked because decriminalization was embedded in a broader public-health system. The reform was backed by state-supported treatment, methadone programs, psychosocial care, and welfare infrastructure. (These factors highlight why decriminalization of substances in Oregon from 2021–2024 was not considered successful; the treatment capacity, access, and diversion programs were not put in place prior to decriminalization of substances.)

Another strength of Portugal's model is institutional coherence. The police, treatment system, and public administration had differentiated but connected roles: police could still target traffickers, while drug users were diverted into a structured process of evaluation and support.

The Netherlands followed a different path from Portugal, yet it also provides evidence that treatment and harm reduction can be more effective than punishment-only strategies. By distinguishing between so-called “soft” and “hard” drugs, allowing regulated tolerance toward cannabis while maintaining stricter control over heroin, cocaine, and organized trafficking, they avoided the false choice between total criminalization and unrestricted permissiveness. Its relative success lay in treating chronic drug dependence as a social and medical issue that required management, rather than assuming that punishment alone would eliminate it.

At the same time, the Dutch case also reveals the limits of tolerance when it is not matched by sufficient enforcement against organized crime. Over time, criticism grew that the Netherlands had become a hub for drug trafficking and related violence, particularly as synthetic drug production and organized criminal networks expanded. Dutch policy has not simply “returned” from treatment to punishment and back again. Rather, it has evolved into a hybrid approach: stronger criminal enforcement against violent networks and traffickers, while retaining treatment and harm reduction for users and vulnerable populations.

As reported in JAMA, the United States has continued to suffer from the highest overdose death rates in the world (Anderer, 2025). This is likely a result of lack of

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treatment infrastructure, lack of health care coverage, criminalization policies that disproportionately target minority communities resulting in higher rates of incarceration (which continues the cycle of broken families and poverty), and poor housing and vocational opportunities for those struggling with substance use disorder.

Portugal, the Netherlands, and the United States show that treatment-centered drug policy can be more effective and humane than punishment-centered policy, and that resources can be used more efficiently, when it is backed by institutional capacity, clear governance, and a realistic division between user management and trafficking control.

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The Kansas State University McNair Scholars Program is a comprehensive two-year program that aims to prepare eligible undergraduate students for graduate education and research-oriented careers. McNair Scholars Programs nationwide work to increase graduate degree attainment — especially PhD degree attainment — by providing opportunities for doctoral degree preparation to students from segments of U.S. society that are underrepresented in higher education.



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View the full list of references [here](#).

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it shifts perspective from simply treating mental illness during incarceration toward creating a continuity of care before, during, and after it.

Evidence-based psychological interventions also play a major role in this process. Cognitive behavioral therapy (CBT) allows individuals to identify and modify patterns of thinking and behaviour that might contribute to psychological distress (American Psychological Association, 2017). Dialectical behavior therapy (DBT) is another intervention that helps individuals emphasize essential skills such as emotional regulation, mindfulness, and distress tolerance (Cleveland Clinic, 2022). These approaches can help individuals by providing them with practical tools to manage psychological distress and develop healthier coping strategies.

Another important component of correctional mental health is trauma-informed care. Several incarcerated individuals have histories of trauma, including experiences of abuse and violence. These approaches recognize that these experiences can influence emotional responses and behaviour, and thus seek to integrate understanding of trauma into treatment and interactions with individuals in correctional settings (Palo Alto University, 2026).

Along with this, another important source of support is peer-led. This provides pivotal assistance as trained incarcerated individuals are able to support their peers, thus reducing stigma and providing encouragement with treatment. This helps reinforce a sense of community within correctional facilities (Palo Alto University, 2026).

Despite all these interventions, they do not guarantee effective care. Mental

health professionals have to constantly balance their responsibilities with the institutional security requirements, along with the already existing issues of limited resources, inadequate staffing, insufficient training, and difficulties with continuity of care (Alves et al., 2026). Along with that, confidentiality also poses another ethical challenge. Since therapeutic relationships depend mainly on trust and privacy, maintaining confidentiality is hard under correctional supervision. This might push incarcerated individuals to be reluctant to disclose sensitive information when they are uncertain about who may have access to that information. This can lead to them not being able to get the treatment they need, along with affecting their circumstances in the facility (Kolodziejczak & Sinclair, 2018; Alves et al., 2026).

These challenges highlight the need for correctional mental health systems that prioritize both effective treatment and the trust necessary for individuals to seek care. Ultimately, mental health care should not end at the prison gate. By ensuring access to compassionate and continuous care during incarceration and after release, the justice system can support recovery, strengthen communities, and ensure that a prison sentence does not become a sentence to untreated mental illness.

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School-to-Prison from page 25

All the young men reported disciplinary issues at school, and most reported experiencing exclusionary discipline, including out-of-school suspension and, more rarely, in-school suspension. Suspensions were employed repeatedly for some young men, sometimes paradoxically as a response for not coming to school. However, the young men did not report that suspensions had any impact on their behavior. For some, suspension was a desired outcome leading to out-of-school time that was often unsupervised and unstructured. For others, suspension was part of escalating behavior that was designed to get a reaction from school officials. Young men described schools that seemed ill-equipped to deal with disciplinary problems, which resulted in discipline that was both exclusionary and poorly communicated to students. Several young men reported having to spend time alone in a dean's or principal's office for entire school days after an incident without contact with other students. Others reported not knowing or understanding that they were suspended or in trouble, leading to disorientation and disengagement:

I got suspended one time but I was never told that I got suspended. So I tried to go back to school not knowing that I was suspended. I got to the front door but the teacher, the principal just came through the front door and told me I was suspended. So since that day I just never went back.

For young people already tenuously attached to school, being overtly told you are not allowed in presents a barrier that is difficult to overcome.

Consistent with the literature (Skiba et al., 2014), several young men described a trajectory that began with exclusionary discipline in earlier grades and escalated to expulsion and transition to an alternative school, ultimately ending in dropout. School transitions for young men with ADHD were problematic. Several young men dropped out between middle school and high school, and in frustration when moving from one school to another when their school records were not transferred or received.

Young men also had considerable difficulty returning to school after criminal-legal-system-related attrition or incidents that resulted in expulsion due to miscommunication, embarrassment, frustration about having to repeat grades, or lack of support. Angel, who has ADHD, depression, and anxiety, described his attempt to return to school to finish his senior year after a period of not attending. He came to the first day of school but was not sure who his teachers would be, and was directed to a classroom for attendance. Since his name did not appear on the roster, he was sent to the dean, who told him she had disenrolled him from school.

Other young men felt pushed out by school, even when there was no formal expulsion. Alternative schools seemed to serve as an “off-ramp” for young men with



Sarah Jalbert, PhD

ADHD. Some, like Noah, believed they would have an opportunity to return to their traditional school, and were frustrated when that opportunity didn't materialize:

My IEP worker would always tell me finish this year off good and next year we'll try to see if we can get you into a public school. I don't think she ever even tried to be honest. I don't think she cared.

All young men interviewed had some experience with law enforcement. Young men with ADHD seemed to become involved with police at an earlier age than those without ADHD. For most young men, police contact was not initiated by school authorities or resource officers, but several reported arrests that were related to incidents at school, primarily fighting or bullying, where police came to their house later to arrest them or inform them of a restraining order. Most young men said they had been held by police many more times than they had been arrested. For young men with ADHD, staying out of trouble while incarcerated could be a struggle. For instance, Alejandro described how his initial 12-month Department of Youth Services (DYS) sentence extended to 24 months:

I kept messing it up... they were letting me go to a step down, but I just kept messing it up. I'd be like fighting somebody at a step down... And so they indicted me, they gave me one more time on top of my time and I couldn't have good time then. Then they just gave me the full time I was supposed to serve. I was supposed to serve like a 12 or 24, and I ended up serving like the 24 months.

It was unclear whether ADHD symptoms made it difficult to follow rules when under correctional supervision. For some, like John, incarceration brought structure and order to an otherwise chaotic life, demonstrating how complex young men's relationships to institutions may be when their pro-social relationships have broken down. As he described it, “*I lived a good life in jail*”. This does not mean jail was a positive influence for John, but instead shows how difficult his life outside of jail has been, and how the many systems involved in John's life have failed him.



Holly Swan, PhD

Discussion

Schools, widely documented as a pro-social protective factor for young people at risk of justice-system involvement, were sources of disconnection and stigma for young men in this study struggling with ADHD and other disorders. Though study participants had serious behavioral challenges that were difficult for schools to manage, these interviews suggest that these are the students who need more protection and intervention from school officials than their peers. Young men with ADHD may be less able to navigate the complexities of remaining in school while under correctional supervision than those without the diagnosis. Aptitude and impairment appeared to influence how young men were treated by institutions, especially schools. Young men with learning disorders (with or without ADHD) reported experiencing little to no encouragement to stay in school, and several even felt pushed out. Even less-impaired students with ADHD felt stigma associated with their special education status. Young men with ADHD also seemed to experience more persistent and escalating discipline relative to those without ADHD, even before their criminal legal system involvement.

Recommendations

This study was small and the conclusions we can draw are limited. However, the findings contribute to a growing body of work that documents how the health care system, the school system, and the justice system are linked by policy failures that differentially harm children of color (Annamma et al., 2014; Sussman, 2011). By damaging family institutions, limiting access to protective institutions, and diminishing the complement of choices available early in childhood or adolescence, institutions both fail to prevent — and ultimately reinforce — negative outcomes for children. The policy response should be clear: bolster in-school support for children with ADHD, especially those who have disciplinary issues, to prevent school detachment and possible criminal

legal system involvement. Behavioral health policy must recognize that children with the most precarious attachments to family, school, and community would also potentially benefit the most from inclusive policies that keep them attached to school and other support services.

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Intercept 1 (Law Enforcement Involvement; Arrest): Under Bail Reform, many individuals, when arrested, are given a desk appearance ticket. With planning and collaboration, this creates a window (often about 20 days) for diversion before they are arraigned. “Fresh Start” is a program run through the Department of Community Mental Health (DCMH) for low-level first-time alleged offenders who are offered a program that, if completed, results in the District Attorney declining to prosecute. OPT-In is a program for individuals charged with low-level drug possession. After arrest and before arraignment, individuals are given the opportunity, through connection to an addiction peer, to access services and also have prosecution of the charges declined.

Intercept 2 (Immediately Post-Arrest): Westchester County has several programs, old and new, to connect with individuals at the first court appearance (arraignment). Those include Treatment Alternatives for Safer Communities (TASC), which began in Westchester’s DCMH in the mid-1980s. TASC is a voluntary diversion program, court-ordered by agreement, with needs identification, treatment, and court reporting. Currently, about 60% of TASC cases are DWIs. Pre-Trial Services, operated by the nonprofit CHOICE-NY, is a contractual program through Westchester County providing predisposition support and supervision for the court-identified population not eligible for bail. At any given time, hundreds of people are assigned electronic monitoring in the county.

Intercept 3 (Court Diversion Models): There is no known correlation between diagnosis and severity of criminal charge. Simply put, it is not the diagnosis that determines the severity of the crime: often it is analogous to whether a \$500 or \$2,500 bicycle was stolen. In 2005, the Westchester County Court collaborated with the DA’s office, Legal Aid Society, DCMH, and the Probation Dept. to begin our Felony Mental Health Court. Individuals with serious

mental health needs, many of whom also have complex substance use issues, are provided an opportunity to participate in the treatment court for 18–24 months with frequent court appearances and monitoring of services that focus on their adherence to recovery goals. Many will receive additional supportive care coordination directly from the DCMH Mental Health Alternatives to Incarceration Program (MHATI) or receive residential support through our Single Point of Access Services (SPOA). Some court participants may be employed or begin the first steps toward future employment, engage in vocational or educational programs, or volunteer in their communities during their time in the court. If successful, many will avoid a lengthy state prison sentence and a reduction of charges.

The Misdemeanor Wellness Hub Court began in 2023. It allows any identified individual in any municipal court facing misdemeanor charges to have their case transferred to one specific court’s calendar. It serves defendants with mental health or co-occurring needs. Similar supports are provided as in the felony part. Adherence to their individualized treatment plans and successful completion within six months to one year will result in a dismissal of charges or a violation.

The 9th Judicial District, of which Westchester is a part, also offers specialized diversion courts for youth/emerging adults, drugs, and veterans.

Intercept 4 (Reentry): Incarcerated individuals returning to the community face a myriad of challenges. Services and supports leading to housing, reacclimating in the community, and employment are crucial. Every point on the social determinants of health is impinged when a person with behavioral health needs is incarcerated.³ Westchester County, in partnership with DCMH and the County Jail, focuses on reentry services for those returning from the jail. This includes our award-winning **CORE (Community Oriented Reentry)** program where individuals participate in groups focusing on such areas as wellness, spirituality, successful recovery, music, art, and creative writing; the St. John’s River-

side Hospital’s Solutions addiction program; and the Lives Forward Program,⁴ as well as discharge planning services coordinated through the jail pre-release staff and/or Wellpath clinicians, Westchester Department of Social Services, and community partners. Our Transitional Managers provide direct connections to longer-term community supports starting at the time of release, often transporting individuals to DSS directly, assisting with obtaining prescribed medications, getting to intake appointments for treatment or housing interviews, checking in with parole or probation, or attending follow-up court dates.

Intercept 5 (Community Corrections – Probation and Parole): On any given day, twice as many people are serving their time on probation or parole than are actually incarcerated.⁵ To help address the needs of those returning on parole, DCMH and its nonprofit partner “Family Services of Westchester” operates the “Reentry Task Force.” As a network of collaboration, nearly 50 different community organizations work together to help support and serve those returning from state prison. Further, many of the services provided in **Intercept 3** are available to those with community correction sentences. The person-centered services offered to individuals can include case management, treatment supports, employment readiness, financial literacy, educational supports, and parenting supports.

Over the past few years, DCMH has developed several corollary tools to support these efforts. First, we have the “RICI” list (Repository for Integrated Criminalistic Information) match. The RICI list is a state-mandated, county-maintained daily list of individuals arrested in the previous 24 hours. In Westchester, our IT Department created software to run that list against our database of individuals served by DCMH programs. Every morning, select DCMH leadership and service staff receive an email of all those we are serving, or have served, who have been arrested in the last day. This is extremely useful for case management, service adjustment, and planning purposes.

DCMH has also expanded our Single Point of Access (SPOA) program to embed a SPOA outreach staff person with County Department of Social Services Adult Protective Services (APS). In Westchester, law enforcement, among many others, refer individuals believed to be abused or neglected to APS. By partnering mental health with APS, individuals’ overlapping needs and concerns are addressed from first service contact.

Additionally, DCMH has created an Intellectual/Developmental Disability (IDD) “Boundary Spanner.” The role is a case manager who works with individuals with IDD needs to initiate eligibility (if necessary) and connect, or reconnect, people to the services they need – in any behavioral health system. Our Boundary Spanner works with referrals from the community, including individuals in our shelters, unsheltered, and justice-involved – even in the county jail as part of pre-release.

In 2025, Westchester’s behavioral health diversion models served nearly 4,000 people.

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risk, many opt instead for a plea deal with no treatment — leaving the underlying condition to continue untreated. Others are barred from participation by their charge alone, regardless of whether an underlying behavioral health need was the root cause.

One source of pushback has been the cost of expanding courts and treatment programs. The TCEA coalition estimates the expansion would cost roughly \$150 million. Yet a [study](#) from Recidiviz estimated that New York would see roughly 1,300 people diverted from state prisons annually, along with another 2,200 diverted from New York City jails. At an [average](#) annual cost of \$115,000 to incarcerate one person in a state prison, and \$225 a day in New York City jails, the expansion of mental health courts could return \$150 million annually in savings. Organizations like the National Alliance on Mental Illness (NAMI) contend that these savings could be reinvested in the mental health system to fund more community-based treatment programs. The TCEA also allows courts to

limit participation based on the availability of treatment programs.

The TCEA expands the scope of existing drug courts to include mental health, intellectual disabilities, and other issues, or any combination of them. This has been a critical gap in access to diversion courts. In the 2026 budget, Governor Hochul included a single set of licensing standards in her [State of the State address](#), which was subsequently passed as standalone legislation, S3051B/A3296C. Organizations like NAMI fought for this to ensure access to treatment for the nearly 60% of individuals with substance use disorders who have a co-occurring mental health issue — about [21.2 million](#) adults nationwide. People with disabilities are about [4.6](#) times as likely to experience mental distress, with 32.9% of those with disabilities experiencing mental health issues. Veterans courts and human trafficking courts see similar overlap. All of this underscores the biggest barrier the TCEA is designed to address: access to care.

Equitable access to mental health support is the top priority of NAMI-NYS. Right now, the shortage of courts, the si-

loing of the behavioral health issues covered, the plea requirements that prevent participation, and the ad hoc nature of the courts operating in the opening created by the 2009 legislation all mean that the very court system meant to stop us from arresting our way out of the opioid crisis is still arresting its way out of the mental health crisis. These are not separate issues — the same underlying behavioral health needs that drug courts attempt to address are what should drive us to implement treatment courts that address the full range of issues affecting the mentally ill, veterans, and human trafficking victims alike.

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facilities in the United States (adult prisons, local jails, and juvenile confinement facilities), that's less than half of 1 percent of correctional facilities nationwide.

The 2024 Federal Rule Change

The regulatory landscape changed significantly in 2024. SAMHSA and the U.S. Department of Health and Human Services published the first substantial revision to 42 CFR Part 8, the federal regulation governing opioid treatment programs, in more than 20 years [5]. The final rule took effect April 2, 2024, with an October 2, 2024 compliance date, and directly addressed correctional institutions and facilities and the need for change: under the newly revised rule, jails and prisons could now register as a hospital or clinic, allowing them to directly dispense methadone to treat OUD and to manage acute opioid withdrawal, rather than relying solely on an outside OTP for every dose [6]. This new rule also replaced the old requirement that inmates must have had at least one year of active addiction for admission into the program with a formalized clinical determination, and it codified telehealth as an additional method of care and allowed for more take-home dose flexibility — which was first introduced during the COVID-19 public health emergency [7]. This was the biggest change in 20 years to the rules on correctional medications for OUD. The rules are starting to catch up with the science. Standards, policies, and surveyor expectations at CARF, NCCHC, and state licensing bodies are still catching up to what the new rules allow.

What Continuity of Care Actually Requires

Accreditation standards translate this new regulatory shift into very specific and real operational requirements. NCCHC now recommends universal OUD screening for everyone entering a facility, initiation or continuation of medications for opioid use disorder (MOUD) during incarceration (sometimes known as medication-assisted treatment, or MAT), and continuity of MOUD treatment at both entry and release, with coordination happening directly with



A. Ant, CADC-II

community-based treatment providers [8]. This “warm handoff” model requires correctional health staff and community SUD providers to share clinical information, confirms the inmate receives an appointment before release rather than simply issuing a referral (hoping the individual actually uses it and makes an appointment), and, in the best-performing facilities, provides a bridge supply of medication so the person is not left without treatment during the first days back in the community, when overdose risk is highest. This population may self-medicate when proper medications are not available to them [9].

The Medicaid Shift

Financing has historically been the weak link, largely because of the Medicaid Inmate Exclusion Policy, which has long prohibited Medicaid from paying for most services delivered during a person's incarceration. That started changing in April 2023, when the Centers for Medicare & Medicaid Services (CMS) issued new guidance inviting states to apply for Section 1115 “reentry” demonstration waivers, partially lifting that exclusion for a defined pre-release window, typically 30 to 90 days, so states could bill Medicaid for services including case management and MOUD before someone was even released [10]. As of April 2025, CMS had approved 19 state reentry waivers, with nine

more pending, and California became the first state to implement its waiver in October 2024 [11]. Separately, the Consolidated Appropriations Act, 2023 requires state Medicaid and Children's Health Insurance Program (CHIP) programs to cover specific services for justice-involved youth starting January 1, 2025 [12]. For accredited providers, the good news is that this means the financing and clinical-coordination pieces for continuity of care are moving in the same direction at the same time and in a growing number of states.

What This Means for Providers

For behavioral health organizations deciding whether to build out justice-involved or correctional-facing SUD services, the key takeaway is that accreditation and continuity-of-care design are no longer separate decisions. A program trying to achieve CARF's Criminal Justice population designation, or a Court Treatment or Diversion/Intervention accreditation, will need to show documented, tested handoff protocols with its correctional and community partners well before any survey, not just policies written to satisfy a CARF standard. A correctional facility considering in-house MOUD dispensing under the revised 42 CFR Part 8 needs to understand upfront that doing so on any meaningful scale using methadone still likely requires NCCHC accreditation specifically, and on a timeline measured in months, not weeks. And any organization operating in a state with an approved or pending Section 1115 reentry waiver has a genuine, near-term financing opportunity to fund pre-release engagement that did not exist five years ago; whether that organization's clinical and billing infrastructure is actually in place to benefit from it is a separate, and sometimes overlooked, question.

The overdose statistics in this article are not new, nor is the underlying diagnosis: people leaving incarceration die because the systems meant to catch them do not talk to each other in time. What has changed is that federal regulations, accreditation standards, and Medicaid financing are simultaneously being rebuilt to close that gap and catch these people before they fall. For organizations serving justice-involved individuals with substance use disorders, this is both the opportunity the field has been

waiting for and the compliance challenge that will separate the providers who can close the gap from those who simply document that they tried.

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View the full list of references [here](#).

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additional solution lies with the expansion of Daniel's Law in New York State. In March 2020, Daniel Prude was experiencing an acute mental health crisis in Rochester, New York, when his family called 911 for help. He was naked in the street in freezing weather, but posed no risk to any other person. Yet Rochester Po-

lice responded in force, handcuffed him, placed a “spit hood” over his head, and held him face down on the cold pavement until he stopped breathing. Daniel Prude was a man experiencing an obvious mental health crisis, and he deserved care and dignity — but he was denied both. Instead, police killed him. In response to the tragedy, city and state elected officials — including previously Zohran Mamdani, then

Assemblymember, and most recently City Councilmember Carl Wilson — have advocated for the expansion of Daniel's Law, which would ensure that every locality in our state has a plan and resources in place for responding to mental health-related emergencies in a sensitive, constructive manner. Last year, the New York City Council devoted discretionary funding awards to help launch and expand peer-in-

involved crisis response programming for the first time, and funding has continued for 2026. The time for peers to become a major part of the solution is clear, and that time is now.

Jim Mutton is the Associate Executive Director of NYC Operations at [Concern Housing](#) and serves as a steering committee member at CCIT-NYC.

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coalition-building approach associated with advocacy efforts supporting community-based disability services in Rhode Island.

The 2026 Inclusive Leadership Impact Awards are judged by professionals with backgrounds in organizational development, corporate leadership, disability in-

clusion, communications, and social impact. The judging panel includes current and former senior executives and advisors with experience across organizations including Children's Aid, NYU Wagner, CVS Health, Tapestry, Disability:IN, and other national institutions.

For Dr. Adusu, the recognition reinforces a principle that has guided much of his work: inclusion is most meaningful when

it results in tangible changes in people's lives. He joined the other 2026 honorees at the Inclusive Leadership Impact Awards ceremony on Wednesday, October 7, where the award was formally presented. The event brought together award recipients, organizational leaders, and other guests to recognize individuals and organizations whose work is expanding access, opportunity, and belonging.

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