Changing the Contours of the Criminal Justice System To Meet the Needs of Persons With Serious Mental Illness

by Arthur J. Lurigio and James A. Swartz

ABSTRACT

Major changes in mental health policies and laws have placed untold numbers of persons with serious mental illness (PSMIs) in the community, where they receive inadequate or intermittent care, or no care at all. These changes have caused criminal justice professionals to become involved with PSMIs at every stage of the justice process. In this chapter, we explore the blurred boundaries between the criminal justice and mental health systems in the United States. We focus on the arrest, incarceration, and community supervision of PSMIs. We review research on the relationship between serious mental illness and violent crime and trace the historical developments that have apparently produced growth in the numbers of PSMIs in the criminal justice system. We also examine how the increased numbers of PSMIs have compelled criminal justice organizations to alter their policies, procedures, and relationships with mental health providers and to confront the difficulties that arise in initiating and sustaining those relationships.

Because of the tremendous prevalence of drug abuse and dependence disorders among PSMIs in the criminal justice system and the correlation between drug misuse and violent behavior, we discuss at length

Arthur J. Lurigio, Ph.D., is Professor and Chairperson with the Department of Criminal Justice, Loyola University, Chicago. James A. Swartz, Ph.D., is Director of Research and Information Services, Treatment Alternatives for Safe Communities, Chicago.

the problem of comorbidity (i.e., serious mental illness and substance abuse and dependence disorders). Throughout the chapter, we briefly describe exemplary criminal justice programs for PSMIs.

We conclude with general recommendations for improving the future care of PSMIs in the criminal justice system, such as building enduring connections between the mental health and criminal justice systems; creating aftercare and consolidated services programs for PSMIs being supervised in the community; developing clear and consistent standards of care for PSMIs in prisons, jails, and community corrections agencies; and pursuing more research on the nature and extent of serious mental illness among different correctional populations.

ABSTRACT

Major changes in mental health policies and laws have placed untold numbers of persons with serious mental illness (PSMIs) in the community, where they receive inadequate or intermittent care, or no care at all. These changes have caused criminal justice professionals to become involved with PSMIs at every stage of the justice process: Police arrest PSMIs because there are few other options to handle their disruptive public behaviors; jail and prison administrators strain to provide for the care and safety of PSMIs; judges grapple with limited sentencing alternatives for PSMIs who fall outside of specific forensic categories (e.g., guilty but mentally ill); and probation officers struggle to obtain scarce community services and treatments for PSMIs and to fit them into existing programs and case management strategies.

In this chapter, we explore the blurred boundaries between the criminal justice and mental health systems in the United States. We focus on the arrest, incarceration, and community supervision of PSMIs. We review research on the relationship between serious mental illness and violent crime, tracing the historical developments that have apparently produced growth in the numbers of PSMIs in the criminal justice system. We also examine how increased numbers of PSMIs have compelled criminal justice organizations to alter their policies, procedures, and relationships with mental health providers and to confront the difficulties that arise in initiating and sustaining those relationships.

Increased numbers of PSMIs have compelled criminal justice organizations to alter their policies, procedures, and relationships with mental health providers.

Because of the tremendous prevalence of drug abuse and dependence disorders among PSMIs in the criminal justice system and the correlation between drug misuse and violent behavior, we discuss at length the problem of comorbidity (i.e., serious mental illness and substance abuse and dependence disorders). Throughout the chapter, we briefly describe exemplary criminal justice programs for PSMIs and make recommendations about how law enforcement and correctional personnel can respond more humanely and effectively to PSMIs. We conclude with general recommendations for improving the future care of PSMIs in the criminal justice system.

The term "serious mental illness" can be defined in several ways. As Jemelka, Rahman, and Trupin (1993) discussed, there is no consensual definition for serious mental illness, and the label "mentally ill offender" has been applied to diverse populations, including those found not guilty by reason of insanity or incompetent to stand trial, mentally disordered sex offenders, and convicted offenders who are admitted to secured mental health facilities in lieu of prisons.

Fueled by sensational media reports, negative stereotypes concerning the dangerousness of PSMIs are longstanding and widespread and seem to have become more entrenched.

Regardless of the definition of "mentally ill offender," the classes of mental illness most often regarded as "serious" include schizophrenia and other psychotic disorders, bipolar disorder (i.e., manic-depressive disorder), and major depressive disorder. (See American Psychiatric Association [1994] for a detailed description of these and other diagnostic categories.)

Other psychiatric disorders, such as posttraumatic stress disorder or panic disorder, can also have severe consequences for their sufferers. Persons with schizophrenia, manic depression, or major depression, however, are among the most severely disabled mentally ill with respect to their inability to function and the chronicity of their illnesses (Barlow and Durand 1999). Thus, for the purpose of this chapter, the term PSMIs refers to persons who are afflicted with one of those three disorders.

The chapter is divided into seven major sections. Section one examines the relationship between crime and mental illness and chronicles research on this topic from its inception to date. Section two presents studies on the criminalization of the mentally ill and explores the factors that have contributed to the increasing numbers of mentally ill persons in the criminal justice system. Section three discusses police handling of mentally ill persons and the variables that make arrest of PSMIs more likely. Section four describes the prevalence and treatment of PSMIs in jails and prisons and involved with probation agencies. Section five discusses the importance of diversionary programs for PSMIs and describes two mental health court programs that are designed to deflect PSMIs from the criminal justice system and into the mental health system. Section six examines the comorbidity of serious mental illness and substance abuse and dependence disorders among mentally disordered offenders. Section seven recommends basic changes that will lead to better care for PSMIs in the criminal justice system.

Crime and Mental Illness

The criminality of PSMIs has been a topic of scholarly debate for more than 70 years. Fueled by sensational media reports, negative stereotypes concerning the dangerousness of PSMIs are longstanding and widespread and seem to have become more entrenched (Link and Stueve 1994; Monahan 1992; Phelan et al. 1997; Shah 1975; Shain and Phillips 1991). Misconceptions and unfounded

fears often determine the responses of both the general public and criminal justice professionals to the mentally ill and can greatly affect social policies and legal practices relating to their sentencing, treatment, and care (Barlow and Durand 1999; Steadman et al. 1998).

Are PSMIs more prone to violent and criminal behaviors than persons without major mental disorders? This question is fundamental to our understanding of whether PSMIs are being criminalized—that is, inappropriately processed through the criminal justice system instead of the mental health system. As Teplin (1991a) noted, the criminalization of the mentally ill is not an issue when PSMIs commit serious crimes, since criminal justice responses are clearly warranted in such cases. Public sentiment and statutes define crimes against persons as being among the most serious crimes committed (Adler, Mueller, and Laufer 1996), and the vast majority of studies regarding the criminality of PSMIs have investigated their propensity toward violent crimes.

Early studies

Although the relationship between mental illness and violence was contemplated more than a century ago (e.g., Gray 1857), one of the first studies ever to investigate whether former mental patients pose a criminal threat to the community was conducted in the 1920s. Ashley (1922) followed a sample of 700 patients for 3 months after their release from hospitals and reported that only 12 were arrested for offenses, including "vagrancy, assault and battery, forgery, swindlery or profiteering" (p. 65). These findings, however, were impossible to interpret because Ashley did not compare the patient arrest rate with the general population arrest rate.

In the four decades following Ashley's work, three major investigations assessed the relationship between mental illness and criminal behavior (Monahan and Steadman 1983). The first major investigation was Pollock's (1938) study of patients paroled from all New York State hospitals in 1937. He found that patients were less likely to be arrested than were members of the general population. The second major investigation was Cohen and Freeman's (1945) study of approximately 1,700 patients paroled from State hospitals in Connecticut. Their results indicated that the arrest rate in the general population was 15 times greater than the arrest rate in the hospital patient sample. These two investigations and other early studies "led to the oft-quoted claim that the mentally ill are no more dangerous than the general population, which was true prior to the era of deinstitutionalization [i.e, the release of large numbers of PSMIs from State psychiatric hospitals] because most potentially dangerous patients were kept in the hospital" for long periods of time (Torrey 1997, 45).

The third major investigation, done by Brill and Maltzberg (1962), was the broadest and most influential study conducted during the early years of deinstitutionalization (Rabkin 1979). Brill and Maltzberg analyzed the arrests of 10,000 New York State hospital patients, 5 years before and 5 years after recent hospitalizations. Patients with previous criminal records had a subsequent arrest rate dramatically higher than did patients with no criminal histories and persons in the general population. In contrast, patients without prior offenses were arrested significantly less often than were members of the general population.

Studies in the era of deinstitutionalization

During the mid-1960s and throughout the 1970s, researchers reported that arrest rates among former mental patients were significantly higher than those in the general population (e.g., Durbin, Pasewark, and Albers 1977; Rappeport and Lassen 1966; Zitrin et al. 1976). Cocozza, Steadman, and Melick (1978), for example, examined the arrest records of nearly 4,000 patients released from New York State mental hospitals and found that patients had a higher arrest rate than persons in the general population for all classes of offenses. They also found that the likelihood of arrest increased when patients had criminal histories before they were hospitalized. Similar to Brill and Maltzberg's (1962) findings, the arrest rate among patients without prior arrests was lower than that of the general population.

According to Cocozza, Steadman, and Melick (1978, 333), the apparent increase in the criminality of mental patients could be attributed to "the changing clienteles of state hospitals," that is, to the growing numbers of patients with previous offense histories. Comparable results and conclusions were reported by Harry and Steadman (1988), Steadman, Cocozza, and Melick (1978), and Rabkin (1979) (cf. Sosowsky 1980).

Monahan and Steadman (1983, 152) reviewed the literature on crime and mental disorders, citing more than 200 studies, and summarized the primary research findings as follows:

> The conclusion to which our review is drawn is that the relation between . . . crime and mental disorder can be accounted for largely by demographic and historical characteristics that the two groups share. When appropriate statistical controls are applied for factors such as age, gender, race, social class, and previous institutionalization, whatever relations between crime and mental disorder are reported, tend to disappear.

Recent research

More recent studies challenge the observation that crime and mental disorders are only spuriously related and help qualify the relationship between mental disorders and violent crimes (Monahan 1993). Swanson and colleagues (1990), for example, analyzed data from the National Institute of Mental Health's Epidemiological Catchment Area Study. The research involved interviews with a representative sample of adult residents of three major cities to estimate the prevalence of psychiatric problems in the general population. Swanson and colleagues focused on the co-occurrence of violence and mental disorders. They found that self-reported violent behaviors were five times higher among individuals who met the criteria for psychiatric diagnoses than among those who did not. In addition, the researchers found no differences in the prevalence of violence among persons who met the criteria for a diagnosis of schizophrenia, major depression, or manic-depressive disorder.

A random community area survey conducted in Stockholm, Sweden, explored the nature and extent of violent crimes committed by PSMIs, compared with persons living in the same city who had never been diagnosed with a major mental illness (e.g., schizophrenia and major affective disorders) (Hodgins 1992). Results showed that men and women with serious mental illnesses were more than 4 and 27 times more likely, respectively, to have been convicted of violent crimes than were persons with no previous psychiatric diagnoses.

Link, Andrews, and Cullen (1992) compared the criminality of former psychiatric patients in New York City with that of 400 adults who lived in the same neighborhoods as the patients but who had never been treated for mental illnesses. The researchers controlled for age, gender, ethnicity, and socioeconomic status and found that a significantly greater percentage of the former patients had been arrested for violent crimes. Furthermore, a greater percentage of the former patients reported violent acts (e.g., hitting, fighting, hurting someone badly) and the use of weapons than did nonpatients (cf. Steadman and Felson 1984).

Link, Andrews, and Cullen (1992, 291) noted that "the association between mental patient status and violent behavior was remarkably robust to attempts to explain it away as artifact." After the investigators controlled for current psychiatric symptoms, however, the relationship disappeared. Specifically, when former patients were experiencing psychotic symptoms (e.g., hallucinations, delusions) their risk of violence was significantly increased; when they were not, their risk of violence was no higher than the risk in the sample of community residents who were free of serious mental illnesses.

In a study of released jail detainees, Teplin, Abram, and McClelland (1994) found that PSMIs who had experienced hallucinations and delusions were more likely than non-PSMIs—but not significantly so—to be rearrested for violent crimes 6 years after their release. Underscoring the importance of treatment in curbing potential violence among PSMIs, Beck (1998) described several studies that showed that the violent acts of schizophrenic persons frequently result from delusions and can be diminished with the proper use of antipsychotic medications.

In light of the independent evidence of Link, Andrews, and Cullen (1992) and Swanson and colleagues (1990), Monahan (1993, 295) revised his earlier position on mental disorders and crime, which declared that PSMIs are no more dangerous than members of the general population:

> Together, these two studies suggest that the currently mentally disordered—those actively experiencing serious psychotic symptoms—are involved in violent behaviors at rates several times those of non-disordered members of the general population, and that this difference persists even when a wide array of demographic and social factors are taken into consideration. Since the studies were conducted using representative samples of the open community, selection biases are not a plausible alternative explanation for their findings.

Large-scale cohort studies have produced compelling evidence for a link between mental disorders and violent crimes. Hodgins and colleagues (1996) used the registries in Denmark to document the number of psychiatric hospitalizations and criminal convictions in a birth cohort of more than 300,000 persons, from birth to age 43. The researchers compared the prevalence, type, and frequency of criminal convictions of persons with previous psychiatric hospitalizations with those of persons who had never been admitted to a hospital for psychiatric treatment. They found that men and women with prior psychiatric hospitalizations were more likely to have criminal convictions than were those with no prior hospitalizations.

A cohort study conducted in Sweden found that persons treated for schizophrenia and later released from the hospital committed four times as many violent crimes as did members of the general population. Moreover, the study found that more than half of the sample of schizophrenic patients also had histories of substance abuse and dependence (Lindquist and Allebeck 1989, 1990). In another study outside the United States, investigators in Finland reported that among all persons arrested for homicide between 1990 and 1991, the rate of schizophrenia was nearly 7 times greater for male homicide arrestees and more than 15 times greater for female homicide arrestees than the rate of schizophrenia in the general population (Eronen, Hakola, and Tiihonen 1996).

Steadman and colleagues (1998) designed a study to overcome the basic methodological flaws of previous research on the topic of mental illness and violence (e.g., biased samples and reliance on only official arrest records or uncorroborated self-reports). The research, known as the MacArthur Violence Risk Assessment Study, was undertaken in three cities and monitored the violent acts of male and female patients during the first year after their release from the hospital. Patients' own reports of violent behaviors, the reports of collateral informants regarding patients' behaviors, and patients' police and hospital reports were compared with the same sources of data for control groups of persons who lived in the same neighborhoods as former patients and had no previous psychiatric hospitalizations.

Confirming the results of Johns (1997) and Swanson and associates (1996), Steadman and colleagues (1998) found that violence prevalence rates were significantly higher for both former patients and members of the general population who were diagnosed with substance abuse and dependence problems. Former patients reported relatively more substance abuse and dependence problems than did persons in the general population, and patients who abused drugs and alcohol committed more acts of violence than did members of the general population who had no substance use problems.

In the MacArthur Violence Risk Assessment Study, patients with personality and adjustment disorders and a co-occurring diagnosis of substance abuse or dependence formed the group most likely to commit violent acts in the followup period. Former patients and community members were more likely to perpetrate their aggressive acts against family members, friends, and acquaintances than against strangers. Also, patients were more likely than community residents to commit violent acts at home. (Several other studies have also reported that family members are often the targets of violent PSMIs [e.g., Runions and Prudo 1983; Straznickas, McNeil, and Binder 1993; Tardiff 1984]). Steadman and colleagues (1998, 403) concluded that it is "inappropriate" to refer to "discharged mental patients as a homogeneous class" and that the "presence of a co-occurring substance abuse disorder [is] a key factor" in explaining the violence among PSMIs.

Correlates of violence among PSMIs

In summary, the research that we have described so far, as well as numerous investigations reported elsewhere, suggests that the PSMIs most likely to engage in violent behaviors are symptomatic (especially with command hallucinations and delusions), are in noncompliance with psychotropic medications, and have histories of criminal and violent activities (Bartels et al. 1991; Taylor 1985; Taylor, Mullen, and Wessely 1993). Perhaps the most important factor

predictive of violence among PSMIs is comorbidity for substance abuse and dependence (Smith and Hucker 1994).

The risk of serious mental illness for violence is probably less than or equal to the added risk that is associated with age, educational level, and gender (Link, Andrews, and Cullen 1992; Swanson et al. 1990). Serious mental illnesses and violent behaviors both have low base rates in the general population and are unlikely to occur together. Hence the contribution of mental illness to overall levels of violence in the United States is probably trivial (Swanson 1994). For example, Torrey (1997) estimated that PSMIs commit 4 percent of all homicides in the United States. Yet data have suggested that PSMIs are being arrested and incarcerated at levels that exceed both their representation in the general population and their tendencies to commit serious crimes, leading numerous mental health advocates and researchers to speculate that PSMIs are being criminalized (Teplin 1991a).

Criminalization of the Mentally Ill

More than 25 years ago, Abramson (1972) noted that PSMIs were being criminalized (i.e., they were increasingly being processed through the criminal justice system instead of through the mental health system). Several other researchers have since concluded that persons who were traditionally being treated in mental health agencies and psychiatric hospitals were being shunted more frequently into jails and prisons (e.g., Gibbs 1983; Guy et al. 1985; Lamb 1984a; Lamb and Grant 1982; Morgan 1981; Teplin 1983, 1984b; Whitmer 1980). The criminalization of PSMIs can be attributed to several factors, including deinstitutionalization, restrictive commitment laws, and the splintered nature of the mental health and other treatment systems (Teplin 1991a).

Deinstitutionalization

Following World War II, a series of scathing exposés in the popular press revealed widespread patient neglect and abuse in the State-run hospital system (e.g., Deutsch 1949). At that time, several mental health care reformers, such as the Group for the Advancement of Psychiatry, also criticized public mental hospitals as inhumane and stigmatizing institutions (Grob 1991). With the advent of effective psychotropic medications in the early 1950s, the lengthy institutional "warehousing" of PSMIs was declared deleterious, unnecessary, and obsolete (Thomas 1998).

In 1961, the Joint Commission on Mental Illness recommended the large-scale establishment of a network of community-based facilities designed to care for psychiatric patients who were formerly treated in the hospital (Grob 1991).

This shift in mental care health policy, known as deinstitutionalization, "was at the heart of what President John Kennedy called a bold new approach to the treatment of mental illness" (Durham 1989, 119). In the wake of deinstitutionalization, the census in State mental hospitals fell steadily, from 560,000 patients in 1955 to 77,000 patients in 1994 (U.S. Department of Health and Human Services, Center for Mental Health Services 1994). The length of stay in psychiatric hospitals and the number of beds available for care also declined sharply (e.g., Kiesler 1982; Kiesler and Sibulkin 1987). The net effect of deinstitutionalization was "the ever-increasing presence of the mentally ill in the community" (Teplin 1991a, 157).

The policy of deinstitutionalization—which was roundly assailed by social commentators, policymakers, and researchers—was never fully funded and fell far short of realizing its ambitious goals (e.g., Bachrach 1989; Dumont 1982; Durham 1989; *New York Times* 1982a, 1982b, and 1984). Although it reduced the use of State hospitals and shifted the costs of caring for PSMIs from the State to the Federal Government, it never succeeded in affording well-coordinated or comprehensive outpatient treatment for large percentages of PSMIs (Talbott 1979). The financial strain of the Vietnam war during the 1960s, the economic crisis of the 1970s, and cuts in Federal funding for mental health services in the 1980s left fewer dollars for the community care of PSMIs (Miller 1987; Teplin 1991a; Thomas 1998). Therefore many PSMIs became unbidden charges of the criminal justice system, arrested for vagrancy and other minor infractions, in part because of the paucity of treatment and services in the community (Barlow and Durand 1999; Durham 1989; Grob 1991; Shadish 1989; Teplin 1991a).

Reductions in Federal expenditures for social welfare programs in the 1990s left even more PSMIs with few treatment options or ancillary services for such essentials as food, clothing, shelter, and medical attention (Thomas 1998). As a tragic result of their persistent economic impoverishment and political disfranchisement, the chronically mentally ill have become a stable part of the underclass (Auletta 1982; Thomas 1998).

Talbott (1975) argued that the term "deinstitutionalization" should be replaced by "transinstitutionalization" to indicate that "the chronically mentally ill patient had his locus of living and care transferred from a single lousy institution to multiple wretched ones" (p. 530)—such as nursing homes, jails, intermediate care facilities, board-and-care homes, and other group residences in which mental health care is often marginal (Bachrach 1986; Goldman, Adams, and Taube 1983; Lamb 1997; Mechanic 1998). Similarly, Mechanic (1998, 86) observed that "deinstitutionalization and managed care have both contributed to a broad dispersion of persons with mental illness among residential facilities,

making it difficult to monitor or even describe clearly the de facto mental health system."

An egregious shortcoming of deinstitutionalization was its failure to adequately treat chronic patients, who are less likely to comply with or respond to medications and are more likely to suffer from intractable social and economic deficits (Shadish, Lurigio, and Lewis 1989). In other words, the unsuccessful transition to community mental health care had the most tragic effects on patients least able to cope with the basic tasks of daily life (Grob 1991).

Because community mental health and social services became highly fragmented, uncoordinated, and inaccessible, thousands of PSMIs were abandoned on the streets where so many remain today among the homeless, without the social and economic resources to fend for themselves (Durham 1989). Estimates suggest that approximately 25 percent of the homeless population in the United States have previous psychiatric hospitalizations and that 30 percent are PSMIs (Koegel, Burnam, and Farr 1988; Robertson 1986). Martell, Rosner, and Harmon (1995) reported that PSMIs entering the criminal justice system in New York City had 40 times the rate of homelessness found in the general population and that homeless PSMIs had significantly higher rates of arrest for violent and nonviolent crimes than did domiciled PSMIs. Homeless PSMIs are also highly likely to be victims of violence (Bachrach 1984).

Mental health law reform

Concerned that the homeless mentally ill and other PSMIs were living in the community without psychiatric or social services, mental health workers have recommended involuntary commitment as a means of getting such persons into treatment (Thomas 1998). Mental health law reforms, however, have made it difficult to commit PSMIs to psychiatric hospitals and are the second major factor contributing to the criminalization of the mentally ill (Torrey 1997). Serious restrictions have been placed on the procedures and criteria for involuntary commitment, limiting psychiatric hospitalizations for PSMIs and increasing the likelihood that they will be processed through the criminal justice system.

Most State mental health codes require psychiatric hospitals to show clear and convincing evidence that patients being committed involuntarily are either a danger to themselves or others or are so gravely disabled by their illnesses that they are unable to care for themselves. In addition, mental health codes have expanded psychiatric patients' rights to due process, which accord patients the constitutional protections granted to defendants in criminal court proceedings (Miller 1987). Consequently, only the most dangerous or profoundly mentally

ill are hospitalized, resulting "in greatly increased numbers of mentally ill persons in the community who may commit criminal acts and enter the criminal justice system" (Lamb and Weinberger 1998, 487).

PSMIs cannot be hospitalized against their will without legal representation and a full judicial hearing. With these legal safeguards, the framers of reformed mental health codes hoped to eliminate capricious hospitalizations and to protect the freedom of patients (Durham 1989). Moreover, as we mentioned, they wanted to grant PSMIs many of the procedural advantages extended to defendants in the criminal justice system. Along with statutory reforms, case precedents such as *O'Connor* v. *Donaldson* (422 U.S. 563 [1975]), *Rennie* v. *Klein* (653 F. 2d 836 [3d Cir., 1981]), *Addington* v. *Texas* (99 S. Ct. 1804 [1979]), *Rogers* v. *Okin* (634 F. 2d 650 [1st Cir., 1980], and *Covington* v. *Harris* (419 F. 2d. 617 D.C. Cir. [1969]) further diminished the use of hospitalization by recognizing the right of PSMIs to refuse treatment and to receive treatment in the least restrictive settings, which often means that they receive no treatment at all (Thomas 1998).

Several critics of these legal reforms have called for a relaxation of commitment standards so that PSMIs can be moved "off the streets and back in facilities designed for people in their condition" (Kanter 1989; Perkins 1985, 38). The American Psychiatric Association has proposed a model commitment law, urging States to replace the criterion of "dangerous" with the criterion of being likely to suffer "substantial mental or physical deterioration" (Lamb 1984b, 47). This standard changes the focus of commitment decisions to whether individuals are capable of tending to their own needs, permits treatment of patients without their consent, and places commitment decisions in the hands of medical rather than legal practitioners (Kanter 1989). The State of Washington, for example, revised its commitment standards in 1979 to allow the hospitalization of people who are judged to be in need of treatment (LaFond and Durham 1992).

Several other States have also enacted outpatient commitment laws for persons who do not require hospitalization (McCafferty and Dooley 1990; Torrey 1997). Under such laws, the court can order individuals to receive mental health treatment in the community even if they do not meet the standard for civil commitment, giving the courts a greater choice of nonrestrictive alternatives (Stefan 1986). These laws, however, have been used rather sparingly (Torrey and Kaplan 1995).

Compartmentalized services

The third major factor that has fostered the criminalization of PSMIs is the compartmentalized, or splintered, nature of mental health and other treatment

systems, which makes it more likely that PSMIs with multiple problems and afflictions will fall through the cracks (Teplin 1991a). The mental health system consists of fragmented services for predetermined subsets of patients. The bulk of psychiatric programs, for example, are designed to treat "pure types" of patients—either mentally ill or developmentally disabled, alcoholic or chemically dependent (Teplin 1991a). By the same token, most substance abuse and dependence programs are unwilling or unable to treat PSMIs and frequently refuse to accept such clients. In addition, mental health and substance abuse treatments are often carved out of managed care plans separately, which results in "significant discontinuities of care for persons with multiple conditions and families with multiple problems" (Mechanic 1998, 90). Hence, individuals with comorbid disorders, who constitute large percentages of PSMIs in the criminal justice system, might be deprived entirely of treatment because they fail to meet stringent admission criteria (Abram and Teplin 1991; Teplin 1991b).

When dually diagnosed persons come to the attention of the police, officers are left with arrest as the most practical response, given the lack of available referrals within the narrowly defined treatment system (Brown et al. 1989). For example, mental health centers often decline to treat alcoholics; PSMIs with drug abuse and dependence problems are considered disruptive to the recovery of non-mentally ill drug addicts and are refused entry into treatment; hospital emergency rooms turn away PSMIs who appear intoxicated or threatening; and community mental health providers reject PSMIs with criminal histories, labeling them as dangerous or resistant to treatment (Lamb and Weinberger 1998; Teplin 1991a). Thus, many of these "forfeited patients" (Whitmer 1980) can end up, by default, in the criminal justice system, the "asylum of last resort" (Belcher 1988).

Evidence for criminalization

Teplin (1991a) reviewed the criminalization of PSMIs using evidence stemming from three primary sources: data on police contacts, incarcerations, and the relative arrest rates of the mentally ill. She concluded that data on police contacts and arrests provide inconclusive support for the criminalization of PSMIs. Studies in the area have employed mostly post-hoc strategies of data collection that are fraught with interpretation problems; for example, asking police officers after the fact to explain their decisions about handling PSMIs produces biased data. Furthermore, small samples, the lack of baseline comparisons, and invalid, inconsistent, and nonstandard assessment procedures limit the usefulness of data on the prevalence of PSMIs in jails and prisons.

Despite the shortcomings of existing studies on the criminalization of PSMIs, Teplin (1991a, 172) concluded that the weight of evidence suggests that "the

mentally ill are being criminally processed when mental health alternatives would be preferable but [are] unavailable." She also argued, however, that the absence of longitudinal research precludes definitive conclusions about the causal relationship between policy changes and the criminalization of PSMIs (also see Lamb and Weinberger 1998; Teplin and Voit 1996). Teplin (1991a, 172) summarized the literature on criminalization:

> In short, while the criminalization hypothesis is not supported as a longitudinal trend, there is ample evidence of criminal processing of the mentally ill as a contemporaneous phenomenon. Clearly, further research must be undertaken to document the extent and conditions under which criminal processing is used to manage the mentally ill.

Cognizant of the shortcomings of prior research, we next describe studies on the police handling and incarceration of PSMIs, highlighting those investigations that provide the clearest data on these topics.

Police and PSMIs

Many of the untreated symptoms and signs of serious mental illness can be frightening or discomforting to the people observing them. Public tolerance for the mentally ill has remained quite low (Torrey 1997), and common stereotypes of PSMIs—held by the police and the general public—typically depict the mentally ill as dangerous, uncontrollable, or violent (Durham 1989). As we discussed in the preceding section, a greater proportion of PSMIs are no longer in hospitals, so there are many more opportunities for those who are untreated to be symptomatic in public (Teplin 1984a). Thus, when confronted with PSMIs who are engaging in bizarre or threatening behaviors, citizens turn to police officers, who have become "street corner psychiatrists" and "gatekeepers" to the mental health system (Sheridan and Teplin 1981; Teplin and Pruett 1992).

Police are often the first persons to encounter PSMIs and are a major source of psychiatric referrals. DeCuir (1982) found that police officers in Los Angeles spent nearly 20,000 hours every month responding to cases involving PSMIs. In two separate studies, data indicated that the police brought in for care more than 30 percent of the people seen in psychiatric emergency rooms in Los Angeles and New York City (Way, Evans, and Banks 1993; Morrell 1989). Growing awareness that the police are coming into increasing contact with PSMIs has led to several studies examining police practices with the mentally ill and police departments' relationships with mental health and social services agencies (Wachholz and Mullaly 1993).

Police discretion and PSMIs

The police have historically played a pivotal role in responding to citizens' complaints about PSMIs, particularly in poorer neighborhoods (e.g., Gilboy and Schmidt 1971; Warren 1977). The legal foundation for police involvement with PSMIs is twofold: the police power function, exercised to protect public safety, and the *parens patriae* function, exercised to protect disabled citizens (Shah 1975).

Bittner's (1967) seminal research on the police handling of PSMIs found that officers initiate psychiatric referrals mostly in situations in which an arrestee is violent, suicidal, or floridly symptomatic. Numerous other studies have also shown that police officers are reluctant to refer arrestees to the hospital unless they are overtly dangerous to themselves or others (e.g., Matthews 1970; Rock, Jacobson, and Janepaul 1968; Schag 1977).

Other factors that the police consider in managing PSMIs include a determination of whether the person has a psychiatric history and the level of public disturbance that the person is creating (Schag 1977). Overall, whether the police characterize PSMIs as "bad" and arrest them, as "mad" and hospitalize them, or as merely "eccentric" and dispose of the situation informally, is influenced as much by discretion as by rules of law (Teplin and Pruett 1992). "Thus the [police] disposition of incidents involving mentally ill persons is a complex social process, and the police develop an informal operative code to handle each situation" (Teplin 1991b, 174).

Evidence of a mental disorder is a critical, situational variable that helps shape police-citizen interactions and guides the subsequent disposition of an incident, including the decision to make an arrest.

In most jurisdictions, the police can initiate emergency hospitalizations for PSMIs who are either a danger to themselves or others or who are unable to provide for their own basic physical needs or to guard themselves against serious harm. In practice, however, officers are sorely restricted in their use of emergency hospitalizations (Bonovitz and Guy 1979; Teplin 1983). These restrictions include the stringent legal criteria surrounding involuntary commitment, the unavailability of community-based treatment slots, the unwillingness of mental health facilities or emergency rooms to accept recalcitrant or intoxicated patients, and the bureaucratic obstacles inherent in the hospitalization process, such as complicated admission procedures and long waiting periods in emergency rooms (Durham 1989; Finn and Sullivan 1989; Gillig et al. 1990; Laberge and Morin 1995; Murphy 1986).

The mental health system, in general, seems unwilling or unable to serve PSMIs with criminal backgrounds (Draine, Solomon, and Meyerson 1994; Laberge and Morin 1995). Hence, without recourse to State hospitals or community mental health centers, police have frequently had to arrest PSMIs, even for minor offenses that stem more from their illnesses than from their criminality (Dvoskin and Steadman 1994). Arrest is often the only feasible mechanism to remove from the streets persons who are not "disturbed enough" for the hospital, yet are regarded by hospital staff as "too dangerous" for inpatient care (e.g., they have a criminal case pending or a history of violence) (Teplin 1983; Teplin and Pruett 1992). As Kagan (1990) noted, the criminal justice system (i.e., police officers) has been assuming the State hospital's responsibility of removing PSMIs from the streets and into custodial care (i.e., jails).

Encounters between police officers and PSMIs

Occurrences of arrests

Teplin (1984a) and her staff observed firsthand more than 1,000 police-citizen contacts and reported that for similar behaviors and offenses, persons showing obvious signs and symptoms of severe mental disorders had greater chances of being arrested than those who did not. Police officers in Teplin's study were accurately able to recognize serious mental illnesses during their street encounters with citizens. Nonetheless, they chose to arrest PSMIs because it was the best option at hand for persons who failed to meet inpatient commitment criteria or who were rejected for care in hospital emergency rooms or other facilities because of their recalcitrant or criminal behaviors.

Teplin (1984a) found that evidence of a mental disorder is a critical, situational variable that helps shape police-citizen interactions and guides the subsequent disposition of an incident, including the decision to make an arrest. The police are primarily motivated by a desire or need to maximize the successful resolution of a street encounter and to avoid returning to the scene.

According to Teplin (1984b), police are most likely to arrest PSMIs under the following circumstances: when hospitalization is an impractical or onerous alternative (e.g., because of time constraints); when a PSMI's behaviors are very visible or disruptive and exceed the public's tolerance for deviance; when there is a high probability that a PSMI's behaviors will continue to cause problems and necessitate a return to the original site of the complaint; when a PSMI obviously suffers from multiple problems (e.g., schizophrenia and alcoholism); when a PSMI behaves disrespectfully toward the police; and when hospital staff deem that a PSMI is dangerous and likely to become a management

problem. Teplin (1984b) also stated that police officers regard arrest as an appropriate option for PSMIs because officers often erroneously assume that mental health diversions are routinely initiated in the criminal justice system.

In summary, when no other community alternatives are available, arrest is an expedient way to get PSMIs into jail settings in which they have a chance to be assessed and treated by mental health professionals (Laberge and Morin 1995). For PSMIs, the criminal justice system has become the "system that can't say no" (Borzecki and Wormith 1985), and "families, friends, and others in the community call on the police to act as agents of social control for mentally ill individuals whose behavior, although disruptive, does not meet criteria for involuntary civil commitment" (Bonovitz and Bonovitz 1981, 974).

PSMI arrestees

In their investigation of police-citizen interactions, Teplin and Pruett (1992) classified PSMIs who are neither arrested nor hospitalized (i.e., those whose cases were handled informally) into three groups. Those in the first group, called "neighborhood characters," are known and tolerated by the police and the public; their behaviors are predictable and regarded as "eccentricities" rather than criminal acts. Those in the second group, called "troublemakers," cause problems for the police and the public but are "thought to be too difficult to handle via arrest or hospitalization" (p. 151). Those in the third group, called "quiet crazies," exhibit unobtrusive symptoms and odd behaviors that are inoffensive to the public and the police.

Lewis and associates (1994) followed a random sample of PSMIs released from Illinois State psychiatric hospitals in the Chicago area for 12 months (see also Lewis et al. 1991). Their findings demonstrated that roughly 20 percent of the former patients were arrested within 1 year after they left the institution. Approximately 75 percent of the offenses committed by the former patients were municipal crimes (e.g., loitering, trespassing, public intoxication) or property crimes (e.g., theft, burglary, damage to property).

Lewis and colleagues (1994) reported that the criminal histories of the former patients who were arrested were more extensive and serious than suggested by their arrests during the followup year. Patient arrestees had an average of nine prior arrests, one quarter of which were for such violent felony offenses as murder, rape, armed robbery, and aggravated assault. Former patients who were likely to pass through the criminal justice system during the investigation were also chronic habitués of State psychiatric facilities. These PSMIs were apparently absorbing both mental health and criminal justice resources at an alarming pace. Patient arrestees, for example, were admitted for psychiatric treatment

twice as often in the course of the study as were patients who had not been arrested. Therefore, chronic patients-arrestees moved back and forth between the mental health and criminal justice systems, each of which is ill-equipped to handle their complex combination of problems and needs (also see Teplin and Voit 1996).

In another study, Lurigio and Lewis (1987) performed case studies of arrested PSMIs and found major differences among them relative to the types of crimes that they committed and their reasons for committing those crimes. Patients with criminal records generally fell into three distinct categories. For the first type, illegal acts were a byproduct of mental illness. Their offenses frequently involved disorderly conduct, criminal trespass, disturbing the peace, and public intoxication. Their main "crime" was expressing the symptoms of mental disorder in public. About 42 percent of the arrested patients fell into this category.

The second type of PSMIs with criminal histories resorted to crime—primarily property offenses (petty theft, shoplifting) and prostitution—simply to survive. Their criminal activity occurred in spurts as a means to obtain money when their Supplemental Security Income or wages were especially meager. Nearly 30 percent of the arrested patients were in this category.

The third type of PSMIs committed more serious offenses, such as burglary, assault, rape, and robbery. Their histories paralleled those of non-mentally ill criminals in the type, frequency, and repetitiveness of their offenses. They were the least seriously impaired by their mental illness, which seemed incidental to their crimes and co-occurred with heavy drug and alcohol use. Approximately 28 percent of the arrested patients were in this category.

Improving practices: Law enforcement

Training

To prepare police agencies to deal effectively and humanely with PSMIs, officers need recruit and inservice training on the signs and symptoms of serious mental illness. Despite the proven benefits of such training (e.g., changing officers' attitudes toward PSMIs and improving their relationships with mental health providers), most departments' training curricula have been deficient in this area (Murphy 1986). Husted, Charter, and Perrou (1995), for example, reported that law enforcement officers in California had been given insufficient training in identifying, managing, and referring PSMIs, even though it was recognized that the officers had a lot of contact with the mentally ill in their routine law enforcement practices. Without special training, "law enforcement

personnel are ill-prepared to effectively handle mentally ill citizens" (Teplin 1991b, 17).

Cross-training will allow both police officers and mental health providers to share their concerns and to discuss the philosophies and exigencies that affect their respective expectations and responsibilities in responding to PSMIs. Cross-training can help build effective working relationships between police officers and mental health staff (Murphy 1986). In addition, family members of PSMIs could benefit greatly from cross-training by learning about appropriate police roles and practices with regard to PSMIs (Hartstone 1990). Hence cross-training would be a welcome addition to future police training agendas.

Strategies

Police officers are often unclear on how calls involving PSMIs should be processed (Teplin 1984a). In the future, all departments' general orders can be written to include unambiguous guidelines on PSMIs (Murphy 1986). These guidelines are most useful when they specify existing relationships between the police department and local mental health providers, which are based on written and formal memoranda of understanding and no-decline agreements. Officers need to know about accessible diversionary options for PSMIs who commit less serious crimes.

Rewards

Police officers are reluctant to work with PSMIs for the reasons that we have cited, but when police officers do work with PSMIs, their work usually goes unrewarded (Hartstone 1990). As Murphy (1986, 62) stated, "[D]epartmental policies seldom offer incentives or rewards for successfully managing PSMIs, and officers seldom receive any feedback on the results of their efforts." Such activities are compatible with officers' duties in the areas of order maintenance and social service referrals, which are important components of many community policing strategies (Rosenbaum 1994) and can be incorporated in guidelines for officer recognition and promotion.

Deane and colleagues (1999) surveyed nearly 200 police departments to examine their responses to PSMIs. More than half (55 percent) of the agencies completing the survey reported that they had no specialized mechanism for dealing with the mentally ill. Those with special programs implemented one of three strategies.

The first strategy was a police-based, specialized police response (3 percent) involving sworn officers who are trained to provide crisis intervention services

and who act as liaisons with the mental health system. The second was a police-based, specialized mental health response (12 percent) involving mental health workers who provide onsite and telephone consultations with sworn officers. And the third was a mental health-based, specialized mental health response (30 percent) involving mobile crisis teams of local mental health professionals who work closely with the police and provide onsite assistance to PSMIs. Mobile crisis teams received higher-than-average effectiveness ratings compared with the other two strategies. Geller, Fisher, and McDermach (1995) also reported that mobile crisis teams appear to be an effective approach for delivering emergency mental health care.

Model programs

Finn and Sullivan (1989) described eight model police programs for handling the mentally ill, operating in such cities as Birmingham, Alabama; Erie, Pennsylvania; Los Angeles, California; and Madison, Wisconsin. The model programs consist of networks of law enforcement and social service agencies that share responsibilities for PSMIs who come to the attention of the police for public disturbances or more serious criminal acts. The network partners sign formal agreements of collaboration that describe the responsibilities of each participating agency. At the core of each network is a crisis unit, on duty or on call 24 hours a day, to conduct screening, referral, or on-scene emergency services. The Birmingham program is an excellent example of a police-civilian partnership for responding to the city's large, transient population of PSMIs (Finn and Sullivan 1989; Murphy 1986; Steadman et al. 1999). The program, initiated in 1976 by the University of Alabama, was started as a pilot project to provide the police department with a team of in-house civilian social workers, known as community service officers (CSOs). CSOs act as liaisons between the police and PSMIs, between PSMIs and social services agencies, and between the police department and mental health facilities.

CSOs have become an integral part of the police department, operating out of police headquarters 7 days a week, 15 hours a day, and relieving officers of the need to respond to mental health-related repeat calls for service or to mental health-related calls in which police action is unnecessary. When they are off duty, CSOs remain on call to come to the immediate aid of a PSMI in response to a police summons on their beepers.

In general, CSOs take control of the case at the scene, allowing officers to return quickly to their beats. CSOs work closely with the mentally ill person's family and with the city's mental health centers and hospitals. The police accompany CSOs to hospital emergency rooms if a PSMI is violent. Once a PSMI has been restrained at the facility, the CSO remains as the police

department's representative for the remainder of the admission proceedings. The university's hospital has made police referrals a priority for its psychiatric beds set aside for the indigent. In 1997, CSOs responded to more than 2,000 calls for service. Police officers are informed of the dispositions on all CSO-assisted cases.

PSMIs in Correctional Settings

PSMIs in jails and prisons

Disturbing conditions

During colonial times, the jailing of PSMIs was a common practice. In 1694, a Massachusetts law authorized the incarceration of any person "lunatic and so furiously mad as to render it [sic] dangerous to the peace or the safety of the good people for such lunatic person to go at large" (Grob 1973, 48). The policy of incarcerating the mentally ill continued until the 1830s, after which it became increasingly less acceptable to use jails to house the mentally ill. Led by mental health reformers such as Dorothea Dix and Louis Dwight, the public began to express outrage at the use of jails for PSMIs, and States began to build psychiatric hospitals to treat the mentally ill. By 1880, there were 75 public psychiatric hospitals in the United States, and a census of the mentally ill showed that PSMIs represented only 0.7 percent of the population of inmates in jails and prisons across the country (Wine 1888).

Torrey and colleagues (1992, iv) observed, "[O]ur jails have once again become surrogate mental hospitals, thus [re]criminalizing the mentally ill" the way they were in the 1830s. Torrey and associates reported that more than 20 percent of the jails surveyed in a national study had no access to mental health services and that nearly half of the jails surveyed had no information on whether PSMIs released from jail received any followup care. According to a National Alliance for the Mentally Ill report (1999), many PSMIs are placed in municipal lockups or sentenced to jails or prisons in which they often languish without adequate care.

Because the linkages between the criminal justice and mental health systems are either tenuous or nonexistent, the mentally ill involved in these systems often fail to receive adequate treatment from either. As a result, their conditions are exacerbated, and they frequently become both chronic patients and repeat arrestees (Lurigio and Lewis 1987). A decade ago, Warner (1989, 18) offered this poignant description of the conditions experienced by many of the PSMIs incarcerated in jails:

> The conditions of detention for mentally ill offenders are, at best, barren and unstimulating, at worst, degrading, dangerous, and inhumane. An entire floor of the ten-story Dade County Jail, for example, is given over to the detention of around 100 mentally ill inmates. The most floridly disturbed of these psychotic people are stripped naked and isolated; the feeding slits in the doors of their cells are sealed so that food cannot be hurled back at the corrections officers. Jail staff may be called to respond to half a dozen or more suicide attempts in the jail on a single night.

Warner also noted that these inadequacies are not the product of isolated instances of detainee abuse or poor management; instead, they are the consequences of a national mental health system that is not meeting the needs or solving the problems of a substantial proportion of PSMIs.

Torrey and associates' (1992) national survey of jails also found that 30 percent of the responding jails, located in 45 States, allowed PSMIs to be detained without criminal charges—a situation that was more likely to occur in States with poor mental health services. PSMIs were commonly arrested and detained for assault and battery, theft, disorderly conduct, and drug- and alcohol-related charges. Forty percent of the jails responding to this survey indicated that PSMIs often are abused physically or verbally by other detainees.

Prevalence studies

On the average, 7 to 9 percent of the inmates in jails are PSMIs (Steadman, McCarty, and Morrissey 1989; Torrey et al. 1992; Warner 1985); hence, as of June 1998, between 41,472 and 53,322 of the 592,462 detainees in our Nation's jails were PSMIs (U.S. Department of Justice [DOJ], Bureau of Justice Statistics [BJS] 1999b). In large urban areas, the percentages of PSMIs in jails might be even higher than the average estimates suggest. Guy and colleagues (1985), for example, reported that 15 percent of a randomly selected sample of admissions to Philadelphia's jail were diagnosed with schizophrenia or bipolar disorder. In Los Angeles County, 85 to 90 percent of the inmates who were referred for mental status examinations had a history of psychiatric hospitalization (Lamb and Grant 1982, 1983).

Teplin and Voit (1996) reviewed more than 20 studies on the prevalence of mentally disordered persons in jails. They found substantial variation in the percentages of incarcerated PSMIs and attributed the differences among the estimates to biased or small samples and to unspecified diagnostic criteria or nonstandardized diagnostic instruments.

In a study designed to overcome the failures of previous investigations on the prevalence of mental disorders among jail inmates, Teplin (1990) reported that

nearly 1 of every 15 admissions, or approximately 6 percent of Cook County Jail (Chicago) detainees, suffered from severe mental disorders at the time of arrest. This figure is triple the rate of psychiatric illnesses in the general population and probably underestimates the true number of mentally ill arrestees because some of them were diverted to hospitals following their arrests (Teplin 1994).

Teplin (1990) also found that, overall, only one-third of the seriously mentally ill inmates in Cook County Jail were ultimately diagnosed and treated. Depressed inmates were especially unlikely to be diagnosed, which is quite problematic because of the threat of suicide among jail inmates. Teplin's results supported the contention that jails have become "mental hospitals for poor persons" or the country's "new asylums" (p. 235) (Grob 1991; Torrey et al. 1992). Teplin and Voit (1996, 305) observed that "because the jail rather than the prison is the more likely repository for at least some mentally ill persons, further epidemiological research on jails in needed."

Studies of the prevalence of PSMIs in prisons, which also have some of the same methodological shortcomings that Teplin and Voit (1996) found in the jail prevalence studies, suggest that "at any given time, 10% to 15% of state prison populations are suffering from a major mental disorder and are in need of the kinds of psychiatric services associated with these illnesses" (Jemelka, Rahman, and Trupin 1993, 11). More recently, Lovell and Jemelka (1998) estimated that the percentage of PSMIs in prison is between 10 and 20 percent. With a State and Federal prison population in the United States of 1,210,034 as of June 30, 1998 (U.S. DOJ, BJS 1999b), we can estimate that our country's prisons house between 121,000 and 242,000 PSMIs (see Proband 1998 for a projection of the prison population at the end of 1999).

Research that has compared the prevalence of serious mental illnesses among prison inmates with that of the general population has produced mixed results. For example, Collins and Schlenger (1983) reported that the prevalence of serious mental illness was lower among prison inmates than among the general population, whereas Hodgins (1990) found higher lifetime prevalence rates of psychiatric disorders among prisoners than among the general population.

In 1970, 378,000 PSMIs were being treated in public psychiatric hospitals. Twenty years later, that number had fallen to 84,000, and it continues to decline (Witkin, Atay, and Manderscheid 1996). During that same time period, the number of persons in our Nation's prisons and jails grew dramatically (e.g., U.S. DOJ, BJS 1988). There are now approximately 1.5 to 3 times more PSMIs in State and Federal prisons than in public psychiatric hospitals (Cote et al. 1997).

The increase of PSMIs in the Nation's jail and prison populations has supposedly occurred, in part, because of the decline in the States' mental hospital populations, substantiating Penrose's (1939) notion that a relatively stable number of persons are confined in industrialized societies (i.e., as the census of one institution of social control—the mental hospital—goes down, the census of another—the prison—goes up). Penrose's seminal work has been cited by numerous authors who have written about the criminalization of the mentally ill (e.g., Cote et al. 1997).

Akin to Boyle's Law in physics, which describes the constant relationship between volume and pressure for an ideal gas, Penrose's theory—also referred to as the "hydraulic hypothesis"—posits that a constant number of psychiatrically disordered persons require institutional care in industrialized or western societies. If psychiatric hospitals are unavailable or unwilling to treat PSMIs, then they will be housed in other institutions (e.g., prisons and jails). Part of the increase in the number and proportion of incarcerated PSMIs is certainly attributable to deinstitutionalization and the other factors that we discussed earlier. The criminalization of PSMIs, however, is unable to completely explain the large number of PSMIs in prison (Jemelka, Trupin, and Chiles 1989).

The 2-percent increase in the proportion of men with previous psychiatric hospitalizations who were sentenced to prison between 1968 and 1978, for example, is much too small a proportion to account for the total number of men who were released from psychiatric hospitals and who later committed crimes during that same time period (Jemelka, Trupin, and Chiles 1989). In addition, the census in State psychiatric facilities has remained relatively flat, while the size of the prison population has been increasing at a rate of 6 percent annually since 1990 (U.S. DOJ, BJS 1999a).

Palermo, Smith, and Liska (1991) examined evidence for the inverse correlation between the number of PSMIs in jails and prisons and those in psychiatric hospitals, using census data that were collected from those three institutions between 1904 and 1987. They concluded that the data corroborated the observation that jails and prisons have become repositories for PSMIs. Teplin and Voit (1996), however, reviewed studies on the imprisonment of PSMIs and were unable to find conclusive evidence that supported the hydraulic hypothesis. Steadman and colleagues (1984), for example, examined imprisonment data in six States, comparing the numbers of prisoners with prior psychiatric hospitalizations in 1968 and 1978. The investigators concluded that the purported shift

Like dolphins among tuna, many mentally ill, drug-using offenders have been caught in the net of rigorous drug enforcement policies.

of PSMIs from State hospitals to prisons was unsupported by the data from the six States that were investigated. What, then, explains the continuing large numbers of PSMIs entering prisons?

Persons who are convicted of drug crimes are among the fastest growing groups of inmates admitted to State and Federal prisons (U.S. DOJ, BJS 1999a). Since the late 1980s, people using and selling illegal drugs (who also have high rates of drug use) have been incarcerated in large numbers. A notable proportion of these offenders have co-occurring severe mental illnesses (see later section on comorbidity). Like dolphins among tuna, many mentally ill, drug-using offenders have been caught in the net of rigorous drug enforcement policies. Several studies, some of which we described in an earlier section of this chapter, show that PSMIs who use illicit drugs are more prone to violence and more likely to be arrested and incarcerated than those who do not (Clear, Byrne, and Dvoskin 1993; Swanson et al. 1997; Swartz et al. 1998). Hence, we believe that the current war on drugs, which started in 1988, and the high rate of comorbidity between drug misuse and psychiatric disorders partially account for the increased numbers of PSMIs in jails and prisons.

Improving practices: Jails and prisons

In a survey of a random sample of more than 1,500 jails, Steadman and Veysey (1997) found that most facilities were "ill equipped" to treat PSMIs. More than 80 percent of the survey respondents reported that 10 percent or fewer of the inmates were receiving mental health care in their jails. Larger jails were more likely than smaller jails to offer a full range of psychiatric services, from screening and evaluation to special housing and psychotropic medications. Few jails, irrespective of size, provided case management services to link detainees to community mental health and other services programs.

Core principles

Steadman (1990) suggested that the following core principles be incorporated in a general strategy for handling PSMIs in jails:

- PSMIs in local jails are a community problem, and jails are part of the community.
- PSMIs who are arrested for misdemeanors—illegal behaviors that are often a means to survive with few resources and little social support—should be diverted to appropriate mental health treatment centers.
- PSMIs who commit felonies have the right to mental health evaluation and treatment and to linkage services in the community.

A statement made by the National Association of Counties in its report on exemplary county mental health programs reflects these core principles (Adams 1988, 2):

> Jail is inappropriate treatment for people with mental illness who commit misdemeanors or no crime at all. Such individuals need to be diverted from jail to a continuum of services which include crisis intervention, outreach, residential, vocational training, family support, case management and other community support services. Further, individuals with mental illness whose crimes warrant their incarceration need access to appropriate mental health services. These services should be provided either through linkages with the community mental health system, and/or the development of programs to deliver mental health services in the jail setting. In Steadman's (1990) view, both diversion and jail mental health services are sorely needed—the former for PSMIs whose crimes are minor, and the latter for those whose crimes or criminal records are serious enough to require pretrial detention.

To better serve the needs of incarcerated PSMIs, it is important that jails become one agency in a continuum of county services and not remain an isolated or self-sufficient institution that stands distinctly apart from other treatment and service sites (Steadman, McCarty, and Morrissey 1989). Toward this end, mental health and jail administrators, judges, and county officials are encouraged to become involved in efforts to develop jail-based mental health programs. In addition, citizen advocacy councils, task forces, and public education initiatives are necessary to foster an abiding interest in the mentally ill and to achieve a mandate to enhance correctional services and noncustodial treatment options.

The most helpful jail-based mental health services focus on identifying patients, performing crisis intervention, stabilizing patients, and referring patients at release rather than on providing PSMIs with extended mental health services, duplicating interventions in the community, and encouraging police and judges to view jails as long-term mental health treatment centers (Cox, Landsberg, and Paravati 1989; Kimmel 1987; Steadman, McCarty, and Morrissey 1989). The case of *Inmates* v. *Pierce* (489 F. Supp. 638 [1980]), which ruled that jailed inmates are entitled to adequate mental health care, is especially instructive:

> The jail is not a mental health facility, nor do administrators intend that it become one. It must, however, be staffed and organized to meet emergency situations, to make appropriate referrals, and to carefully care for and protect those who must be housed in the jail for whatever reasons despite their mental illness.

Proper screening is an important first step in providing adequate future mental health treatment to PSMIs in jails and is defined as "a process completed during intake in which new inmates are routinely asked about mental health status and history, using a standardized form to guide the interview" (Jemelka 1990, 39). The American Medical Association, the American Psychiatric Association, the American Correctional Association, and the American Association of Correctional Psychologists have established standards for screening jail inmates for mental illnesses and the potential for violent or suicidal behaviors (see Steadman, McCarty, and Morrissey 1989). According to Steadman, McCarty, and Morrissey (1989, 34), "all of the standards rank intake screening as one of the most significant mental health services that a jail can offer."

Effective mental health intake screening is best done by trained booking officers and is composed of at least three basic components. The first involves carefully reviewing any health-related records or papers that inmates bring to central booking. The second involves asking inmates questions about their mental health histories, including hospitalizations, suicide attempts, episodes of alcohol or drug treatment, and prior use of psychotropic medications. The third involves a brief mental health status examination, noting such obvious signs or symptoms of mental illness as delusions, hallucinations, and peculiar speech or demeanor. The Summit County Jail in Ohio has an especially extensive, three-tier screening process for detainees, involving a preliminary mental status examination conducted by a booking officer, a cognitive function examination conducted by a mental health worker, and a full-scale mental status examination conducted by a clinical psychologist (Steadman and Veysey 1997).

Standardized tools such as the Referral Decision Scale (RDS), developed by Teplin and Swartz (1989), can be used by highly trained jail staff to conduct preliminary assessments of inmates at intake and can serve as the basis for referring inmates for further mental health evaluations performed by mental health professionals. RDS consists of 14 items selected from the National Institute of Mental Health Diagnostic Interview Schedule, a reliable and valid instrument for assessing major psychiatric illnesses. Using the 14 items selected for RDS, trained raters were able to discriminate between inmates who have serious mental illness (i.e., diagnoses of schizophrenia, bipolar disorder, and major depression) and those who do not.

Suicide potential is a critical component of mental health screening in jails, from both a psychiatric and a legal perspective. LeBrun (1989) found that jail inmates with major psychiatric disorders were highly prone to suicide attempts. In his study of suicide in Sacramento County Jail (California), he found that more than 75 percent of the inmates who attempted suicide had histories of prior mental health treatment. Similarly, Ivanoff (1989) reported that jail

inmates who have histories of previous psychiatric treatment also have high rates of suicide attempts.

Issues of care

Steadman, McCarty, and Morrissey (1989) suggested several practical measures for establishing a continuum of care for PSMIs, such as allocating mental health staff's time between the jail and community service agencies to provide in-house screening and services and to encourage case diversion and postrelease, followup care; assigning the responsibility for providing mental health services to full-time jail staff; and appointing a transagency administrator to coordinate the provision of both mental health and correctional services for PSMIs. Steadman, McCarty, and Morrissey found that the greatest interagency conflict occurred in jail mental health programs in which services fell under the auspices of both the mental health and jail systems.

There is no one best strategy for meeting the mental health needs of future jail inmates. Jail programs for PSMIs can be tailored to the size of the jail and its inmate population, the jail's current organizational structure and resources, and the nature and extent of existing community-based mental health services. To avoid future conflicts regarding community-based treatment and aftercare services for incarcerated PSMIs, jails are advised to establish long-term linkages with local or State mental health departments or agencies that are based on memoranda of agreement, with clearly defined service populations and compatible safety and service goals.

In the late 1970s, Hampshire County Jail in Massachusetts adopted a thorough case management approach for detainees, following them from intake to discharge planning. Detainees are assigned individual case managers who counsel inmates, meet with their families, and refer them for services within and outside the facility (Steadman and Veysey 1997).

PSMIs' needs for psychiatric screening, evaluation, treatment, and discharge planning also apply to those incarcerated in prisons. Unlike jails, however, prisons must be prepared to provide longer term treatment to the mentally ill. A 1988 survey of mental health services in prisons conducted by the Center for Mental Health Services found that 2.5 percent of the inmates were receiving psychiatric care (Swanson et al. 1993), which is well below the approximate rate of 10 to 20 percent of the prisoners who require such services. The landmark case of *Ruiz* v. *Estelle* (503 P. Supp. 1265.1323 [1980]) set forth the standards for "a minimally adequate mental health treatment program." These standards include the following:

- The systematic mental health screening and evaluation of inmates.
- The capacity to ensure that treatment involves more than just inmate segregation.
- The provision of individualized treatment by trained mental health professionals.
- The maintenance of accurate and complete mental health records.
- The supervision and review of prescriptions.
- The identification of inmates with suicidal tendencies (Jemelka, Rahman, and Trupin 1993).

The basic components of psychiatric care established in *Ruiz* v. *Estelle* and the standards for health services published by the National Commission on Correctional Health Care (1998) are well-intentioned guidelines for mental health services, but their vagueness makes them difficult to translate into definitive practices or programs. This results in prison-based mental health services that differ widely in both the quality and quantity of services provided to mentally ill prisoners (Lovell and Jemelka 1998). Hence, it is crucial that State and Federal prison systems develop and disseminate clearer blueprints for future practices, which can produce humane and effective psychiatric care for PSMIs. These blueprints can build on and elucidate existing standards of prison health care and incorporate the input of mental health professionals, prison administrators, legal experts, and consumers of mental health services.

PSMIs on probation

Paucity of data

PSMIs on probation have been an especially neglected group (Lurigio 1996b). Few data are available on the prevalence of PSMIs on probation. A handful of estimates suggests that 6 to 9 percent of the Nation's probationers are PSMIs (Boone 1995), which would indicate that a total of between 192,000 and 288,000 PSMIs were on probation at the end of 1996 (U.S. DOJ, BJS 1999a). Despite these large numbers, only 15 percent of the probation departments responding to a national survey reported that they operated special programs for mentally ill clients (Boone 1995).

Mental disorders in community corrections populations are likely to be ignored unless the offenders' psychiatric symptoms are an explicit part of their offenses or are florid at the time of sentencing (Carroll and Lurigio 1984). Mentally ill

probationers with less-outwardly-expressed symptoms usually receive scant attention from community corrections staff. Also, probation officers generally lack the experience and background necessary to deal effectively with emotionally troubled clients (Veysey 1994, 1996). Overall, PSMIs sentenced to probation are an underidentified and underserved population, and most probation officers are unable to handle the problems of these offenders successfully (Veysey 1994).

The multiple problems of PSMIs complicate case assessments and require Mental Health Unit officers to proceed with caution when they attempt to build relationships and trust.

With additional resources and training for probation officers, probation can be an appropriate sentencing option for PSMIs convicted of more serious crimes (Lurigio 1996b). By using probation as a sentencing platform, mandated mental health treatment and other related interventions can be conditions of release. Some probation departments have already implemented special caseloads for PSMIs in which intensive case evaluation and management are combined with counseling, crisis stabilization, and supervised referrals for services (Veysey 1996).

Specialized program

The Cook County (Chicago) Adult Probation Department's Mental Health Unit (MHU) has been recognized by the American Probation and Parole Association as an example of "best practices" in community corrections (Lurigio and Martin 1998). The unit consists of five probation officers and one supervisor, each with a background in mental health. Officers spend the majority of their time monitoring their caseloads, which are significantly smaller than standard probation caseloads. Potential MHU clients can be referred to the unit by judges or other probation officers working in Chicago and in surrounding suburban court locations.

MHU officers initially screen probationers to determine offenders' eligibility for the unit. Officers base their decisions mostly on probationers' previous psychiatric histories and hospitalizations. MHU officers gather this information from probationers' hospital and mental health treatment records, from the probationers themselves, and from the probationers' families. Rapport between officers and clients develops very slowly, and MHU clients take longer to adjust to probation than do clients in regular caseloads (Lurigio, Thomas, and Jones 1996).

The multiple problems of PSMIs complicate case assessments and require MHU officers to proceed with caution when they attempt to build relationships and trust with PSMIs. Notwithstanding these difficulties, program officers are committed to their clients, helping clients to deal more effectively with everyday problems and to maintain their treatment and medication regimens. Furthermore, officers are familiar with both the clinical and criminological issues confronting their clients and know how to strike a balance between these two areas (Lurigio, Thomas, and Jones 1996).

MHU officers refer probationers for mental health services, matching them with treatment facilities and changing services if a different treatment regimen is warranted. Mental health services can involve outpatient or inpatient treatment as well as longer term residential care. Probationers are most often referred to community mental health centers in the areas in which they live.

MHU officers engage in a number of activities to help clients fulfill their treatment mandates. They counsel probationers, help them budget their time and resources, and support them with any difficulties they experience in treatment. Officers also help clients to access disability benefits, to get Supplemental Security Income, and to obtain medical cards. Through MHU's efforts, the Cook County Adult Probation Department was approved as a site for Medicaid reimbursements.

Improving practices: Probation

Specialization

Future services for mentally ill probationers can be most effective when they are provided through special programs staffed by officers with educational backgrounds and experience in the mental health domain. Specialized units can monitor smaller caseloads, which is crucial because probationers with severe mental illnesses require a lot of time and attention. In general, this population has multiple problems: comorbidity with substance abuse disorders and developmental disabilities, poor physical health, housing and financial difficulties, homelessness, joblessness, and a lack of social support (Veysey 1996). These clients need habilitation as much as rehabilitation. As Veysey (1996, 156) has written:

> For probation services to be successful in the supervision of persons with mental illness, they must address the broad range of offender needs. This does not mean that probation departments must provide all of these services. They must, however, collaborate closely with the community services agencies that provide mental health, substance abuse, health care, and other human services.

To avoid net-widening, a special program's target population of PSMIs and its criteria for client eligibility must be clearly defined and communicated to the regular probation staff who transfer or refer probationers to specialized mental health units and to the judges who sentence them to such programs. Without this communication, there is a danger of inappropriate clients (e.g., persons with substance abuse problems only or difficult clients with no mental illnesses or psychiatric histories) being "dumped" into the program, increasing the difficulty of keeping caseloads down to a reasonable size. Moreover, repeated rejection of inappropriate placements might make judges and probation staff less willing to refer good candidates to the program. When everyone involved in referring clients to the program understands client admittance requirements, such problems can be minimized from the outset.

Agreements with providers

Mental health agencies are sometimes reluctant to accept mentally ill probationers because of their criminal backgrounds; other agencies reject PSMIs because of their dual diagnoses or lack of insurance (Lurigio and Martin 1998). Repeated rejections of clients can be avoided if program administrators sign contractual agreements with local mental health agencies to ensure that clients will be accepted for services. Absent these agreements, placements into treatment will be haphazard. Forging formal agreements will also give program staff an opportunity to tout their efforts and to cultivate long-term professional relationships with mental health practitioners. The collaboration and coordination of probation and mental health staff are essential to the success of any special programming for PSMIs on probation. As Boone (1995, 38) noted, however, "[T]urf issues and boundaries [between the mental health and criminal justice systems] seem to present a monumental impediment to serving the mentally ill probationer or parolee."

Training

Cross-training for mental health and correctional staff goes a long way toward increasing their mutual understanding and respect. In addition, cross-training greatly improves the working relationships between the two groups. Most important, cross-training encourages a team approach to working with clients.

Handling technical violations

Probation officers are well advised to find alternative strategies for handling the technical violations of probationers with mental illnesses. According to Veysey (1996, 158), "if community supervision staff adhere to rigid sanctions

for technical violations with regard to treatment compliance, special-needs clients—particularly those with mental illness—are likely to fail." Violations are often a function of clients' symptoms or difficulties in following directions. A failure to report, for example, might result from cognitive impairment, delusions, confusion, or side effects of medication. As a rule, incarceration or other harsh penalties should be avoided when responding to such situations. More effective options include relapse prevention techniques and systems of progressive sanctions. Probation officers can view technical violations as opportunities to build closer alliances with PSMIs and to assist them in avoiding future, and more serious, problems, including subsequent criminal activity.

Consultation

As we noted earlier, probationers with serious mental illnesses demand considerable attention and time. Clinical consultation from psychiatrists and psychologists can be vital in helping probation officers manage specialized caseloads of PSMIs. For example, mental health specialists can lend their expertise in diagnosing and managing difficult clients, and these specialists can help sharpen staffs' diagnostic and clinical skills during case conferences. If funding is available, psychiatrists should be hired to dispense medications onsite, a tremendous asset to programs, given clients' typically poor compliance with medication regimens. Mental health professionals can also support and encourage program staff and help relieve the stress and discouragement that inevitably arise when dealing with PSMIs.

Comprehensive care

Finally, the National Coalition for Mental and Substance Abuse Health Care in the Justice System recommended that any comprehensive vision of care for PSMIs on probation contain the following elements (Lurigio 1996a, 168):

- Build lasting bridges between the mental health and criminal justice systems, leading to coordinated and continual health care for clients of both systems.
- Involve clients in treatment decisions.
- Ensure public safety as well as the safety of offenders.
- Facilitate the successful integration of offenders into the community.
- Promote offender responsibility and self-sufficiency.

- Permit equal access to all health care services, including medical, psychiatric, substance abuse, and psychological interventions.
- Avoid discriminating against or stigmatizing PSMIs.
- Accommodate clients with multiple needs and problems.
- Be sensitive and responsive to the special needs of mentally ill women and people of color by developing diverse, culturally sensitive programs.
- Require families to be involved in treatment and supervision plans of PSMIs.
- Match services and treatments to each client's specific problems and needs.
- Raise public awareness about PSMIs in the criminal justice system.

Diversion Programs

Importance of diversion

The criminal justice system must expand its existing options for diverting PSMIs. Diversion can occur at several points in the criminal justice process (Draine and Solomon 1999). Police officers can redirect a person in custody into treatment instead of into bond court or jail. Jail staff can remove inmates from the stressful jail environment to a secure and safe treatment setting. Probation officers can refer PSMIs to more intensive treatment and services in lieu of a court hearing and more punishment in response to technical violations of probation.

At bond and misdemeanor sentencing hearings, judges must be highly cognizant of the role that serious mental illness can play in a person's current charges. Traditionally, mental illness is considered only if it is a salient feature of the case (i.e., if there are explicit questions concerning insanity or fitness to stand trial) (Carroll and Lurigio 1984). Judges should make defendants' mental status and psychiatric histories paramount considerations in a much broader set of cases. In particular, judges should be mindful of the American Bar Association's guidelines (1983) that state that a noncriminal disposition should be sought when an apparently mentally disordered person is arrested for a misdemeanor.

As Teplin (1984a) recommended, the least restrictive alternative—preferably treatment in a mental health setting—should be used for mentally ill persons with pending misdemeanor charges. Such alternatives would protect the mentally ill from "becoming the victims of their own disorder, unless they commit serious crimes that require immediate criminal processing" (Teplin 1984a, 801).

The criminal justice system must be willing to invest in pretrial or predetention diversion projects—such as specialized court liaison programs that divert PSMIs out of the criminal justice system and into the civil court system—that are better able to handle the needs of the mentally ill through civil commitment or other mechanisms (Jemelka 1990; Steadman and Veysey 1997). The Substance Abuse and Mental Health Services Administration (U.S. Department of Health and Human Services 1999, 2) expressed the nature and importance of diversion in this way:

> The best diversion programs see detainees as citizens of the community who require a broad array of services, including mental health and substance abuse treatment, housing, and social services. Diversion programs are often the most effective means to integrate an array of mental health, substance abuse and other support services to break the cycle of people who repeatedly enter the criminal justice system.

Specialized mental health courts have shown great promise in diverting PSMIs from the criminal justice system and ensuring that mentally ill defendants receive psychiatric treatment and other services.

Diversion not only benefits PSMIs, but it can also help save the criminal justice system money by lowering the recidivism rate of mentally ill offenders who frequently return to the system because their symptoms lead to continued arrests and incarcerations.

Specialized mental health courts

Specialized mental health courts have shown great promise in diverting PSMIs from the criminal justice system and ensuring that mentally ill defendants receive psychiatric treatment and other services. We strongly recommend that these initiatives be further implemented and researched. Two jurisdictions have recently established specialized mental health courts for PSMIs. The first mental health court in the Nation was implemented in Broward County, Florida, in May 1997. The Broward County program involves a specialized court dedicated to handling PSMIs accused of nonviolent, low-level misdemeanor offenses, excluding driving under the influence and domestic violence crimes. The court was "created specifically to balance issues of treatment and punishment for defendants with mental illness and retardation" (Baker 1998, 20). "The mission of the mental health court is to address the unique needs of the mentally ill in [the] criminal justice system" (*Mental Health Court Progress Report* 1998, 4). Funding for the program was provided through the budgets of State and county governments: $1.5 million from State funds, $250,000 from the Broward

County Department of Human Services, and $400,000 from a lawsuit settled against Broward County that stemmed from jail overcrowding.

Defendants who are charged with assault can be admitted into the program with the victims' accedence. The court is staffed by a judge, a State's attorney, a public defender, and a court monitor, all of whom have received extensive training in mental health issues and are assigned to the court on a permanent basis. The court liaison is a mental health professional who refers defendants for psychiatric and social services.

Defendants in Broward County's program are initially evaluated for competency and, if necessary, are referred to inpatient or outpatient treatment for stabilization. Competent defendants appear in court for a review hearing. The mental health court team decides whether the defendant is appropriate for the program and can safely be released into the community. The team then formulates a treatment plan for defendants accepted into the program. A case manger and court monitor oversee defendants' participation in treatment and prepare periodic reports to the court on each defendant's progress. After a defendant has participated successfully in treatment and arrangements are made for longer term psychiatric care, the mental health court judge will dismiss the defendant's charges.

King County, Washington's, mental health court, modeled after the Broward County program, is another effort to bridge the chasm between the mental health and criminal justice systems for the mentally ill misdemeanant population. King County's program is funded by the Bureau of Justice Assistance, the local criminal justice and mental health systems, and contributions of resources and staff from collaborating agencies. The annual cost of the program is $900,000, most of which is spent on treatment (Barker 1999).

The goals of the program are to process the cases of PSMIs more quickly, to improve PSMIs' access to public mental health care, to protect public safety, to reduce the return of PSMIs to the criminal justice system, and to improve the mental health and well-being of defendants who come into contact with the court. King County's mental health court, which provides one point of contact for PSMIs, is staffed by a judge, a prosecutor, a public defender, a treatment liaison, and probation officers (*Mental Health Court Fact Sheet* 1999).

The court can receive referrals from a variety of sources, including jail psychiatric staff, police officers, attorneys, family members, or probation officers. The majority of defendants in mental health court are accused of nonviolent nuisance crimes, such as urinating in public, sleeping in airports, and harassing people in front of stores or restaurants. Participation in the program is voluntary,

and defendants are asked to waive their rights to a trial. Defendants receive court-ordered treatment in lieu of standard sentences, and successful participation in the program can lead to a dismissal of charges.

The court liaison develops a treatment plan and links the defendant to mental health services. Defendants sentenced to probation are assigned to a special probation officer who works in the mental health court and carries a reduced caseload of fewer than 40 cases, which allows the officer to provide the intensive services that are necessary to respond to the needs of PSMIs (Barker 1999). The court holds regular status hearings to chart the treatment progress of PSMIs.

The experiences of these two trail-blazing mental health courts suggest that a number of elements, such as staffing, are crucial to the court's success (Mental Health Court Task Force 1998). Mental health courts operate best with a team approach for obtaining treatment and services for PSMIs. Representatives from the mental health system must be core members of the team; they are experts in diagnoses and treatment and are most knowledgeable about the availability and accessibility of mental health services. Program staff are most effective and productive when they have received training in each other's respective areas (i.e., court staff should be trained on mental health policies and procedures, and mental health staff should be trained on criminal justice policies and procedures).

Multiple layers of services should be available to mental health court defendants. Although PSMIs suffer from common afflictions, defendants' service needs can be quite different, depending on the severity of their mental illnesses, their treatment histories, and their social support networks. Hence, the court's treatment plans should be flexible and tailored to each defendant. In addition, access to a variety of services is more likely when the court has established and clarified its relationships with treatment providers. These linkages can be solidified with the imprimatur and mediation of mental health authorities at the State and county levels.

Comorbidity Among PSMIs

The current war on drugs in the United States, beginning with the 1988 passage of the Anti-Drug Abuse Act, has swelled this country's probation, jail, and prison populations with a large number of drug-abusing and drug-dependent offenders (U.S. DOJ, BJS 1993, 1995, 1997; Harlow 1998) and has led to the implementation and evaluation of numerous drug treatment programs in correctional settings (Pan et al. 1993; Peters 1993; Wexler 1995). Lost in the emphasis

on providing drug treatment to offenders, however, is the fact that drug-abusing and drug-dependent persons have very high rates of comorbid psychiatric disorders (Kessler et al. 1994; Regier 1990).

Prevalence studies

Depending on the sampling procedures, settings, and definitions of psychiatric disorders, as well as on the assessment tools used in the studies, estimates of the portion of drug users with lifetime comorbid psychiatric disorders vary from 25 to 50 percent (Regier et al. 1990). The converse is also true: Persons with major psychiatric disorders have comparably high rates of drug abuse and dependence (Buckley 1998; Mueser, Bellack, and Blanchard 1992; Regier et al. 1990). Comorbidity rates for major psychiatric disorders are high for untreated drug-dependent persons, higher for persons in treatment programs, and higher yet for prison inmates with drug problems. A national epidemiological study, for example, found a 90-percent comorbidity rate for antisocial personality disorder, schizophrenia, and bipolar disorder among prison inmates dependent on alcohol or other drugs (Regier et al. 1990). Studies of male jail detainees also have found high rates of severe psychiatric disturbances and comorbid addictions among inmates (Abram and Teplin 1991; Teplin 1994).

Inadequate programs

Despite high rates of psychiatric comorbidity among addicted offenders, drug treatment programs in criminal justice settings, like community-based programs in general, have concentrated on drug treatment and have failed to adequately address psychiatric comorbidity (Edens, Peters, and Hills 1997). (For an exception, see Sacks et al. 1997.) A national survey, for example, found that substance abuse treatment was a condition of probation for 41 percent of the country's adult probationers, and 7 percent were required to undergo psychiatric or psychological treatment during their probation terms (U.S. DOJ, BJS 1997). No research to date, however, has provided information on the percentage of offenders who receive both types of services concurrently.

The war on drugs inspired an emphasis on using treatment resources within the criminal justice system to break the cycle of addiction and crime. The resulting treatment programs, however, have neglected the clinical needs of drug-dependent persons with comorbid psychiatric disorders. Although descriptions of drug treatment programs in criminal justice settings address the presence of comorbid psychiatric disorders (Sacks et al. 1997; Wexler 1994), these discussions often present mental illness in the context of such ancillary problems as vocational and educational deficits, medical conditions, and familial dysfunctions (e.g., Barthwell et al. 1995; Peters 1993; Wexler 1994). In other words, treating

comorbid psychiatric disorders is secondary to dealing with drug or alcohol addictions.

Psychiatric comorbidity has rarely been conceptualized as a unique or singular clinical entity (or perhaps as entities, depending on the configuration of comorbid disorders) warranting specific interventions, rather than as a mere reason to add psychiatric services to the usual drug treatment regimen (El-Mallakh 1998; Mueser, Drake, and Miles 1997). Programs that provide psychiatric services as an adjunct to or following drug treatment services have been less successful than those that have developed a truly integrated treatment model with consistent philosophies and treatment plans (El-Mallakh 1998; Mueser, Drake, and Miles 1997).

The lack of specific programs for comorbid offenders is counterproductive. Comorbid disorders differ from single disorders in their clinical courses and treatment requirements (Abram and Teplin 1991; El-Mallakh 1998; Ries and Comtois 1997; Sacks et al. 1997). Persons with comorbid disorders are more difficult to treat, need more intensive treatment services, and have poorer outcomes than those with only drug or psychiatric problems (El-Mallakh 1998; Ries and Comtois 1997; Sacks et al. 1997). To underscore the need for specialized treatment programs for this population, persons with comorbid disorders are at higher risk than the general population for HIV infection and AIDS (Cournos and McKinnon 1997; Woody et al. 1997).

Special programs for comorbidity would facilitate the matching of patients with treatments within the drug treatment system. Previous research has attempted to improve treatment retention and outcomes by determining what patient characteristics and (less often) program factors could be used to match drug-dependent persons more precisely with specific types or intensities of treatment. (See, for example, Condelli [1994] for a discussion of the closely related issue of treatment retention.)

Drug treatment-matching studies have focused largely on matching participants with particular treatments or services according to their drug use histories or demographic characteristics (see McLellan and Alterman 1991). Few (if any) treatment-matching studies, however, have specifically examined psychiatric comorbidity and attempted to match comorbid participants with specialized treatment programs.

The use of psychiatric comorbidity as a matching variable might lead to greater retention in treatment and to more effective drug treatment for comorbid PSMIs. McLellan and associates (1981), for example, found that improvement in psychological functioning was strongly associated with patients' overall

improvement in multiple domains, including reduction in alcohol and other drug abuse. This finding led the authors to conclude that "it may be that therapy directed toward the psychological problems of addicted individuals has more pervasive and powerful effects on overall outcome than therapy centered upon their substance abuse problems alone" (p. 237). Their endorsement of treatment programs designed to address patients' psychological and drug problems concurrently has been largely ignored.

Programs that provide appropriate services to offenders with comorbid disorders are seriously needed. Except for studies of the general prison or jail populations (e.g., Abram and Teplin 1991; Regier et al. 1990), few investigations have explored the prevalence of comorbidity among offenders in drug treatment programs. Such research would be valuable in ascertaining the proportion of the population of addicted offenders with comorbid psychiatric disorders who require specific treatment programs.

It is especially important to establish how many offenders in drug treatment have a comorbid severe mental illness, such as schizophrenia, bipolar disorder, or major depression (see Johnson [1997] for an overview of serious mental illness) or an antisocial personality disorder. Studies have suggested that drug-addicted persons who are comorbid with serious mental illness are among the most difficult to treat with traditional interventions, require more services, have poorer outcomes, and have a greater need for specialized treatment programs than those with only drug or only psychiatric problems (Buckley 1998; Mueser, Drake, and Miles 1997; Woody et al. 1997).

A study of comorbidity

Swartz and Lurigio (1999) examined the prevalence of psychiatric disorders and comorbidity rates in a sample of 204 pretrial detainees. More than half of the sample had one or more lifetime psychiatric diagnoses. The rates of serious mental illness in the jail sample were higher than the lifetime prevalence rates in the general population. The great majority of inmates with a serious mental illness or antisocial personality disorder were comorbid for substance abuse and dependence. These results suggested that severe mental disorders comorbid with drug abuse and dependence are common in incarcerated populations and require specialized interventions (also see Abram 1990; Regier et al. 1990).

It is difficult to find community-based drug treatment programs that readily accept PSMIs or that offer seamlessly integrated services for comorbid persons.

Swartz and Lurigio's results also suggested that serious mental illness was even more prevalent among detainees in drug treatment than in the general population of jail inmates. More important, the study also found that addicted offenders with serious comorbid psychiatric disorders are often afflicted with other psychiatric disorders as well (e.g., posttraumatic stress disorder). In agreement with findings from the National Comorbidity Study, psychiatric problems tend to cluster among those with the most severe disorders (Kessler et al. 1994). Abram and Teplin (1991, 1036) noted the "fragmented configuration" of the public health system and stated, "[A]lthough a complex array of services is available, each subsystem designs its programs to fit a specific need, and many programs are managed as if clients were pure types." Little has changed since they made this observation. Only a few "mentally ill/substance abuser," "mentally ill/chemical abuser," or therapeutic community programs are available for addicted offenders in the criminal justice system or the community.

It is difficult to find community-based drug treatment programs that readily accept PSMIs or that offer seamlessly integrated services for comorbid persons. While the Nation's jail and prison populations continue to grow, adequate and well-designed treatment systems are needed more urgently than ever to address psychiatric comorbidities among addicted offenders. The findings from Swartz and Lurigio (1999) and other studies indicate that both the problem of comorbidity and the demand for integrated treatment are pervasive.

Conclusions and Recommendations

Based on the studies reviewed in this chapter, we recommend a number of changes that will lead to more effective interventions and services for PSMIs in the criminal justice system. Many of these recommendations were touched upon throughout the text. In this final section, we focus on basic areas of needed improvement in the care of PSMIs that are relevant across various domains of criminal justice practice (i.e., law enforcement, courts, and corrections), that transcend the boundaries between the criminal justice and mental health systems, and that fill gaps in the criminal justice system's present capacity for handling PSMIs.

The literature indicates that the following efforts should be made to improve the care of PSMIs in the criminal justice system:

- Build enduring connections between the mental health and criminal justice systems.
- Create aftercare and consolidated services programs for PSMIs being supervised in the community.

- Develop clear and consistent standards of care for PSMIs in prisons, jails, and community corrections agencies.
- Pursue more research on the nature and extent of serious mental illness among different correctional populations.

Systems coordination

The absence of ongoing dialogue and coordination between the mental health and criminal justice systems further impedes the recognition and treatment of mentally ill offenders. Local mental health and criminal justice systems often deal with the same groups of chronically troubled and troublesome individuals (Lurigio and Lewis 1987). In practice, however, the two systems of social control rarely exchange cases, information, and resources. Furthermore, mental health and criminal justice practitioners approach the problems of mentally ill offenders from two widely disparate philosophies: treatment versus punishment.

To benefit PSMIs in the future, staff in both domains must begin regularly communicating and collaborating at the system and practitioner levels so they can understand each other's capacities and constraints in dealing with the same clients and so they can promote effective and humane care for PSMIs. The end product should be a unified, accountable case management system for maintaining the mentally ill in the community (Craig and Kissell 1986).

The absence of systems coordination is quite apparent in the area of aftercare services. Many PSMIs in jail receive psychiatric services during their incarceration, but they are usually discharged with no referrals to community treatment, no income or housing, and "none of the support that they need to remain in treatment, maintain their psychiatric stability, and stay out of trouble" (Barr 1999, iii). Postincarceration case management services can ensure continuity of care between jail- and community-based treatments and services.

Case management activities should begin before release. Ventura and colleagues (1998) found that mentally ill inmates who received case management services both in the jail and after they were discharged were significantly less likely to be rearrested or were rearrested after a longer period of time than were mentally ill inmates who did not receive such services. Jail staff should collaborate with community service providers to assist inmates in their attempts to readjust to living in the community. For this collaboration to succeed, more funds have to be spent on community aftercare programs.

Systems coordination must also be achieved between the mental health and drug treatment systems. Treatment providers in both domains must recognize

that many PSMIs are afflicted with co-occurring mental health and substance abuse and dependence problems and require interventions that can address these disorders simultaneously. More extensive and integrated networks of care will reduce the likelihood of these persons falling through the cracks between treatment programs and into the criminal justice net (Teplin 1984a). Practitioners' lack of training on codisorders and their lack of experience with dually diagnosed populations, however, have been major obstacles to integrated services for comorbid offenders. Several key features of successful interventions for dually diagnosed persons have been identified through research and should be incorporated in programs for PSMIs with drug problems (Peters and Hills 1997).

Two programs are noteworthy for their achievement of systems coordination and collaboration in providing services for PSMIs in the criminal justice system. The first is the Wisconsin Correctional Service's Community Support Program (CSP), established in 1978 and located in Milwaukee. CSP effectively combines the leverage of court-ordered program participation and close monitoring with basic social and health care services, including psychiatric treatment, money management, and housing. CSP's goal is to keep clients out of both jail and the hospital (McDonald and Teitelbaum 1994).

The second is Maryland's Community Criminal Justice Treatment Program (MCCJTP), which targets mentally ill persons in jail and on probation and parole (Conly 1999). MCCJTP involves a multiagency collaboration among treatment and criminal justice professionals. MCCJTP provides PSMIs with mental health care, shelter, and case management services (i.e., screening, crisis intervention, counseling, discharge planning, and community followup). Case managers and clients have reported that MCCJTP's services have greatly improved the quality of participants' lives.

Assertive community treatment

Future criminal justice programs for PSMIs could benefit greatly by adopting continuous care models with single-point access to services, especially for PSMIs with lengthy records of hospitalization and arrest. PSMIs on community supervision at the pretrial, postadjudication, or postrelease levels can be managed effectively with assertive community treatment (ACT), models of which have demonstrated their success with the chronically mentally ill (Veysey 1996). Originating in Madison, Wisconsin, in the late 1960s, ACT employs a team approach to providing intense, comprehensive, coordinated, and integrated services (psychiatric, rehabilitative, and support) to persons with serious and persistent mental illnesses. ACT has been widely implemented and extensively researched in the United States, Canada, and Australia and has proven clinical

success and cost-effectiveness (e.g., Burns and Santos 1995; Test 1992; Torrey 1986; Wolff, Helminiak, and Diamond 1995).

ACT is a particularly suitable modality for many PSMIs in the criminal justice system: persons with chronic mental illnesses, limited insight, severe functional impairments, substance abuse and dependence problems, limited financial resources, and criminal involvement. In addition, many PSMIs in the criminal justice system have frequently avoided or have responded poorly to traditional outpatient mental health care (Lurigio and Lewis 1987). ACT is, therefore, a highly appropriate model for PSMIs participating in pretrial release or probation programs.

The ACT team's services include mental health and substance abuse treatment, health education, nonpsychiatric medical care, case management, ongoing assessments, employment and housing assistance, family support and education, and client advocacy. Extensive and reliable services are available 24 hours a day, 365 days a year, and adhere to the following fundamental principles (Assertive Community Treatment Association 1999):

- **Primary provider of services.** The multidisciplinary composition of the team and its small client-to-staff ratio require minimal referrals to other mental health programs or providers. All members of the team are jointly responsible for planning, securing, monitoring, and evaluating services. The team shares offices and staff and performs many interchangeable functions, ensuring that services are not disrupted by staff turnover or illness. In addition, program participants are clients of the team, not of individual staff members. Former patients are invited to serve paraprofessional and peer-counselor roles on the team.

- **Services outside the office.** The team can assist clients in the jail or hospital as well as in their homes, neighborhoods, workplaces, and other community settings (i.e., where clients live, work, and spend their leisure time), providing practical onsite support. A core tenet of ACT is to "bring care to the patient."

- **Highly individualized services.** Based on thorough and regular assessments, clients' treatment plans are tailored to met their unique histories, symptoms, and psychosocial resources. The input of the entire ACT team in the assessment and case

Recovery from serious mental illnesses and substance abuse and dependence problems is an arduous and challenging process that demands constant attention and a lengthy commitment to treatment.

management processes results in a more holistic view of the clients' problems, needs, and prognoses.

- **Proactive approach.** The team is proactive in delivering continuing services to support clients in their efforts to live self-sufficient and constructive lives in the community. The team's activities are designed to prevent crises and setbacks in client recovery and reintegration and to emphasize the attainment of such basic skills as caring for physical health and appearance, complying with medication regimens, coping with daily demands and stressors, obtaining and managing financial entitlements, and maintaining a household. The ACT team members actively seek out clients for medication and other followup care and become client advocates in obtaining available services and in developing needed services that are unavailable.

- **Vocational focus.** The team emphasizes to clients the importance of acquiring realistic entry-level employment skills that will strengthen their independence, enhance their self-esteem, provide opportunities to contribute to their communities, and present them with income-generating alternatives to crime.

- **Long-term services.** The team recognizes that recovery from serious mental illnesses and substance abuse and dependence problems is an arduous and challenging process that demands constant attention and a lengthy commitment to treatment.

- **Collaboration.** Clients and their families and significant others are educated about mental illnesses and substance abuse disorders to gain their cooperation in clients' treatment plans. Future episodes of psychiatric hospitalization and incarceration can often be avoided when clients and their social support networks are fully involved in the recovery process.

- **Community integration.** The team encourages clients to become more active and less socially isolated in their communities. Clients are exposed to opportunities to become active members of local organizations and churches in the targeted community areas.

Mental health training

The need for mental health training for law enforcement, corrections, and court professionals is a common theme expressed throughout the literature on PSMIs in the criminal justice system. Without basic knowledge about psychiatric illnesses and treatments, criminal justice staff can never achieve lasting, substantive improvements in the care of PSMIs under their authority. Hence, specialized

mental health training for criminal justice staff is a necessary first step in responding to the specific problems of PSMIs.

The core curriculum should consist of a variety of topics, including the etiology and prevalence of serious mental illness, the signs and symptoms of serious mental illness, the latest advances in treatment, the involuntary commitment process, and the use of mental health referrals. Education sessions should be conducted with police, judges, attorneys, probation and social services staff, and correctional personnel. After educators lay a basic foundation of knowledge relating to mental disorders, they must tailor their training sessions to prepare each group for the job-related decisions that they have to render about PSMIs.

The police, for example, must learn effective, on-the-street procedures for identifying, arresting, and deflecting mentally disordered persons. Moreover, police must be taught about immediate alternatives to arrest and strategies to negotiate for care with mental health professionals in hospitals and outpatient settings.

Standards of care

Carefully developed standards of screening and care for PSMIs should be widely disseminated throughout the criminal justice system. Accrediting bodies and other interested organizations (e.g., the National Alliance for the Mentally Ill) should formulate clear and specific practice guidelines for screening and treating PSMIs in the criminal justice system, especially for those incarcerated in jails and prisons. Such standards would help hold agencies accountable for providing at least a minimum level of mental health screening and care, and would help to eliminate the wide variability that currently exists in the quality of services available to PSMIs in the criminal justice system.

Future research

More and better research is needed on the nature and extent of serious mental illnesses among people involved at every level of the criminal justice system. National surveys containing questions on psychiatric treatment histories should be implemented in jails, prisons, and probation agencies. Criminal justice agencies also should employ standardized assessment tools at intake to determine the prevalence of serious mental illnesses within their own populations and should send the data to a clearinghouse that would compile the information for national prevalence estimates. In addition, standardized screening for severe mental illnesses should be done at admission to drug treatment programs to identify persons with comorbid disorders and to refer them to integrated treatment programs. Moreover, future research should explore racial and gender

differences among PSMIs in the criminal justice system, laying the groundwork for more gender- and race-sensitive programs for mentally disordered offenders.

Fulton (1996), for example, enumerated the benefits of collecting comprehensive data on PSMIs for probation departments. Among these benefits was the ability to answer the following basic questions: Do the risks and needs of PSMIs justify the development of specialized services and programs? Relative to workload information, how many PSMIs can an officer effectively manage in a generalized or specialized caseload? What is the most efficient and effective way to supervise PSMIs, given accessible mental health and social services in a particular jurisdiction? Based on probation outcomes, where should limited treatment resources be allocated?

In conclusion, as this discussion has demonstrated, a significant number of PSMIs are being handled by the criminal justice system, which does not have enough resources or expertise to respond fully to the afflictions and service demands of the mentally ill. Although there is no absolute longitudinal evidence that the number of PSMIs in the criminal justice system has been increasing during the past 20 years (Teplin 1991a), there are several compelling reasons to conclude that the criminalization of PSMIs is indeed a common phenomenon and that it will persist well into the 21st century. Among the most important causes of the purported rise of PSMIs in jail and prisons and on probation caseloads are the diminution of the State hospital population, the lack of available community care, and the fragmented nature of the mental health and other treatment and social service systems.

Unlike many treatment facilities, criminal justice institutions do not impose any restrictions or requirements for entry (Abram and Teplin 1991). The criminal justice system is essentially the one that "can't say no." Jails and prisons have become the last resort for care; the mentally ill are often incarcerated because no other settings are amenable or accessible (Barr 1999; Craig and Kissell 1986). Dramatic financial cutbacks in social services have made the criminalization of PSMIs even more likely, as jails and prisons have become the "hospitals of last resorts" (Barr 1999). We can not afford to allow this situation to continue.

References

Abram, K.M. 1990. The problem of co-occurring disorders among jail detainees. *Law and Human Behavior* 14:333–345.

Abram, K.M., and L.A. Teplin. 1991. Co-occurring disorders among mentally ill jail detainees. *American Psychologist* 46:1036–1045.

Abramson, M.F. 1972. The criminalization of mentally disordered behavior: Possible side-effect of a new mental health law. *Hospital and Community Psychiatry* 23:101–107.

Adams, R.D. 1988. *Exemplary county mental health programs: The diversion of people with mental illness from jails and in-jail mental health services.* Washington, D.C.: National Association of Counties.

Adler, F., G.O.W. Mueller, and W.S. Laufer. 1996. *Criminal justice: The core.* New York: McGraw-Hill.

American Bar Association. 1983. *Criminal justice mental health standards.* Washington, D.C.: American Bar Association.

American Psychiatric Association. 1994. *Diagnostic and statistical manual of mental disorders.* 4th ed. Washington, D.C.: American Psychiatric Association.

———. 1989. *Psychiatric services in jails and prisons: Report of the Task Force on Psychiatric Services in Jails and Prisons.* Washington, D.C.: American Psychiatric Association.

Ashley, M. 1922. Outcome of 1,000 cases paroled from the Middletown State Hospital. *State Hospital Quarterly* 8:64–70.

Assertive Community Treatment Association. 1999. Assertive community treatment. Retrieved 5 January 2000 from the World Wide Web: www.actassociation.com.

Auletta, K. 1982. *The underclass.* New York: Random House.

Bachrach, L.L. 1989. Deinstitutionalization: A semantic analysis. *Journal of Social Issues* 45:161–171.

———. 1986. Deinstitutionalization: What do the numbers mean? *Hospital and Community Psychiatry* 37:118–121.

———. 1984. Deinstitutionalization and women: Assessing the consequences of public policy. *American Psychologist* 39:1171–1177.

Baker, D. 1998. Special treatment. *American Bar Association Journal* 51:17–23.

Barker, K. 1999. County's mental health court aims to prevent crime. *Seattle Times,* 21 February.

Barlow, D.H., and M.V. Durand. 1999. *Abnormal Psychology.* 2d ed. New York: Brooks/Cole Publishing Company.

Barr, H. 1999. *Prisons and jails: Hospitals of last resort.* New York: Correctional Association of New York and the Urban Justice Center.

Bartels, J., R.E. Drake, M.A. Wallach, and D.H. Freeman. 1991. Characteristic hostility in schizophrenic outpatients. *Schizophrenia Bulletin* 17:163–171.

Barthwell, A.G., P. Bokos, J. Bailey, M. Nisenbaum, J. Devereux, and E.C. Senay. 1995. Interventions/Wilmer: A continuum of care for substance abusers in the criminal justice system. *Journal of Psychoactive Drugs* 27:39–47.

Beck, J.L. 1998. *Mental illness and violent acts: Protecting the patient and public.* Paper presented at the Annual Meeting of the American Psychiatric Association, November, Toronto.

Belcher, J.R. 1988. Are jails replacing the mental health system for the homeless mentally ill? *Community Mental Health Journal* 24:185–195.

Bittner, E. 1967. Police discretion in emergency apprehension of mentally ill persons. *Social Problems* 14:278–292.

Bonovitz, J.C., and J.S. Bonovitz. 1981. Diversion of the mentally ill into the criminal justice system: The police intervention perspective. *American Journal of Psychiatry* 138:973–976.

Bonovitz, J.C., and E.B. Guy. 1979. Impact of restrictive civil commitment procedures on a prison psychiatric service. *American Journal of Psychiatry* 136:1045–1048.

Boone, H.B. 1995. Mental illness in probation and parole populations: Results from a national survey. *Perspectives* 19:14–26.

Borzecki, M., and J.S. Wormith. 1985. The criminalization of the psychiatrically ill: A review of the Canadian perspective. *Psychiatric Journal of the University of Ottawa* 10:241–247.

Breakey, W.R., and P.J. Fischer. 1990. Homelessness: The extent of the problem. *Journal of Social Issues* 46:31–47.

Brill, H., and B. Maltzberg. 1962. Statistical report on the arrest record of male ex-patients released from New York State mental hospitals during the period 1946–48. In *Criminal acts of ex-mental hospital patients*, supplement no. 153. Washington, D.C.: American Psychiatric Association, Mental Hospital Service.

Brown, V.B., M.S. Ridgely, B. Pepper, I.S. Levine, and H. Ryglewicz. 1989. The dual crisis: Mental illness and substance abuse. *American Psychologist* 44:565–569.

Buckley, P.F. 1998. Substance abuse in schizophrenia: A review. *Journal of Clinical Psychiatry* 59:126–130.

Burns, B.J., and A.B. Santos. 1995. Assertive community treatment: An update of randomized trials. *Psychiatric Services* 46:669–675.

Carroll, J.S., and A.J. Lurigio. 1984. Conditional release on probation and parole: Diagnosis, prediction, and treatment. In *Mental health and criminal justice,* edited by. L. Teplin. Beverly Hills: Sage Publications.

Chaiken, J.M., and M.R. Chaiken. 1990. Drugs and predatory crime. In *Drugs and crime,* edited by M. Tonry and J.Q. Wilson. Vol. 13 of *Crime and justice: A review of research.* Chicago: University of Chicago Press.

Clear, T.R., J.M. Byrne, and J.A. Dvoskin. 1993. The transition from being an inmate: Discharge planning, parole, and community-based services for mentally ill offenders. In *Mental illness in America's prisons,* edited by H.J. Steadman and J.J. Cocozza. Seattle: National Coalition for the Mentally Ill in the Criminal Justice System.

Cocozza, J.J., H.J. Steadman, and M.E. Melick. 1978. Trends in violent crime among ex-mental patients. *Criminology* 16:317–334.

Cohen, L., and H. Freeman. 1945. How dangerous to the community are State hospital patients? *Connecticut State Medical Journal* 9:697–700.

Collins, J.J., and W.E. Schlenger. 1983. The *prevalence of psychiatric disorders among admissions to prison.* Paper presented at the Annual Meeting of the American Society of Criminology, November, Denver.

Condelli, W.S. 1994. Domains of variables for understanding and improving retention in therapeutic communities. *International Journal of the Addictions* 29:593–607.

Conly, C. 1999. *Coordinating community services for mentally ill offenders: Maryland's Community Criminal Justice Treatment Program.* Program Focus, NCJ 175046. Washington, D.C.: U.S. Department of Justice, National Institute of Justice.

Cote, G., A. Lesage, N. Chawky, and M. Loyer. 1997. Clinical specificity of prison inmates with severe mental disorders. *British Journal of Psychiatry* 170:571–577.

Cournos, F., and K. McKinnon. 1997. HIV seroprevalence among people with severe mental illness in the United States: A critical review. *Clinical Psychology Review* 17:259–269.

Cox, J.F., G. Landsberg, and M.P. Paravati. 1989. The essential components of a crisis intervention program for local jails: The New York forensic suicide prevention crisis service model. *Psychiatric Quarterly* 60:103–118.

Craig, R.T., and B.A. Kissell. 1986. *The mentally ill offender: Punishment or treatment?* State Legislative Report, No. 11 (13). Denver: National Conference of State Legislatures.

Deane, M.W., H.J. Steadman, R. Borum, B.M. Veysey, and J.P. Morrissey. 1999. Emergency partnerships between mental health and law enforcement. *Psychiatric Services* 50:99–101.

DeCuir, W.J. 1982. *Officer-in-charge: Los Angeles Police Department Mental Evaluation Unit.* Los Angeles: Los Angeles Police Department.

Deutsch, A. 1949. *The mentally ill in America: A history of their care and treatment from Colonial times.* New York: Columbia University Press.

Draine, J., and P. Solomon. 1999. Describing and evaluating jail diversion services for persons with serious mental illness. *Psychiatric Services* 50:56–61.

Draine, J., P. Solomon, and A.T. Meyerson. 1994. Predictors of reincarceration among patients who received psychiatric services in jail. *Hospital and Community Psychiatry* 45:163–167.

Dumont, M.P. 1982. Review of *Private lives/public spaces,* by E. Baxter and K. Hopper, and *Shopping bag ladies,* by A.M. Rousseau. *American Journal of Orthopsychiatry* 52:367–369.

Durbin, J., R. Pasewark, and D. Albers. 1977. Criminality and mental illness: A study of arrest rates in a rural State. *American Journal of Psychiatry* 134:80–83.

Durham, M.L. 1989. The impact of deinstitutionalization on the current treatment of the mentally ill. *International Journal of Law and Psychiatry* 12:117–131.

Dvoskin, J.A., and H.J. Steadman. 1994. Using intensive case management to reduce violence by mentally ill persons in the community. *Hospital and Community Psychiatry* 45:679–684.

Edens, J.J., R.H. Peters, and H.A. Hills. 1997. Treating prison inmates with co-occurring disorders: An integrative review of existing programs. *Behavioral Science and Law* 15:439–457.

El-Mallakh, P. 1998. Treatment models for clients with co-occurring addictive and mental disorders. *Archives of Psychiatric Nursing* 12:71–80.

Eronen, M., P. Hakola, and J. Tiihonen. 1996. Mental disorders and homicidal behavior in Finland. *Archives of General Psychiatry* 53:497–501.

Finn, P., and M. Sullivan. 1989. Police handling of the mentally ill: Sharing responsibility with the mental health system. *Journal of Criminal Justice* 17:1–14.

Fulton, B. 1996. Persons with mental illness on probation and parole: The importance of information. In *Community corrections in America: New directions and sounder investments for persons with mental illness and codisorders,* edited by A.J. Lurigio. Seattle: National Coalition for Mental and Substance Abuse Health Care in the Justice System.

Geller, J.L., W.H. Fisher, and M. McDermach. 1995. A national survey of mobile crisis services and their evaluation. *Psychiatric Services* 46:893–897.

Gibbs, J.J. 1983. Problems and priorities: Perceptions of jail custodians and social service providers. *Journal of Criminal Justice* 11:327–349.

Gilboy, J.A., and J.R. Schmidt. 1971. "Voluntary" hospitalization of the mentally ill. *Northwestern University Law Review* 66:429–453.

Gillig, P.M., M. Dumaine, J.W. Stammer, J.R. Hillard, and P. Grubb. 1990. What do police officers really want from the mental health system? *Hospital and Community Psychiatry* 41:663–665.

Goldman, H.H., N.H. Adams, and C.A. Taube. 1983. Deinstitutionalization: The data demythologized. *Hospital and Community Psychiatry* 34:129–134.

Gray, J.P. 1857. Homicide in insanity. *American Journal of Insanity* 14:119–143.

Grob, G.N. 1991. *From asylum to community: Mental health policy in modern America.* Princeton, New Jersey: Princeton University Press.

———. 1973. *Mental institutions in America.* New York: Free Press.

Guy, E., J.J. Platt, I. Zwerling, and S. Bullock. 1985. Mental health status of prisoners in an urban jail. *Criminal Justice and Behavior* 12:29–53.

Harlow, C.W. 1998. *Profile of jail inmates 1996.* Special Report, NCJ 164620. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics.

Harry, B., and H.J. Steadman. 1988. Arrest rates of patients treated at a community mental health center. *Hospital and Community Psychiatry* 39:862–866.

Hartstone, E. 1990. The mentally ill and the local jail: Policy and action. In *Effectively addressing the mental health needs of jail detainees,* edited by H.J. Steadman. Seattle: National Coalition for the Mentally Ill in the Criminal Justice System.

Hodgins, S. 1992. Mental disorder, intellectual deficiency, and crime: Evidence from a birth cohort. *Archives of General Psychiatry* 49:476–483.

———. 1990. Prevalence of mental disorders among penitentiary inmates in Quebec. *Canada's Mental Health* 3:1–4.

Hodgins, S., S.A. Mednick, P.A. Brennan, F. Schulsinger, and M. Engberg. 1996. Mental disorder and crime. *Archives of General Psychiatry* 53:489–496.

Husted, J.R., R.A. Charter, and B. Perrou. 1995. California law enforcement agencies and the mentally ill offender. *Bulletin of the American Academy of Psychiatry and the Law* 23:315–329.

Ivanoff, A. 1989. Identifying psychological correlates of suicidal behavior in jail and detention facilities. *Psychiatric Quarterly* 60:73–83.

Jemelka, R. 1990. The mentally ill in local jails: Issues in admission and booking. In *Effectively addressing the mental health needs of jail detainees,* edited by H.J. Steadman. Boulder, Colorado: U.S. Department of Justice, National Institute of Corrections.

Jemelka, R.P., S. Rahman, and E.W. Trupin. 1993. Prison mental health: An overview. In *Mental illness in America's prisons,* edited by H.J. Steadman and J.J. Cocozza. Seattle: National Coalition for the Mentally Ill in the Criminal Justice System.

Jemelka, R., E.W. Trupin, and J.A. Chiles. 1989. The mentally ill in prisons: A review. *Hospital and Community Psychiatry* 40:481–490.

Johns, A. 1997. Substance misuse: A primary risk and a major problem of comorbidity. *International Review of Psychiatry* 9:233–241.

Johnson, D.L. 1997. Overview of severe mental illness. *Clinical Psychology Review* 17:247–257.

Kagan, D. 1990. Landmark Chicago study documents rate of mental illness among jail inmates. *Corrections Today* 712 (December):164, 166–68.

Kanter, A.S. 1989. Homeless but not helpless: Legal issues in the care of homeless people with mental illness. *Journal of Social Issues* 45:91–104.

Kessler, R.C., K.A. McGonagle, S. Zhao, C.B. Nelson, M. Hughes, S. Eshleman, H.U. Wittchen, and K.S. Kendler. 1994. Lifetime and 12-month prevalence of *DSM–III–R* psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry* 51:8–19.

Kiesler, C.A. 1982. Public and professional myths about mental hospitalization: An empirical reassessment of policy-related beliefs. *American Psychologist* 37:1323–1339.

Kiesler, C.A., and A.E. Sibulkin 1987. *Mental hospitalization: Myths and facts about a national crisis.* Beverly Hills: Sage Publications.

Kimmel, W. 1987. *Services for the mentally ill inmate: An exploratory inquiry.* Rockville, Maryland: U.S. Department of Health and Human Services, National Institute of Mental Health, Office of Policy Analysis and Coordination.

Koegel, P., M.H. Burnam, and R.K. Farr. 1988. The prevalence of specific psychiatric disorders among homeless individuals in the inner city of Los Angeles. *Archives of General Psychiatry* 45:1085–1092.

Laberge, D., and D. Morin. 1995. The overuse of criminal justice dispositions: Failure of diversionary policies in the management of mental health problems. *International Journal of Law and Psychiatry* 18:389–414.

LaFond, J.Q., and M.L. Durham. 1992. *Back to the asylum: The future of mental health law and policy in the United States.* New York: Oxford University Press.

Lamb, H.R. 1997. The new State mental hospitals in the community. *Psychiatric Services* 10:1307–1310.

———. 1984a. Deinstitutionalization and the homeless mentally ill. *Hospital and Community Psychiatry* 35:889–907.

———, ed. 1984b. *The homeless mentally ill: A task force report of the American Psychiatric Association.* Washington, D.C.: American Psychiatric Association Press.

Lamb, H.R., and R.W. Grant. 1983. Mentally ill women in a county jail. *Archives of General Psychiatry* 40:363–368.

———. 1982. The mentally ill in an urban county jail. *Archives of General Psychiatry* 39:17–22.

Lamb, H.R., R. Shaner, D.M. Elliot, W.J. DeCuir, and J.T. Foltz. 1995. Outcome for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services* 46:1267–1271.

Lamb, H.R., and L.E. Weinberger. 1998. Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services* 49:483–492.

LeBrun, L. 1989. Characteristics of male suicide attempts in the Sacramento County Jail: 1985–1987. *Jail Suicide Update* 2:1–7.

Lewis, D.A., A.J. Lurigio, S. Riger, T.W. Pavkov, S.C. Reed, and H. Rosenberg. 1994. *The State mental patient and urban life: Moving in and out of the institution.* Springfield, Illinois: Charles C. Thomas.

Lewis, D.A., S. Riger, H. Rosenberg, H. Wagenaar, A.J. Lurigio, and S. Reed. 1991. *Worlds of the mentally ill: How deinstitutionalization works in the city.* Carbondale: Southern Illinois University Press.

Lindquist, P., and P. Allebeck. 1990. Schizophrenia and crime: A longitudinal follow-up of 644 schizophrenics in Stockholm. *British Journal of Psychiatry* 157:345–350.

———. 1989. Schizophrenia and assaultive behavior: The role of alcohol and drug abuse. *Acta Psychiatrica Scandinavica* 82:191–195.

Link, B., H. Andrews, and F. Cullen. 1992. The violent and illegal behavior of mental patients reconsidered. *American Sociological Review* 57:275–292.

Link, B., and A. Stueve. 1994. Psychotic symptoms and the violent/illegal behavior of mental patients compared to community controls. In *Violence and mental disorder: Developments in risk assessment,* edited by J. Monahan and H. Steadman. Chicago: University of Chicago Press.

Lovell, D., and R. Jemelka. 1998. Coping with mental illness in prisons. *Family and Community Health* 21:54–64.

Lurigio, A.J. 1996a. Responding to the mentally ill on probation and parole: Recommendations and action plans. In *Community corrections in America: New directions and sounder investments for persons with mental illness and codisorders,* edited by A.J. Lurigio. Seattle: National Coalition for Mental and Substance Abuse Health Care in the Justice System.

———, ed. 1996b. *Community corrections in America: New directions and sounder investments for persons with mental illness and codisorders.* Seattle: National Coalition for Mental and Substance Abuse Health Care in the Justice System.

Lurigio, A.J., and D.A. Lewis. 1987. Toward a taxonomy of the criminal mental patient. Manuscript prepared for Northwestern University, Center for Urban Affairs and Policy Research, Evanston, Illinois.

Lurigio, A.J., and N. Martin. 1998. Casework practice with mentally ill probationers. In *Best practices: Excellence in corrections,* edited by R.A. Wilkinson. Lanham, Maryland: American Correctional Association.

Lurigio, A.J., J. Thomas, and M.E. Jones. 1996. *A study of the Mental Health Unit operations.* Chicago: Cook County Adult Probation Department.

Martell, D.A., R. Rosner, and R.B. Harmon. 1995. Base-rate estimates of criminal behavior by homeless mentally ill persons in New York City. *Psychiatric Services* 46:596–601.

Matthews, A. 1970. Observations on police policy and procedures for emergency detention of the mentally ill. *Journal of Criminal Law, Criminology, and Police Science* 61:283–295.

McCafferty, G., and J. Dooley. 1990. Involuntary outpatient commitment: An update. *Mental & Physical Disability Law Reporter* 14:277–287.

McDonald, D.C., and M. Teitelbaum. 1994. *Managing mentally ill offenders in the community: Milwaukee's Community Support Program.* Program Focus, NCJ 145330. Washington, D.C.: U.S. Department of Justice, National Institute of Justice.

McGlothlin, W.H. 1978. The etiologic relationship between drug use and criminality. In *Research advances in alcohol and drug problems IV,* edited by Y. Israel, F.B. Glaser, H. Kolant, R.E. Papham, W. Schmidt, and R.G. Smart. New York: Plenum Press.

McLellan, A.T., and A.I. Alterman. 1991. Patient treatment matching: A conceptual and methodological review with suggestions for future research. In *Improving drug abuse treatment.* Pub. no. ADM 91–17544. Washington, D.C.: U.S. Department of Health and Human Services.

McLellan, A.T., L. Luborsky, G.E. Woody, C.P. O'Brien, and R. Kron. 1981. Are the "addiction-related" problems of substance abusers really related? *Journal of Nervous and Mental Disease* 169:232–239.

Mechanic, D. 1998. Emerging trends in mental health policy and practice. *Health Affairs* 17:82–98.

Mental Health Court Fact Sheet. 1999. *Mental Health Court: A King County District Court program.* Retrieved 17 February 2000 from the World Wide Web: www.co.king.wa.us/kcdc/mhfact.htm.

Mental Health Court Progress Report. 1998. Broward County, Florida: 17th Judicial Circuit.

Mental Health Court Task Force. 1998. *Recommendations for the King County mental health court.* Seattle: Mental Health Court Task Force.

Miller, R.D. 1987. *Involuntary civil commitment of the mentally ill in the post-reform era.* Springfield, Illinois: Charles C. Thomas.

Monahan, J. 1993. Mental disorder and violence: Another look. In *Mental disorder and crime,* edited by S. Hodgins. Newbury Park, California: Sage Publications.

———. 1992. Mental disorder and violent behavior: Perceptions and evidence. *American Psychologist* 47:511–521.

Monahan, J., and H. Steadman. 1983. Crime and mental disorder: An epidemiological approach. In *Crime and justice: An annual review of research,* edited by N. Morris and M. Tonry. Vol. 5. Chicago: University of Chicago Press.

Morgan, C. 1981. Developing mental health services for local jails. *Criminal Justice and Behavior* 8:259–273.

Morrell, L.K. 1989. *The law enforcement/mental health interface: A pilot study of the impact of public policy changes upon access to emergency psychiatric services.* Rockville, Maryland: U.S. Department of Health and Human Services, National Institute of Mental Health.

Mueser, K.T., A.S. Bellack, and J J. Blanchard. 1992. Comorbidity of schizophrenia and substance abuse: Implications for treatment. *Journal of Consulting and Clinical Psychology* 60:845–856.

Mueser, K.T., R.E. Drake, and K.M. Miles. 1997. The course and treatment of substance use disorders in persons with severe mental illness. In *Treatment of drug-dependent individuals with comorbid mental disorders,* edited by L.S. Onken, J.D. Blaine, S. Genser, and A.M. Horton. Washington, D.C.: U.S. Department of Health and Human Services.

Murphy, G.R. 1986. *Special care: Improving the police response to the mentally disabled.* Washington, D.C.: Police Executive Research Forum.

National Alliance for the Mentally Ill. 1999. *The criminalization of people with mental illness.* Retrieved 6 January 2000 from the World Wide Web: http://www.nami.org/update/unitedcriminal.html.

National Commission on Correctional Health Care. 1998. *Standards for health services in prisons.* Chicago: National Commission on Correctional Health Care.

New York Times. 1984. Editorial, Suffering in the streets.

New York Times. 1982a. Editorial, Another round.

New York Times. 1982b. Editorial, Willowbrook plan.

Palermo, G.B., M.B. Smith, and F.J. Liska. 1991. Jail versus mental hospitals: A social dilemma. *International Journal of Offender Therapy and Comparative Criminology* 35:97–106.

Pan, H., F.R. Scarpitti, J.A. Inciardi, and D. Lockwood. 1993. Some considerations on therapeutic communities in corrections. In *Drug treatment and criminal justice,* edited by J.A. Inciardi. Beverly Hills: Sage Publications.

Penrose, L. 1939. Mental disease and crime: Outline of a comparative study of European statistics. *British Journal of Medical Psychology* 18:1–15.

Perkins, J. 1985. New institution for the homeless. *Wall Street Journal,* 26 February.

Peters, R. 1993. Drug treatment in jails and detention settings. In *Drug treatment and criminal justice,* edited by J.A. Inciardi. Beverly Hills: Sage Publications.

Peters, R., and H.A. Hills, 1997. *Intervention strategies for offenders with co-occurring disorders: What works?* Delmar, New York: National GAINS Center For People with Co- occurring Disorders in the Criminal Justice System.

Phelan, J., B. Link, A. Stueve, and B. Pescosolido. 1997. Public conceptions of mental illness in 1950 and today: Findings from the 1996 General Social Survey Module on Mental Health. Paper presented at the annual meeting of the American Sociological Association, Toronto.

Pollock, H.H. 1938. Is the paroled patient a threat to the community? *Psychiatric Quarterly* 12:236–244.

Proband, S.C. 1998. Corrections populations near 6 million. *Overcrowded Times* 9:4.

Rabkin, J. 1979. Criminal behavior of discharged mental patients: A critical appraisal of the research. *Psychological Bulletin* 86:1–27.

Rappeport, J.R., and G. Lassen. 1966. The dangerousness of female patients: A comparison of the arrest rate of discharged psychiatric patients and the general population. *American Journal of Psychiatry* 123:413–419.

Regier, D.A., M.E. Farmer, D.A. Rae, B.Z. Locke, S.J. Keith, L.L. Judd, and F.K. Goodwin. 1990. Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiological Catchment Area Psychiatric Illness and Comorbidity (ECA) Study. *Journal of the American Medical Association* 264:2511–2518.

Ries, R.K., and K.A. Comtois. 1997. Illness severity and treatment services for dually diagnosed severely mentally ill outpatients. *Schizophrenia Bulletin* 23:239–246.

Robertson, M.J. 1986. Mental disorder among homeless people in the United States: An overview of recent empirical literature. *Administration in Mental Health* 4:14–27.

Rock, R., M. Jacobson, and R. Janepaul. 1968. *Hospitalization and discharge of the mentally ill.* Chicago: University of Chicago Press.

Rosenbaum, D.P. 1994. *Community policing: Testing the promises.* Thousand Oaks, California: Sage Publications.

Runions, J., and R. Prudo. 1983. Problem behaviors encountered by families living with a schizophrenic member. *Canadian Journal of Psychiatry* 28:383–386.

Sacks, S., J. Sacks, G. DeLeon, A.I. Bernhardt, and G.L. Graham. 1997. Modified therapeutic community for mentally ill chemical "abusers": Background, influences, program description, preliminary findings. *Journal of Substance Use & Misuse* 32:1217–1259.

Schag, D. 1977. Predicting dangerousness: An analysis of procedures in a mental health center. Ph.D. diss., University of California, Santa Cruz.

Shadish, W.R. 1989. Private sector care for chronically mentally ill individuals: The more things change, the more they stay the same. *American Psychologist* 44:1142–1147.

Shadish, W.R., A.J. Lurigio, and D.A. Lewis. 1989. After deinstitutionalization: The present and future of mental health long-term care policy. *Journal of Social Issues* 45:1–15.

Shah, S.A. 1975. Dangerous and civil commitment of the mentally ill: Some public policy considerations. *American Journal of Psychiatry* 132:501–505.

Shain, R., and J. Phillips. 1991. The stigma of mental illness: Labeling and stereotyping in the news. In Risky business: *Communicating issues of science, risk, and public policy,* edited by L. Wilkins and P. Patterson. Westport, Connecticut: Greenwood Press.

Sheridan, E.P., and L.A. Teplin. 1981. Police referred psychiatric emergencies: Advantage of community treatment. *Journal of Community Psychology* 9:140–147.

Smith, J., and S. Hucker. 1994. Schizophrenia and substance abuse. *British Journal of Psychiatry* 165:13–21.

Sosowsky, L. 1980. Explaining the increased arrest rate among mental patients: A cautionary note. *American Journal of Psychiatry* 137:1602–1605.

Steadman, H.J., ed. 1990. Introduction to *Effectively addressing the mental health needs of jail detainees.* Seattle: National Coalition for the Mentally Ill in the Criminal Justice System.

Steadman, H.J., and J.J. Cocozza. eds. 1993. *Mental illness in America's prisons.* Seattle: National Coalition for the Mentally Ill in the Criminal Justice System.

Steadman, H.J., J. Cocozza, and M. Melick. 1978. Explaining the increased crime rate of mental patients: The changing clientele of State hospitals. *American Journal of Psychiatry* 135:816–820.

Steadman, H.J., M.W. Deane, R. Borum, and J.P. Morrissey. 1999. Comparing outcomes of major models for police responses to mental health emergencies. Manuscript submitted for publication.

Steadman, H.J., and R.B. Felson. 1984. Self-reports of violence. *Criminology* 22:321–342.

Steadman, H.J., D.W. McCarty, and J.P. Morrissey. 1989. *The mentally ill in jail: Planning for essential services.* New York: Guilford Publications.

Steadman, H.J., J. Monahan, B. Duffee, E. Hartstone, and P.C. Robbins. 1984. The impact of State mental hospital deinstitutionalization on United States prison populations, 1968–1978. *Journal of Criminal Law and Criminology* 75:474–490.

Steadman, H.J., E.P. Mulvey, J. Monahan, P.C. Robbins, P.S. Appelbaum, T. Grisso, L.H. Roth, and E. Silver. 1998. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry* 55:393–401.

Steadman, H.J., and B.M. Veysey. 1997. *Providing services for jail inmates with mental disorders.* Research in Brief, NCJ 162207. Washington, D.C.: U.S. Department of Justice, National Institute of Justice.

Stefan, S. 1986. *Outpatient commitment: Evaluation of criteria and programs.* Washington, D.C.: Mental Health Law Project.

Straznickas, K.A., D.E. McNeil, and R.L. Binder. 1993. Violence toward family caregivers by mentally ill relatives. *Hospital and Community Psychiatry* 44:385–387.

Swanson, J.W. 1994. Mental disorder, substance abuse, and community violence: An epidemiological approach. In *Violence and mental disorder: Developments in risk*

assessment, edited by J. Monahan and H.J. Steadman. Chicago: University of Chicago Press.

Swanson, J., R. Borum, M. Swartz, and J. Monahan. 1996. Psychotic symptoms and disorders and the risk of violent behavior in the community. *Criminal Behavior and Mental Health* 6:317–332.

Swanson, J., S. Estroff, M. Swartz, R. Borum, W. Lachicotte, C. Zimmer, and R. Wagner. 1997. Violence and severe mental disorder in clinical and community populations: The effects of psychotic symptoms, comorbidity, and lack of treatment. *Psychiatry* 60:1–22.

Swanson, J., C. Holzer, V. Ganju, and R. Jono. 1990. Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area surveys. *Hospital and Community Psychiatry* 41:761–770.

Swanson, J., J. Morrissey, I. Goldstrom, L. Rudolph, and R. Manderscheid. 1993. Funding, expenditures, and staffing of mental health services in State adult correctional facilities: United States, 1988. *Mental Health Statistical Note 208.* Washington, D.C.: U.S. Department of Health and Human Services.

Swartz, J.A., and A.J. Lurigio. 1999. Psychiatric illness and comorbidity among adult male detainees in drug treatment. *Psychiatric Services* 50:1628–1630.

Swartz, M.S., J.W. Swanson, V.A. Hiday, R. Borum, R. Wagner, and B.J. Burns. 1998. Violence and severe mental illness: The effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry* 155:226–231.

Talbott, J.A. 1979. Deinstitutionalization: Avoiding the disasters of the past. *Hospital and Community Psychiatry* 30:621–624.

———. 1975. Current clichés and platitudes in vogue in psychiatric vocabularies. *Hospital and Community Psychiatry* 26:530.

Tardiff, K. 1984. Characteristics of assaultive patients in private hospitals. *American Journal of Psychiatry* 141:1232–1235.

Taylor, P.J. 1985. Motives for offending amongst violent and psychotic men. *British Journal of Psychiatry* 147:491–498.

Taylor, P.J., P. Mullen, and S. Wessely. 1993. Psychosis, violence, and crime. In *Forensic psychiatry: Clinical, legal, and ethical issues,* edited by J. Gunn and P.J. Taylor. London: Butterworth-Heinemann.

Teplin, L.A. 1994. Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health* 84:290–293.

———. 1991a. The criminalization hypothesis: Myth, misnomer, or management strategy. In *Law and mental health: Major developments and research needs*, edited by S. Shah and B. Sales. Washington, D.C.: U.S. Department of Health and Human Services.

———. 1991b. Police handling of the mentally ill: Styles, strategies, and implications. In *Effectively addressing the mental health needs of jail detainees*, edited by H.J. Steadman Seattle: National Coalition for the Mentally Ill in the Criminal Justice System.

———. 1990. The prevalence of severe mental disorders among male urban jail detainees: Comparisons with the Epidemiologic Catchment Area Program. *American Journal of Public Health* 80:663–669.

———. 1984a. Criminalizing mental disorder. *American Psychologist* 39:794–803.

———. 1984b. Managing disorder: Police handling of the mentally ill. In *Mental health and criminal justice*, edited by L.A. Teplin. Beverly Hills: Sage Publications.

———. 1983. The criminalization of the mentally ill: Speculation in search of data. *Psychological Bulletin* 94:54–67.

Teplin, L.A., K.A. Abram, and G.M. McClelland. 1994. Does psychiatric disorder predict violent crime among released jail detainees? *American Psychologist* 49:335–342.

Teplin, L.A., W. Filstead, G. Hefner, and E. Sheridan. 1980. Police involvement with the psychiatric-emergency patient. *Psychiatric Annals* 18:46–54.

Teplin, L.A., and N.S. Pruett. 1992. Police as streetcorner psychiatrist: Managing the mentally ill. *International Journal of Law and Psychiatry* 15:139–156.

Teplin, L.A., and J.A. Swartz. 1989. Screening for severe mental disorder in jails. *Law and Human Behavior* 13:1–18.

Teplin, L.A., and E.S. Voit. 1996. Criminalizing the seriously mentally ill: Putting the problem in perspective. In *Mental health and law: Research, policy, and services*, edited by B.D. Sales and S.A. Shah. Durham, North Carolina: Carolina Academic Press.

Test, M.A. 1992. Training in community living. In *Handbook of psychiatric rehabilitation*, edited by R.P. Liberman. New York: Macmillan.

Thomas, A. 1998. Ronald Reagan and the commitment of the mentally ill: Capital, interest groups, and the eclipse of social policy. *Electronic Journal of Sociology* 003.004:1–13. Retrieved 7 January 2000 from the World Wide Web: www.sociology.org.

Torrey, E.F. 1997. *Out of the shadows: Confronting America's mental illness crisis.* New York: John Wiley& Sons.

———. 1986. Continuous treatment teams in the care of the chronic mentally ill. *Hospital and Community Psychiatry* 37:1243–1247.

Torrey, E.F., and R.J. Kaplan. 1995. A national survey of the use of outpatient commitment. *Psychiatric Services* 46:778–784.

Torrey, E.F., J. Steiber, J. Ezekiel, S.M. Wolfe, J. Sharfstein, J.H. Noble, and L.M. Flynn. 1992. *Criminalizing the seriously mentally ill.* Washington, D.C.: Public Citizen's Health Research Group and the National Alliance for the Mentally Ill.

U.S. Department of Health and Human Services, Center for Mental Health Services, Survey and Analysis. 1994. *Resident patients in State and county mental hospitals.* Rockville, Maryland.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 1999. *Jail diversion knowledge development & application program.* Retrieved 6 January 2000 from the World Wide Web: www.prainc.com/jail.

U.S. Department of Justice, Bureau of Justice Statistics. 1999a. *Correctional populations in the United States, 1996.* Special Report, NCJ 171684. Washington, D.C.

———. 1999b. *Prison and jail inmates at midyear 1998.* NCJ 173414. Washington, D.C.

———. 1997. *Characteristics of adults on probation, 1995.* Special Report, NCJ 164267. Washington, D.C.

———. 1995. *Substance abuse and treatment of adults on probation, 1995.* Special Report, NCJ 166611. Washington, D.C.

———. 1993. *Survey of State prison inmates, 1991.* NCJ 136949. Washington, D.C.

———. 1988. *Prisoners in 1987.* Washington, D.C.

Ventura, L.A., C.A. Cassel, J.E. Jacoby, B. Huang. 1998. Case management and recidivism of mentally ill persons released from jail. *Psychiatric Services* 49:1330–1337.

Veysey, B.M. 1996. Effective strategies for providing mental health services to probationers with mental illness. In *Community corrections in America: New directions and sounder investments for persons with mental illness and codisorders,* edited by A.J. Lurigio. Seattle: National Coalition for Mental and Substance Abuse Health Care in the Justice System.

———. 1994. Challenges for the future. In *Topics in community corrections.* Longmont, Colorado: U.S. Department of Justice, National Institute of Corrections.

Wachholz, S., and R. Mullaly. 1993. Policing the deinstitutionalized mentally ill: Toward an understanding of its function. *Crime, Law, and Social Change* 19:281–300.

Warren, C.A. 1977. *The social construction of dangerousness.* Los Angeles: University of Southern California.

Warner, R. 1989. Deinstitutionalization: How did we get where we are? *Journal of Social Issues* 45:17–30.

———. 1985. *Recovery from schizophrenia: Psychiatry and political economy.* Boston: Routledge & Kegan Paul.

Way, B.B., M.E. Evans, and S.M. Banks. 1993. Analysis of police referrals to 10 psychiatric emergency rooms. *Bulletin of the American Academy of Psychiatry and the Law* 21:389–397.

Wexler, H.K. 1995. The success of therapeutic communities for substance abusers in American prisons. *Journal of Psychoactive Drugs* 27:57–66.

———. 1994. Progress in prison substance abuse treatment: A five year report. *Journal of Drug Issues* 24:349–360.

Whitmer, G. 1980. From hospitals to jails: The fate of California's deinstitutionalized mentally ill. *American Journal of Orthopsychiatry* 50 (1): 65–75.

Wine, F.H. 1888. *Report on the defective, dependent, and delinquent classes of the population of the United States.* Washington, D.C.: U.S. Government Printing Office. Reported in E.F. Torrey, J. Steiber, J. Ezekiel, S.M. Wolfe, J. Sharfstein, J.H. Noble, and L.M. Flynn, *Criminalizing the seriously mentally ill* (Washington, D.C.: Public Citizen's Health Research Group and the National Alliance for the Mentally Ill, 1992), 12.

Witkin, M.H., J. Atay, and R.W. Manderscheid. 1996. Trends in State and county hospitals in the U.S. from 1970 to 1992. *Psychiatric Services* 47:1079–1081.

Wolff, N., T.W. Helminiak, and R.F. Diamond. 1995. Estimated societal costs of assertive mental health care. *Psychiatric Services* 46:898–906.

Woody, G.E., D. Metzger, H. Navaline, T. McLellan, and C.P. O'Brien. 1997. Psychiatric symptoms, risky behavior, and HIV infection. In *Treatment of drug-dependent individuals with comorbid mental disorders,* edited by L.S. Onken, J.D. Blaine, S. Genser, and A.M. Horton. NIH pub. no. 97–4172. Washington, D.C.: U.S. Department of Health and Human Services, National Institutes of Health.

Zitrin, A., A.S. Hardesty, E.I. Burdock, and A.K. Drossman. 1976. Crime and violence among mental patients. *American Journal of Psychiatry* 133:142–149.