

Decriminalizing Mental Illness: Background and Recommendations

**A White Paper Prepared by the Forensic Taskforce of the
NAMI Board of Directors**

FULL REPORT

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Introduction

The enormously increased presence of persons with serious mental illness in the criminal justice system is one of the great problems of our day. As a result, mental health professionals and society have become increasingly concerned about the number of persons with mental illness in jails and prisons, as well as the treatment provided to these persons, both in such facilities and after release. These issues are relatively recent ones. Reports of large numbers of persons with mental illness in American jails and prisons began appearing in the 1970s, a phenomenon that had not been reported since the 19th century. In keeping with the priorities of NAMI, the focus here will be on persons with serious mental illness. The Forensic Taskforce of the NAMI Board of Directors will examine how criminalization came about, the extent of criminalization and how to reduce criminalization.

Magnitude of the Problem

The nation's prisons and jails held 2,299,116 inmates as of June 30, 2007.¹ Methodologically sound estimates of the percentages of persons diagnosed with serious mental illness (schizophrenia, schizo-affective disorder, bipolar disorder, and major depression) range from 10 to 19 percent in jails, 18 to 27 percent in state prisons, and 16 to 21 percent in federal prisons as determined by the National Commission on Correctional Health Care.²

By using the lower percentages to avoid overstating this phenomenon, the estimates of inmates in jails with serious mental illness were 76,601 (10%), in state prisons were 245,779 (18%), and in federal prisons were 30,573 (16%) as of June 30, 2006. Thus, the total number of persons in jails and prisons who were diagnosed with serious mental illness was at least 352,953 as of 2006 and is probably higher today.

One of the major concerns of mental health advocates is that placement in the

criminal justice system is a serious impediment to the treatment and rehabilitation of persons with serious mental illness. Even when quality psychiatric care is provided in jails and prisons, the person is doubly stigmatized as both a person with a mental illness and a criminal record.³

Further, jails and prisons have been established to mete out punishment and to protect society; their primary mission and goals are not to provide treatment. The correctional facility's overriding need to maintain order and security, as well as its mandate to implement society's priorities of punishment and social control, greatly restrict the facility's ability to establish a therapeutic milieu and provide all the necessary interventions to treat mental illness successfully. In fact, conditions of confinement within these facilities and the punitive methods frequently used by correctional staff to respond to people in crisis may further exacerbate psychiatric symptoms.⁴

Causes of Criminalization

A number of reasons for the placement of persons with mental illness in the criminal justice system have been suggested, and they include: deinstitutionalization, inadequate capacity for acute, intermediate and long-term psychiatric hospitalization in state and local hospitals, more formal and rigid criteria for civil commitment, the lack of adequate support systems, including housing, for persons with mental illnesses in the community, and the difficulties that persons coming from the criminal justice system have in gaining access to community mental health treatment.⁵ It has also been suggested that persons with serious mental illness and a co-occurring substance abuse disorder that have been caught up in the war on drugs are more likely to be fast tracked into the criminal justice system.⁶ Many law enforcement personnel believe that they can deal with deviant behavior more quickly and efficiently within the criminal justice system than in the mental health system.

The Role of the Police

Since the advent of deinstitutionalization and the exodus of persons with mental illness into the community, the role of law enforcement agencies in the management of persons who are experiencing psychiatric crises has grown. The rationale for police intervention in the lives of persons with mental illness derives from two common-law principles: the power and the authority of the police to protect the safety and welfare of the community and the government's paternalistic or *parens patriae* authority, which dictates protection of citizens with disabilities, such as people with acute mental illnesses, who cannot care for themselves.⁷

The police are typically the first and often the sole community resource called on to respond to urgent situations involving persons with mental illness. They are often called upon to decide whether the person they are dealing with has a mental illness and is in need of treatment. In that case they have to be able to connect the person with the proper treatment resources. Alternatively, they may decide that, regardless of the perceived mental status of the individual, the nature of the illegal act requires that the person be arrested and entered into the criminal justice system. This responsibility thrusts them into the role of primary gatekeepers who determine whether the individual will enter the mental health or the criminal justice system.

Police officers have a legal obligation to respond to calls and to provide services 24 hours a day, seven days a week. With respect to persons with mental illness, police in all states have the power to transport persons for psychiatric evaluation and treatment when there is probable cause to think that they are a danger to themselves or to others because of their mental condition. As a result, law enforcement officers have assumed the role of "street-corner psychiatrist" by default. A major problem with having to fulfill this role is that the police have little training in performing this kind of triage. This lack of training, coupled with an overall lack of alternative treatment options, is one of the factors that have played an important part in the criminalization of persons with mental illness. The training of law enforcement officers will be a major focus of the recommendations of this taskforce.

Some Characteristics of People with Serious Mental Illnesses who are Incarcerated

We know that there are very large numbers of persons with serious mental illness in our jails and prisons. What do we know about them in terms of their criminal histories and legal status? What psychiatric services do they use while incarcerated and what challenges might they present in psychiatric treatment after release?

A study by Lamb, et al (2007) attempted to answer these questions. It was a retrospective study of inmates with serious mental illness who were arrested and placed in a large, urban county jail.⁸ It should be noted at the outset that the findings do not necessarily represent what one would find in a similar study conducted in state and federal prisons, or even in other jails. However, these findings are congruent with clinical impressions of persons with serious mental illness in these other facilities. The study revealed that 76% of these inmates required and received psychiatric inpatient care or its equivalent for part of their time in jail during the current offense. Clearly, a large number of people with serious mental illness are receiving their acute psychiatric inpatient treatment in the criminal justice system rather than the mental health system.

With respect to these inmates' history before the current arrest, at least 92% were known to be non-adherent to psychiatric medications, 94% had prior arrests, 72% had prior arrests for violent crimes, and 76% were known to have a history of substance abuse. Given these data, in addition to the fact that three-quarters required inpatient psychiatric care in the jail, it would appear that the jail had acquired the responsibility to manage and treat many of the most difficult and expensive to treat persons with serious mental illness.

That 92% of the study sample had a history of being non-adherent to psychiatric medications suggests that successful reentry into the community requires evaluation, supervision, and timely access to appropriate services and supports such as, but not limited to, assertive community treatment (ACT), integrated mental health and substance abuse treatment, and supported housing. It also requires that reinstatement to entitlements occur concurrently with the release, so that the person has access to medical care and medications without delay.

Diverting Persons with Mental Illness from the Criminal Justice System

It was observed in the preceding study, as it frequently is in jails generally, that a number of persons with serious mental illness are arrested when it appears that their offending conduct was due primarily to their illness. The nature and circumstances of the offenses suggest that they should have been treated in a psychiatric hospital instead of being taken to jail.

The growing awareness of the very large and increasing number of persons with serious mental illness in jails and prisons has sparked efforts to divert them from the criminal justice system to the mental health system. Jail diversion generally takes two forms: pre-booking diversion and post-booking diversion.

Pre-booking diversion occurs before the person is actually booked into jail. These interventions include mobile crisis teams of police officers and/or mental health professionals. They require coordination between police and mental health professionals as well as mental health training for law enforcement officers. Pre-booking diversion programs may help in reducing arrests.

Post-booking diversion consists of interventions that occur after a person enters the criminal justice system. It includes specialized mental health courts that deal exclusively with offenders who have mental illnesses. Mental health consultation to arraignment and other courts can assist the court by offering recommendations for treatment in lieu of incarceration. One approach could be assigning court appointed specialized mental health advocates whose task is to support offenders with mental illness during court proceedings, advise courts of mental health alternatives to incarceration, and advocate for necessary community services and supports. Serious consideration should be given to training consumers of mental health services to serve in this role.

Another model to consider is one currently operating on a statewide basis in Connecticut. The Connecticut Department of Mental Health and Addictions Services operates jail diversion programs in all 22 arraignment courts in the state. Mental health clinicians, operating out of local community mental health centers, work with the arraignment courts to link individuals with serious mental illness and co-occurring substance use disorders with treatment as an alternative to incarceration. Outcomes data

collected by this program demonstrates that individuals diverted to treatment subsequently spend significantly fewer days in jails and psychiatric hospitals as compared with those who do not receive these services.⁹

Crisis Intervention Teams (CIT) and Other Mobile Crisis Programs

The demand is growing for law enforcement officers to become front-line responders to people with serious mental illness who are in crisis. However, there is evidence that most police officers are not adequately trained to recognize the symptoms of mental illness and to relate effectively to persons who have mental illnesses.¹⁰ For example, they may have been trained to use the standard police tactic of surrounding or closing in on an individual, but may not know that this could make the problem worse or precipitate a violent incident when they are dealing with a person in a psychiatric crisis.

Law enforcement officers know that they lack adequate training to manage this segment of the population. They want to know how to recognize mental illness, how to de-escalate a crisis situation, how to handle violence or potential violence, and what to do when a person is threatening suicide. They also want to know what community resources are available and how to gain access to them. They are eager to learn how to identify people with mental illness, who appear to be at risk of causing harm to themselves or to others. They want to know how to move those people into the mental health system rather than the criminal justice system.

This kind of mental health education is likely to be useful to all police officers, not just for those who are part of the specialized mobile crisis teams. For example, CIT programs typically include training for dispatchers, since these individuals play a key role in communicating essential information to responding police officers.

An increasing number of jurisdictions use sworn police officers who have special and extensive mental health training in the provision of crisis intervention services. These officers are members of Crisis Intervention Team (CIT) programs that are closely linked to their community mental health system. This approach is often referred to as the “Memphis Model” because it was developed in Memphis, Tennessee.¹¹

These specially trained officers may deal with mental health emergency situations on-site or act as consultants to the officers at the scene. This model places a heavy reliance on psychiatric emergency services that have agreed to a no-refusal policy for persons brought to them by the police.

The CIT model has been adopted in hundreds of communities in 35 states and is being implemented on a statewide basis in Florida, Georgia, Kentucky, Ohio and Utah. Outcomes studies conducted on CIT programs show that they are successful in reducing arrests and re-arrests, increasing referrals and participation in mental health treatment, changing officer attitudes towards people with mental illnesses, reducing officer injuries, reducing involvement of SWAT teams in incidents involving people with mental illnesses, and decreasing police shootings of people with mental illnesses.¹²

Mental Health Courts

Post-booking diversion strategies are increasingly available through specialty mental health courts.¹³ Initially, these courts were limited to hearing cases involving persons with mental illness who were charged with misdemeanors. In recent years, they have increased their purview to serve people with mental illness charged with felonies.¹⁴

In mental health courts, all the courtroom personnel, such as the judge, prosecutor, defense counsel, and other relevant professionals have experience in mental health issues and are familiar with relevant community resources. Mental health courts hear cases involving defendants with mental illness in a non-adversarial proceeding. They work with the local mental health system to identify and order appropriate treatment and they monitor the defendant's compliance with its orders. Noncompliance may involve sanctions by the court, although with many courts, these sanctions include jail only as a last resort.

The mental health court system collaborates with the local mental health service provider and other social service agencies to prepare and implement a treatment plan that includes medications, therapy, housing, as well as social and vocational rehabilitation. The goal of the treatment plan is to assure that the person has the tools and motivation necessary to achieve and maintain a timely and durable recovery. Sometimes, despite the

best intentions, community resources are not adequate to implement the treatment plan. For instance, there is often insufficient community psychiatric treatment, rehabilitation, and housing capacity in the existing mental health system to accommodate persons with mental illness diverted from the criminal justice system.

Underlying the concept of mental health courts is the principal of *therapeutic jurisprudence*, which emphasizes that the law should be used, whenever possible, to promote the mental and physical well being of the people it affects. It assumes that the application of the law can have therapeutic consequences.¹⁵ It should be emphasized that therapeutic jurisprudence does not diminish the importance of public safety, which is fully taken into account by the court.

In keeping with the “therapeutic” nature of these systems, mental health court judges typically respond to people with serious mental illnesses in a more flexible way than their counterparts in *drug courts*. For example, whereas a drug court judge may sanction a defendant who fails a drug test by sending him or her back to jail, mental health court judges are less inclined to automatically punish individuals for deviating from treatment plans. They recognize that psychiatric symptoms can sometimes interfere with compliance and thus tend to approach non-compliance more flexibly. They work in partnership with the individual and the treatment team to address barriers that may be interfering with compliance.

In a system characterized by therapeutic jurisprudence, people with serious mental illnesses charged with crimes may be diverted into programs designed to address their treatment and service needs, rather than simply being incarcerated while their treatment needs are neglected. Even individuals with serious mental illnesses convicted of serious crimes can be provided with humane and appropriate treatment while incarcerated. Generally, mental health courts facilitate linking offenders with serious mental illness to appropriate services and supports upon discharge from jail in order to enable them to successfully reenter their communities.¹⁶

In many traditional criminal courts, which are not mental health courts, the judge maintains jurisdiction over the person with mental illness, who reports directly to the court on a regular basis. In addition, the treating clinician may send periodic reports of the person’s progress in treatment to the judge or probation officer. The judge uses his or

her authority and interest in the individual to ensure that the person adheres to treatment and remains in recovery. Moreover, the person is expected to refrain from violence and illegal activity. Such arrangements have been highly successful in many non-mental health criminal courts.

Integrating Treatment and Case Management

The purpose of case management is to help people obtain the right services, in the right place, at the right time, and in the right amount, for as long as necessary to achieve a timely and durable recovery. The integration of modern concepts of case management with clinical treatment is an important component of successful outpatient treatment for all people with serious mental illness. It is particularly important for people at risk of involvement with criminal justice systems.¹⁷

Case management requires a designated professional or team of professionals who have responsibility to work with the consumer of services to identify, select, provide, and monitor the effectiveness of the chosen services and supports. The case manager/treatment team formulates an individualized treatment and rehabilitation plan in collaboration with the consumer of services, mental health professionals and criminal justice professionals. As care progresses, the case manager/treatment team monitors the person to determine if he or she is receiving treatment, has an appropriate living situation, has adequate funds, and has access to vocational rehabilitation. In addition, the case manager and/or treatment team professionals work with the person wherever he or she is living, whether alone, with family, in a board-and-care home, or in another residential setting.

Forensic Assertive Community Treatment (FACT) Programs

The Assertive Community Treatment (ACT) model focuses on consumers of mental health services with the most severe disabilities and it uses a multidisciplinary fully integrated treatment team, with a small individual to staff ratio, to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support.

Services are provided wherever the person happens to be at any given time.¹⁸

Forensic Assertive Community Treatment (FACT) programs have been established specifically to serve individuals with serious mental illnesses who have a history of cycling in and out of criminal justice systems.¹⁹ Many of these individuals have co-occurring substance-related disorders. These programs are typically staffed by teams of professionals and peers (psychiatrists, case managers, substance abuse counselors, and peer support specialists) who have relatively small caseloads. Services are carefully coordinated and integrated. They are designed to prevent or reduce incarceration and hospital admissions and to improve the person's quality of life. FACT teams engage in mobile outreach to serve people who may be in danger of de-compensation or relapse. One of the keys to the success of FACT teams is that parole and probation officers are often part of the team and thus are less apt to revoke and re-incarcerate individuals for treatment failures.

Supported and Therapeutic Living Arrangements

For most people who have a serious mental illness, survival in the community depends on an appropriately supportive and structured living arrangement. The person sometimes lives with family but it is not unusual for people who have a mental illness to live alone successfully. Nevertheless, there are times when the kind and degree of structure the person needs can be found only in a living arrangement with a high staff to resident ratio, where medication is dispensed by staff, and where recovery oriented therapeutic activities are offered. Successful models of therapeutic living arrangements include:

- Permanent supportive housing linked to health, mental health, employment and other support services;
- Group homes and other congregate living arrangements in which small groups of individuals with mental illnesses reside together, often with a full-time or part-time counselor; and
- Housing First programs, in which people who are homeless and have serious mental illnesses are provided with permanent independent housing. While

services are available and participation in these services is encouraged, people are not required to participate as a condition for entering and/or retaining housing. However, aggressive outreach, treatment, and support is provided, usually through ACT teams.²⁰ The Pathways to Housing program in New York City is an example of a “Housing First” type program.²¹

Treatment of Co-Occurring Disorders

It is estimated by mental health professionals and other professional personnel in the criminal justice system, who are knowledgeable about incarcerated persons with serious mental illness, that at least 75% of these individuals meet the DSM-IV-TR criteria for drug and/or alcohol abuse or dependence. Clearly, if treatment after release is to be successful, both the mental illness and substance abuse must be addressed concurrently.²²

These services should be integrated in the community and it has been found that the same treatment team should provide and coordinate both mental health and substance abuse treatments. This is often a long term process involving both coordinated inpatient and outpatient treatment.

Working with the Family and Peers

Family members and peers should be considered vital resources in the recovery of offenders with mental illnesses. Social support found in religious affiliations, social clubs, advocacy and peer support organizations, recreational facilities, and social service agency programs, coupled with support of family and friends are keys to reintegration into the community. Assessing problems that may develop between the person and family members or significant others is essential if contact between them is anticipated. Moreover, family members should be involved in support groups to help them during crises. In self-help programs, they can benefit from the experience of other families in similar situations and educational programs such as NAMI’s Family to Family are important sources of useful information about how to help a loved one navigate the mental health system.

Likewise, peer education and support programs such as NAMI's Peer to Peer, NAMI Connections, and In Our Own Voice are powerful mechanisms for empowering consumers to take control over their own treatment and to help others navigate the complexities of mental health and criminal justice systems. These programs and others like them should be encouraged and supported in all communities.

Crisis Services and Inpatient Treatment

In most cases, crisis care and psychiatric inpatient treatment should be the responsibility of the mental health system and not the criminal justice system.²³ As noted earlier, by the year 2006, at least 361,182 people with serious mental illness were incarcerated in jails and prisons rather than receiving appropriate mental health services. If there were not shortages of both acute and tertiary care inpatient beds in the mental health system, many of these individuals would not have come to the attention of law enforcement officers. Or if they had, they would have been transported to a crisis center, an emergency room, an acute/intermediate care psychiatric inpatient treatment facility, or a state hospital, rather than entering the criminal justice system.

Although some states and local communities have recognized the need for more crisis resources, there are still not enough of them to meet the demand. The shortage of acute and intermediate care beds continues to grow as more community hospitals close existing psychiatric units and state psychiatric hospitals remain chronically in excess of budgeted and/or licensed census. In the absence of access to an appropriate and timely treatment facility, even with the best of intentions, the highest motivation, and the necessary training to accomplish effective diversion, it will not happen.

Access to crisis services and inpatient psychiatric acute, intermediate, and tertiary care beds must become a high priority for the mental health system.²⁴ That would make it possible for a shift in inpatient focus from managing census to achieving the best possible outcome for the individual being treated. For example, stays in acute facilities would be long enough to stabilize the person and there would not be pressure to discharge in an unreasonably short time. This would have a direct impact on the number of people with mental illnesses in jail or prison because people who are discharged before

they are stabilized often find their way into the criminal justice system. It is crucial that inpatient treatment be tied closely to the community after care treatment system, so that when the individual leaves the hospital, he or she will already be integrated into community treatment and follow up.

Cultural Competency

It is important that mental health professionals understand the roles that ethnicity, race, culture, gender, and age play in the ways that mental illness manifests itself. It is also important to know how these variables should influence what treatments are offered and how they are delivered. It is only in this context that the mental health system can provide appropriate services to people of diverse racial, cultural, and ethnic backgrounds as well as persons of all ages and genders.

Necessary Expansion of Services in the Community Mental Health System

A significant increase in mental health services for persons with serious mental illness, from outpatient treatment and case management to 24-hour care, would no doubt result in far fewer people with mental illnesses committing criminal offenses. The stigma attached to people with mental illness is already a terrible burden, but that burden is magnified when they have been in a jail, prison, or forensic hospital. They have been categorized as having both mental illnesses and being offenders, which makes it extremely difficult to find community treatment and housing programs that will accept these individuals. If the goal of reducing the criminalization of people with serious mental illness is to be accomplished, the mental health and criminal justice systems must be provided with all the necessary resources to identify and treat these individuals in the most appropriate setting. It cannot be emphasized enough that the criminal justice system should not be viewed as a suitable substitute for the mental health system.

Policy Recommendations

Pre-Booking Diversion, CIT, and Training of Law Enforcement Officers

- Resources should be directed from all levels of government (federal, state, and local) to support the development and implementation of Crisis Intervention Team (CIT) programs. CIT programs have been proven to reduce costs associated with incarceration and to increase the safety of law enforcement officers and the people with serious mental illness to whom they are responding.
- Since police today are first responders to people with serious mental illness in crisis, all police officers should be trained to recognize the symptoms of mental illness and to relate effectively to persons with serious mental illness. Additionally, a subgroup of officers (approximately 25%) should receive specialized, intensive CIT training and be designated, whenever possible, to respond to calls involving people experiencing psychiatric crises.

Post-Booking Diversion

- A variety of post-booking jail diversion options should be considered and supported at state and local levels, including Mental Health Courts, diversion programs through regular, non-mental health courts, such as Connecticut's statewide jail diversion project and Memphis' Jericho Project, and Court Appointed Special Mental Health Advocates.

Linkages Between Criminal Justice and Mental Health Systems

- Strong linkages should be established at state and local levels between law enforcement, the courts, corrections and the mental health system to ensure that the mental health and related service needs of incarcerated people with serious mental illness are addressed immediately following release.

Mental Health Services and Supports

- A range of supported, therapeutic, and community-based living options should be available for people with serious mental illnesses involved or at risk of being involved with criminal justice systems. These should include:
 - Permanent supportive housing options;
 - Group homes and other congregate living arrangements; and
 - "Housing first" programs, which provide permanent independent housing and the availability of services on a voluntary basis for individuals with serious mental illness who are homeless.
- Integrated mental health and substance abuse treatment services must be available in one setting for individuals with mental illness involved or at risk of involvement with the criminal justice system. Studies suggest that at least 75% of people with serious

mental illness who are incarcerated also meet DSM-IV-TR criteria for drug and/or alcohol abuse or dependence.

- Family and peer support and educational programs are vital resources in the recovery of offenders with serious mental illnesses and should be available for all who can benefit from them. For example, the Forensic Peer Specialist model developed in New York City offers promise as a model for helping offenders with mental illnesses reintegrate into their communities.
- Adequate numbers of inpatient beds for acute, intermediate and tertiary psychiatric care must be maintained for individuals who need them. It is cruel, inhumane and highly inappropriate to use jails and prisons as substitute inpatient treatment facilities.
- Mobile crisis management teams and crisis stabilization services should be available and easily accessible for individuals in crisis who need immediate assistance. This would significantly reduce burdens on law enforcement as first responders.
- Mental health services should be culturally competent and designed to respond to the unique needs of people of diverse racial, cultural and ethnic backgrounds as well as people of different ages and genders.
- Funding for inpatient and community-based services for people with serious mental illnesses must be increased significantly so that the needs of all individuals with these illnesses are addressed. Adequate funding of mental health services will result in savings for other systems, such as criminal justice, that have in recent years frequently been forced to assume the burdens of responding to people in crisis.

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