

Task Force Report

Outpatient Services for the Mentally Ill Involved in the Criminal Justice System

A Report of the Task Force on Outpatient Forensic Services

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"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, all members of the task force, or all members of the American Psychiatric Association. The views expressed are those of the authors of the individual chapters. Task force reports are considered a substantive contribution of the ongoing analysis and evaluation of problems, programs, issues, and practices in a given area of concern." – *APA Operations Manual*.

INTRODUCTION

In this Task Force Report, the APA focuses on the development of outpatient services to reduce the number of mentally ill individuals subjected to incarceration. For more than a generation, mentally ill individuals have flooded into jails and prisons in alarming numbers where they too frequently receive substandard care. Even where treatment conditions are adequate, incarceration undermines therapeutic goals; mentally ill inmates suffer from the stress and rigors of confinement in institutions designed for punishment and security. Moreover, the dislocation of incarceration is profoundly disruptive to the provision of services and social functioning. To survive in the threatening prison environment, mentally ill inmates adopt patterns of behavior that are maladaptive in civil hospitals and community settings (Rotter et al., 2005). As a result, following release from incarceration, many mentally ill individuals are not re-integrated into their communities and receive no treatment, social services, or support. Not surprisingly, many become repeat offenders and are re-arrested, perpetuating and deepening the process of marginalization.

A study from the state of Washington illustrates this dismal cycle. A cohort of mentally ill individuals convicted of felonies was followed post-release. In the first year in the community, only 16% received any form of mental health treatment; by the end of year three, nearly 40% had been re-arrested (Lovell, Gagliardi, & Peterson, 2002). McGuire and Rosenheck (2004) report similarly bleak data.: in a large sample of homeless people with severe mental illness who entered a program of assertive community treatment case management, at the end of one year less than 12% of those with a significant criminal history had received any psychiatric outpatient services. This subgroup was much more likely to be re-arrested. Indeed, a large study of Texas inmates showed that those with serious mental disorders were much more likely to have multiple incarcerations over a six year period than non-disordered inmates (Baillargeon, 2009): see Figure 1 (non-disordered inmates risk set at 1.0). Our current outpatient approaches to mentally disordered offenders have failed.

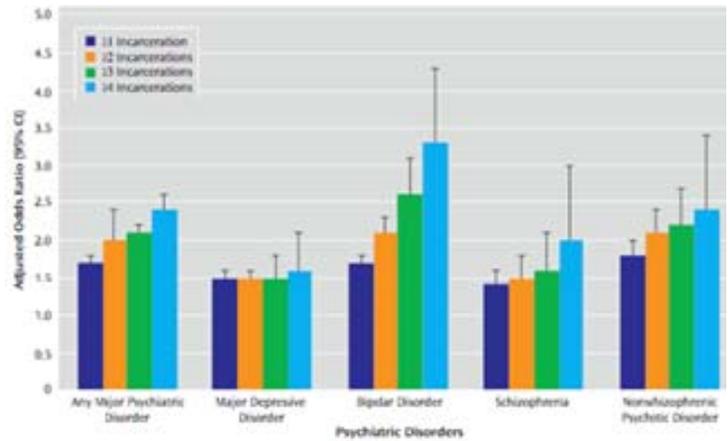


Figure 1. Risk of Previous Incarceration among Texas Prison Inmates by Presence of a Psychiatric Disorder

In the past, society relied on psychiatry to manage the problematic behavior of mentally ill individuals. This function was accomplished in a historical period of large mental institutions, loose commitment standards, and relaxed procedural protections for the mentally ill. Unlike today, arrest and incarceration of the mentally ill were not routine. In present times, the challenges of providing safe and effective care for patients who have committed criminal acts are very different and, as the Report will demonstrate, call for innovation.

This Task Force Report is intended to promote the development of innovative services for mentally ill individuals involved in or at risk for becoming involved in the criminal justice system. The need for innovation is apparent by the number of patients incarcerated, the number of mentally ill people released into the community who receive no services, and—for those who do receive services—the failure of commonly employed interventions such as assertive community treatment and case management to keep them out of jail. Available evidence suggests that outpatient services designed for ordinary patients do not address the needs of those who have become enmeshed in the criminal justice system. Yet, the Task Force is convinced that substantial progress in providing humane care can be made by adopting policy and programmatic changes outlined in this Report. Moreover, the Task Force believes that it is imperative that psychiatry resume leadership in providing care for this desperately needy population.

The Task Force Report reviews the historical factors that have led to the large-scale incarceration of individuals with serious mental illnesses. Then, the Report reviews evidence regarding the impact of ordinary outpatient services on rates of incarceration of the mentally ill. The Report then reviews characteristics of the incarcerated mentally ill. This review is intended to identify segments of the population that have not been adequately served in existing systems and those at-risk. The Report reviews innovative models for the provision of outpatient mental health services to released inmates and identifies critical issues relevant to the implementation of needed services. Finally, recommendations are made regarding changes within the field of psychiatry and the system of care for the incarcerated mentally ill.

THE MENTALLY ILL IN JAILS AND PRISONS: HISTORICAL BACKGROUND

Deinstitutionalization

The connection between psychiatric institutionalization and criminal incarceration has long been recognized (Penrose, 1939). Indeed, in the United States, the plight of the incarcerated mentally ill motivated reformers in the first half of the nineteenth century to advocate for public psychiatric hospitals (Grob, 1973). Many of the first patients admitted to the new state hospitals were drawn from jails and prisons and, as a result, the presence of the mentally ill in jails and prisons was dramatically reduced. In 1880, the government undertook

a census of “insane persons” in the United States (Wine, 1888). At the time, when the U.S. population stood at approximately 50 million, 92,000 insane persons were identified. Of these, 41,000 were in the 75 newly created state institutions. Fewer than 400 mentally ill inmates were located in jails or prisons, which at that time housed more than 58,000 people. Thus, according to the official census, less than 1% of the incarcerated population was identified as mentally ill. A few reports from the early era of institutionalization suggest that the state hospital system could not accommodate all the incarcerated mentally ill (Jarvis, 1857); and that mental illness was under-recognized in correctional settings (Chapin, Clarke, & Allison, 1898). However, with the rise of institutionalization, the issue of the criminalization of the mentally ill disappeared from the national agenda for almost a century.

By 1956, the number of people in state mental health facilities reached more than 560,000. At this juncture in history, effective treatments for psychosis were being introduced. Institutional care was largely protective, providing asylum for the seriously mentally ill. Civil commitment standards and procedures left considerable discretion in the hands of psychiatrists. Lengths of stay were long—measured in months or years—as psychiatrists gauged when patients would be safe to return to the community. However, in the 1950s, the movement that has been called “deinstitutionalization” began. The community mental health movement of this time emphasized outpatient treatment over institutional care. President Kennedy gave a substantial boost to this movement when he signed into law the Community Mental Health Centers Act of 1963 (Title II, Public Law 88-164) providing federal financial support for construction of local outpatient treatment facilities for the mentally ill and mentally disabled. In addition, state legislatures were reluctant to fund the rising costs of public sector institutional care. The pace of deinstitutionalization increased during the 1960s, with the introduction of federal health insurance programs that stimulated the rise of private sector psychiatric hospital units. On the legal front, civil commitment laws were dramatically transformed between the late 1960s and the mid-1970s (Appelbaum, 1994; Hoge, Appelbaum, & Geller, 1989). This wave of libertarian reform replaced the old “need for treatment” standard with a requirement that “dangerousness” be demonstrated. More stringent procedural safeguards, including higher standards of proof, were put into place.

At present, there are roughly 44,000 patients hospitalized in state and county facilities at any given time. Of these, it is estimated that about 14,000 are confined in forensic psychiatric hospitals, pursuant to court-ordered pre-trial evaluations or, alternatively, following criminal court adjudication as not guilty by reason of insanity (Gillece, 2009; Manderscheid, Atay, Male, Blacklow, Forest, Ingram, Maedke, Sussman, Ndikumwami, 2002). One recent review suggests that the United States is in need of an additional 95,000 public sector psychiatric beds (Torrey et al., 2008), and another has found that greater availability of public psychiatric beds (but not private ones) have a crime-reducing effect (Markowitz, 2006).

Increasing societal reliance on punishment and incarceration

During the period of rapid deinstitutionalization, there were important developments in correctional policy that helped set the stage for criminalization of the mentally ill. Beginning in the 1970s, the United States began to rely increasingly on incarceration as a solution to societal problems (Travis, 2002). This is reflected most dramatically in the rate of incarceration per 100,000 adults. For several decades, this rate held steady at about 100. Through the late 1970’s through the 1990’s, the rate steadily rose, reaching more than 500 per 100,000 (U.S. Census Bureau, 2004). At present, the United States is the global leader in the use of incarceration, with a rate of imprisonment 4 to 7 times that found in other western nations. These rates are not accounted for by higher crime rates (Hartney, 2006).

A full discussion of the factors underlying this sea change in policy is beyond the scope of this report. However, familiarity with a few of these factors is important to understanding the increased rate of incarceration of people with mental illness. First, the drug culture took root in the 1960s. In the 1970s, it was perceived that treatment-based approaches to the “war on drugs” had failed; federal and state policy makers began to turn to punishment. Indeed,

much of the increase in the incarceration rate can be attributed to drug-related offenses (Travis, 2002). It should also be noted that the widespread availability of drugs of abuse has proven to be particularly problematic for many individuals with mental illness, due to destabilizing effects.

A second important factor underlying the higher rate of incarceration has been the reduction of judicial discretion with respect to sentencing and release decisions. Previously, judges could exercise wide discretion in the imposition of sentences. Moreover, sentences were indeterminate in nature, allowing parole boards to release inmates when they saw fit. Responding to concerns about unfairness in sentencing and parole decisions, and particularly about racial discrimination and to political pressures to get tough on crime, legislatures enacted sentencing guidelines, reducing judges’ discretion (Travis, 2002). And, “truth in sentencing” legislation, eliminating or drastically reducing early parole, “good time”, and other sentence reduction schemes, has ensured that inmates serve longer periods incarcerated.

Deinstitutionalization, therefore, occurred during a period of important social and correctional change. People with mental disabilities were released into a culture in which drug use was becoming endemic, a development that would provide ongoing challenges to the young and vulnerable, especially those at risk for psychiatric illness. Ready to exercise their newly found freedom, deinstitutionalized individuals entered a crime-weary society ready to punish their misdeeds. Moreover, they faced a criminal justice system less inclined to reduce the burden of punishment on the basis of mitigating factors such as mental illness. Not surprisingly, many found their way into correctional institutions. And in subsequent decades, mentally ill individuals who had not been long-term institutionalized patients would follow.

The rise of mental illness in our jails and prisons

In the wake of civil commitment reform and deinstitutionalization in California in the 1970’s came early reports that mentally ill individuals were appearing in increasing numbers in jails, and reports from prisons soon followed (Abramson, 1972; Stelovich, 1979; Swank & Winer, 1976; Whitmer, 1980).

In the 1980s, several groups of researchers applied modern diagnostic criteria to various incarcerated populations. Employing standardized assessment techniques, they reported rates of serious mental illness several times that of the non-incarcerated population. A study of male detainees at Cook County jail found a lifetime prevalence of schizophrenia and bipolar disorder of 3.8% and 2.2%, respectively (Teplin, 1990). The Epidemiological Catchment Area (ECA) Study, a large-scale examination of the prevalence of mental disorders in the United States, reported one-year prevalence rates for schizophrenia and bipolar disorder of 5% and 6%, respectively in a sample of prison inmates (Robins & Regier, 1991). Steadman and coworkers, employing a somewhat broader definition of mental disorder, found 8% of New York State prisoners to be affected (Steadman, Fabisiak, Dvoskin, & Holohean, 1987).

In more recent years, the federal government has undertaken periodic surveys of inmates in jails, state prisons, and federal prisons, as well as those on probation. These surveys have constructed estimates of mental illness based on self-report of illness, treatment, or hospitalization. In a large sample—the 1997 Bureau of Justice Statistics (BJS) survey involved 30,000 individuals—an estimated 16.2% of state prisoners were found to have significant mental illness; 7.4% of federal prisoners; 16.3% of jail inmates; and 16.0% of those on probation (Ditton, 1999). The rate of mental disorders in subpopulations may be higher. For example, there is some evidence to suggest that incarcerated women have higher rates of mental illness than do incarcerated men (Teplin, Abram, & McClelland, 1996).

The estimates of mental illness in correctional settings have received support from collateral sources. For example, BJS surveys indicate that about 10% of state inmates are prescribed psychotropic medication (Beck & Maruschak, 2001). Based on these studies, as well as the experience of clinicians and administrators in the field, it is generally accepted that roughly 6 to 11% of jail and prison inmates have a serious mental illness (such as schizophrenia or bipolar disorder); approximately 10-15% have some form of mental disorder requiring treatment; and an even larger number—as many as

50%—may experience some symptoms during incarceration (James & Glaze, 2006). Of course, the rate of mental illness observed in a facility will depend on a variety of factors: the definition of mental illness employed, the effectiveness of institutional procedures in identifying mentally disordered inmates, and the presence of local diversion programs.

When one applies estimated percentages to the total population in corrections, the numbers are staggering. Based on the BJS estimates, there are more than 800,000 mentally ill individuals under the control of correctional authorities at any given time: 180,000 state prisoners, 8000 federal prisoners, 97,000 jail inmates, and 547,000 on probation. It is important to note that the jail population turns over rapidly, so that the annual intake is 10 to 20 times the average daily census. Thus, it is reasonable to estimate that a million or more arrests per year involve mentally ill offenders.

Similar statistics regarding rates of arrest of the mentally ill have not been kept by law enforcement agencies. However, there is some useful evidence from the previous generation of violence research, which examined the arrest rates of hospitalized mentally ill patients. Studies conducted prior to the reform era tended to show that mentally ill individuals who were hospitalized were less likely to have arrest records when compared to non-mentally ill controls; later studies showed higher comparative arrest rates (Monahan and Steadman, 1983). Taken in whole, these studies suggest that prior to deinstitutionalization the management of problematic behavior among the mentally ill relied on commitment and hospitalization. Following reform, arrest and incarceration has increased.

In retrospect, this is not surprising. Prior to reform, police authorities could rely on psychiatric interventions—in the form of institutional care—to manage mentally ill offenders' problematic, criminal behavior. Hospital beds were plentiful and lax commitment standards combined with long lengths of stay led authorities to be assured that the community would be safe. But with the onset of deinstitutionalization and commitment reform, the psychiatric system could no longer be relied upon. Psychiatric beds rapidly disappeared, so that there was no longer capacity to accommodate the mentally disordered offenders. And psychiatrists no longer controlled admission and discharge, as commitment reform brought attorneys and judges to the fore. Lengths of stay plummeted, as pressure to make way for more acute patients pushed caregivers to discharge patients who were less acute, but whose behavior remained potentially problematic if released to community settings. Increasingly, it must have appeared to police, the psychiatric system seemed less able to exert control over problematic mentally ill individuals. In the face of these new uncertainties, the familiar route of arrest and incarceration became the only reliable option available to the police to protect public safety.

Police departments, courts, jails and prisons have struggled to manage the new and rising flood of mentally ill that have entered their systems. Historically, police officers had little training in responding to crises associated with mental illness. Judges have been frustrated by the repeated appearance of mentally ill defendants in their courts, repeat offenders who do not respond to the threat of punishment in the same way, who have problems and needs that seem impossible to address from the bench, problems that require complex responses and clinical expertise. Jail and prison administrators watch stone-faced as their budgets swell with the costs of medication, their time and energy increasingly consumed with challenges their predecessors never faced. How do you recruit mental health professionals to work in the remote settings where correctional institutions often are located? How best to provide for feeding, clothing, cell block assignments of the differing populations of disturbed mentally ill defendants? And, when incarceration ends, how does one manage the process of obtaining outpatient care? Housing? Community support?

Conclusion #1: As a result of deinstitutionalization and a greater reliance on incarceration for social control, large numbers of mentally ill individuals have been swept into our jails and prisons. The status quo is unacceptable: it is unfair to rely so heavily on incarceration for problems related to mental illness. The fact that mental illness is over-represented in correctional facilities indicates that related functional and cognitive impairments are important causes of problematic aberrant behavior. Social justice requires that

services be provided to the disabled such that the need for criminal justice intervention can be reduced. At present, we are falling woefully short of this goal.

Conclusion #2: This Report focuses on the provision of outpatient services to reduce the need for relying on incarceration as a response to people with mental illness. In the opinion of the Task Force, a return to the policies and practices of large-scale institutionalization is not practicable or desirable. While some increase in beds to address the short-term needs of patients would be useful, the solutions to the problems of mentally ill offenders must be found in the outpatient sector. The mental health system must find ways of reliably addressing the clinical needs of this population, while accommodating the legitimate needs of public safety.

THE IMPACT OF ORDINARY OUTPATIENT SERVICES ON RATES OF INCARCERATION

The need for a more complete and comprehensive system of public mental health care has long been recognized. The New Freedom Commission on Mental Health (2003) detailed the deficiencies and explicitly drew the connection between lack of treatment and incarceration. In this section, the Task Force examines the evidence related to ordinary outpatient service (i.e., services not designed specifically for mentally disordered offenders).

Fisher and colleagues at the University of Massachusetts Medical Center examined the relationship between community mental health services and incarceration (Fisher, Packer, Simon, & Smith, 2000). As a result of the settlement of a class action suit, for more than a decade prior to the study western Massachusetts had received a substantially higher level of funding for outpatient adult mental health services than had central Massachusetts. In comparison with central Massachusetts, the western part of the state had nearly twice the resources per capita for a diverse range of outpatient services, including emergency services, case management, residential programs, clinical treatment, and support services. Comparing western and central Massachusetts, Fisher et al. found that the rate of hospitalization was 60% higher in central Massachusetts (396 days per 100,000 versus 247 days), which they believed reflected the lower intensity and availability of outpatient services. The research team also examined jail admissions in western and central Massachusetts over a six-month period. An overall rate of mental disorder of 9.7% was found (schizophrenia, 2.5%; major depression, 6.1%; bipolar disorder, 1.1%). No significant difference was found in the rate of mental illness among jail admissions in the two jurisdictions. Thus, it appears that the superior outpatient service system in western Massachusetts did not result in a reduction in incarceration of the mentally ill. Supporting this finding is a review of assertive community treatment and intensive case management that found these treatment modalities had little or no effect on rates of arrest (Mueser, Bond, Drake, & Resnick, 1998).

A treatment option not employed in Massachusetts at the time of the cited study is mandated outpatient treatment (also known as outpatient civil commitment). Mandated outpatient treatment is theoretically available in all jurisdictions, but is not widely employed outside of New York. The New York program of Assisted Outpatient Treatment (AOT) applies to adults with serious mental illnesses who have histories of non-compliance with treatment that resulted in violence toward self or others; admission criteria include a requirement of either hospitalization or incarceration twice within the last three years. A commitment to AOT involves a comprehensive treatment program: medication management, case management or ACT services, residential placement and related social services. These services must be in place before the commitment order is granted. By law, those who have been deemed eligible for AOT have priority in accessing services.

After AOT is in place, compliance with the treatment plan is monitored carefully. A local AOT program is in weekly contact with all service providers; this program is itself monitored by state and, in some localities, city overseers. Findings from the first five years of operation indicate that rates of arrest, incarceration, and hospitalization under AOT decreased 83%, 87%, and 77% respectively, when compared to the pre-AOT period. Beneficial treatment

outcomes were evidenced by reductions in homelessness of 74% and substantially improved functional abilities across a range of activities (New York Office of Mental Health, 2005). An independent evaluation of AOT by Swartz and colleagues (2009) found similar beneficial outcomes—including lower rates of arrest— in patients receiving mandated outpatient treatment. In this non-randomized study, patients who received similar services, but were not court-ordered to comply, did not achieve a reduction in the rate of arrest.

Conclusion #3: Our current system of outpatient psychiatry has evolved during an era of incarceration in which arrest is too commonly the response to problematic patients. Although the empirical research base is small, available evidence and clinical experience support the conclusion that something more than ordinary clinical interventions will be needed to remedy the over-reliance on incarceration of problematic mentally ill individuals. Mandated outpatient treatment, if properly funded and monitored, may be a useful option.

CHARACTERISTICS OF THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYSTEM

Why are patients who are incarcerated so difficult to engage and to treat successfully? In order to understand how the current outpatient system has failed to prevent the incarceration of large numbers of mentally ill people, so that better crafted services can be designed, this question must be answered. As this section will detail, the incarcerated mentally ill represent a select and severely disordered segment of the mentally ill population that has been alienated from formal systems of care. It is important to acknowledge that incarcerated mentally ill people bear a double burden of stigmatization. In characterizing this group, we should not lose sight of the fact that there is substantial diversity within the population, and varying problems and needs that require individualized approaches in care and services. Nonetheless, examination of group characteristics will help to explain why this population is so challenging to treat and why outpatient treatment failure is so common in existing programs.

Co-morbidities

It has been consistently reported that correctional mentally ill populations have high rates of alcohol and substance abuse conditions co-morbid with primary psychiatric disorders. Teplin (1994) examined co-morbidity in her study of mental disorders in the Cook County jail. Among male detainees with a severe mental disorder (here defined as schizophrenia, major depression, or bipolar disorder), 85% were found to have a co-morbid alcohol abuse or dependence disorder; 58% were found to have a drug abuse or dependence disorder (non-exclusive). Rates of primary substance abuse disorders in the incarcerated population as a whole are high. In the ECA Study, the rate of any substance abuse disorder was found to be 72% in the prison sample (56% alcohol related, 54% related to other drug use) (Robins & Regier, 1991). Based on its survey results, the BJS reported that mentally ill inmates when compared with non-mentally ill inmates had significantly higher rates of use of drugs and alcohol at the time of their offense and in the month prior to offense (Ditton, 1999).

Individuals with mental illness and substance abuse disorders, in general, have worse prognoses than those with uncomplicated mental illness. Co-morbidity is associated with a higher degree of psychotic symptoms, depression and suicidality, violence, lower functioning, higher rates of non-compliance, treatment relapse and rehospitalization, and HIV infection (Osher & Drake, 1996). Inmates with co-morbid mental illness and substance abuse disorders may be systematically excluded from treatment programs within correctional institutions (Hills, 2000). The availability of inpatient and outpatient programs equipped to address this population following release to the community is not sufficient to serve those in need. Moreover, anecdotal evidence suggests many of the programs that do exist are unwilling to serve correctional populations or those recently released from incarceration. Finally, as previously noted, intoxication is a very common correlate of criminal

behavior. Thus, recidivism is likely to be the outcome of relapses, which are a common feature of the course of substance abuse disorders. For example, a study in Massachusetts comparing mentally disordered offenders with and without a substance abuse diagnosis found higher rates of re-incarceration in the dual diagnosis group (Hartwell, 2004).

A second important co-morbid condition is Antisocial Personality Disorder (APD). In a study of jail inmates, Abram and Teplin (1991) found rates of APD ranging from 68% in those with schizophrenia and major depression, to 82% in those with bipolar disorder. Approximately 40% of the incarcerated population is estimated to have a diagnosis of APD (Hare, 1983). APD co-morbidity also greatly complicates the treatment and management of mentally disordered offenders because it is associated with manipulative behavior and a predisposition to commit criminal acts (DSM-IV-TR, 2000).

Conclusion #4: Outpatient programs deployed to provide care for mentally ill individuals enmeshed in the criminal justice system must be designed to treat and manage patients with co-morbid substance abuse problems and antisocial personality disorder.

Social Disabilities

Homelessness has been consistently found as a correlate of incarceration for the mentally ill. BJS statistics reveal that people with mental illnesses have roughly double the rates of homelessness as those without mental illness (state prisoners, 20% versus 9%; federal prisoners 19% versus 3%; jail inmates, 30% versus 17%) (Ditton, 1999).

Homelessness among the mentally ill is associated with serious alienation from health systems and family, and treatment failure. Substance abuse disorders contribute to the problem. McGuire and Rosenheck (2004) reported relevant data from the Access to Community Care and Effective Services and Supports (ACCESS) demonstration project, which involved 18 sites in nine states. In this project, 5774 homeless individuals with severe mental illness were provided comprehensive, integrated services, including assertive community treatment and intensive case management. The sample was grouped into three, roughly equal groups, based on incarceration history. A strong association was found between co-morbidity with substance abuse and incarceration. Homeless mentally ill people with no history of incarceration had rates of co-morbid alcohol dependence (26%) or drug dependence (25%), significantly lower than those with a lifetime incarceration history of six months or less (alcohol dependence, 44%; substance dependence, 37%); and those with more than six months incarceration history (mean, 48.9 months; alcohol dependence, 57%; drug dependence, 51%) (Figure 2.).

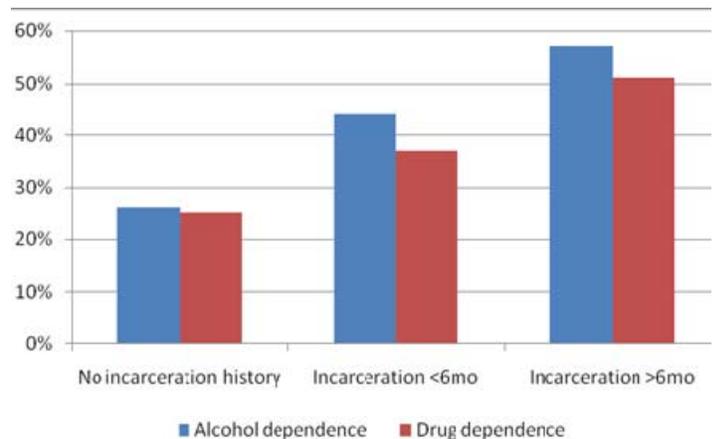


Figure 2. Adapted from data presented in McGuire and Rosenheck, 2004.

Those with long-term incarceration histories (greater than six months) also exhibited higher scores on psychiatric symptom measures. In a one-year follow up, those with the longer incarceration histories spent more time in jail, and had

lower service utilization, including outpatient treatment contacts, engagement in employment services, and substance abuse services. In addition, those with incarceration histories received lower public support payments.

Unemployment or reliance on federal or other public assistance is disproportionately found in the incarcerated mentally ill population. At the time of arrest or conviction, 39% of mentally ill state prisoners, 38% of mentally ill federal prisoners, and 47% of jailed mentally ill are unemployed (Ditton, 1999). These rates exceed those found in non-mentally ill prisoners.

Conclusion #5: Outpatient programs for people with mental illness must be prepared to address the problems related to chronic disability, unemployment, and homelessness which are especially high among those with histories of incarceration.

Risk of Violence

The literature on the relationship of mental illness to violent or criminal behavior is voluminous. In mentally ill populations, a strong relationship has been established between substance abuse co-morbidity and violent behavior. In a carefully designed study, Steadman and associates (1998) followed more than 1000 patients who had been hospitalized for mental illness and compared their violent behavior with that of a comparison non-mentally ill group from the community. Data were collected from the mentally ill group for one year following discharge from the hospital. Based on patient and family reports, released patients with no co-morbid substance abuse diagnoses were no more likely than the comparison subjects to commit a violent act. However, patients who were co-morbid for substance abuse diagnoses were significantly more likely to be violent during the follow up period (one year prevalence rate of violence was 31%, compared to 18% in released patients without co-morbidity). In a re-analysis of ECA study data, Swanson and colleagues (1990) found a substantially greater risk of violence in community respondents who were dually diagnosed with mental disorder and substance abuse compared to those with mental disorder alone.

As discussed above, the mentally disordered correctional populations have high rates of these risk-enhancing co-morbid disorders. Therefore, it is not surprising to find evidence of violent behavior among incarcerated mentally ill people. The BJS data support this conclusion (Ditton, 1999). Based on conviction offenses for prisoners and probationers, and charges faced for jail detainees, the BJS found higher rates of violent offenses in mentally ill inmates when compared with non-mentally ill inmates (state prisoners, 53% compared with 46% in non-mentally ill; federal prisoners, 33% and 13%; jail inmates, 30% and 26%; and probationers, 28% and 18%). The increased rate of violent offenses among the mentally ill extended to comparisons of inmates who were repeat offenders. Baillargeon and colleagues (2009) examined a cohort of more than 79,000 Texas inmates and found that those who were mentally disordered were more likely to have committed assault offenses when compared with non-disordered inmates. Those with more serious disorders, such as schizophrenia and psychotic disorders, were more likely to have assault, homicide, and robbery offenses.

It is important to keep in mind that mentally disordered offenders are a diverse group. While many are charged with or convicted of a violent offense, a substantial number are not. Indeed, as the BJS data summarized above indicates, most jail detainees with mental illness have been incarcerated for non-violent offenses (Ditton, 1999). Nor is it necessarily correct to conclude that those charged with violent offenses are best managed in the criminal justice system. Many may be safely diverted to treatment programs. On the other hand, from the standpoint of treatment providers and outpatient mental health systems, some individuals who are violent, homeless, and suffering co-morbidity may require specialized approaches to be successfully and safely accommodated in treatment programs.

Conclusion #6: Service programs must be prepared to manage patients with significant risk for violence. Programs that exclude mentally ill offenders charged with or convicted of violent offenses thereby eliminate a significant proportion of the incarcerated

population. Programs that are intended to serve this group of mentally ill offenders with violent offense histories may require specialized approaches.

Inadequate Treatment in Correctional Settings

The quality of care in correctional facilities has been the subject of scrutiny and litigation. This section summarizes the findings of recent studies with the purpose of highlighting aspects of correctional treatment that are problematic from the perspective of community providers.

Jails

It is very difficult to provide mental health services in jails, which house a mix of pre-trial detainees and post-adjudication inmates serving short terms of incarceration (generally, less than one year). Most arrestees are detained for brief periods: typically a matter of days. Identifying mental illness, screening for emergencies, verifying medication regimens, and referral to professional services are substantial challenges for many facilities. In fact, many mentally ill offenders are not identified at all before release, or are identified weeks or months after incarceration. The failure to identify mental illness at admission results in interruption of ongoing medication regimens or in delays instituting effective treatments for noncompliant patients. The intervening period without treatment may lead to serious relapse or bizarre behavior that stigmatizes the inmate for the duration of incarceration.

As part of a National Institute of Justice sponsored initiative, Steadman and Veysey (1997) surveyed 1053 jails of varying sizes regarding the mental health services provided; conducted more extensive telephone interviews with 100; and visited 10. They found that 84% of jails reported less than one-tenth of inmates received any kind of mental health service. Crisis intervention programs were available in only 43% of jails; psychiatric medications in 42%; inpatient care in 72%; special housing in 36%; and discharge planning in 21%. Smaller jails tended to provide no services beyond suicide screening and prevention. Case management or similar services designed to link detainees to treatment on release were seldom provided.

Discharge planning is particularly difficult in jails. Release dates for pre-trial jail detainees are often not certain. Unlike a hospital setting where therapeutic goals drive release, mentally ill detainees are released based on the vagaries of their legal cases (e.g., charges dropped, bail made). As a result, detainees with mental illnesses may be released with no, or inadequate, discharge planning.

Prisons

Recent government reports provide some insight into the scope of mental health services in state prisons. The National Commission on Correctional Health Care, in a recent report to Congress (2002a), noted, "most jails and prisons do not conform to nationally accepted guidelines for mental health screening and treatment." Comparing federal surveys from 1988 and 2000, Manderscheid and colleagues (2004) concluded "the growth in prison facilities and the growth in prisoner populations are outstripping the more meager growth in mental health services," and warned that services are becoming less available. The inadequacy of services is illustrated by examining unmet treatment needs. Examining the status of mentally ill state prisoners due to be released within 12 months, Beck (2000) found 43% had not received treatment. In addition, only about 20% of inmates with alcohol or substance abuse problems—not necessarily co-morbid—had received treatment.

Many barriers to treatment exist in correctional settings, not least of which is inadequate funding. Other barriers that have been identified include inadequate training of correctional officers in identification and management of inmates with mental disorders, poorly trained mental health professionals, institutional bias toward characterizing the mentally ill as malingers, and the use of segregation units to manage disruptive behavior caused by mental disorder (Center for Mental Health Services, 1995; National Commission on Correctional Health Care, 2002a, b; The Correctional Association of New York,

2004). In addition, in many institutions inadequate protection of privacy undermines treatment of the mentally ill: some inmates choose to forgo assessment and medications rather than risk being preyed upon by inmates who target those identified as impaired. And facilities often have no method to enforce treatment when psychotic inmates refuse medication.

Maladaptive behavior resulting from incarceration

Jails and prisons have cultures that often lead to maladaptive behaviors in mentally ill offenders that subsequently undermine treatment (Rotter et al., 1999). In a process sometimes referred to as "prisonization," inmates are acculturated to distrust institutional staff (including caregivers), and to show strength, demand respect, and hide weakness. As a result, many mentally ill inmates do not seek treatment and, when identified by mental health staff, show lack of involvement in treatment and therapeutic activities; many refuse medication rather than be identified as weak and potentially vulnerable. Moreover, mentally ill inmates may learn to use intimidation and violence as accepted modes of social interaction. These behaviors can undermine their relationships with treatment providers in the facility. Upon discharge, community mental health providers unfamiliar with the norms of correctional institutions view these behaviors as indicative of deeply engrained resistance, antisocial pathology, and lack of motivation, resulting in adverse effects on treatment relationships (Carr et al., 2006).

Conclusion #7: Because of the multiple obstacles to delivering clinical care in custody, providers of transitional services and outpatient care must take treatment deficiencies and resulting unmet needs into account when they develop care plans.¹

INTERNATIONAL PERSPECTIVES

People leaving jails and prisons in the United States are usually treated by the same psychiatric services that treat other patients. In other countries, a similar range of clinical challenges has sometimes led to the development of specialized services. In the U.K. and some other European countries forensic psychiatry is essentially a service-based discipline (Wilson and MacCulloch, 2007) and forensic psychiatrists, individually and collectively, have been instrumental in the development of these outpatient-based programs. In contrast, in the United States, the historical roots of forensic psychiatry are to be found in performing court-ordered evaluations and providing expert witness services. In recent years, while some U.S. forensic psychiatrists have adopted a more treatment-based focus, the services in which they work generally have been based in correctional institutions or forensic hospitals, not outpatient settings.

Where specialized forensic out-patient services have developed elsewhere in the world, several distinct rationales have been offered. Canadian teams have been designed to assist re-integration into the community re-integration to reduce rates of re-incarceration and to improve the quality of life of mentally disordered offenders (see Wilson et al., 1995). In the U.K. forensic outpatient provision has been seen as a means by which forensic psychiatric inpatient admissions can be shortened (Judge et al., 2004). The key administrative distinction between types of services derives their relationship to generic services for adult patients living in the community. Specialist forensic clinicians

¹Over the last 40 years, the APA has advocated to improve the plight of the mentally ill in our jails and prisons. The APA has called for psychiatric services in correctional settings to be provided at the same level as that provided in the community, in a timely manner, and in a humane and therapeutic environment (APA Position Statement, 1974, APA Position Statement, 1988). A generation later, the quality of care in our correctional settings remains woefully inadequate (Center for Mental Health Services, 1995; National Commission on Correctional Health Care, 2002a, b; The Correctional Association of New York, 2004). Addressing the problems associated with the fragmentation of care is critical to improving the outcomes of the mentally ill in correctional systems. Continued advocacy and, perhaps, litigation is necessary.

are either integrated into existing mental health teams or work in separate, parallel, services. Parallel services, at least in the UK, have been characterized as having physically separate team bases, separate referral meetings, specialist management lines, specialist clinical supervision, protected funding, specialist training of staff, good links with criminal justice and capped caseloads (Mohan et al., 2004). These dedicated specialty groups seem to have fostered a shared sense of mission and brought a more informed approach to care.

In Denmark, Finland and Italy, the outpatient treatment of mentally disordered offenders is provided by general psychiatry (Sestoft and Engberg, 2000; Eronen et al., 2000; Traverso et al., 2000). New Zealand has also developed parallel systems of outpatient care for patients leaving forensic inpatient units, these patients also being handed on to general psychiatry after two to three years (Brinded, 2000). In Austria, however, parallel systems of care in some parts of the country have been blamed for the reluctance of general psychiatrists in other parts to care for offender patients (Schanda et al., 2000). In Sweden a "forensic pseudo out-patient service" has developed in parallel with general psychiatric services. Patients are placed on leave from inpatient forensic units for extended periods, living in the community while they continue to receive treatment from the hospital that has discharged them (Belfrage and Fransson, 2000).

Germany's outpatient forensic services are directed largely to discharges from forensic hospitals. They have suffered by virtue of their being unable to take advantage of the economies of scale available to their generic equivalents. Theoretically forensic patients have available to them the same services as other clients. Twelve percent of patients in one forensic psychiatric hospital in the 1990s, however, were there because no services were available for them in the community (Nedopil and Banzer, 1996; Müller-Isberner et al., 2000). These problems have been addressed in part by the development of "shared" case management, under which general psychiatric services remain involved with, and responsible for, each forensic patient (Freese, 2003). Forensic services provide both care and advocacy within an ACT model and aim to transfer patients to general psychiatry when they are clinically stable in their community placement (Seifert et al., 2003).

Canada's Inter-Ministerial Project (IMP), introduced to assist community re-integration of mentally disordered offenders leaving prison, has provided some of the most assertive management. Caseworkers contact their clients frequently and the literature includes descriptions of clinicians transporting clients to services. Caseworkers liaise with community agencies and act as advocates for clients. IMP clients have been shown to have fewer jail days than those in a comparison group and longer intervals before next contact with criminal justice (Wilson et al., 1995). Those administering such services see the key ingredient as "specialized social support." In Holland, forensic psychiatrists staff prison services for mentally disordered offenders. Dutch reports blame the small scale of forensic outpatient service provision for the relative lack of research describing its function and level of effectiveness (van Merle, 2000).

The international literature identifies several advantages to parallel forensic outpatient provision. Specialized services can create economies of scale and help staff to develop specialized skills. Those specialized skills, in turn, can allow the identification of previously unrecognized needs and the development of new treatments. Psychological services in particular, including anger management and specialist treatment for sex offenders, may be able to be provided only when a specialist service has concentrated sufficient demand to make its provision viable (Buchanan, 2002). In Australia services for those convicted of stalking or threatening others have developed following a similar rationale (Warren et al., 2005). Australian descriptions also aspire to a greatly expanded role for outpatient forensic services, arguing that forensic services to prison and general hospitals should be a development of outpatient provision, not the other way around (Mullen et al., 2000).

Several disadvantages of separate provision also recur in the literature. Specialized services can become marginalized, affecting staff morale (Bhui et al., 2000) and increasing the stigma that attaches to forensic services (Gunn, 1977). Opponents of parallel services complain also that services should be designed to reflect the natural histories of the clinical conditions from which

clients suffer, not their criminal histories (Burns, 2001). Finally, locating forensic clients within a separate service inevitably reduces the exposure of generic services to these patients with a consequent reduction in those services' skills and comfort in caring for people who face criminal charges or have histories of imprisonment.

There is a lack of empirical data to complement the enthusiasm of the advocates of different approaches. To the extent that lessons can be drawn from qualitative descriptions it seems that services for mentally disordered offenders leaving prison are likely to contain many of the elements of an "assertive treatment" model, whether or not this is backed up by legal sanctions. Those services are likely to emphasize liaison with other health and criminal justice agencies, including substance abuse services and probation. They can often be provided from within general psychiatry. Subject to considerations of critical mass, however, it may make sense to develop separate services, especially where specialist needs are not currently met by general services. If this is done, experience outside the U.S. suggests that safeguards will be necessary to guard against the isolation and stigmatization of forensic services and their clients.

More empirical study is needed to evaluate the systems described here. As noted, one study of the Canadian system shows superior outcomes in the form of reduced jail days and criminal justice contact. One study in Great Britain found increased rates of mental illness among the incarcerated on par with that in the U.S. summarized earlier (see Brugha et al., 2005). A review article summarizing surveys from a number of western countries concluded that the prevalence of mental illness in incarcerated populations fell within a narrow range. Thus, it appears that the problem of incarceration of mentally ill individuals is common in westernized nations, and that no country has found a comprehensive solution.

Conclusion #8: A number of models for providing treatment to mentally ill individuals connected to the criminal justice system have been described in the international literature. These models may provide a starting point for development of services in the United States. However, there is no empirical basis for selecting any particular model.

Conclusion #9: Separate, specialized services have advantages related to applying expert knowledge and enhanced commitment to the mission. However, there is some risk of further stigmatizing the patient group. Attention to the size and feasibility of providing services to smaller populations is important in determining whether to provide specialized services.

EMERGING DISCHARGE AND TRANSITION PLANNING PROGRAMS FOR REDUCING INVOLVEMENT OF THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYSTEM

In this section, the Task Force reviews discharge and transition planning programs that have been developed in the United States to reduce recidivism. These programs are outpatient-based and involve linking released mentally ill inmates to community-based outpatient programs. This report does not encompass programs that are within the control of the criminal justice system and based on the threat of incarceration, such as mental health courts, and treatment provided under conditions of probation and parole. Diversion and management programs of this nature may be useful in reducing incarceration of mentally ill offenders; they are well summarized on the Council of State Governments Criminal Justice Mental Health website (<http://consensusproject.org/programs>).

In ordinary hospital settings, it has long been recognized that careful attention to discharge planning is necessary to reduce relapse and re-admission rates. Correctional institutions have begun to appreciate the importance of discharge and transition planning as the problematic nature of prisoner re-entry to society has received considerable attention over the last several years (Travis, 2002). Facilitating successful return to the community and re-integration into family, work, and other social roles serves multiple purposes. In general, released inmates who are able to make a successful

transition are less likely to recidivate or to place other burdens on societal resources.

There are many barriers to prisoner re-entry that result from a variety of social policies, or that occur as a consequence of incarceration. These barriers disproportionately affect the mentally ill population. Prisoners, particularly those being released after lengthy prison terms, often are alienated from their families and communities. This is particularly true of mentally ill prisoners, who often have become estranged from families as a result of their psychiatric disturbances and the criminal behaviors frequently associated with their illnesses. In addition, they face pervasive societal stigmatization of mental illness, as well as that related to incarceration.

Social policies further impede the transition process. Mentally ill inmates are disproportionately reliant on public assistance and SSI or SSDI benefits in order to obtain needed treatment and to ensure continuity of care following release from prison. However, these benefits are discontinued during incarceration and, following release, the process of reinstatement may take 45 to 90 days or longer. This process is not automatic; negotiating the bureaucracy may be beyond the abilities of some of the serious mentally ill. In the absence of medical and fiscal benefits, the prospects for receiving treatment or obtaining psychotropic medication are bleak.

Barriers to transition extend to housing and general public assistance. As previously discussed, the burden of homelessness is especially high on the incarcerated mentally ill. Those who have served time for violent offenses may face exclusion from Section 8 and other public housing. Drug-related felons may face a lifetime ban from federal public assistance and food stamps.

Mentally ill individuals released from incarceration face significant barriers to receiving care. The public mental health system is increasingly resource-constrained and, in many jurisdictions, access to outpatient services is restricted or prioritized to patients released from civilian hospitals. In other cases, services may simply not be made available to the incarcerated population. One of countless possible examples involved a class action lawsuit in New York City concerning the lack of programs for mentally ill individuals with substance abuse disorders who have been ordered into treatment as a result of parole violations. Because treatment programs were not available, it was alleged, these inmates could not be released and were obligated to serve their time in prison (*William G. and Walter W. v. Pataki*). At present, the legal and regulatory framework supporting discharge planning is weak. Correctional institutions are required to provide care to individuals with serious medical needs housed therein (*Estelle v. Gamble*, 1976), but only recently have correctional facilities been required by courts to consider the need for aftercare planning (see, e.g., *Wakefield v. Thompson*, 1999).

Outpatient treatment options are limited due to some providers' fear of former inmates and concerns about liability for their actions. Maladaptive behaviors that patients have learned during incarceration—distrust of caregivers, use of intimidation, posturing as "strong" rather than acknowledging need for help—heighten concerns about safety, undermine treatment relationships, and are not well understood by psychiatrists in community settings (Rotter et al., 1999). The Re-entry After Prison (RAP) program is an innovative attempt to address these behaviors in mentally ill inmates. RAP employs cognitive behavioral treatment (CBT) and psycho-educational techniques to help participants relinquish maladaptive behaviors acquired in jail and prison, and to replace them with more adaptive skills (Rotter et al., 2005; Carr et al., 2006; Rotter, in press). A complementary educational program directed toward clinicians, SPECTRM (Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management) seeks to enhance the therapeutic alliance between community-based providers and mentally ill patients who have acquired maladaptive behaviors during incarceration. SPECTRM aims to overcome traditional treatment staff reluctance to work with patients who have correctional histories by promoting understanding of their maladaptive behaviors. The program also teaches methods of engaging this patient population more effectively (Rotter et al., 1999).

Jail Transition Programs

Discharge planning is essential to ensuring continuity of care upon release from incarceration. A survey of jail services (Steadman & Veysey, 1997) found that discharge planning was available to about 20% of discharged mentally ill inmates; smaller jails provided this service less often. An important difference between discharge planning in jails and in prisons arises because jails hold pre-trial detainees as well as sentenced inmates. Detainees are often released within a few days. Therefore, discharge planning for detainees must, of necessity, occur in a context of incomplete information, ongoing mental health needs assessment, and uncertain release dates. Jail planning processes for detainees resemble crisis intervention programs (Hartwell & Orr, 2000).

Discharge planning for those released from jails has received increased national attention in the wake of a class action settlement requiring New York City to provide discharge planning services to inmates with mental illness released from Riker's Island, one of the largest jails in the country (Brad H. v. City of New York, 2003). In 2003, the City of New York entered into a settlement agreement with a class of individuals certified by the court as eligible for discharge planning from the New York City Jails. Under the stipulation of settlement, the City agreed to provide class members with a number of services in preparation for release, including: referrals or appointments to providers in the community, a supply of medication and/or prescriptions, Medicaid applications, public assistance (welfare) applications, transportation and referrals for supportive housing. New York continues to operate under this stipulation of settlement.

In recent years, a few specialized programs have emerged, designed to manage mentally ill inmates in the re-entry process and in the post-release period. These innovative programs, which have embraced the dual role of improving the treatment of this population and reducing rates of recidivism, have reported success, although in small or uncontrolled studies (Project Link, 1999; Ventura, Cassel, Jacoby, & Huang, 1998; Lambert, Weisman, Schwarzkopf, Price, Ashton, & Trompeter, 2001; The Thresholds State, County Collaborative Jail Linkage Project, 2001). A survey of more than 300 county behavioral health directors resulted in the identification of 16 programs in nine states involving the management of the mentally ill upon release from incarceration (Lambert, Weisman, & Faden, 2004). Thirteen of the 16 programs addressed re-entry and post-release management of ordinary mentally ill jail inmates (the remaining three included two diversion programs and a specialized service to manage insanity acquittees).

In 1998 the state of California established the Mentally Ill Offender Crime Reduction Grant program (MIOCRG) that provided more than \$80 M in grants to 30 programs in 26 counties to develop and evaluate projects to help mentally ill offenders avoid further involvement with the criminal justice system (Mentally Ill Offender Crime Reduction Grant Program, 2004). Grant recipients were free to design programs to meet local needs and to leverage existing resources. The programs that emerged varied in admission criteria and the precise composition of services.

Grant recipients were required to randomize offenders into two groups: one receiving experimental, enhanced services and the other receiving treatment as usual; all to be followed for two years post-release. Twenty programs provided data suitable for analysis, involving a total of more than 4700 inmates. Inmates receiving enhanced services had better criminal justice outcomes than those who received routine services. In the follow up period, they were booked less often (53% versus 56%), convicted less often (35% versus 38%), were less likely to be jailed (54% versus 57%) and spent less time in jail (13.7 versus 15.2 days). Larger differences were found in treatment outcomes. At the end of the follow up period, those receiving enhanced services were less likely to have a drug problem (45% versus 55%) or an alcohol problem (38% versus 49%). Functioning, as assessed by the Global Assessment of Functioning Scale, indicated that those receiving enhanced services were less likely to worsen (21% versus 32%). Similar differences were found in quality of life and social measures: those receiving enhanced services were less likely to be homeless (7% versus 12%) and to be economically insufficient throughout the follow up period (30% versus 53%). All findings were statistically significant.

Additional analyses from the MIOCRG provide preliminary evidence regarding who might be most likely to benefit from transition programs. As evidenced by a lower likelihood of being booked for a criminal offense during the follow up period, inmates who were more than 30 years old (52% versus 58% who received treatment as usual), had more extensive criminal histories (63% versus 72%), and did not have substance abuse disorders (48% versus 52%) benefited more.

Qualitative evaluation of the various programs resulted in the identification of several factors related to success. These included interagency collaboration and multi-disciplinary partnerships, comprehensive and flexible services, intensive case management, involvement of the court, mental health courts, assistance with benefits, use of flex funds, and residential assistance (MIOCRG, 2004).

In its final evaluation of MIOCRG, the California Board of Corrections identified assertive community treatment as the most common element, reported by 19 of the 30 programs. The second most common feature was the use of mental health courts (9 programs). Three major strategies were identified within the programs: the use of multidisciplinary teams, intensive case management, and flexible service delivery.

While there were substantial challenges, these programs resulted in subjects being more comprehensively diagnosed across psychiatric and social functioning, more quickly provided with services, and more closely monitored to permit quick interventions in the event of relapse, decompensation, or new illegal behaviors. In some counties, the increased mental health costs were offset by reduced criminal justice costs, though this analysis was limited by the short-term (two year) nature of the grant funding and data collection.

The GAINS Center has published a best practices model for discharge planning (Osher, Steadman, & Barr, 2002). The APIC model (APIC stands for assess, plan, identify, coordinate) is a pragmatic approach that is named for its four steps: assess, plan, identify, and coordinate. These elements have been expanded upon, as follows (Hoge, 2007):

- Assess the inmate's clinical and social needs, and public safety risks. This assessment should identify unmet treatment needs, including treatment of alcohol- and drug-related problems. In addition, transition planners should review the inmate's past record of compliance and their current level of interest in community-based treatment following release. Review of pre-incarceration treatment records and consultation with family members will be necessary in some cases. The inmate's plans and prospects for meeting housing and financial needs should be reviewed. The assessment of public safety risks should focus on past violent and criminal conduct. Efforts should be made to identify factors related to problematic behavior, particularly symptoms of mental illness, noncompliance with medication, and substance abuse.
- Plan for treatment and services required to address the inmate's needs. A comprehensive plan should be constructed that addresses the inmate's needs. The plan should identify and prioritize services necessary for a successful transition, including services needed to minimize the risk of recidivism. Inmates with serious mental disorders or significantly impaired decision-making capacities should be considered for long-term psychiatric treatment, guardianship, or, in some jurisdictions, outpatient civil commitment. Coercive measures should be strongly considered for inmates who have a pattern of noncompliance and symptoms of mental illness that have been associated with violent behavior.
- Identify required community and correctional programs responsible for post-release services. The availability of services will vary considerably from community to community. Transition planners should maintain lists of providers and programs willing to accept released inmates.
- Coordinate the plan to ensure implementation and avoid gaps in care with community-based programs. Special assistance should be given to the more serious mentally ill inmates who may have difficulty making and keeping appointments, negotiating transportation, or renewing SSI or SSDI benefits. Ideally, community-based providers will meet with their correctional counterparts and the inmate prior to release.

Prison Transition Programs

Given the longer period of incarceration and greater investment of resources at the point of release, there is greater opportunity for comprehensive discharge planning. However, the literature contains no descriptions of the range of discharge planning services typically provided by prisons. Anecdotally, it appears that transitional services in many prisons consist of supplying a few days or weeks worth of medication and a list of providers in the community.

Since 2001, the Maryland Division of Corrections (MDOC) and Baltimore Mental Health Systems, Inc. have collaborated to provide male prisoners with mental illness nearing their release dates with transitional mental health programming. In partnership, mental health and MDOC social work staff prepare inmates during the last few months of the incarceration for release. Programs include stress management, assertiveness training, and budget management as well as more traditional mental health treatment. In addition, case managers from Baltimore (the jurisdiction of origin for 70% of the MDOC) enter the prison to meet with the inmate during the last few months to establish a relationship and to work on developing a community transition plan. This case manager continues to work with this inmate for several months after release, ultimately transferring responsibility for care to other community agencies. Of 215 individuals served in this program between 2001-2005, 53% remained in the community after 2 years, 35% were returned to DOC on technical violations, and only 12% were re-incarcerated on new charges. A recent workgroup in Maryland recommended that this initiative be broadened to include all other jurisdictions in the state. (Final Report, Maryland House Bill 990/Senate Bill 960: Adult Criminal Justice/Mental Health Workgroup, January 2007)

Second Chance Act: Community Safety Through Recidivism Prevention

The Second Chance Act: Community Safety Through Recidivism Prevention (also known as the Second Chance Act of 2007, enacted as Public Law 110-199) is a new federal initiative designed to ease the burden of prisoner re-entry. The Act authorizes federal grants to government agencies and community based organizations to provide employment assistance, substance abuse treatment, housing and other services with the goal of reducing recidivism and violations of probation and parole. The Act covers offenders in jails, prisons, and juvenile facilities. Congress has approved \$25 M to fund programs in 2009 for state and local demonstration projects. Evidence of positive outcomes is to be demonstrated by improved recidivism rates and increased participation in substance abuse and mental health services. The Act also includes funds for the establishment of a database to enhance the availability of information regarding mental health and medical services, substance abuse treatment, employment, housing, transportation and other services to improve the re-entry process. Substance abuse treatment, mental health services, case management and aftercare programs are eligible for funds. Mentally ill prisoners leaving federal incarceration are given priority in receiving services.

Mentally Ill Women in the Criminal Justice System

There are a number of areas of special need for women re-entering the community. First of all, women inmates have high rates of substance abuse and mental illness (Green et al., 2005; Jordan et al., 1996; Morash et al., 1998; Teplin et al., 1996). About 75% of women in jails and 73% of women in state prison report a mental health problem (James and Glaze, 2006). In a sample of women entering jail, over 80% met criteria for a lifetime psychiatric disorder, and 70% were symptomatic during the preceding six months. Rates were higher than community rates for all disorders except for schizophrenia. (Teplin et al., 1996) In a sample of women entering prison in North Carolina who received diagnostic interviews to assess prevalence of eight different psychiatric disorders, about half the women interviewed met criteria for one or more disorders. Prevalence rates were highest for substance abuse disorder

and antisocial personality disorder, but depression rates were also higher than in a community sample (Jordan et al., 1996).

Incarcerated women also have very high rates of trauma history (Morash et al., 1998; Green et al., 2005; Jordan et al., 1996). Green and colleagues (2005) found lifetime rates of trauma exposure as high as 98% in a sample of female jail inmates. Jordan and colleagues (1996) found that 78% of female prisoners reported a lifetime history of trauma, while 30 % reported active PTSD symptoms within the previous six months. Teplin and co-workers (1996) found that 33.5% of female pretrial detainee had PTSD.

Women who are trauma victims will need ongoing treatment for trauma issues so they can learn better ways of interacting with the world. They may need intensive work on self-esteem in order to avoid repeating the mistakes of the past. Often lacking job skills, they will need job training in order to earn a steady income and avoid returning to unhealthy dependent relationships (Green et al., 2005).

Two thirds of incarcerated women have children under the age of 18 (Morash et al., 1998). Women with children will need a safe place for the children to live. If they are going to work or study, they will need safe and reliable childcare arrangements. They will need access to health care for their children and for themselves. Many women also need to learn parenting skills. If they have been involved with the street drug culture they may never have learned good parenting and may feel overwhelmed with some of the new tasks. They often have unrealistic expectations of their children, use corporal punishment to maintain control and may use their children to further their own needs (Green et al., 2005).

Access to routine medical care is very important. Incarcerated women often have significant health problems in addition to mental health and substance abuse issues. If they have been involved with street drugs they are at risk for HIV, hepatitis and tuberculosis. They have often neglected their health and have developed other common health problems as well. If access to health care is difficult, they will not tend to these issues. Given their limited job skills, they are not likely to obtain good employment-related health insurance; without insurance, access is further limited.

Access to mental health and substance abuse services is also of key importance. Women released from a term of incarceration often will need ongoing treatment for a variety of behavioral health problems, including PTSD and substance abuse disorders. If they are not able to access these services in a timely fashion, their entire reintegration plan can be jeopardized and they may quickly end up back in the criminal justice system.

Few re-entry programs for women have published in the traditional professional literature, although it is likely that there are local programs which have been developed with considerable thought but which have not yet been reported formally. The same few are often mentioned in discussions of women's issues and re-entry in general. They include the KEY/CREST program in Delaware, the Forever Free program in California and the TAMAR program in Maryland. KEY/CREST and Forever Free focus primarily on drug rehabilitation, but are often listed in discussion of mental health issues. KEY is a single-sex therapeutic community program for women in prison and CREST is a coed work release therapeutic community. Treatment begins during incarceration and continues during work release. The coed nature of the work release program offers an opportunity to address issues with the opposite sex in a therapeutic environment. Forever Free is a six-month residential drug addiction treatment and re-entry program designed to begin during the last four to six months of incarceration and to continue for up to six months during parole (NIJ, 2005).

The TAMAR program in Maryland has both specialized treatment services for incarcerated women with trauma disorders and community-based services for their children. The TAMAR Children's project includes specialized services for women who are pregnant or post-partum, including specialized residential services and group therapy in the community. (Gillece and Russell, 2001; Gillece, 2004; Bender, 2004)

Conclusion #10: Special programs for women released from incarceration may be required to promote their reintegration back into the community. Women are more likely to have histories of trauma. Programs designed to assist incarcerated women in gaining parenting skills and caring for dependent children are needed.

SUMMARY OF CONCLUSIONS

These conclusions in the body of the Report are summarized below.

1. An unacceptably large number of mentally ill individuals have been swept into our jails and prisons. It is unfair to rely so heavily on incarceration as a response to the problems brought on by mental illness. Social justice requires that services be provided to the disabled to reduce the need for intervention by the criminal justice system.
2. The quality of care in correctional settings varies from nonexistent to adequate. In general, psychiatric care in jails and prisons is fragmented and inconsistent. Moreover, correctional programs do not articulate or coordinate well with civilian mental health systems.
3. In order for an outpatient-based system to function in providing better care for mentally ill offenders, better access to inpatient beds is necessary. More beds are necessary to alleviate the pressure on police to arrest the mentally ill.
4. Services above and beyond those currently available are necessary to address the needs of mentally ill offenders. There is evidence that mandated outpatient treatment may be useful in reducing rates of arrest and incarceration when properly funded and monitored.
5. Programs must be designed to treat and manage patients with comorbid substance abuse problems and antisocial personality disorder.
6. Outpatient programs must be prepared to address the problems related to chronic disability, unemployment, and homelessness.
7. Programs must be prepared to manage patients with significant risk for violence.
8. Mentally ill women in the criminal justice system have special needs due to high rates of trauma history and PTSD. In addition, many will need assistance in parenting, supporting, and providing care for children.
9. Models for caring for mentally ill offenders exist in other countries. They may be useful as starting points in designing a system for the United States, but there is no empirical basis for selecting one particular model.
10. The international experience suggests that implementing separate, specialized services has advantages related to concentration of expertise and developing commitment to the mission. However, there is a risk that the mentally ill offender population will be stigmatized by a programmatic tracking approach.
11. Large numbers of incarcerated mentally ill inmates would benefit from improved discharge and transition planning.

RECOMMENDATIONS

Within public sector psychiatry, the shift to a community-based model of service provision has resulted in increased autonomy and a higher quality of life for many individuals who may have been institutionalized in the past. Public sector psychiatry has had limited success, however, with the mentally ill who are prone to involvement with the criminal justice system. The evidence is clear: too many mentally ill individuals are incarcerated, post-release treatment is inadequate, as evidenced by lack of follow up and poor outcomes, and recidivism rates are too high. We can only conclude that at-risk patients are not being served adequately in existing outpatient treatment programs.

How do we change the status quo? It will not be easy as there are no cheap or quick solutions. The greatest challenge is convincing society and psychiatrists that change is necessary. A sympathy-weary, cost-conscious public will not step forward eagerly to bear the required expense, particularly when so many are fearful of the mentally ill and exaggerate their propensity for violence. Acculturated to view psychiatrists as soft and gullible, many are likely to view incarceration—the longer the better—as the best solution for managing problematic mentally ill individuals. And, at present, from a cost perspective, incarceration in facilities inadequately funded to provide needed care may appear to be a good deal. Fifty years ago, the primary locus of responsibility for the most problematic of the mentally ill population resided in large, underfunded state institutions. The poor conditions that prevailed in many of those facilities have been well documented and given rise to the term “warehousing” to connote that care was not their true function. Following decades of progress, the rise of government Medicare and Medicaid and other entitlement programs, disability rights advocacy and the fruits of mental health legal reform, and deinstitutionalization, society has relegated the care of those with serious mental illness to another set of underfunded and inadequate institutions. What will lead society to bear the expense of change now? What will convince the average member of the public to assume the personal risk—as they will see it—of unleashing mentally ill offenders?

Within psychiatry, outside of a small cadre of correctional psychiatrists, there is no groundswell of interest in improving the plight of the incarcerated mentally ill. Other priorities have prevailed. President Kennedy’s vision in 1963 of a national network of community mental health centers was never realized as public enthusiasm for funding the enterprise quickly waned. Many years later, the New Freedom Commission on Mental Health (2003) concluded that the United States has no system of care.

[F]or too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today’s mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

In this difficult environment, underfunded outpatient mental health centers have struggled to remain viable and to stretch scanty resources to care for too many needy patients. Problematic patients have found their way back to the shrinking state hospitals, or in increasing numbers, to jails and prisons. Some may have believed that if these patients were not amenable to care in the community, they would get good care in the criminal justice system.

The Task Force recommends continued education of the public and policymakers. The facts are clear: the current approach to mentally ill offenders is costly and ineffective. The costs of incarceration are high; and as correctional facilities are pressed to provide adequate mental health services, these costs will continue to rise disproportionately for the mentally ill. Advocacy groups have increasingly focused litigation efforts on the quality of care in jails and prisons. These efforts will have the advantage of improving care, jurisdiction by jurisdiction, but will also drive up costs. High rates of recidivism among the released mentally ill offenders provide strong proof that incarceration does not lead to greater public safety. Psychiatrists should

advocate for innovative programs designed to provide effective treatment, primarily in the community, as an alternative. In addition, psychiatrists should call for greater emphasis on treatment of the mentally ill who commit substance abuse-related offenses, rather than the current reliance on incarceration.

The psychiatric community is becoming increasingly aware of the problems of correctional mental health care. Few, however, are aware of the magnitude: how many public sector patients now fall within the domain of the criminal justice system and are destined to receive poor care and follow-up. Nor are most psychiatrists aware that the prison environment is anti-therapeutic: engendering maladaptive behavioral patterns that render future care more difficult. Once aware of this grim reality, it is no longer possible to believe that problematic patients not served by public sector psychiatrists are receiving good care in the criminal justice system.

Finally, there is the matter of fairness and justice. It is unfair for society to rely so heavily on incarceration to address the problems of those with mental illness. Of course, individuals with mental illness have the capacity to commit crimes with full intent. However, the fact that the mentally ill are so over-represented in correctional populations indicates that their cognitive and behavioral disabilities are significant contributors to criminal behavior. Social justice demands that services be provided to reduce criminal justice interventions in this population.

In the following sections, the Task Force outlines goals and principles for reform and recommends changes within the field of psychiatry are described. Finally, a proposed system of care designed to reduce incarceration of mentally ill individuals is outlined.

Goals and Principles

Achieving the goal of better access to outpatient services has been identified as critical to reducing incarceration of persons with mental illness (New Freedom Commission, 2003). The Task Force agrees that this is an important and necessary foundation for improving the status quo. However, relevant research suggests that improved access alone will not be sufficient (Fisher et al., 2000; McGuire & Rosenheck, 2004; Mueser et al., 1998).

The Task Force proposes the following goals that are related to outpatient services for the mentally ill offender population.

1. Reduce the incarceration rate of the mentally ill. Social justice demands that services be provided as necessary such that the rate of mental illness in our correctional facilities is substantially reduced.
2. Reduce recidivism rates. Similarly, the rate of recidivism of the mentally ill offender population should be reduced by the provision of needed outpatient based services.

The Task Force believes that these goals can be accomplished within a therapeutic framework that balances the legitimate concerns for public safety and the therapeutic needs of mentally disordered offenders. The principles that should apply are as follows: (1) interventions are to be targeted toward mentally ill offenders likely to recidivate and to be responsive to therapeutic interventions, and (2) civil, therapeutic interventions are to be favored over criminal sanctions.

Proposal for Changes within Psychiatry

Numerous changes are needed within the field of psychiatry; in the view of the Task Force, a renewed commitment to the mentally ill offender population is needed. Within the field, we need to adopt a fresh view of incarceration, based on the grim realities detailed in this report. Psychiatrists should regard incarceration of a mentally ill person as a sentinel event, as it is indicative of treatment system failure and portends the onset of a chain of serious and long-term detrimental outcomes (alienation from caregivers, loss of social support and services, poor or no care, inculcation of maladaptive behaviors, and discontinuity of ongoing care). Incarceration or the threat of incarceration should mobilize the mental health system to strenuous and extraordinary

efforts to intervene and, when possible, to return the patient to a therapeutic setting. And, in the aftermath, vigorous efforts should be made to understand what happened, the relationship of illness to the behavior, and identification of points of system failure that can be remedied to prevent future episodes of criminal justice involvement.

The Task Force recommends the following actions.

1. Renewed commitment to the mentally ill offender population within general psychiatry. Increasingly, public sector psychiatry involves patients connected with the criminal justice system. In order to restore the psychiatric system to primacy in responding to problematic behavior, public sector psychiatrists will need to embrace this mission and to adopt the attitudes, methods, and concepts related to management of the correctional population.

Understanding of the criminal justice system and instruction in management will need to be conveyed through educational programs, conferences, and in residency training programs. Although there are large numbers of psychiatric patients in correctional systems and there is an urgent need to provide care, few residencies have rotations in correctional settings or provide meaningful outpatient-based experiences with this population.

A generation ago, at the nadir of the public mental health system in the United States, academic institutions responded to the challenge by the creation of public sector divisions. These divisions brought academic energy to a dispirited and low prestige public sector and can be credited for creating a climate of higher standards and innovation. Applying this approach to correctional psychiatry seems likely to result in a similar outcome.

2. Forensic psychiatry. The skills related to assessment and management of mentally ill offenders fall within the purview of the subspecialty of forensic psychiatry. Since formal recognition of forensic psychiatry as a subspecialty by the American Board of Psychiatry and Neurology in 1992, fellowship programs have placed greater emphasis on this aspect of the field. However, forensic psychiatry has made few inroads into outpatient public sector psychiatry. Forensic psychiatric leadership in the outpatient sector is urgently needed.
3. Enhancement of skills. Public sector psychiatrists will need to gain a number of skills as they take on the care and management of mentally disordered offenders. These include risk assessment and management, the therapeutic use of coercive interventions, management of anti-social personality disorders and co-morbid substance abuse, and sophistication in spanning systems. In many outpatient public sector programs, these skills are available and actively applied; in others they are not. The Task Force believes that these are essential skills and should be consistently available in all public sector settings. Forensic psychiatrists can play a useful role in bringing these skills to the public sector.
4. Research. There has been little attention paid to services research related to mentally ill offenders. The Task Force recommends that funding agencies provide increased funding to support research that will address identification of patients at-risk for criminal justice involvement, the development of preventive interventions, and their effectiveness. The field needs a more solid empirical basis for implementing interventions for mentally disordered offenders.

Proposal for System Changes

Improved access to care

1. Improve access to treatment for all patients. Certain segments of the patient population, however, are at higher risk and should receive greater attention. The programs that have had the most success in caring for mentally offenders share several elements that should be generalized to all public sector treatment settings:
 - a. Individualized assessment and treatment planning. This should include careful attention to problems of non-compliance and failure to follow through with treatment, particularly when there is a history of problematic behavior. One focus should be on the prevention of behavior likely to call for police intervention or to produce disruptive behavior.
 - b. Attention to history of correctional involvement. Outpatient programs should institute procedures to identify patients who have had involvement with the police and correctional facilities. In each identified case, there should be consideration of a change in the clinical approach, including careful consideration the impact of non-compliance on behavior. Where non-compliance is a significant factor in the genesis of problematic behavior, coercive interventions should be considered, such as mandated outpatient treatment.
 - c. Therapeutic interventions geared to the needs of the patient, including the ability to address co-morbid conditions, including substance abuse, antisocial personality disorder, homelessness, and history of violent behavior. Among other services, increased attention to risk assessment and management is necessary.
 - d. Provision of cognitive behavioral interventions for patients with correctional histories and evidence of maladaptive behaviors.
 - e. An emphasis on treating the patient in a therapeutic setting, rather than resorting to incarceration for problematic behaviors. In some cases, this may call for a longer hospitalization for particularly high-risk patients who may benefit from more intensive inpatient programming.
 - f. The resources and expertise within the program to link patients to needed public services and supports.
 - g. Aggressive follow-up, generally including case management and often ACT.
 - h. The ability to apply coercive interventions when necessary and appropriate. This includes expanded use of outpatient civil commitment, particularly when there is evidence of repeated past involvement with police and the criminal justice system.
2. Improve access to inpatient beds. Ready and rapid access to inpatient beds is necessary to ensure that disruptive patients are hospitalized, not arrested. Downward pressure on public and private psychiatric beds has barred the doors of admission to needy patients, forced inpatients to the streets without adequate discharge plans, and constrained the options of police attempting to address mentally disordered offenders. More beds are needed in the system, to alleviate the use of arrest. Rapid assessment and decision-making are necessary to reduce the pressure on police to arrest problematic mentally ill offenders.

Jail Release

1. Jail release procedures are unpredictable and undermine continuity of care for mentally ill offenders. Judicial procedures should be modified to allow for appropriate discharge planning prior to release. In some cases, continuity of care may be best accomplished by transferring the mentally ill offender to a civil psychiatric facility. In other cases, it may be necessary to extend detention until an adequate plan is in place. Such emergency detention should only be rarely employed.
 - a. In many states, authority to order commitment exists, but criminal court judges are unaware of this power, do not have professional guidance regarding how to select appropriate detainees, and are

unfamiliar with the civil commitment process. In addition to legal authority, courts and jails must have the infrastructure to enable identification of disordered offenders in a timely fashion.

2. Public health approaches should be applied to our jail systems. Contact with the criminal justice system may be the only or the primary contact that a mentally ill offender has with a system that is capable of providing care. Roughly 1 million mentally ill individuals are flowing through US jails on an annual basis. The application of standard public health approaches, such as case identification, primary intervention, and follow-up to ensure treatment, would likely yield substantial improvements.
3. Mentally ill offenders should be provided with individualized services. The MIOCRG program has demonstrated that treatment outcomes can be improved and jail time reduced for mentally ill offenders.
 - a. Programs should include a full range of services: assistance in securing disability entitlements, housing, vocational training, and employment; residential and outpatient mental health treatment; individual and group counseling; substance abuse education and counseling; life skills training; medication education, management, and support; transportation services; socialization training and support; advocacy; and crisis intervention.
 - b. Effective programs require interagency collaboration and multi-disciplinary partnerships, comprehensive and flexible services, intensive case management, involvement of the court, mental health courts, assistance with benefits, use of flex funds, and residential assistance.
 - c. Dedicated staff members, skilled at spanning the boundary between the mental health system and the criminal justice system, are necessary.

Discharge Planning from Prisons

1. Discharge planning from prisons involves greater lead time and known release dates. Mentally ill inmates should be provided with comprehensive preparation for release. For the many prisoners with co-morbid substance abuse problems, treatment programs should be completed in advance of release. Psychoeducational programs and cognitive treatment of maladaptive behaviors should be a part of preparing mentally ill inmates for release.
2. Federal and state governments should remove barriers to housing and entitlements. Mentally ill offenders should return to the community with housing, entitlement benefits, and financial support cushioning the re-entry process.

There are important parallels that can be drawn between the current state of correctional mental health services and that of the civil public psychiatric system a generation ago. For many years, the public sector struggled with the problem of treatment failure reflected in "revolving door" readmissions. With benefit of hindsight, the causes are clear. In many localities, community mental health care services were not adequately funded to provide the needed outpatient services. In addition, the magnitude of the need for social support and outreach services for the severely mentally ill was not anticipated at the outset of deinstitutionalization. Nearly a generation passed before a conceptualization of assertive community services was developed and began to serve as a model for care (Stein & Test, 1980). Finally, the early, widespread experience of revolving door readmissions for seriously mentally ill individuals appeared unsolvable, until the walls between hospital and outpatient providers were torn down, and providers began to work collaboratively on discharge planning and transition to community management.

Innovation in the care and treatment of mentally ill offenders is needed. The lessons that have been learned from public sector psychiatry can be modified and applied to the offender population. It is our hope that this Task Force Report will contribute to the dissemination of information regarding emerging programs and will serve as a stimulus to further innovation.

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