

---

---

## Limitations and Potential in Current Research on Services for People with Mental Illness in the Criminal Justice System

---

---

JEFFREY DRAINE

AMY BLANK WILSON

WENDY POGORZELSKI

**ABSTRACT** Intervention at the intersection of the mental health and criminal justice systems has followed a small set of service models with limited success and a narrow impact on the quality of treatment available to people with mental illness who experience arrest, court processing, incarceration, and release. In reviewing research on police, court, and corrections interventions, innovation seems to be largely limited to services for select individuals who are deemed worthy of access to treatment. doi:10.1300/J076v45n03\_07 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <[docdelivery@haworthpress.com](mailto:docdelivery@haworthpress.com)> Website: <<http://www.HaworthPress.com>> © 2007 by The Haworth Press, Inc. All rights reserved.]

**KEYWORDS** Mental illness, diversion, specialty courts, reentry, investigation

The discourse surrounding mental health services has moved from a focus on deinstitutionalization to decriminalization. In the deinstitutionalization era, policy and services were governed by questions of "How shall we respond to the large numbers of people who are now in the community who once were, or would have been, under the custodial care of a long term hospital?" During this era, developing the opportunity of life in the community was seen as a humane transition in attitudes toward

people with psychiatric disability. Mental health leaders sought to create services for people with mental illness and their families that were intended to surround these individuals with care, concern, and resources. The deinstitutionalization era fostered a set of ideas about how mental health services should be organized (Mechanic, McAlpine, & Olfson, 1998; Morrisey, 1982; Schlesinger & Gray, 1999). Thinking in this area took on new urgency as homelessness rose as a social problem and became focused on the plight of people with mental illness (Bachrach, 1992; Dattalo, 1990; Issac & Armat, 1990; Stern, 1984).

Forty years later the vision of emptying the madhouses and replacing them with community-based services seems oversimplified. It fails to account for the fact that people have always moved back and forth between asylum and community (Kiesler & Sibulkin, 1987; Mechanic, 1989). This simple vision also fails to take account of the demographic and budgetary changes that would accompany shifting massive numbers of people into the community. Demographically, this shift left a larger pool of people in the young adult age range in the community at a time when they were at risk for both a first psychotic break and a first criminal arrest. Before this shift, these individuals may have already been housed in institutions, thus limiting their contact with the criminal justice system during these vulnerable years.

In the present era we focus on decriminalization as another institutional conundrum. The idea that people with mental illness are criminalized has gained widespread attention (Abramson, 1972; Kupers, 1999; Lamb & Weinberger, 1998; Teplin, 1983, 1984). In this era the earlier policy response to homelessness has been applied to people with mental illness who were involved in the criminal justice system. Thus service interventions stress the need for mental health services to collaborate more efficiently with other service systems in order to better serve this client population (Draine, Solomon, & Meyerson, 1994; Jacoby & Kozie-Peak, 1997; Lamb & Grant, 1982; Lamb & Weinberger, 1998).

The current emphasis on the intersection of the criminal justice and mental health systems is premised on the idea that gaps in treatment access lead to arrest (Draine, 2003; Haimowitz, 2002; Lamb, Weinberger, & Gross, 2004; Teplin, 1983). Behaviors that lead to arrest that are not necessarily criminal in nature. Yet the premise is that a lack of treatment causes an individual to engage in the unusual behavior that brings them to the attention of law enforcement. Thus, these interventions are designed to bridge the gaps between the criminal justice and mental health systems, by linking people to the needed treatment services.

The issue of access to treatment services is constructed more often as a person's inability to link to existing resources and less as an issue of the capacity of the mental health system or the goodness of fit between the services available in this system and the treatment needs of this client population (Wolff, 1998). Focusing on access as an issue of linkage supports has led to the proliferation of case management services as the policy response. Case management relies heavily on existing community resources to meet the needs of their clients. Thus, it still leaves open the question of whether community mental health systems have the capacity to serve more than a small subset of people with mental illness involved in the criminal justice system or whether these existing resources are able to provide the full range of services that this client population needs.

Treatment engagement is often one of the main endpoints by which these programs are assessed. Yet these outcome measures rarely assess service system capacity and the goodness-of-fit between client needs and available services. Thus, the burden is on the client to engage, but not the professional service provider. Global measures of engagement provide very little depth of information on the type, duration, or intensity of services, providing few ways to gauge whether the client has gained access to the services that they need, or ones that can actually treat mental illness. More detailed conceptualizations of access are an essential component of an outcome model for a client population that presents with multiple sets of problems. This more detailed conceptualization is important because co-occurring issues like substance abuse, mental illness, poverty, and homelessness limit the effectiveness of a single problem focused system, even in cases where clients gain easy access to the front doors of the system (Wilson, Tien, & Eaves, 1995; Wolff, 1998).

A further, linked question is whether the mental health system has the capacity to shift away from limited demonstration projects that broker access to existing treatment services for a select subset of people and move toward service *systems* to address the needs at a population level for people with mental illness at each intervention point of the criminal justice system. This population approach to services calls for examinations of the mental health system's overall capacity to provide the needed services as well as penetration rates for these services in the context of sectors of the criminal justice system.

In the following sections we review the research and conceptual basis of three major service models that are currently promoted to address the treatment needs of people with mental illness who are involved in the criminal justice system. We specifically assess the capacity of these service models to respond to the population level treatment needs of

individuals with mental illness in the justice system, and the extent to which they represent a promise for access to effective treatment. We situate these services within the institutional and legal context that frame their daily operations because this allows us to understand the whole population at risk for deeper involvement in the justice system. Thus we review the service models in terms of sectors of the justice system: police, courts, and corrections.

### **POLICE-BASED INTERVENTION**

The premise of diversion is that police discretion, arrest, and jail facilities are being used in lieu of psychiatric professionals, hospitals, and clinics to address mental illness. Large numbers of people with mental illness in jails support this premise (Abramson, 1972; Draine & Solomon, 1999; Lamb & Weinberger, 1998; Lamb et al., 2004; Teplin, 1983). The response, simply put, is to not send them there in the first place. Because the premise is based on arrest having been used in lieu of treatment, access to psychiatric services figures prominently in most diversion models. A truism expressed often in diversion discussions is that these program models are not just about diversion *from* jail, but also diversion *to* care.

Diversion program strategies have been broken down into pre-booking and post-booking diversion (Draine & Solomon, 1999; Steadman et al., 1999; Steadman & Naples, 2005). Pre-booking diversion is focused on police-based strategies to avoid arrest. Prominent among these strategies is a model called Crisis Intervention Teams (CIT), referenced colloquially as the "Memphis Model" for its initial development in the Memphis police department (Dupont & Cochran, 2000). Police-based diversion programs (or pre-booking) focus heavily on police officer training and resources, particularly with expedited access to the mental health system (Steadman et al., 2001). Post-booking diversion models identify individuals with mental illness later in the arraignment and jail detention pipeline, and rely on mechanisms of controlled release from custody and access to psychiatric services in the context of courts, jails, prisons, and probation and parole (Draine, Blank, Kottsieper, & Solomon, 2005; Lattimore, Broner, Sherman, Frisman, & Shafer, 2003).

The preponderance of police-based diversion and intervention studies examine the process of implementing pre-booking diversion, with a recent more intensive focus on implementation of CIT. Earlier studies demonstrated a need for community-based connections and resources for police officers who encounter people with mental illness (Finn & Sullivan,

1989; Holley & Arboleda-Florez, 1988), and that police have less confidence in mental-health-based interventions than police-based interventions for mental illness (Borum, Deane, Steadman, & Morrissey, 1998; Panzarella & Alicea, 1997; Steadman, Deane, Borum, & Morrissey, 2000). The greater buy-in by police for the police-based programs may have a role in promoting the idea of an "appropriateness" standard for mental health intervention. Some studies of pre-booking diversion programs address outcomes for those with mental illness who are the subjects of these encounters, with greater reduction of arrest associated with police-based programs as opposed to mental-health-system-based programs (Steadman et al., 2000). Given the proliferation of CIT, there are very few studies showing post-encounter outcomes for this intervention (Steadman et al., 2000; Teller, Munetz, Gil, & Ritter, 2006). Some results show fewer jail days and greater service access embedded in the recent SAMHSA multi-site evaluation (Broner, Lattimore, Cowell, & Schlenger, 2004; Lattimore et al., 2003). Recent studies of the training of CIT officers and increased identification of mental illness where CIT is implemented increase a demand for effective mental health response as well as police response (Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Strauss et al., 2005; Teller et al., 2006).

Substance abuse was addressed as a core issue in an early study of police encounters (Holley & Arboleda-Florez, 1988), but it did not reappear significantly as a key factor of the research until the multi-site comparisons from the SAMHSA study, which required co-occurring substance use as a criterion for entering the studies (Broner et al., 2004; Lattimore et al., 2003). During this time, even though it was well known that very high proportions of those in jail with mental illness have co-occurring substance use disorders (Teplin, 1994), the programs for diversion were being developed without addressing this key element of police encounters. This may be specifically important when addressing single point drop-off locations, an oft mentioned element for the implementation of pre-booking diversion programs (Steadman et al., 2001). These locations may be where mental illness and substance abuse get sorted out clinically. The integral role of these centers in police-based diversion has not been adequately researched in general, much less with a specific focus on the role of treating both mental illness and substance abuse in these centers after a police drop-off.

Culpability of people with mental illness for their behavior is sometimes addressed directly in studies of police-based intervention, but most often implied by the framing of the presenting problem. Most often mentioned is a categorical assessment that treatment was "more appropriate"

than arrest (Lamb, Shaner, Elliott, DeCuir, & Foltz, 1995; Lamb, Weinberger, & DeCuir, 2002). Another assertion is that the crimes of those with mental illness are "most likely non-violent, and due to their illness" (Husted, Charter, & Perrou, 1995). This assertion is often made without data or data-backed citation. Nor is there a comparison to other populations who are arrested. This presumption that people with mental illness are categorically less culpable for their behavior results in intervention ideas being presented as treatment access in lieu of arrest. There is no room in this conception to provide treatment access for everyone who may have mental illness, regardless of their perceived guilt or innocence. Only those who are deemed less culpable are "appropriate" for expedited access to treatment. Thus, neglected avenues for intervention include arraignment hearings or police precinct/district outreach in addition to training police officers.

Finally, the popularity of CIT has largely focused on training as the mechanism for changing police behavior. What about a change in available treatment linkages? In locations where CIT has been implemented with the police drop-off treatment linkage, no research has tested the rival hypothesis that it was the treatment resource that changed police behavior, perhaps to an equal or greater extent than police officer training. This would have great implications for where mental health systems may invest time and efforts at reducing the numbers of individuals with mental illness who are arrested.

### ***COURT-BASED SERVICES***

Specialty courts such as drug or mental health courts developed in reaction to a lack of effectiveness in traditional court processing. People with addictions or mental illness spun continuously through the court's "revolving door," yet the criminal justice system was not prepared, or inclined, to address the complex web of problems that accompanied these individuals criminal behavior. Drug courts have led the way for problem-solving courts. Many others are following suit. Currently, there are almost 2,000 drug courts in the U.S. (Marlowe, Heck, Huddleston, & Casebolt, 2006; Wilson, Mitchell, & Mackenzie, 2006). In 1997 there was one mental health court; in 2004 there were over 100 (Redlich, Steadman, Monahan, Robbins, & Petril, 2006). DUI courts, domestic violence courts, and re-entry courts are also proliferating. Research on drug courts, now called the first generation of drug courts, has shown a 10-20% reduction in recidivism among participants and that length of

time in treatment is the best predictor of lower recidivism rates (Roman, Townsend, & Bhati, 2003).

Research on mental health courts to date is primarily descriptive, focusing on criminal justice and treatment operations and structure. Scholarly attention has been given to identifying types of mental health court models, their defining elements, and strategies for the systematic evaluation of their effectiveness (McGaha, Stiles, & Petrila, 2002; Redlich et al., 2006; Wolff & Pogorzelski, 2005). Issues such as court type (e.g., pre- or post-plea, misdemeanor, or felony), program planning and implementation, and the client selection and referral process have been addressed (Hiday, Moore, Lamoureaux, & De Magistris, 2005; Luskin, 2001; O'Keefe, 2006; Steadman & Redlich, 2006).

Evaluations of both drug courts and mental health courts have focused on engagement in treatment and recidivism as the primary outcome measures. The unique mechanism of mental health courts is its perceived authority to enforce linkages of clients with treatment services. Therefore examining the effectiveness of these linkages is consistent with the model (Boothroyd, Poythress, McGaha, & Petrila, 2003; O'Keefe, 2006; Trupin & Richards, 2003). Program retention (length of time in program), compliance with treatment plans, social functioning, reduced hospitalizations, and some measurement of services delivered (units of service delivered) are other measures of treatment effect (Boothroyd, Mercado, Poythress, Christy, & Petrila, 2005; Cosden, Ellens, Schnell, & Yamini-Diouf, 2005; Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003; Herinckx, Swart, Ama, Dolezal, & King, 2005; O'Keefe, 2006). Criminal justice measures include results of drug screenings, time incarcerated, types of offenses, use of sanctions, and criminal recidivism measures (Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005; Cosden et al., 2005; Cosden et al., 2003; Griffin, Steadman, & Petrila, 2002; Moore & Hiday, 2006; Steadman & Redlich, 2006).

Such measures are intuitively connected to evaluating a drug or mental health court program's output. These measures however have not been able to explain what might seem to be working when these courts appear to work (Goldkamp, White, & Robinson, 2001). Further, reliance on such outcome measures alone has not helped us define the ingredients and processes necessary to replicate these programs in a systematic way.

The dynamic and interactive effects of these courts require more nuanced measures that account for court processes. We know little about how clients are seeing their movement through these programs, including movement into these programs as alternatives to conventional courts. Research on traditional defendants can be a guide. If what most defendants

desire is to be a different person than the person who was arrested (Casper, 1972), how are mental health or drug courts facilitating this change? In traditional court processing 95% of defendants plead guilty in order to limit their time under the supervision of the criminal justice system. Such processing leaves the defendant with little in return for their plea. The traditional plea just keeps something away (namely more prison time). Perhaps one difference from conventional courts is that the plea in a drug court or mental health court now means something important to the defendant (client) because they are given something substantive in return. They are out of jail and perceive themselves as receiving help for their addiction or mental illness (or both), as well as assistance with other key necessities such as housing, employment, and medical care. For many defendants this is or may be perceived as the first time "the system" has taken an interest in them and viewed them as a person worthy of assistance. Indeed, Boothroyd and colleagues (Boothroyd et al., 2003) found that across procedural justice dimensions mental health court clients were more satisfied with their treatment, including respect from authorities and fairness, than misdemeanor defendants. We know little about the client's perception of these courts, subsequent treatment services, and their influence on program outcomes.

If drug, mental health, and other specialty courts have developed from a dissatisfaction with the effectiveness of traditional case processing, we should develop models that improve the way the criminal justice and behavioral health systems interact in a broad sense rather than extracting certain (small) populations and treating them (presumably) more effectively. A discourse on folding the practices of specialty courts into traditional court processing (Farole, Puffett, Rempel, & Byrne, 2005; Fox & Berman, 2002) and on alternatives to specialty courts (Grudzinskas, Clayfield, Roy-Bujnowski, Fisher, & Richardson, 2005; Selzer, 2005; Wolff, 2003) is emerging, but may be drowned out by the rapid rate at which new specialty courts are opening. Such subdivisions within the court system require the behavioral health system to divide its services and perpetuate a different kind of fragmented service.

### ***CORRECTIONS-BASED INTERVENTIONS***

Corrections-based interventions include the re-entry, post-booking diversion, discharge planning, and community-based "forensic case management" services that reach into the jail to identify and work with clients before and after the client is released from jail. At a fundamental level,



these services are alike because they are working at the same intervention point, trying to identify inmates in need of transition planning, so they can facilitate the access to mental health services at the point of release.

The operating premise of each of the services listed above is that the facilitation of timely access to mental health services at the point of release will limit the client's future involvement in the criminal justice system (*Criminal Justice/Mental Health Consensus Project*, 2002). Yet, to date no studies have included detailed evaluations of the types of service linkages that are facilitated by these programs, or the appropriateness and quality of these linkages. This gap in the literature is partially due to the fact that research on corrections-based interventions for people with mental illness is still catching up with the emerging interest in re-entry.

The studies that have been completed to date are a collection of individual initiatives that lack a cohesive research agenda. These studies include evaluations of individual program initiatives (Hartwell, 2003; Hartwell & Orr, 1999; Hoff, Baranosky, Buchanan, Zonana, & Rosenheck, 1999; Hoff, Rosenheck, Baranosky, Buchanan, & Zonana, 1999; Lamberti et al., 2001; Roskes & Feldman, 1999; Wilson et al., 1995); one randomized trial of an ACT program for people who are homeless, mentally ill, and leaving jail (Solomon & Draine, 1995b); two reviews of the service strategies being used with this client population (Lamberti, Weisman, & Faden, 2004; Wilson & Draine, 2006), and several naturalistic assessments of the returning offender's adjustment to the community post-incarceration (Feder, 1991; Jacoby & Kozie-Peak, 1997; Lovell, Gagliardi, & Peterson, 2002; Solomon, Draine, & Marcus, 2002).

Despite the important role that linkage to treatment services plays in corrections-based programs for people with mental illness, not all of the studies report treatment linkage rates in their outcomes (Felton et al., 1995; Hoff, Baranosky et al., 1999; Hoff, Rosenheck et al., 1999; Ventura, Cassel, Jacoby, & Huang, 1998; Wilson et al., 1995). Of the studies that do report these linkage rates, most include only global indices of linkage in the form of percentages of people involved in community treatment or mental health services at a specified time point after release (Hartwell, 2003; Hartwell & Orr, 1999; Roskes & Feldman, 1999). For the most part, measures of linkages provide no details about the types, intensity, duration, or clinical appropriateness of the services that are received. Some analysis of the Solomon and Draine study provided services level data concerning the services provided by case managers in that program, and found associations between a higher number of collateral contacts with other providers and jail recidivism

(Draine & Solomon, 1994). However, an explicit analysis following linkages to services outside case management was never conducted.

Global indices of service linkages fail to provide meaningful measures of service usage on several levels. First, point-in-time estimates of service usage, do not provide any information on the intensity, consistency and duration of the services used by the client, thus we cannot test the service system's capacity to provide timely access to treatment services that meet these clients' needs. Second, in these global estimates of service use, service linkages are coded as either receiving service, or not. Such measures lack the specificity necessary to evaluate whether clients are actually receiving access to meaningful levels of treatment services, and whether the services that they are receiving are sufficient to meet their individual treatment needs. Finally, these global measures are biased by the fact that they focus on treatment completers, and provide no details or analysis of the service experiences of clients who are not engaged in any treatment services at the point of measurement.

Another issue with the existing examinations of treatment linkage patterns is a curious absence of reports on linkages to drug and alcohol treatment services. Still, these studies report that most, if not all, of the clients have high rates of co-occurring substance abuse problems. One explanation for this discrepancy could be a reliance on integrated co-occurring psychiatric treatment as a state of the art standard for this population (Mueser, Torrey, Lynde, Singer, & Drake, 2003), based in mental health settings. While some may doubt this explanation, it again points to the lack of specificity in describing linkages to know for sure.

Interestingly, the only study to date that has attempted to measure the returning offender's linkage to "clinically meaningful treatment services," is not attached to an evaluation of a specific service. Rather this study tracked the service usage patterns of a cohort of people with mental illness who were released from prison over a three-year time period (Lovell et al., 2002). This study analyzed the service usage patterns of a cohort of returning offenders in part by assessing the nature, intensity, and duration of the mental health services that were received. It found that only 16% of the sample consistently received mental health services in the first year after release, and only 5% received drug and alcohol services.

Lovell and colleagues characterized the participant's experiences with community mental health services as being mired with delays, interruptions, and low intensity. In fact they reported that those individuals receiving community-based mental health services typically received between two and five hours of service per month (Lovell et al., 2002).

This led the authors to question whether returning offenders were receiving the clinically meaningful services that they needed to address their complex sets of problems.

The vast majority of the current research on correctional interventions lacks the specificity needed to assess whether clients are being linked to effective or clinically meaningful treatment services. Lovell et al.'s (2002) work suggests that there are serious problems with returning offender's connection to effective treatment services that need to be examined further. Such detailed analyses like Lovell's work are undercut by the simplistic assumption that the issue facing returning offenders is simply one of "linkage," and not also the capacity and appropriateness of the available services (Wolff, 1998), or the service system's willingness to treat this client population (Lamb et al., 2004). Yet this simplistic assumption is challenged by research conducted by Solomon and colleagues (Draine & Solomon, 1994; Solomon & Draine, 1995a; Solomon et al., 2002) which found that service linkages to treatment services with high monitoring capacity, and weak treatment services can actually increase a person's risk of recidivism, not reduce it. Further, Blank (2006) illustrates the important role that goodness of fit between the client's treatment needs and the service system's capacity plays in shaping a client's linkage to specific treatment services. All of which goes to support the need for closer examinations of the type, nature, intensity, and appropriateness of the full range of service linkages that need to be made for people with mental illness who are returning to the community after a period of incarceration.

## ***DISCUSSION***

Concern for the criminalization of mental illness has led to the development of three major types of services for people, with mental illness, who are involved in the criminal justice system: police-based diversion, mental health courts, and re-entry services. Each of these services is built around a specific set of intervention points in the criminal justice system and maintains an organizing premise that treatment access should be the major focus of intervention (Munetz & Griffin, 2006). Each of these three service strategies generally assumes that treatment is often a more "appropriate" response than arrest or incarceration for people with mental illness (Haimowitz, 2002; Kupers, 2000; Lamb et al., 2002; Lamb et al., 2004; Steadman et al., 1999; Wolff, 1998). What is often not mentioned is that these intervention systems are also designed to

screen out the "inappropriate" people without offering treatment options for the group that is screened out. Making decisions about appropriateness for treatment is a routine part of most mental health services. But, within the context of the criminal justice system, decisions regarding the allocation of mental health services are not driven by objective assessments of the severity of a person's illness or services needs. We contend that within this service context decisions about eligibility for these treatment services have become entangled with informal assessments of the person's guilt, culpability, and competence as well as security control factors like population management. This is an important distinction because these screening procedures act to limit the pool of people with mental illness who will receive access to the treatment services that many policy makers believe they need, to only a small subset of the population found in the criminal justice system.

This screening process creates a situation where decisions about access to treatment services are contingent on normative judgments about who is believed to "deserve" a chance at treatment. For example, in mental health courts, the decision about appropriateness is based on a person's willingness to admit to the crime and accept mental illness as the source of one's trouble (Boothroyd et al., 2003; Grudzinskas et al., 2005; Haimowitz, 2002; Moore & Hiday, 2006; Poythress, Petrila, McGaha, & Boothroyd, 2002; Watson, Hanrahan, Luchins, & Lurigio, 2001). Re-entry services are often restricted to those offenders who demonstrate a "motivation to change" (Wheeldon & Heidt, 2006; Wolff, 2006).

In practice, the criminal justice system's emphasis on an individual's culpability and responsibility for their crime has prioritized mental health services provided in this milieu to individuals who assume some level of guilt or remorse for their actions as opposed to a demonstrated need for treatment. This reflects one of the differences between the mental health and criminal justice systems. The mental health system is guided by individualized care and person centered treatment, while the criminal justice system is guided by public safety and individual accountability. This distinction is critical to the development and implementation of mental health services in the criminal justice system.

The public health approach to treatment services that have typically guided the development of mental health services emphasizes services that are explicitly designed to reach the entire population of individuals with a particular condition or affliction. Over the last thirty years, the criminal justice system has been characterized by an increasingly harsh, punitive approach to law violators (Garland, 2001; Gottschalk, 2006;

Whitman, 2003). Order maintenance has guided policy and practice across criminal justice components. Law enforcement has focused on quality of life offenses; courts have been mandated to impose lengthy minimum sentences with little room for individualized responses. In correctional settings, there is a limited set of health and medical conditions where treatment is mandated by law. Outside of these parameters there is wide variability in health services provided to prisoners. If the goal of program development is to maximize the service's capacity to treat the clinical needs of the population of people with mental illness who are involved in the criminal justice system, then these services models current approach to client selection needs to be broadened substantially.

### CONCLUSION

A public health conceptualization of the issues relating to mental illness in police interactions, courts, and correctional facilities need not accept a criminalization of mental illness formulation of the problem. One need not conclude that arrest, court appearances, and jail time are "inappropriate" to acknowledge that people, with mental illness, who are in the justice system need treatment services, regardless of the reasons for their involvement. Services and supports from this premise could be more effective than those that operate under the criminalization premise (Draine, Salzer, Culhane, & Hadley, 2002; Draine, 2003). Future innovation in this direction needs to account for sufficient access and engagement with treatment services that are effective toward meeting treatment needs. Furthermore, such innovation would explore new "no-fault" intervention mechanisms that do not rely on decision points based on admission of guilt or legal culpability.

### REFERENCES

- Abramson, M. F. (1972). The criminalization of mentally disordered behavior: possible side-effect of a new mental health law. *Hosp Community Psychiatry, 23*(4), 101-105.
- Bachrach, L. L. (1992). What we know about homelessness among mentally ill persons: an analytical review and commentary. *Hosp Community Psychiatry, 43*(5), 453-464.
- Blank, A. E. (2006). *Access for some, justice for any? The allocation of mental health services to people with mental illness leaving jail*. University of Pennsylvania, Philadelphia.

- Boothroyd, R. A., Mercado, C. C., Poythress, N. G., Christy, A., & Petrila, J. (2005). Clinical outcomes of defendants in mental health court. *Psychiatr Serv*, 56(7), 829-834.
- Boothroyd, R. A., Poythress, N. G., McGaha, A., & Petrila, J. (2003). The Broward Mental Health Court: process, outcomes, and service utilization. *International Journal of Law and Psychiatry*, 26(1), 55-71.
- Borum, R., Deane, M. W., Steadman, H. J., & Morrissey, J. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness. *Behavioral Sciences and the Law*, 16, 393-405.
- Broner, N., Lattimore, P. K., Cowell, A. J., & Schlenger, W. E. (2004). Effects of diversion on adults with co-occurring mental illness and substance use: outcomes from a national multi-site study. *Behavioral Sciences and the Law*, 22(4), 519-541.
- Casper, J. D. (1972). *American criminal justice: The defendant's perspective*. Englewood Cliffs, NJ: Prentice-Hall.
- Christy, A., Poythress, N. G., Boothroyd, R. A., Petrila, J., & Mehra, S. (2005). Evaluating the efficiency and community safety goals of the Broward County Mental Health Court. *Behavioral Sciences and the Law*, 23(2), 227-243.
- Compton, M. T., Esterberg, M. L., McGee, R., Kotwicki, R. J., & Oliva, J. R. (2006). Brief reports: crisis intervention team training: changes in knowledge, attitudes, and stigma related to schizophrenia. *Psychiatric Services*, 57(8), 1199-1202.
- Cosden, M., Ellens, J., Schnell, J., & Yamini-Diouf, Y. (2005). Efficacy of a Mental Health Treatment Court with assertive community treatment. *Behav Sci Law*, 23(2), 199-214.
- Cosden, M., Ellens, J. K., Schnell, J. L., Yamini-Diouf, Y., & Wolfe, M. M. (2003). Evaluation of a mental health treatment court with assertive community treatment. *Behavioral Sciences and the Law*, 21(4), 415-427.
- Criminal Justice / Mental Health Consensus Project*. (2002). New York: Council of State Governments.
- Culhane, D. P., Averyt, J. M., & Hadley, T. R. (1997). The rate of public shelter admission among Medicaid-reimbursed users of behavioral health services. *Psychiatric Services*, 48(3), 390-392.
- Dattalo, P. (1990). Widening the range of services for the homeless mentally ill. *Administration and Policy in Mental Health*, 17(4), 247-256.
- Draine, J. (2003). Where is the 'illness' in the criminalization of mental illness? In W. H. Fisher (Ed.), *Community based interventions for criminal offenders with severe mental illness*. Oxford: JAI Press.
- Draine, J., Blank, A., Kottsieper, P., & Solomon, P. (2005). Contrasting jail diversion and in-jail services for mental illness and substance abuse: do they serve the same clients? *Behavioral Sciences and the Law*, 23(2), 171-181.
- Draine, J., Salzer, M. S., Culhane, D. P., & Hadley, T. R. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*, 53(5), 565-573.
- Draine, J., & Solomon, P. (1994). Jail recidivism & the intensity of case management services among homeless persons with mental illness leaving jail. *Journal of Psychiatry & the Law*, 22, 245-261.

- Draine, J., & Solomon, P. (1999). Describing and evaluating jail diversion services for persons with serious mental illness. *Psychiatric Services, 50*(1), 56-61.
- Draine, J., Solomon, P., & Meyerson, A. (1994). Predictors of reincarceration among patients who received psychiatric services in jail. *Hospital and Community Psychiatry, 45*(2), 163-167.
- Dupont, R., & Cochran, S. (2000). Police response to mental health emergencies—barriers to change. *Journal of the American Academy of Psychiatry and Law, 28*(3), 338-344.
- Farole, D. J., Puffett, N., Rempel, M., & Byrne, F. (2005). Applying problem-solving principles in mainstream courts: Lessons for state courts. *The Justice System Journal, 26*(1), 57-75.
- Feder, L. (1991). A comparison of the community adjustment of mentally ill offenders with those from the general prison population: An 18 month follow up. *Law and Human Behavior, 15*, 477-493.
- Felton, C. J., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, E., et al. (1995). Consumers as peer specialists on intensive case management teams: impact on client outcomes. *Psychiatric Services, 46*(10), 1037-1044.
- Finn, P., & Sullivan, M. (1989). Police handling of the mentally ill: Sharing responsibility with the mental health system. *Journal of Criminal Justice, 17*, 1-14.
- Fox, A., & Berman, G. (2002). Going to scale: A conversation about the future of drug courts. *Court Review, 4*, 4-13.
- Garland, D. L. (2001). *The culture of control: Crime and social order in contemporary society*. Chicago: University of Chicago Press.
- Goldkamp, J. S., White, M. D., & Robinson, J. B. (2001). Do drug courts work? Getting inside the drug court black box. *Journal of Drug Issues, 31*(1), 27-72.
- Gottschalk, M. (2006). *The prison and the gallows: The politics of mass incarceration in America*. New York: Cambridge University Press.
- Griffin, P. A., Steadman, H. J., & Petrila, J. (2002). The use of criminal charges and sanctions in mental health courts. *Psychiatric Services, 53*(10), 1285-1289.
- Grudzinskas, A. J., Jr., Clayfield, J. C., Roy-Bujnowski, K., Fisher, W. H., & Richardson, M. H. (2005). Integrating the criminal justice system into mental health service delivery: the Worcester diversion experience. *Behavioral Sciences and the Law, 23*(2), 277-293.
- Haimowitz, S. (2002). Can mental health courts end the criminalization of persons with mental illness? *Psychiatric Services, 53*(10), 1226-1228.
- Hartwell, S. (2003). Short-term outcomes for offenders with mental illness released from incarceration. *International Journal of Offender Therapy and Comparative Criminology, 47*(2), 145-158.
- Hartwell, S. W., & Orr, K. (1999). The Massachusetts forensic transition program for mentally ill offenders re-entering the community. *Psychiatric Services, 50*(9), 1220-1222.
- Herinckx, H. A., Swart, S. C., Ama, S. M., Dolezal, C. D., & King, S. (2005). Rearrest and linkage to mental health services among clients of the Clark county mental health court program. *Psychiatric Services, 56*(7), 853-857.
- Hiday, V. A., Moore, M. E., Lamoureaux, M., & De Magistris, J. (2005). North Carolina's mental health court. *Popular Government*(Spring/Summer), 24-30.

- Hoff, R. A., Baranosky, M. V., Buchanan, J., Zonana, H., & Rosenheck, R. A. (1999). The effects of a jail diversion program on incarceration: a retrospective cohort study. *Journal of the American Academy of Psychiatry and Law*, 27(3), 377-386.
- Hoff, R. A., Rosenheck, R. A., Baranosky, M. V., Buchanan, J., & Zonana, H. (1999). Diversion from jail of detainees with substance abuse: the interaction with dual diagnosis. *American Journal of Addictonst*, 8(3), 201-210.
- Holley, H. L., & Arboleda-Florez, J. (1988). Criminalization of the mentally ill: Part I. Police perceptions. *Canadian Journal of Psychiatry*, 33(2), 81-86.
- Husted, J. R., Charter, R. A., & Perrou, B. (1995). California law enforcement agencies and the mentally ill offender. *Bulletin of the American Academy of Psychiatry and Law*, 23(3), 315-329.
- Issac, R., & Armat, V. (1990). *Madness in the streets: How psychiatry and law abandoned the mentally ill*. New York: Free Press.
- Jacoby, J. E., & Kozie-Peak, B. (1997). The benefits of social support for mentally ill offenders: prison-to-community transitions. *Behavioral Sciences and the Law*, 15(4), 483-501.
- Kiesler, C. A., & Sibulkin, A. E. (1987). *Mental hospitalization : myths and facts about a national crisis*. Newbury Park: Sage Publications.
- Kupers, T. A. (1999). *Prison madness : the mental health crisis behind bars and what we must do about it* (1st ed.). San Francisco: Jossey-Bass.
- Kupers, T. A. (2000). How are problems of mental illness being handled in the prison system? *Harvard Mental Health Letter*, 17(1), 8.
- Lamb, H. R., & Grant, R. W. (1982). The mentally ill in an urban county jail. *Archives of General Psychiatry*, 39(1), 17-22.
- Lamb, H. R., Shaner, R., Elliott, D. M., DeCuir, W. J., Jr., & Foltz, J. T. (1995). Outcome for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services*, 46(12), 1267-1271.
- Lamb, H. R., & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: a review. *Psychiatric Services*, 49(4), 483-492.
- Lamb, H. R., Weinberger, L. E., & DeCuir, W. J., Jr. (2002). The police and mental health. *Psychiatric Services*, 53(10), 1266-1271.
- Lamb, H. R., Weinberger, L. E., & Gross, B. H. (2004). Mentally ill persons in the criminal justice system: some perspectives. *Psychiatric Quarterly*, 75(2), 107-126.
- Lamberti, J. S., Weisman, R., & Faden, D. I. (2004). Forensic assertive community treatment: preventing incarceration of adults with severe mental illness. *Psychiatric Services*, 55(11), 1285-1293.
- Lamberti, J. S., Weisman, R. L., Schwarzkopf, S. B., Price, N., Ashton, R. M., & Trompeter, J. (2001). The mentally ill in jails and prisons: towards an integrated model of prevention. *Psychiatric Quarterly*, 72(1), 63-77.
- Lattimore, P. K., Broner, N., Sherman, R., Frisman, L., & Shafer, M. S. (2003). A comparison of prebooking and postbooking diversion programs for mentally ill substance using individuals with justice involvement. *Journal of Contemporary Criminal Justice*, 19(1), 30-64.
- Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior, Spec No*, 80-94.



- Lovell, D., Gagliardi, G. J., & Peterson, P. D. (2002). Recidivism and use of services among persons with mental illness after release from prison. *Psychiatric Services, 53*(10), 1290-1296.
- Luskin, M. (2001). Who is diverted? Case selection for court monitored mental health treatment. *Law and Social Policy, 23*(2), 217-236.
- Marlowe, D. B., Heck, C., Huddleston, C. W., & Casebolt, R. (2006). A national research agenda for drug courts: Plotting the course for second-generation scientific inquiry. *Drug Court Review, 5*(2), 1-31.
- McGaha, A., Stiles, P. G., & Petrila, J. (2002). Emergency involuntary psychiatric examinations in Florida. *Psychiatric Services, 53*(9), 1171-1172.
- Mechanic, D. (1989). *Mental health and social policy* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.
- Mechanic, D., McAlpine, D., & Olfson, M. (1998). Changing patterns of psychiatric inpatient care in the United States. *Archives of General Psychiatry, 55*, 785-791.
- Moore, M. E., & Hiday, V. A. (2006). Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants. *Law and Human Behavior, 30*, 659-674.
- Morrissey, J. (1982). Deinstitutionalizing the mentally ill: Processes, outcomes, and new directions. In W. Gove (Ed.), *Deviance and mental illness*. Beverly Hills, CA: Sage Publications.
- Mueser, K. T., Torrey, W. C., Lynde, D., Singer, P., & Drake, R. E. (2003). Implementing evidence-based practices for people with severe mental illness. *Behavior Modification, 27*(3), 387-411.
- Munetz, M. R., & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57*(4), 544-549.
- O'Keefe, K. (2006). *The Brooklyn Mental Health Court Evaluation: Courtroom dynamics and participant outcomes*. New York: Center for Court Innovation.
- Panzarella, R., & Alicea, J. O. (1997). Police tactics in incidents with mentally disturbed persons. *Policing: An International Journal of Police Strategies and Management, 20*(2), 326-338.
- Poythress, N. G., Petrila, J., McGaha, A., & Boothroyd, R. (2002). Perceived coercion and procedural justice in the Broward mental health court. *International Journal of Law and Psychiatry, 25*(5), 517-533.
- Redlich, A. D., Steadman, H. J., Monahan, J., Robbins, P. C., & Petrila, J. (2006). Patterns of practice in mental health courts: A national survey. *Law and Human Behavior, 30*(3), 347-362.
- Roman, J., Townsend, W., & Bhati, A. S. (2003). Recidivism rates for drug court graduates: Nationally based estimates. In U. S. D. of Justice (Ed.): National Institute of Justice.
- Roskes, E., & Feldman, R. (1999). A collaborative community-based treatment program for offenders with mental illness. *Psychiatric Services, 50*(12), 1614-1619.
- Schlesinger, M., & Gray, B. (1999). Institutional change and its consequences for the delivery of mental health services In A. Horwitz & T. Scheid (Eds.), *A handbook for the study of mental health: Social context, theories, and systems*. Cambridge: Cambridge University Press.

- Selzer, T. (2005). Mental health courts: A misguided attempt to address the criminal justice system's unfair treatment of people with mental illnesses. *Psychology, Public Policy, and Law*, 11(4), 570-586.
- Solomon, P., & Draine, J. (1995a). Jail recidivism in a forensic case management program. *Health Social Work*, 20(3), 167-173.
- Solomon, P., & Draine, J. (1995b). One year outcomes of a randomized trial of case management with seriously mentally ill clients leaving jail. *Evaluation Review*, 19, 256-273.
- Solomon, P., Draine, J., & Marcus, S. C. (2002). Predicting incarceration of clients of a psychiatric probation and parole service. *Psychiatric Services*, 53(1), 50-56.
- Steadman, H. J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services*, 51(5), 645-649.
- Steadman, H. J., Deane, M. W., Morrissey, J. P., Westcott, M. L., Salasin, S., & Shapiro, S. (1999). A SAMHSA research initiative assessing the effectiveness of jail diversion programs for mentally ill persons. *Psychiatric Services*, 50(12), 1620-1623.
- Steadman, H. J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behavioral Sciences and the Law*, 23(2), 163-170.
- Steadman, H. J., & Redlich, A. D. (2006). An evaluation of the Bureau of Justice Assistance Mental Health Court Initiative. In U. S. D. of Justice (Ed.): Bureau of Justice Assistance, National Institute of Justice.
- Steadman, H. J., Stainbrook, K. A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A specialized crisis response site as a core element of police-based diversion programs. *Psychiatric Services*, 52(2), 219-222.
- Stern, M. J. (1984). The emergence of homelessness as a public problem. *Social Service Review*, 58, 291-301.
- Strauss, G., Glenn, M., Reddi, P., Afaq, I., Podolskaya, A., Rybakova, T., et al. (2005). Psychiatric disposition of patients brought in by crisis intervention team police officers. *Community Mental Health Journal*, 41(2), 223-228.
- Teller, J. L., Munetz, M. R., Gil, K. M., & Ritter, C. (2006). Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services*, 57(2), 232-237.
- Teplin, L. A. (1983). The criminalization of the mentally ill: speculation in search of data. *Psychology Bulletin*, 94(1), 54-67.
- Teplin, L. A. (1984). Criminalizing mental disorder. The comparative arrest rate of the mentally ill. *American Psychologist*, 39(7), 794-803.
- Teplin, L. A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health*, 84(2), 290-293.
- Trupin, E., & Richards, H. (2003). Seattle's mental health courts: Early indicators of effectiveness. *International Journal of Law and Psychiatry*, 26, 33-53.
- Turner, J., & TenHoor, W. (1978). Community Support Program: Pilot approach to a needed social reform. *Schizophrenia Bulletin*, 4, 319-348.

- Ventura, L. A., Cassel, C. A., Jacoby, J. E., & Huang, B. (1998). Case management and recidivism of mentally ill persons released from jail. *Psychiatric Services, 49*(10), 1330-1337.
- Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A. (2001). Mental health courts and the complex issue of mentally ill offenders. *Psychiatric Services, 52*(4), 477-481.
- Wheeldon, J., & Heidt, J. (2006). *Toward a complementary approach to prison programming: New directions for social and moral development*. Paper presented at the American Society of Criminology, Los Angeles.
- Whitman, J. (2003). *Harsh Justice*. Oxford: Oxford University Press.
- Wilson, A. B., & Draine, J. (2006). Collaborations between criminal justice and mental health systems for prisoner reentry. *Psychiatric Services, 57*(6), 875-878.
- Wilson, D., Tien, G., & Eaves, D. (1995). Increasing the community tenure of mentally disordered offenders: an assertive case management program. *International Journal of Law and Psychiatry, 18*(1), 61-69.
- Wilson, D. B., Mitchell, O., & Mackenzie, D. L. (2006). A systematic review of drug court effects on recidivism. *Journal of Experimental Criminology, 2*, 459-487.
- Wolff, A. (2006). *A prisoner reentry program through the eyes of the participants*. Paper presented at the American Society of Criminology, Los Angeles.
- Wolff, N. (1998). Interactions between mental health and law enforcement systems: problems and prospects for cooperation. *Journal of Health Politics Policy Law, 23*(1), 133-174.
- Wolff, N. (2003). Courts as therapeutic agents: Thinking past the novelty of mental health courts. *Journal of the American Academy of Psychiatry and Law, 30*, 431-437.
- Wolff, N., & Pogorzelski, W. (2005). Measuring the effectiveness of mental health courts. *Psychology, Public Policy, and Law, 11*(4), 539-569.

#### AUTHORS' NOTES

Jeffrey Draine is affiliated with the School of Social Policy and Practice, University of Pennsylvania, Locust Walk, Philadelphia, PA.

Amy Blank Wilson is affiliated with the Institute for Health, Health Care Policy, and Aging Research, Rutgers, The State University of New Jersey.

Wendy Pogorzelski is affiliated with the Department of Criminal Justice, Georgia State University.

Research for this paper was supported by the Center for Mental Health Services and Criminal Justice Research at Rutgers, The State University of New Jersey; funded by NIMH through grant P20-MH068170.

Address correspondence to Jeffrey Draine, School of Social Policy and Practice, University of Pennsylvania, 3701 Locust Walk, Philadelphia, PA 19104 (E-mail: jdraine@sp2.upenn.edu).

Copyright of *Journal of Offender Rehabilitation* is the property of Haworth Press and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.