# Screening and access to services for individuals with serious mental illnesses in jails.

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## Abstract:

High rates of serious mental illnesses (SMI) among jail inmates pose challenges for the criminal justice system and risks for the individual with SMI. Research has identified actions to address these issues; it is unclear to what extent they have been operationalized. This study examines jails in one state, exploring how individuals with SMI are identified and treated, and comparing these with research-based recommendations. Results indicate that jails are not using evidence-based screenings, staff require training in SMI, access to services and medications for jailed individuals with SMI is often slow, and coordination between community providers and jails is limited.

**Keywords:** jail | criminal justice | screening | continuity of care | serious mental illness | social work

## Article:

Introduction

Over the past four decades, individuals with serious mental illnesses (SMI) have come into increased contact with the criminal justice system (Brink 2005; Lamb and Weinberger 1998), leading some to describe the current situation as a crisis where prisons and jails have become the new psychiatric hospitals for those with SMI (Torrey 1995). A national study estimated that approximately 16% of jail and prison inmates have a mental disorder, defined as either self-report of a “mental or emotional condition” or an overnight stay in a psychiatric hospital (Ditton 1999). Studies looking specifically at SMI have also indicated elevated rates among incarcerated populations; the Epidemiological Catchment Area study revealed that nearly 7% of prisoners had a lifetime history of schizophrenia symptoms (Robins and Reiger 1991) and a comparison of jail

inmates in Cook County with the general population found a two to three fold higher prevalence of schizophrenia and major affective disorders in the jail population (Teplin 1990).

Conversely, individuals with SMI living in the community also report high rates of incarceration, and SMI has been shown to be a predictor of incarceration (Greenberg and Rosenheck 2008). A study by the National Alliance of the Mentally Ill (1992, (as cited in Weisman et al. 2004)) found that 40% of individuals with SMI surveyed reported having been arrested. A more recent study in San Francisco reported that in a sample of individuals with SMI in residential facilities 71.4% reported an arrest (White et al. 2006) and a study of outpatient mental health agencies found that 45% of new clients had a history of involvement with the criminal justice system (Theriot and Segal 2005). Individuals with SMI share a number of predictors of criminal behavior with others in the criminal justice system, include high rates of substance abuse, poverty, and homelessness (Richardson 2009). In addition behaviors related to untreated mental illness such as responding to voices, confused thinking, or wandering may result in charges of disturbing the peace or trespassing. One study revealed that nearly half of the crimes committed by individuals with SMI were for minor non-violent crimes against public order (Fisher et al. 2006; Lamberti 2007).

This intertwining of SMI and incarceration poses both significant challenges for the criminal justice system and significant risks for the individual with SMI. Research has identified actions to address these risks and challenges; however, it is unclear to what extent they have been operationalized. This study examines the jails in one southern state, exploring the procedures used to identify and treat individuals with SMI and comparing these processes with research-based recommendations.

## Risks to Individuals with SMI

The high prevalence of mental disorders in criminal justice populations can result in harm to the individual as well as challenges for the criminal justice system. Individuals with SMI often do not receive needed treatment while incarcerated (Lurigio and Swartz 2006), thus increasing risk of decompensation and need for hospitalization. A study of jail inmates across a number of sites found that less than 10% received any mental health care (Steadman and Veysey 1997), while the study by Ditton (1999) found that less than 40% of prison inmates and 60% of jail inmates with mental illness received treatment while incarcerated.

Incarcerated persons with mental disorders are at high risk of victimization by other inmates, with one prison study finding inmates with SMI nearly three times more likely to be sexually victimized than those without a disorder (Wolff et al. 2007). Persons who go to jail—especially those who are there for the first time—are also at significantly increased risk for suicide. While jail suicides have declined from a rate of 129 per 100,000 inmates in 1983 to 47 per 100,000 inmates in 2002, suicide still accounts for 32% of all jail deaths in the U.S. according to the U.S. Dept. of Justice (Mumola 2005). Also, conditions of incarceration per se, including crowding,

lack of privacy (and conversely, solitary confinement), noise, threat, and confusion, are likely to exacerbate symptoms of SMI Finally, symptoms of SMI that result in inability to follow orders, or in violence and aggression, may result in disciplinary action by correctional staff; higher rates of discipline problems in individuals with mental disorders have been observed in both state prison (62.2% vs. 51.9%) and jails (24.5% vs. 16%; Ditton 1999).

## Challenges to the Criminal Justice System

The criminal justice system is increasingly taxed in dealing with individuals with SMI (Lamb et al. 2004) and the needs of this population can drain system resources. Legal rulings at regional levels have determined that jails and prisons are required to provide needed medical care, including mental health care, to inmates (Lurigio and Swartz 2006). For example a requirement for "minimally adequate mental health treatment" was established for inmates in the case of Ruiz v. Estelle (1980), and a requirement for mental health treatment and aftercare for jail detainees defined in Brad H. et al. v. City of New York et a (2000).

Among persons with SMI, a considerably higher number are incarcerated in jail than in prison. This is due both to the minor nature of many offenses committed by individuals with SMI and to higher turnover of jails in general, such that individuals with SMI are either held in jail pending trial or held in jail for shorter sentences (Theriot and Segal 2005). Thus the over-representation of individuals with SMI in correctional systems is a particularly serious financial burden to the local criminal justice system and community via jail costs (White et al. 2006). Additionally, since jails are largely municipal administrative organizations tied to local budgets while prisons are state institutions, variations among screening procedures and system resources can be great.

## Previous Research-Based Recommendations

High rates of incarceration among individuals with SMI have been highlighted as a priority issue in the President's New Freedom Commission on Mental Health report, emphasizing the need for adequate coordinated treatment rather than incarceration for people with SMI (New Freedom Commission on Mental Health: Achieving the promise: Transforming mental health care in America. Final report 2003). An extensive recent literature has identified effective interventions to screen, divert, or treat individuals with SMI who come into contact with the justice system. These interventions include a range of jail diversion/treatment access interventions such as Crisis Intervention Team (CIT) training for police officers who respond to crises (Teller et al. 2006), case management interventions (Loveland and Boyle 2007), and mental health courts (McNiel and Binder 2007). In additions, interventions exist that focus on treatment while incarcerated (Chandler and Spicer 2006), or on recidivism prevention post-incarceration using modified Assertive Community Treatment teams (Morrissey et al. 2007).

Findings on effective ways to screen and treat individuals with SMI in jail settings are summarized in the final report of the Criminal Justice/Mental Health Consensus Project (Council of State Governments Justice Center 2002). These recommendations include: (1) screen all detainees for mental illness using a standardized instrument and with a trained screener; (2) positive screens should result in a referral to a mental health professional for full assessment; (3) screening protocols should include identification of suicide risk; (4) facilitate release of information between jail and provider; (5) have in-house capacity to provide crisis response and short-term mental health treatment; (6) facilitate individual's continued use of prescribed psychotropic medication; (7) begin discharge planning at the time of booking (pp. 102–109).

A recent article by Lamberti (2007) synthesizes the current research and proposes that the key to decreasing recidivism in adults with SMI is through engagement in treatment interventions that will target risk factors for repeat offending. These risk factors include such things as substance abuse, problematic or no employment, few pro-social connections, homelessness, and psychotic symptoms. Engagement in treatment to address these factors involves both participation in treatment and adherence to treatment, including medications. He posits that lack of adherence mediates the relationship between risk factors and criminal behavior. To address nonadherence Lamberti identified three essential elements of intervention: (1) competent and evidence-based community mental health services; (2) access to these services; and (3) legal leverage such as community supervision for those individuals who refuse competent and accessible treatment.

## Study Questions

Despite a strong research literature with clear recommendations for actions to address the overrepresentation of people with mental illnesses, the criminal justice system continues to face challenges in the screening, treatment, and referral of detainees with mental illnesses. This study therefore sought to examine the practices and protocols of county and regional jails in a southern state with regard to mental illness by interviewing the jail administrators for each jail in the state. Our specific questions were: (1) What is the process by which detainees are screened for mental illnesses?; (2) How is mental health care provided to jail inmates with mental illnesses?; (3) What is the nature and quality of coordination of inmate's care between jail and community providers?; and (4) How do these processes compare with research-based recommendations?

## Methods

### Interview Guide Development

A telephone interview protocol and thirty-question interview guide for jail administrators was developed with input from an advisory group whose membership included the director of the state advocacy group for individuals with disabilities, the head of the state Division of Mental Health Criminal Justice Section (a section within the Division of Mental Health under the cabinet-level Department of Health and Human Services), a professor from the university system who engages in research in the area of disabilities, two advocates who have experienced a mental illness, two family members of individuals with mental illnesses, and two legal advocates for individuals with disabilities. The final protocol and interview guide were reviewed by this group of advisors, who provided feedback and suggestions for content inclusion. Interview questions focused on four domains: (1) screening for mental illness; (2) access to mental health services; (3) access to medications; (4) communication with community providers. All study documents and protocols were approved by the Behavioral Institutional Review Board (IRB) of the University of North Carolina at Chapel Hill.

## Participant Recruitment

A comprehensive list of sheriffs and jail administrators for each county in the state was developed from county-based public web sites. Detailed letters describing the study and introducing the research team were then sent to the sheriffs in each county and to jail administrators in each of the state's 93 active jails. (Note: Some counties have multiple facilities, but the facilities in each county are run by the same administration; for the purposes of this study, these multiple units were counted as a single jail.) These letters explained the purpose of the study and informed the recipients that researchers would be calling in the near future to request a telephone interview with the jail administrator or his/her designee. The letter explained that the study was voluntary, that all interview findings would be confidential, and that no individual, jail, or county would be identified in the study report.

Following the introductory letters, jail administrators were contacted by telephone and asked to consent to participation in a 30-question telephone interview. Some administrators designated another jail official or jail medical official to complete the interview. Interviews ranged in length from 15 to 60 min, with most taking approximately 30 min. Eighty jails participated in the study, for a response rate of 86%.

## Data Collection and Analysis

To avoid concerns of inter-rater reliability, a single researcher conducted all interviews. All participants were asked each of the 30 questions. In addition, after answering each question, participants were given the opportunity to make additional comments about the question topic and provide any additional information they felt relevant. Participant responses were typed

verbatim into a laptop computer while the interview was taking place and transcripts were developed from these files. A second researcher reviewed the transcripts, consulted with the first researcher to ensure full understanding of each participant response, coded and entered data from the transcripts, and performed descriptive statistical analyses using the statistical package SAS 9.1.

## Results

### Respondent Characteristics

The majority were jail administrators (73%), followed by jail medical administrators (11%), assistant jail administrators (8%), other jail medical staff (8%), and a program director (1%). Most (67%) respondents were responsible for smaller jails, with an average daily census of under 200, and over one-fifth had a daily census of under 50. A comparison of jails responding to the study versus those not responding found that more non-responding jails served rural counties than responding jails (30% vs. 17%); specific differences in daily census could not be determined, since these data were obtained by participant report.

### Screening for Mental Illnesses

Of the 80 jails studied, 77 (96%) reported that they screen all inmates for mental illness at booking. However, when asked how inmates were screened we found that no jail employed an evidence-based screening tool. Rather, each jail had its own set of questions, which usually included general questions, not specific to mental health, asking about prior treatment for any medical condition (e.g. “Have you ever been treated for any health condition?”), current medications (e.g. “Are you taking any medicine prescribed by a doctor?”), and recent hospitalizations (e.g. “Have you been hospitalized for any reason in the past year?”). Only 4 (5%) jails reported asking detailed and specific questions about mental health symptoms and treatment, family history of mental illness, history of child abuse or other mental health-related issues. Screening for suicidality was similarly erratic. Each jail reported its own combination of assessment elements, which could include officer observation, questions about current suicidal ideation, past suicide attempts, and/or questions about current mental state. Though it is possible that some of these screening tools may effectively identify individuals with SMI, their lack of psychometric testing results in risk of under-identification of individuals with SMI in jails.

Screening for mental illness was most often done by a jail official (63 jails, or 79%). In some cases (8 jails, or 10%), particularly in larger jails, screening was conducted by a jail medical staff, and in 6 jails (8%) screenings were conducted by jail staff but reviewed by medical staff.

Three respondents were unsure who conducted screenings at their jail. All jails reported that their officers completed 6 hours of education in mental illness (which included both mental illness and mental retardation) and an additional 5 hours in suicide prevention during a 180 hour Detention Officer Certification. Twenty-eight jails (35%) reported that their officers received continuing education in mental illness beyond their initial training. In addition, some respondents reported feeling that they and their staff were not adequately trained to serve this population; one stated that because of lack of training "(our) facilities aren't staffed to perform services for this population…I don't think we're doing them justice."

Since mental illness is a stigmatizing condition, and research has shown that inmates with mental illnesses are vulnerable to victimization by other inmates (Wolff et al. 2007), it is likely that detainees would be reluctant to discuss their mental status in front of other inmates. A private setting is therefore important if detainees are to be able to provide honest answers to screening questions. When asked if screening for mental illness occurred in a private setting, less than half (33, or 41%) reported consistently conducting these in private settings where no one could overhear detainee responses. A third (26, or 33%) of jails reported rarely or never conducting screenings in private settings, and 17 jails (21%) reported doing so only some of the time.

Access to Mental Health Treatment

Only 12 (15%) jails reported having mental health staff who provided care within the jail, either as employees of the jail or through contract with a private provider. When asked if community mental health agency staff would come into the jail to provide treatment, 20 jails (25%) reported that the community mental health agency would send staff on a regular basis, another 18 jails (23%) reported that the agency would occasionally send staff to the jail, and 42 jails (52%) reported that their community mental health agency never sent staff into the jail. In no case did the community mental health agency send a psychiatrist to the jail. In all, 33 of the jails (42%) reported that when an inmate required mental health assessment or care they would always be required to transport the inmate to a community provider.

Respondents reported that jail inmates who are referred for mental health assessment and treatment, either through initial screening or as a result of behavior while incarcerated, have varied lengths of time until their first face-to-face contact with a provider. Waiting times for non-emergency visits (i.e., no immediate risk of harm) varied; nearly one-third (32%) of jails reported inmates waited over 5 days for their first face-to-face contact with a mental health provider following a non-emergency referral. In emergencies, most jails (64, or 80%) reported inmates were seen within one day, a clinically reasonable timeframe given the urgency of the need. However, over 10% of jails reported that inmates waited up to 5 days for an emergency assessment. Times from referral to contact are summarized in Fig. 1.

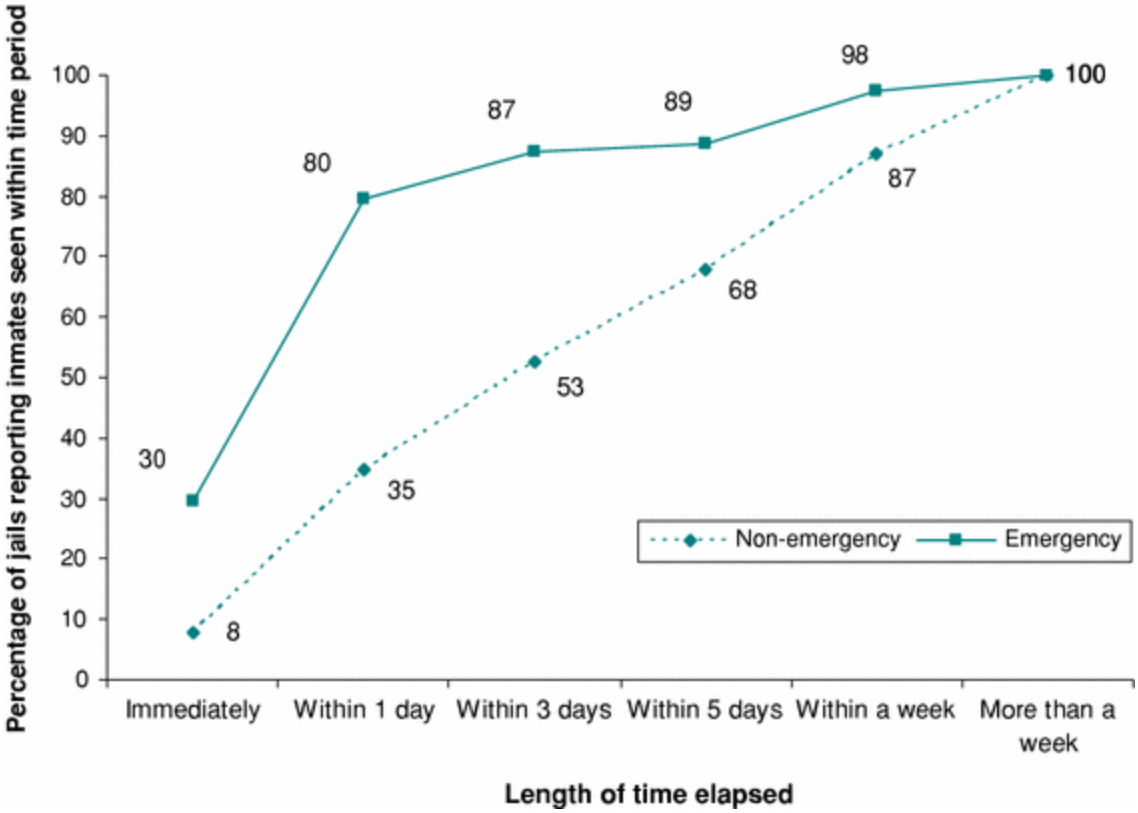


**Fig. 1**

Time from referral to face-to-face contact with a mental health provider (*N* = 80)

A common theme voiced by respondents was that jails were ill-equipped to serve persons with SMI, particularly during crises. In times of crisis jails used multiple hospital resources. Most frequently (64, or 80%), they reported taking inmates to the state psychiatric hospital while a smaller number (19, or 24%) utilized local hospital beds. In addition, 38 (48%) jails reported regular use of the state's medical facility at the central prison, referred to as Safekeeping, and another 20 (25%) jails reported occasional use of this facility. Many respondents reported difficulty in having inmates admitted to the state psychiatric hospital, noting that they needed to have the inmate "put on detainer" first, meaning that the hospital would not release the inmate at the conclusion of treatment but return him or her to jail; other jails reported that they often try to have an inmate's charges dropped or bond reduced to secure hospital admittance. Similarly, they reported that having inmates admitted to Safekeeping can also be cumbersome and complex, involving a local doctor, a doctor at the central prison, and an order from the judge. Each county is guaranteed only two patient beds at any time, and these beds are often taken by persons with complex medical conditions such as AIDS or emphysema. Safekeeping is also prohibitively expensive for some counties, especially small, rural ones. A final challenge reported by jails when hospitalizing inmates with mental illness involved the officer time involved in transport and supervision of the inmate until hospitalized. State psychiatric facilities may be several hours

away, and respondents reported that officers could be gone for an entire day or longer when transporting an inmate for involuntary hospitalization.

Access to Psychotropic Medications

Psychotropic medication is often essential for the treatment of individuals with SMI, and a disruption in medication adherence as a result of incarceration can result in decompensation. Most of the jails interviewed (69, or 86%) allowed inmates to bring their medication with them to jail. Of these, 21 jails (26%) specifically stated that they encourage inmates' family members to bring their prescription to the jail if possible. Respondents reported that after an inmate's arrival, jail officials or jail medical staff inspect the medication and, upon receiving the inmate's authorization to release his or her medical information, verify the prescription with the inmate's psychiatrist, mental health clinic, or pharmacy. At this point the medication can be dispensed as prescribed.

For inmates who do not bring medication to jail, respondents report that obtaining a prescription is much more difficult. The jail must first secure the inmates' written permission to contact their provider, contact that provider and obtain a new prescription. Inmates who have not recently seen a provider must be examined by a psychiatrist before a prescription can be written.

Figure 2 shows the time from referral until medication is received, according to jails interviewed. Nearly half of the jails stated that inmates with current prescriptions receive medication the same day (26, or 33%) or the next day (10 or 12%). However, 15 jails (19%) reported taking 5 days or longer. Nine respondents (11%) were unable to provide data.

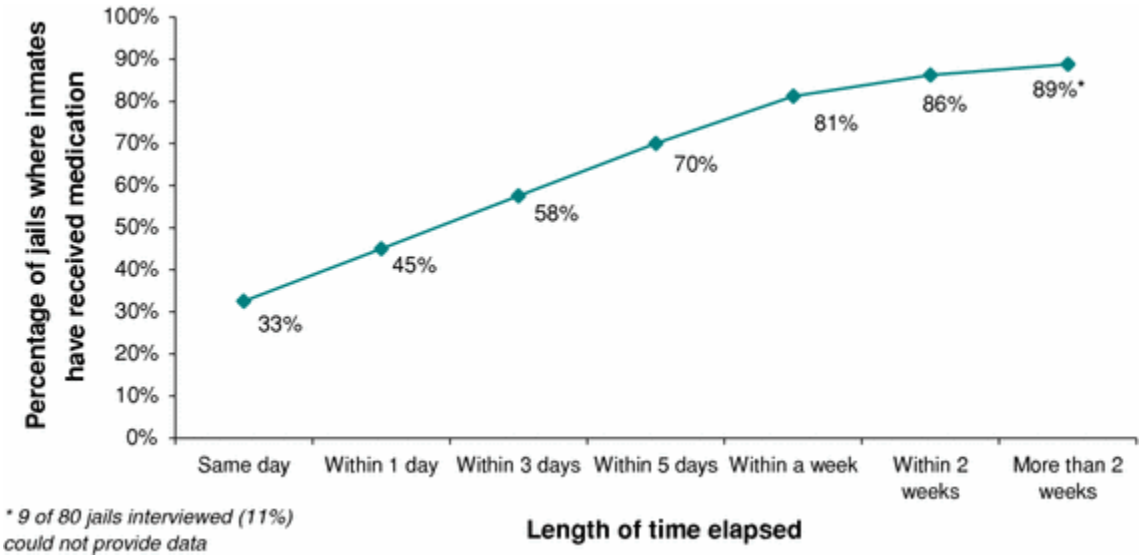


Fig. 2

Time from referral until medication received (N = 80)

Many respondents expressed great concern regarding the cost of psychotropic medication, which was the responsibility of the jail and ultimately the county. They reported having small pharmacy budgets that could easily be overwhelmed by the needs of a few inmates. A number of jails identified cost-cutting measures in response to the high costs of psychotropic medications, as well as medications for other chronic medical conditions. Thirty-one jails (39%) reported using a formulary for prescription medications, and an additional 16 (20%) stated that though they have no official formulary they did make substitutions for expensive medications at least some of the time.

Communication with Community Providers

Since only a few jails in the state (12, or 18%) reported providing mental health care in-house, most jails must work closely with local providers to obtain mental health services for their inmates. As can be seen in Table 1, jails reported differing levels of communication with local mental health providers. More than half of the jails interviewed (49, or 61%) reported that they always contact the mental health care provider of incoming inmates with known mental illness, if only to secure an inmate's prescription medication. However, fewer than one in five jails (15, or 19%) said they always contact an inmate's care provider upon release, although those who said they did so sometimes or occasionally (33, or 42%) said they did notify providers for inmates who seem at particularly high risk. Just over a third (30, or 38%) of jails interviewed said they always refer an inmate to a mental health provider upon release if they do not already have one; 29 jails (36%) said they never made such referrals. Jails gave a variety of reasons for this lack of follow-up, including inadequate staffing, high level of inmate turnover (approaching 15% per day in many jails) and the fact that jail medical staff, who may be the only ones aware that an inmate has a mental illness, often are not informed that an inmate has been released until after the fact. Reciprocal communication from community mental health providers to the jail was also inconsistent. Only seven of the jails interviewed (9%) reported that community providers always contact them; 23 jails (28%) said they never received communication from providers.

Table 1

Communication between jail and community providers (N = 80)

| | Always | Sometimes | Occasionally | Never | Unsure |
|---|---|---|---|---|---|
| Jail contacts mental health provider at admission | 49 (61%) | 24 (30%) | 3 (4%) | 3 (4%) | 1 (1%) |
| Jail contacts mental health provider at release | 15 (19%) | 22 (28%) | 11 (14%) | 28 (35%) | 3 (4%) |
| Jail makes referral for inmates without a mental health provider | 30 (38%) | 8 (10%) | 3 (4%) | 29 (36%) | 10 (12%) |
| Mental health provider contacts jail | 7 (9%) | 22 (28%) | 26 (32%) | 23 (28%) | 2 (3%) |

In addition to answering specific interview questions, a number of respondents volunteered information regarding their perspective on the relationship between the jail and community providers. In 14 (18%) cases respondents specifically stated that they felt the providers worked well with the jail, making comments such as “The medical director and I coordinate a lot together.” However, 24 (30%) interviewees expressed concern about the ability of the community mental health system to provide adequate services to inmates and those at risk of arrest, voicing their worry about the lack of community services and resultant increase in individuals with SMI in the jails. One stated: “Facilities like my jail have become home to mentally retarded, to mentally ill, to street people, to everyone else. This is not the place for [them]. I’m sorry, it’s not. But until [the decisions-makers in the mental health system] do something… how are we supposed to cope?”

## Discussion

Based on our findings, a picture begins to emerge of a troubled intersection of two systems—the jail system and the mental health services system. Both systems are under stress, attempting to provide services without sufficient resources to meet the needs of all who come to them. Those with multiple challenges who require specialized services, such as individuals who have been arrested and have a mental illness, may well have the lowest chance of getting their needs met.

This study highlights the need for additional resources in both the mental health and jail systems. Given that respondents reported that only about 6% of Detention Officer training time (11 hours out of 180) focuses on mental illness, and the fact that respondents repeatedly stated they felt ill-

prepared to handle these challenging individuals, additional resources are needed to provide training for jail staff in the identification and management of individuals with SMI in the jails. This includes training in the use of evidence-based screening tools for identification. In addition, resources are needed to provide mental health treatment, including medication, while people are in jail, to provide sufficient mental health staff to ensure coordination of care between jail and community, including inreach by community providers while the individual is in jail, and to provide alternatives to jail and a competent treatment system that can decrease recidivism rates. Finally, this study identifies a lack of coordination, communication, and intentional action between these two systems in order to maximize the utility of the resources that do exist.

Though informative, we acknowledge a number of limitations to this study. First, all data were based in self-report, and thus subject to both recall and social desirability bias. In addition, selection bias may have been present. The jail administrators who refused to participate in the study may have been significantly different in their responses and views than those willing to be interviewed; we did determine that non-responding jails were more likely to serve more rural counties, and could thus also have differing resources and service availability. Finally, the study provides a picture of the situation in jails only in one state and thus generalizability of findings is limited.

Despite its limitations, this study provided a snapshot of the current situation in one state's jails. The picture that emerged from our research was one of jails that on the whole struggle to do the right thing given limited resources and limited knowledge. We found evidence of stigma regarding people with SMI among jail staff, with occasional references to "those kinds of people" or "people with mental medications." However, we also heard statements of true concern and kindness from jail staff. One respondent stated: "[Inmates] are human beings and they deserve to be treated as such…. These people are someone's sons and daughters, and someone out there loves them."

Our findings also demonstrate that though research has provided guidance on best-practices for individuals with SMI in jail settings, few jails are operationalizing these recommendations. In no case did we find a jail that followed all of the recommendations in the Criminal Justice/Mental Health Consensus Project, and in many cases jails followed none of the recommendations. Increased focus on dissemination of best practices and on translation of research to practice is needed. Education and training for jail staff, mental health providers, and policy makers on the existence of and need for use of research-based interventions is essential. In addition, study of the structural and systemic barriers preventing the implementation of best practices is also needed. Advocacy and intervention at a system and policy level are needed to ensure that individuals with SMI receive adequate mental health care both during and after incarceration.

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## References

Brink, J. (2005). Epidemiology of mental illness in a correctional system. *Current Opinion in Psychiatry, 18*, 536–541.

Chandler, D., & Spicer, G. (2006). Integrated treatment for jail recidivists with co-occurring psychiatric and substance use disorders. *Community Mental Health Journal, 42*(4), 405–425.

Council of State Governments Justice Center. (2002). *Criminal justice/mental health consensus project*. New York: Council of State Governments.

Ditton, P. (1999). *Mental health treatment of inmates and probationers (No. 174463).* Washington, D.C.: Bureau of Justice Statistics.

Fisher, W., Roy-Bujnowski, K., Grudzinskas, A., Clayfield, J., Banks, S., & Wolff, N. (2006). Patterns and prevalence of arrest in a statewide cohort of mental health care consumers. *Psychiatric Services, 57,* 1623–1628.

Greenberg, G., & Rosenheck, R. (2008). Jail incarceration, homelessness, and mental health: A national study. *Community Mental Health Journal,59*(2), 170–177.

Lamb, H. R., & Weinberger, L. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services, 49*(4), 483–492.

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. (2007). Understanding and preventing criminal recidivism among adults with psychotic disorders. *Psychiatric Services, 58,* 773–781.

Loveland, D., & Boyle, M. (2007). Intensive case management as a jail diversion program for people with a serious mental illness: A review of the literature. *International Journal of Offender Therapy and Comparative Criminology, 51*(2), 130–150.

Lurigio, A., & Swartz, J. (2006). Mental illness in correctional populations: The use of standardized screening tools for further evaluation or treatment.*Federal probation, 70*(2), 29–35.

McNiel, D., & Binder, R. (2007). Effectiveness of a mental health court in reducing criminal recidivism and violence. *American Journal of Psychiatry,164,* 1395–1403.

Morrissey, J., Meyer, P., & Cuddeback, G. (2007). Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal, 43*(5), 527–544.

Mumola, C. J. (2005). *Suicide and homicide in state prisons and local jails (Report NCJ 210333).* Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics.

New Freedom Commission on Mental Health: Achieving the promise: Transforming mental health care in America. Final report. (2003). Retrieved 12/02/03, from www.mentalhealthcommission.gov/reports/finalreport/fullreport-02.htm.

Richardson, T. (2009). Conceptual and methodological challenges in examining the relationship between mental illness and violent behaviour and crime. *Internet Journal of Criminology*. Retrieved 4/2/09, from http://www.internetjournalofcriminology.com/Richardson%20-%20Mental%20Illness%20Violent%20Behaviour%20and%20Crime.pdf.

Robins, L., & Reiger, D. (1991). *Psychiatric disorders of America: The epidemiologic catchment area study*. New York: Free Press.

Ruiz v. Estelle 503 F. Supp. 1265 (S.D. Tex. 1980).

Steadman, H., & Veysey, B. (1997). *Providing services for jail inmates with mental disorders (Publication No. NCJ 162207).* Washington, D.C.: U.S. Department of Justice National Institute of Justice.

Teller, J., Munetz, M., Gil, K., & Ritter, C. (2006). Crisis intervention team training for police officers who respond to local mental disturbance calls.*Psychiatric Services, 57,* 232–237.

Teplin, L. (1990). The prevalence of severe mental disorder among male urban jail detainees: Comparison with the epidemiologic catchment area program. *American Journal of Public Health, 80*(6), 663–669.

Theriot, M., & Segal, S. (2005). Involvement with the criminal justice system among new clients at outpatient mental health agencies. *Psychiatric Services, 56,* 179–185.

Torrey, E. (1995). Editorial: Jails and prisons, America's new mental hospitals. *American Journal of Public Health, 85,* 1611–1613.

Weisman, R., Lamberti, J., & Prince, N. (2004). Integrating criminal justice, community healthcare, and support services for adults with severe mental disorders. *Psychiatric Quarterly, 75*(1), 71–85.

White, M., Chafetz, L., Collins-Bride, G., & Nickens, J. (2006a). History of arrest, incarceration and victimization in community-based severely mentally ill. *Journal of Community Health, 31*(2), 123–135.

White, M., Goldkamp, J., & Campbell, S. (2006b). Co-occurring mental illness and substance abuse in the criminal justice system: Some implications for local jurisdictions. *The Prison Journal, 86,* 301–326.

Wolff, N., Blitz, C., & Shi, J. (2007). Rates of sexual victimization for inmates in prison with and without mental disorders. *Psychiatric Services*, *58*, 1087–1094.