Psychiatric Quarterly, Vol. 75, No. 1, Spring 2004 (© 2004)

INTEGRATING CRIMINAL JUSTICE, COMMUNITY HEALTHCARE, AND SUPPORT SERVICES FOR ADULTS WITH SEVERE MENTAL DISORDERS

R.L. Weisman, D.O., J.S. Lamberti, M.D., and N. Price, M.S., R.N., N.P.P.

Persons with severe mental disorders are overrepresented in our nation's jails and prisons. Factors including cooccurring substance use disorders, homelessness, and lack of access to community services have contributed to this problem, as have gaps between criminal justice, healthcare, and community support systems. In order to address these issues, Project Link was developed by the University of Rochester Department of Psychiatry in collaboration with five local community agencies. Project Link is designed to prevent involvement of individuals with severe mental illness from entering the criminal justice system. While many models of diversion programs exist, they are all dependent on access to appropriate community-based services. This paper will describe

Dr. Weisman is Director, Project Link and ACT Programs, Assistant Professor of Psychiatry, University of Rochester Medical Center and Faculty of the Charles E. Steinberg Fellowship in Psychiatry and the Law.

Dr. Lamberti is Associate Chair for Clinical Programs, Associate Professor of Psychiatry, University of Rochester Medical Center.

Ms. Price is Team Leader and Nurse Practitioner for Strong Ties ACT team, University of Rochester Medical Center.

Address correspondence to Robert L. Weisman, D.O., Strong Ties Community Support Program, 1650 Elmwood Avenue, Rochester, NY 14620; e-mail: Robert_Weisman@urmc.rochester.edu.

0033-2720/04/0300-0071/0

the steps that Project Link has taken towards integrating criminal justice, healthcare, and community support services for individuals with severe mental disorders involved in the criminal justice system.

KEY WORDS: criminal justice; mental health; schizophrenia; diversion; assertive community treatment.

Many adults with severe mental disorders are now residing in our nation's jails and prisons. Between 6 and 15% of all inmates suffer from a severe mental illness, a prevalence rate that is three to four times higher than the rate found in the general population (1,2). Factors cited as causes of mentally ill individuals entering the criminal justice system include deinsitutionalization, rigid civil commitment criteria, violence at the time of arrest, attitudes of police and society, lack of adequate community support, and lack of access to outpatient treatment (3). As a result of these factors, individuals with severe mental illness who have been involved with nuisance behaviors or committed minor offenses may be arrested and prosecuted instead of being placed in mental health treatment (4). Arrest is a common experience among persons with severe mental illness. According to a survey conducted by the National Alliance for the Mentally Ill, 40% of all individuals with schizophrenia and manic-depressive illness reported having been arrested at some time in their lives (5). Among those who commit crimes, it is possible that a significant number would not have engaged in criminal behavior had they been receiving adequate and appropriate mental health treatment (6).

A history of arrest and incarceration can form a significant barrier to receiving treatment in the community, especially when combined with substance abuse, homelessness, and non-compliance. Individuals with such histories may be viewed as "problem patients" or as "treatment resistant" by community healthcare and residential services staff. In addition, community mental health centers often lack the capacity to provide assertive community treatment or other forms of intensive outreach that are necessary to promote engagement in outpatient psychiatric services**.** In the absence of adequate community-based services, jails and prisons may present the only opportunity for some severely mentally ill persons to receive psychiatric treatment.

While correctional facilities have been described as "the last mental hospitals" in this country (7), they are a poor alternative for adults who suffer from severe mental illness. According to Steadman and Veysey, less than half of all U.S. jails provide psychotropic medications or crisis

intervention services (8). Furthermore, the stress of incarceration can be particularly harmful for the mentally ill, increasing both the risk of relapse and the potential for suicide. Torrey and colleagues noted that detainees with serious mental illness were more likely to be abused by other prisoners while in jail and were more likely to refuse medication while in jail, increasing the risk of more severe psychiatric symptoms (9). Incarceration can also isolate people with serious mental illness from already fragile community supports, reducing the likelihood of subsequent engagement in community mental health treatment (10).

Once released from correctional facilities, persons with severe mental illness commonly experience difficulties connecting to psychiatric services in the community. The connection process is especially difficult for those who cycle in and out of correctional facilities. According to Beck, 41% of all inmates released from jails and prisons are reincarcerated within three years (11). Despite efforts to coordinate follow-up treatment, appointments arranged between jails and community healthcare centers are often missed due to a number of factors. These include transportation barriers, lack of residential planning, interagency miscommunication, and interrupted social service support. All to often, most prisoners with mental illness are released to the streets with minimal, if any, treatment and no immediate access to medication (12). Such problems may occur despite the presence of jail diversion programs. Current models of diversion include jail-based programs (13), mental health courts (14,15), and police and mental health response teams (13,16,17). While various models exist, they are dependent upon access to appropriate services in the community in order to successfully divert mentally ill individuals. At a recent *Bridges and Barriers* mental health and criminal justice conference held in Rochester, New York, Steadman underscored this point when he stated, "There are many diversion programs around; the problem is diversion to what (18)?" In addition, Veysey et al found that less than half of all diverted persons actually receive services after release regardless of the diversion strategy used (19). For patients who do access community based services following release, difficulties in coordinating the efforts of criminal justice and healthcare providers may arise. These can include difficulties maintaining patient confidentiality, delayed information exchange, poor treatment engagement strategies, lack of cross training for front line employees, and differing attitudes on how best to serve the patient clinically (16,20). In addition, opinions often vary within mental health and criminal justice agencies on whether or not an arrest is warranted for patients who violate terms of probation or parole.

To effectively treat individuals with severe mental disorders and criminal justice histories, models that integrate criminal justice, community healthcare and support services are necessary. This paper will describe the steps towards service integration at multiple points taken by Project Link, a comprehensive community-based program designed to prevent incarceration among severely mentally disordered adults at risk for criminal justice involvement.

PROJECT LINK

Project Link is a university-led community consortium that spans healthcare, criminal justice and social service systems. General descriptions of the program and preliminary data about its effectiveness have been presented previously (21–23), and will be updated later in this paper. Briefly, Project Link represents a new hybrid model of care that incorporates elements of three models of service delivery: assertive community treatment (ACT), the modified therapeutic community, and jail diversion. The project features a mobile treatment team, access to a dual diagnosis treatment residence, culturally competent staff, and close coordination with the criminal justice system. Project Link's mobile treatment team is staffed by a forensic psychiatrist, nurse practitioner, and five bachelor's level case advocates supervised by the team coordinator. The forensic psychiatrist and nurse practitioner assist the case advocates in providing *in-vivo* treatment services within the community. With the goal of prevention of incarceration and the delivery of comprehensive care for enrolled patients, Project Link offers service level integration at multiple points within the criminal justice, healthcare and community support systems.

MULTIPOINT SERVICE INTEGRATION

According to the Bazelon Center for Mental Health Law, Project Link represents a comprehensive diversion program that forges linkages at several points along the criminal justice continuum (24).

Employing a mobile treatment team, Project Link staff members work closely with police, jail staff, judges, probation and parole officers. Beyond linking with criminal justice representatives, the project also works to develop broad linkages with various community support services. These include residential, vocational and entitlement services. In order to integrate these various service points in Upstate, New York,

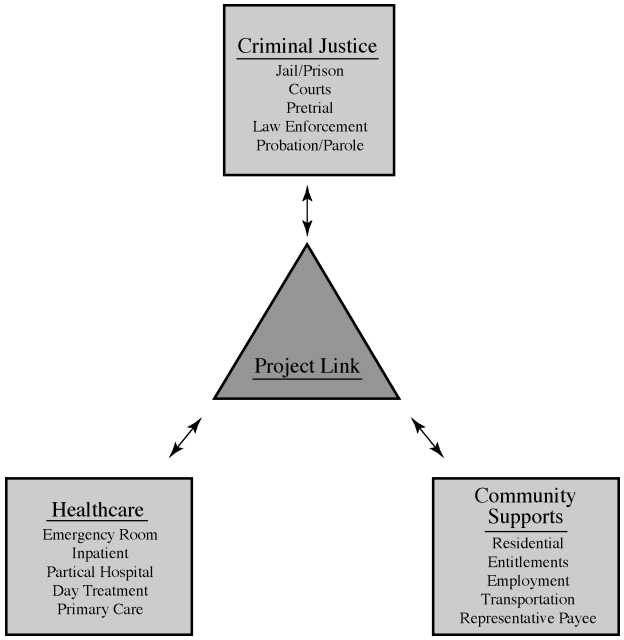

FIGURE 1. Multipoint service integration.

Project Link functions as central locus for referral and entry to care for at-risk individuals requiring community mental health services. Figure 1 displays the multiple points of service integration developed by Project Link. By creating these linkages between the local criminal justice, healthcare and community support services, the project integrates and delivers comprehensive treatment to enrolled patients.

Integration within Project Link begins by creating channels for referrals that originate from a variety of sources. Criminal justice referrals come from law enforcement officers, mobile crisis teams, jail and prison staff, courts, attorneys, pretrial services and departments of parole and probation. Mental health services referrals to Project Link come from, state institutions, emergency rooms, mobile crisis teams, as well as other community inpatient and outpatient healthcare agencies. Community support agencies including homeless shelters, churches, social service programs and advocacy groups also refer to the project. These multiple points of contact have promoted integration of clinical, criminal justice, and social services, and have facilitated the community adjustment of patients enrolled in the program as described below.

POINTS OF SERVICE INTEGRATION

Criminal Justice Services

A priority at initiation of Project Link was integration with local criminal justice agencies, including law enforcement, corrections and the courts. This process began by arranging a series of meetings between representatives of both Project Link and the criminal justice system. Following initial discussions between the directors of Project Link and representatives from the county court and jail, presentations led by county court and law enforcement staff were held for the project's mobile treatment team staff. Sessions included topics on mental health and medical services within the jail, booking procedures, legal terminology, criminal procedure law and review of the various agencies that comprise the Department of Corrections. In response, Project Link provided orientation seminars to the various local criminal justice agencies. Informational presentations were provided to several agencies within Monroe County, New York, including the Departments of Parole, Probation, the Rochester Police and Sheriff's Departments, Alternatives to Incarceration and the Monroe County Bar Association. During these seminars, program description, admission criteria and referral forms were disseminated to all attendees.

As noted above, Project Link receives mental health referrals from a wide variety of criminal justice sources, including the county jail, state prisons, attorneys, and court justices. When referrals arrive from the Monroe County Jail Clinic for Socio-Legal Services (Socio-Legal Clinic) a mental health clinic located within the County jail, Project Link team members enter the jail to perform preliminary diagnostic evaluations. These evaluations allow Project Link's clinical staff to assess appropriateness of the referrals and to acquire the clinical data necessary for enrollment. This assertive approach to engaging patients within the criminal justice system allows Project Link to bridge traditional service delivery gaps by arranging services prior to release of the patient. The mobile treatment team's case advocates are responsible for arranging support services, including reinstatement of social services funding, arrangement of appropriate residential services, and linkage with primary medical care providers.

Once assigned to a Project Link case advocate, patients are assisted within courtroom and jail settings where the advocates routinely talk with judges, counsel and jail staff. Due to ever increasing docket volumes, individuals suffering from severe mental disorders frequently

wait several hours for their dispositions from the court. These routine delays may exacerbate symptomatic behaviors of mental illness such as acting out in bizarre or paranoid ways, or exiting the court prematurely. Such behaviors and absences can lead to unnecessary bench warrants or jail time, and may contribute to the stigma of seriously mentally disordered persons as being "dangerous" and "difficult." To examine these issues and possible solutions, meetings between the court justices, bailiffs and Project Link staff were held. Through discussions with several court justices, the Project Link was able to identify a single judge with a special interest in hearing the cases of persons with severe mental disorders. This process has enabled Project Link patients to be served primarily by one judge, resulting in the development of an informal mental health court. As a result of this collaborative effort, Project Link patients are now given priority in the courtrooms to expedite their legal proceedings and reduce the likelihood of premature exits from court and additional legal charges.

The regular interaction of Project Link staff members with representatives of the criminal justice system promotes and facilitates the disposition of patients into the project's mobile treatment team. Patients are often referred to the project as an alternative to incarceration after being placed on conditional release to the Departments of Parole and Probation. Project Link clinical staff members actively collaborate with the local Departments of Probation and Parole for their patients monitored under those programs. In order to promote integration of services, specific officers within each department were identified to assist Project Link, and initial meetings were arranged to discuss coordination of services. During these meetings, the officers and Project Link representatives shared information about their respective programs, and they exchanged lists that included emergency phone numbers of their staff members, supervisors and administrators. This collaboration has cleared confusion over their respective roles in the community, and has promoted ongoing communication and improved delivery of services. In addition, after obtaining necessary releases of information, the ability of probation and parole officers to reinforce clinical treatment recommendations has enabled Project Link to generate therapeutic leverage. For patients with high levels of impairment due to combined chemical abuse and psychosis, such leverage can be essential in promoting sobriety as well as participation in potentially life saving treatment.

Project Link also works to achieve integration of mental health and criminal justice services through the activities of the project coordinator, a psychiatric nurse with criminal justice system experience. The

coordinator functions as an administrative liaison to criminal justice system representatives, in addition to managing the referrals from the Socio-legal Clinic and supervising the case advocates. The Socio-Legal Clinic provides forensic mental health evaluations to the courts and psychiatric services within the county jail, and its daily involvement within the facility provides a natural gateway for patient referrals from the local criminal justice system into Project Link. By working closely with the Socio-Legal Clinic director, the Project Link coordinator can discuss new referrals and inquire into needed mental health, medical and social services, thus ensuring continuity of care between the jail and the community. This relationship also provides a channel for Project Link to obtain current information about the clinical and legal status of those enrolled patients who are reincarcerated. Utilizing office space provided by the Socio-Legal Clinic, the project coordinator is able to review records of reincarcerated patients promptly. By having access to records and by serving as a liaison between Project Link and Socio-Legal Clinic staff, the coordinator is able to ensure proper follow-up of all reincarcerated patients while in the jail and integrate services prior to discharge to the community.

Healthcare Services

Due to the very significant healthcare needs of patients in Project Link, access and continuity of care for enrollees requires integration between a number of mental health and medical services within the community. In response to these needs, Project Link staff have delivered in-service presentations and forged contacts within both the mental health and primary care systems. This proactive approach to engaging mental health and primary care providers has increased access to care for this difficult patient population that is often shunned by traditional healthcare agencies. It has also provided channels for direct consultation and disposition to Project Link from crisis-based services.

Patients requiring emergency room services are preferentially diverted to the host hospital of the Project Link mobile treatment team. Updated contact lists and on-call numbers for mobile treatment team staff are maintained and protected in the host hospital's emergency room to ensure continuity of care for Project Link patients. This strategy avoids unnecessary delays in information exchange and helps to prevent inappropriate psychiatric admissions. Liaison with members of the local Mobile Crisis Team, an emergency intervention team associated with the emergency department, has provided synergy to better serve those enrolled. If the Mobile Crisis Team responds to an urgent

request for evaluation of an enrolled patient living in the community, they can notify the on-call Project Link staff for assistance and rapid follow up services.

For those Project Link patients requiring inpatient psychiatric hospitalization, efforts have been made to integrate the mobile treatment team's care with the host hospital's psychiatric inpatient unit. As a result of orientation meetings with providers on this unit, Project Link staff have lessened the burden to both the patient and clinician during the admission process and at discharge. Previously, individuals admitted to the inpatient unit have ended up on vastly different medication regimens furthering their risk of nonadherence. Collaboration between providers now includes a focus on optimal pharmacological management, including use of long-acting antipsychotics and avoidance of benzodiazepines at discharge for the addiction prone. Project Link also assists inpatient staff in obtaining safe and therapeutic residential placement limited options over frequently utilized temporary housing or shelters. Building continuity of care between these mental health services has also limited resistance to admit those Project Link patients requiring emergency evaluation and psychiatric admission. As noted above, inpatient providers have notoriously been left without safe discharge plans for such patients in the past. This problem has resulted in the use of less appropriate treatment alternatives such as lengthy emergency room stays and repeated short-term hospitalizations to manage the complex needs for some of these individuals. Project Link maintains ongoing contact with providers during admission and represent a definitive and appropriate access point at the time of discharge. Overcoming these barriers to communication and insufficient residential placement has provided lasting benefits to Project Link recipients, inpatient providers, and limiting the number of cases lost to follow up.

Upon discharge from inpatient units, some Project Link patients may receive step down care at the host hospital's Partial Hospitalization program. As with inpatient units, Project Link works to assist with the exchange of clinical information and to facilitate disposition planning at the time of discharge from the Partial Hospitalization program. Project Link also integrates service delivery for patients enrolled in the hospital's Continuing Day Treatment (CDT) program. Integrating with the CDT program offers Project Link ongoing psychosocial and vocational opportunities that are not typically available to patients with substantial histories of criminal behavior. Access to such care is promoted by the availability of Project Link staff for immediate clinical back-up in the event that crisis intervention is needed at the CDT program.

Ultimately, these collaborations within the healthcare system have also lead to direct referrals to Project Link from the Partial Hospital, CDT program and other community-based mental health service providers.

Individuals with severe mental disorders at risk for criminal justice involvement face limited access to necessary primary care medical services. In order to bridge this barrier to care, all Project Link patients can receive their primary health care from the Medicine in Psychiatry Service (MIPS). MIPS is a medical clinic specializing in primary care of the mentally ill that is affiliated with Project Link's host hospital. Integration with the MIPS clinic was incorporated during the development of Project Link, and this relationship creates comprehensive healthcare services for those patients enrolled without a primary care provider. This linkage allows for rapid consultation between Project Link and the MIPS for shared patients. Other benefits of this collaboration include having medical care providers sensitive to the special needs of the severely mentally ill, a reduction in unnecessary delays for medical care, and a reduction in unnecessary use of emergency rooms for routine primary care needs.

Community Support Services

In order to successfully transition patients from jails and prisons into the community, it was also necessary to develop linkages and integrate with local social services offices. Patients who receive financial support through these offices typically have their support, including Medicaid, discontinued due to their incarceration. Delays in acquiring or reactivating services were common for these individuals before development of Project Link. Such delays would leave patients without a means to pay for necessary medication, housing, transportation and other essential services. With the support from the Monroe County Office of Mental Health, dedicated liaisons were identified within the local Department of Social Services offices. This improved access, combined with escorts by Project Link staff to initial visits, facilitates reinstatement of benefits, while minimizing the risk of failed appointments for patients.

Access to safe and recovery-oriented residential services represents a significant challenge for mentally disordered individuals with criminal justice involvement upon release to the community. While traditional ACT programs work to link patients to housing in the community, existing housing programs are often reluctant to accept patients with histories of crimes such as assault, burglary and arson. Prior to establishing a therapeutic residence, failures experienced in safely housing

individuals in the community were all too common for Project Link staff and patients. Initial housing for Project Link patients included a dual diagnosis residence operated by DePaul Group Homes, Inc., a ten bed supervised apartment facility that afforded a unique environment to promote abstinence and residential stability. Based on the modified therapeutic community model, the residence provided supervised housing on a 24-hour daily basis, including a certified substance abuse counselor on staff. Such residential support for this population was a key element in the success for Project Link (21). Since that time, Project Link has developed access to various residential settings within the DePaul system, including a Single Room Occupancy (SRO) facility, depending on clinical stability and substance use needs of each patient. This innovative arrangement offers a flexible model of housing and allows for step-down or "graduation" for patients as their needs and requirements for supervised housing change.

PROGRAM EVALUATION

The primary goals of Project Link are to prevent jail and hospital recidivism while promoting community reintegration of individuals with severe mental disorders who are involved in the criminal justice system. In order to examine the effectiveness of Project Link at accomplishing these goals, data was collected on the first 60 patients enrolled in the program. The methodology of this study has been described previously (22). The single largest source of referrals for this group of patients was the local county jail, followed by the state psychiatric hospital. Eighty percent of the patients were male, with a mean (SD) age at enrollment of 35.8 (8.7) years. Sixty-eight percent were African American, 20% were Caucasian, 7% were Hispanic, and 5% were from other ethnic groups. Fifty-three percent met DSM IV criteria for schizophrenia, 22% for psychotic disorder NOS, 10% for schizoaffective disorder, 8% for bipolar disorder, and 7% for other diagnoses. Over 90% percent of patients in the group had histories of co-occurring substance abuse or dependency at the time of admission.

Criminal justice involvement data was gathered from clinical interviews and available medical and criminal justice records on each patient at the time of admission. Nearly half of the patients referred to Project Link had some form of legal status or pending charges at admission. Of those individuals admitted to Project Link, 32% were on parole, 15% were on probation and 13% had charges pending. Figure 2 shows the breakdown of crimes by type for the first 44 patients to complete one

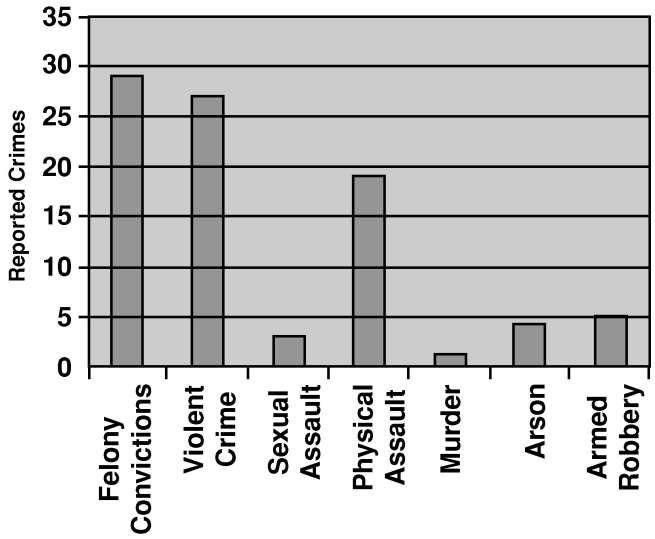

FIGURE 2. Prior crimes reported ($N = 44$).

year of treatment in Project Link. Over 60% reported prior felony convictions, representing both violent and nonviolent crimes. In addition, 57% of the group has committed a violent crime at some point in their lives. This data represents both felony and misdemeanor violent crimes, and crimes reported that may not have resulted in a conviction.

Criminal justice and mental health service utilization data was also collected for the first 44 patients to complete one year of enrollment in Project Link. During the year prior to enrollment the 44 completers utilized a mean (SD) of 103.6 (130.4) jail days and 114.0 (130.8) hospital days per patient. During the first year of enrollment in Project Link, service utilization decreased significantly to mean (SD) of 45.2 (81.0) jail days per patient ($p < .05$; Wilcoxon test, two-tailed), and a mean (SD) of 7.9 (18.2) hospital days per patient ($p < .001$; Wilcoxon test, two-tailed). Significant reductions were also noted in mean number of arrests per patient ($p < .05$; Sign test, two-tailed), and in average number of incarcerations and hospitalizations per patient ($p < .05$, $p < .005$; Sign test, two-tailed). In order to assess community adjustment, the Multnomah Community Ability Scale (MCAS) was administered to all patients at the time of enrollment and readministered one year later. Significant improvement was noted, with the mean (SD) MCAS score increasing from 51.6 (7.4) at enrollment to 61.2 (8.5) after one

year in Project Link ($p < .001$; Wilcoxon test, two-tailed). Engagement in substance abuse treatment was assessed through administration of the Substance Abuse Treatment Scale (SATS) at enrollment and one year later. Significant improvement was also noted, with the mean (SD) SATS score increasing from 2.3 (1.7) at enrolment to 4.8 (2.3) after one year ($p < .001$; Wilcoxon test, two-tailed).

A preliminary cost analysis was conducted to examine changes in direct service costs and residential costs resulting from treatment in Project Link. Utilizing audited year-end financial statements, all direct service costs during Project Link enrollment including inpatient, outpatient, emergency room, and CDT were calculated. Residential costs were calculated by assigning a monthly charge of $1974.35 to all Project Link patients after enrollment, minus days spent in jail or the hospital. Residential costs were not assigned to patients prior to enrollment in Project Link. Jail costs were calculated at a local rate of $77 per day, and inpatient hospital costs as a local rate of $578 per day. Multiplying all costs by service frequencies, the average yearly service cost per patient decreased from $73,878 during the year prior to enrollment to $34,360 during the first year in Project Link.

CONCLUSIONS/FUTURE DIRECTIONS

The number of individuals suffering from severe mental illness entering our nation's jails and prisons appears to be growing (1). Speaking about incarceration of the severely mentally ill, Dave Norman, attorney for Washington D.C.'s Public Defender Service stated: "Their crimes are as much a result of our failure to coordinate the efforts of our mental health and criminal justice systems in a way that will best address their unique circumstances and bring an end to this cycle (25)." Project Link has worked to span existing boundaries by promoting integration of healthcare, support and criminal justice services at multiple points of operation. Given the considerable barriers that currently separate these service systems, development of an integrated model of care is best understood as a long-term goal. Future directions to consider in pursuing this goal include: a) incorporation of basic criminal justice system orientation and education into existing mental health training programs; b) creation of combined mental health/criminal justice funding streams to stimulate development of hybrid service programs; c) establishment of mental health and community support liaisons within the criminal justice system with the capacity to represent corrections, judicial and law enforcement aspects of the criminal justice system; and

d) further study of the role of outpatient civil commitment programs in reducing jail recidivism and promoting adherence to treatment for persons with severe mental disorders.

Project Link represents a step towards providing multipoint access to care that is integrated in nature and comprehensive in scope. While our outcome data suggests that Project Link is a cost-effective model of care, several study limitations should be noted. These include quasi-experimental design, elimination of non-completers, small sample size and retrospective acquisition of pre-enrollment data. Further studies are necessary to evaluate the effectiveness of this model of care.

ACKNOWLEDGMENTS

The authors wish to thank all members of Project Link for their efforts. This paper is dedicated in memory of Morton Weisman.

REFERENCES

1. Lamb RH, Weinberger LE: Persons with severe mental illness in jails and prisons: A Review. Psychiatric Services 49(4):483–492, 1998
2. Health Care Reform for Americans with Severe Mental Illness: Report of the National Advisory Mental Health Council. American Journal of Psychiatry 150(10):1447–1465, 1993.
3. Lamb RH, Weinberger LE, Gross BH: Community treatment of severely mentally ill offenders under the jurisdiction of the criminal justice system: A review. Psychiatric Services 50:907–913, 1999.
4. Valdiserri EV, Carroll KR, Hartl AJ: A study of offenses committed by psychotic inmates in a county jail. Hospital and Community Psychiatry 37 (2):163–166, 1986.
5. Steinwachs D, Kasper J, Skinner E: Final Report: NAMI Family Survey. Supported by the MacArthur Foundation, Arlington, VA, National Alliance for the Mentally Ill, 1992.
6. Dvoskin JA, Steadman HJ: Using intensive case management to reduce violence by mentally ill persons in the community. Hospital and Community Psychiatry 45:679–684, 1994.
7. Gilligan J: The last mental hospital. Psychiatric Quarterly 72:45–61, 2001.
8. Steadman HJ, Veysey BM: Providing services for jail inmates with mental disorders. National Institute of Justice Research in Brief. Washington, DC, U.S. Department of Justice, 1997. (NCJ-162207)
9. Torrey EF, Steiber J, Ezekiel J, et al: Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals. Washington, DC, Public Citizen's Health Research Group and the National Alliance for the Mentally Ill, 1992.
10. O'Flaherty B: Making Room: The Economics of Homelessness. Cambridge, MA, Harvard University Press, 1996.

11. Beck AJ: State and Federal Prisoners Returning to the Community: Findings from the Bureau of Justice Statistics. Washington, DC, Bureau of Justice Statistics, April 13, 2000.
12. Regan C, Mental illness and the criminal justice system. Mental Health World 9(2):22, 2001.
13. Steadman HJ, Deane MW, Morrissey JP, et al: A SAMHSA research initiative assessing the effectiveness of jail diversion programs for mentally ill persons. Psychiatric Services 50:1620–1623, 1999.
14. Watson A, Hanrahan P, Luchins D, *et al:* Mental health courts and the complex issue of mentally ill offenders. Psychiatric Services 52:477–481, 2001.
15. Sipes GP, Schmetzer AD, Stewart M, *et al:* A hospital based mental health court. Community Mental Health Journal 22:229–237, 1986.
16. Deane MW, Steadman HJ, Borum R, et al: Emerging partnerships between mental health and law enforcement. Psychiatric Services 50:99–101, 1999.
17. Steadman HJ, Stainbrookl KA, Griffin P, *et al:* A specialized crisis response site as a core element of police-based diversion programs. Psychiatric Services 52:219–222, 2001.
18. Steadman H: Keynote address: Bridges and Barriers Conference. University of Rochester Medical Center, Fall, 2002.
19. Veysey B, Steadman H, Morrisey J, et al: In search of the missing linkages: Continuity of care in U.S. jails. Behavioral Sciences and the Law 15:383–397, 1997.
20. Hartwell SW, Orr K: The Massachusetts forensic transition program for mentally ill offenders re-entering the community. Psychiatric Services 50:1220–1222, 1999.
21. Gold Award. Prevention of jail and hospital recidivism among persons with severe mental illness: Project Link. Psychiatric Services 50:1477–1480, 1999.
22. Lamberti JS, Weisman RL, Schwarzkopf SB, et al: The mentally ill in jails and prisons: Towards an integrated model of prevention. Psychiatric Quarterly 72:63–77, 2001.
23. Lamberti JS, Weisman RL: Preventing incarceration of adults with severe mental illness: Project link. in: Serving Mentally Ill Offenders. Edited by Landsberg G, Rock M, Berg L, New York, Springer, pp. 133–143, 2002.
24. Bazelon Center for Mental Health Law. Fact Sheets on the Criminalization of People with Mental Illness. Available at: www.bazelon.org/issues/criminalization/factsheets/criminal9.htm.
25. Mentally ill don't belong in prison. Psychiatric News: Viewpoints, December 19, 1999, pp. 22,24.