

MENTALLY ILL OFFENDERS: COMPONENTS OF AND THE NEED TO PROVIDE
EFFECTIVE TREATMENT PROGRAMS

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Mentally Ill Offenders: Components of and the Need to Provide
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Statement of the Problem

Research showed that the deinstitutionalization of the mentally ill during the 1960s left many individuals fend for themselves; individuals who at times required 24-hour supervision and assistance. Due to the lack of community support and treatment programs, those with mental illness found themselves caught up in a criminal justice system that seems unfit to their unique needs.

Around two-thirds of inmates within local jails met the criteria for having a mental problem while over half and nearly half of the inmates in state and local federal prisons were diagnosed as having a mental illness. A review of the literature examined the challenges mentally ill individuals may face throughout the criminal justice process, beginning with initial contact with law enforcement and throughout the incarceration period.

Methods and Procedures

All research was gathered from secondary sources. All information gathered for this paper came from secondary sources. Each source was from peer reviewed journal articles, the National Institute of Mental Health, Department of Justice, textbooks, and/or reviews of treatment programs. The data collected was used to formulate recommendations for the development of effective treatment programs for offenders with mental illness.

Summary of Results

With the deinstitutionalization of the mentally ill during the 1960s came a phenomenon known as the criminalization of the mentally ill. Instead of being provided with treatment facilities and rehabilitation programs, individuals suffering from mental illness became caught up in the criminal justice system.

While incarcerated, mentally ill inmates were faced with noisy and crowded conditions that exacerbated the symptoms of mental illness. As a result, many were placed into solitary confinement as a method of punishment. Further, the strained relationships between mentally ill inmates, fellow inmates, and correctional guards prevented the allowance of adequate treatment.

Crisis Intervention Teams (CITs), post-booking jail-based diversion programs, mental health courts, and Forensic Assertive Community Treatments (FACT) were collaborative community treatment programs that appeared to assist in providing mentally ill offenders with adequate and necessary, and effective treatment. Such programs also proved to be cost-effective. The Chief Justice's Task Force on Criminal Justice and Mental Health in Wisconsin may be utilized as the foundation for states to build cost-effective and collaborative interventions for individuals diagnosed as having a mental illness.

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I. Introduction

During the 1960s, 93 percent of psychiatric beds were emptied following the implementation of deinstitutionalization; those who once occupied the beds either ended up in prison or had to fend for themselves (Rivera, 1999). Many individuals with serious mental illness have since failed to receive necessary and adequate treatment, and some have turned to a life of crime, a life in prison, or a life lived on the streets (Lyons, 2007). A Federal Bureau of Justice Statistics study found that more than half of all prison and jail inmates have a mental health problem (Glaze & James, 2006). Following deinstitutionalization, police officers and the criminal justice system became a mental health adjunct (Rivera, 1999).

Today, individuals suffering from mental illness are put through the same criminal justice system as those without such issues. Limited community treatment and/or support, along with inadequate officer training, may lead an individual with a mental illness to a life in jail or prison. Life inside prison may be difficult for even those without the added issue of a mental illness, and such offenders pose different challenges than typical inmates to themselves, other inmates, and correctional officers.

Statement of the Problem

The National Institute of Mental Health has noted that around two-thirds of inmates in local jails currently have, within the previous year, met the criteria for having a mental health problem. This means inmates in local jails have the highest prevalence of mental health problems. Furthermore, 56 percent and 45 percent of inmates have been diagnosed as having a mental health problem in both state and federal prisons, respectively. Prior to their arrest, less than one half (49 percent) of these individuals had ever received any mental health treatment,

and following their arrest this number fell to only 34 percent.

Implications of the Study

Throughout this paper, the reader will be presented with some viewpoints pertaining to the current criminal justice system and its handling of those with mental illnesses. From the initial contact with law enforcement to the incarceration process, mentally ill offenders often face many challenges that the traditional offender does not. Law enforcement personnel may not always receive adequate training to handle mentally ill offenders and correctional settings may not always be appropriate for such individuals. The cost of housing mentally ill offenders in correctional settings may come at a high cost, a cost that may be eliminated through the use of treatment programs. While the financial aspect of treatment options is necessary to examine, so, too, is the cost of one's mental health. In other words, correctional settings may run the risk of increasing one's mental health issues while treatment options may decrease such problems. Therefore, an analysis of the non-monetary costs of both correctional settings and treatment programs is essential. Further along in the literature review, the reader will be presented with different types of treatment programs that seek to reduce the challenges mentally ill offenders may face in the criminal justice systems and its correctional facilities. Following these reviews, the readers will be given the necessary framework to implement effective and ideal treatment programs for those offenders suffering from mental illness.

It is anticipated that this study will allow for there to be a greater understanding of the limitations within the traditional criminal justice system, and for those offenders suffering from mental illness to receive the most appropriate and adequate care possible.

Methods of Approach

All information gathered for this paper came from secondary sources. Each source was

from peer reviewed journal articles, the National Institute of Mental Health, Department of Justice, textbooks, and/or reviews of treatment programs.

Contributions to the Field

This paper will allow for there to be a closer connection between the fields of criminal justice and psychology in regards to mental illness. Through this connection, there is the hope that offenders suffering from mental illness will be provided with the opportunity to receive effective and ideal treatment that fits their needs rather than being subjected to remain in a system not meant for them.

Anticipated Outcomes

It was anticipated that this literature would provide its readers with information regarding the fact that typical jail and prison settings may not be appropriate for those offenders suffering from mental illness. From the provided literature, then, it is hoped that further research will offer more information regarding the appropriateness and benefits of mentally ill offenders participating in treatment programs.

II. Literature Review

Rise of Criminalization of the Mentally Ill

During the 1960s, a movement began in an attempt to fully eliminate involuntary commitment. People began to view mental health institutions as “snake pits” (Vitiello, 2010, p. 2) while others believed them to be holding cells in which a diagnosis of mental illness was given as a means to control and limit dissent (Vitiello, 2010). This anti-psychiatry movement brought about an expansion for the rights of those with mental illness and played a role in the deinstitutionalization of mental health care. During this time, another movement began to remove public funding from state mental institutions. With these two movements came the promise that those with mental illness would be provided with community-based care, allowing for greater freedoms while at the same time not leaving them to their own devices. While community-based treatments were certainly found to be effective, many were unable to receive adequate resources, funds, and were incapable of keeping up with the demand of those being released from other institutions.

Those with mental illness still required 24-hour supervisions, but due to the closings of mental health facilities and a lack of sufficient housing, many became homeless. The general public began to fear such individuals, who could be found on street corners talking to themselves, urinating in the public, or illegally using drugs as a method of self-medicating. In an effort to starve off hunger, afford housing, or obtain money for their drug habits, those with mental illness could also be found begging for money or committing thefts. In turn, law enforcement officials were pressured into arresting and incarcerating them because of their petty crimes or attempts at self-medicating. As a result, mentally ill individuals became caught up in the process of transinstitutionalization - bouncing between courts, jails, and prisons. Also,

correctional facilities became “front-line mental health providers”, thus bringing about the criminalization of the mentally ill (Tapley, 2010, p. 185).

Law Enforcement Involvement

Police officers are typically the first to arrive at the scene involving those with a mental illness, and around 10 percent of all police contacts involve such individuals. Further, about one-third of those seen in an emergency mental health facility are referred by law enforcement (Broussard, Krishan, Hankerson-Dyson, Husbands, D’Orio, Thompson, Watson, & Compton, 2011). The three main objectives of law enforcement officials are to protect the public, serve those residing in communities, and serve and protect the law; these three objects may at times compete. When serving those with a mental illness, the public may view it as a failure to protect because of the belief that incarceration is the correct solution to disobeying the law. Officers may also hold the perception that compassionately serving an individual with a mental illness is outside their job description, and that being labeled or treated as a social worker is belittling (Chief Justice’s Task Force, 2010).

Upon arrival to the scene, an officer’s perceptions may play a role in the decision to arrest the individual, refer the offender to mental health services, or take no action. Factors that may influence the officer’s decision to act depend on whether a crime was committed, the severity of it, the behavior of the individual, and the officer’s own understanding of the individual’s situation. If an officer enters a situation with the knowledge of the person having a mental illness, the officer’s perceptions of the dangerousness, unpredictability, and incompetence of the offender may result in inappropriate handling of the incident.

An individual may be perceived as disrespectful, disobedient, and unreliable if an officer is not aware of the mental illness. In order for officers to respond aptly to situations involving

those with mental illness, ample training should help officers evaluate information, physical cues, or body language that may indicate the person they have come in contact with has a mental illness. When faced with an individual with a mental illness, officers may utilize the acronym of AUTISM when responding to calls with persons with autism and other mental disabilities (Debbaudt & Rothman, 2001). Each letter in AUTISM is a reminder as to how to properly handle the individual:

A: Approach the person quietly and in a non-threatening way

U: Understand that touching the individual may produce a defensive and protective fight or flight reaction

T: Talk to the person in a calm voice

I: Instructions should be kept simple and direct

S: Seek all indicators to assess the situation as it unfolds

M: Maintain a safe distance until any inappropriate behaviors decrease.

Correctional Systems

Incarceration Process

Due to the limited availability of community treatments for those with mental illness, arrest rates for this population have increased (Adams & Ferrandine, 2008); those diagnosed with a mental disability are about seven times more likely to have contact with law enforcement (Tapley, 2010). One finding for this phenomenon is that approximately 40 percent of people with mental illness do not receive treatment. The lack of treatment may cause these individuals to turn to substance abuse, crimes of trespassing, disorderly conduct, or public intoxication (Lyons, 2007). For most with a mental illness, abnormal, antisocial, inappropriate, and acting out behaviors are the causes for arrest and incarceration. Some will confess to crimes not

committed with the intentions of pleasing authority, therefore becoming wrongfully incarcerated. Also, these individuals may inappropriately respond to police interrogation questions or misinterpret what the interviewer is saying, therefore appearing to be either incompetent, unreliable, or guilty (Debbaudt & Rothman, 2001).

Issues While Incarcerated

Incarceration may negatively affect most offenders, but mentally ill inmates often face unique challenges. Because these individuals are looked upon as people whom are best kept at a distance, prison life provides the grounds for stigmatization, isolation, and misunderstandings for such individuals (Lord, 2008). Inmates with mental health problems may be seen as easy targets for harassment and can quickly come into conflict with other offenders (Norton, 2005). The prison atmosphere as a whole enhances the negative issues for those with mental illness, and the crowded and noisy conditions further exacerbate the experiences of mentally ill offenders. The fragile personalities of such inmates may also be disturbed due to the strict rules and regulations of the prison (Vitiello, 2010).

Unlike most, those with mental illness either cannot accept or have trouble understanding that a wrongdoing was committed and the reason for the prison sentence. As a result, they may aggressively act out and be unable to recall why they did so and be incapable of explaining what it was they did (Lord, 2008). In response to their acting out, correctional officers may turn to the use of physical force and place them in solitary confinement. Typically, solitary confinement may be viewed as a consequence meant to provide safety and act as a disciplinary action. Instead, segregation may have detrimental effects and is under scrutiny. Those with mental illness, though, represent the majority of those in confinement. Psychological effects for any prisoner placed in isolation may include psychosis, anxiety, perceptual distortions, depression,

obsessive thoughts, paranoia, cognitive disturbances, and anger, but when mental illness is added to the mixture, solitary confinement is no longer a place for safety. One federal judge stated that “putting mentally ill prisoners in isolated confinement is the mental equivalent of putting an asthmatic in a place with little air” (Metzner & Fellner, 2010, p. 5). Because of the isolation, the type and amount of mental health services prisoners receive becomes restricted, and programming and treatment are no longer available (Metzner & Fellner, 2010; Lunau, 2010). Therefore, many mentally ill prisoners in segregation will not improve while locked up (Metzner & Fellner, 2010).

Those with mental illness find it challenging to negotiate prison environments long enough to become involved in self-improvement programs. According to Lord (2008), earning a General Educational Development (GED) is a desirable goal that a typical inmate may pursue while in prison. A GED is closely tied to becoming successful upon release, but mental illness may hinder a prisoner’s obtainment of such a goal. Because inmates may fall asleep in class, due to medications, only sporadically attend classes due to spending time in acute psychiatric care, or have difficulty with the assignments, earning a GED is often not attainable.

Mentally ill inmates become the prison’s untouchables; they are seen as people who should be kept at a distance and are therefore often stigmatized, isolated, and misunderstood (Lord, 2008). Some inmates who suffer from serious psychosis and who exhibit odd mannerisms may be viewed as potentially dangerous by other inmates and staff. Other inmates and staff may believe their unpredictability makes them inappropriate candidates for sharing living or work areas within the prison. Therefore, natural and necessary socialization for those with mental illness decreases and voluntary isolation increases.

Research indicates that nearly all mentally ill inmates engage in disruptive behaviors

(Roy & Ruddell, 2004). Such inmates have a disproportionate effect on safety and discipline within adult correctional institutes, accounting for 90 percent of self-harming incidents, 80 percent of inmate suicides, and 80 percent of assaults on staff (Mueller, 2009). Since the disruptive behaviors of those with mental illness are very unlike those of the general population, the ability of the staff to perform their duties and the inmates to serve their time can in turn be severely disrupted (Lord, 2008). For other inmates, residing next to or sharing any living quarter with a person with mental health issues may not be conducive to serving out a sentence. That is, most inmates seem to wish to participate in school, work, and treatment programs while at the same time completing typical daily chores. When the prison environment is disrupted by an inmate with mental health issues, it may be difficult for other inmates to complete their wishes when disturbances interfere with their tasks.

Relationships between the mentally ill and other inmates may be strained because of the disruptive, odd, and unusual behaviors of mentally ill offenders, and this may then result in verbal abuse and physical assaults. These inmates are often viewed as troublesome and vulnerable, and other inmates may therefore fear and target such inmates (Vitiello, 2010); abuse and assaults are common experience (Dumond, 2000). Furthermore, loud and abusive mentally ill inmates increase their likelihood of experiencing intolerance and abuse from fellow inmates. These offenders are more likely to sustain injuries during a fight while in a state prison, with approximately 10 percent of those with mental illness compared to 4 percent without having been injured (Lord, 2008). In prisons, about 80 percent of all unusual incidents (incidents concerning only those viewed to present a serious threat to the safety and security of a facility and its prisoners) involved mentally ill prisoners.

When facing release, those with mental illness are often not provided with proper

community reintegration. According to a Bureau of Justice Statistics survey, only about one third of mentally ill offenders received proper treatment (Lyons, 2007). Without care, these offenders often continue a life of crime and incarceration following their release. If the individual is homeless, has unresolved addiction problems, or does not have adequate support within the community, the likelihood of a successful reentry into the community decreases and the recidivism rate increases (Roy & Ruddell, 2004). For this population, the recidivism rate is between 60 and 70 percent (Usher, Hayes-Boober, O'Leary, Fagan, Miller, LaVerne, 2010).

Components of Effective Treatment Programs

Due to the crimes committed by those with mental illness, communities may begin to reject such individuals and may come to believe that their neighborhood will be safe only when they are incarcerated or hospitalized (Hodgins, Tengström, Eriksson, Österman, Kronstrand, Eaves, Hart, Webster, Ross, Levin, Levander, Tuninger, Müller-Isberner, Freese, Tiihonen, Kotilainen, Repo-Tiihonen, Väänänen, Eronen, Vokkolainen, & Vartiainen, 2007). This fear may make it more difficult to convince politicians and the public that community treatment options require funding and support. In comparison to long-term hospitalization or incarceration, community programs allow for more humane, less expensive, and highly structured treatment options. Recidivism rates, even among the higher risk patients, could also be prevented when diverting mentally ill offenders to community programs. Further, long-term hospitalization and incarceration may result in the loss of daily living skills. Therefore, community treatment options may provide the opportunity for the individual to learn healthy life skills and prosocial behaviors.

Programs require a collaborative effort between correctional and mental health personnel. Five features of successful programs have been identified, with the first being the need for highly

structured, intense, and multiple components that target a specific problem. The treating clinicians should also accept a two-fold role, to treat the individual and prevent criminality and violence. Successful programs were likewise found to involve treating clinicians who accept the responsibility of guaranteeing that the patients followed through with their individualized program. The fourth component pertains to the fact that the treating clinicians could promptly re-hospitalize the patient against his will if deemed necessary in order to stabilize acute symptoms. Lastly, certain patients may require having their court records available to ensure compliance with each aspect of the program.

Treatment programs may differ in size, type, and operation. To be effective in being a true diversion program, each will need to include treatment components that specifically acknowledge every presenting problem. Supervision for some of the patients may also be required to ensure medication taking, abstinence from drugs and/or alcohol, and other daily life skills are occurring. The bottom line for effective diversion treatment options is that each must match and respond to the needs of the patient.

Mentally Ill Offender Programs

Although there have been numerous diversion programs throughout the years, five specific types of programs have been identified by the Bazelon Center for Mental Health Law (Loveland & Boyle, 2007). These diversion programs include:

- Pre-booking, police-based programs that provide mental health treatment in lieu of arrests
- Post-booking, jail-based diversion programs that divert individuals into psychiatric treatment in lieu of incarceration or reduced incarceration
- Post-booking, court-based jail diversion programs that use a variety of adjudication or post-adjudication methods, including specialized mental health courts, to divert individuals into treatment in lieu of incarceration or reduced incarceration and possibly reduced charges

- Re-entry programs that help individuals on parole or have completed their sentence acquire treatment and resources after incarceration and possibly combined with early release from incarceration
- Comprehensive diversion programs that employ two or more of these interventions (Loveland & Boyle, 2007, p. 133)

CIT

Crisis Intervention Teams (CITs) fall into the first category of diversion program types. That is, they involve mentally ill offenders who have come into contact with law enforcement officials. Instead of being charged with a crime, they are diverted into a care program without further involvement with the criminal justice system. Beginning in Memphis, Tennessee as a pioneer program for law enforcement personnel, CITs were designed for those first responders who may come into contact with crisis situations involving individuals with mental illness (Dooley, 2010). The Memphis community joined together following a 1987 incident in which a mentally ill individual was shot and killed after contact with local police. The public became outraged, which led to collaboration between the Memphis Police Department, the National Alliance on Mental Illness (NAMI), the University of Memphis, and the University of Tennessee Medical School to develop effective ways to train officers when handling these situations (Shannon, 2010). The CIT then embraced its mission of “improv[ing] safety for officers and persons with mental illness” (Dooley, 2010, p. 70). Law enforcement, mental health and substance abuse treatment systems, mental health advocacy groups, and the consumers and families of mental health services joined together to form a partnership to implement CITs.

Post-Booking, Jail-Based Diversion Programs

Post-booking, jail-based diversion programs involve those mentally ill offenders who have been arrested and booked for an offense. These programs contain three core components:

“screening, assessment, and negotiation between diversion staff and criminal justice personnel to create a mental health treatment disposition and to waive or reduce charges or time spent in jail or prison” (Lattimore, Broner, Sherman, Frisman, & Shafer, 2003, p. 32).

The screening process takes place once the individual is booked into jail and is conducted by trained correctional officers. The officers screen the offender in order to distinguish between those who may be suffering from a mental illness and those who are not. Further evaluations then took place by jail-based mental health professionals in order to verify the presence of a mental illness. Participation in these programs were voluntary, and once the screening process took place, the negotiations begin. Staff from the diversion team and criminal justice system, along with the offender, discuss the terms of the individualized program and necessary components for successful completion. Charges may then be dismissed once the participant fully and adequately completes all terms of the program within the allotted time frame. Throughout the program, jail-based diversion staff will provide case management to all the offenders involved.

A post-booking, jail based diversion program for those with mental illness was assessed for its effectiveness in South Florida (Rivas-Vazquez, 2009). Termed relationship-based care, this program was meant to allow for such offenders to have access to primary and psychiatric health care through a theoretical framework specifically designed for these individuals. Data from 151 individuals diverted into the relationship-based care program was evaluated against the data from 78 individuals who were diverted into other programs within the community. Upon analysis of the results, it was found that a significant reduction in arrest rates occurred for those in the relationship-based care program when compared to those in the control group.

Post-booking, jail diversion programs are said to be more coercive due to the fact that

there are pending criminal charges against the individual (Lattimore et al., 2003, p. 32).

Participation in such programs is encouraged and supervised via courts and other case management personnel, therefore possibly allowing for participants to become more successful within these programs than compared to others.

Mental Health Courts

Mental health courts are dedicated, court-based jail diversion programs that involve a presiding judge, a mental health professional, a probation officer with proficiency in mental health issues, the prosecutor and the public defender. The Bureau of Justice Assistance (BJA) identified 150 mental health courts in effect today, each designed to lower the frequency of mentally ill offenders' contact with the criminal justice system. Mental health courts were meant to improve social functioning, while providing support services, treatment, housing, and employment.

Although diverse, each mental health court possesses four similar characteristics: 1) a specialized court docket, which employs a problem-solving approach to court proceedings in lieu of more traditional court procedures for certain defendants with mental illnesses, 2) judicially supervised, community-based treatment plans for each defendant participating in the court, which a team of court staff and mental health professionals design and implement, 3) regular status hearings at which treatment plans and other conditions are periodically reviewed for appropriateness, incentives are offered to reward adherence to court conditions, and sanctions are imposed on participants who do not adhere to the conditions of participation, and 4) criteria defining a participant's completion of (sometimes graduation from) the program (Thompson, Osher, & Tomasini-Joshi, 2007, p. 7).

Mental health courts are voluntary programs in which the offender and the treatment

team devise a plan that spells out incentives to successfully complete the program and the consequences of non-compliance. Once assessed for eligibility and provided with the terms of the treatment plan, the offender is connected with a community-based mental health program in lieu of incarceration.

Because mental health courts focus solely on those with mental illness, participants fare better than when put through traditional court systems. That is, traditional court systems do not provide the necessary treatment options as mental health courts and do not consist of the proper personnel to handle such individuals. Therefore, traditional courts run the risk of creating a cycle of offending and involvement within the criminal justice system.

FACT

Forensic Assertive Community Treatments (FACT) are based on the premise that those with mental illnesses have a 67 percent higher probability of being arrested than those without. They also have a 60 to 70 percent recidivism rate (Cusak, Morrissey, Cuddeback, Prins, & Williams, 2010). As a comprehensive, team based service, FACT is unique in terms of diversion options because it addresses those with previous arrests, recognizes referrals from criminal justice agencies, recruits criminal justice agencies as partners, encourages participation through the use of court sanctions, includes probation officers as part of its team, and makes re-arrest prevention a priority. With a team including a psychiatrist and a full-time probation officer, FACT allows for there to be low staff to client ratios and around-the-clock services.

A recent randomized clinical trial implemented in a California County examined the effects of a FACT intervention versus treatment as usual (TAU) with mentally ill offenders. Three hypotheses were posited in regards to those receiving the FACT intervention: recidivism rates would decrease, individuals would have fewer hospitalizations, and costs for both

behavioral health and criminal justice services would decrease. FACT participants were provided with support for housing, employment assistance, team-based substance abuse and mental health services, advocacy, and benefits applications. A probation officer was likewise available to the FACT participants, and this position obtained pre-existing and subsequent arrests, incarceration, and days spent in jail. Those in the TAU condition did not receive any of these additional services, and were instead exposed to only what was typically available in the county's public behavioral health system.

The 72 participants of the FACT intervention were held in the county jail at the time of the study, and following determination of eligibility, 62 participants were included in the TAU comparison group. Following close examination, it was found that these two randomized groups (FACT and TAU) were essentially comparable in terms of both measurable and immeasurable variables, thus allowing for greater reliability of the trial. Within the first twelve months, results indicated that FACT participants had significantly fewer bookings than those within the TAU group, and following the second year these same outcomes were again found. The first two years of the study resulted in no significant differences between FACT and TAU in terms of days spent in jail. As far as costs, the FACT group showed lower per individual inpatient costs when compared to TAU (\$5,426 and \$8,852, respectively). On the other hand, the findings for outpatient costs were opposite of those for inpatient, with the FACT group averaging \$13,474 and TAU \$5,115 during the first twelve months. Lastly, a significant difference was found in the amount of money spent per person. That is, \$814 was spent on each participant in the FACT group while \$2,226 was spent on those in the TAU. Although costs for FACT were found to be higher than TAU in some instances, the decrease in jail and inpatient services for FACT offset the increase in outpatient costs.

As hypothesized, forensic assertive community treatment does allow for there to be fewer jail bookings and a higher likelihood of remaining out of jail each year when compared to those who receive treatment as usual. Although individuals in FACT did not spend fewer days in jail, FACT participation resulted in a decrease in hospitalizations when compared to TAU. While the findings from this clinical trial provide positive outcomes for FACT, further research into such programs will be necessary to determine the cost-effectiveness of this option and to further promote FACT's effectiveness in decreasing jail bookings.

Costs of Mentally Ill Offenders

Research on the costs of incarceration versus treatment programs for mentally ill offenders appears limited; however, some evidence suggests there may be a financial difference between each option. The cost difference between incarceration and diversion programs does not stop at dollar amounts; if a price could be placed on human well-being, a significant distinction is also found.

Incarceration

Those with mental illness place a financial burden on corrections and law enforcement personnel (Usher et al., 2010). Throughout the past 20 years, state spending on corrections has increased 350 percent, from \$10 billion to \$45 billion. This may be in part due to the fact that the mentally ill inmate population has grown 14 percent from 2006 to 2008, while the general inmate population has shown an increase of 4 percent (Mueller, 2009). Because Medicaid prohibits billing for services while individuals are detained in county jails, this financial burden falls to the local governments (Usher et al., 2010). In Wisconsin alone, nearly \$60 million was spent on inmate mental health care during fiscal year 2007-2008 (Mueller, 2009). The Department of Corrections provided a breakdown of mental health expenditures for fiscal year

2007-2008, with \$20 million going towards staff costs, \$6 million for psychotropic medications, and \$33 put forth for the housing of the inmates. Of the 755 inmate assaults on staff in the past three years, those with mental illness accounted for approximately 80 percent of the incidents. These incidents resulted in \$874,200 going towards worker's compensation awards. Also, the Wisconsin Department of Justice estimates that \$1.1 million each year is spent on defending the State in regards to inmate health care litigation, along with \$4.8 million in settlements in the past five years.

The atmospheres within jails and prisons have proven to be costly in terms of the well-being of mentally ill inmates. Higher suicide rates, more self-harm behaviors, and higher incidents of aggressions towards staff and other prisoners are more likely among those with mental illnesses than those without (Lord, 2008).

Community Diversion

The Wisconsin government discovered ways to reduce the costs of treating mentally ill offenders through the use of appropriate mental health services. A 45-bed addition to the Wisconsin Resource Center (WRC) would use about \$11.1 million of the state's budget, with another \$7.6 million to build additional treatment space at Taycheedah. Although the building of such housing and treatment areas require a substantial amount of money, the financial burden would be removed from county jails and instead placed on appropriate mental health services and Medicaid.

The FACT (Forensic Assertive Community Treatment) program also boasts lower costs when compared to incarceration (Cusak et al., 2010). When compared to the control group, treatment as usual (TAU), the FACT option reduced hospital stays and recidivism costs. The per person inpatient costs for FACT totaled \$5,426 while TAU resulted in costs near \$9,000.

Although outpatient costs for FACT were greater than TAU (\$13,474 versus \$5,115), the decrease in inpatient costs offset those of outpatient and jail prices.

Appropriate mental health care within these facilities would provide mentally ill offenders with environments necessary to aid in their well-being. That is, the atmosphere within prisons may exacerbate mental illness and may cause issues between mentally ill inmates, staff, and other prisoners. Once removed from this type of atmosphere, mentally ill offenders may no longer require the ill-fitting segregation techniques and may no longer act out aggressively towards others (Vitiello, 2010).

III. Theory Application

General Strain Theory

Robert Agnew (1992) presented the idea that crime occurs due to the strains in life and the challenges associated with dealing with them. According to the General Strain Theory (GST), three specific types of strain are the results of negative “relationships in which others are not treating the individual as he or she would like to be treated” (Cullen & Agnew, 2006). In other words, individuals may use the coping technique of crime due to being prevented from achieving positively-valued goals, the removal of or the threat to remove positively-valued stimuli, or the presentation of or the threat to present negatively-valued or noxious stimuli. Upon being presented with any one of these three negative life situations, some individuals become pressured into committing crimes in response to the feelings of anger or frustration linked to the strains; crime may become a way to escape from or reduce the negative events, seek revenge on those who have mistreated them, or to alleviate the depressing emotions that come as a result of the strains. Although not all individuals use crime as a method to cope with strain, some lack the ability to effectively verbalize emotions or effectively negotiate with those who have wronged

them, individuals such as those with mental illness.

Mental illnesses are “medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning. [They] are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life” (“What is Mental Illness”, 1996). Within this definition is the notion that mentally ill individuals do not appropriately cope with the daily stresses of life, therefore resulting in inappropriate responses to the strains and those who may trigger them. Agnew (1992) listed examples of strains that may be more prone to result in criminal acts and that may be appropriately applied to some issues those with mental illness may experience. Rejection by parents, chronic unemployment, criminal victimization, homelessness, discrimination based on characteristics, child abuse and neglect, work in the secondary labor market, and poor school experiences are specific situations individuals with mental illness may undergo.

The diagnosis of mental illness itself may prevent the individual from achieving positively-valued goals, remove positively-valued stimuli, and/or present the individual with negative or noxious stimuli. With this, the GST would then state that the mentally ill individual would become angered and frustrated and, in an attempt to cope with the negative experiences, would criminally act out (Agnew, 1992).

The General Strain Theory suggests that crime is a coping technique, that it is a result of feelings of frustration and anger towards the inability to obtain positive goals, the removal of positive stimuli, and the presentation of negative stimuli. All people undergo strains throughout a lifetime, yet those with mental illness experience stress as a result of others’ reactions to the mental illness or a result of the diagnosis itself. Either way, mentally ill individuals live a disrupted life that prevents them from effectively coping with daily demands, therefore resulting

in criminal behaviors.

Labeling Theory

According to Howard Becker (1991), “social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders” (p. 78). Therefore, deviance becomes a consequence of the application of the term to those who have committed a certain act instead of a quality of the behavior of a person; deviance is not viewed as an act itself but instead a labeling term formulated by society. Thus, the labeling theory of criminology focuses not on the criminal act itself but on society’s reaction to the behavior, along with the negative effects it may have on those individuals who become labeled as deviants (Matsueda, n.d.). Further, the self-fulfilling prophecy comes into play when this theory is applied to the causes of crime. In other words, individuals labeled as deviant may take on that title as their master status and conduct their daily lives in accordance to the term; such individuals may find criminal behaviors as the only way of life.

The Webster Dictionary defines deviant as “differing from a norm or from accepted moral or societal standards” (Webster’s II, 1999, p. 310). Members of society who are seen on street corners talking to themselves, begging for food or money, or urinating in public may be feared by others and viewed as violating societal norms (Vitiello, 2010). Such individuals are often times those with a mental illness, and according to the definition of the term and the labeling theory, would be considered a deviant. Without proper treatments, mentally ill persons may face unemployment, inappropriate incarceration, substance abuse, and/or homelessness (“What is Mental Illness”, 1996). These situations may have stigmatizing consequences that the mentally ill individual must face. As a result of society’s perception of deviance, the individual

may be unable to fend off the deviant label because society does not typically view unemployment, incarceration, substance abuse, and homelessness as normal living.

In accordance to the labeling theory, those with mental illness would turn to a life of crime because society termed them as being deviant individuals based upon specific characteristics and behaviors. Once said to be deviant, a mentally ill person would then adopt the label as the master status and live accordingly.

IV. Recommendations

There seems to be limitations within the traditional criminal justice system that may interfere with mentally ill offenders receiving the most appropriate and adequate care possible. Therefore, there appears to be a need for both the criminal justice and mental health systems to work collaboratively together in order to develop recommendations as to how to best serve those individuals who are at risk of entering or who have already come into contact with the criminal justice system. The State of Wisconsin's Chief Justice's Task Force on Criminal Justice and Mental Health Courts was launched as a way to analyze and critique current mental health programs within the state and to point out challenges such programs may face (Chief Justice's Task Force, 2010). More importantly, the Task Force in Wisconsin provided numerous recommendations that could be used as models for assisting other states in the handling of those with mental illness.

The challenge of proper funding also seems to plague the development and continuity of treatments for those with mental illness. With this, states may need to turn to the process of applying for grants.

State of Wisconsin's Chief Justice's Task Force on Criminal Justice and Mental Health

In February of 2010, Chief Justice Shirley S. Abrahamson responded to the need for

improvement when responses to those with mental illness who are at risk of coming into contact with the criminal justice system (Chief Justice's Task Force, 2010). Abrahamson developed a statewide task force to provide recommendations that would allow for there to be clear, coordinated, and cooperative community efforts to bridge the gap between the criminal justice and mental health systems. This multi-disciplinary task force included law enforcement officers, attorneys, public defenders, judges, Department of Corrections and Department of Health Services staff, state mental health directors, mental health advocates, hospital administrators, consumers, county board members, and county executives. With the alliance of individuals from a variety of positions, the task force comes with the ability to focus on the needs of each agency that may be involved in dealing with a mentally ill person.

The task force was built with the mission to “develop models of research-based, cost-effective intervention processes that can be implemented to improve responses of the criminal justice system to persons with mental illnesses” (Chief Justice's Task Force, 2010, p. 4). It held its first meeting in March of 2010 with three main goals 1) to identify current programs and initiatives operating across the state, 2) analyze gaps in services in the mental health and criminal justice systems, and 3) develop a best-practices model of research-based, cost-effective interventions to improve responses to people with mental illnesses (Chief Justice's Task Force, 2010, p. 4).

The task force focused on the Sequential Intercept Model as a framework for communities to plan and organize strategies for the mentally ill who had contact with the criminal justice system. This model is based on the “points of interception” (Chief Justice's Task Force, 2010, p. 5) between the criminal justice and mental health systems. At each of these interception points, there may be opportunities for a partnership between the two systems that

may prevent mentally ill individuals from entering or continuing on into the system.

Upon analyzing the current programs across the state and the gaps in services, the task force recommended that the courts, service providers, community leaders, and law enforcement begin to identify those with mental illness earlier in the criminal proceedings. Also, there are adequate programs already in progress that should be expanded upon and replicated, and new programs should be created if possible. These programs, then, should be monitored and the results communicated to others. Finally, the task force recommended the implementation of community partnerships, information sharing, training, and education.

Based on the findings of the current initiatives within Wisconsin and the challenges that have arisen, the task force then developed a list of future initiatives they felt ought to be implemented. Following is a verbatim listing of such initiatives:

A. Mobile Crisis Response Teams and Regional Health Hubs

- Encourage collaborative efforts to serve smaller population counties with fewer resources and pool and leverage existing services.
- Develop provider network and mechanisms to share information across a county or region.
- Develop 24-hour point of entry to mental health system where law enforcement can bring a person who appears to be experiencing a mental health crisis.

B. Ride-Alongs

- To build trust, collaboration and communication between law enforcement officers and mental health professionals, one inexpensive suggestion is to have professionals ride along with patrol officers, and vice-versa.
- During a police ride-along, officers and professionals can see what officers are up against and also how professional responses might produce superior results.
- During a mental health ride along (*e.g.*, while a case manager supervises patients), officers are able to develop rapport with patients when they are not in a state of crisis and are sensitized to when something may be “off.”

C. Develop Rapport with Patients

- Develop rapport with patients when they are not in a crisis stage.
- Create a medical alert card that contains emergency information for persons who come into contact with law enforcement.

D. Educate 911 Dispatchers

- The tone a 911 dispatcher sets and the information the dispatcher conveys when contacting first responders is critical. Making sure responders are aware of mental health issues is an important step in the right direction.

E. Cross Training

- Create ongoing core competency training and cross training in mental health and criminal justice systems.

F. Release Planning

- Every county should have a one page, standardized discharge summary. It is a cost-effective first step to providing continuity of care.
- The summary would be available to future care providers and, perhaps more importantly, it would be available to the jail and prison system should an individual be incarcerated again.
- Consider notification of law enforcement when a person is released from a mental health facility or has failed to show up for community-based medication checks to help offices respond more effectively.

G. Free Calls

- The State Public Defender has an arrangement with AT&T whereby defendants are not charged for initial calls to the office by those in custody.
- A similar program might encourage defendants with mental health issues to get in touch with a community service program that might assist in sustaining the continuity of their care.

H. Video Links

- Video conferencing may be used for communication and consultation between patient and service provider.

I. Human Services' Web Sites and Technical Assistance

- Web sites could list network of local, county, regional and state mental health services, providers, and crisis intervention trained law enforcement officers.
- Provide technical assistance to practitioners on legal requirements of various mental health and privacy laws.

J. Liaison Programs

- Liaisons are needed to assist person in mental health crisis by facilitating communication between systems and linkage to services.

K. Universal Screening

- Universal screening should be undertaken as soon as possible.
- The sooner the system can identify individuals with serious mental health issues, the sooner the system can begin to work on appropriate responses.
- The screening report should be shared with the prosecutor, defense counsel, courts and treatment personnel.

L. Deferred Prosecution Agreements

- Use of deferred prosecution agreements should be expanded.
- Arranging for attorneys to meet with clients before charging may create more options for the prosecutor.

M. Consider Special Plea

- If a court or legislature permitted a special plea for those suffering serious mental illnesses (*e.g.*, “guilty but less culpable due to mental illness”), it might create an opening for an array of special procedures focused on treating the mental illness so as to avoid future brushes with the criminal justice system. In other realms within the system, in cases involving juveniles and NGI pleas, the plea triggers such special arrangements.

N. Increase Number of Mental Health Courts

- Establishing a mental health court brings together stakeholders in the community, creates an environment to build relationships, provides an opportunity to cross train, and focuses efforts to improve our responses to persons with mental illness.

O. Consolidated Court Calendars

- Consolidate cases involving a person with mental illness.
- The consolidation allows a judge to become familiar with all the cases, insures greater consistency and continuity in handling cases, and facilitates appearances by all stakeholders.

P. Accessibility of County Jail Booking Lists

- Mental health providers should have access to county jail booking lists.

Q. Provide Services for Persons with Co-Occurring Disorders

- Persons with mental illness often suffer from drug and alcohol abuse; assessments and services should address co-occurring disorders.

R. Information about Legal System

- Develop handouts providing information on the legal processes to persons with mental illness.

S. Increase Funding

- Funding is needed in all aspects and at each intercept of the Sequential Intercept Model for mental health services, programs, facilities, training, transport, assessment, reentry, and ancillary services.
- Grant funding helps establish a pilot program and generate outcome data, but the need is for permanent funding.

T. Develop Peer Support Network

- Support is a significant component of a person's successful transition to the community. Support sources outside of a family need to be established and integrated into case management services.
- Mentor programs provide on-call support or assistance with daily tasks and responsibilities.

U. Medication Formularies

- A statewide medication formulary or more inclusive medication formularies in jail are needed. (Chief Justice's Task Force, 2010, pp. 47-50).

Funding

Funding and support for mental health programs may be provided through a variety of sources. The Bureau of Justice Assistance (BJA) has provided funding to projects and programs that look to aid communities wishing to implement collaborative efforts between the criminal justice and mental health systems that will better address the needs of those offenders with mental illness (BJA, n.d). Each year, thousands of applications are received by the BJA from agencies wishing to implement such programs. Grants are awarded on a rolling basis, and as of September 30, 2011 a total of \$2,029,052,393 was provided to 3,469 applicants throughout the United States. These several thousand applicants were most likely awarded grants because the BJA looked for ideas that are innovative, collaborative, and provide evidence-based strategies. For communities seeking to begin collaborative programs and projects, the application for grants through the BJA may be located at the Office of Justice Programs website.

The Substance Abuse and Mental Health Services Administration (SAMHSA) likewise awards grants to programs and projects that provide those with mental illness the proper services within the criminal justice system. The state of Wisconsin received a total of \$57,719,464 from SAMHSA to put towards mental health funds and substance abuse funds, with \$13,105,152 being awarded to mental health.

V. Conclusion

This paper identified challenges that the criminal justice system poses to those with mental illness. When 93 percent of psychiatric beds were emptied during the 1960s, the country began to witness the criminalization of the mentally ill. People feared these individuals who could be found talking to themselves on street corners, using illegal drugs, and participating in other such petty offenses. Therefore, the police were called in to assist and were pressured into

arresting and incarcerating those with mental illness. From this first encounter with police and throughout the sentencing process, mentally ill offenders were viewed as disrespectful, defiant, and as being easy targets for harassment and abuse from fellow inmates and correctional officers. The prison atmosphere, with its often noisy and crowded conditions, exacerbated the symptoms of mental illness and cause the offender to act out in negative ways. In response, mentally ill offenders may face the use of physical force and punishment within solitary confinement. Although solitary confinement is a method of punishment for all prisoners, those with mental illness may experience far worse psychological effects.

The implementation of collaborative community programs seems to become the preferred option over long-term hospitalization or incarceration, and in order to become and remain effective, certain core components should exist. Crisis Intervention Teams (CITs), post-booking jail-based diversion programs, mental health courts, and forensic assertive community treatments (FACT) have been shown to be effective, humane, and cost-effective options in comparison to incarceration. Because such programs include collaborative efforts of those involved in the mental health and criminal justice systems, they provide an opportunity for those with mental illness to receive adequate and appropriate care outside of the traditional criminal justice system. These programs also matched and responded well to the exact needs of the patient.

Providing community programming for those with mental illness seems to be economically cost effective. At the same time, there appeared to be a difference in cost between the typical criminal justice system and community programming in terms of the price that may be placed on human well-being. Throughout the past 20 years there has been a 350 percent increase in spending for each state's correctional systems, an increase that may be in part due to the fact that the mentally ill inmate population has experienced a 14 percent growth. While the

Department of Corrections monies may be spent on worker's compensation (resulting from injuries by those with mental illness), housing, and psychotropic medications, community programming finances may be put towards proper care and rehabilitation of mentally ill offenders. Further, the mental well-being of those with mental illness within correctional settings seems to come at a cost in terms of the high suicide rates, self-harming behaviors, and more incidents of aggressive behaviors (Lord, 2008). Allowing mentally ill offenders the opportunity to rehabilitate in a system built around their unique needs may then improve the welfare of such individuals.

The recommendations presented in this paper provide the framework for what may be done to provide mentally ill offenders the opportunity to receive appropriate care. The Chief Justice's Task Force on Criminal Justice and Mental Health in Wisconsin is a multi-disciplinary group that develops clear, coordinated, and cooperative community efforts to bridge the gap between the criminal justice and mental health systems.

Funding of these community efforts may be provided through the use of grants. The Bureau of Justice Assistance (BJA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) accept applications from the developers of community programs on an annual basis. To be considered, ideas for such programs should be innovative, collaborative, and should provide evidence-based strategies.

Following deinstitutionalization, prisons began to experience an increase in the mentally ill inmate population. Based on the research, prison does not appear to be an appropriate setting for the mentally ill. Therefore, further research should consist of providing evidence about specialized and appropriate treatment services to prevent mentally ill offenders from being placed within a system that seems unable to match and meet their specific and unique needs.

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