

**Using Criminal Justice Involvement as a Mental Health
Outcome Measure:
Issues in Interpretation and Measurement**

April 5, 2008

**Prepared for the National Association of State Mental Health Program Directors
Research Institute**

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Criminal Justice Involvement of Persons with Serious Mental Illness: A Brief History and Current Status

In 1841, moral entrepreneur Dorothea Dix was invited to teach a Sunday school class for 20 inmates of the East Cambridge Jail in Cambridge, Massachusetts. What Dix saw there concerned her greatly. Mixed in with common criminals were individuals who clearly suffered from mental illness and who, in her opinion, would be more appropriately and humanely housed in a mental hospital. This experience would launch a four-decade national crusade, interrupted only by the Civil War, in which Dix advocated tirelessly for expansion of humane institutional care for persons with mental illness. A flurry of state mental hospital construction in the late nineteenth century bears witness to the effectiveness of Dix's crusade.

But within a century, as the mental hospitals Dix championed fell from favor and more persons with mental illness came to reside in the community, the problem of incarcerated persons with mental illness reappeared. Beginning in the early 1970's expressions of concern regarding the "criminalization of mentally disordered behavior" – the arrest and sometimes jailing of individuals with mental illness, often for low-level, misdemeanor offenses such as trespassing or disorderly conduct (Abramson, 1972), began to appear in the psychiatric literature with increasing frequency. (There are several excellent, comprehensive reviews of this voluminous literature, including Lamb and Weinberger, 1998; Lamb, Weinberger and DeCuir, 2002 and others.)

Evidence that persons with mental illness were becoming involved with the criminal justice system in ever larger numbers and housed there disproportionately came from a number of sources. Using field epidemiologic methods, Teplin (1990) and colleagues (Teplin, Abram & McClelland, 1996) found that the population of both male and female detainees at Chicago's Cook County Jail featured a larger than expected lifetime and recent prevalence of schizophrenia, major depression and mania. Other observations echoed concerns over the frequency with which persons with mental illness were entering the criminal justice system. In a 1995 editorial, Dr. E.Fuller Torrey noted that the Los Angeles County Jail system had surpassed all psychiatric specialty providers as the nation's largest institutionally-based provider of

mental health services. More recently, Morrissey and colleagues, using data from a variety of official sources, estimated that a person with mental illness is now 150% more likely to be jailed than admitted to any kind of psychiatric inpatient facility. They also note that, owing to the difficulty in accessing state mental hospitals, such individuals are 800% as likely to be jailed as admitted to a state psychiatric hospital (Morrissey, Meyer & Cuddeback, 2007). These observations suggest that if Dorothea Dix were to return to some of the nation's jails 160 years after her experience in East Cambridge, she might find that, with respect to the presence of persons with mental illness in the inmate population, little had changed.

Criminal Justice Involvement among Persons with Serious Mental Illness: The Perspectives of Agencies and Advocates

By the 1990s, there was growing consensus among numerous stakeholders that something needed to be done about the growing problem of criminal justice involvement among persons with mental illness. In a annual survey of state mental health directors conducted by the National Association of State Mental Health Program Directors Research Institute (NRI), roughly three-quarters of respondents listed criminal justice involvement among their agencies' clientele among their top three concerns (Personal Communication, Noel Mazade, PhD, Director, NRI). Mental health advocates, such Torrey and colleagues (1992), also expressed concerns, many of them focused on perceived failures of mental health systems to provide adequate and appropriate community-based services which, they assume, would prevent individuals from becoming entangled in the criminal justice system, particularly with respect to so-called "nuisance arrests."

Officials from the criminal justice system have weighed in as well. Police called to intervene in circumstances involving persons with mental illness often report that the process of transporting and seeking hospitalization of such individuals is frustrating, and instead use arrest as a last resort (Borum, Deane, Steadman & Morrissey, 1998). However, both police who arrest such persons and officials at the jails which sometimes receive them see these situations as an unnecessary use of scarce criminal justice resources. They contend that they are forced to assume a role

that goes beyond their public mandate – one they feel is more properly the responsibility of the mental health system. All stakeholders – mental health officials, mental health advocates, criminal justice officials, clinicians - concur that arresting and jailing persons with mental illness on low level charges is costly, inappropriate, and fraught with a host of risks to the persons with mental illness themselves (LaBerge & Morin 1995; Soros Open Society Institute 1996)

These concerns launched a drive toward developing a new array of services that would reduce inappropriate arrests of persons with mental illness, urged on by mental health advocates such as the National Alliance for the Mentally Ill (NAMI) and by human rights advocates such as Human Rights Watch (2003) and the Soros Open Society Foundation (1996) and by local, state and federal officials and policy makers (Council of State Governments, 2002). These efforts have contributed to the development of services operating at key points at the interface of the justice and mental health systems (recently termed “intercept points” (Munetz & Griffin et al, 2006)). These include pre- and post-booking jail diversion programs that shift low-level misdemeanor and non-violent drug offenders (and to an increasing extent persons convicted of felonies) from the “criminal justice” system to the mental health service system (Steadman, Morris & Dennis, 1995), as mental health courts and court sessions, in which judges use the court’s leverage to offer mental health treatment in lieu of criminal sanctions for defendants with mental illness (Steadman, Davidson & Brown, 2001).

Is Criminal Justice Involvement of Mental Health System Clientele a Quality Indicator for Mental Health Services?

Underlying the design of these programs is a set of assumptions about mental health services, criminal justice involvement, and the relationship between the two. One of these assumptions is that criminal justice involvement among persons with mental illness stems mainly from their disconnection from the mental health system, which has in turn led to increased involvement with substance use, discontinuation of medications, and homelessness. Some criminal justice involvement occurs when persons become disorderly, trespass, steal or commit other “survival crimes.” In a

process that has been referred to as “mercy booking,” police officers are known to arrest persons who they feel are in danger of freezing to death or at high risk for other serious outcomes (Hiday, 1999). The nature of these arrests would appear to be lack of appropriate services or the failure of mental health systems to engage and retain certain individuals and to meet their clinical and social needs. Mechanisms such as diversion and re-entry services strive to reconnect such individuals to mental health services and treatment in the hope that this will prevent recurrence of the cascade of events that led to their arrest.

But what is the relationship between mental health services and criminal justice involvement of a system’s clients? Is it strong enough to justify arrest, for example, as a measure of system performance? A review of the literature in this area yields at least five perspectives. One derives from the surprisingly scanty research on the global effects of service systems and resources on criminal justice involvement. The second is more focused, and highlights specific systemic problems associated with arrest. A third comes from evaluations of criminal justice involvement effects of specific programs, such as Assertive Community Treatment (ACT). A fourth, related, perspective comes from evaluations of programs which have attempted to tailor ACT and other service modalities to meet the needs of persons with mental illness involved with the justice system. The fifth comes from system implications of outcomes of jail diversion programs.

1. Mental Health Services and Criminal Justice Involvement

Few would debate the appropriateness of providing individuals with serious mental illness the treatment, housing, rehabilitation services, case management and other services they need to survive in the community. Clearly, failing to do so will inevitably lead clinical decompensation and a cascade of social problems such as homelessness and involvement with the criminal justice system. But whether providing *more* services significantly reduces the prevalence of these problems remains unclear, and as we consider the use of arrest as a systemic outcome, we should examine the empirical evidence.

Among the most prominent pieces of evidence pointing to inadequate services as a factor in the inappropriate arrest and incarceration of persons with mental illness has been a report developed on behalf of the National Alliance for the Mentally Ill by E. Fuller Torrey and colleagues. This document, entitled *The Abuse of Jails as Mental Hospitals*. (Torrey, Steiber, Ezekial et al., 1992) presents case studies of locales where individuals with mental illness had been detained in jails without being charged or via other legally questionable practices. The authors of this document did not represent it as a description of ‘business as usual’ across the nation, but rather as an expose of some of clearly inappropriate possible abuses of criminal justice processing of persons with mental illness attributable to mental health system failures. What their document shows is what can happen when a jurisdiction has virtually *no* available mental health services and no plan is in place to manage psychiatric emergencies. In such circumstances, the jail becomes the “default option” as the setting in which to place an individual whose mental illness causes him or her to pose a danger to themselves or others.

Are clients of mental health systems which do provide access to case management, residential programs and other mental health services still at risk for criminal justice involvement? Two recent studies suggest that they are. Fisher, Roy-Bujnowski, Grudzinskas and colleagues (2006) identified a cohort of over 13,000 individuals between 18 and 64 with severe and persistent mental illness who had received either inpatient, residential and/or case management services from the Massachusetts Department of Mental Health (DMH) between July 1, 1991 and June 30, 1992. An examination of these individuals’ arrest records over the ensuing 10 years showed that, in spite of having access to and established eligibility for DMH services, 27.9% of cohort members, and 50% of persons between the ages of 18-25, experienced at least one arrest. Charges ranged from serious crimes against persons to low level motor vehicle, disorderly conduct and a range of what were termed “poverty” crimes. Using a similar methodology, a California study of Medicaid recipients with serious mental illness, who on the basis of their beneficiary status were receiving an array of mental health services, found a similar pattern and roughly similar prevalence of arrest (Cuellar, Snowden and Ewing, 2007).

The view that significantly increasing the availability of community-based services is the way to reduce criminal justice involvement among persons with mental illness has not been rigorously tested. One study addressed this issue by examining the prevalence of serious mental illness in two county jails in Massachusetts. One jail served a county with greatly expanded resources resulting from a court-ordered deinstitutionalization program; the other, in an adjacent county, operated in the context of a mental health service system that received far less funding for community services. This comparison showed that despite a significant difference between the counties with regard to the availability of expanded emergency, case management and residential programs, the prevalence of schizophrenia, depression and bipolar disorder was roughly equal (Fisher, Packer, Simon et al., 2000). Unfortunately, no data are available reading whether arrests rates changed, or in what ways, as the array of services in the more resource rich of the districts expanded.

2. Arrest versus Mental Health Referral: Evidence from Research on Police-Mental Health System Interactions

Police officers are often the first responders to crises involving persons with serious mental illness (Green, 1997). As more persons with mental illness come to reside in community settings, there has been increased contact with police and elevated arrest rates for persons with mental illness. Indeed, a recent study of police calls in one urban setting found that fully 20% of all calls for assistance involved in some way a person with mental illness (Kaminski, 2004). Likewise, an official from the New York Police Department estimated that his department receives a call involving a person with mental illness roughly every seven minutes (Personal communication, the late James Fyfe, Ph.D., former Deputy Commissioner, NYPD).

Organizational theorists have categorized organizations as residing on a continuum ranging between “people processing” agencies, whose goal is to move individuals they encounter from their purview to those others, to “people changing” agencies, which work with individuals referred to them to address their problems. Patrol officers are essentially the former (Hasenfield, 1972). And while some have characterized police as “street corner psychiatrists” (Teplin & Pruett, 1992), modern-

day patrol officers see their job as transitioning arrestees to lockups, summoning ambulances for the injured, and handing off persons with mental illness to other parties (Maguire, 2003). As discussed in nearly four decades of research on police interactions with individuals perceived as having mental illness, officers in the field have enjoyed significant discretion in their management of incidents involving such persons. They may use arrest, referral or transport to a mental health service portal, or attempt to use informal means for resolving the situation “on the scene.” As “people processors,” police officers will typically opt for the strategy that offers them the quickest resolution and fastest return to patrol.

Research on contemporary police / mental health system interactions suggest that in some locales officers involved in such interactions find that people processing is inefficient when the mental health referral option is selected. These studies suggest that officers may find available community-based mental health services as inaccessible or ineffective as settings to which they can transfer custody and may thus may use them reluctantly, (Patch & Arrigo, 1999; Appelbaum, Nestelbaum, Fisher et al, 1992). Moreover, despite the benign views of police approaches to mental health-related incidents described by Green (1997), Teplin and Pruett (1992) and others, there is evidence that police officers sometimes resent being thrust in the role of “mental health gatekeeper,” a role they see as impairing their ability to carry out their principal task of law enforcement. These various frustrations likely contribute to the seeming discontent observed among some police officers frequently interacting with the mental health systems in some locales (Borum, Deane, Steadman et al., 1998). Much of this literature suggests that when police officers find emergency mental health services inaccessible or ineffective, they may use them reluctantly, opting instead to make an arrest on a low-level misdemeanor charge resulting in a quick resolution to the incident and removal of the individual from the street.

Studies of police decision making suggest that arrest is more likely to be used in a mental health related crisis when officers experience long waiting times in emergency settings or when emergency room providers see the person and release them; to paraphrase one officer in Worcester, Massachusetts interviewed by the author, “We get annoyed when we leave a guy at the ER and see him back on the

street within an hour.” Moreover, the negative views of officers regarding local mental health services may diffuse through a precinct or department, so that not only the “actual” inconvenience or inaccessibility of services becomes problematic, the services may develop a reputation for inconvenience and ineffectiveness. One study showed that when this occurred, officers would opt to arrest individuals who, it was later determined, would easily have met criteria for involuntary hospitalization had they taken the individuals to the emergency room (Appelbaum, Nestelbuam, Fisher et al., 1992).

Similar conclusions regarding emergency service effectiveness can be found in studies of the outcomes of police-mental health system interaction, focusing primarily on the use of “mental health system” outcomes as opposed to arrest. Steadman and colleagues compared outcomes associated with “major models” of mental health emergency response. Based on a national survey, the authors selected three jurisdictions using three major approaches: a “police-based mental health response” staffed by “non-sworn-officer” mental health professionals; one employing a “mental-health based specialized mental health response team” comprised of mental health workers with cooperative agreements between police and mental health agencies, and a crisis intervention or “police-based specialty unit.” Examining 100 calls to each department for assistance in managing an individual displaying what appeared to be symptoms of mental illness, they observed large between-site differences in the proportion of calls resulting in a “specialized mental health response.” Furthermore, Steadman and colleagues observed that on one important outcome measure – the use of referral to emergency services, *differences were best explained by the availability of a crisis drop-off center maintaining a “no-refusal policy” for police referrals.* Of any of the approaches, *those featuring a specific “drop off point” appeared to be of most direct benefit to police* (Steadman, Deane, Borum et al., 2000). In such models, police are provided with a point specifically focused on receiving persons such as those likely to be referred by police. Using this service, police could achieve a “mental health disposition” not requiring negotiation of the emergency room system while at the same time being assured that their detainee would be properly managed from both

a public safety and mental health standpoint (Cordner 2000; Cochran Deane & Borum 2000; Steadman, Stainbrook, Griffin, et al 2001).

From this body of research, the use of arrest, as opposed to a mental health referral, seems to be an outcome associated with a particular system deficit – the availability (or lack thereof) of accessible, adequate, reliable emergency services to which police can refer persons with mental illness. When these are in place and police are made aware of them, they will likely use them; when they are not available, or are found not to work, officers may resort to arrest as the default option. This research could be seen as suggesting that the use of mental health services, particularly emergency services, by police may be a reasonable marker of these services' accessibility and effectiveness.

3. Assertive Community Treatment and Criminal Justice Involvement

Assertive Community Treatment (ACT) is an acknowledged evidence-based practice (Mueser, Torrey, Lynde et al., 2003). ACT and its programmatic variants have diffused greatly since the original ACT team first came on the scene in the late 1970s, and now can be found in more than three-fifths of the states. Since its inauguration in Madison, Wisconsin, evidence of the effectiveness of ACT in various domains has been documented in over 40 studies, and the results of these studies have been well summarized in a number of reviews (c.f., Lewin Group, 2000; Bond et al., 2001). But ACT is not a panacea, and one its areas of weakness is the prevention of criminal justice involvement. Bond and colleagues (2001) examined the outcome patterns for ACT programs in 25 randomized studies. The pattern of findings from this body of studies, summarized by Morrissey, Meyer & Cuddeback (2007) suggests that ACT's principal effect is in reducing psychiatric hospital admissions. Of ten studies in which arrests, jail time or other forms of criminal justice involvement were include as outcome measures, only two showed improvement on this outcome, with seven studies finding no effects and one showing increased involvement among ACT clients. Indeed, even in the original evaluations of ACT by Marx, Test and Stein (1973) ACT showed little effect on reducing criminal justice involvement.

4. Tailoring ACT for “forensic” populations

The totality of data on ACT’s role in preventing criminal justice involvement among persons with mental illness has led some to conclude that, by itself, ACT is not sufficient to accomplish this goal, and that something else needs to be added to the model to increase its effectiveness in this area (Morrissey, Meyer & Cuddeback, 2007). This view has recently led to the development of alterations to ACT designed exclusively to address the specific issues of persons with mental illness and criminal justice involvement (Lamberti, Weisman & Faden, 2004). In these models, the focus of ACT goes beyond simply attempting to reduce the risk of re-hospitalization to address reduction in the risk of jail detention. Because, as we noted, the clientele of such programs are often given the label “forensic,” the programs have come to be called “Forensic ACT” or “FACTs.” An alternative to the FACT model employs the Intensive Case Management (ICM) modality, and the “forensic” adaptations of these programs are termed “FICMs.”

In their review of these programs, Morrissey and colleagues indicate that, while a number of FACTs and FICMs have been implemented, the field has not yet coalesced around a model for these programs, and also note that in some cases components of ACT have been eliminated, while features specific to the criminal justice system involvement of their clientele, such as the probation officers, have been added.

As of yet there have been few randomized trials of FACTs and FICMs. Two pre-post studies, neither with control groups found some reductions in criminal justice involvement (Morrissey, Meyer & Cuddeback, 2007). FICMs were used in the SAMHSA-funded multi-site jail diversion programs (Steadman, Deane, Morrissey et al., 1999). Since some of these programs are designed to allow the circumvention of arrest in some circumstances, one would naturally expect their development to result in fewer arrests. Evaluations of these programs generally suggest that they do, in fact, reduce jail time, but at a cost; the intensive focus on avoiding criminal justice outcomes appears to have diminished their effectiveness in other domains, such as re-hospitalization. Overall, however, Morrissey and colleagues (2007) conclude that the evidence of effectiveness for FACTs and FICMs is weak, and that further

development of these models is necessary before it can be concluded that these are the solution to the problems posed by persons with mental illness who are chronically involved with the criminal justice system.

5. Evidence from the evaluation of jail diversion programs

A third perspective comes from the experiences of jail diversion programs. Arguably the most intensively studied programs of this kind were the nine cities involved in SAMHSA's multi-site jail diversion study (Steadman, Deane, Morrissey et al., 1999). The evaluative data from this study present a mixed picture with regards to the ability of these programs to prevent re-arrest. But an overview of these findings suggests that it was *the quality and availability of mental health services in the diversion programs' locales, not the diversion programs themselves, that generated the sometimes disappointing results* (Steadman and Naples, 2005). Again, this view is consistent with the notion that available mental health services are "necessary but not sufficient" to prevent criminal justice involvement among mental health system clientele.

Summary

This discussion is not intended to be an overview of new interventions for reducing criminal justice involvement, but rather an attempt at examining the various ways in which the relationship between mental health services and criminal justice involvement has been addressed, with the goal of assisting mental health agency administrators in thinking about arrest as a measure of service system performance.

This brief review suggests the following points:

- In locales with *no* services at all, or where services are extremely difficult to access, such as the jurisdictions described by E. Fuller Torrey and his colleagues, the criminal justice system will likely be the "default option" for managing mental health crises:
- Jail diversion and other programs targeting persons with mental illness involved with the justice system are not successful unless adequate community-based services are in place;

- Studies of police management of persons with mental illness suggest the availability of one particular service modality -- a “24/7, no-refusal drop off” emergency mental health service reduces the use of arrest and increases the use of mental health referral by police officers;

However,

- Compared with those in less - well resourced systems, clients of extensively developed community-based service systems do not necessarily display reduced risk of criminal justice involvement among their clientele;
- Persons receiving even the “Cadillac” of community based programs, ACT, do not appear to have lower risk of arrest than persons not receiving such services.
- Newer service entities such as FACTs and FICMs are not well enough developed or evaluated to determine whether they represent a solution. Existing data present a “mixed bag” of outcomes.

Arrest as an outcome measure: Debating the pros and cons

Based on the previous discussion, should arrest, or change in what we will term for convenience “arrest status,” be used as a systems indicator? A first and obvious question is “**What does an arrest record mean?**”

An arrest is simply an intervention by a police officer taken to detain a person who engages in or is alleged to have engaged in activities which may be violations of the law. An arrest is not a finding of guilt. Depending on what various jurisdictions include in their official arrest data, an arrest record could simply refer to the fact that an individual was detained by police and taken to the police station, as is the case, for example, in Virginia (?) or that the person was arraigned in court (as in Massachusetts). In Massachusetts, the Criminal Offender Record Information (CORI) data, which are the official arrest records for the state, record an official arraignment and the specific offense(s) with which the person has been charged. Close examination of these records often reveal that some or all charges are dropped, individuals are found not guilty, the case is continued without a finding and so on. These factors suggest two points regarding the use of “arrest” in its unqualified form as a system indicator.

- Administrators need to decide whether using as system performance indicators records of arrests on charges that are subsequently dropped or on which individuals are found not guilty provides meaningful information.
- Using arrest as indicator of system performance without a clear understanding of what level of criminal justice penetration they signify (i.e., simple detention vs. actual arraignment or booking) can lead to misleading conclusions.
- Knowledge of the criminal justice procedures that generate arrest records, the uniformity with which those procedures are followed across the state, and the ability to determine the outcomes of an arrest are critical preliminary steps if administrators plan to use such information.

Interpreting arrest rates at the system level

As we noted earlier, over the last ten or fifteen years, jurisdictions have launched numerous interventions at key “intercept points” at the interface of the mental health and criminal justice systems. As discussed, these have included pre-booking diversion programs, such as crisis intervention teams, post-booking diversion programs, mental health courts and other innovative service entities. Among the stated purposes of these programs is the prevention or minimization of criminal justice involvement or re-involvement. Whether in the aggregate these programs meet their stated goals remains something of an open question, but where they are successful many will have the effect of depressing arrest rates.

Given what we noted about the emphasis placed on forging alliances between *local* mental health and criminal justice agencies, however, (and the way in which federal funds supporting such interventions is dispersed by SAMHSA and the Bureau of Justice Assistance), state mental health agencies may or may not always be aware of what services are being developed. In a large state with many local mental health agencies, implementation of these programs may be spotty. Some of these initiatives may involve multiple stakeholders and be visible as “programs”; others, however, may simply involve the informal coming together of local police and officials from a facility providing the bulk of emergency mental health services used by police to develop protocols such as “24/7 no-refusal” policies. These informal agreements may make it easier for police officers to access the mental health system and thus less likely to resort to arrest as a means of managing a psychiatric emergency incident.

Such initiatives may never rise to the level of official recognition or come to the attention of state administrators.

While these initiatives have the potential to lower the number of mental health agency clients for whom an arrest is reported, other initiatives may create “perverse incentives” that lead to increased arrest rates. It is conceivable, for example, that the situation of a jurisdiction with a mental health court or an inpatient forensic setting known for having a low threshold for court utilization but a difficult-to-access psychiatric emergency service could induce law enforcement to arrest persons with mental illness somewhat liberally, assuming that the person in question will ultimately find his or her way into a mental health treatment setting.

This discussion carries two sets of implications for administrators’ use of changes in arrest patterns as system indicators:

- Changes in arrest rates, both upward and downward, may be due to special initiatives developed at the local level;
- Administrators need to maintain an awareness of new local programs potentially affecting the criminal justice involvement of agency clientele, even those not operated or funded by the state mental agency.

What can be learned from arrest rates?

While the above caveats certainly signal caution in using arrest rates as indicators, these rates can nonetheless provide useful information for administrators. Examining arrest at local levels, within, for example, “catchment” or other administrative areas can help in

- identifying areas which exhibit consistently high levels of arrest;
- identifying areas that display significant changes in levels, either upward or downward.

Issues in identifying persons with mental illness who have been arrested

Currently, the approach to identifying persons with serious mental illness who have been arrested employs two basic methodologies, *self report* and the *use of administrative data* maintained by state and/or local criminal justice agencies. Each of

these approaches carries certain inherent advantages and disadvantages, which we discuss below.

Self report of recent arrest

An obvious approach to learning about arrest in a previous year is simply to ask individuals if they have been arrested during that period. States have adopted two approaches to obtaining such information. Some states employ the Consumer Survey, which is usually conducted as part of an anonymous survey of a sample of served consumers. Others states use a direct mode of inquiry and incorporate the data obtained in their state mental health agency client record systems. In these states, the state/provider-maintained client record includes information regarding whether the consumer has been arrested. Obtaining this information requires the clinician or case manager to ask consumers regularly if they have been arrested and maintain the information as part of individuals' records.. States obtaining arrest information in this manner typically included it as part of their regular mental health agency data systems and therefore exist for all clients. But Straightforward as such an approach would seem, however, it has numerous methodological and other problems, including:

- misinterpretation of events and of actions taken by police and courts;
- variations in local police and criminal justice system practices;
- sampling issues;
- validity of self-reports of arrest;
- potentially stigmatizing effects of the question itself for persons with mental illness.

We discuss these issues in detail below.

Misinterpretations on the part of the arrestee with mental illness: It was recently observed that persons with serious mental illness live with a burden of coercion unlike that experienced by virtually any other group of adults living in the United States (Dennis & Monahan, 1996). In addition to the interventions of police arising from violations of law, persons with mental illness are also subject to involuntary hospitalization, which sometimes involves being taken into custody by police.

Individuals in crisis may be transported to a psychiatric emergency setting, sometimes against their will. Many jurisdictions also maintain some form of mandated outpatient treatment, in which individuals are ordered by the court to comply with a treatment plan and to appear for regularly scheduled clinic appointment. In some jurisdictions, police can be asked to pick up a person who fails to appear for such visits and bring them either to the emergency room of a hospital or to the clinic.

As we noted earlier, over the last several decades many jurisdictions have launched collaborative efforts between local criminal justice and mental health authorities designed to reduce the criminal justice involvement of persons with mental illness. These have taken a number of forms, in particular jail diversion programs. As we also observed, these programs are of two kinds, “pre-booking” and “post-booking.” The protocols of some programs may leave individuals with a confused picture of their legal status and arrest history. Pre-booking diversion programs are designed to move persons from the street to the mental health system with as little exposure to criminal justice settings as possible. They may or may not spend time in jail.

Among the most visible of such programs is the police Crisis Intervention Team (CIT) (Deane, Steadman, Borum et al., 1999; Hails & Borum, 2003). The CIT model originated in Memphis in the late 1980s as a collaborative effort between law enforcement and the area mental health authority initiated in the aftermath of a fatal shooting by Memphis police officers of a man known to have mental health and substance abuse problems. CITs are a specially-trained cadre of officers who are dispatched to crises involving persons displaying symptoms of mental illness. Two of the goals of CITs are reduced use of arrest, particularly for misdemeanors, and increased use of designated mental health emergency services. The mental health referral typically involves transport by a CIT officer in his or her cruiser, but does not entail arrest. The individual is nonetheless placed in a cruiser, often against his or her will.

None of the interventions typically involve arrest, unless an officer is assaulted or some other violation of the law occurs in the process. However, the individual’s status vis-à-vis the law may not be clear to him or her, especially if they are in the

throes of a crisis. If the person is later asked whether he or she had been arrested in the past year, such an episode may come to mind, and be reported as an arrest. If this pattern prevails among a significant number of surveyed individuals it could result in an overestimate of the prevalence of arrest in the population.

Conversely, the actions of courts and mental health entities such as jail diversion programs operating at the interface of the mental health and criminal justice systems may lead an individual who has been arrested to believe that the arrest has somehow been “made to go away.” Post-booking diversion programs and mental health courts work with individuals who have been arrested and “booked,” and therefore have formally been arrested. The conditions imposed in these programs often include court-ordered entry into and continued participation in treatment programs. Compliance can result in charges being dropped; non-compliance in a stayed sentence being imposed. However, regardless of the outcome, *the individual’s arrest stands*. There is, however, the potential for an individual to believe that somehow the arrest has disappeared, and that he or she wasn’t “really arrested.” Again, if this misperception is widespread (and there are no data on this topic, unfortunately) it could lead to an under-reporting of arrest.

Variations in local criminal justice and policing practices. As we have learned in the course of the Data Infrastructure Grant (DIG) project, states, and municipalities within states, vary with respect to the official status of arrest. In some states arrest automatically leads to booking and generates an official arrest record, while in others persons can be placed under arrest by officers “in the field” but have their charges dropped at the police station, generating no official record.

Validity. These factors would lead one to conclude that the use of self report as a means of obtaining information about arrest would be likely to incur significant levels of error. There has been little empirical research on this issue. One study, conducted in Hawaii by Crisanti and colleagues, compared self report of arrest with data in official criminal justice records and found a reasonable rate of concurrence (Crisanati, Laygo, Claypoole et al., 2005). This has not been the case, however, with some of the states

participating in the DIG criminal justice effort, leading us to question whether the basic premise that self report in and of itself is a reasonable means of data collection, or whether it might be reasonable, given additional work to understand jurisdiction- and person-specific issues in arrest.

Sampling problems. Surveying persons with serious mental illness regarding various life situations carries enormous potential for sampling bias owing to the fact that in some cases the very factors that the survey addresses may increase or decrease the likelihood that individuals will be available for or, in the parlance of epidemiology, “at risk for” being surveyed. An example of the effects of this selective exclusion problem arises in projects such as the National Comorbidity Survey (NCS) (Kessler, McGonagle, Zhao et al., 1994), a national probability survey of persons living in households in the U.S. This sampling “universe,” excludes, of course, persons who are homeless, living in homeless shelters, residential programs and hospitals for persons with mental illness, detoxification facilities, prisons, jails and other settings which are of importance to the population of persons with serious mental illness and substance abuse issues (Fisher and Banks, 2005).

Similar problems can arise when surveying persons regarding arrest. Anyone who was recently arrested and is being held in jail, either because bail money was unavailable, bail was denied, or because they were convicted of an offense and sentenced to jail or prison, would be unavailable unless the interviewers chose to seek out individuals in those settings. Similarly, states that include arrests as part of the mental health agency data systems need to see the client for a clinical visit, a method that is precluded if the individual has been detained in jail. Obtaining data under those circumstances would require that the case manager be aware that the individual had been arrested and then visit him or her in jail. In addition, homeless persons, who are known to be at elevated risk of arrest, may be hard to reach.

Stigma. Beyond the technical problems associated with the validity of self report regarding arrest, there is the additional problem of the potential stigma associated with the question of arrest itself. With the exception of job, gun license or adoption

application processes, there are few instances in which persons in the general public are asked about whether they have been arrested. The survey used in the NCS does include a somewhat vague question regarding “trouble” with police or the courts. However, the respondents to this survey know that they have been selected for the survey as part of a national sample, not specifically because they are clients of the public mental health system. Other questions may arise, including unfounded but nonetheless important concerns held by the individual regarding the consequences of answering “yes,” to a question regarding arrest.

Use of official criminal justice records

When employers, adoption agencies or other parties need to learn about an individual’s criminal history they typically turn to a governmental agency, often an arm of the state’s trial court, which maintains official criminal history records. In recent years these records have become computerized and thus accessible electronically. Within the limitations of official data, these are probably the most reliable record of whether or not an individual has been arrested, when and on what charges. These records also have the advantage of providing some information about disposition, a factor which, as we pointed out, is one that should be considered in examining criminal justice involvement.

In using these data, we would anticipate that the mental health agencies’ electronic records would include the identifying fields necessary to request criminal justice records, although, as we discuss below, data privacy and the structure of the criminal justice data themselves may be limiting factors. But while efficient, informative and reliable, the use of criminal justice records, as with the use of self-report information, has its inherent issues; These include:

- formats of criminal justice data; and
- protected health information and privacy issues raised by cross-agency data sharing.

Formatting of criminal justice data As with many administrative data bases, arrest records are first and foremost a source of information on individuals or a small group of individuals who, for a variety of reasons, are being screened -- by a potential

employer, a landlord or housing official, a probation officer taking a new case, or by a police officer in the field using his or her in-cruiser computer to learn whether a person in custody may have outstanding arrest warrants. The data base is thus designed to provide *reports readable by persons*, not other computers. They are, in the parlance of yesteryear, electronic “rap sheets.” In Massachusetts, for example, these reports are constructed in Word or WordPerfect. They contain a set of specific fields, along with a sheet of information that helps to interpret the numerous abbreviations and codes used in the reports. Among the data elements included in the in the Massachusetts CORI report are name, known aliases, arraignment date, last known address, date of birth, race, and charges, as well as the court action (stayed, continued, etc.). These are also updated to show the final resolution of the case following a trial, if in fact a trial actually occurs. This data base design allows an information requester to get a sequential record of an individual’s offenses, and also to examine the course of an individual’s offending over their adult life. For some individuals, printed “CORIs” go on for pages. (In Massachusetts and many other jurisdictions, juvenile court records are sealed and not included in response to a request for an adult’s criminal history. Access to these records requires an additional level of permission.)

The “bad news” regarding these records is that many of the data elements exist as alphanumeric code; the “good news,” however, is that the fields in which various data elements reside are fixed. With the help of the late Steve Banks, a SAS program was written that read in the data and used elements or portions of elements, such as names and dates of birth, to match up with the DMH’s records. This allowed us to create a file which included basic demographics, service use information, and arraignment records and charges. This effort, we should point out, was part of a research project funded by the National Institute of Mental Health and not a routinized process (See Fisher et al., 2006) Nonetheless, the procedures utilized in this project are ones that could easily be routinized, given the availability of appropriate code, and processes similar to these have been undertaken in a number of states.

As the above example suggests, the technical aspects of merging state mental health agency records and official criminal records are not daunting. The requirements

for this process include data elements that are common to both data sets. The criminal justice records may include significant levels of information and built-in redundancies; the criminal justice system needs as much information as possible to ensure that the individual in question is, in fact, the person whose information is being requested, and will thus have numerous identifiers, such as name, date of birth and social security number. While the courts make every effort to be certain that information on these records is correct, the data entry errors that exist in every data set exist on these data as well. Defendants providing inaccurate or deliberately misleading information may further compromise these data sets.

Legal and confidentiality Issues in merging state mental health agency data with criminal records An important distinction between the records maintained by the criminal justice system and the data used by state mental health agencies rests is that the latter is *protected health information*, while, with some minor restrictions on access, adult criminal history records are a matter of public record, and enjoy none of the privacy of health data. Individuals or agencies seeking to access criminal justice records typically provide the record-keeping agency with the data elements necessary to retrieve the appropriate information. However, the 1996 Health Insurance Portability and Accountability Act (HIPAA) imposed strict limitations on the sharing of individual health records. This may create problems in some areas. For example, in the Massachusetts study described earlier, the mental health agency's privacy officials were reluctant to provide the CORI agency with identifying information on mental health agency clients, since, *just by virtue of these individuals being part of a request from the state's mental health agency, significant protected information on agency clients would have been revealed*, albeit only to another state agency.

If such mergers are to be accomplished, interagency agreements, memoranda of understanding, or other procedure mechanisms will need to be established to ensure that the protected health status and confidentiality of agency clientele is protected. We should mention, of course, that states will differ with respect to the interagency mechanisms required, and it is difficult to provide more concrete discussion in this general overview. A multi-state discussion of what HIPAA requirements actually

mean, what information can and cannot be shared, and how best to accomplish such sharing with minimal human resource and privacy would be helpful in addressing this issue.

Arrest and criminal justice involvement as outcomes: What are we trying to measure?

Up until now we have focused our discussion on the pros and cons of arrest as an outcome measure, and whether simply “asking people” about a recent arrest yields data that are as accurate as the information that would be obtained from official criminal justice sources. For a variety of reasons, the answer to that question seems to be “no.” As we also indicated, however, an arrest can be the result of a number of factors, and context, at least with respect to the offenses with which an individual has been charged, their seriousness, the findings of the court, etc., is necessary for arrest information to be useful.

But useful for what? If we simply want to know whether certain individuals’ behaviors have been seen by a police officer as violating the law, then arrest is useful is a useful indicator. But what are the systemic implications of such information. If some persons are repeatedly arrested for trespassing, shoplifting or other survival crimes, an argument could be made that mental health agencies need to ensure that these individuals have adequate access to basic life necessities, and also determine whether there are systemic gaps which are preventing such access, such as inadequate or inaccessible access points for police drop-off of persons with mental illness.

Arrest vs. a “Night in Jail”: Capturing Other Meaningful Measures of Criminal Justice System Penetrations

If we are concerned about “meaningful” involvement with the criminal justice system on the part of mental health agency clients – involvement that may place them at clinical or psychosocial risk, arrest may be an overly broad indicator. A clearer cause for concern, perhaps, might be whether individuals *spend a night in jail*. As we noted earlier, most local jails are not set up to deal with the clinical and psychosocial needs and characteristics of persons with serious psychiatric disorders. Jail detention,

particularly when associated with a misdemeanor arrest, may be symptomatic of a number of the systemic problems described above.

The process of routinely capturing data on whether a person has experienced jail time is somewhat more complicated than obtaining information on arrest. This may be particularly true in jurisdictions which allow the use of “preventive detention” – taking persons into custody and detaining them in jail person for their own protection, often without charges being filed. It is reasonable to assume that state level criminal justice records of the kind we discussed earlier will fail to capture many such episodes. That said, many of the research studies cited here (e.g., Lamberti, Weisman & Faden, 2004; Morrissey et al., 2007) have used “jail days” as an outcome measure, suggesting that such information can be retrieved. “Number of jail days” has to our knowledge not been widely adopted as a performance measure for mental health service systems.

One approach to identifying individuals who have experienced a jail episode is to develop a process that captures such events in “real time.” Anecdotally, there are a number of case management offices in Massachusetts which have made arrangements with the jails in their catchment areas to receive a daily fax with the names of persons who were newly detained as of the previous night. This process allows case managers to know immediately if one their clients has been detained, and helps in beginning a transition process, seeing to it that appropriate medications are made available if the individual is to be detained, etc. If a state mental health agency is interested in collecting data of this kind, mandating that case managers maintain a data base of persons who have experienced jail detention and incorporating such information in state level data bases might be a useful experiment.

Conclusions

This discussion has attempted to outline the issues associated with the validity of arrest as a mental health outcome, the pros and cons of its use as a quality indicator, how information on arrest might best be obtained, and what alternatives might exist for capturing meaningful data on criminal justice involvement among state mental health agencies clientele. We could summarize these points as follows.

- Arrest, particularly on minor charges, may be a reflection of inadequate service system development, but the data that address this issue more directly tend to see it as a measure of availability of emergency mental health services which police can easily access. There does not seem to be a body of systematic data suggesting that arrest on more serious charges is related to service system characteristics or individual service use.
- If arrest data are to be used, it is important to learn about charges and outcomes. It may be hard to interpret arrest data even in the aggregate without some information on the array of charges for which clientele were arrested.
- Arrest rates can change as a result of system interventions, such as jail diversion and other programs that circumvent arrest in favor of referrals to mental health services.
- There are numerous pitfalls associated with using self-report as a means of capturing arrest. These include poor understanding of legal status on the part of detainees, social desirability and stigma issues, and the non-availability for interview of persons who were arrested and detained in the criminal justice system or other setting which excludes them from the sample of agency clientele to be interviewed.
- The merger of official criminal justice data with state mental health agency data may be a desirable course to pursue. State mental health agencies need to understand what kinds of criminal justice involvement episodes are captured in such data. Mental health officials may need to work with criminal justice agencies to develop procedures for merging data so as to minimize disclosure of protected health information on agency clients.
- The collective experience of the states involved Data Infrastructure Grant suggests that states, and possibly regions within states, may record different forms of criminal justice involvement differently. The existence of such differences suggests caution in making any kind of between-state comparisons.
- Alternatives to arrest as a measure, such as whether an individual has spent a night in jail, may be as or more meaningful than simply asking whether a person has been arrested. Strategies for obtaining such information on a statewide basis might be explored, and SAMHSA might wish to explore the viability of such alternatives. Such a question could be posed either as a simple “yes” or “no” item, or as a two part question that could follow up by asking about number of jail stays or number of nights spent in jail during the period. Such information would be useful in determining not only levels of criminal justice involvement but in some cases, perhaps, the need for strengthened linkages between mental health systems and local jails. This process, too, is of course subject to the same problems inherent in self-report of arrest.

As we have discussed here, criminal justice involvement among the clientele of state mental health agencies is not as simple a phenomenon as it would appear, and what such involvement says about services and systems is similarly complex. Criminal justice involvement comes about as a result of a complicated interplay of biopsychosocial, socioenvironmental and service system factors, many of which are beyond the control of mental health services providers (Fisher, Silver and Wolff, 2006). That said, criminal justice involvement is inarguably a significant concern for individuals, families, advocates and providers and for the administrators of mental health and criminal justice agencies alike. It is vitally important that mental health agencies be aware of the level of such involvement among their clientele. How best to achieve that awareness and how best to interpret the information acquired remains a challenge.

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