

Paved with Good Intentions:

*A policy analysis on the disproportionate incarceration
of people with mental illness in Washington State*

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A thesis submitted in partial fulfillment of
requirements for the degree of

Master of Public Health

University of Washington

2017

Committee:
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Program authorized to offer degree:

Public Health

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Abstract

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A policy analysis on the disproportionate incarceration of people
with mental illness in Washington State

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Washington State is currently experiencing an unprecedented surge in incarceration among individuals with mental illness. This policy analysis aims to characterize the structural, judicial, legislative and policy decisions have led to this issue in Washington State, determine the barriers and facilitators of the problem, assess the efficacy of various interventions and develop recommendations for policy makers hoping to ameliorate the issue moving forward. Using historical and literature review, a mini-systematic review of mental health courts effect on jail recidivism and key informant interviews of stakeholders working with this population, the analysis outlines the scope and context of incarceration of people with mental illness and explores the feasibility potential interventions aimed at preventing arrest or mitigating poor outcomes after arrest.

Acknowledgement

I would like to acknowledge the individuals who provided their time and insight to help inform this project.

Kimberly Mosolf
Attorney
Disability Rights Washington: AVID Jail Project

Callista Welbaum
Program Manager
King County District Regional Mental Health Court

Richelle Nordeen
Director of Forensic Services
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Table of Contents

Introduction	4
Historical Context	5
Institutionalization	5
Deinstitutionalization	7
Transinstitutionalization	12
Criminalization of mental illness	15
Today	17
Scope and Character	19
Types of crime	19
Intersectionality and vulnerable populations	20
Consequences	21
Consequences for people with mental illness	21
Consequences for society	22
Conceptual Framework	23
Sequential Intercept Model	23
Stakeholders	28
Key informant interviews	28
Interview methods	29
Community mental health	29
Police departments	30
Mental health courts	31
Local health and social services departments	32
Advocacy organizations	33
Themes	34
Lack of affordable housing	34
Limited community mental health	35
Crisis services	35
Low participation in mental health court	36
Lack of coordination between agencies	37
Lack of inpatient psychiatric beds	37
Assault in the third degree	37
Workforce issues	38
“Pockets of Innovation”	38
Analysis of Potential Approaches	38

Table of Evidence on Interventions	40
Housing Support	41
Crisis Intervention Teams and Other Crisis Solutions	44
Mental Health Courts	48
Conclusions	51
References	53
Appendices	63
Appendix 1: Abbreviations	63
Appendix 2: Timeline	64
Appendix 3: Key Informant Interview Questions	66
Appendix 4: Mini - Systematic Review of Mental Health Courts	67

Introduction

Prisons and jails have become America's *de facto* psychiatric hospitals. The statistics are sobering. In 2005, the US Department of Justice published a report noting that more than half of all prison and jail inmates have a mental health problem.¹ There are now more than three times as many people with serious mental illness in jails and prisons than in psychiatric hospitals nationwide.²

Washington State is not immune from these national trends. Many consider state's mental health system severely inadequate, with one of the lowest per-capita numbers of inpatient psychiatric beds and one of the highest prevalence rates of mental illness in the nation.³ The limitations in our community mental health system and trends in incarceration have led to a shift in the locus of care for people with mental illness. A recent study among Medicaid recipients booked into jails in Washington showed 58% had a mental health diagnosis and over 78% had active behavioral health needs.⁴ Other studies show that 27.5% of patients discharged from state psychiatric hospitals in Washington face arrest within 2 years of leaving the hospital.⁵

This analysis explores the problem of incarceration among people with mental illness in Washington State. In this analysis, we will first outline the history of mental health care in Washington State and how various social, legal and political factors coalesced into the disproportionate incarceration of people with mental illness today. Next, we will characterize the scope and consequences of the issue based on literature review. We will then present a framework for conceptualizing this issue and describe key stakeholders working with those at risk of incarceration. Lastly, informed by literature review and key informant interviews, we will analyze various solutions to the factors that have led to disproportionate incarceration of

individuals with mental illness and propose recommendations for mitigating the issue moving forward.

Historical Context

Mental health care in Washington State has been subject to overarching national trends that led to the disproportionate incarceration of those with mental illness today. In studying the treatment of people with mental illness in Washington State and beyond, we see how various factors led to an era of deinstitutionalization and how the vacuum left by deinstitutionalization resulted in transinstitutionalization and ultimately, criminalization of mental illness. This historical analysis will explore the complex web of cultural zeitgeist, court rulings and policy changes that impacted our current state (see Appendix 2 for an overarching timeline). By looking to our past, we can hopefully mitigate or even avoid the pitfalls that have paved the way to the current situation and inform the development of solutions to our current system.

Institutionalization

Initially touted as a progressive alternative to life on the streets or criminal punishment, institutionalization in psychiatric hospitals promised more humane care of people with mental illness when they initially appeared in the United States shortly before the civil war.⁶ Prior to this time, mental illness was often viewed as a moral failure on the part of the affected individual and many people with mental illness were left to “wander the countryside.”⁶ The first psychiatric hospital in the territory that would later become Washington State was the “Insane Asylum of Washington Territory.” The hospital initially only housed 21 patients when it opened in Fort Steilacoom 1871. The name was later changed to “Western State Hospital” when Washington reached statehood in 1889.⁷

Over the subsequent decade, Western State Hospital's patient census ballooned to over 200 patients, necessitating the creation of Eastern State Hospital in Medical Lake in 1891.⁸ Overcrowding in both hospitals continued to escalate and eventually spurred public outcry, which led to the opening of Northern State Hospital in 1912.⁹ The bar for civil commitment during this era was especially low, generally only requiring referral to treatment by someone other than the patient -- often a family member.⁶ Individuals institutionalized during this time often stayed in state hospitals indefinitely with no clear pathway towards discharge. National trends during this time show a stark picture - the average length of stay in a state psychiatric hospital by 1950 was 20 years.⁶ This contributed to steep increases in state psychiatric hospital populations. The population of people admitted to psychiatric hospitals grew significantly during this period as an increasing number of individuals were hospitalized indefinitely in state hospitals, usually on an involuntary basis and occasionally for political or personal reasons unrelated to mental illness.⁶ By 1955, we see the peak of the number of people institutionalized in Washington State, with over 7,500 housed in state psychiatric hospitals.^{10,11} The nation was experiencing a similar peak in the overall psychiatric hospital population at the time, with over a half million individuals institutionalized in the US that year.¹²

During this period, people with mental illness faced very limited treatment options and admission to a psychiatric hospital was often the only option available for most people with severe mental illness. Treatments that did exist were largely ineffective and occasionally highly debilitating. With the advent of frontal lobotomy and the popularization of unmodified electroconvulsive therapy and insulin/cardiazol shock therapies, the 1940s and early 1950s saw a particularly severe era of experimentation in psychiatry.⁶ Beyond these limited and typically

ineffective treatments, state psychiatric hospitals could offer little to patients beyond custodial care and most patients saw little relief from their psychiatric symptoms.

Deinstitutionalization

By the mid-1950s, public support for state psychiatric hospitals began to wane as the costs to taxpayers increased alongside hospital censuses. Stories of deteriorating conditions due to understaffing and overcrowding within the psychiatric hospitals began to surface in the popular media. During this time, Mary Jane Ward published a semi-autobiographical exposé on coercive and barbaric conditions she experienced in a state psychiatric hospital.¹³ Other books describing similar conditions, like *One Flew Over the Cuckoo's Nest* by Ken Kesey, also gained popularity and further spurred outrage.¹⁴

Discussion of the problems associated with institutionalization increased in academic circles. Prominent physician and lawyer, Mortin Birnbaum, published an article during this time where he argues that it is unethical to strip patients of their liberty when psychiatric hospitals are unable to provide adequate treatment to restore their freedom. He argued that, in cases when treatment offered in a psychiatric hospital is inadequate, freedom in the community (even if it means that mental illness goes untreated) is ethically superior to indefinite institutionalization without recourse in a psychiatric hospital.¹⁵ Birnbaum's article (titled "The Right to Treatment") and others like it became a rallying cry for the increasing public dissatisfaction with institutionalization during this era.

“A Miracle Drug”

Just as Washington State reached the peak of state hospital censuses, a new solution gained popularity. In 1953, marketing began for a “miracle drug” called Thorazine. Thorazine was the first of many psychiatric drugs debuted during this period that showed strong efficacy in managing symptoms of psychosis.¹⁶ Thorazine changed the way severe mental illness was viewed in society. For the first time, mental illness could be reasonably managed as a chronic condition instead of a permanently untreatable disability, and providers began to consider treatment on an outpatient basis as a more humane and economically viable alternative to lengthy inpatient treatment in state psychiatric hospitals. Despite the drug’s promise, many providers were skeptical that the drug could be a total replacement for the care provided in state psychiatric hospitals and acceptance of the drug was slow among the psychiatric community at the time.¹⁷ To bypass the reluctance of mental health providers, the manufacturer of Thorazine (then Smith, Kline & French) created a task force targeting state legislators with the message of Thorazine as a potential solution to expensive and unpopular psychiatric hospitals.^{6,17}

With a new “miracle drug” alternative on the horizon, and the increasing unpopularity of institutionalization, political pressures mounted to decrease the burdens imposed by state psychiatric hospitals. Washington State saw a drastic change in admissions and discharge policy in psychiatric hospitals due to these pressures. Hospitals developed policies that aimed to discharge patients as soon as possible in lieu of keeping them institutionalized indefinitely. Between 1955 and 1966, the psychiatric hospitals in Washington State saw their patient censuses cut in half and the number of individuals released annually increased by 68%.¹⁰ Washington psychiatric hospitals were successful in reducing average lengths of stay and limiting overall hospital population size. However, these policies came with a price. During this

period, readmission of patients increased by 73%, leading to a doubling of annual admissions rates.¹⁰ The gap still existed between inpatient care and care in the community. As one public health official cited at the time - “[t]he slowly rising readmission rate in Washington reflects the lack of community facilities available to provide assistance to the former mental patient.”¹⁰

Meanwhile, in spite of dramatically increasing admission rates, funding for state hospitals was increasingly limited and staffing became inadequate -- usually failing to meet patient-provider ratio standards set by the American Psychiatric Association (APA). By 1961, only 18 social workers cared for a total average daily population of over 5,000 and Washington hospitals needed another 74 social workers to meet APA standards.¹⁸ Nursing and psychiatrist staffing similarly failed to meet accepted professional standards. Facilities at the time reported high turnover and were increasingly unable to hire and retain staff. According to their own reports at the time, Washington’s psychiatric hospitals were increasingly ill-equipped to provide the care necessary to restore patients to a level appropriate for discharge into the community and unable to provide patient resources to adequately prevent readmission.¹⁸

Community Mental Health Centers

The trend of deinstitutionalization was also playing out on the national stage. By 1963, President John F. Kennedy signed the Community Mental Health Act with the goal of funding community-based care centers and decreasing state psychiatric hospital censuses by 50%.¹⁹ Federal funding from the act helped float the initial construction and staffing of 786 community mental health centers (CMHC) throughout the country, with priority given to high-poverty and rural areas.^{12,20} In Washington State, the act had funded multiple CMHC in Seattle, Bellevue, Richland, Tacoma and Bellingham.²¹ The establishment of Medicaid in 1965 encouraged further

psychiatric hospital closures as states increasingly moved patients with serious mental illness to now federally-funded nursing homes as a cost-saving measure.²² These policies spurred a further drop in psychiatric hospital populations nationwide. Over the next 5 years, individuals housed in state psychiatric hospitals dropped by over a third.¹² By 1973, lack of funding and political unpopularity forced the closure of Northern State Hospital in Sedro-Woolley.⁹

Although advertised as an alternative to institutionalization, these new CMHC tended to care for individuals with less severe mental illness and were often not equipped to care for severely mentally ill populations that would otherwise be institutionalized.^{12,23,24} The more involved, wraparound services necessary to keep individuals with severe mental illness out of inpatient care (like supportive housing) were not funded by the Community Mental Health Act. The creation of CMHC therefore did not minimize initial psychiatric hospital admissions or readmissions in such patients.²⁴ While state hospital populations continued to dwindle, there were still significant costs associated with keeping remaining hospitals open such that the actual savings to states from deinstitutionalization were fairly minimal. As budgets for mental health gradually decreased, downsizing state psychiatric hospitals did not make funds available to strengthen the CHMC meant to replace them.²⁴

Deinstitutionalization via the Courts

Driven by public outcry, the 1970s saw multiple court cases that set out to address the low bar required for involuntary commitment at the time and further spurred deinstitutionalization. The first was in 1971 in a case called *Wyatt v. Stickney*, where a federal court in Alabama ruled for the first time that individuals kept involuntarily in psychiatric hospitals had a constitutional right to treatment that would provide patients a “realistic opportunity to be cured or to improve his or

her mental condition” such that their liberty be restored.²⁵ Mortin Birnbaum, the author of *The Right to Treatment*, brought the case before the court as co-counsel.⁶ The ruling outlined a set of expensive standards that were very difficult to meet by Alabama’s already deteriorating state psychiatric hospitals and it ultimately took 33 years for the state to meet the standards set by the case.^{6,25–27} The case set a precedent that simple custodial care, customary during the previous era, was an inadequate justification for barring the liberty of people with mental illness.

Another landmark case in 1975, *Donaldson v. O’Connor*, significantly heightened the requirements necessary for involuntary commitment. Brought before the US Supreme Court (again with Birnbaum as co-counsel), it ruled that simply being mentally ill was not sufficient to justify institutionalizing an individual against their will and that individuals ought to be free from commitment if it is possible to “survive safely in freedom” in the community. Ultimately, this case set danger for “imminent death” as the standard for involuntary institutionalization.^{6,28,29} That same year, this standard was further refined in another Supreme Court Case, *Lessard v. Schmidt*, where it was ruled that involuntary hospitalization is only permissible if there is “an extreme likelihood that if the person is not confined he will do immediate harm to himself or others” and required that the civil commitment proceedings have similar constitutional protections as required for criminal cases.^{6,30,31}

Washington's Involuntary Treatment Act

Washington State took notice of these national trends and passed its own Involuntary Treatment Act in 1974, which reflected the considerations outlined in *Lessard v. Schmidt*.³² Shortly after passage of the law, changes to the law were spurred by an infamous murder case in 1978 where a man who was denied voluntary admission to Western State Hospital went on to murder

his neighbor.³² The changes expanded the criteria for involuntary commitment to also include “danger to property” and “grave disability” due to medication noncompliance while also placing further caps on admissions to Western State Hospital.³²

In spite of modest improvements in the care of people with mental illness in the US brought by CMHC and similar federal programs in the 1970s, the subsequent decade found an administration that favored limiting such spending on social services. By 1981, President Reagan began dismantling the progress made in the prior era by gradually defunding the CMHC act and the National Institutes of Mental Health.^{12,24} States and local jurisdictions struggled to keep CMHC open in their communities and services were increasingly limited in those remained.¹²

Transinstitutionalization

The crises of homelessness and the jail population explosion have in many ways become 'political footballs', with responsible parties attempting to deflect the problem to one another and thereby avoiding the burden of solution and/or failure.³³

By the 1980s, state psychiatric hospital inpatient censuses nationwide were less than a fifth of what they were during their heyday in 1955 and signs indicating the chasms between the remaining CHMC and state psychiatric hospitals begin to appear.³⁴ With the newly established legal standards and court proceedings required to civilly commit individuals, and the defunding of state hospitals in favor of under-resourced outpatient treatment, individuals with severe mental illness were increasingly referred to alternative arrangements. For example, the trend of funneling patients with serious mental illness into nursing homes that stemmed from the creation of Medicaid continued to grow through the subsequent decade. By 1980, severe mental

illness was the primary diagnosis of 44% of all federally funded nursing home residents.²⁴ This practice of shifting care to nursing homes ended with the Omnibus Budget Reconciliation Act of 1981, which cut federal funding to nursing homes that primarily treated patients with mental health issues and required the screening of patients “to assure they had a legitimate medical illness.”²²

Increase in Homelessness

This era also saw a dramatic uptick of homelessness nationwide. Between 1984 and 1987 the number of individuals experiencing homelessness in the US nearly doubled.³⁵ The state of Washington saw similar trends -- between 1988 and 1990 the number of people staying in emergency shelters rose by 55%, with over 115,000 turned away every night due to lack of beds.³⁶ Although many factors contributed to this uptick in homelessness, including a recent recession and high unemployment, deinstitutionalization and the lack of adequate mental health care invariably contributed to the increase in populations forced to live on the streets.^{33,37,38} During this time, reports from major cities (especially along the west coast), suggested a high prevalence of mental illness among the homeless, with many reporting little to no contact with the community mental health system established to address their needs.^{33,39} In 1989, Seattle service providers reported roughly 30% of shelter clients had serious mental illness.⁴⁰

Meanwhile, in Washington State, efforts to deinstitutionalize were continuing full tilt. The passage of the Washington State Mental Health Reform Act in 1989 led to decentralization of state mental health care in favor of local mental health authorities called Regional Support Networks (RSN).⁴¹ Tasked with strengthening alternatives to inpatient care, RSN set incremental goals to decrease the number of state psychiatric hospital beds with the aim of

shifting short-term psychiatric hospitalizations to community hospitals and outpatient crisis facilities.^{41,42} Over a three-year period, state psychiatric hospital use decreased by 22% .⁴¹

“Tough on Crime”

Policies from this era created another unintended side effect for people with mental illness. The late 1970s and early 1980s was the dawn of a “tough on crime” era in national and local policy. As the “War on Drugs” policies began in the 1970s started to take full effect and new sentencing reform in the mid-1980s required mandatory prison sentences for low-level drug crimes, incarceration rates soared.^{43,44} The Bureau of Justice Statistics reported the average jail population increased four-fold between 1983 and 1993.³⁴ The dramatic consequences of these national trends appeared in Washington State at this time where, between 1985 and 1999, the overall imprisonment rate increased by 60.9% and the number of felony convictions increased by 206.7%.⁴⁵

As more and more people were swept up in the trend of mass incarceration, those with mental illness, often faced with limited access to treatment by an under-resourced community mental health system, also saw increasing rates of incarceration.³⁴ With more individuals experiencing untreated mental illness on the streets and increasingly punitive policing policies, arrests of those with mental illness for nonviolent or administrative reasons was increasingly common. U.S. Department of Health and Human Services (HHS) cited the many pathways that led to interaction with the justice system among these populations:

They may be the object of a call involving a citizen or business complaint, an office may observe them acting in an inappropriate, bizarre or criminal manner, or police may have a court order or warrant for an emergency psychiatric apprehension.³⁴

Between 1980 and 1992, the number of people with mental illness incarcerated in jails increased by 154%.⁶ By 1990, the HHS reported “approximately 700,000 admissions to US jails are individuals with acute or severe mental illness.”³⁴

Mental health care in jails and prisons

Once incarcerated, people with mental illness met a system that was far less equipped to address their needs than the ailing state psychiatric hospitals and under-resourced CMHC. While cases filtered through the courts that established standards for involuntary commitment in psychiatric hospitals, other court rulings also established minimum standards for mental health care in prisons and jails. The 1970s saw cases like *Estelle v. Gamble* and *Bowring v. Godwin* which ruled that jails and prisons must provide basic psychiatric services in cases where a medical professional deems it necessary. Although these rulings established a requirement of access to care for inmates with mental illness, there were important limitations left in place. Mental health care ordered by a medical professional was guaranteed, however, there were few protections on the quality or efficacy of mental health care rendered in jails and prisons. Inmates were only able to file claims about the inadequacy of their care in cases of “deliberate indifference” where care rendered “is not actually medical in nature, or they are so extreme or abusive as to be completely outside the range of professional medical judgment.”⁴⁶ Alongside this, the provision of psychiatric care for inmates had limitations not shared by medical care, namely “the court restricted the right to treatment by excluding those prisoners whose illnesses are incurable or incapable of being substantially alleviated and by not requiring any treatment that might be considered too costly or too time-consuming.”^{47,48} These cases informed policies that shaped the way mentally ill individuals are cared for in the justice system today.

Criminalization of mental illness

Academics have coined the term “the criminalization of the mentally ill” to describe the trend of increasing rates of incarceration among people with mental illness. Many have suggested that the deinstitutionalization via the decrease of inpatient psychiatric hospital beds during the 1960s and 1970s, at least partially caused this issue -- a phenomenon called “transinstitutionalization” or “re-institutionalization.”^{6,33,37,49–54} One researcher attributed 4-7% of the total incarceration growth in the US between 1980 and 2000 directly to deinstitutionalization.⁵² Yoon et al. looked at King County between 1993 and 1998 and found that “a decrease in the supply of psychiatric hospital beds is significantly associated with a great probability of jail detention for minor charges among persons diagnosed with severe mental illness,” with substance use mediating this effect.^{55,56} Similar to national trends, Yoon found that each 10% reduction psychiatric inpatient beds in King County during this period accounted for 5.3% of the likelihood of jail detention for minor changes in individuals with serious mental illness.⁵⁵

It is important to note that not all researchers agree that there is a direct causal relationship between deinstitutionalization and increased incarceration of the mentally ill.⁵⁷ Some suggest that the increased visibility of mentally ill individuals in public during this time, possibly spurred by deinstitutionalization, changed public sentiment on the perceived dangerousness of mentally ill individuals since the 1950s (thus increasing arrests), with one study reporting an increase in perceived dangerousness of 250% between 1950 and 1996.^{6,58} Others have attributed limited access to community mental healthcare to the increased incarceration rates among mentally ill. The increased use of models of managed care during the early 1990s and the lack of mental health parity protections in health insurance may also have been to blame.¹² One study, also based in King County, suggested that a substantial decrease in expenditures on the county

mental health system during the introduction of managed care in Washington between 1993 and 1998 led to a significantly increased probability of jail use for Medicaid recipients.⁵⁹ Regardless of the cause, it is almost universally accepted that more mentally ill individuals are incarcerated today than in recent history.

Today

The side effects of deinstitutionalization gradually became apparent in the late 1980s and through the 1990s. Since then, the state of Washington tried, with limited success, to walk back the effects of deinstitutionalization. Since the passage of the Involuntary Treatment Act in 1973, there were 14 amendments to the law that aimed to lower the high bar set for involuntary civil commitment.⁶⁰ By 2011, the Washington State Institute for Public Policy (WSIPP) published a report that predicted the Washington State's psychiatric inpatient bed capacity would be outpaced by the increase in demand for inpatient beds with the loosening of restrictions afforded by an amendment to the law in 2010.^{60,61} They later reported that Washington "ranked nearly last among all states in the total number of psychiatric beds available per person."³ A recent study among Medicaid recipients showed that as many as 55% of people entering jail in Washington State had some sort of a mental health diagnosis (compared to 34% of unincarcerated Medicaid recipients).^{4,62} As report for the State of Washington Office of Financial Management noted: "[t]hese data suggest that people with mental illness are cycling in and out of Washington's criminal justice system, many of them without receiving treatment."⁶²

Psychiatric boarding and Trueblood

During this period, emergency rooms in Washington State began filling with psychiatric patients who were involuntarily detained in hospital emergency rooms (a practice commonly referred to

as “psychiatric boarding”), sometimes for as long as 100 days, with little to no behavioral care while waiting for limited inpatient psychiatric beds.⁶¹ This severely limited capacity came to a head in 2014, when the Washington State Supreme Court saw a case, *D.W. et al v. DSHS and Pierce County*, filed on behalf of 10 patients who were involuntarily boarded in hospital emergency departments. The court ruled the practice unlawful and demanded changes to hospital policies.^{61,63} Washington’s Involuntary Treatment Act was revised in response to the *D.W.* case to allow for “single bed certifications” in cases where hospitals can promise to provide “provide timely and appropriate mental health treatment” outside of the typical certified psychiatric inpatient evaluation and treatment facilities.^{64,65}

Meanwhile, that year saw another case brought before the courts stemming from the bottleneck of limited inpatient psychiatric bed capacity. The case, *Trueblood et al. v. DSHS*, was on behalf of inmates with mental illness in Washington jails, who experienced long waits for court-ordered inpatient mental health care to restore their competency to stand trial.⁶⁶ Many in the *Trueblood* class were kept in segregation or on suicide watch for as long as 75 days before they were sent to state psychiatric hospitals for evaluation or competency restoration.^{66,67} The average number of days waiting for an inpatient bed in a state psychiatric hospital was over a month when the case was presented. One inmate in the case committed suicide in jail while waiting for a state hospital bed.⁶⁷ The courts required the Washington Department of Social and Health Services (DSHS) to decrease wait times for competency evaluations to 7 days or less or face criminal fines. On appeal, this ruling was later amended to 14 days. By opening new alternative sites and increasing state hospital capacity, DSHS was able to increase the number of psychiatric inpatient beds in state hospitals by 96 total beds and decrease the average wait time for

inmates substantially.⁶⁸ However, DSHS was not able to meet the requirements of the court by the prescribed 2016 deadline. DSHS must now pay fines until these standards are met under the ongoing monitoring of the courts. As of March 2017, fines for the case surpass \$4.2 million dollars.⁶⁹

Washington State was subject to national trends over the decades that led to inadequate care of some of our most vulnerable populations. The responsibility for people with mental illness shifted from a centralized system based on state psychiatric hospitals to a diffuse system with multiple stakeholders and loci of care, with many patients going without treatment (or with inadequate treatment) and appearing in inappropriate places. Our recent history reveals the urgency of the issue for communities in Washington and provides the impetus for advancing appropriate and sustainable solutions to the issue of incarceration of people with mental illness.

Scope and Character

The scope of mental illness among inmates is difficult to measure. Counts of individuals who are booked into jail with acute symptoms do not adequately capture the full prevalence of mental illness in this population.⁷⁰ In Washington State, this difficulty in evaluation is compounded by limited use of validated screening tools for incoming inmates, with only 10% of jails in Washington using any sort of formal screening tool upon booking.⁶² A recent study of current and former DSHS/Health Care Authority clients, who accounted for 86% of all detainees, booked into jails in Washington in 2013, found that 58% of the study population had mental health treatment needs, 61% had substance use disorder needs and 41% had co-occurring disorders.⁴ When compared to non-incarcerated Medicaid recipients, those booked into jail were significantly more likely to have a mental health diagnosis than the general Medicaid

population.⁴ Although these data do not reflect the entire population of individuals booked into jail, it is sufficient evidence to indicate that incarceration of people with mental illness is likely very common in Washington State.

Types of crime

By and large, most mentally ill individuals are incarcerated for nonviolent offenses. A study looking at justice system involvement among adults receiving mental health services in Washington State reported, that although over a third of all of their clients have a criminal history, only 6.9% were ever charged with a violent felony, with the bulk of the crimes charged as low-level misdemeanors.⁷¹ Another study looking at mentally ill recidivists in Washington State shows similar trends - the authors noted that 72% of crimes were supervision violations or misdemeanors, with “felony crimes against persons” accounting for only 4.4% of the study population.⁷²

Intersectionality and vulnerable populations

Independently, mental illness and incarceration history are already highly stigmatizing. This issue tends to affect those who are part of particularly vulnerable subgroups alongside their status as those with mental illness at risk of incarceration. People who end up in this category tend to have more severe mental illnesses like schizophrenia, bipolar or other psychotic disorders, often with co-morbid substance disorders.⁷³ As suggested in the historical analysis, there is an important intersection between homelessness and incarceration in mentally ill individuals. One study looking at mentally ill individuals in New York City suggest that being mentally ill and homeless increases your risk of incarceration by 25 times the rate of solely being mentally ill.⁷⁴ As with the general inmate population, men make up a disproportionate

number of the incarcerated mentally ill, however, women who are incarcerated are far more likely to be mentally ill than men, with some studies reporting as much as 80% of incarcerated women reporting mental illness.^{73,75} Also reflective of overall trends in general incarceration, African Americans have an increased risk of incarceration while mentally ill. One report revealed that African Americans make up more than a third of high-utilizing jail recidivists with mental illness in King County.⁷⁶ Another study looking at the effect of decreased psychiatric bed capacity in Washington State on incarceration rates noted that African American women with severe mental illness were the most affected by deinstitutionalization and are particularly underserved in the community mental health system.⁵⁶

Consequences

Consequences for people with mental illness

Historical and legal precedences have left the justice system poorly designed to address the needs of the mentally ill. Although jails and prisons have a legal obligation to provide minimal health care (including mental health care) to inmates, many facilities are severely under-resourced to meet inmates mental health needs. This often results in a lack of mental health care - only 1 in 6 jail inmates and 1 in 3 prison inmates with mental illness receive any form of treatment.¹ With many correctional facilities understaffed or with limitations on medication formulary, the mental health care provided to incarcerated individuals is often fairly limited.⁷⁷

Inmates with mental illness often decompensate while in custody. This leads to an increased prevalence of behavioral problems among mentally ill inmates.¹ They are also more likely to be victimized by other inmates.⁷⁸ Correctional facilities often resort to the use of punitive measures

to address behavioral issues that often result from the symptomology of an inmate's mental illness.¹ Inmates with mental illness are twice as likely to end up in segregation than inmates without mental illness.^{79,80} Once in segregation, inmates with mental illness tend to stay in segregation far longer than the general population. Segregation of mentally ill inmates often leads to further decompensation of mental illness and some studies show an association with increased risk of self-harm.^{80,81} Behavioral issues stemming from undertreated (or often untreated) mental illness often lead to significantly increased recidivism once upon release.¹ Jail recidivism among people with mental illness is particularly concerning in our state -- among the those waiting for court-ordered mental health evaluations in Washington State, 70% had at least 2 arrests in the past year.⁶²

Consequences for society

There is a variety of consequences for communities at-large due to incarceration of people with mental illness. The foremost is costs to taxpayers as involvement of people with mental illness in the justice system is expensive. Between the court costs, the costs of policing, the increased staffing and healthcare needs once incarcerated, and the tendency toward long lengths of stay and increased recidivism, mentally ill inmates are substantially more expensive than those without mental illness.^{82,83} One study in King County shows that incarceration of inmates needing psychiatric care costs as much as three times the monthly cost of non-mentally ill inmates.⁵⁹

With such limited mental health treatment in jails and prisons, the social consequences of incarcerating the mentally ill can also include the indirect costs associated with allowing mental illness to continue unchecked without adequate treatment. Individuals with undertreated mental

illness are more likely to have other comorbidities, more likely to abuse substances and more likely to be homeless - further overwhelming already strapped social services and filling hospital emergency departments once no longer incarcerated. Impaired public safety is also a potential social side effect of inadequately treated mental illness. Although it is very important to note that people with mental illness are far more likely to be victimized than to victimize, there are some recent high profile examples, like the case of Isaiah Kaleb in 2009 and James Williams in 2008, where individuals who were unable to obtain adequate mental health care (but were repeatedly cycled through the justice system) went on to commit violent crimes.⁸⁴⁻⁸⁶

Conceptual Framework

Sequential Intercept Model

Munetz and Griffin developed a conceptual framework, the Sequential Intercept Model (SIM), in 2006 to help researchers and policy makers understand the various points where interventions can be targeted to prevent incarceration of people with mental illness, facing poor outcomes while incarcerated, and/or becoming reincarnated.⁸⁷ While developing this model, the authors worked under the premise that:

[p]eople with mental illness who commit crimes with criminal intent that are unrelated to symptomatic mental illness should be held accountable for their actions, as anyone else would be. However, people with mental illness should not be arrested or incarcerated simply because of their mental disorder or lack of access to appropriate treatment—nor should such people be detained in jails or prisons longer than others simply because of their illness.⁸⁷

The authors envisioned a series of filters that act as “opportunities for an intervention to prevent people with mental illness from entering or penetrating deeper into the criminal justice system.”⁸⁷

They ranked these filters by their capacity to address underlying mental health issues early to prevent incarceration or worsening of outcomes during or after incarceration. The earliest filters indicate the most upstream targets of intervention, potentially affecting the most individuals, and

the latest filters aimed to address more downstream issues, potentially affecting the least individuals. In all, their model aims towards proactive solutions, rather than the reactive responses commonly found in policy development.

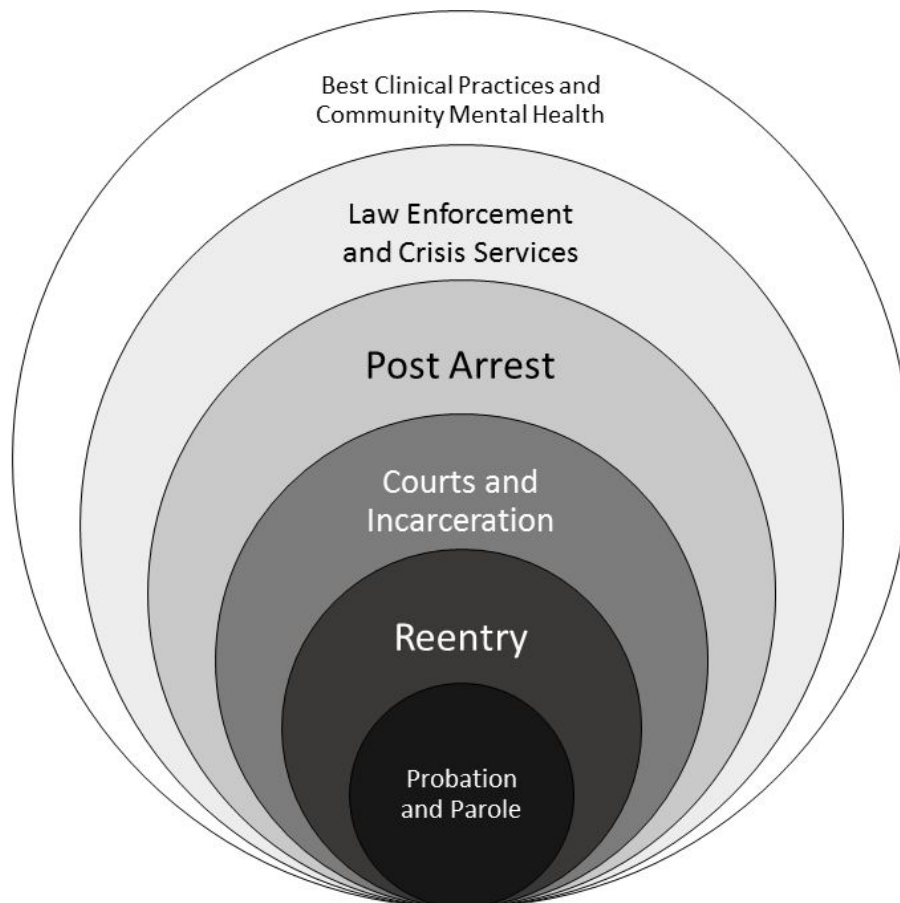


Image shows the filters of the Sequential Intercept Model adopted from Munetz and Griffin.

Below are descriptions of the various filters discussed by Munetz and Griffin and ranked in order of capacity:

- *Best clinical practices and community mental health:* The authors label best clinical practice (BCP) as the “ultimate intercept.” They argue that accessible, comprehensive, evidence driven, and effective mental health treatment is the most important determinate

of criminalization of mental illness. They suggest that best clinical practice requires supportive resources like competent clinicians, support services like case management, medications, vocational/education training, crisis services and affordable housing to be most effective.⁸⁷ Limitations on any of these resources, they argue, can be detrimental to the capacity of agencies to uphold best clinical practice. According to this model, any efforts to address the criminalization of the mentally ill should prioritize best clinical practice when developing interventions.

- *Intercept 1 - Law enforcement and crisis services:* The authors describe law enforcement and emergency services as “the first point of interception.” They note that even when community mental health systems are optimal, there will still inevitably be some interaction between individuals with mental illness and law enforcement. Police officers are tasked foremost with protecting public safety, however, encounters with mentally ill individuals are often caught within a gray area of non-violent public nuisance complaints like trespassing. Historically, police officers have had a wide range of discretion in resolving interactions with mentally ill individuals and are typically siloed from mental health systems. Law enforcement can only use the tools available to them in addressing encounters with mentally ill individuals on the streets. Law enforcement may perceive arrest as the only option to resolve a complaint when they lack guidance on how to interact with mentally ill populations or alternatives to arrest, thus perpetuating the cycle of incarceration and recidivism. A potential intervention at this intercept level is beginning to gain popularity as police departments nationwide are increasingly partnering with community mental health and emergency crisis programs to train officers in interacting with individuals with behavioral health issues and to divert individuals to appropriate

services. Many police departments have taken a step further and developed specialized Crisis Intervention Teams (CIT) to respond to behavioral crises. There are many models for CIT. Most models involve teams that include licensed mental health professionals and police officers with specialized training in the needs of mentally ill individuals. Such teams respond to behavioral crisis calls with the aim of diversion into treatment in lieu of arrest.

- *Intercept 2 - Post arrest:* Even when robust diversion systems are in place, there are cases where the nature of the crime necessitates the arrest of a mentally ill individual. It is at this level that some systems opt for pre-conviction diversion, where the mental health status is considered at the initial court hearing and mentally ill individuals are potentially diverted to appropriate treatment systems prior to (or sometimes in lieu of) conviction. In systems that lack robust pre-arrest diversion, this diversion is often isolated to mentally ill individuals who commit low-level, nonviolent crimes, but in systems with less porous pre-arrest filters, many arrests are for more serious crimes that will necessitate some sort of conviction and are therefore addressed at the next level of interception.
- *Intercept 3 - Courts and incarceration:* Ideally, most people with mental illness are filtered out prior to this intercept. Judging from the prevalence of mental illness among jail and prison populations, opportunities for intervention must be bypassed relatively frequently for many individuals incarcerated in the US.⁸⁷ However, even at this level of interception, there are chances for diversion. Some systems divert mentally ill individuals to Mental Health Courts (MHC) when they appear at this level of intercept. Mental Health

Courts differ from the traditional judicial process in that they are designed to identify and link those with mental illness with long-term, community-based mental health treatment in lieu of jail time or with reduced jail time.⁸⁸ The choice to participate in MHC is voluntary and participants work alongside the court to develop and adhere to an overarching treatment plan, with emphasis on rehabilitation in lieu of punitive action. The scope of MHC varies between jurisdictions. Some courts offer the option to participate in MHC only to low-level nonviolent offenders and other jurisdictions offer MHC to all but those charged with particularly serious violent crimes.⁸⁸ Another potential point of intervention at this intercept stems from the correctional facilities themselves. Jails and prisons that are well-equipped to provide mental health care and stabilization, preferably with limited use of restraint or seclusion, can help mitigate decompensation of mental illness or limit later recidivism. In spite of often limited resources, many jails and prisons have developed innovative models in an attempt to best serve mentally ill inmates who have appeared at this intercept, like the use of mental health step down units as an alternative to administrative segregation. In cases where an inmate's mental competency is questioned or where competency is determined to be impaired, ability to quickly coordinate evaluation and potentially forensic hospitalization can also determine a correctional facility's capacity to serve mentally ill populations, as seen in the *Trueblood* case.

- *Intercept 4 - Reentry*: Upon release from a prison, jail or forensic hospital unit, the coordination of care between community mental health systems and correctional facilities is critical in reducing recidivism. Many facilities have various levels of

post-release planning where housing, medical, mental health and substance use treatment are coordinated prior to release to ensure the success and continuity of care.

- *Intercept 5 - Probation and parole:* One of the main drivers of recidivism in people with mental illness is supervision violations. Some programs have specific supervision officers for mentally ill populations, mental health treatment as a condition of probation/parole or offer flexibility in enforcement of conditions of parole in efforts to combat recidivism.

For the purposes of this analysis, we will focus on interventions that potentially have the highest impact on the broadest population - specifically, starting at BCP/community mental health and going through to sentencing with mental health courts. Although intercepts after sentencing are important and often underappreciated, most research suggests that early intervention is best in mitigating poor outcomes.

Stakeholders

To adequately characterize the roots of the issue and propose relevant solutions, it is vital to speak with people who are working in the community with mentally ill populations at risk for incarceration. Speaking with a variety of agencies across multiple intercepts, we can understand the unique position each agency experiences and the concerns they have moving forward. Most agencies are making some progress toward ameliorating this issue and their successes (and pitfalls) can inform future solutions.

Key informant interviews

Key informant interviews of stakeholders from various agencies serving mentally ill populations at risk of incarceration in Washington State were conducted as part of the analysis. Key informants were identified through faculty contacts and publicly-available directories and websites. Prior to the interviews, institutional review was obtained and deemed exempt by the UW Human Subject Division.

Interview methods

A total of 5 key informants, identified from various public agencies over a 3 month period, agreed to a one-on-one interview. Interviews were in a semi-structured format informed by the Sequential Intercept Model and based on a list of questions provided in Appendix 3. Extensive notes were taken during the interviews and the notes were later analyzed for overarching themes. Themes found in at least 4 of the 5 participants are described below as “key themes” and themes offered by at least 2 to 3 participants are described as “less common themes” in the thematic analysis section below.

Key stakeholders

Below is an analysis of the stakeholders interviewed as part of this project and the agencies they represent.

Community mental health

Robust community mental health systems represent the front line in preventing incarceration of people with mental illness. Sound Mental Health (SMH) is one of the largest mental health provider networks in Washington State. Established in 1966, SMH runs 15 facilities throughout

King County and provided cares for over 20,000 clients annually.⁸⁹ SMH offers a wide range of services from outpatient therapy and crisis services to supportive housing. The organization has a range of services targeted specifically at individuals with a criminal record or at-risk of developing a criminal record. SMH has a large outpatient program that screens patients for recent criminal history, probation/parole status or outstanding restraining orders and directs such individuals to specially trained mental health providers. SMH has implemented multiple speciality programs targeted at individuals at high risk of recidivism in King County. One such program is the Offender Reentry Community Safety Program (ORCS). The ORCS program targets mentally ill individuals recently released after serving sentences for violent crimes and involves intensive, multidisciplinary wraparound services intended to ensure successful transition to the community and reduce recidivism.⁹⁰ The interview with the SMH forensic unit director revealed an apparent increase in forensic patients seen at SMH over the past decade, from roughly 200 patients to around 1,000 patients today. The director reports that SMH understands the urgency of their role in preventing incarceration among their patients - "if we can get folks enrolled in services, we can keep them out of jail."

Police departments

Police departments are tasked with both enforcing the law and protecting the safety of communities. Often, the police are the alternative of last resort when other social services fail. The Seattle Police Department (SPD) has offered its officers limited training on crisis intervention since 1998. A series of highly publicized events, including the shooting death of a local woodcarver with mental illness in 2010, lead to an investigation of the SPD by the US Department of Justice (DOJ) and eventual consent decree in 2012.^{91,92} As a condition of the decree, SPD was required by the DOJ to strengthen their crisis intervention program and

increase crisis intervention training among its officers.⁹³ The decree spurred a number of improvements on how SPD treats individuals facing behavioral crisis.

As of 2015, every new SPD officer is required to complete crisis intervention training. Training aims to expose officers various forms of mental illness and provide officers with tools for de-escalation, means of obtaining a mental health evaluation, and potential diversion to appropriate services. SPD also established policies to guide officers through the “gray area” of non-violent offenses where diversion may be more appropriate to arrest.⁹⁴ A specialized Crisis Response Unit was also established to respond to serious behavioral crises, follow up on incidents involving serious behavioral crisis and provide support for other officers interacting with people with mental illness. For this project, I interviewed a team coordinator for the SPD Crisis Response Unit. Since its inception, the Crisis Response Unit was able to significantly decrease use of force within its unit, with only 7.6% of crisis incidents resulting in arrest.⁹⁵

Mental health courts

Mental Health Courts provide an alternative to incarceration and an opportunity to connect people with mental illness to appropriate treatment services, but vary widely by jurisdiction. I interviewed a program manager from King County District Regional Mental Health Court (RMHC), who provides services for defendants diagnosed with a mental illness charged within the municipalities of King County.⁹⁶ County prosecutors can refer an individual to RMHC and, if the defendant is amenable after a screening process, an individualized working treatment plan will be created with the help of a multidisciplinary team of attorneys, advocates, clinicians and mental health specialists.⁹⁶ Defendants must adhere to the conditions of the treatment plan. Those who cannot adhere to the plan face referral back to traditional courts. However, as this is

a therapeutic court, some nonadherence to the treatment plan is tolerated and treatment plans are often revised to best fit defendant needs. Defendants must participate in the program for 2 years. Roughly 60% of participants in RMHC complete the program. Unlike many MHC models, King County takes defendants with almost all charges (excluding Class A and B felonies). The ultimate aim of RMHC is to address the underlying mental illness that spurred the charges at hand and provide an appropriate alternative to incarceration.

Local health and social services departments

Local cities and counties can provide resources and governance for strengthening social safety nets and institutional policies that prevent incarceration of people with mental illness. As part of this analysis, I interviewed a project manager from Diversion and Reentry Services (DRS), within the King County Division of Behavioral Health and Recovery. In 2014, DRS undertook an initiative, partially funded by the King County Transformation Plan, to improve the outcomes of jail recidivists with mental illness.⁹⁷⁻⁹⁹ The project, called the Familiar Faces Initiative (FFI), aims to improve the coordination between social, health and criminal justice agencies and provide a more client-centered continuum of care for those with mental illness who are at risk for further recidivism. As defined by DRS, “Familiar Faces” are individuals with mental illness who were booked at least 4 times into jails in King County over the past calendar year.¹⁰⁰ An analysis of this high-utilizer population found that 94% of people who have been booked over 4 times in the past year had an behavioral health issue.¹⁰⁰ FFI encompasses a number of proposed improvements on the current social and health services system in King county. For example, the initiative has led to the initial development of a pilot program that will allow managed-care caseworkers work with the Familiar Faces population while incarcerated to assist with release

planning and transitional care.¹⁰¹ An integrated data system to allow for responders, health providers and courts to collect and share data, enhance interagency collaboration and allow for improved population-level analysis is underway as part of the initiative. DRS is also planning the establishment of a “Single Diversion Portal” to enable quick access to diversion resources for first responders working with individuals with mental illness. Additionally, DRS is developing a partnership with the King County Prosecuting Attorney’s Office to “remediate legal barriers that contribute to client recidivism.”¹⁰¹

The forefront of the work with FFI is an interdisciplinary “Intensive Care Management Team” Program called “Vital.” Informed by a Forensic Assertive Community Treatment model, Vital provides intensive, wraparound services for high-utilizing jail recidivists with behavioral health needs.¹⁰² Working closely with local diversion and social services programs, Vital currently provides integrated primary care and behavioral health with and life-skills development and housing options for 60 individuals as part of a pilot program.^{101,102} DRS has many potential improvements underway in King County under the auspices of FFI related to the issue of incarceration of people with mental illness. DRS recognize the significant barriers that this population faces and work to create a more client-centered system for such individuals.

Advocacy organizations

Advocacy organizations help provide a voice to those who have fallen through all of the previous filters and find themselves incarcerated. Disability Rights Washington (DRW) is a non-profit organization that aims to protect the rights of individuals with disabilities in Washington State. Since 2015, they have worked with jails and prisons in King County to monitor and advocate for individuals with disabilities (including mental illness) under the Amplifying Voices of Inmates with Disabilities (AVID) Jail Project.¹⁰³ As part of this project, I

interviewed an attorney with AVID. Attorneys with the project visit inmates in jails and prisons around King County, inform them of their rights while incarcerated and provide technical and administrative assistance in filing grievances and limited legal representation for inmates with mental health issues.¹⁰³ They also have produced a variety of reports on conditions for people with disabilities while incarcerated. Attorneys from AVID have advocated to decrease the use of forced medication and segregation for inmates with mental illness and to provide better screening of mental health conditions upon booking.^{103,104} AVID attorneys call for improvements in how mental illness is addressed in jails and prisons. However, they feel that solely improving mental health care in jails and prisons is relatively downstream and that this issue would be best addressed in the community when possible.

Themes

Several key themes were identified from the key informant interviews. The respondents suggested many potential contributors to this issue from their agency's perspective and had considerations to prioritize moving forward. Many of the themes identified from the interviews aligned with other surveys of local stakeholders of this issue.^{62,105}

Key Themes

The following themes were universally or almost-universally discussed as major factors in this issue.

Lack of affordable housing

Lack of affordable housing was universally described as one of the most limiting issues among interview respondents. When asked where they would prioritize resources to this issue, almost

all respondents had housing as their first choice. As discussed earlier in this report, many inmates with mental illness tend to be homeless. Some key informants suggest that lack of a stable home significantly decreases adherence to treatment and increases risk of incarceration. Issues with finding affordable housing, therefore, can limit the efficacy of social services. Furthermore, people with mental illness often have limited rental or credit history, are recipients of public benefits and/or have a criminal record - all red flags for many potential landlords. In some cases, key informants reported that inability to find a placement upon reentry from incarceration (for MHC cases) or hospitalization can lead to longer stays as social services work to find housing. This is especially true for the transitional or supportive housing necessary for many people with serious mental illness recently released or discharged from hospitals or jails.

Limited community mental health treatment

Respondents reported limited access to robust community mental health services. Respondents noted long waits for an appointment and limited provider availability for many mental health agencies. This was especially true for the intensive, wraparound case and medication management necessary for individuals with severe mental illness who are most prone to incarceration. For this population, traditional clinic-based services may not be sufficient to prevent incarceration. Respondents voiced a need for more robust bridges between traditional outpatient services and inpatient care. Some respondents called for a more robust “continuum of care” where larger varieties of services are available depending on need or population. One respondent suggested increasing capacity for “treatment on demand” or services that served patients where they are -- outside traditional clinics in an outreach-based approach.

Crisis services

In the space between traditional community and inpatient care, there seems to be a gap for patients who are in crisis or who have marginal psychiatric functioning, but who are not acute enough to warrant hospitalization. It is in this space, according to some respondents, where many mentally ill individuals face arrest. With the high bar for civil commitment and the limitations in around-the-clock community mental health access, many behavioral crises outside weekday business hours go unaddressed by most social services agencies, thus resulting in law enforcement response with limited access to viable alternatives. Additionally, of the few available diversion options for individuals after-hours, many impose restrictions on their accepted client population and exclude people with outstanding warrants, significant behavioral issues or significant criminal records.

Low participation in mental health court

Like other therapeutic court models, the choice to participate in MHC is voluntary. Although some flexibility is tolerated in adherence to the treatment plan, the requirements imposed by the courts, especially in terms of drug and alcohol cessation, are often perceived as burdensome by defendants. This aversion may be compounded by the 2 year length of the participation period, which can extend beyond the sentencing length in traditional courts. For lower level charges especially, the length of participation in the program may far outlast the length of a potential traditional sentence and there is therefore less incentive for participation among low-level offenders. In spite of the support provided in MHC and the potential for bypassing a jail or prison stay for those offered the option of MHC, only a small proportion chose to participate. This is especially true for individuals with particularly serious mental illness who may lack the insight to assess the potential benefits of this option. Of the high-utilizing jail recidivists studied as part of

the Familiar Faces Initiative in 2014, only 8.5% chose to participate in an therapeutic court (mental health or drug courts).¹⁰⁰

Less Common Themes

The following themes were not uniformly discussed in the key informant interviews, but were potentially important to consider moving forward

Lack of coordination between agencies

As one respondent noted “for any one mentally ill person out there, there are a multitude of different agencies with a multitude of different systems, speaking a multitude of different languages, hoping to keep him or her out of jail.” Some respondents shared this sentiment -- that there was a lack of understanding and information sharing between the many agencies (police, CMHC, hospitals, etc.) that interact with this population. Although some note improvement over recent years, a lack of centralized coordination seems to result in inefficiency and duplication in an already resourced-strapped system. This seems to be especially true of high service utilizers, who are followed by many agencies. Such individuals find a highly fragmented system that requires extensive administrative navigation and expertise.

Lack of inpatient psychiatric beds

Although there has been some improvement in inpatient bed capacity in a response to the Trueblood and D.W. decisions, limited inpatient psychiatric beds continue to pose a problem for many in behavioral health crisis, according to some respondents. Some report that the acuity of those seen in outpatient community mental health facilities is increasing alongside inpatient

psychiatric bed shortages and lack of inpatient beds can pose difficulties for MHC and reentry placements.

Assault in the third degree

Since 1997, Washington State law automatically charges anyone who “[a]ssaults a nurse, physician, or health care provider who was performing his or her nursing or health care duties at the time of the assault” with a Class C felony.¹⁰⁶ Some respondents note that spitting or shoving on a healthcare provider while in the middle of a behavioral health episode can lead to the inappropriate incarceration of an individual with severe mental illness and call for a revision of this law.

Workforce issues

Between the difficulties in working with severely mentally ill individuals with a host of social, physical and mental comorbidities and the limited reimbursement from Medicaid for counseling and case management, some respondents note that there is little incentive for designated mental health professionals to work with this population. In line with trends seen earlier in Washington's history, respondents report that these issues result in a shortage of mental health professionals and high turnover among some social services agency employees.

“Pockets of Innovation”

Some areas around the state have recently implemented progressive solutions that show early promise in addressing this issue. As one respondent reported, Washington has many “pockets of innovation” that can potentially be scaled to fit the needs of other communities within the state.

Analysis of Potential Approaches

There are many potential avenues to address the issues discussed in the key informant interviews. Using the themes considered most important during the interviews, considering the historical context of themes and outlining the strengths/weaknesses of various interventions according to the literature. We will also present examples of interventions implemented in Washington State and finally suggest key recommendations related to each potential avenue of improvement to our current system. Below are descriptions of the frameworks used to analyze potential approaches to ameliorating this issue.

- Historical context of possible solutions

The history preceding our current era of criminalization of mental illness may provide context or inform the implementation of potential solutions to the issue.

- Strengths and weakness of possible solutions

To understand the solutions to this issue that would produce the greatest impact, it is important to assess the strengths and weaknesses of different options.

Strengths/weakness analysis was conducted using multiple measures oriented towards the capacity for change and the support of peer-reviewed literature (See Table Below).

The measures used in the strengths and weaknesses analysis are:

- Sequential Intercept Model Intercept: Using the SIM conceptual model, we can assess what level of filter is used in a given intervention. Preference is given for

more preventative intercepts that may allow for prevention of arrest or incarceration.

- Support of Literature: Using available systematic reviews and meta-analysis, we will categorize the strength of evidence for a given intervention in preventing initial incarceration or preventing recidivism. It is important to note that studies of community-based interventions are rife with the potential for bias and are difficult to draw robust conclusions. Systematic reviews and meta-analysis provide a particularly high bar for community-based interventions like those studied here. Limitations revealed from a systematic review may not necessarily suggest that an intervention is ineffective, rather that more robust data is needed to support a claim that an intervention is evidence-driven.
- Targeting of Intervention: Targeted interventions are necessary for specific population impact with limited resources. Many of these interventions also have the potential to affect individuals who are not mentally ill or not at risk of incarceration. The targeting of an intervention is therefore assessed to show how specific an intervention is in preventing incarceration of people with mental illness.

- Pockets of Innovation

Communities throughout Washington have developed solutions to address this issue across multiple intercepts. These interventions may be modified and scaled for other areas throughout our state or can inform similar solutions to incarceration of the mentally ill.

Table of Evidence on Interventions

	SIM Intercept	Strength of Evidence		Targeting
		Initial Arrest	Recidivism	
Housing Support	BCP	Yes ¹⁰⁷	Low ^{107,108}	Diffuse
CIT	Intercept 1	Mixed ¹⁰⁹	None	Less Diffuse
MHC	Intercept 2	N/A	Limited ¹¹⁰	Targeted

Housing Support

According to the key informants, lack of affordable housing is one of the biggest barriers for social service agencies in preventing this issue. Homelessness can prevent individuals with mental illness from effectively engaging in treatment and can be a rate-determining-factor for recovery in many individuals. Many informants call for low-barrier housing or housing supports as a solution for people with severe mental illness who are most at-risk for incarceration.

Historical Context

- Deinstitutionalization was attributed to a rise in homelessness alongside increased incarceration among individuals with mental illness. Historically, homelessness appears to be a common comorbidity in individuals with mental illness at-risk of arrest. Some argue that a lack of federal support for housing services was one of the factors that prevented CMHC funded through the Community Mental Health Act from filling the gaps in mental health care left from the closing of state psychiatric hospitals.²⁴

Strengths

- A systematic review conducted by WSIPP suggests that providing housing supports to individuals at risk for homelessness leads to reduction of initial incarceration. The authors also note that other potential benefits in this population, including reduced homelessness and reduced use of hospitals among participants.¹⁰⁷
- Housing support provides an intervention at the broadest SIM intercept, which allows the capacity to prevent this issue far upstream.
- Housing supports could theoretically increase the effectiveness of other social services agencies and community mental health treatment centers.
- Although there is limited evidence that housing supports offset criminal justice costs, one systematic review suggests that a “Housing First” model can offset the costs of shelters and emergency department visits in some populations.¹¹¹ Another single study on a Housing First model showed substantial cost savings for homeless individuals with severe alcohol problems.¹¹²

Weaknesses

- Cities across the country have struggled to address issues with affordable housing. Homeowners and landlords in many areas are opposed to low-income or supportive

housing in their neighborhoods, citing the potential for decreased property values and increased crime.¹¹³ Finding appropriate sites to send vulnerable and often highly stigmatized population can be fairly difficult.

- This is a very diffuse intervention. Housing supports may not be necessary for many people with mental illness and is not as targeted to the issue of incarceration among the mentally ill as other interventions. Any efforts to provide housing supports as a means to ameliorate this issue must be targeted to those with mental illness who are most at-risk of incarceration
- Between the increasing costs of properties and the sheer magnitude of homelessness, securing affordable housing for any vulnerable population (let alone one with sizable barriers to housing) has been an immense challenge in most major cities. Regardless of potential cost offsets in other sectors, the expenses of establishing affordable housing may be fairly prohibitive for many jurisdictions.
- Housing alone is not enough to address many of the social issues faced by this population. Most individuals will also require robust social and mental health services to stay out of jail.

Pockets of Innovation

- *King County Forensic Intensive Supportive Housing at SMH*
King County offers a Forensic Intensive Supportive Housing (FISH) program for individuals found to be incompetent to stand trial but do not qualify for immediate civil commitment or Mental Health Courts.¹¹⁴ The FISH program provides supportive housing with assertive case management and mental health treatment aimed to prevent recidivism and improve mental health outcomes.¹¹⁴ The FISH program is built on a Housing First model, where participants are provided housing without any requirement to participate in services. Among the first two cohorts, enrollment into the program was associated with reduced jail days, reduced use of crisis services, reduced psychiatric hospital admissions and increased days in the community.¹¹⁴

Recommendations

- *Prioritize Housing Support*
Key informants that were interviewed noted that lack of affordable housing, especially supportive housing, was the rate-determining factor in their agencies ability to respond

to this issue. This is in line with the literature and other policy analyzes on this problem.⁶² There is an important intersection between homelessness or precarious housing circumstances and poor outcomes with individuals experiencing mental illness. Affordable housing and support to overcome barriers to housing is the most important adjunct to the community mental health and social services necessary to preventing incarceration of the mentally ill. Although supportive housing with wrap-around services like King County's FISH program may be necessary for recidivists with severe mental illness, strengthening systems for housing vouchers and rent assistance may be a reasonable start in supporting outpatient mental health treatment in the community. This limitation is in line with a survey of inmates affected by the Trueblood v. DSHS case - when asked to prioritize what diversion method is most helpful in preventing incarceration, the majority of inmates in the Trueblood class ranked housing as the most important.¹⁰⁵

Crisis Intervention Teams and Other Crisis Solutions

The key informant interviews revealed a chasm between traditional outpatient programs and inpatient care. They note that many individuals who experience mental health crisis while not under the care of a mental health professional or outside normal business hours have limited options. These cases often force law enforcement to intervene. Crisis Intervention Teams and other crisis diversion solutions have been suggested as an alternative to arrest.

Historical Context

- Between the heightening of the bar for civil commitment, the emptying of state psychiatric hospitals and the defunding of CMHC, the gap between inpatient and outpatient care is the product of many historical factors. Recent cases involving psychiatric boarding reveal other consequences of that gap. Crisis programs that narrow the gap between inpatient and outpatient care may support this goal.

Strengths

- This intervention is an early intercept that allows for diversion prior to arrest.
- CIT is more targeted in preventing incarceration of mentally ill populations than other interventions.
- Research has suggested that CIT models change officer attitudes. The training necessary for CIT programs can lead to higher quality interactions between officers and the public. Officers learn de-escalation practices that may be helpful with populations beyond those with behavioral crisis.¹⁰⁹

Weaknesses

- CIT is dependent on the options available to offers for diversion. As one author notes “[w]ithout accessible non-jail options, prebooking jail diversion models such as CIT will not realize their potential to yield positive results.”¹¹⁵
- The evidence of CIT in the prevention of initial incarceration is mixed - an early systematic review showed some promise but the author noted severe limitations in the quality of evidence. A larger, more recent systematic review and meta-analysis by Taheri found no effect of CIT on arrests of people with mental illness.¹⁰⁹ Taheri does not call for the discontinuation of CIT programs but suggests more robust research is needed to support their use.
- No meta-analysis or systematic review has been conducted to date that assesses if CIT reduces recidivism.
- Police officers have limited choices when encountering mentally ill people who have committed more serious crimes. Arrest can be required if individual is caught committing certain crimes against persons.

Pockets of Intervention

- *SPD/KCSO Law Enforcement Assisted Diversion*
The Seattle Police Department and the King County Sheriff’s Office are currently piloting a pre-arrest diversion program targeted toward individuals charged with low-level crime (like limited drug possession or prostitution) in the city of Skyway or the Belltown neighborhood in Seattle called Law Enforcement Assisted Diversion (LEAD).¹¹⁶ Informed by a harm reduction model, the program aims to divert individuals to community-based services and case management, including housing and mental health treatment, with the hope of limiting incarceration and recidivism in the study population.¹¹⁷ Recent program evaluations found that the program reduced the likelihood of arrest by 60%, felony charges by 52% and the average number of jail days by 39 when compared to the system-as-usual group.^{118,119}
- *King County Crisis Solutions Center at DESC*
King County has partnered with the Downtown Emergency Services Center to open a Crisis Solutions Center (CSC) in 2012. The program aims to provide first responders, hospitals and law enforcement alternatives to jail and hospital settings when engaging

with individuals in behavioral health crisis.¹²⁰ Individuals in behavioral health crisis are diverted to a voluntary 16-bed Crisis Diversion Facility that provides mental and physical health screenings and case management. Once the immediate behavioral health crisis is resolved, a longer-term facility with additional services is offered to those experiencing continual mental health needs and homelessness.¹²⁰ Although this is a potentially vital solution in filling the aforementioned gaps between hospital and outpatient services, the key informant interviews revealed that there are reportedly some limitations on eligibility that make this option underutilized by police officers in King County. Nevertheless, the CSC program served 2,897 people in crisis in 2015 alone, primarily as a step down from hospital admission or ED utilization.¹²¹ Program evaluation is still needed to determine if this intervention has met its stated goals, however, this option may prove to be an important tool in diverting individuals in crisis.

Recommendations

- *Support the Adoption of Crisis Intervention Teams/Training in Other Jurisdictions*
Police diversion is a vital intercept in behavioral crisis situations. Programs like King County's LEAD project should be considered in other jurisdictions. In areas where resources for a CIT are limited, Crisis Intervention Training that focuses on diversion policies and harm reduction tenants may be a viable alternative in preventing the incarceration of mentally ill individuals. It is important to note that diversion programs can only be as robust as the options available for diversion. Strong partnerships with community mental health and crisis resources ensures the efficacy of CIT diversions.

- *Support Increased Capacity for Treatment of Serious Mental Illness*
Many social services agencies are severely limited in the outpatient care they can provide, especially when it comes to the wraparound services necessary to prevent incarceration in individuals with serious mental illness. Providing resources to community mental health facilities to support the development of intensive outpatient programs for individuals with severe mental illness would be wise choice in preventing incarceration, especially among high utilizers. This is similarly in line with the opinions of the Trueblood class inmates, who noted medication and case management as the second and third most important factors that prevent incarceration respectively.¹⁰⁵

Increasing psychiatric inpatient capacity is also an important consideration in ensuring the efficacy of social services and police diversion but may be limited to a point by the high bar of civil commitment. Supporting more lower acuity, voluntary residential programs may be a better alternative to state psychiatric hospital support for most individuals.

Mental Health Courts

When individuals commit certain crimes, police officers are often required to arrest them regardless of their mental health status. Once individuals have filtered through earlier intercepts, there are dwindling options available to prevent incarceration. For individuals who can not be diverted through other means, Mental Health Courts can be a viable option, however, the key informant interviews reveal low participation in this model.

Historical Context

- Although legal protections established in the 1970s guarantee access to provider-prescribed mental health care in jails and prisons, the quality and efficacy of such care is not guaranteed. In practice, many individuals incarcerated with mental illness go without proper care. MHC can divert individuals to appropriate services outside of correctional facilities.

Strengths

- Depending on the jurisdiction, MHC can be used for mentally ill individuals who have committed more serious crimes that have slipped through previous intercepts.
- MHC can provide some incentive to encourage individuals who are resistant to treatment.
- A systematic review conducted for this analysis shows that, although the data are fairly limited, those who participate in MHC do exhibit reductions in recidivism (see Appendix 4).

Weaknesses

- Systemic limited participation in MHC.
- MHC is farther downstream than other interventions, well after the costs and poor outcomes of incarceration may have developed. MHC cannot prevent initial incarceration.
- MHC can be expensive. One study did not show cost savings in the 3 years after enrollment and suggested that “the added treatment costs exceed for many participants the criminal justice cost savings.”^{62,122}

Pockets of Innovation

- *SSB 6430: Suspension of Medicaid*

Connecting people with mental illness to community mental health services upon reentry can help stop the cycle of recidivism due to symptoms of mental illness. Enrollment into Medicaid can lower financial barriers to care and increase mental health care access. Washington has historically terminated Medicaid eligibility upon incarceration.⁶² Federal laws bar Medicaid payments during incarceration, however, termination of eligibility in incarcerated populations is not required. Termination of Medicaid eligibility often poses a significant hurdle for detainees with mental illness upon reentry, as many do not understand the administration or necessity of health insurance or how it can facilitate access to mental health care.⁶² Studies of recently-released jail detainees with mental illness in Washington State show that expedited enrollment into Medicaid is associated with increased use of mental health treatment.^{123,124} The Kaiser Family Foundation recommends the “suspension” of Medicaid eligibility upon incarceration in lieu of termination to allow for expedited reinstatement of Medicaid benefits upon reentry.^{62,125} Washington recently passed Substitute Senate Bill 6430 to meet these recommendations. The law directs the Washington Health Care Authority to end the termination of Medicaid benefits upon incarceration in favor of suspension of Medicaid benefits starting in July of 2017.¹²⁶ Hopefully, this will allow for better continuity of care and potentially reduced recidivism among recently incarcerated people with mental illness.

Recommendations

- *Increase participation MHC*

Mental Health Court may be a viable option for individuals who have criminal charges that cannot be resolved through diversion. An increasingly large body of evidence that suggests that MHC participants see some benefit in reduced recidivism, however participation is fairly low, especially among those who may see the most benefit. Strengthening community and inpatient mental health systems, as described before, may increase the efficiency of MHC, but the issue of low participation must be addressed. In jurisdictions where MHC is reserved for low-level crimes, there is insufficient incentive for participation. Expanding MHC offerings to those accused of more serious crimes may make MHC a more viable option. Increasing flexibility in time

served by MHC or the requirements of the court may also make MHC a more appealing option. One author suggests that expansion of MHC to include co-occurring substance users may provide more value than current models.¹²² As substance use is a common comorbidity in MHC populations and one of the most common reasons for MHC failure, considering a Harm Reduction-based approach may also increase participation. Ultimately, MHC is a downstream intervention, well after the incurrence of most of the costs to the individual and society. To affect the broadest number of individuals, other recommendations offered in this analysis should have priority before strengthening MHC.

Conclusions

Incarceration of individuals with mental illness is a costly and unnecessarily common occurrence in Washington State. The implications of this issue extend throughout society and are of particular urgency today. However, this problem did not appear in a vacuum. When looking to our history, we see that deinstitutionalization coupled with under-resourced community mental health left a chasm that drove many individuals to incarceration. The recent *Trueblood* and *D.W.* cases revealed some of the many adverse outcomes of eliminating inpatient psychiatric beds and Washington has been since been working to ameliorate the effects of these policy decisions.

However, history also shows that we cannot (practically and ethically) go back to the opposite end of the spectrum where individuals with mental illness are warehoused without recourse. Although currently Washington needs inpatient psychiatric beds, to the extent that is possible, we also must find solutions that support the ability for individuals with mental illness to “survive safely in freedom”. Resources that allow people with mental illness to thrive safely in the community to the extent that is possible is most responsible and practical path forward if we are to hoping to prevent incarceration of people with mental illness.

The key informant interviews in this analysis showcase the many venues in which change can be achieved for this issue. Fortunately, the State of Washington has many programs that have been experimenting with methods to mitigate these trends. If we can disseminate the knowledge and innovation found in areas, we may be able to target those most vulnerable to this unfortunate outcome. However, we do not have to reinvent the wheel. Providing resources that

allow existing community mental health and jail diversion programs to work the more effectively and serve more people would affect the broadest population and could be the frontline in decreasing arrests of those with mental illness and other poor outcomes. The literature review and key informant interviews conducted for this analysis suggest that prioritizing housing support would be the best first step for the State of Washington in ameliorating this issue. If we are aiming to close the gap between inpatient and outpatient care that leads to incarceration of people with mental illness, there will also need to be a gradient of evidence-driven, well-supported programs targeting a range of populations. This analysis therefore suggests that increasing capacity for a more robust continuum of services that closes the gap between traditional inpatient and outpatient clinics would also be a wise choice for the State of Washington. The best method for increasing capacity in this area would involve prioritizing wrap-around services outside of traditional clinic models and crisis diversion programs. With thoughtful policy, we can prevent the disproportionate incarceration of individuals with mental illness and support their participation in our communities.

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Appendices

Appendix 1: Abbreviations

APA	American Psychiatric Association
AVID	Amplifying Voices of Inmates with Disabilities Jail Project
BCP	Best Clinical Practice
CIT	Crisis Intervention Team
CMH	Community Mental Health
CMHC	Community Mental Health Centers
CSC	Crisis Solutions Center
DOJ	Department of Justice
DRS	King County Diversion and Reentry Services
DRW	Disability Rights Washington
DSHS	Washington Department of Social and Health Services
FFI	King County Familiar Faces Initiative
FISH	Forensic Intensive Supportive Housing
HHS	U.S. Department of Health and Human Services
LEAD	Law Enforcement Assisted Diversion
MHC	Mental Health Courts
ORCS	Offender Reentry Community Safety Program
RMHC	King County District Regional Mental Health Court
RSN	Regional Support Networks
SIM	Sequential Intercept Model
SMH	Sound Mental Health
SPD	Seattle Police Department
TAU	Treatment As Usual
WSIPP	Washington State Institute for Public Policy

Appendix 2: Timeline

Year	Event	Actor	Implications
Era of Institutionalization			
1871	Western State Hospital Opens	Washington State	First psychiatric hospital in Washington
1891	Eastern State Hospital Opens	Washington State	
1912	Northern State Hospital Opens	Washington State	
1948	"The Snake Pit" published	Mary Jane Ward	Recounted poor conditions in psychiatric hospitals. Public outcry on institutionalization
1953	Thorazine first used for mental illness	SmithKline	First effective treatment for mental illness. SmithKline markets it as opportunity for legislators to close expensive state hospitals.
Era of Deinstitutionalization			
1960	"The Right to Treatment" published	Mortin Birnbaum	Prominent physician/lawyer argues that people should get treatment when institutionalized and if not able to be treated - they should be sent home. Informs later court cases.
1962	"One Flew Over the Cuckoo's Nest" published	Ken Kesey	Recounted poor conditions in psychiatric hospitals. Public outcry on institutionalization
1963	Community Mental Health Centers Act	Congress	Funded outpatient community based care centers as an alternative to institutionalization.
1971	<i>Wyatt v. Stickney</i>	US District Court for the Middle District of Alabama	Judge orders that psychiatric hospitals must provide treatment. Outlines standards required for adequate treatment of mental illness. Further spurs deinstitutionalization since states were not able to fund the requirements
1972	<i>Lessard v. Schmidt</i>	US District Court for the Eastern District of Wisconsin	Sets risk of imminent harm as bar for civil commitment. Required that the civil commitment proceedings have similar constitutional protections as required for criminal cases.
1973	Northern State Hospital Closes	Washington State	
1974	Involuntary Treatment Act	Washington State Legislature	Aligned Washington's civil commitment requirements with <i>Lessard v. Schmidt</i>

1975	<i>Donaldson v. O'Connor</i>	SCOTUS	Sets danger of imminent death as the bar for incarcerating someone. Mental illness alone is no longer a sufficient reason to require incarceration. Encouraged deinstitutionalization.
1976	<i>Estelle v. Gamble</i>	SCOTUS	Guarantees access to medical care in jails and prisons, but inmates can only file malpractice in cases where care is "so extreme or abusive as to be completely outside the range of professional medical judgment."
1976	<i>Bowring v. Godwin</i>	US Fourth Circuit Court of Appeals	Guarantees access to mental health care in jails and prisons, but only in cases of "deliberate indifference" can inmate's file malpractice claims.
1981	Omnibus Budget Reconciliation Act	Congress	Cut federal funding to nursing homes that primarily treated patients with mental health issues. Eliminated the option of federally subsidized nursing home care for people serious mental illness.
Era of Transinstitutionalization			
1986	Anti-Drug Abuse Act	Congress	Imposes mandatory minimum sentences. Marks the beginning of the "War on Drugs."
1989	Washington State Mental Health Reform Act	Washington State Legislature	Lead to the decentralization of state mental health care in favor of Regional Support Networks. Tasked with strengthening alternatives to inpatient care.
1995	Introduction of managed care for Medicaid in Washington	Washington State	Under funded outpatient mental health care. May have spurred transinstitutionalization.
2014	<i>DW et al. v. DSHS</i>	Washington State Supreme Court	Providers cannot involuntarily board people in emergency departments while awaiting inpatient psychiatric beds.
2014	<i>Trueblood et al. v. DSHS</i>	US District Court for the Western District of Washington	DSHS must reduce wait times for inmates slated to receive care at state psychiatric hospitals.

Appendix 3: Key Informant Interview Questions

1. How is incarceration of mentally ill individuals a problem? How does this issue affect your work?
2. What is the scope of the issue? Where have you seen evidence of it?
3. What is the historical context of the problem from your perspective? What historically has contributed to this issue? What trends do you see?
4. Who are major players in contributing or resolving this issue? How is your agency affected or dealing with the problem?
5. What contributes to or mitigates the issue?
6. What potential solutions do you suggest? What solutions do you feel are most compelling? How do you predict they may affect your work?

Appendix 4: Mini - Systematic Review of Mental Health Courts

Background

- Background on field

The use of Mental Health Courts (MHC) has been proposed as a possible solution to recidivism of the mental ill. Mental Health Courts differ from the traditional judicial process in that they are designed to identify and link those with mental illness with long term, community-based mental health treatment in lieu of jail time or with reduced jail time.⁸⁸ Participation in MHC is voluntary and participants work alongside the court to develop and adhere overarching treatment plan. One of the main aims of MHC is to address the untreated or undertreated mental illness that often leads mentally ill individuals back to jail. This model is relatively new. Although there are now roughly 250 MHC in the US, it has only gained prominence in the past decade and research into the effect of the model is sparse.

Objectives

- Goals of Analysis

Little research has been done to determine if the MHC meets its stated goal of reducing recidivism among individuals experiencing mental illness. The research that has been done often is naturalistic/quasi-experimental in nature and may lack the rigor to confidently support model proponents stated claims. This analysis will explore the existing data on the effect of MHC on recidivism, with a focus on more rigorous controlled clinical trials.

- Study Aim

To understand the effect of MHC programs on recidivism in mentally ill adults.

- Specific research question

Do Mental Health Courts reduce recidivism among adults experiencing mental illness?

Methods

- PICOTS framework

- Types of studies: Controlled Clinical Trial
- Types of participants: Adults diagnosed with any mental illness charged with a crime
- Types of interventions: Mental Health Courts vs. Treatment-As-Usual (unmodified traditional courts)
- Types of outcome measures: Jail/Prison Recidivism Rates

- Search Strategy/Search Terms

- Search Terms: (recidivism* or incarceration*) and (mental health court*)
- Limited to studies within the past 10 years but did not limit based on the “clinical trial” metatag as many of the studies were recent and yet to be categorized.

- Names of databases searched

- PubMed

PRISMA Flow Diagram		
Identification	Records Identified through database searching n = 39 ↓	Additional records identified through other sources n = 0 ↓
Screening	Records after duplicates are removed n = 39 ↓	
	Records screened n = 39 ↓	→ Records excluded n = 29
Eligibility	Full-text articles assessed for eligibility n = 10 ↓	→ Full-text articles excluded with reasons n = 5
Included	Studies included in qualitative synthesis n = 5	
<i>*Quantitative synthesis not completed*</i>		

- Search Strategy Results

- Search returned 39 articles (See end for full listing)

- Upon initial screening of the query results

- 15 were not a controlled clinical trial
- 6 were not comparing against treatment-as-usual
- 3 were looking at youth populations
- 2 did not have recidivism as an outcome
- 1 did not research mental health courts
- 1 was a correction
- 1 looked at dual diagnosis populations (mental illness + substance use disorders)

- 10 were selected for full - text eligibility screening
 - Upon analyzing for eligibility
 - 2 were not a controlled clinical trial
 - 2 were not comparing against treatment-as-usual
 - 1 was a duplicate of another cohort
 - 5 were selected for qualitative analysis
 - We see a limited number of articles returned in this search. As mentioned in the background, research into this model is relatively nascent as the model itself has only recently gained popularity. The bulk of the research encountered in this search were not controlled trials. Many of the studies were population-based before/after intervention or individual-based before/after intervention trials and not “controlled” in the conventional sense. Many of the studies did not compare to treatment-as-usual but rather another similar treatment-focused model. Some of the papers were solely commentary on the model and some were looking outside of the populations selected for this analysis (children, substance abuse, etc.). Upon full-text review, more were excluded for not fulfilling the controlled and treatment-as-usual requirements. One study examined the same cohort of another selected for analysis. In all, 5 studies were selected for qualitative analysis.

Studies Selected for Qualitative Analysis				
#	Title	URL	Authors	Journal
1	Recidivism following mental health court exit: Between and within-group comparisons.	/pubmed/26595703	Lowder EM, Desmarais SL, Baucom DJ.	Law Hum Behav. 2016
2	Stopping the revolving door: effectiveness of mental health court in reducing recidivism by mentally ill offenders.	/pubmed/24881521	Anestis JC, Carbonell JL.	Psychiatr Serv. 2014
3	Effect of mental health courts on arrests and jail days: a multisite study.	/pubmed/20921111	Steadman HJ, Redlich A, Callahan L, Robbins PC, Vesselinov R.	Arch Gen Psychiatry. 2011
4	Effectiveness of a mental health court in reducing criminal recidivism and violence.	/pubmed/17728425	McNiel DE, Binder RL.	Am J Psychiatry. 2007
5	Longer-Term Impacts of Mental Health Courts: Recidivism Two Years After Exit.	/pubmed/26567933	AldigÃ© Hiday V, Ray B, Wales H.	Psychiatr Serv. 2016

- Tools used to rate quality of evidence/bias
 - In concordance with the recommendations for systematic reviews of mental health courts outlined by Loong, et al., I used the Cochrane 6-item risk of bias checklist to assess bias in these studies.¹²⁷

Cochrane 6-Item Checklist as outlined by Loong, et al. ¹²⁷
1. Adequate sequence generation - Group assignments of participants follow rules that are based on chance.
2. Allocation concealment - Schedule of random assignments are kept concealed from personnel involved in study enrollment.
3. Blinding - Participants and personnel are masked of the knowledge of which intervention was received.
4. Incomplete outcome data - There is no significant difference between groups who withdraw from the study.
5. Selective reporting - Study results are not selectively reported.

6. Recruitment strategy - The recruitment process is open to all potential participants who meet the study eligibility criteria.

- Software used
 - Google sheets

- Analysis methods
 - Alongside the Cochrane bias checklist suggested by Long, et al., I also developed a list of metrics related to the quality of study methodology specific to MHC studies that may be useful in characterizing the quality and comparability of the studies that were analyzed. Among the metrics collected are:
 - Study Type - The type and chronology of each study was collected to characterize the potential biases outlined in each study type.
 - Was the MHC model described? - There is variation in how the MHC model was administered. Scholars of the MHC model have developed essential standards that may help characterize true fidelity to the MHC model.⁸⁸ Unfortunately, none of the studies articles had sufficient detail to determine true fidelity to the MHC model. It is still an important quality indicator that authors at least outline how the MHC model was administered in their study jurisdiction. Therefore the metric of if the model was described was recorded for each study.
 - Number of Sites, Case/Control Numbers - The number of study sites and the number of those in the Case and Control groups were recorded to determine robustness of the study population.

- Treatment-as-Usual Population (Control) - There was some variation in how the Treatment-as-Usual (TAU) population was recruited/determined in each study. The description of TAU population was collected for comparison between studies.
- Length of Follow Up - The determination of the study period varied significantly between studies. The potential Length of Follow up was collected for comparison.
- Length of Treatment - This metric was intended to assess the potential measurement of “dose” of MHC intervention exposure in subjects.
- Was there an analysis of non-completers of the MHC program? - As you will see in the limitations of these studies, there is likely a significant “survival effect” in the characteristics of who “graduate” the program. Many of the studies did analysis on the characteristics of those who completed the program vs. those who did not - a potentially important indicator of quality.

DETAILED STUDY DESCRIPTIONS

#	Setting	Data Source	Recidivism Outcome Measures	Eligibility Determination	Group N (# Completed MHC)	Gender (% Men)	Mean Age (standard deviation)
1	"Ramsey County Mental Health Court"	"secondary, administrative data"	jail Days, charges, convictions	MHC Participants: - >18 years of age - charged with misdemeanor/gross misdemeanor - no history of violent offenses - diagnosed with MI by mental health professional	57 (30)	45.60%	34 (9.62)
				TAU: - Court reviewed all misdemeanor cases in the last 3 years - Randomly selected 400 cases and screened to include those self-reporting MI at intake (That did not participate in MHC). -Randomly 40 cases from the screened pool.	40	52%	36 (9.55)
2	"MHC in the southeastern United States"	"court databases"	rearrest, length to reoffense, number of arrests	MHC Participants: Not described	198 (not described)	69%	36.42 (12.47)
				TAU: "Mentally ill offenders assigned to traditional criminal court"	198	74%	35.45 (11.21)
3	"4 MHCs included in this study are San Francisco County, CA, Santa Clara County, CA, Hennepin County (Minneapolis), MN, and Marion County (Indianapolis), IN."	" program data from the study sites"	number of new arrests, annualized arrest rates, and county jail and state prison incarceration days	MHC: "newly enrolled MHC participants"	447 (89.4)	58.20%	37.5 (not provided)
				TAU: "similar subjects who were eligible for the MHC but were never referred to it or were never rejected from the MHC" "Newly booked jail detainees identified by jail mental health staff as having mental health problems"	600	63.20%	36.6 (not provided)
4	"San Francisco county court"	"deidentified administrative databases associated with the San Francisco county court and jail systems"	length to reoffense, length to reoffense for violent crimes	MHC: "diagnosed as having a DSM-IV axis I mental disorder or, in some circumstances, developmental disabilities, and they must be amenable to treatment in the community mental health system"	170 (81)	74.00%	37.3 (11)
				TAU: "concurrently potentially eligible for consideration for selection into the mental health court—that is, other individuals with mental disorders who entered the San Francisco jail during the same period"	8,067	78.00%	37.9 (11)
5	MHC in District of Columbia	"Archival data from the pretrial services agency"	any rearrest, number of rearrests, any felony	MHC: "competent, are charged with misdemeanors, and have no pending charge or conviction in the prior five years of a dangerous or	408 (238)	50%	not provided

			arrest, and time to rearrest	violent felony"			
				TAU: "MHC-eligible defendants in TCC who were also under SSU supervision on pretrial release and who received individualized plans from the same package of services and supervision from the same pretrial services and community agencies"	687	63%	not provided

Results

Results of Quality Rating/Bias

STUDY METHODOLOGY METRICS										
#	Study Type	MHC Model Described	Number of Sites	Length of Treatment	TAU Population	Case n	Control n	Length of Follow Up	Analysis of non-completers	Comments
1	Retrospective Cohort	Yes	1	Varied	Randomly-selected self-reported mentally ill, misdemeanor offenders	57	40	1 year after program exit	Yes	
2	Retrospective Cohort	No	1	Unknown	Mentally ill offenders assigned to traditional criminal court"	198	198	1 year following index offense	No	
3	Prospective Matched Cohort	Yes	4	Varied	"similar subjects who were eligible for the MHC but were never referred to it or were never rejected from the MHC"	447	600	18 months after MHC enrollment	Yes	
4	Retrospective Cohort	Yes	1	Varied	"...others who were concurrently potentially eligible for consideration for selection into the mental health court"	172	8,067	Date of arrest through 5/27/2005	Yes	
5	Retrospective Cohort	Yes	1	Varied	"MHC-eligible defendants in TCC who were also under SSU supervision"	408	687	2 years after arrest	Yes	May not be true TAU

In the study methodology metrics table we see that most of the studies were retrospective cohort studies, with study 3 being the only outlier. This will be an important consideration when we consider the biases these studies are subject to in the next table. We also see that most of the studies do describe their jurisdiction's interpretation of the MHC model, with study 2 as the only study that did not describe their MHC process. Length of treatment varied universally. In this table it is noted that the TAU group were typically other mentally ill offenders who were never referred to MHC, although were some deviations including one study that randomly

selected those screened for mental illness and another that had a TAU group that received some light case management for their illness (which may arguably suggest that the study didn't have "true" TAU). There was some variation in the number of cases and controls ranging from 57 - 447 cases and 40 - 8067 controls. There was also much variation in the timepoints marking the beginning and ending of each study assessment period. Most started at the date of arrest, which may be convenient for comparison to the controls. Others started after program exit or enrollment. All studies extended through at least one year after start, with one study extending in a variable survival-time fashion. All but one study analyzed the characteristics of non-completers.

RISK OF BIAS CHECKLIST OF ANALYSED STUDIES							
Study #	Adequate Sequence Generation	Allocation Concealment	Blinding	Incomplete outcome data	Selective Reporting	Recruitment Strategy	Total
1	-1	-1	-1	-1	1	0	-3
2	-1	-1	-1	0	-1	0	-4
3	-1	0	-1	-1	1	0	-2
4	-1	-1	-1	1	1	0	-1
5	-1	-1	-1	1	1	0	-1

The risk of bias checklist was not kind to these quasi-experimental studies. The checklist scores can range from -6 to 6, with any total scores under 2 equating to "High Risk of Bias." All of the studies in this analysis extended below -1 for their total bias score - indicating all had a high propensity to bias. Much of the sources of bias for these studies lie in the first three questions of the checklist. Given that it is ethically unsound to randomize participants, difficult to conceal allocation (in retrospective studies) and impossible to blind the intervention, all of the studies did poorly in the first few questions of the check list. Of the studies that analyzed non-completers of the MHC model, half found significant differences and half did not. The majority of studies

reported all outcomes they set out to measure, except study 2, that was vague about some of their outcomes.

The MHC model is administered in a way that puts into question if all that are eligible are offered the intervention. In many cases it is non-medically qualified prosecutors who determine who can proceed to MHC. The guidelines on MHC qualification vary between jurisdictions and are not very transparent. I therefore could not assess from the descriptions provided (or not provided) by the study authors if question 6 of the Cochrane checklist was satisfied.

Summary of Evidence Tables

#	Number of People Rearrested	Length to Re-Offence	Number of Jail Days	Number of Arrests	Number of Convictions	Annual Arrest Rate
1	No effect		Significantly Lower in MHC		No effect	
2	Significantly Lower in MHC	Significantly Longer in MHC		Significantly Lower in MHC		
3	Significantly Lower in MHC		Significantly Lower in MHC			Significantly Lower in MHC
4		Significantly Longer in MHC				
5	Significantly Lower in MHC	Significantly Longer in MHC		Significantly Lower in MHC		

The results were almost universally in favor of MHC and included many differing measures of recidivism - only study number one reported non-significant findings. The majority measured the number of offenders who were rearrested over the study-designated follow up period. "Survival analysis" of length to rearrest was also used frequently. Less frequent were number of jail days, total number of arrests (in aggregate). Rarely used was number of convictions (not all arrests led to convictions) and annual arrest rate.

Discussion

- Interpretation
 - The results of these studies are almost universally in favor of MHC but these studies have inherent methodological issues that put them at significant risk for bias as defined by the Cochrane checklist. Additionally, there is much apparent heterogeneity on the measures of recidivism used, who is counted in the TAU group, who is offered MHC and length/definitions of follow up.
 - There are also biases inherent in the implementation of the model that any study of this model will likely be subject to. Participation in MHC is required to be voluntary. This makes sense, as it would be unethical and potentially counter-therapeutic for inmates to be forced to forgo traditional courts for this new model. However, it allows for self-selection into the intervention which means that no studies of this model would (ethically) be able to blind or randomize participants. Additionally, as discussed earlier in this paper, the courts system is subject to a lack of transparency and consistency on who is offered MHC. This means that not all eligible inmates are guaranteed to be offered the intervention, allowing for further possibility of selection bias.

- Contribution to the literature
 - Little has been done to rigorously review research that assesses the ability of MHC to reduce recidivism when compared to TAU controls. This meta-analysis fills gaps that may be important for policy makers.

- Policy implications
 - Policy makers should consider MHC as a potential solution to recidivism among the mentally ill. However, policies that establish MHC should also consider building in robust data collection systems to allow for later program evaluation.

- Limitations
 - This analysis only looked at one clinically-oriented database, PubMed. Other databases that included justice system or psychological journals may have allowed for more results. However, any current study counts will likely be limited by nascency of research into the MHC model.
 - This analysis only looked at controlled studies foregoing any population-based or naturalistic studies that may have offered additional information at the risk of lowering the level of rigor for the analysis.
 - The Cochrane checklist seemed to be more appropriate for RCT-like studies. There are other bias checklists designed for quasi-experimental studies that may have been more appropriate.
 - There are similar programs to MHC (like Assisted Outpatient Therapy) that do very similar things to the MHC model. Other analysis might consider including such programs.
 - As described earlier, we cannot assess fidelity to the model in these studies. It is therefore hard to know if we are actually measuring “true” MHC in this analysis.

- Recidivism is only one of many outcome measures that may be clinically and socially important in the assessment of how worthwhile MHC is in addressing mentally ill inmates.

- Next steps/ future work
 - Researchers should consider a prospective study design with transparency on who is offered MHC to minimize the biases inherent in the model.
 - Standardization on best outcome measures/populations may help support future research.
 - Measuring other important outcomes potentially affected by MHC (like adherence to mental health treatment, reduction of violence or costs) is also necessary in determining if MHC are worthwhile.
 - Comparison to other proposed solutions to the problem of recidivism may be appropriate.

Conclusions

Ultimately, the consistently promising results of this intervention may suggest that MHC delivers on its claims of reducing recidivism. However, more rigorous research must be completed before we can adequately assess if MHC is worthwhile in the effort to reduce recidivism.

Regardless of the outcomes of this intervention, more must be done to address this dire issue of incarceration of the mentally ill.

Full list for mini-metaanalysis

#	Title	Authors	Journal	Screening	Eligibility
1	Recidivism following mental health court exit: Between and within-group comparisons.	Lowder EM, Desmarais SL, Baucom DJ.	Law Hum Behav. 2016	*	Selected
2	Stopping the revolving door: effectiveness of mental health court in reducing recidivism by mentally ill offenders.	Anestis JC, Carbonell JL.	Psychiatr Serv. 2014	*	Selected
3	Effect of mental health courts on arrests and jail days: a multisite study.	Steadman HJ, Redlich A, Callahan L, Robbins PC, Vesselinov R.	Arch Gen Psychiatry. 2011	*	Selected
4	Effectiveness of a mental health court in reducing criminal recidivism and violence.	McNiel DE, Binder RL.	Am J Psychiatry. 2007	*	Selected
5	Longer-Term Impacts of Mental Health Courts: Recidivism Two Years After Exit.	Aldigé Hiday V, Ray B, Wales H.	Psychiatr Serv. 2016	*	Selected
6	Effectiveness of a short-term mental health court: criminal recidivism one year post exit.	Hiday VA, Wales HW, Ray B.	Law Hum Behav. 2013	*	Duplicate Cohort as paper #5
7	Arrests two years after exiting a well-established mental health court.	Hiday VA, Ray B.	Psychiatr Serv. 2010	*	Not a Controlled Clinical Trial
8	Multidimensional evaluation of a mental health court: Adherence to the risk-need-responsivity model.	Campbell MA, Canales DD, Wei R, Totten AE, Macaulay WA, Wershler JL.	Law Hum Behav. 2015	*	Not a Controlled Clinical Trial
9	The Impact of Community Treatment on Recidivism Among Mental Health Court Participants.	Han W, Redlich AD.	Psychiatr Serv. 2016	*	Not Comparing to TAU
10	Long-term recidivism of mental health court defendants.	Ray B.	Int J Law Psychiatry. 2014	*	Not Comparing to TAU
11	Correction to Hiday, Wales, and Ray (2013). : "effectiveness of a short-term mental health court: criminal recidivism on year post exit".	[No authors listed]	Law Hum Behav. 2015	Correction	
12	Interventions for drug-using offenders with co-occurring mental illness.	Perry AE, Neilson M, Martyn-St James M, Glanville JM, McCool R, Duffy S, Godfrey C, Hewitt C.	Cochrane Database Syst Rev. 2014	Dual-Diagnosis	
13	Psychiatric symptoms and mental health court engagement.	Canada KE, Markway G, Albright D.	Psychol Crime Law. 2016	Not a Controlled Clinical Trial	
14	Preventing Criminal Recidivism Through Mental Health and Criminal Justice Collaboration.	Lamberti JS.	Psychiatr Serv. 2016	Not a Controlled Clinical Trial	

15	The effectiveness of mental health courts in reducing recidivism and police contact: a systematic review protocol.	Loong D, Bonato S, Dewa CS.	Syst Rev. 2016	Not a Controlled Clinical Trial	
16	Does the evidence support the case for mental health courts? A review of the literature.	Honegger LN.	Law Hum Behav. 2015	Not a Controlled Clinical Trial	
17	Cost analysis of long-term outcomes of an urban mental health court.	Kubiak S, Roddy J, Comartin E, Tillander E.	Eval Program Plann. 2015	Not a Controlled Clinical Trial	
18	Short- and Long-Term Outcomes of Mental Health Court Participants by Psychiatric Diagnosis.	Comartin E, Kubiak SP, Ray B, Tillander E, Hanna J.	Psychiatr Serv. 2015	Not a Controlled Clinical Trial	
19	Updates since Brown v. Plata: alternative solutions for prison overcrowding in California.	Horne C, Newman WJ.	J Am Acad Psychiatry Law. 2015	Not a Controlled Clinical Trial	
20	Why do mental health courts work? A confluence of treatment, support & adroit judicial supervision.	Edgely M.	Int J Law Psychiatry. 2014	Not a Controlled Clinical Trial	
21	Law & psychiatry: what can we say about mental health courts today?	Goodale G, Callahan L, Steadman HJ.	Psychiatr Serv. 2013	Not a Controlled Clinical Trial	
22	Public policy and limits of diversion programs for reducing jail exposure of persons with serious mental illness.	Fisher WH, Grudzinskas AJ, Roy-Bujnowski KM, Wolff N.	Psychiatr Serv. 2011	Not a Controlled Clinical Trial	
23	Procedural justice and the mental health court judge's role in reducing recidivism.	Wales HW, Hiday VA, Ray B.	Int J Law Psychiatry. 2010	Not a Controlled Clinical Trial	
24	The Nevada mental health courts.	Palermo GB.	Int J Law Psychiatry. 2010	Not a Controlled Clinical Trial	
25	Correctional policy for offenders with mental illness: creating a new paradigm for recidivism reduction.	Skeem JL, Manchak S, Peterson JK.	Law Hum Behav. 2011	Not a Controlled Clinical Trial	
26	[Mental Health courts: therapeutic jurisprudence in action].	Jaimes A, Crocker A, BÃ©dard E, Ambrosini DL.	Sante Ment Que. 2009	Not a Controlled Clinical Trial	
27	Mental health courts.	Schneider RD.	Curr Opin Psychiatry. 2008	Not a Controlled Clinical Trial	
28	A theoretical evaluation of a youth mental health court program model.	Davis KM, Peterson-Badali M, Skilling TA.	Int J Law Psychiatry. 2016	Not Adults	
29	Correlates of Competency to Stand Trial Among Youths Admitted to a Juvenile Mental Health Court.	Bath E, Reba-Harrelson L, Peace R, Shen J, Liu H.	J Am Acad Psychiatry Law. 2015	Not Adults	
30	Juvenile mental health courts for adjudicated youth: role implications for child and adolescent psychiatric mental	Burriss FA, Breland-Noble AM, Webster JL, Soto	J Child Adolesc Psychiatr	Not Adults	

	health nurses.	JA.	Nurs. 2011		
31	What Happens to Mental Health Court Noncompleters?	Ray B, Hood BJ, Canada KE.	Behav Sci Law. 2015	Not comparing to TAU	
32	Mental health court outcomes by offense type at admission.	Ray B, Kubiak SP, Comartin EB, Tillander E.	Adm Policy Ment Health. 2015	Not comparing to TAU	
33	The impact of judge-defendant communication on mental health court outcomes.	Gottfried E, Carbonell J, Miller L.	Int J Law Psychiatry. 2014	Not comparing to TAU	
34	Predictors of Criminal Justice Outcomes Among Mental Health Courts Participants: The Role of Perceived Coercion and Subjective Mental Health Recovery.	Pratt C, Yanos PT, Kopelovich SL, Koerner J, Alexander MJ.	Int J Forensic Ment Health. 2013	Not comparing to TAU	
35	Psychosocial and reincarceration risks among older adults in mental health courts.	Canada KE, Engstrom M, Jang E.	Am J Geriatr Psychiatry. 2014	Not comparing to TAU	
36	Mental health diversion courts: a two year recidivism study of a South Australian mental health court program.	Lim L, Day A.	Behav Sci Law. 2014	Not comparing to TAU	
37	Psychiatric disorders and repeat incarcerations: the revolving prison door.	Baillargeon J, Binswanger IA, Penn JV, Williams BA, Murray OJ.	Am J Psychiatry. 2009	Not looking at MHC	
38	Criminal justice and behavioral health care costs of mental health court participants: a six-year study.	Steadman HJ, Callahan L, Robbins PC, Vesselinov R, McGuire TG, Morrissey JP.	Psychiatr Serv. 2014	Not looking at Recidivism	
39	Procedural justice in mental health courts: judicial practices, participant perceptions, and outcomes related to mental health recovery.	Kopelovich S, Yanos P, Pratt C, Koerner J.	Int J Law Psychiatry. 2013	Not looking at Recidivism	