

Some Perspectives on Criminalization

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In recently published articles, there has been an underemphasis on the role serious mental illness (SMI) plays in causing persons to be in the criminal justice system. Increasing attention has been paid to other factors, including criminogenic needs. While these needs may be present and contribute to criminal behavior, persons with SMI who are at greatest risk of criminalization are those who are not receiving adequate treatment, structure, social control, and, when necessary, 24-hour care in the mental health system. Cognitive behavioral therapy (CBT) has been used to reduce recidivism for prisoners, including those with SMI, but persons impaired by their untreated psychotic symptoms may not be able to profit from it. The importance of psychiatric treatment must not be underestimated. Moreover, given their current constraints, correctional systems may not be able to continue accepting large numbers of persons with SMI. Many offenders with serious mental illness pose difficult and expensive problems in treatment and management, such as nonadherence to medication, potential for violence, and substance abuse. The mental health system needs to be given more funding and to take more responsibility for these challenging individuals.

J Am Acad Psychiatry Law 41:287–93, 2013

A decade ago, it appeared to be generally accepted that there was a relationship between deinstitutionalization and the criminalization of persons with serious mental illness.¹ However, this relationship is again being questioned, and the extent of criminalization itself is being minimized.^{2–4} Many persons with serious mental illness in jails and prisons are now said to be there for reasons other than mental illness, such as an antisocial personality pattern, substance abuse, or homelessness. This theory may be true of some, but the underemphasis of the role of mental illness in causing these persons to be in the criminal justice system greatly impedes the efforts to reverse criminalization.

Deinstitutionalization resulted in the movement of a large number of persons with mental illness from hospitals to community settings. As the hospitals closed, tens of thousands of persons were discharged into the community to face the stresses of the world. Moreover, a new generation of individuals with serious mental illness, who had never been hospitalized, grew into adulthood. Many decompensated to the

point where 24-hour structured care became necessary. However, the hospitals had been permanently closed and many of these persons found their way into other alternatives, including jails and prisons.

Before deinstitutionalization, a large proportion of persons with serious mental illness would have lived their lives in state hospitals. Although the conditions in the hospitals were often abysmal, these persons were not treated as criminals, nor did they live on the streets for long periods, as is true of a sizeable minority of those who have been discharged.

Community care has proven successful for the great majority of those who formerly would have resided in state hospitals, providing that adequate community treatment resources are available. However, funding shortages and giving priority to persons who are likely to be treatment adherent and nonviolent, as will be discussed later, lessens the potential success of community treatment for persons who today are at risk of becoming criminalized. It is widely thought that many with serious mental illness who have been criminalized could be treated successfully in the community, if there were adequate and accessible community treatment facilities.⁵ Unfortunately, the inadequate and underfunded community treatment of individuals who are the most difficult to treat and the insufficient number of hospital beds, acute, intermediate and long term, for those who need them, are among the realities of deinstitutionalization that have set the stage for criminalization.¹

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Disclosures of financial or other potential conflicts of interest: None.

In examining criminalization of persons with serious mental illness, it is important to keep in mind the number of people who may be affected. The U.S. prison population, including both federal and state prisons and county and city jails, was 2,361,123 in 2010.⁶ The percentage of jail and prison inmates assumed to be seriously mentally ill has generally been estimated at about 16 percent.⁷ Using these numbers yields an estimate of 377,779 incarcerated persons with serious mental illness in jails, and state and federal prisons ($2,361,123 \times 16\% = 377,779$). The actual number may be somewhat higher or lower, depending on the accuracy of the percentage (16%) of inmates who in fact have a serious mental illness.

A Neglected Group

Most persons with serious mental illness recognize that they are mentally ill, are adherent to treatment, are often able to work, do not have major problems with substance abuse and violence, and show much potential for recovery. It has been observed that it is this group who receive the most attention in the literature and in discussions about persons with serious mental illness.⁸ There are some inmates with serious mental illness in jails and prisons who fall into this group; however, there is a substantial number who do not and receive considerably less attention. These persons may not believe they are mentally ill (may have anosognosia),^{9,10} are nonadherent to psychiatric treatment, may have acute psychotic symptoms and serious substance abuse problems, may become violent when stressed, and show less potential for recovery. The latter need treatment that includes structure, social control, and, when necessary, 24-hour care; these are the persons with serious mental illness who are at greatest risk for criminalization.¹¹ It must be mentioned, however, that the provision of structure and social control, including hospitalization in public mental health systems, is frequently inhibited by civil libertarian concerns and funding shortages.

In our experience (more than 30 years in three states treating psychiatric patients in a large urban county jail, in forensic state hospitals, in a federal prison, and in community treatment programs for offenders), this difficult-to-treat group, comprises a large proportion of inmates with serious mental illness who have been criminalized. This is an everyday fact of life for those mental health professionals who

work with them and observe them in jails and prisons. Yet, these concerns are not often described clearly and given the appropriate emphasis in the literature. Unfortunately, those frontline clinicians who work with this population in correctional facilities are generally not the people who tend to publish and describe their experiences firsthand.

Emphasizing Antisocial Characteristics and De-emphasizing the Role of Serious Mental Illness

The connection between deinstitutionalization and criminalization has also been blurred by a tendency of some professionals to attribute criminal acts by most persons with serious mental illness primarily to criminal characteristics, rather than their not having received appropriate community psychiatric treatment.¹²⁻¹⁴ It is now being said that while there are incarcerated individuals who may have serious mental illness, a large proportion of them are in correctional facilities primarily because they also have criminogenic relationships, antisocial attitudes, and a lack of problem solving and self-control skills that contribute to their criminal behavior.¹⁵ Consequently, a primary intervention suggested to reduce recidivism is to focus on the antisocial cognitions of these persons.

A model of correctional assessment and treatment that is now much discussed in understanding and preventing arrest, incarceration, and recidivism is the risk-need-responsivity (R-N-R) model, which incorporates cognitive social learning.¹⁶⁻¹⁸ Risk, need, and responsivity describe the three core principles of this model. Risk refers to matching the level of treatment services to the offender's risk to reoffend. Need focuses on the offender's criminogenic and non-criminogenic needs that should be targeted in treatment. With regard to need, Bonta and Andrews¹⁸ list seven major risk factors for future criminal behavior: an antisocial personality pattern; procriminal attitudes that comprise rationalizations for crime and negative attitudes toward the law; social supports for crime from criminal friends; substance abuse; poor family and marital relationships; poor performance and low levels of satisfaction from school and work; and a lack of involvement in prosocial recreational and leisure activities. Responsivity is defined as maximizing "the offender's ability to learn from a rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the

learning style, motivation, abilities and strengths of the offender” (Ref. 18, p 1).

Some researchers have suggested that there is little relation between mental illness and the risk for criminal behavior.¹⁹ According to one estimate, the criminalization hypothesis accounts for only 1 in 10 offenders with mental illness.²⁰ If we were to accept that criminalized psychiatric behavior refers only to situations such as untreated psychotic symptoms of a serious mental illness that directly cause an individual to engage in criminal behavior (e.g., a command hallucination that orders the person to assault a stranger or steal a television from a store), then the ratio of 1 in 10 might be correct. However, the argument that the remaining 9 of 10 individuals are criminalized mostly because of criminogenic factors is misleading. It does not take into consideration the crucial facts that these persons generally did not receive the treatment they needed in the community mental health system, either because of a lack of resources or the individual’s denial of mental illness; and these persons’ untreated or inadequately treated psychiatric condition contributed in a major way to their illegal behavior.^{11,21} There is a failure to acknowledge that people with serious mental illness who are untreated or inadequately treated may consequently experience the following: a tendency to have acute psychotic symptoms; homelessness or at least inadequate housing in disadvantaged social settings; an intensification of their potential for abusing substances; poverty; and unemployment.²² Perhaps of greatest importance is that inadequately treated serious mental illness may result in an individual’s exhibiting impaired judgment and cognition, lack of control of aggressive impulses, and greater manifestations of paranoia, all of which may contribute to the criminal behavior that leads to arrest.

On the other hand, many persons with serious mental illness in the criminal justice system may have antisocial tendencies, often to the extent of justifying an Axis II diagnosis of antisocial personality disorder and for which an R-N-R cognitive behavioral approach may be used. Cognitive behavioral therapy (CBT) may be a necessary component of the treatment regimen for many such offenders in reducing their recidivism; however, to be effective, it must be combined with psychiatric treatment. Clearly, persons whose thinking and judgment are impaired by their untreated psychotic and manic symptoms may not be able to profit from CBT interventions. For

some persons with serious mental illness who have been in the criminal justice system, a two-pronged approach, psychiatric treatment and CBT, may be used to address both their mental conditions and the likelihood of reoffending.²³

Moreover, there is evidence that Forensic Assertive Community Treatment (FACT) programs, especially those that maintain fidelity to the original FACT core principles, including competent care, access to services, supervised housing, and legal leverage via collaboration with criminal justice agencies, may reduce recidivism.^{24,25} For those persons with both serious mental illness and psychopathic traits, CBT may be added as part of the FACT approach in an effort to treat criminogenic risk factors and further reduce recidivism.²³

While keeping in mind the significance of criminogenic characteristics, there must be caution not to downplay the importance of psychiatric treatment as a key intervention for most persons with serious mental illness in the criminal justice system. We believe that effective mental health treatment for this population has always included: emphasis on adherence to treatment, including medications; structured housing; substance abuse treatment; assertive community treatment and intensive case management; assistance with the skills of everyday living; incorporation of family support; the availability of inpatient and outpatient commitment; and the availability of both acute short- and long-term hospitalization. Thus, community treatment with close structure and supervision is an essential component of the mental health treatment plan.²⁶

Some Problems of Community Treatment

The criminalization of persons with serious mental illness has also been influenced by some developments in community treatment. One such development has been the adoption of more formal and rigid criteria for involuntary hospitalization in the latter decades of the 20th century. Thus, the inability to compel treatment for persons who need it but who will not otherwise adhere to it, leads to the decompensation of many such individuals and behavior that violates laws and brings them to the attention of law enforcement (e.g., disorderly conduct, disturbing the peace, trespassing, assaultive behavior ranging from minor acts to acts causing serious or lethal injury, terrorist threats, petty theft and grand theft,

drug charges, and spousal and child abuse).⁵ In our opinion, the criteria for involuntary treatment, both inpatient and outpatient, should be made more flexible.

A second development has been the shortage of acute psychiatric beds. Although the police may take acutely psychotic persons to psychiatric hospitals, the inability to find a bed for them may result in their being released from the emergency room. Even if they are admitted, the common practice of brief hospitalization and discharge before a sufficient period of stabilization has taken place could well give rise to further contact with the police and ultimately to arrest.

Another contributing factor is an ideology, on the part of some, that rejects most involuntary treatment in the mental health system, on both an inpatient and outpatient basis. There are some clinicians and administrators who believe that psychiatric treatment should almost always be voluntary and that persons with serious mental illness should have the freedom to decide whether to participate in treatment, unless they are a clear danger to themselves or others.^{27,28} Thus, many such persons with serious mental illness in the community may not choose appropriate treatment; consequently, their inadequately treated mental condition may result in behavior that sets off a chain of circumstances that leads to arrest.

In addition, there are many policy makers, mental health clinicians, and mental health advocacy groups who are not comfortable with or in favor of providing the social control, structure, involuntary treatment, and hospitalization that, in our opinion, is an essential and appropriate part of mental health treatment of this population. Their attitudes have long been a problem in the mental health system, and as a result of criminalization, it has often been left to the criminal justice system to provide the needed structure and social control.

Moreover, despite a growing number and wide range of re-entry programs that are in place in many jurisdictions,²⁹ clinicians who work in correctional settings continue to be frustrated with trying to find appropriate resources in the community for their patients when they are released. Clinicians attempt to develop adequate discharge plans but cannot find stable housing and mental health treatment facilities that are able or willing to accept the discharged mentally ill offender.^{30,31} Often, community housing

and mental health treatment facilities are simply not equipped to manage and treat persons who need large amounts of structure and security, who are resistant to treatment, including nonadherence to psychiatric medications, whose symptoms are difficult to control, and whose potential for violence may inspire fear in the staff. Considering the characteristics of the persons being referred and the capabilities of the facilities to which the referrals are being made, the frequent rejection of the referrals by these facilities may be understandable.

State Hospital Beds

A recent study indicated that the need for state hospital beds in the United States is 50 long-term beds per 100,000 population.³² However, the actual number of state hospital beds in 2010 was 43,318 or 14.1 beds per 100,000 population.³³ If the 50 beds per 100,000 population were available, an additional 35.9 beds per 100,000 population (110,840 beds) would be available for psychiatric inpatients. That number may seem large and unrealistic, but considering the amount of funding needed, it is only 30 percent of the more than 370,000 persons with serious mental illness in our jails and prisons. Surely a large number of these additional state hospital beds could be used for persons who otherwise qualify for psychiatric hospitalization but are now in the criminal justice system. However, it must be mentioned that consideration of the appropriate number of long-term beds is complicated by the *Olmstead* decision,³⁴ the Center for Medicare and Medicaid Services, and other agencies that promote the idea of continued release of psychiatric patients from long-term beds into the community.

The types of persons with serious mental illness who might well benefit from state hospitalization would be those who: are nonadherent to community treatment; cycle in and out of acute psychiatric hospitalization and the streets; and frequently come to the attention of law enforcement when hospitalization is indicated but not available. When there is a lack of adequate psychiatric treatment, these persons are often at risk of engaging in criminal behavior, including nonserious, nonviolent offenses (such as petty theft). After a few such instances, with no adequate disposition available to the court, the judge may have no option other than to sentence the individual to prison for offenses such as petty theft with priors, which is a felony in some jurisdictions. An

effort to increase the number of hospital beds may well result in a substantial reduction of criminalization, particularly for persons with serious mental illness.

On the other hand, it is not our position that state hospital beds should be used to accommodate persons with serious mental illness who have committed major crimes (such as armed robbery, assault with a deadly weapon, attempted murder, and multiple burglaries). Even though these persons have serious mental illness, the gravity of their offense makes the criminal justice system the more appropriate disposition.

Is the Mental Health System Willing to Treat Persons Who Would Otherwise Be Criminalized?

Is society willing to provide, in the community, the resources needed to treat persons with serious mental illness who have been or are at risk of being criminalized? It should be recognized that there are factors, such as determinate sentencing, that mandate incarceration and prevent the mental health system from taking jurisdiction over persons with serious mental illness who are convicted of crimes. Such determinate sentencing not only results in long sentences, but contributes to jail and prison overcrowding.

On the other hand, many clinicians in the community may be reluctant to treat or may be unable to treat persons who are nonadherent to treatment, have acute psychotic symptoms, pose a potential for violence, need involuntary treatment, abuse substances, and need a great deal of limit setting.⁸ In our opinion, these factors are some of the reasons for the continued presence of public mental health systems. It is understandable that many in the community mental health system would prefer to provide treatment for the kind of clientele who require less supervision and structure and pose less of a threat to the community and themselves. Likewise, the community is not necessarily the most benign treatment site at all times for all persons with serious mental illness. Access to hospital care for those who need it, for as long as they need it, is essential to the success of deinstitutionalization.¹ Even if sufficient funds were available for all the community resources that are needed, there are still many persons with serious mental illness who would probably need 24-hour structured care in settings such as hospitals and intermediate-care facilities.

The use of medication is an important component. Certainly, we must be careful to not overmedicate and to try to use interpersonal interactions, when appropriate and possible, as a way to work with persons with serious mental illness, including those who are or may become aggressive or violent. But, we also must be willing to recognize that medication is often the most effective, efficient, and least restrictive alternative for diminishing the person's psychotic, possibly violent, behavior.

If the mental health system does want to treat persons who would otherwise be criminalized, there must be a belief by both clinicians and the public that treatment under the mental health system can be safe and effective and that using inpatient and structured outpatient modalities such as assisted outpatient treatment, when acute psychotic symptoms and physically aggressive actions call for it, is an ethical approach. If the community mental health system declines to treat such individuals, then it must be acknowledged that the only time when these persons are likely to receive treatment is if they are believed to have committed a crime, are arrested, and thus fall under the jurisdiction of the criminal justice system.

Conclusion: Return to the Mental Health System

Working with persons with serious mental illness who have been or are at risk of being criminalized reveals that they often lack internal controls and consequently need high degrees of structure, to prevent offending and incarceration, or, if that fails, after release from jail or prison. When and if community treatment is appropriate and available, these individuals need a range of therapeutic interventions such as: assertive community treatment, including FACT programs; intensive case management; structured, stable, secure, supervised housing; co-occurring substance abuse and mental illness treatment; pre- and postbooking diversion; and often the structure of a legal mechanism that provides legal leverage, such as conservatorship (as practiced in California), treatment as a condition of probation and parole, or assisted outpatient treatment (AOT).^{26,35} In addition, there should be continuing and frequent consultation and liaison among the various mental health clinicians and the client's parole or probation officer. There are data showing that if the mental health system is willing and able to provide such an array of services and has the funding to do so, fewer of these

persons would decompensate, come to the attention of law enforcement, and enter, or be returned to, the criminal justice system.^{25,35} Sometimes, however, even these interventions are not sufficient, and a 24-hour locked facility is needed.⁸

Clients who are not adherent to their psychiatric medications, who have antisocial tendencies, who have a potential to be violent or are at minimum fear inspiring, and whose most effective treatment is expensive (in cost and resources) may not be the most desirable persons to treat from the perspective of some mental health professionals. That many of these individuals have become, at least for the present time, the responsibility of the criminal justice system solves a thorny problem for the mental health system.

Is it appropriate for the mental health system to treat all persons with serious mental illness who are now being placed in the criminal justice system? With regard to violence, we prefer to use the phrase potential for violent behavior in describing persons who have yet to commit violent acts, to distinguish them from persons who have actually committed acts of serious violence. Treating the latter is probably a step too far for the mental health system alone and one that we do not advocate. Treating such individuals would call for even greater levels of security to protect staff and clients than are appropriate for community mental health facilities. Already, the victimization of mental health clinicians in outpatient facilities and hospitals is unacceptably high.³⁶ The heightened security that would be necessary to treat these persons safely in the community would probably be objectionable to mental health clinicians and administrators and indeed might well be inappropriate.

Another important concern to take into consideration is that, in the foreseeable future, the criminal justice system may not continue to remain the system that can't say no. Many correctional facilities in the United States are experiencing serious overcrowding and budget constraints. For example, in 2011, the United States Supreme Court in *Brown v. Plata*³⁷ found that the California Department of Corrections and Rehabilitation must reduce their prison overcrowded population to 137.5 percent (a reduction of 46,000 inmates statewide) of the institutions' combined design capacity by June 2013. When there is pressure, judicial and financial, to reduce overcrowding, incarcerated persons who are believed to be among those least likely to recidivate and pose the

least amount of danger to the community are typically chosen for release. Some individuals with serious mental illness may be included in this group in the belief that they will transition well into the community with the available mental health and housing resources. If this belief becomes a trend, it can only lead to limiting the number of persons with serious mental illness in our prison system.

Given the overcrowding and financial situation in many states' jails and prisons, the criminal justice system may be taking a very hard look at who really belongs there and warrants the use of scarce criminal justice resources. One segment of the population currently incarcerated that may be affected by such a development is persons with serious mental illness who have not committed major or violent crimes. Their release from jails and prisons as well as the reluctance to incarcerate them at the outset may well send a clear message to the mental health community—namely, that we must accept more responsibility for these individuals' care and treatment. Is that not our mission: to help those persons with mental illness, especially those who are at most need, in a humane, therapeutic, and dignified manner?

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