A NATIONAL STRATEGIC RESEARCH FRAMEWORK TO DECRIMINALIZE MENTAL ILLNESS

Amy C Watson
Leah G Pope
Michael T Compton
Kellan McNally

Sozosei Foundation®
Otsuka

December 2025

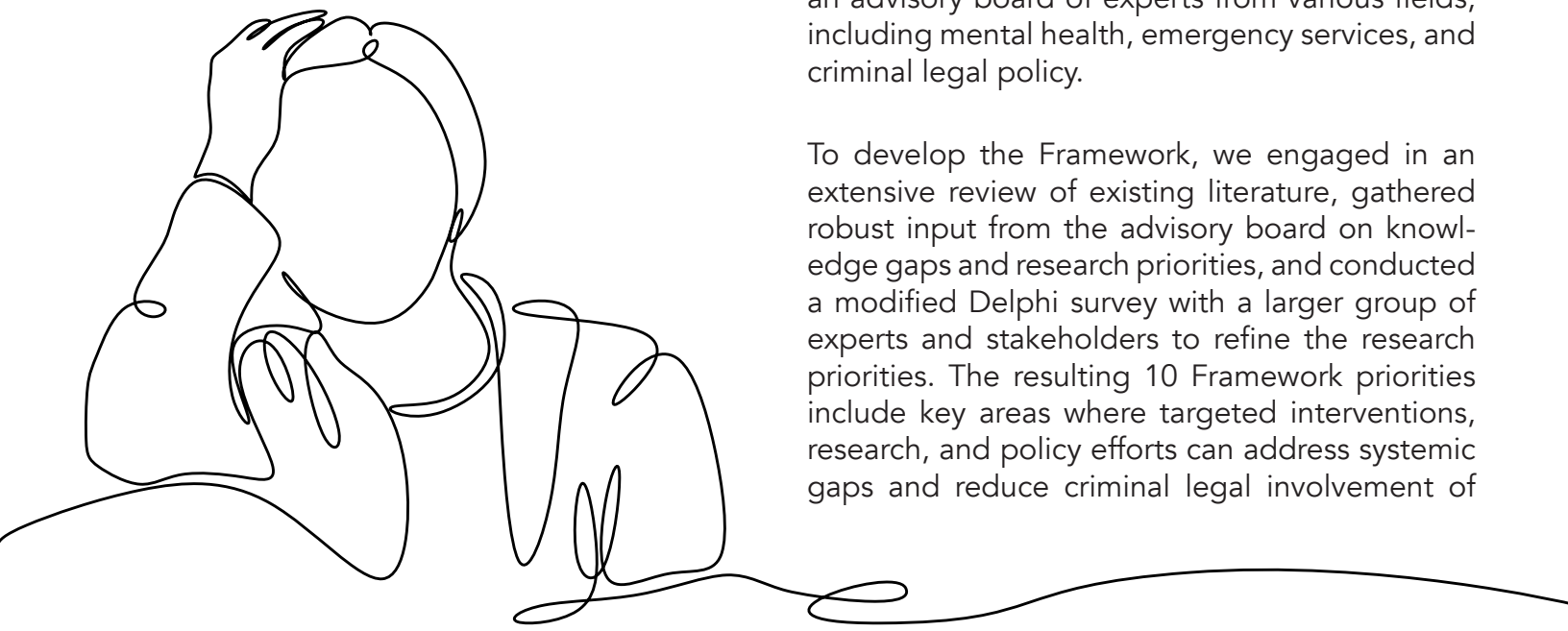
CONTENTS

This work was made possible by the generous support of the Sozosei Foundation. It was guided by the expertise of the Framework Advisory Board (see pages 5 & 6) and reflects work conducted between 2022 and 2024.

EXECUTIVE SUMMARY: A NATIONAL STRATEGIC RESEARCH FRAMEWORK TO DECRIMINALIZE MENTAL ILLNESS

The overrepresentation of people with serious mental illnesses (SMI) in the criminal legal system is driven by multiple factors that include systemic failures to provide adequate mental health care and ensure that the basic needs of vulnerable groups are consistently met. SMI places people at higher risk for many factors associated with criminal legal system involvement, making them more likely to be arrested, detained, and incarcerated. They serve longer sentences, experience higher rates of probation and parole revocation, and are at greater risk of rearrest. These patterns highlight how gaps in mental health care, poverty, and other social vulnerabilities fuel the ongoing arrest and incarceration of people with SMI, or what is often referred to as criminalization.

Despite extensive research and policy attention to this issue over the past 25 years, the overrepresentation of people with SMI at every point of the criminal legal system continuum has endured. While the existing body of research provides insight into the nature of involvement and the experiences of people with SMI at various points of contact with the criminal legal system and evidence for some intervention strategies, there are many gaps in the research base, and we know little about how to prevent people with SMI from having contact with the criminal legal system altogether. Current federal attention on the expansion of behavioral health crisis services, while promising, also presents new questions about the impact of these initiatives on involvement of people with SMI in the criminal legal system. Thus, the goal of this project was to develop a National Strategic Research Framework to identify research and funding priorities with the greatest potential to move the needle on decriminalization of mental illness.



The work to develop the Framework was led by Amy Watson, PhD (Wayne State University), Michael Compton, MD, MPH, and Leah Pope, PhD (Columbia University), in collaboration with an advisory board of experts from various fields, including mental health, emergency services, and criminal legal policy.

To develop the Framework, we engaged in an extensive review of existing literature, gathered robust input from the advisory board on knowledge gaps and research priorities, and conducted a modified Delphi survey with a larger group of experts and stakeholders to refine the research priorities. The resulting 10 Framework priorities include key areas where targeted interventions, research, and policy efforts can address systemic gaps and reduce criminal legal involvement of

people with SMI. We focused on intercepts 0 through 2 of the Sequential Intercept Model, as well as what we call intercept -1 (social determinants), as we believe intervening earlier before people become fully entangled in the criminal legal system holds the most promise for reducing criminalization. The priorities outlined in this framework provide a roadmap for investigating:

1. **Pathways in and out of the criminal legal system and involvement with other social, community, and medical services for people with SMI**

2. **The impact of available gateways to mental health services in communities on criminal legal system entry and persistence for people with SMI**

3. **Housing First interventions for people with serious mental illnesses who are at risk for criminal legal system involvement**

4. **Interventions for co-occurring disorders (e.g., Integrated Dual Disorder Treatment) for people with SMI at risk for criminal legal system involvement**

5. **Preventive interventions that focus on supporting families with at-risk children and youth**

6. **The impact of early intervention services for people at high risk for or experiencing their first episode of psychosis**

7. **Variations in response models for behavioral health crises, including those that do and do not involve law enforcement**

8. **Peer-based crisis services (e.g., mobile crisis teams, crisis peer respite)**

9. **The impact of 988 and its relationship to 911**

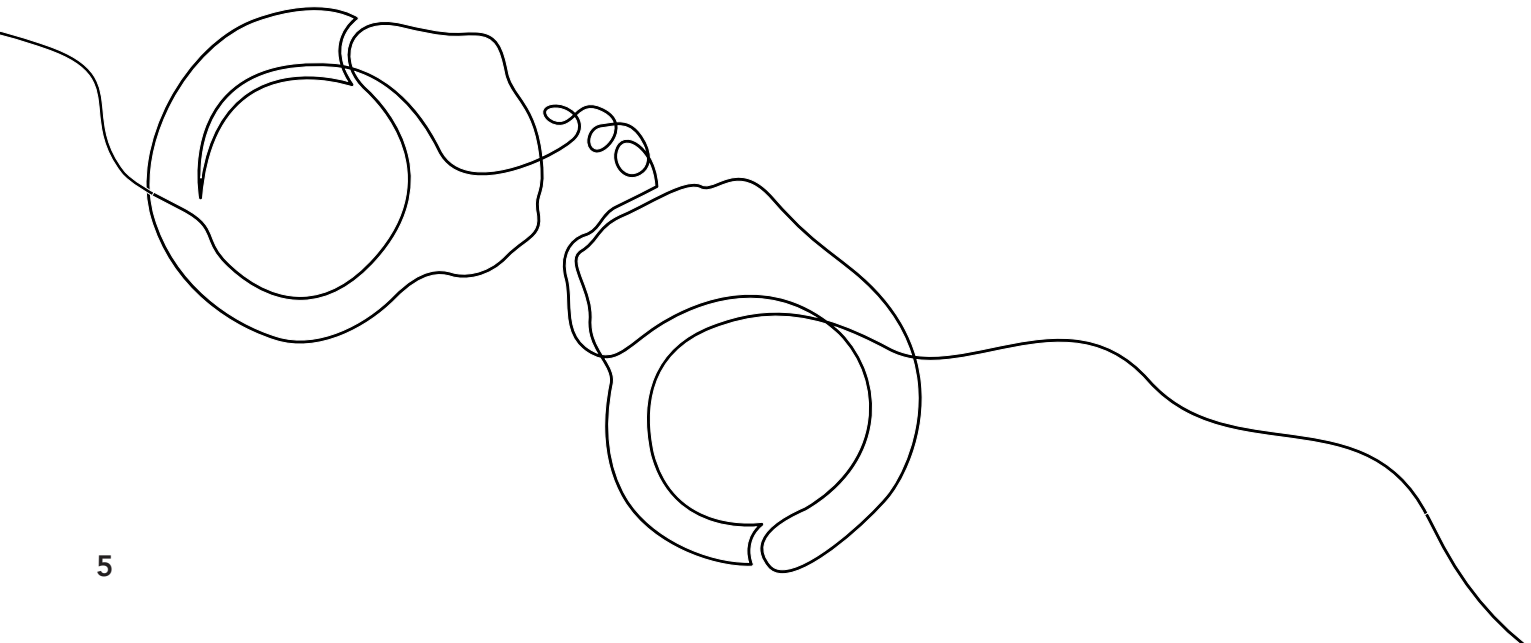
10. **The impact of housing and homelessness policy on criminal legal system involvement for people with serious mental illnesses**

The Framework provides a guide for funders, researchers, practitioners, and policymakers that is designed to expand understanding and advance efforts to reduce the involvement of individuals with SMI in the criminal legal system. By advancing research in these critical areas, this framework furthers dialogue and discovery of strategies for moving away from simply building a mental health system within the criminal legal system and toward equitable and effective community-based solutions.

THE PROBLEM: CRIMINALIZATION OF PEOPLE WITH SERIOUS MENTAL ILLNESSES

Despite extensive research and policy attention over the past 25 years, the overrepresentation of people with serious mental illnesses (SMI) at every point of the criminal legal system continuum has endured. Over 30 percent of people with SMI have lifetime histories of arrest (Kennedy-Hendricks et al., 2016) and analysis of population data indicates a relationship between psychiatric disorders and arrests (Swartz & Lurigio, 2007). Further, despite a general population prevalence rate of 6% (SAMHSA, 2024), people with SMI are estimated to make up 15 to 31% of the jail population, 8-14% of the prison population, and 11-19% of the community corrections population (Prins & Draper, 2009; Vaughn et al., 2012). Once arrested, people with SMI serve more days in pretrial detention, and, if convicted, are more likely to receive a jail sentence, serve more of their jail or prison sentences, and have their probation or parole revoked; they also are at higher risk of rearrest than offenders without SMI (Baillargeon et al., 2009; Cloyes et al., 2010, Magee et al., 2021; Prins & Draper, 2009; Skeem et al., 2006).

The existing body of research provides insight into the nature of involvement and the experiences of people with SMI at various points of contact with the criminal legal system. It also provides some evidence for interventions and strategies to provide care for and/or divert individuals away from the criminal legal system. However, there are many gaps in the research base, and we know little about how to prevent people with SMI from having contact with the criminal legal system altogether. The implementation of 988, federal guidance, and support for the development of crisis services presents new opportunities to decriminalize mental illness, shifting the focus away from expanding the capacity (and role) of the criminal legal system in providing care to the development of crisis and community mental health services that do not rely on the criminal legal system. This shift creates areas in need of research to understand which approaches, programs, and policies are most effective. Thus, the goal of this project was to develop a National Strategic Research Framework to identify research and funding priorities with the greatest potential to move the needle on decriminalization of mental illness.



THE PROJECT TEAM AND ADVISORY BOARD

The project leads, Amy Watson, PhD from Wayne State University, and Michael Compton, MD, MPH and Leah Pope, PhD from Columbia University, have a long history of collaboration focused on decriminalizing mental illness and improving care for people with SMI. Dr. Watson has led research on mental illness stigma, mental health courts, prison re-entry programs, the experiences of people with SMI in police encounters, and the Crisis Intervention Team (CIT) model. Dr. Compton's research has focused on the CIT model, early intervention in psychosis, and strategies to support people with SMI in the community. Dr. Pope has expertise in police-based and alternative models of crisis response, mental illness as a risk factor for incarceration, and care transitions across criminal legal and mental health settings.

Our work to develop the National Strategic Research Framework to Decriminalize Mental Illness, hereafter referred to as "the Framework," was guided by an advisory board comprised of a diverse group of researchers and key partners, ensuring a broad range of expertise and perspectives. It included researchers with specialized knowledge in areas such as SMI, crisis services, suicide prevention and intervention, health disparities, mental health services and policy, health care finance, peer support services, criminal legal services and policy, policing, and emergency communications. Particular attention was given to engaging scholars of color and those with lived experiences. Throughout the project period, the advisory board met quarterly via Zoom. These sessions provided a platform for introducing and discussing key topics and objectives related to the development of the Framework. During these quarterly meetings, the group provided guidance on the project team's approach, discussed data and reports that had been shared between sessions, and engaged in discussions of Framework priorities. An in-person convening immediately following the 2022 Sozosei Summit provided an opportunity for advisory board members to engage in focused discussions about the definition of and process that produces criminalization and provide guidance on the structure and focus of our review of existing research. At the 2024 Sozosei Summit, advisory board members assisted with our Action Track session that gathered participant feedback on research priorities and methods. This structured approach to engaging the advisory board set the stage for productive discussions of research gaps and priorities.

Advisory Board Members

Chyrell Bellamy, PhD, MSW	Professor, Department of Psychiatry, Yale University School of Medicine; Director, Yale Program for Recovery Services and Research	community-based participatory research, culturally responsive and recovery-oriented services, peer providers
Jennifer Bronson, PhD	Senior Research Scientist, Pacific Institute for Research and Evaluation	medical sociology, behavioral health research
Enrico Castillo, MD, MSHPM	Medical Director for Clinical Innovations and Strategy, San Francisco Department of Public Health	public psychiatry, health services and policy
Erin Comartin, PhD, LMSW	Professor, School of Social Work, Wayne State University	criminal legal and mental health system and services
Jenni Cox, PhD	Associate Professor of Psychology, University of Alabama; Co-Director, Southern Behavioral Health and Law Initiative	forensic psychology
Brandon del Pozo, PhD, MPA, MA	Assistant Professor of Health Services, Policy and Practice (Research), Assistant Professor of Medicine (Research), Brown University	the intersection of public health, public safety, and the criminal legal system
Sarah Desmarais, PhD	President at Policy Research Associates, Inc. (PRA)	forensic psychology and law
Matt Epperson, MSW, PhD	Associate Professor; Director, Smart Decarceration Project, Crown School of Social Work, Policy, and Practice, University of Chicago	interventions to reduce criminal legal system involvement among people with mental illnesses
Matt Goldman, MD, MS	Clinical Assistant Professor, Department of Psychiatry and Behavioral Sciences, University of Washington; Crisis Systems Medical Director, King County, Washington	crisis services, mental health services research
Leah Jacobs, MSW, PhD	Assistant Professor, School of Social Work, University of Pittsburgh	the intersection of social welfare and criminal legal system policy and intervention
Lester Kern, MSW	Doctoral candidate, Crown School of Social Work, Policy, and Practice, University of Chicago	criminal legal system and behavioral health research, crisis services
Lauren Kois, PhD	Research Instructor, Institute of Law, Psychiatry and Public Policy, University of Virginia School of Medicine	competency, practices to de-criminalize mental illness
Rebecca Neusteter, PhD	Executive Director, Health Lab, University of Chicago	equity in the criminal legal and health care systems, 911 and emergency communications
Brad Ray, PhD	Senior Researcher, Justice Practice Section, RTI	sociology, behavioral health and criminal legal research
Amy Blank Wilson, PhD, MSW	Associate Professor, University of North Carolina at Chapel Hill School of Social Work; Co-Director of the Tiny Homes Village	interventions to address the needs of people with serious mental illnesses in the criminal legal system
Jennifer Wood, PhD	Professor of Criminal Justice and Vice Provost for Faculty Affairs, Temple University	criminology, policing and public health

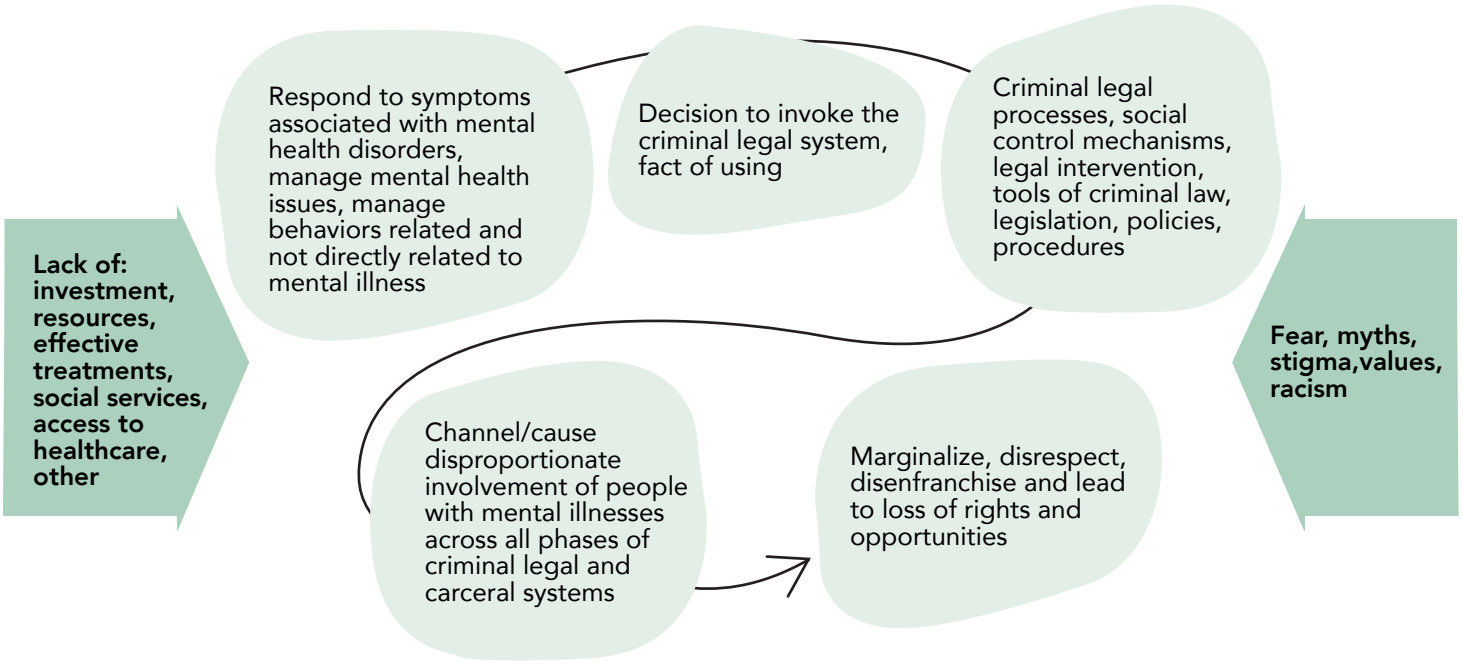
OUR APPROACH

Our approach involved defining the target population and scope of the work, conceptualizing criminalization, reviewing the existing evidence base, identifying knowledge gaps, and defining research priorities. Here, we briefly summarize how we approached each component of the work.

Defining the Scope. Advisory board discussions helped define the focal population of individuals with SMI, including persons with co-occurring substance use disorders, and the scope of our work to encompass Intercepts 0 through 2 of the Sequential Intercept Model (Abreu et al., 2017). We also include what we are calling Intercept -1, which refers to conditions that influence the risk of contact with the criminal legal system, while Intercepts 0 through 2 encompass mental health-based crisis services, emergency communications and law enforcement, and initial detention/court hearings, respectively.

Conceptualizing Criminalization. We worked with the Advisory Board to unpack our conceptualization of the criminalization process as shown in the figure below. Criminalization occurs within a broader social and political environment that has historically failed to invest in effective health and social services and has perpetuated stigma about people with SMI, particularly Black and Brown people with SMI. It begins with someone responding to symptoms associated with SMI or attempting to manage behaviors that are perceived as being related to SMI (even though they may not be). It continues with a decision

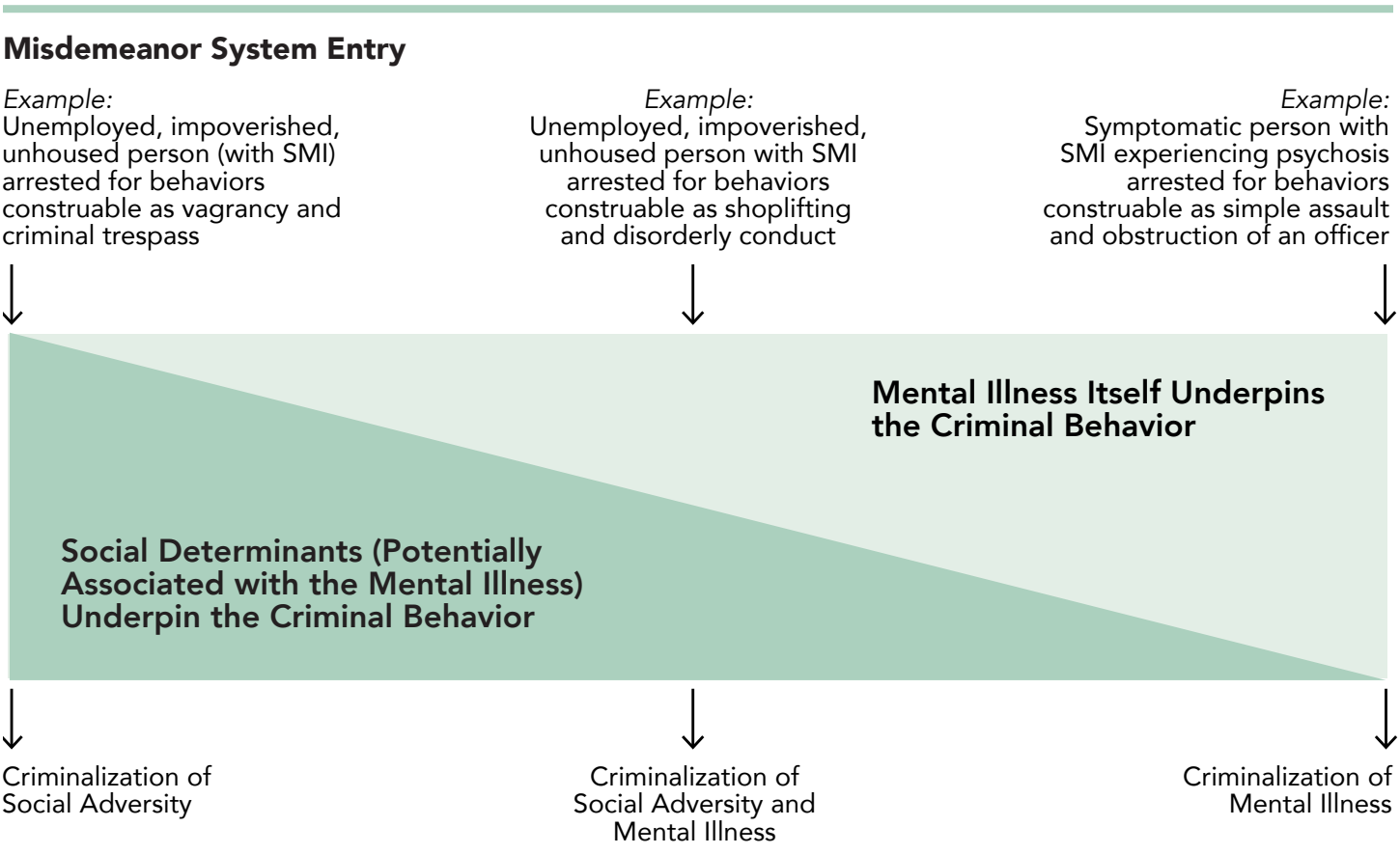
Unpacking the "criminalization" of mental illness



to invoke the criminal legal system as part of the response, which often leads to a cascade of processes that result in the disproportionate involvement of people with SMI at all phases of the criminal legal system. Over time, this leads to further marginalization of people with SMI.

Our discussions about the criminalization process also highlighted the complex interplay between social determinants of health and SMI in leading to criminal legal system involvement. As shown in the figure below, for instance, at one end of the continuum, a person with SMI that is experiencing psychosis and responding to voices may be arrested for simple assault when confronted by a store owner who asks them to leave. At the other end of the continuum, a person who is unemployed, impoverished, unhoused, and living with SMI might get arrested for behaviors that fall under vagrancy or criminal trespass laws, with the SMI itself being irrelevant to the arrest. In the middle of the continuum, a multiply stressed individual with SMI could engage in shoplifting or disorderly conduct, behaviors resulting in arrests. These scenarios underscore the criminalization of both social adversity and mental illness as existing on a gradient, where economic injustices and mental illness are intertwined, leading to criminal legal system involvement. This same gradient also influences continued entanglement in the system once someone has entered it, since some people may become entangled in the system as a more direct result of their SMI (e.g., being referred for competency evaluation and restoration) and others with SMI may experience entanglement as a result of social adversity (e.g., being unable to afford bail).

Reviewing the Knowledge Base. A review of available research relevant to criminalization as conceptualized above was conducted to understand the current state of knowledge and to identify gaps. We structured our literature search and resulting annotated bibliography around three primary questions:



Question 1: What is the nature of involvement in the criminal legal system among people with SMI?

This included examining the demographics of individuals with SMI at each point of contact (or intercept) with the criminal legal system and the types of behaviors and charges involved.

Question 2: What factors increase or decrease the risk of criminal legal system contact/involvement for people with SMI?

This question was informed by Alegria and colleagues' (2022) framework, which considered policies, laws, and regulations; operation of institutional systems; neighborhoods and communities; and individual and family factors

Question 3: What do we know about interventions designed to prevent criminal legal system contact and/or divert/deflect people with SMI away from the criminal legal system?

We again utilized the Alegria et al. (2022) framework domains to guide our search for research on interventions at the policy, intuitional system, community, and individual/family levels.

The advisory group played a central role in brainstorming the types of research to look for and in identifying articles and reports to include. Through an iterative process, we gathered and discussed literature and created an annotated bibliography organized around our three questions; the existing literature was coded based on domain and methods. Appendix A contains the three complete annotated bibliographies.

Identifying Gaps and Research Priorities. We distributed the annotated bibliographies to the advisory board members and asked them to respond to a series of questions about research funding priorities based on the existing knowledge (or lack thereof) related to each of our three questions. The objective was to identify actionable research priorities that would address gaps where additional knowledge and/or validation was needed. Given the overlap in responses related to Questions 1 and 2, we combined them. We also grouped responses to Question 3 into those related to individual, community/system, and policy level interventions. This resulted in the identification of seven research priority areas related to the nature of and risks for criminal legal system involvement (Question 1 and Question 2), 20 related to individual level interventions, 15 related to community/system interventions, and seven related to policy interventions (Question 3).

Next, we asked members of the advisory board to rate and rank the nominated priorities based on their potential to reduce the involvement of people with SMI in the criminal legal system. Results of the rankings allowed us to trim the list to a more manageable number of items for the next round of prioritization, which also engaged experts outside of the advisory board.

Modified Delphi Survey. Following the initial prioritization survey, a modified Delphi survey process was employed to refine and assess the identified research priorities further and gather input from external experts. Delphi surveys are typically used to achieve consensus among a panel of experts through multiple rounds of questioning, making them effective for refining and prioritizing key elements of a framework based on specific criteria. This process engaged the advisory board members and a broader network of stakeholders, ensuring a comprehensive and consensus-driven approach. Our methodology, adapted from Choi et al. (2020), asked participants to rate research priorities on three dimensions: *importance*, *feasibility*, and *transformative potential*. The 31 items presented in this survey were derived from the ranked outcomes of the previous advisory board survey. We first asked advisory board members to complete the survey and nominate additional re-

searchers with relevant expertise to invite to complete the survey. We then emailed the external experts, explaining the project and inviting them to complete the survey. This participatory method aimed to extract a clear set of research priorities upon which a strategic research framework, validated and supported by expert consensus, could be developed.

Thirty-three people completed the survey including the 15 members of the advisory board and 18 external respondents. The majority of respondents were white (79%). Sixteen respondents identified as female, fifteen as male, and two did not indicate their gender. Respondents reported years of experience that ranged from six to fifty with an average of twenty years. Two-thirds of respondents work in universities but represent a range of research/practice areas such as criminal legal and behavioral health systems, public health administration, and law. Most respondents indicate personal and/or familial experiences with SMI (67%) and/or the criminal legal system (42%).

Based on the ratings of importance and transformative impact, we selected the 10 highest rated items for inclusion in the Framework. Table 1 displays the selected research priorities across the four categories (the nature of and risks for criminal legal system involvement, individual level interventions, community/system interventions, and policy interventions). For each priority, we show the number of respondents that rated the priority as highly or somewhat important or highly or somewhat likely to have a transformative impact. We do not include feasibility ratings in the table, as after the fact, it was not clear if participants had rated the feasibility of advances in the area of research impacting criminalization or if they were rating the feasibility of conducting the research.

At the 2024 Sozosei Summit Research Framework Action Track session, we engaged a diverse group of approximately 100 participants, inclusive of researchers, practitioners, policy makers and people with lived experience in brainstorming and rating research questions and research methods related to each research priority area. We incorporated this work as a means of further fleshing out each of the 10 research priorities.

RESEARCH PRIORITIES

Framing the Research Priorities

As is evident from the above, we do not have individual research priorities focusing on equity, urban versus rural considerations, or including impacted populations/communities. Rather, these areas must be foundational to all research priorities. As such, we view these areas as lenses through which all research priorities should be considered and addressed. First, with regard to equity, given the fact that minoritized racial groups—most prominently, African Americans—have been over-policed and over-incarcerated, every research priority, research team, research project, research question, research method, and research reporting must continually consider racial equity as an intentional and specifically planned goal. Second, in terms of urban versus rural considerations, research priorities are likely to vary considerably by geographic setting. Our identified research priorities are therefore generalities, with a high likelihood that priorities in urban settings might well differ from those in rural settings. Third, including impacted populations/communities is essential across all research priorities. This inclusion should occur at every phase of the research process, from the study conceptualization to the reporting of results.

RESEARCH PRIORITY # 1

Pathways in and out of the criminal legal system and involvement with other social, community, and medical services for people with SMI

It is well established that, regardless of the specific measure of SMI, people with SMI are overrepresented across the criminal legal continuum. Over thirty 30 percent of people with SMI have lifetime histories of arrest (Kennedy-Hendricks et al., 2016), and once arrested, they are at higher risk of rearrest; serve more days in pretrial detention, and, if convicted, serve more of their jail or prison sentences; and are more likely to have their probation or parole supervision revoked than offenders without SMI (Baillargeon et al., 2009; Cloyes et al., 2010; Magee et al., 2021; Prins & Draper, 2009; Skeem et al., 2006). This overrepresentation has been linked to myriad factors including deinstitutionalization and inadequate funding of community-based mental health services, social psychological risk factors, poverty and community-level risk factors, and an array of social determinants of health that both people with SMI and those charged with criminal offenses are more likely to experience (e.g., poverty, unemployment, housing instability) (Bronson & Berzofsky, 2017; Caruso, 2017; Prins, 2011).

Considering the types of charges that bring people with SMI into the criminal legal system, property offenses, including criminal trespass, followed closely by alcohol/drug possession, simple assault, and disorderly conduct have been report-

ed as the most common charges (Baillargeon et al., 2009; Clark et al., 1999; Compton et al., 2022; Fisher et al., 2006; Hiday & Ray, 2010). However, there is evidence that the nature of criminal legal system involvement varies over time—early offenses commonly involve marijuana possession, driving under the influence, shoplifting, and burglary, and offenses later in the course of illness commonly involve system-related offenses such as probation violations, obstructing an officer, and failure to appear to court (Compton, Graves et al., 2022). This suggests criminal legal system involvement itself generates additional charges that keep people entangled. There is also evidence of varied offending trajectories that can be identified in terms of age of onset of offending, onset of mental illness, timing of first homelessness episode; frequency and nature of offending; criminogenic needs; and substance use, and that these trajectories may not vary by service use or psychiatric profile (Fisher et al., 2010; Lemieux et al., 2020). Receipt of mental health services has been shown to reduce recidivism among people with SMI already involved in the criminal legal system (Constantine et al., 2012; Evans Cuellar, 2006; Van Dorn, 2013); however, those with co-occurring substance use disorders may benefit less (Jacobs et al., 2022). Thus, while studies have examined mental health service use, or specific behavioral health interventions and criminal legal trajectories/recidivism, future research that examines pathways across multiple systems over time is needed.

Examples of potential research questions in this area might include:

1. What are the temporal patterns of service use and criminal legal system involvement (arrest, incarceration, community corrections) and how do these patterns differ by geographic and demographic characteristics?
2. Do explicit triage and diversion protocols in crisis response (911/988) correlate with a reduction in law enforcement involvement in mental health crises and impact mental health service and criminal legal pathways?
3. Do alternatives to traditional competency restoration (e.g., community-based competency restoration, deferred prosecution) lead to different long-term mental health and legal system trajectories compared to competency restoration as usual?

Example research designs for Question 1:

- **Longitudinal linked data set study:** Develop a linked data set across mental health, health, social service, and criminal legal agencies, identify individuals with SMI within the data set, and analyze temporal patterns (pattern analysis, temporal pattern mining and visualization).
- **Qualitative life trajectory study:** Conduct semi-structured interviews with people with SMI and explore mental health services and criminal legal system contact overtime.

RESEARCH PRIORITY #2

The impact of available gateways to mental health services in communities on criminal legal system entry and persistence for people with SMI

The relationship between mental health service availability and criminal legal system involvement is a critical but still poorly understood and debated phenomenon. On the one hand, the criminalization hypothesis suggests that the overrepresentation of people with SMI in the criminal legal system is the result of deinstitutionalization, underfunding of community mental health treatment, and tightening of involuntary commitment laws (Bonfine et al., 2020). According to this hypothesis, care for people with SMI has shifted from the community to the criminal legal system because of an overburdened and underfunded community mental health system. This aligns with recent evidence suggesting that U.S. counties with fewer community treatment services have a higher jail population per capita (Ramezani et al., 2022). On the other hand, the criminogenic risk perspective posits that criminal legal involvement is not the result of mental illness per se but a result of myriad risk factors that overlap with mental illness, including low socioeconomic status, substance use, and a history of antisocial behavior. This perspective cites evidence showing that traditional mental health treatment alone has failed to reduce recidivism and suggests that criminogenic needs must be a focus of treatment to reduce criminal legal entry and persistence for people with SMI (Bonfine et al., 2020). Continued research is needed to understand how available gateways to community mental health services impact criminal legal system entry or re-entry, particularly considering the proliferation of diversion programs and broad-scale policy changes like Medicaid expansion that have enabled state and local governments to leverage federal funding to meet the health needs of criminal legal system-involved people. For example, given the diversity of diversion programs, research is needed to compare different models and identify the specific elements of diversion programming that have the most impact on criminal legal system recidivism. Further research is also needed to understand the impact of Medicaid expansion on service provision and criminal legal system involvement and recidivism for people with SMI.

Examples of potential research questions in this area might include:

1. How does voluntary versus court-ordered mental health treatment impact entry or re-entry to the criminal legal system?
2. How has Medicaid expansion influenced entry or reentry to the criminal legal system for people with SMI as well as for those without SMI?
3. How has the increased availability of crisis services (e.g., mobile crisis teams, crisis receiving and stabilization facilities), impacted criminal legal system entry for people with SMI?

Example research designs for Question 1:

- **Longitudinal cohort study:** Compare people with criminal legal involvement receiving the same suite of services accessed through two different pathways (i.e., voluntary services versus court-ordered services); examine outcomes including future police contacts, arrests, and emergency department visits.
- **Data linkage study:** Integrate criminal legal and behavioral health data at a local or state level to understand overlap in service utilization (e.g., how many people served by the crisis system also have a history of arrest) as well as temporal patterns of community-based crisis service utilization and criminal legal system involvement.

RESEARCH PRIORITY #3

Housing First interventions for people with serious mental illnesses with or at risk for criminal legal system involvement

Housing First (HF) prioritizes permanent homes for unhoused people, including individuals with SMI, without preconditions like sobriety or treatment adherence. HF is grounded in the belief that stable housing is a basic right and foundation for sustaining safety and recovery. This method differs from a practice of making individuals address mental health and/or substance use issues before qualifying for housing, delays that can extend homelessness and increase risks. Instead, immediate access to housing allows individuals to focus on recovery and integrate into their communities.

Systematic review of HF studies points to its effectiveness at reducing homelessness, promoting housing stability, and decreasing criminal legal system involvement for people with SMI (Leclair et al., 2019). O'Campo et al. (2016) found that those with mental health support plus housing faced fewer arrests compared to similarly supported individuals without housing. According to Ellsworth (2022), the likelihood of arrest falls the longer a person with SMI is housed. These studies underscore the need to explore how stable housing impacts long-term health, community integration, and holistic recovery beyond reducing criminal legal system involvement.

HF research has predominantly utilized quantitative methods, including randomized controlled trials (RCTs) and quasi-experimental designs, to assess outcomes such as arrest rates, housing stability, and service utilization. Although these methods have provided key insights into HF's immediate impacts, unknowns about long-term processes and experiences of people with SMI who transition to stable housing call for broader research questions and analytical strategies.

Examples of potential research questions in this area might include:

1. What are the most effective HF approaches to prevent individuals with SMI from entering or re-entering the criminal legal system?
2. How does the proximity of HF initiatives to mental health services facilitate and promote use of services?
3. How does HF interact with the release and community re-entry (from incarceration) of individuals with SMI?

Example research designs for Question 1:

- **Randomized controlled study of Housing First model variations:** Randomize individuals with SMI to HF variations and measure criminal legal system involvement (arrests, incarceration) over an extended follow-up period. Assess variation in impacts based on race/ethnicity, gender, co-occurring conditions, and prior criminal legal system involvement.
- **Qualitative longitudinal study:** Conduct in-depth interviews with people with varied rates of utilization of psychiatric services who are served in HF programs, exploring perceptions of housing stability and its relationship to quality of life, social support, service use, psychiatric symptoms, and criminal legal system involvement.

RESEARCH PRIORITY #4

Interventions for co-occurring disorders (e.g., Integrated Dual Disorder Treatment) for people with SMI with or at risk for criminal legal system involvement

Combinations of comorbid psychiatric disorders and substance use disorders, also called co-occurring disorders (CODs), are common; population-based studies show that as many as 50–70% of those with SMI have a COD (Regier et al., 1990). The most common drugs used by individuals with SMI, in descending order of prevalence, are tobacco, alcohol, cannabis, and cocaine; use of multiple substances with multiple comorbid SUDs is also common (Manseau & Bogenschutz, 2016; Selzer & Lieberman, 1993; Soyka et al., 1993). CODs are associated with worse outcomes: more severe psychiatric symptoms, higher rates of violence and suicidality, worse overall functioning, higher rates of homelessness and legal problems, worse treatment engagement, and more intensive healthcare services use (Bennett & Gjonbalaj, 2007; Swofford et al., 2000; Talamo et al., 2006). Efforts to integrate treatment for both the SMI and the SUD into single programs, which is the recommended approach, is referred to as integrated dual diagnosis (or dual disorder) treatment (IDDT). Key components of IDDT are: treatment in a single program by a team of clinicians with expertise in both; interventions are staged to motivation level; motivation enhancement techniques are used; psychotherapeutic interventions focus on coping skills, harm reduction, and relapse prevention; pharmacotherapy for psychiatric symptoms are guided by best practices with regard to substance use disorders; anti-addiction medications are used when available and appropriate; and services are delivered with a long-term perspective (e.g., expecting relapse). There is some experimental evidence that an integrated approach is generally more effective than a non-integrated (i.e., serial or parallel) approach in terms of treatment engagement, substance use and addiction severity, psychiatric hospitalization rates, and likelihood of arrest (Dixon et al., 2010; Hellerstein et al., 1995; Herman et al., 1997; Herman et al., 2000; Mangrum et al., 2006). In addition to IDDT, other treatment approaches are crucial, including medication assisted treatment (MAT), behavioral or psychological therapies, and residential treatment programs, among others. IDDT is generally recognized as the ideal approach to the treatment of CODs, and MAT is the standard of care for specific SUDs, including opioid use disorder. Minimal research exists, however, on the extent to which IDDT, MAT, and other COD-related interventions may reduce criminal legal system involvement.

Examples of potential research questions in this area might include:

1. Do mental health crisis receiving and stabilization facilities that offer MAT in conjunction with specific evidence-based psychosocial interventions have a higher efficacy in reducing criminogenic behaviors, arrests, and incarceration for individuals with CODs compared to those only offering MAT?
2. What impact do criminal thinking interventions (e.g., cognitive-behavioral therapy and related interventions) have in reducing criminogenic behaviors, arrests, and incarceration for individuals with CODs as compared to those with SMI only or SUD only?
3. To what extent is remission of specific SUDs among individuals with CODs associated with reduced risk of criminogenic behavior, arrests, and incarceration?

Example research designs for Question 1:

- **Cluster randomized design:** Randomize newly established mental health crisis receiving and stabilization facilities to provide MAT versus MAT in addition to a specific evidence-based psychosocial intervention among clients with CODs, with outcomes of interest pertaining to criminogenic behaviors, arrests, and incarceration. Examine outcomes by race/ethnicity, gender, and indicators of SES.
- **Retrospective design:** Conduct a retrospective analysis of clients utilizing mental health crisis receiving and stabilization facilities that vary in terms of providing MAT versus MAT in addition to a specific evidence-based psychosocial intervention among clients with CODs. Examine outcomes of interest pertaining to criminogenic behaviors, arrests, and incarceration.

RESEARCH PRIORITY #5

Preventive interventions that focus on supporting families with at-risk children/youth

Research has consistently demonstrated that adverse childhood experiences (ACEs), behavioral health challenges, child welfare system involvement, and socioeconomic disadvantage are associated with higher rates of criminal legal system involvement across the life course (Calhoun, 2018; DeHart et al., 2014; Edalati et al., 2017; Kerridge et al., 2020; Yi & Wildeman, 2018). There is also evidence that punitive school policies contribute to the flow of youth into the juvenile and adult criminal legal systems, disproportionately impacting children of color and children with behavioral and emotional disorders (APA, 2008; Monterastelli, 2018; Skiba et al., 2014). Thus, consideration of interventions at the policy, school, family, and child level is warranted.

The research to date on strategies to address these known risks and support families with at-risk children spans a range of topics. Studies of cash transfers (Morris et al., 2017) and emergency financial assistance (Palmer et al., 2019) for at-risk families have found that financial interventions can reduce problem behaviors among disadvantaged youth, suggesting potential for reducing criminal legal system involvement. There is substantial evidence that child and family participation in early childhood programs such as Head Start has a protective effect against ACEs and is associated with long-term mental health benefits and reduced criminal legal system involvement in adolescence and adulthood (Garces et al., 2002; Heckman et al., 2010; Reynolds et al., 2001; Shonkoff et al., 2012). At the school level, there is evidence that restorative approaches to school discipline can reduce expulsions and referrals to law enforcement and improve school climate and student mental health outcomes (Augustine et al., 2018; Gregory et al., 2016).

Although there is promising evidence for financial support to families and restorative practices in schools, the impacts of these interventions on juvenile and adult criminal legal system involvement and longer-term mental health outcomes are unknown. Similarly, Honisett *et al*. (2022) reviewed HUB models of care delivery and pointed to their mixed effectiveness in shaping positive health outcomes, but did not explore their impact on legal risk and subsequent involvement in the criminal legal system. Further, there is a large body of research on early childhood and family interventions; however, with a few exceptions, most of this research has not examined the impact on criminal legal system involvement across the lifespan, or the intersection of criminal legal system involvement and SMI. Adapting the Sequential Intercept Model (SIM), as scholars like Heilbrun et al. (2017) have done for juvenile justice, may offer a framework for examining how early behavioral health interventions can influence long-term outcomes, including legal system involvement across the lifespan.

Examples of potential research questions in this area might include:

1. Does family involvement in the design and implementation of school-based discipline models prevent or reduce student involvement with police and other criminal legal system contact?
2. Can family unity programs prevent or reduce involvement in the child welfare system, and subsequent criminal legal system involvement?
3. Are HUB models of service delivery to children and families effective for preventing child welfare and criminal legal system involvement?

Example research designs for Question 1:

- **Stepped wedge crossover design**: Test a school-level intervention that engages families in the design and implementation of school-based restorative discipline models. Examine outcomes including police calls for service at schools to address discipline issues, and student entry into the criminal legal system.
- **Longitudinal study:** Use longitudinal data (e.g., data from Fragile Families) to compare youth in states with child welfare policies that support family reunification to youth in states with policies less supportive of family reunification. Compare mental health and criminal legal outcomes, and examine impact by race, ethnicity, and gender.

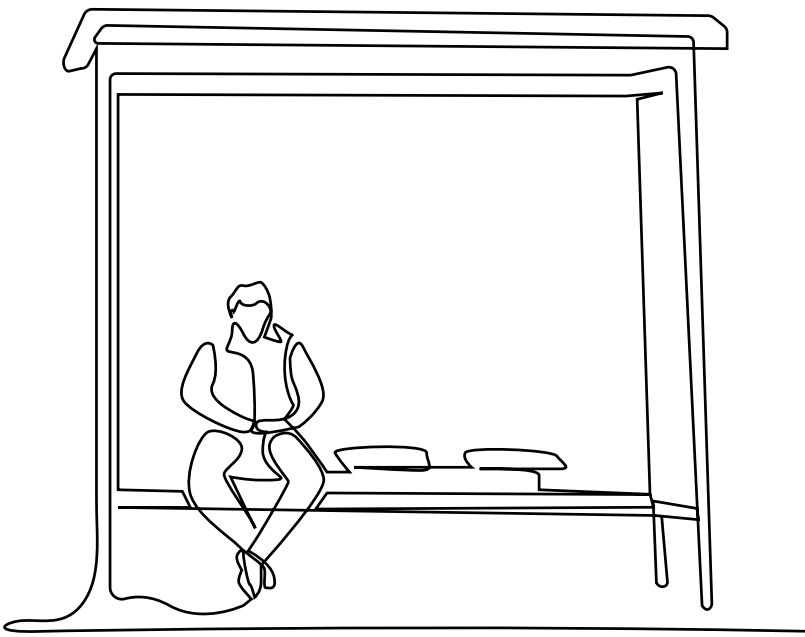
RESEARCH PRIORITY #6

The impact of early intervention services for people at high risk for or experiencing their first episode of psychosis

Coordinated specialty care (CSC) is a multidisciplinary, recovery-oriented approach to delivering evidence-based interventions for the treatment of first-episode psychosis (FEP). Typical service components of CSC include: recovery-oriented principles of care; shared decision-making; helping young people with early psychosis achieve their goals for school, work, and social relationships; medication management using the lowest possible effective dosages; individual psychotherapy, skills training, family psychoeducation and support, and case management; supported employment and supported education; and screening, assessment, and treatment for substance use disorders and for suicidality (Compton & Manseau,

2020). The CSC model in the U.S. grew in part from the Recovery After an Initial Schizophrenia Episode (RAISE) projects funded by the National Institute of Mental Health (NIMH). Launched in 2008, RAISE aimed to develop and demonstrate effectiveness of a treatment model for FEP that could be implemented in non-research settings. Two RAISE studies, the RAISE Early Treatment Program (ETP) (Kane et al., 2016) and the RAISE Implementation and Evaluation Study (RAISE-IES) (Dixon et al., 2015), laid the groundwork for larger-scale implementation. Based in part on the promising results from the NIMH-funded RAISE projects, in 2014, U.S. House of Representatives bill 3547 provided an increase of 5% to the Community Mental Health Block Grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), requiring states to set aside 5% of their block grant allocation to support "evidence-based programs that address the needs of individuals with early SMI, including psychotic disorders." This was increased to 10% in 2016, and has spurred the dissemination of CSC programs across the U.S. In addition to growth in funding strategies, national initiatives are now underway with regard to training, technical assistance, and developing resources for broad dissemination. Even earlier in the illness trajectory than CSC for early or first-episode psychosis, a number of "clinical high risk" programs are now in operation (though primarily in research settings) aimed at identifying young people at risk for psychotic disorders and providing preventive interventions trying to reduce the risk of developing psychosis.

Even as first-episode programs are flourishing in community settings, we know little about how to identify, engage, possibly divert, and treat these individuals in criminal legal system settings (Ford, 2015), and efforts should be made both to reduce the number of these individuals inappropriately prosecuted within the criminal legal system and to begin in-jail efforts to engage them in treatment, in anticipation of their eventual return to the community (Ford, 2015). Some initial evidence suggests that pathways from jail to CSC can be created once criminal legal involvement occurs (Compton et al., 2023; Compton et al., 2024), though more collaboration is needed between mental health services and existing diversionary programs (Wasser et al., 2017). Very limited research exists, however, on the ways in which CSC or "clinical high risk" programs may impact criminal legal involvement, though it is known that such involvement is very common even at these early stages of psychosis / SMI (Ramsay et al., 2011; Ramsay et al., 2014). Opportunities for detection, diversion, and intervention in the criminal legal system should be strengthened (Pope & Pottinger, 2022).



Examples of potential research questions in this area might include:

1. Are there differences in criminal legal system outcomes by race/ethnicity, gender, geography, insurance status, and age among clients receiving early intervention services?

2. Within the array of services offered by early intervention services, what are the interventions/dosage factors that lead to the best outcomes with regard to criminal legal system outcomes?
3. How are enrollment into, engagement in, and eventually transitioning out of CSC and other early intervention services temporally associated with criminal legal system involvement?

Example research designs for Question 1:

- **Examining existing datasets:** As standardized data collection from networks of early intervention services grows, examine criminal legal system outcomes with regard to race/ethnicity and other demographic variables.
- **Qualitative research:** Conduct interviews or focus groups with individuals participating in CSC and other early intervention services (and their family members) to increase understanding about how the various components of CSC are associated with reduced risk of criminal legal system involvement, how any such reduced risk varies by race/ethnicity and other demographic variables, and ways in which CSC services could be made more culturally responsive.

RESEARCH PRIORITY #7

Variations in response models for behavioral health crises (including those that do and do not involve police)

Behavioral health crisis response models include mobile crisis teams, community responder teams, co-responder teams, and police-only responses such as the Crisis Intervention Team (CIT) model. There is significant variation across and within these response "types" in terms of team composition, how they are accessed/dispatched, and the kinds of crisis situations to which they respond. Research on mobile crisis teams, which are typically comprised of clinicians or clinicians and peers and accessed via a crisis line, indicates that they can reduce emergency department visits and hospitalizations and increase connections to services in the community (Center for Policing Research and Policy, 2021). Very little research has been published on community responder/alternative responder teams, which are usually dispatched via 911 and may be comprised of clinicians, peers, crisis workers, and/or medics. Evaluations of existing teams indicate they can safely handle many calls that police would otherwise respond to. The only peer-reviewed research to date found that implementation of a community responder team reduced reports of misdemeanor crimes (Dee & Pyne, 2022). There is some evidence that co-responder teams, which are generally comprised of a law enforcement officer and a clinician dispatched via 911, may reduce emergency department transports (Puntis et al., 2018), police use of force in suicide-related calls (Blais & Brisbois, 2021), and the immediate risk of arrest (Bailey et al., 2021). However, the only randomized controlled trial to date did not find that co-response, compared to police-as-usual response, resulted in improvement of key outcomes related to emergency medical

services events, jail bookings, or behavioral health treatment encounters (Ray et al., 2024). The research on CIT has consistently shown that CIT training improves officers' knowledge, attitudes and self-efficacy for responding to mental health crisis (Compton et al., 2014). There is also evidence that CIT-trained officers are more likely to transport or otherwise link people to mental health care than their non-CIT-trained counterparts (Kubiak et al., 2017; Watson et al., 2021). The evidence regarding the impact of CIT on arrests and use of force is mixed, with a few studies showing reduced arrests and uses of force, and other studies finding no effect. To date, a randomized controlled trial of CIT training for law enforcement officers has not been completed; however, one is in progress. Overall, research indicates that these crisis response models have potential to increase connections to care in the community; however, evidence of their impact on immediate and longer-term criminal legal system involvement is limited.

Examples of potential research questions in this area might include:

1. To what extent does co-response or alternative/community response, compared to police-only response reduce involuntary hospitalizations, arrests, and physical harm?
2. To what extent does co-response or alternative response, compared to police-only response improve access and engagement to the continuum of care?
3. To what extent do outcomes associated with co-response or alternative/community response differ by population characteristics (e.g., SMI, youth, adults, people experiencing homelessness, race/ethnicity, gender)?

Example research designs for Question 1:

- **Quasi-experimental longitudinal design:** Conduct a multi-site study comparing outcomes of different models with a minimum of a one-year follow-up period. Select sites with different models matched based on geography, community demographics, available crisis services. Examine outcomes by population, and interactions of model by population.
- **Mixed methods design:** Examine outcomes (quantitative) and experiences (qualitative) by population (SMI, youth, adults, people experiencing homelessness, race/ethnicity, and gender) served by different models.

RESEARCH PRIORITY #8

Peer-based crisis services (e.g., mobile crisis, crisis peer respite)

Peer specialists are people with lived experience of mental health and/or substance use disorders that have been trained to provide recovery support in a variety of service settings. Peer specialists may work on warm lines; as members of mobile crisis or co-response teams; and as staff at emergency departments, crisis receiving and stabilization facilities, and living rooms. They may also work in peer-run organizations that provide crisis care, including mobile crisis and crisis respite services. SAMHSA strongly recommends the integration of peers within the crisis services continuum, and many state Medicaid programs are paying for peer specialists working on mobile crisis teams and in crisis receiving and stabilization facilities.

There is a growing body of quasi-experimental and qualitative research that provides support for the inclusion of peer specialists as providers of crisis care. There is evidence that peer warm line services may reduce emergency services use and improve community integration (Dalgin et al., 2018), and peers on mobile crisis teams help people feel less alienated and may reduce use of crisis and emergency services (Wusinich et al., 2020). Having peers in emergency departments, crisis stabilization units, peer respites, and living room settings is associated with reduced hospitalizations, reduced use of emergency services, reduced costs, fewer adverse experiences, increased social connectedness, and increased communication and collaboration (Ashcroft & Anthonly, 2006; Bouchery et al., 2018; Heyland et al., 2021). While randomized trials of peer specialist crisis care interventions have not yet been conducted, a randomized controlled trial of peer-supported self-management for people discharged from a crisis team found a reduced rate of hospital readmission (Johnson et al., 2018). Randomized trials of peer support interventions in other (non-crisis) settings indicate that peer support improves illness management and adherence and quality of life; increases hope, empowerment, recovery and social support; and reduces internalized stigma (Reinke et al., 2022). While there is growing recognition of the value of peer services for people with mental health conditions and criminal legal system involvement, research on forensic peer services is limited and largely descriptive. However, two studies have found forensic peer support jail re-entry interventions to be associated with reduced criminal legal system recidivism (Bellamy et al., 2019; Reingle Gonzalez, 2019).

The research on peer-provided crisis services suggests many positive outcomes; however, the existing research has not examined the impacts on criminal legal system involvement. While the limited research on forensic peer support is promising in terms if impacts on criminal legal system involvement, more research is needed.

Examples of potential research questions in this area might include:

1. What impact does peer involvement in alternative/community and co-responder models have on outcomes related to referral and connection to services, arrest, and well-being?
2. In what way does the presence of peers on mobile crisis teams and in emergency rooms impact instances of re-hospitalization, involuntary admissions, length of stay, and engagement in outpatient services?
3. How do client characteristics (e.g., neighborhood, race, age, ethnicity) impact the efficacy of peer interventions in alternative response (openness to services, connection with services, diversion)?

Example research designs for Question 1:

- **Randomized controlled trial:** Randomize community responder team (or co-responder) dispatches to teams that include and do not include a certified peer responder. Examine call-related outcomes (referral, arrest, transport to hospital) and service use and arrests in the follow-up period.
- **Qualitative study:** Conduct qualitative interviews of people who have received a crisis response with and without peer team members by recruiting a subsample of individuals receiving response in the randomized controlled trial for qualitative interviews about their experiences.

RESEARCH PRIORITY #9

The impact of 988 and its relationship to 911

The federal government launched the 988 Suicide and Crisis Lifeline in July 2022, creating an easier-to-remember alternative to reach the existing 10-digit National Suicide Prevention Lifeline and its network of over 200 state- and locally-funded crisis centers. Call volume for 988 is steadily rising, with more than 10 million calls, texts, and chats since launch and an 80% increase in monthly contacts when comparing May 2024 to May 2022 (Saunders, 2024). Even so, research documents low public awareness and use. Three nationally representative surveys conducted in the year after launch by Pew Charitable Trusts (2023), the National Alliance on Mental Illness (NAMI) (2023), and New York University (Purtle et al., 2023), found that 18–64% of respondents had heard of 988 and that only 0.8–1.0% of respondents reported contacting 988. In Purtle et al.'s (2023) study, non-Hispanic Black respondents and Hispanic respondents were significantly less likely to have heard of 988 but also significantly more likely to report being very likely to use it in the future if they or a loved one were experiencing a mental health crisis.

Emerging research also highlights the need to better understand how 988 exists within the broader crisis services continuum and in relation to 911. While public surveys indicate that most Americans want mental health crisis responses that do not involve police (NAMI, 2023), the Pew and NAMI polls documented low public knowledge about *when* to use 988. Other research with mental health clients, family members, and general community members suggests that

people want to use 988 as an alternative to 911 when they are not in danger (Pope et al., 2024). Caller preference may be related to the confidentiality and privacy afforded by 988 since 988 call takers currently do not know where callers are located (though they can reach out to 911 for location information if they have concerns about an immediate risk to life). However, proposed rule-making to add georouting capabilities to 988 (i.e., the ability to connect callers to the crisis center closest to their physical location without transmitting their precise location) may change user preferences. More research is needed to understand how 988 and 911 systems operate and interact at a local level and what impact this has on callers to each line and the services they are able to receive. As it relates to the criminalization of mental illness, it will be important to understand whether 988 leads to reduced contact with police and the criminal legal system.

Examples of potential research questions in this area might include:

1. Have the different mechanisms of 988 rollout, including training for both 911 and 988 call takers, affected response time and service delivery? What are the different impacts, such as access to treatment services or hospitalization and criminal legal involvement?
2. Has awareness of 988 increased among disadvantaged communities?
3. Will the proposed Federal Communications Commission rule change around georouting for 988 change call volume for 911 and/or 988? If so, how?

Example research designs for Question 1:

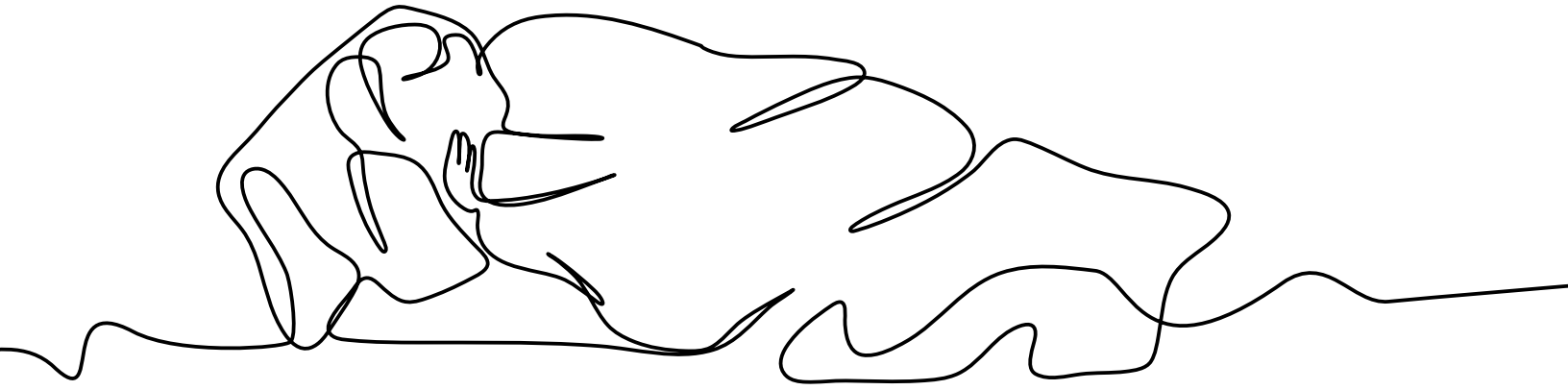
- **Randomized controlled trial of training approaches:** Design a randomized trial to compare different types of training for 988 call takers and its impact on service delivery (including equity) and caller outcomes (both proximal and long-term outcomes).
- **Case study:** Compare caller outcomes from two call centers in similar environments using call logs and administrative data (e.g., records of hospitalization/arrest).

RESEARCH PRIORITY #10

The impact of housing/homelessness policy on criminal legal system involvement for people with serious mental illnesses

Homelessness and housing policies are central to addressing the criminal legal involvement of individuals with SMI. Although interconnected, policy research in these areas (homelessness and housing) address distinct issues: whereas housing scholars may focus on affordability and accessibility, homelessness research may explore the integration and delivery of behavioral health services. Both grapple with issues of scalability and finance to achieve lasting and equitable outcomes.

Policy studies are key to translating what is known into actionable strategies with broad impacts. Housing First research, for example, demonstrates that stable housing both improves the health of people who experience chronic homelessness and reduces arrest rates and recidivism (Ellsworth, 2022; Leclair et al., 2019; O'Campo et al., 2016). Policy researchers have demonstrated that punitive displacement policies (measures that penalize and remove unhoused individuals from public spaces through fines, arrests or forced relocation) trap unhoused individuals in cycles of displacement, exacerbating mental health issues and increasing their involvement with the criminal legal system by criminalizing unmet basic needs (Herring et al., 2020; Sparks, 2018).



Researchers can help demonstrate alternatives that replace harmful approaches to public safety with policies that effectively meet the needs of people with SMI.

Intervention research has relied primarily on experimental and quasi-experimental designs to assess the immediate effects of housing access. Studies of public safety policies are limited in scope, evaluating effects for specific localities without broader implications. To go beyond these small-scale studies, there is a need for broader empirical methods, such as comparative policy analysis and longitudinal studies, to evaluate scalability and long-term impacts for people with SMI involved in the criminal legal system.

Examples of potential research questions in this area might include:

1. How does the removal of criminal record restrictions on public housing access impact recidivism (specifically probation violations)?
2. What is the effect of immediate housing support for people with SMI being released from incarceration on subsequent violations of probation?
3. Do jurisdictions with high shelter bed ratios demonstrate lower rates of arrests for people with SMI?

Example research designs for Question 1:

- **Quasi-experimental study:** Compare recidivism rates for individuals with SMI between two sites—one with removed criminal record restrictions on public housing access and one without. Focus on the impact of policy changes on reducing recidivism for people with SMI by controlling for pre-existing differences between sites.
- **Retrospective cohort study:** Compare large data sets of individuals with SMI with or without access to public housing free of criminal record restrictions. Analyze long-term outcomes using existing data, highlighting factors that influence criminal legal involvement.

REFERENCES

Abreu, D., Parker, T.W., Noether, C.D., Steadman, H.J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. Behavioral Sciences and the Law, 35(5-6), 380-395.

Alegria, O'Malley, I. S., DiMarzio, K., & Zhen-Duan, J. (2022). Framework for Understanding and Addressing Racial and Ethnic Disparities in Children's Mental Health. Child and Adolescent Psychiatric Clinics of North America, 31(2), 179–191. https://doi.org/10.1016/j.chc.2021.11.001

American Psychological Association Zero Tolerance Task Force. (2008). Are zero tolerance policies effective in the schools? An evidentiary review and recommendations. American Psychologist, 63(9), 852-862.

Ashcraft, L., & Anthony, W. A. (2006). Crisis services in the 'living room'. *Behavioral healthcare*, *26*(7), 12–14.

Augustine, C. H., Engberg, J., Grimm, G. E., Lee, E. W., Wang, E. L., Christianson, K., & Joseph, A. A. (2018). Can restorative practices improve school climate and curb suspensions? RAND Corporation.

Bailey, K., Lee, G., Victor, G., Sightes, E., Comartin, E., Grommon, E., & Ray, B. (2021). Crisis event dispositions following a crisis response team intervention. *Psychiatric Rehabilitation Journal, 44*(4), 310-317.

Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: the revolving prison door. *American Journal of Psychiatry*, 166, 103–109.

Bellamy, C., Kimmel, J., Costa, M. N., Tsai, J., Nulton, L., Nulton, E., Kimmel, A., Aguilar, N. J., Clayton, A., & O'Connell, M. (2019). Peer support on the "inside and outside": Building lives and reducing recidivism for people with mental illness returning from jail. *Journal of Public Mental Health, 18*(3), 188-198. https://doi.org/10.1108/JPMH-02-2019-0028

Bennett, M. E., & Gjonbalaj, S. (2007). The problem of dual diagnosis. In M. Hersen, S. M. Turner, & D. C. Beidel (Eds.), *Adult psychopathology and diagnosis* (5th ed.). Wiley.

Blais, E., & Brisebois, D. (2021). Improving police responses to suicide-related emergencies: New evidence on the effectiveness of co-response police-mental health programs. *Suicide and Life-Threatening Behavior, 51*(6), 1095–1105.

Bonfine, N. B., Wilson, A. B., & Munetz, M. R. (2020). Meeting the needs of justice-involved people with serious mental illness within community behavioral health systems. *Psychiatric Services, 71*(4), 355-363. https://doi.org/10.1176/appi.ps.201900453

Bouchery, E. E., Barna, M., Babalola, E., Friend, D., Brown, J. D., Blyler, C., & Ireys, H. T. (2018). The effectiveness of a peer-staffed crisis respite program as an alternative to hospitalization. *Psychiatric Services, 69*(10), 1069-1074. https://doi.org/10.1176/appi.ps.201700451

Bronson, J., Berzofsky, M. (2017). *Indicators of mental health problems reported by prisoners and jail inmates, 2011-12*. (Special Report NCJ 250612). Washington, DC, U.S. Department of Justice.

Calhoun, S. (2018). "That's just the tip of it because it goes deeper than that": A qualitative exploration into the role of mental illness in offending onset and subsequent offending behavior. *Criminal Justice Policy Review, 29*(4), 341–364. https://doi.org/10.1177/0887403416633267

Caruso, G. D. (2017). *Public Health and Safety: The Social Determinants of Health and Criminal Behavior*. UK: Researchers Links Books.

Center for Police Research and Policy. (2021). *Assessing the impact of mobile crisis teams: Academic training to inform police responses best practice guide*. University of Cincinnati. https://www.informedpoliceresponses.com/_files/

ugd/313296_8d01cdc7187a489893197f2d07300ee6.pdf

Clark, R. E., Ricketts, S. K., Mchugo, G. J. (1999). Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatric Services, 50*, 641–647.

Cloyes, K. G., Wong, B., Latimer, S., & Abarca, J. (2010). Time to prison return for offenders with serious mental illness released from prison: A Survival Analysis. *Criminal Justice Behavior, 37*, 175-187.

Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D'Orio, B. M., Oliva, J. R., Thompson, N. J., & Watson, A. C. (2014). The police-based crisis intervention team (CIT) model: I. effects on officers' knowledge, attitudes, and skills. *Psychiatric Services, 65*(4), 517-522. https://doi.org/10.1176/appi.ps.201300107

Compton, M. T., & Manseau, M. W. (2020). Evidence-based models of service delivery. In J. A. Lieberman, T. S. Stroup, D. O. Perkins, & L. B. Dixon (Eds.), *The American Psychiatric Association Publishing textbook of schizophrenia* (2nd ed., pp. 251–271). American Psychiatric Association Publishing.

Compton, M. T., Graves, J., Zern, A., Pauselli, L., Anderson, S., Ashekun, O., Ellis, S., Langlois, S., Pope, L., Watson, A. C., & Wood, J. (2022). Characterizing arrests and charges among individuals with serious mental illnesses in public-sector treatment settings. *Psychiatric Services, 73*(10), 1102–1108. https://doi.org/10.1176/appi.ps.202000581

Compton, M. T., Pope, L. G., Tan De Bibiana, J., Boswell, T., Fu, E., Zern, A., Bello, I., Broussard, B., Ford, E., Jones, N., Monahan Pollard, J., Watson, A. C., & Dixon, L. (2023). Changes in knowledge, behavioural expectations, self-efficacy, and stigma after an educational campaign about early psychosis for jail correction officers. *Early Intervention in Psychiatry, 17*(8), 798–806.

Compton, M. T., Zern, A., Pope, L. G., Gesser, N., Stagoff-Belfort, A., Tan de Bibiana, J., Watson, A. C., Wood, J., & Smith, T. E. (2023). Misdemeanor Charges Among Individuals With Serious Mental Illnesses: A Statewide Analysis of More Than Two Million Arrests. *Psychiatric Services, 74*(1), 31–37. https://doi.org/10.1176/appi.ps.202000936

Compton, M. T., Tan de Bibiana, J., & Pope, L. G. (2024). Identifying individuals with early psychosis in jail: Lessons learned for coordinated specialty care services. *Psychiatric Services*. https://doi.org/10.1176/appi.ps.20230125

Constantine, R. J., Robst, J., Andel, R., & Teague, G. (2012). The impact of mental health services on arrests of offenders with a serious mental illness. *Law and Human Behavior, 36*(3), 170-176. https://doi.org/10.1037/h0093952

Dalgin, R. S., Dalgin, M. H., & Metzger, S. J. (2018). A longitudinal analysis of the influence of a peer run warm line phone service on psychiatric recovery. *Community Mental Health Journal, 54*(4), 376-382. https://doi.org/10.1007/s10597-017-0161-4

Dee, T. S., & Pyne, J. (2022). A community response approach to mental health and substance abuse crises reduced crime. *Science advances*, *8*(23), eabm2106. https://doi.org/10.1126/sciadv.abm2106

DeHart, D., Lynch, S., Belknap, J., Dass-Brailsford, P., & Green, B. (2014). Life history models of female offending: The roles of serious mental illness and trauma in women's pathways to jail. *Psychology of Women Quarterly, 38*(1), 138–151. https://doi.org/10.1177/0361684313494357

Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., Lehman, A., Tenhula, W. N., Calmes, C., Pasillas, R. M., Peer, J., Kreyenbuhl, J., & Schizophrenia Patient Outcomes Research Team (PORT) (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia bulletin*, *36*(1), 48–70. https://doi.org/10.1093/schbul/sbp115

Dixon, L. B., Goldman, H. H., Bennett, M. E., Wang, Y., McNamara, K. A., Mendon, S. J., Goldstein, A. B., Choi, C. W., Lee, R. J., Lieberman, J. A., & Essock, S. M. (2015). Implementing Coordinated Specialty Care for Early Psychosis: The RAISE Connection Program. *Psychiatric Services*, *66*(7), 691–698. https://doi.org/10.1176/appi.ps.201400281

Edalati, H., Nicholls, T. L., Crocker, A. G., Roy, L., Somers, J. M., & Patterson, M. L. (2017). Adverse childhood experiences and the risk of criminal justice involvement and victimization among homeless adults with mental illness. *Psychiatric Services, 68*(12), 1288-1295. https://doi.org/10.1176/appi.ps.201600330

Ellsworth, J. T. (2022). Housing and criminality: The effect of housing placement on arrests among chronically homeless adults. *Journal of Social Distress and Homeless, 31*(2), 130–141. https://doi.org/10.1080/10530789.2021.1897935

Evans Cuellar, A., McReynolds, L. S., & Wasserman, G. A. (2006). A cure for crime: Can mental health treatment diversion reduce crime among youth? *Journal of Policy Analysis and Management, 25*(1), 197-214. https://doi.org/10.1002/pam.20162

Fisher, W. H., Roy-Bujnowski, K. M., Grudzinskas, A. J., Jr, Clayfield, J. C., Banks, S. M., & Wolff, N. (2006). Patterns and prevalence of arrest in a statewide cohort of mental health care consumers. *Psychiatric Services*, *57*(11), 1623–1628. https://doi.org/10.1176/ps.2006.57.11.1623

Fisher, W. H., Banks, S. M., Roy-Bujnowski, K., Grudzinskas, A. J., Simon, L. J., & Wolff, N. (2010). Categorizing temporal patterns of arrest in a cohort of adults with serious mental illness. The Journal of Behavioral Health Services & Research, 37(4), 477-490. https://doi.org/10.1007/s11414-009-9188-9

Fisher, W. H., Silver, E., & Wolff, N. (2006). Beyond criminalization: toward a criminologically informed framework for mental health policy and services research. *Administration and Policy in Mental Health*, *33*(5), 544–557. https://doi.org/10.1007/s10488-006-0072-0

Ford, E. (2015). First-episode psychosis in the criminal justice system: Identifying a critical intercept for early intervention. *Harvard Review of Psychiatry, 23*(3), 167–175.

Garces, E., Thomas, D., & Currie, J. (2002). Longer-Term Effects of Head Start. *The American Economic Review, 92*(4), 999-1012.

Gregory, A., Clawson, K., Davis, A., & Gerewitz, J. (2016). The promise of restorative practices to transform teacher-student relationships and achieve equity in school discipline. *Journal of Educational and Psychological Consultation, 26*(4), 325-353

Hall, D., Lee, L.-W., Manseau, M. W., Pope, L., Watson, A. C., & Compton, M. T. (2019). Major mental illness as a risk factor for incarceration. Psychiatric Services, 70(12), 1088-1093. https://doi.org/10.1176/appi.ps.201800425

Heckman, J. J., Moon, S. H., Pinto, R., Savelyev, P. A., & Yavitz, A. (2010). The Rate of Return to the HighScope Perry Preschool Program. Journal of Public Economics, 94(1-2), 114-128.

Heilbrun, K., Goldstein, N. E. S., DeMatteo, D., Newsham, R., Gale-Bentz, E., Cole, L., & Arnold, S. (2017). The Sequential Intercept Model and juvenile justice: Review and prospectus. *Behavioral Sciences & the Law, 35*(4), 319–336. https://doi.org/10.1002/bsl.2291

Hellerstein, D. J., Rosenthal, R. N., & Miner, C. R. (1995). A prospective study of integrated outpatient treatment for substance-abusing schizophrenic patients. *American Journal on Addictions, 4*(1), 33-42.

Herman, S. E., BootsMiller, B., Jordan, L., Mowbray, C. T., Brown, W. G., Deiz, N., Bandla, H., Solomon, M., & Green, P. (1997). Immediate outcomes of substance use treatment within a state psychiatric hospital. *Journal of Mental Health Administration*, *24*(2), 126–138. https://doi.org/10.1007/BF02898508

Herman, S. E., Frank, K. A., Mowbray, C. T., Ribisl, K. M., Davidson, W. S., 2nd, BootsMiller, B., Jordan, L., Greenfield, A. L., Loveland, D., & Luke, D. A. (2000). Longitudinal effects of integrated treatment on alcohol use for persons with serious mental illness and substance use disorders. *The Journal of Behavioral Health Services & Research*, *27*(3), 286–302. https://doi.org/10.1007/BF02291740

Herring, C., Yarbrough, D., & Marie Alatorre, L. (2020). Pervasive penality: How the criminalization of poverty perpetuates homelessness. *Social Problems, 67*(1), 131-149. https://doi.org/10.1093/socpro/spz004

Heyland, M., Limp, M., & Johnstone, P. (2021). Utilization of peer support specialists as a model of emergency psychiatric care. *Journal of Psychosocial Nursing and Mental Health Services, 59*(5), 1-37. https://doi.org/10.3928/02793695-20210107-02

Hiday, V. A., & Ray, B. (2010). Arrests two years after exiting a well-established mental health court. *Psychiatric Services*, *61*(5), 463–468. https://doi.org/10.1176/ps.2010.61.5.463

Honisett, S., Loftus, H., Hall, T., Sahle, B., Hiscock, H., & Goldfeld, S. (2022). Do Integrated Hub Models of Care Improve Mental Health Outcomes for Children Experiencing Adversity? A Systematic Review. *International Journal of Integrated Care, 22*(2), 24. https://doi.org/10.5334/ijic.6425

Jacobs, L. A., Branson, Z., Greeno, C. G., Skeem, J. L., & Labrum, T. (2022). Community behavioral health service use and criminal recidivism of people with mental, substance use, and co-occurring disorders. *Psychiatric Services, 73*(12), 1397-1400. https://doi.org/10.1176/appi.ps.202100530

Johnson, S., Lamb, D., Marston, L., Osborn, D., Mason, O., Henderson, C., Ambler, G., Milton, A., Davidson, M., Christoforou, M., Sullivan, S., Hunter, R., Hindle, D., Paterson, B., Leverton, M., Piotrowski, J., Forsyth, R., Mosse, L., Goater, N., Kelly, K., … Lloyd-Evans, B. (2018). Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial. *Lancet (London, England)*, *392*(10145), 409–418. https://doi.org/10.1016/S0140-6736(18)31470-3

Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., Addington, J., Brunette, M. F., Correll, C. U., Estroff, S. E., Marcy, P., Robinson, J., Meyer-Kalos, P. S., Gottlieb, J. D., Glynn, S. M., Lynde, D. W., Pipes, R., Kurian, B. T., Miller, A. L., Azrin, S. T., & Heinssen, R. K. (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *The American Journal of Psychiatry*, *173*(4), 362–372. https://doi.org/10.1176/appi.ajp.2015.15050632

Kennedy-Hendricks, A., Huskamp, H. A., Rutkow, L., & Barry, C. L. (2016). Improving Access To Care And Reducing Involvement In The Criminal Justice System For People With Mental Illness. *Health Affairs (Project Hope)*, *35*(6), 1076–1083. https://doi.org/10.1377/hlthaff.2016.0006

Kerridge, B. T., Chou, S. P., Huang, B., & Harford, T. C. (2020). Sociodemographic characteristics, adverse childhood experiences, and substance use and psychiatric disorders among adolescent-limited, adult-onset, life-course-persistent offenders and nonoffenders in a general population survey. *Crime & Delinquency*, *66*(12), 1729-1753. https://doi.org/10.1177/0011128720915697

Landers, G. M., & Zhou, M. (2011). An analysis of relationships among peer support, psychiatric hospitalization, and crisis stabilization. *Community Mental Health Journal, 47*(1), 106-112. https://doi.org/10.1007/s10597-009-9218-3

Leclair, M. C., Deveaux, F., Roy, L., Goulet, M.-H., Latimer, E. A., & Crocker, A. G. (2019).The impact of Housing First on criminal justice outcomes among homeless people with mental illness: A systematic review. *Canadian Journal of Psychiatry, 64*(8), 525-530. https://doi.org/10.1177/0706743718815902

Lemieux, A. J., Leclair, M. C., Roy, L., Nicholls, T. L., & Crocker, A. G. (2020). A typology of lifetime criminal justice involvement among homeless individuals with mental illness: Identifying needs to better target intervention. *Criminal Justice and Behavior, 47*(7), 790-807. https://doi.org/10.1177/0093854819900305

Kubiak, S., Comartin, E., Milanovic, E., Bybee, D., Tillander, E., Rabaut, C., Bisson, H., Dunn, L. M., Bouchard, M. J., Hill, T., & Schneider, S. (2017). Countywide implementation of crisis intervention teams: Multiple methods, measures and sustained outcomes. *Behavioral sciences & the law*, *35*(5-6), 456–469. https://doi.org/10.1002/bsl.2305

Magee, L. A., Fortenberry, J. D., Rosenman, M., Aalsma, M. C., Gharbi, S., & Wiehe, S. E. (2021). Two-year prevalence rates of mental health and substance use disorder diagnoses among repeat arrestees. *Health & Justice*, *9*(1), 2. https://doi.org/10.1186/s40352-020-00126-2

Mangrum, L. F., Spence, R. T., & Lopez, M. (2006). Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of*

Substance Abuse Treatment, *30*(1), 79–84. https://doi.org/10.1016/j.jsat.2005.10.004

Manseau, M., & Bogenschutz, M. (2016). Substance Use Disorders and Schizophrenia. *Focus*, *14*(3), 333–342. https://doi.org/10.1176/appi.focus.20160008

Monterastelli, S. (2017). Every hand's a loser: the intersection of zero-tolerance policies, mental illness in children and adolescents, and the juvenile justice system. *Law and Psychology Review, 41*, 209-228.

National Alliance on Mental Illness. (2023, July 13). *NAMI/Ipsos poll: 988 one year anniversary survey topline*. https://www.nami.org/wp-content/uploads/2023/08/NAMI-988-One-Year-Anniversary-Survey-Topline-2023.pdf

O'Campo, P., Stergiopoulos, V., Nir, P., Levy, M., Misir, V., Chum, A., Arbach, B., Nisenbaum, R., To, M. J., & Hwang, S. W. (2016). How did a Housing First intervention improve health and social outcomes among homeless adults with mental illness in Toronto? Two-year outcomes from a randomised trial. *BMJ Open, 6*(9), e010581-e010581. https://doi.org/10.1136/bmjopen-2015-010581

Pew Charitable Trusts. (2023, May 23). *Topline & methodology: The Pew Charitable Trusts/Ipsos poll.* https://www.pewtrusts.org/-/media/assets/2023/05/mhj_topline.pdf

Pope, L. G., & Pottinger, S. (2022). First-episode psychosis: Considerations for the criminal justice system. SAMHSA/CMHS. https://www.nasmhpd.org/sites/default/files/2022-03/DH-First-Episode-Psychosis-Considerations-Criminal-Justice-rev3.pdf

Pope, L. G., Patel, A., Watson, A. C., & Compton, M. T. (2024). Making Decisions About Calling 988 Versus 911: Understanding End-User Views Before the Launch of 988. *Psychiatric services,* (7), 646–651. https://doi.org/10.1176/appi.ps.20230016

Prins S. J. (2011). Does transinstitutionalization explain the overrepresentation of people with serious mental illnesses in the criminal justice system? *Community mental health journal*, *47*(6), 716–722. https://doi.org/10.1007/s10597-011-9420-y

Prins, S., & Draper, L. (2009). *Improving outcomes for people with mental illnesses under community corrections supervision: A guide to research-informed policy and practice*. Council of State Governments Justice Center. https://csgjusticecenter.org/publications/improving-outcomes-for-people-with-mental-illnesses-under-community-corrections-supervision-a-guide-to-research-informed-policy-and-practice/

Puntis, S., Perfect, D., Kirubarajan, A., Bolton, S., Davies, F., Hayes, A., Harriss, E., & Molodynski, A. (2018). A systematic review of co-responder models of police mental health 'street' triage. *BMC Psychiatry, 18*(1), 256-256. https://doi.org/10.1186/s12888-018-1836-2

Purtle, J., McSorley, A.M., Adera, A.L., Lindsey, M.A. (2023). Use and Awareness of the 988 Suicide & Crisis Lifeline by Level of Psychological Distress. *JAMA Network Open, 6*(10), e2341383. https://doi:10.1001/jamanetworkopen.2023.41383

Ramezani, N., Breno, A. J., Mackey, B. J., Viglione, J., Cuellar, A. E., Johnson, J. E., & Taxman, F. S. (2022). The relationship between community public health, behavioral health service accessibility, and mass incarceration. *BMC Health Services Research, 22*(1), 966. https://doi.org/10.1186/s12913-022-08306-6

Ramsay, C. E., Goulding, S. M., Broussard, B., Cristofaro, S. L., Abedi, G. R., & Compton, M. T. (2011). Prevalence and psychosocial correlates of prior incarcerations in an urban, predominantly African-American sample of hospitalized patients with first-episode psychosis. *The Journal of the American Academy of Psychiatry and the Law*, *39*(1), 57–64.

Ramsay Wan, C., Broussard, B., Haggard, P., & Compton, M. T. (2014). Criminal justice settings as possible sites for early detection of psychotic disorders and reducing treatment delay. *Psychiatric Services*, *65*(6), 758–764. https://doi.org/10.1176/appi.ps.201300206

Ray, B., Hofer, M. S., Lu, T. T., Aldridge, A. P., Grommon, E., Sightes, E., Lowder, E., & Bailey, K. (2023). Outcomes from a randomized controlled trial of a co-response police-mental health team. Arnold Ventures. https://doi.org/10.17605/OSF.IO/AC3KG

Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *JAMA*, *264*(19), 2511–2518.

Reingle Gonzalez, J. M. (2019). *Project CRE-001 evaluation of DSHS re-entry project (Rider 73): Final evaluation report*. Hogg Foundation for Mental Health Grant Program. https://hogg.utexas.edu/wp-content/uploads/2019/02/Re-Entry-Peer-Support-Final-Report-Jan-10-2019.pdf

Reynolds, A. J., Temple, J. A., Robertson, D. L., & Mann, E. A. (2001). Long-term Effects of an Early Childhood Intervention on Educational Achievement and Juvenile Arrest: A 15-Year Follow-up of Low-Income Children in Public Schools. *JAMA, 285*(18), 2339-2346.

Saunders, H. (2024, July 29). *988 Suicide & Crisis Lifeline: Two years after launch*. Kaiser Family Foundation. https://www.kff.org/mental-health/issue-brief/988-suicide-crisis-lifeline-two-years-after-launch/

Selzer, J. A., & Lieberman, J. A. (1993). Schizophrenia and substance abuse. *The Psychiatric Clinics of North America*, *16*(2), 401–412.

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., Pascoe, J., & Wood, D. L. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics, 129*(1), e232-e246.

Skeem, J. L., Emke-Francis, P., & Louden, J. E. (2006). Probation, mental health, and mandated treatment: A national survey. *Criminal Justice and Behavior, 33*(2), 158-184.

Skiba, R. J., Arredondo, M. I., & Williams, N. T. (2014). More Than a Metaphor: The Contribution of Exclusionary Discipline to a School-to-Prison Pipeline. *Equity & Excellence in Education, 47*(4), 546–564. https://doi.org/10.1080/10665684.2014.958965

Soyka, M., Albus, M., Kathmann, N., Finelli, A., Hofstetter, S., Holzbach, R., Immler, B., & Sand, P. (1993). Prevalence of alcohol and drug abuse in schizophrenic inpatients. *European Archives of Psychiatry and Clinical Neuroscience*, *242*(6), 362–372. https://doi.org/10.1007/BF02190250

Sparks, T. (2018). Reproducing disorder: The effects of broken windows policing on homeless people with mental illness in San Francisco. *Social Justice, 45*(2/3), 45-74. https://www.jstor.org/stable/26677656

Substance Abuse and Mental Health Services Administration. (2024). 2023 Companion infographic report: Results from the 2021, 2022, and 2023 National Surveys on Drug Use and Health (SAMHSA Publication No. PEP24-07-020). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-2022-2023-nsduh-infographic

Swartz, J. A., & Lurigio, A. J. (2007). Serious mental illness and arrest: The generalized mediating effect of substance use. *Crime & Delinquency, 53*(4), 581–604. https://doi.org/10.1177/0011128706288054

Swofford, C. D., Scheller-Gilkey, G., Miller, A. H., Woolwine, B., & Mance, R. (2000). Double jeopardy: schizophrenia and substance use. *The American journal of drug and alcohol abuse*, *26*(3), 343–353. https://doi.org/10.1081/ada-100100248

Talamo, A., Centorrino, F., Tondo, L., Dimitri, A., Hennen, J., & Baldessarini, R. J. (2006). Comorbid substance-use in schizophrenia: relation to positive and negative symptoms. *Schizophrenia research*, *86*(1-3), 251–255. https://doi.org/10.1016/j.schres.2006.04.004

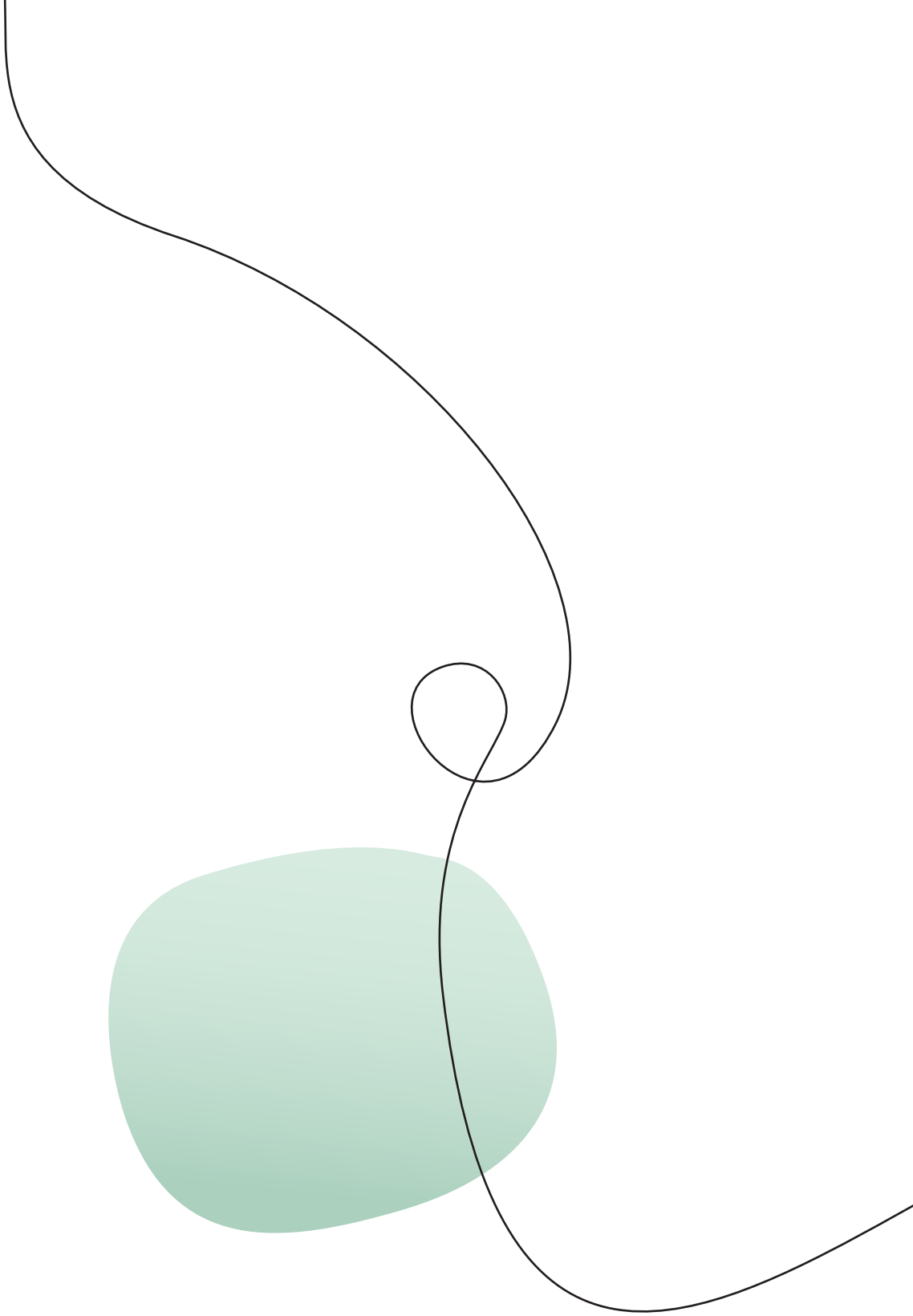
Vaughn, M. G., DeLisi, M., Beaver, K. M., Perron, B. E., & Abdon, A. (2012). Toward a criminal justice epidemiology: Behavioral and physical health of probationers and parolees in the United States. *Journal of Criminal Justice, 40*(3), 165–173. https://doi.org/10.1016/j.jcrimjus.2012.03.001

Van Dorn, R. A., Desmarais, S. L., Petrila, J., Haynes, D., & Singh, J. P. (2013). Effects of outpatient treatment on risk of arrest of adults with serious mental illness and associated costs. *Psychiatric Services, 64*(9), 856–862. https://doi.org/10.1176/appi.ps.201200406

Wasser, T., Pollard, J., Fisk, D., & Srihari, V. (2017). First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities. *Psychiatric Services*, *68*(10), 994–996. https://doi.org/10.1176/appi.ps.201700313

Watson, A. C., Owens, L. K., Wood, J., & Compton, M. T. (2021). The Impact of Crisis Intervention Team Response, Dispatch Coding, and Location on the Outcomes of Police Encounters with Individuals with Mental Illnesses in Chicago. *Policing*, *15*(3), 1948–1962. https://doi.org/10.1093/police/paab010

Yi, Y., & Wildeman, C. (2018). Can foster care interventions diminish justice system inequality? *The Future of Children, 28*(1), 37-58. https://doi.org/10.1353/foc.2018.0002



Stone Soup
CREATIVE