

## ELEVENTH JUDICIAL CIRCUIT CRIMINAL MENTAL HEALTH PROJECT

### Hon. Steven Leifman

Special Advisor on Criminal Justice and Mental Health, Supreme Court of Florida  
Associate Administrative Judge, Miami-Dade County Court, 11th Judicial Circuit

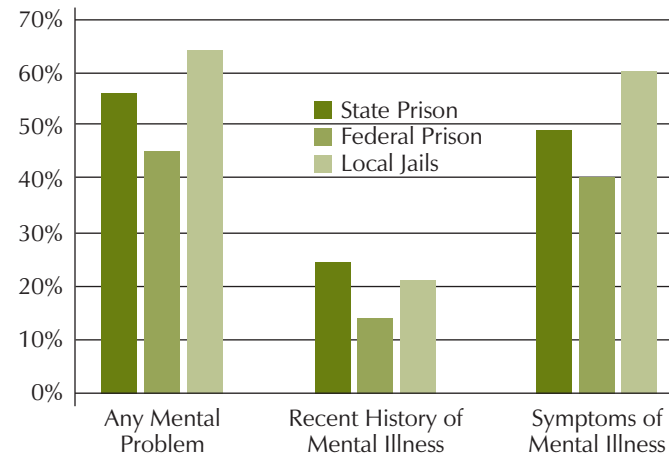
*The 11th Judicial Circuit Criminal Mental Health Project (CMHP) diverts individuals with serious mental illnesses or co-occurring substance-use disorders into community-based treatment and support services. CMHP provides an effective, cost-efficient solution by eliminating gaps in services and by forging productive and innovative relationships among all stakeholders with an interest in the welfare of one of our community's most vulnerable populations.*

### The Problem

Every day, in every community in the United States, law-enforcement agencies, courts, and correctional institutions are witness to a parade of misery brought on by untreated or undertreated mental illnesses. A recent study suggests that people with serious mental illnesses (SMI), such as schizophrenia, bipolar disorder, or major depression, are arrested and booked into jails in the United States more than two million times annually (Steadman et al., 2009). Roughly three-quarters of these individuals also experience co-occurring substance-use disorders, which increase their likelihood of becoming involved in the justice system (Abram and Teplin, 1991). As of midyear 1998, the U.S. Department of Justice estimated that almost 300,000 people with mental illnesses were incarcerated in jails and prisons across the United States, and more than 500,000 people with mental illnesses were on probation (Ditton, 1999). Based on the most recent data reported by the Department of Justice, it is estimated that there are currently 400,000 people with mental illnesses in jails and prisons and more than 800,000 on probation or parole.

Although these national statistics are alarming, the problem is even more acute in Miami-Dade County, Florida, which is home to the largest percentage of people with SMI of any urban community in the United States. Roughly 9.1 percent of the population (nearly 220,000 individuals) experience SMI, yet fewer than 13 percent of these individuals receive care in the public mental-health system (Perez, Leifman,

Percentage of Prison and Jail Inmates in the United States with Mental Health Problems



Source: United States Department of Justice, Bureau of Justice Statistics, 2006

and Estrada, 2003). As a result, law-enforcement and correctional officers have increasingly become the first, and often only, responders to people in crisis due to untreated mental illnesses.

On any given day, the Miami-Dade County jail houses approximately 1,200 individuals with mental illnesses. This represents 17 percent of the total inmate population, and costs taxpayers more than \$50 million annually.<sup>1</sup> The county jail now serves as the largest psychiatric institution in the state of Florida, housing more beds serving people with mental illnesses than any in-patient hospital in the state and nearly half as many beds as there are in all state civil and forensic mental-health hospitals combined.<sup>2</sup> On average, people with mental illnesses remain incarcerated eight times longer than people without mental illnesses arrested for the exact same charge, at a cost seven times higher (Miami-Dade County Grand Jury, 2004). With little treatment available, many individuals cycle through the system for the majority of their adult lives.

The 11th Judicial Circuit Criminal Mental Health Project (CMHP) was established nine years ago to divert misdemeanor offenders with SMI, or co-occurring SMI and substance-use disorders, from the criminal-justice system into community-based treatment and support services. Since that time the program has expanded to serve defendants that have been arrested for less serious felonies and other charges as determined appropriate. The program operates two components: pre-arrest diversion consisting of Crisis Intervention Team (CIT) training for law-enforcement officers and post-arrest diversion serving individuals who are in jail and awaiting adjudication. All participants are provided with individualized transition planning, including linkages to community-based treatment and support. Services available to program participants include supportive housing, supported employment, assertive community treatment (ACT), illness self-management and recovery (Wellness Recovery Action Planning, or WRAP), trauma services, and integrated treatment for co-occurring mental-health and substance-use disorders.

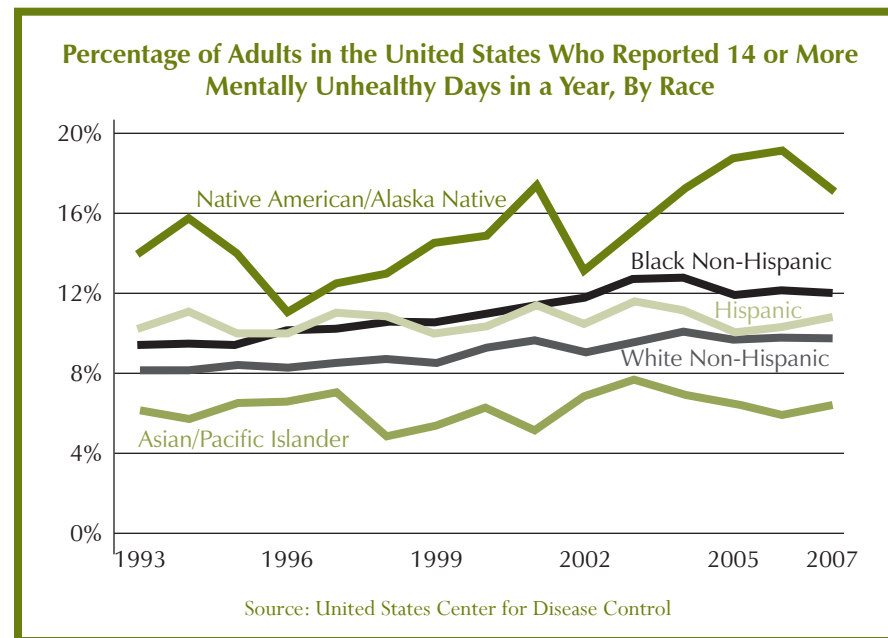
Short-term benefits include reduced numbers of defendants with SMI in the county jail, as well as more efficient and effective access to housing, treatment, and

wraparound services for individuals reentering the community. This decreases the likelihood that individuals will reoffend and reappear in the criminal-justice system and increases the likelihood of successful mental-health recovery. The long-term benefits include reduced demand for costly acute-care services in jails, prisons, forensic mental-health-treatment facilities, emergency rooms, and other crisis settings; decreased crime and improved public safety; improved public health; decreased injuries to law-enforcement officers and people with mental illnesses; and decreased rates of chronic homelessness. Most important, the CHMP is helping to close the revolving door, which results in the devastation of families and the community, the breakdown of the criminal-justice system, wasteful government spending, and the shameful warehousing of some of our community's most vulnerable and neglected citizens.

### Program Development

Initial support for the development of the CMHP was provided in 2000 through a grant from the National GAINS Center,<sup>3</sup> which enabled the court to convene a two-day "summit" meeting of traditional and nontraditional stakeholders throughout the community. The purpose of the summit was to review the ways in which Miami-Dade County collectively responded to people with mental illnesses involved in the justice system. The GAINS Center provided technical assistance and helped the community map existing resources, identify gaps in services and service delivery, and develop a more integrated approach to coordinating care. Stakeholders included judges and court staff, law-enforcement agencies and first responders, attorneys, mental-health and substance-abuse treatment providers, state and local social-service agencies, consumers of mental-health and substance-abuse treatment services, and family members.

What we discovered was an embarrassingly dysfunctional system. Before the summit, it was readily apparent that people with mental illnesses were overrepresented in the justice system. What was not readily apparent, however, was the degree to which stakeholders were unwittingly contributing to and perpetuating the problem. Many participants were shocked to find that a single person with mental illness was accessing the services of almost everybody in the room, including law enforcement, emergency medical services, mental-health-crisis units, emergency rooms, hospitals, homeless shelters, jails, and the courts.



Furthermore, this was occurring over and over as individuals revolved between a criminal-justice system that was never intended to handle overwhelming numbers of people with serious mental illnesses and a community mental-health system that was ill-equipped to provide the necessary services to those most in need.

A common theme among summit participants was the frustration of repeatedly serving the same individuals and that seemingly little that could be done to break the cycles of crises, homelessness, recidivism, and despair. Part of the problem was that stakeholders were largely disconnected from one another, and no mechanisms were in place to coordinate resources or services. Everyone was so busy doing their jobs that no one was looking at the bigger picture to see the ways in which individual roles come together to impact the welfare of the system, and the individual, as a whole. The police were policing, the lawyers were lawyering, and the judges were judging. Treatment providers knew little about what went on when their clients were arrested and, because of barriers to accessing information and laws that prohibit reimbursement for services provided to people who are incarcerated, had little incentive to learn. For individuals who had no resources to pay for services (e.g., insurance, Medicaid), crisis units, hospitals, and the jail were often the only options to receive care. Ironically, while many individuals could not access the most basic prevention and treatment services in the community, they were being provided the most costly levels of crisis and emergency care over and over again.

The degree of fragmentation in the community not only prevented the mental-health and criminal-justice systems from responding more effectively to people with mental illnesses, but actually created increased opportunities for people to fall through the cracks. By the conclusion of the summit we began to realize that people with untreated serious mental illnesses may be among the most expensive

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population in our society not because of their diagnoses, but because of the way we treat them.

Using information generated from the summit meeting, program operations were initiated on a limited basis. Additional funding was secured from a local foundation to conduct a planning study of the mental-health status and needs of individuals arrested and booked into the county jail, as well as the processes in place to link individuals to community-based services and supports. Information from this planning study was used to develop a more formal program design and to secure a three-year, federal targeted-capacity-expansion grant, which enabled the CMHP to significantly expand its staffing and operations. At the conclusion of the federal grant period, the county assumed continuation of funding for all positions. Because of the early success of the program and demonstrated outcomes, the CMHP was recently awarded another three-year grant by the state of Florida to further expand post-booking diversion operations to serve people charged with less serious felonies.

Since its inception the CMHP has received ongoing support from the Florida Department of Children and Families. This support has included the funding of case-management positions, as well as resources to pay for housing, medications, and transportation for program participants. Early in its development, the program also benefited from a partnership established with researchers from Florida International University. This facilitated program planning and evaluation, as well as the preparation and submission of funding proposals.

The CMHP's success and effectiveness depend on the commitment, consensus, and ongoing effort of stakeholders throughout the community. To this end, the courts are in a unique position to bring together stakeholders who otherwise may not have opportunities to engage in such problem-solving collaborations. In establishing the CMHP, a mental-health committee was established within the courts. In addition, a local chapter of the statewide advocacy organization, Florida Partners in Crisis, was formed. Both of these bodies are chaired by the judiciary and provide a venue and opportunity for discussion of issues that cut across community lines. This has been particularly effective in resolving problems that arise from poor communication and cross-systems fragmentation. Staff for the CMHP are employed through the

Eleventh Judicial Circuit of Florida, Administrative Office of the Courts, and work closely with all stakeholders in the community.

## Program Overview

### Pre-Booking

The CMHP has embraced and promoted the Crisis Intervention Team (CIT) training model developed in Memphis, Tennessee in the late 1980s (see University of Memphis Crisis Intervention Team and Crisis Intervention Team of South Florida Web sites). Known as the Memphis Model, the purpose of CIT training is to set a standard of excellence for law-enforcement officers with respect to treatment of individuals with mental illnesses. CIT officers perform regular duty assignment as patrol officers, but are also trained to respond to calls involving mental-health crises. Officers receive 40 hours of specialized training in psychiatric diagnoses; suicide intervention; substance-abuse issues; behavioral de-escalation techniques; the role of the family in the care of a person with mental illness; mental-health and substance-abuse laws; and local resources for those in crisis.

The training is designed to educate and prepare officers to recognize the signs and symptoms of mental illnesses and to respond more effectively and appropriately to individuals in crisis. Because police officers are often the first responders to mental-health emergencies, it is essential that they know how mental

illnesses can impact the behaviors and perceptions of individuals. CIT officers are skilled at de-escalating crises, while bringing an element of understanding and compassion to these difficult situations. When appropriate, individuals are assisted in accessing treatment in lieu of being arrested and taken to jail.

Because CIT programs operate in jurisdictions and municipalities countywide, and officers are called on to respond to a variety of situations ranging from relatively minor incidents to urgent crises, there is no single point of entry and no standard intervention provided. Rather, officers are trained to quickly assess situations and assist individuals in accessing a full array of crisis and noncrisis services and

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resources across the community. These include providing transportation to hospitals and crisis-stabilization units in emergency situations; accessing the services of a mobile crisis team consisting of mental-health professionals providing on-site assessment and referral services in the community; and providing informational resources to assist individuals in locating and accessing health and social services throughout the county.

Analysis of data on individuals served by the pre-booking diversion program indicates that slightly more than half of individuals (56 percent) are female, with an average age of 38 years old. Approximately 53 percent of individuals are white and 41 percent are black, with the race of the remaining 6 percent unknown. Forty-four percent of individuals are Hispanic.

The pre-booking diversion program has demonstrated excellent results. To date, CIT training has been provided to more than 2,300 officers from 36 of the 38 law-enforcement agencies across the county. In addition, there are currently more than 900 CIT-trained police officers on duty. As a result of CIT, fewer individuals in acute psychiatric crisis are being arrested and booked into the jail, and more individuals are being linked to crisis care in the community. There has also been a dramatic reduction in fatal shootings and injuries of people with mental illnesses by police officers. From 1999 through 2005 there were 19 persons with mental illness that died as the result of altercations with law-enforcement officers in Miami-Dade County. Since 2005, there have only been two such incidents.

### Post-Booking

The CMHP was originally established to divert nonviolent, misdemeanor defendants with SMI, and possible co-occurring substance-use disorders, from the criminal-justice system into community-based treatment and support services. Since that time, the program has been expanded to serve defendants that have been arrested for less serious felonies and other charges as determined appropriate.

All defendants booked into the jail are screened for signs and symptoms of mental illnesses by correctional officers using an evidence-based screening tool known as the Brief Jail Mental Health Screen. Additionally, defendants undergo medical screening by health-care staff at the jail, which includes additional assessment of

### Select Characteristics of State Prison Inmates, by Mental Health Status

Who ...	Percent of Inmates in State Prison	
	With Mental Problems	Without Mental Problems
were homeless in the past year	13%	6%
were employed in the month before arrest	70%	76%
were ever physically or sexually abused	27%	11%
received public assistance while growing up	43%	31%
ever lived in a foster home	19%	10%
while growing up lived most of the time with both parents	42%	48%
had parents or guardians that abused alcohol/drugs	39%	25%
had a mother who was ever incarcerated	7%	4%
had a father who was ever incarcerated	20%	13%
had a brother who was ever incarcerated	36%	29%
had a sister who was ever incarcerated	7%	5%

Source: United States Department of Justice, Bureau of Justice Statistics, 2006

psychiatric functioning. Those who are identified as being in possible psychiatric distress are referred to corrections health services' psychiatric staff for more thorough evaluation. Individuals charged with misdemeanors who meet program admission criteria (SMI diagnosis and need for acute-care services) are transferred from the jail to a community-based crisis-stabilization unit within 24 to 48 hours of booking.

Individuals charged with felonies are referred to the CMHP through a number of sources, including the public defender's office, the state attorney's office, private attorneys, judges, corrections health services, and family members. All participants must meet diagnostic and legal criteria, as well as eligibility requirements for accessing entitlement benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid. All participants must voluntarily

*Individuals who voluntarily agree to services are assisted with linkages to a comprehensive array of community-based treatment, support, and housing services that are essential for successful community reentry and recovery outcomes.*

consent to mental-health treatment and services. At present, only individuals charged with third-degree felonies are eligible for program participation, and all referrals must be approved by the state attorney's office, with the consent of victims when appropriate.

Jail diversion participants are assisted with community reentry and engagement in continuing-care services by a peer support specialist who serves as a "Recovery Coach." These are individuals who identify themselves as having a mental illness and possible co-occurring substance-use disorder and are receiving or have received behavioral health treatment/services for their illness. Due to their life experience they are uniquely qualified to perform the functions of the position. A primary function of the peer support specialists is to ensure that participants have adequate access to treatment and support services that promote recovery and lead to improved functioning in the community. Peer specialists also serve as consultants and faculty to the project's Crisis Intervention Team (CIT) training program.

Upon stabilization, legal charges may be dismissed or modified in accordance with treatment engagement. Individuals who voluntarily agree to services are assisted with linkages to a comprehensive array of community-based treatment, support, and housing services that are essential for successful community reentry and recovery outcomes. The CMHP uses the APIC Model to provide transition planning for all program participants. This is a nationally recognized best-practice model that provides a set of critical elements that improve outcomes for people with mental illnesses and co-occurring substance-use disorders who are released from jails. CMHP staff assess, plan, identify, and coordinate (APIC) transition plans that are individualized for each program participant. The goal is to support community living, reduce maladaptive behaviors, and decrease the chances that individuals will reoffend and reappear in the criminal-justice system.

Analysis of data on individuals served by the post-booking diversion program indicates that roughly 60 percent of individuals entering the program are homeless at the time of arrest and over 70 percent experience co-occurring substance-use disorders. Roughly 85 percent of program participants are diagnosed with schizophrenia or another psychotic disorder. Nearly 90 percent of program participants are male and the average age of program participants is 41 years old.

Race is split evenly between black (51 percent) and white (49 percent), and about a third of participants are Hispanic.

### **Access to Entitlement Benefits**

Stakeholders in the criminal-justice and behavioral-health communities consistently identify lack of access to public entitlement benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid as among the most significant and persistent barriers to successful community reintegration and recovery for individuals with serious mental illnesses and co-occurring substance-use disorders. The majority of individuals served by the CMHP are not receiving any entitlement benefits at the time of program entry. As a result, many do not have the necessary resources to access adequate housing, treatment, or support services in the community.

To address this barrier and maximize limited resources, the CMHP developed an innovative plan to improve the ability to transition individuals from the criminal-justice system to the community. Based on an agreement established between Miami-Dade County and the Social Security Administration, a Gap Funding program was developed to provide interim assistance for individuals applying for federal entitlement benefits, such as SSI/SSDI, during the period between application for and approval of benefits. Funding for housing is reimbursed to the county when individuals are approved for Social Security benefits and receive a retroactive payment.

Toward this goal, all participants in the program who are eligible to apply for Social Security benefits are provided with assistance using a best-practice model referred to as SOAR (SSI/SSDI, Outreach, Access, and Recovery). This approach was developed as a federal technical-assistance initiative to expedite access to Social Security entitlement benefits for homeless individuals who are mentally ill.

Access to entitlement benefits is essential in successful recovery and community reintegration for many justice-system-involved individuals with serious mental illnesses. The immediate gains of obtaining SSI, SSDI, or both for these people are clear: it provides a steady income and health-care coverage, which enables individuals to access basic needs, including housing, food, medical care, and

psychiatric treatment. This significantly reduces recidivism to the criminal-justice system, prevents homelessness, and is essential to the process of recovery.

The CMHP has developed a strong collaborative relationship with the Social Security Administration to expedite and ensure approvals for entitlement benefits in the shortest time frame possible. All CMHP participants are screened for eligibility for federal entitlement benefits, with staff initiating applications as early as possible using the SOAR model. Program data demonstrates that 90 percent of the individuals are approved on the initial application in 51 days. By contrast, the national average across all disability groups for approval on initial application is 37 percent. In addition, the average time to approval for CMHP participants is 62 days. This is a remarkable achievement compared to the ordinary approval process, which typically takes 9 to 12 months.

The CMHP Post-Booking component serves approximately 300 individuals annually. The 12-month recidivism rate to the justice system, which had been in excess of 70 percent, has been reduced to 22 percent for program participants. It is expected that with the addition of felony defendants, approximately 500 individuals will be served annually. It is also anticipated that recidivism will decrease further.

### **Conclusion**

The CMHP has demonstrated substantial, cost-effective gains in the effort to reverse the criminalization of people with mental illnesses. The idea was not to create new treatment services, which may duplicate existing services in the community, but rather to create more efficient and effective linkages to these services. The project works by eliminating gaps in services and by forging productive and innovative relationships among all stakeholders who have an interest in the welfare and safety of one of our community's most vulnerable populations.

The CMHP offers the promise of hope and recovery for individuals with SMI, who have often been misunderstood and discriminated against. Once engaged in treatment and community support services, individuals have the opportunity to achieve successful recovery, to be reintegrated to the community, and to reduce their recidivism to jail. The CMHP is a national model of excellence and has received numerous recognitions, including the 2008 Center for Mental Health



Services/National GAINS Center Impact Award, the 2007 National Association of Counties Achievement Award, the 2006 United States Department of Housing and Urban Development's HMIS National Visionary Award, the 2006 Prudential Financial Davis Productivity Award, and the 2003 National Association of Counties Distinguished Service Award.

The CMHP provides an effective and cost-efficient solution to a community problem. Program results demonstrate that individualized transition planning to access necessary community-based treatment and services upon release from jail will ensure successful community reentry and recovery for individuals with mental illnesses, and possible co-occurring substance-use disorders, who are involved in the criminal justice system.

## ENDNOTES

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<sup>1</sup>These figures are based on unpublished information provided courtesy of the Miami-Dade County Department of Corrections and Rehabilitation. Average bed/day cost across all jail beds is approximately \$125.

<sup>2</sup>The state's largest inpatient psychiatric treatment facility is Florida State Hospital in Chattahoochee. As of February 6, 2009, this facility was reported by the Florida Department of Children and Families to have a total of 1,018 civil and forensic treatment beds. The total number of civil and forensic hospital beds statewide is 2,718 (see Florida Dept. of Children and Families, 2009).

<sup>3</sup>The National GAINS Center is a federally funded organization concerned with the collection and dissemination of information about effective services for people with co-occurring mental-health and substance-use disorders in contact with the justice system. GAINS stands for gathering information, assessing what works, interpreting/integrating facts, networking, and stimulating change (see Center for Mental Health Services' National GAINS Center).

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