

CHAPTER 21

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IDENTIFYING, TREATING, AND REDUCING RISK FOR OFFENDERS WITH MENTAL ILLNESS

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INDIVIDUALS with serious and often disabling mental illnesses like schizophrenia, bipolar disorder, and major depression are grossly overrepresented in the criminal justice system. Compared to the general population, the lifetime prevalence rate of these serious mental illnesses in the correctional population is twice as high for both men and women (Teplin 1990; Teplin, Abram, and McClelland 1996; see also Prins and Draper 2009). Of offenders with serious mental illness, nearly 3 of 4 have a co-occurring substance abuse disorder (Abram and Teplin 1991; Abram, Teplin, and McClelland 2003). These figures take on new meaning when considered in context. Currently, there are over 7.3 million people in the United States under correctional supervision (Bureau of Justice Statistics 2009). Roughly 1 in 7 of these men (15 percent) and 1 in 4 of these women (31 percent) suffer from a major mental illness (Steadman, Osher, Robbins, Case, and Samuels 2009; see also Fazel and Danesh 2002). Given the population's gender composition (Glaze and Bonczar 2009; West and Sabol 2009), over 1.3 million people with serious mental illness in the United States are on probation and parole or incarcerated in jail or prison. That is, nearly 1 in 5 people (18 percent) involved in our correctional system suffer from a major mental illness.

Offenders with mental illness are unusually likely to struggle in the correctional system, whether they are incarcerated or supervised in the community. Compared to their relatively healthy counterparts, these offenders are placed in “supermax” or solitary confinement more often (Lovell, Johnson, and Kane 2007; Toch and Adams 2002; for a review, see Fellner 2006). After they are released from prison on parole, they are two times more likely to be reincarcerated than offenders without mental illness (Eno Louden and Skeem, 2011; see also Cloyes, Wong, Latimer and Abarca 2010; Porporino and Motiuk 1995). Similarly, those who are placed on probation—which is, by far, the most common correctional disposition—are significantly more likely to have their community term suspended or revoked (Dauphinot 1996; Skeem, Manchak, Vidal, and Hart 2009).

These figures indicate that a large number of individuals with serious mental disorders enter the criminal justice system each year, and many plunge deeply into the correctional system over time. This problem has captured the attention of practitioners and policy makers in corrections (APPA 2003; BJA 2009; NIC 2009). Over recent years, the Council of State Governments Justice Center (CSG 2002, 2009) has been leading a national effort to bring together professionals in law enforcement, the courts, corrections, and mental health to identify programs that have been developed for offenders with mental illness, distill what is known about their nature and effectiveness, and provide technical assistance to help communities implement them. Reflecting the nature of virtually all programs that have been developed for offenders with mental illness, this laudable effort casts one factor as the linchpin to successful response: access to effective or evidence-based mental health services (e.g., CSG 2002, Policy Statement #1 and Chapter 7).

Contemporary policy largely assumes that mental illness is the direct cause of criminal behavior and that psychiatric treatment is the solution. In this chapter, we describe flawed assumptions that underpin this model and offer an alternative model that describes multiple pathways from mental illness to criminal behavior. We then summarize the limited effectiveness of current programs and outline hypotheses about *how* these programs work, when they do reduce recidivism. We conclude by summarizing implications of current research for smarter sentencing and correctional policies for this population, from assessment to problem solving over violations.

EVALUATING THE CURRENT POLICY MODEL: MENTAL ILLNESS AS DIRECT CAUSE

The model underpinning current programs is easily summarized. “People on the front lines every day believe too many people with mental illness become involved in the criminal justice system because the mental health system has somehow failed. They believe that if many of the people with mental illness received the services they

needed, they would not end up under arrest, in jail, or facing charges in court” (CSG 2002, 26).

Perhaps instinctively, contemporary sentencing and correctional practices for offenders with mental illness respond to the offender’s “master status” (Fisher, Silver, and Wolff 2006) with a demand for mental health services. Oftentimes, the court mandates mental health treatment as part of a sentence or suspended sentence agreement. For example, a probationer or parolee may be required to abide by a special condition to participate in treatment, in addition to the standard conditions typically imposed (e.g., maintain employment). According to the United States Code, “the court may provide, as further conditions of a sentence of probation . . . that the defendant . . . undergo available medical, psychiatric, or psychological treatment” (Title 18 §3563). Typically, judges’ orders for psychiatric treatment are generic—they rarely specify a particular treatment, agency, or program (Skeem and Eno Loudon 2008). Correctional practices tend to be similarly non-specific. In institutional settings, there is emphasis on psychotropic medication, suicide/crisis intervention, and psychotherapy designed to facilitate mental illness recovery (for a review, see Bewley and Morgan, 2011). In community settings, a variety of programs have been developed to enhance coordination between the criminal justice and mental health system and link offenders to community treatment services (Draine, Wilson, and Pogorzelski 2007), generating a “proliferation of case management services as the policy response” (p. 161) for this population.

ISSUE #1: MENTAL ILLNESS RARELY DIRECTLY CAUSES CRIMINAL BEHAVIOR

The fundamental problem with current problem-solving efforts is that there is little evidence that mental illness directly causes criminal behavior—or that psychiatric treatment will reduce it. With respect to the first issue, current evidence indicates that: (1) the availability of mental health services is unrelated to incarceration rates for people with mental illness; (2) police rarely arrest citizens with mental illness disproportionately or for inappropriate reasons; (3) psychosis (e.g., false beliefs, hallucinations) is rarely related to violence in offender populations; and (4) only a small proportion of offenders with mental illness have arrests or patterns of offenses that can be directly attributed to mental illness (for a review, see Skeem, Manchak, and Peterson, 2010).

The last point warrants emphasis. As one group of investigators concluded, “persons with serious mental illness may be overrepresented in jails and prisons, but we can offer little evidence . . . that it was their illness that got them there” (Junginger, Claypoole, Laygo, and Cristiani 2006, 881). Junginger et al. (2006) interviewed 113 arrestees with serious mental illness and co-occurring substance abuse disorders shortly after their booking into jail, and reviewed police records of the arrest. All

arrestees had been deemed eligible for a jail diversion program. In the view of independent and reliable raters, psychiatric symptoms (ranging from delusions and hallucinations to depression and irritability) probably-to-definitely caused the arrest of only 8 percent of these offenders. Similarly, Peterson, Skeem, Hart, Vidal and Keith (2010) interviewed 112 parolees with serious mental illness who were enrolled in a special reentry program, as well as a matched sample of 109 parolees without mental illness. On the basis of interview data and parole records, reliable raters classified each parolee into one of five patterns of lifetime crime. They found that the modal pattern of offending for the vast majority of parolees—whether they were mentally ill or not—reflected hostility, impulsiveness, and reactivity. Only 5 percent of parolees with mental illness manifested a pattern that was attributable to hallucinations, delusions, and other symptoms of psychosis. Thus, although mental illness directly causes criminal behavior for a small but important minority of offenders with mental illness, it is not a direct causal risk factor or “criminogenic need” for the vast majority (for additional evidence, see Monahan and Steadman, *in press*).

Similarly, there is little evidence that the risk of incarceration has uniquely increased for those with mental illness over time. Frank and Glied (2006) examined changes in estimated living arrangements for people with serious and persistent mental illness (SPMI) in the United States from 1950 to 2000. During this period, the proportion of people with SPMI living in psychiatric institutions dropped 23 percent, whereas the proportion living in correctional institutions rose only 4 percent. The rise in incarceration rates for those with SPMI follows a predictable pattern, remaining at 1 percent from 1950–1970, but rising to 3 percent by 1990 and 5 percent by 2000. As a function of “get tough on crime” policies, incarceration rates for the entire population—most of whom do not have SPMI—grew sharply in the 1980s and 1990s (Bureau of Justice Statistics 2009). As Frank and Glied (2006) conclude, “it would be a mistake to attribute the increase in . . . incarceration among people with SPMI directly to the experience of deinstitutionalization” (p. 128); instead, the increase in this “undesirable circumstance” seems shared with the general population.

Indeed, it seems that most offenders with mental illness have the same criminogenic needs as offenders without mental illness (Bonta, Law, and Hanson 1998). What are these needs? According to one empirically supported model, there are eight main risk factors for crime: an established criminal history (especially with an early onset and diverse pattern), an antisocial personality pattern (stimulation seeking, low self-control, hostility-antagonism), antisocial cognition (attitudes, values, and thinking styles supportive of crime), antisocial associates, substance abuse, employment instability, family problems, and low engagement in pro-social leisure pursuits (Andrews, Bonta and Wormith 2006). These factors are assessed in a risk-needs tool called the Levels of Services Inventory/Case Management Inventory (LS/CMI; Andrews, Bonta, and Wormith 2004). Probationers and parolees with mental illness obtain significantly higher scores on the LS/CMI than those without mental illness (Girard and Wormith 2004; Skeem, Nicholson, and Kregg 2008), particularly on the antisocial pattern scale (Skeem et al. 2008). Similarly, offenders with

mental illness obtain scores on a validated measure of antisocial cognition or “criminal thinking” that are similar to, or higher than, those obtained by offenders without mental illness (see Morgan, Fisher, and Wolff 2010).

Based on such evidence, Skeem, Manchak, and Peterson (2010) developed a policy-relevant theory about how mental illness relates to crime. Here, we elaborate that theory to suggest that those with serious mental illness follow one of three different pathways to criminal behavior. For a small subgroup (perhaps 1 in 10; Juninger et al., 2006; Peterson et al. 2010; Toch and Adams 1989), mental illness *directly* causes criminal behavior, including (1) violence motivated by delusions or hallucinations, and (2) arrests for minor crimes, such as public disturbance (e.g., “being psychotic in the wrong place at the wrong time”). This group may not engage in criminal behavior until later in life, *after* the onset of their symptoms (see Hodgins 2000). For this group, effective mental health services would reduce recidivism.

For the other two subgroups, effective mental health services would play a lesser role. For one of these subgroups, mental illness is incidental to or *independent* of criminal behavior. Here, conduct disorder and criminal behavior may begin at a young age (Hodgins and Carl-Gunner 2002), based on general causal factors that include a disinhibited temperament and/or poor parenting and supervision. For the other subgroup, mental illness causes criminal behavior *indirectly*, by exposing individuals to general risk factors for crime. For example, prodromal symptoms of psychosis can include impulsivity, aggression, and other conduct problems (Kim-Cohen, Caspi, Moffitt, Harrignton, Milne, and Poulton 2003). When psychosis itself emerges during late adolescence, it may disrupt the development of pro-social identities, careers, and relationships (see Tessner, Mittal, and Walker 2011). This may cause some individuals to gravitate toward disadvantaged social and geographical environments that model, reinforce, and create opportunity for antisocial behavior. In short, mental illness could lead to crime indirectly through such risk factors as poverty (i.e., inability to hold a job), criminal peers (i.e., problems maintaining positive social bonds; exposure to other marginalized groups), or substance use (i.e., “self-medicating” symptoms; Walker, Kestler, Bollini, and Hochman 2004).

ISSUE #2: EVIDENCE-BASED PSYCHIATRIC TREATMENT AND SYMPTOM REDUCTION RARELY REDUCE CRIMINAL BEHAVIOR

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If the theory above is correct, evidence-based treatment for general offenders that targets criminal thinking and attitudes may be necessary to reduce recidivism for the vast majority of offenders with mental illness. After all, even if mental illness is a distant cause of criminal behavior (as in the indirect group), it seems unlikely that

mental health services will address the proximal factors that now maintain it (e.g., antisocial pattern, criminal peers).

Still, the “direct cause” model dominates contemporary policy. As testament to treating mental illness as the master status for this population, contemporary programs for offenders with mental illness focus on adapting existing evidence-based psychiatric services, including Assertive Community Treatment (ACT) and Integrated Dual Diagnosis Treatment (IDTT; for a list, see Monahan and Steadman, *in press*). These services have been shown to achieve important clinical outcomes such as reducing repeated hospitalization or improving psychosocial functioning.

So far, there is little compelling proof that evidence-based mental health services reduce recidivism for offenders with serious mental illness. By compelling proof, we mean evidence from studies that randomly assign offenders to the evidence-based services versus a comparison condition, given that experimental designs are the standard for drawing causal inferences about the effects of a program. “Pre-program, post-program” studies tend to inflate the apparent effects of a program (Weisburd, Lum, and Petrosino 2001; cf. Pearson, Lipton, Cleland and Yee 2002), as do studies that exclude individuals who drop out of the program (Lowenkamp, Latessa, and Holsinger 2006).

Three experiments are relevant. First, based on a sample of 223 patients with co-occurring disorders who were randomly assigned to Assertive Community Treatment (ACT) versus standard case management, Clark, Ricketts, and McHugo (1999) found no treatment-related difference in police contacts (80 percent) and arrests (44 percent) over a three-year period. In another randomized controlled trial for patients with co-occurring disorders, Calsyn, Yonker, Lemming, Morse, and Klinkenberg (2005) found no treatment-related difference in arrests and incarcerations between those assigned to ACT, Integrated Dual Diagnosis Treatment (IDDT), or treatment as usual. Similar results were obtained for a sample of offenders with co-occurring disorders who were randomly assigned to IDDT or treatment as usual (Chandler and Spicer 2006; see also Drake, Morrissey, and Mueser 2006). Given such results, scholars have cautioned that positive outcomes observed for evidence-based mental health services (e.g., reduced hospitalization, improved symptoms) will not necessarily extend to criminal behavior, and have called for “interventions that specifically target reduction of criminal behavior” (Casyln et al. 2005, 245; see also Drake et al. 2006; Morrissey, Meyer, and Cuddeback 2007).

An alternative way of evaluating the “direct cause” model underpinning current policy is to assess whether offenders who (for whatever reason) show marked symptom improvement during a program are less likely to recidivate than those whose symptoms remain unchanged or worsen. According to existing data, they do not. Using data on over 1,000 participants with mental illness in a multisite jail diversion study, Steadman et al. (2009) found that no relationship between symptom reduction and the number of re-arrests over time. Similarly, based on approximately 360 probationers with serious mental illness, Skeem et al. (2009) found that trajectories of symptom change bore no relation to the probability of arrest or revocation over a one-year period.

SYNOPSIS OF CURRENT PROGRAMS AND EFFECT ON RECIDIVISM

Thus far, we have cast doubt on the assumption that mental illness is the direct cause of criminal behavior and that evidence-based psychiatric treatment will reduce it. Although most contemporary programs for offenders with mental illness are based on this model, there is probably substantial diversity in how narrowly the model is implemented for this population, both within and across program types.

Skeem et al. (2010) summarized the main types of current programs for offenders with mental illness and evaluated their effectiveness. As shown in table 21.1 (from Skeem et al. 2010), most of these programs are derivatives of criminal justice models, including jail diversion programs, mental health courts (a frequently studied form of post-booking jail diversion), specialty probation or parole caseloads, and jail transition or prison reentry programs. Two programs adapt ACT, the most extensively studied mental health service (see above), to create “Forensic Assertive Community Treatment” (FACT) and “Forensic Intensive Case Management” (FICM). FACT or FICM may be used independently, or in conjunction with criminal-justice derived programs (e.g., a mental health court). These programs are united by their focus on linking offenders to community treatment services, but that goal does not wholly define all of them. Some programs include special court supervision, probation supervision, or both.

Skeem et al. (2010) drew three major conclusions about these programs. First, there is little evidence that recidivism is reduced by mental health–centric models that include FACT and FICM (see Morrissey et al. 2007, for a review) and jail diversion programs driven heavily by case management. Second, as suggested earlier, there is no evidence that recidivism reduction is achieved by linking individuals with psychiatric treatment or by reducing symptoms. Third, there is some evidence (if mixed) that criminal justice–based models that emphasize supervision by specialized courts or probation officers, or that include an emphasis on “criminal thinking” (Sacks, Sacks, McKendrick, Banks, and Stommel 2004) reduce recidivism.

WHAT (REALLY) WORKS FOR OFFENDERS WITH MENTAL ILLNESS? THREE HYPOTHESES

It is clear that contemporary programs for offenders with mental illness can “work.” How they work, however, is an open and important question. It seems unlikely that they reduce recidivism for the reasons practitioners expect (i.e., because they link offenders with psychiatric treatment and control symptoms). Arguably, the most pressing challenge for this field is to isolate the active ingredients of programs that

Table 21.1. Contemporary Programs for Offenders with Mental Illness (from Skeem et al. 2010)

Program	Premise	Solution/Description	Exemplar or Prototype of Program	Focal Study	Reduced Recidivism in Study?	Reduced Symptoms in Study?
<i>Criminal Justice Models</i> Jail Diversion	Some PMIs are arrested when the more appropriate response to their behavior is treatment	Divert these PMIs from jail into treatment, either pre- or post-booking	Crisis Intervention Teams (Dupont and Cochran 2000)	Multisite Jail Diversion Study (Steadman and Naples 2005) —quasi-experimental, N = 617 diverted and 570 comparisons	No difference between groups in rearrests over one year; jail diversion associated with more time in community	No difference between groups in symptom change
Mental Health Courts	Traditional case processing allows some PMIs to cycle through the system repeatedly without addressing the problem that drives their criminal behavior	Consolidate these PMIs' cases and process them through a single judge who will enforce linkages with treatment	San Francisco Mental Health Court (McNiel and Binder 2007)	San Francisco Mental Health Court (McNiel and Binder 2007) — quasi-experimental, N = 170 MHC clients and 8,067 comparisons	Yes, probability of rearrest was 42% (MHC) vs. 57% (control) by 18 months	Not assessed
Specialty Mental Health Probation or Parole	PMIs have unique characteristics and pronounced needs that cannot be met via traditional community supervision	Assign these PMIs to officers who manage specialized, reduced size caseloads and work directly with treatment providers	Prototypic specialty probation model (Skeem et al. 2006)	Dallas specialty probation (Skeem, Manchak, et al. 2009) —quasi-experimental, N = 183 specialty vs. 176 traditional probationers	Specialty probationers modestly less likely to be arrested, and less likely to be revoked over one year	No difference between groups in symptom change

<p>Jail Aftercare and Prison Reentry Programs</p>	<p>Discontinuation of treatment at release from incarceration leads some PMIs to decompensation and rearrest</p>	<p>Facilitate timely access to community treatment at the point of release for these PMIs</p>	<p>Prison reentry programs (Wilson and Draine 2006)</p>	<p>Therapeutic community in prison, with- vs. without- aftercare at release (Sacks et al., 2004) experimental, N = 43 aftercare and 32 comparisons</p>	<p>Yes, aftercare group less likely to be reincarcerated over one year (5% vs. 16%)</p>	<p>Not assessed *Note: program targeted criminal thinking beyond symptoms</p>
<p><i>Mental Health Models</i> Forensic Assertive Community Treatment (F-ACT)</p>	<p>ACT is an intensive, evidence-based mental health practice for patients with serious mental illness. With some adjustment, it should also reduce recidivism for offenders with serious mental illness.</p>	<p>Provide ACT to offenders, but with the explicit goal of preventing recidivism; include criminal justice professionals on the multidisciplinary treatment team of psychiatrists, nurses, and case managers</p>	<p>Core F-ACT elements (Lamberti, Weisman, and Faden 2004)</p>	<p>No published, controlled studies available; one unpublished report on a controlled study of 20 programs evaluated in California (Morrissey et al. 2007) —quasi-experimental, N unknown</p>	<p>“Small differences (3-4%) favoring the intervention groups” (p. 535) on re-convictions, jail bookings, and jail time</p>	<p>Unclear, but unspecified improvement in functioning for intervention groups</p>
<p>Forensic Intensive Case Management (FICM)</p>	<p>F-ACT is too costly, but a less resource-intensive variant should reduce recidivism for offenders with mental illness</p>	<p>Case managers provide assertive, community-based services, but without a multidisciplinary team, 24/7 capacity, or direct provision of psychiatric services (which are instead brokered).</p>	<p>FICM elements (Morrissey et al. 2007)</p>	<p>Most controlled studies overlap with Multisite Jail Diversion Study (see Table 2); one independent study compares FICM with FACT and usual care (Solomon and Draine 1995) — experimental, N = 60 ACT, 60 ICM, and 80 control</p>	<p>No difference in rearrests for FICM and controls (but FACT yielded <i>higher</i> rearrests than both comparisons)</p>	<p>No differences among groups in social or clinical changes over one year</p>

are effective for this population. Why? Because understanding what is critical to treatment and how it operates will help develop fewer, more efficient, and more effective interventions for offenders with mental illness (see Kazdin 2007). If we pinpoint the mechanisms of change to define a coherent model of “what really works” for this population, this will help “exnovate” programs that are ineffective (see Frank and Glied 2006), disseminate clearly articulated programs that are effective, and protect active program ingredients in difficult economic times.

Based on the little evidence that is available, we formulated three hypotheses about how contemporary programs reduce recidivism, when they are able to do so. These programs may reduce recidivism (broadly construed) by (1) disproportionately targeting the small minority of offenders for whom the relation between mental illness and criminal behavior is direct to reduce new crimes; (2) targeting general criminogenic needs and improving core correctional practices to reduce new crimes; and (3) reducing stigma of mental illness and increasing tolerance for minor rule infractions to supervision “failure” in the absence of new crimes. Although these hypothesized mechanisms are not mutually exclusive (i.e., all may operate simultaneously) and have not been systematically tested, the last two seem likely to explain the lion’s share of the variance of contemporary programs in improving criminal justice outcomes for offenders with mental illness. Each of these is discussed next.

Disproportionately Targeting the Small, “Direct” Subgroup

As suggested earlier, for a small minority of these offenders (perhaps 1 in 10), linkage with effective mental health services *will* reduce recidivism because their mental illness actually drives criminal behavior, that is, it is a criminogenic need. When this minority subgroup is disproportionately well-represented in a particular program or study, the effect of psychiatric treatment on criminal behavior would shine through. That is, the positive effect for this subgroup would not be completely swamped by the lack of effect in the group as a whole. One way of testing this hypothesis would be to determine whether subgroup membership moderates the effect of psychiatric treatment on new crimes. In contemporary mental health-oriented programs for this population, are offenders whose criminal behavior began *after* their symptoms less likely to be rearrested for a new crime than offenders whose criminal behavior began *before* their symptoms?

Targeting General Criminogenic Needs and Improving Core Correctional Practices

Symptoms of mental illness are not a criminogenic need for most offenders in this population. Instead, these offenders share the strongest criminogenic needs with their relatively healthy counterparts. For these reasons, we hypothesize that when contemporary programs for offenders with mental illness reduce new crimes, they do so for much the same reason as programs for general offenders.

Targeting Criminogenic Needs

Beyond mental illness, these programs may also (implicitly) target general criminogenic needs like antisocial cognition, substance abuse, or poor employment. A major principle of effective treatment for general offenders is the *need* principle: “the most effective programs for reducing recidivism are those that target needs closely related to criminality” (Bonta, Law, and Hanson 1998, 138; see also Andrews, Bonta, and Wormith 2006). That is, the effectiveness of programs is associated with the number of criminogenic needs they target (i.e., changeable risk factors for crime, like antisocial peers), relative to noncriminogenic needs (i.e., disturbances that impinge on functioning, like depression; Andrews et al. 1990). Second, cognitive behavioral treatment (CBT) programs that target a constellation of particularly strong criminogenic needs—antisocial cognition—are consistently ranked “in the top tier with regard to effects on recidivism” (Lipsey and Landenberger 2006, 57).

Formal CBT programs are rarely applied to offenders with mental illness in the United States, in both community and institutional settings (Skeem, Peterson, and Silver, in press; Bewley and Morgan, 2011). In fact, Skeem et al (2010) could locate only one small controlled outcome study for offenders with mental illness that focused on a program with any emphasis on “criminal thinking” (see Sacks et al. 2004, in table 1). Moreover, only one validated CBT program has been adapted for offenders with mental illness and systematically studied. Four small studies conducted on inpatient forensic wards in the United Kingdom and Germany provide preliminary evidence that this program, “Reasoning and Rehabilitation-2 for Mentally Disordered Offenders” (Young and Ross 2007) increases motivation to change, reduces criminal thinking and attitudes, and reduces disruptive behavior on inpatient units (see Antonowicz 2005; Young, Chick, and Gudjonsson 2010). Its effect on criminal behavior, however, is unknown. We hope that future research and practice will examine the extent to which evidence-based correctional treatments reduce new crimes for this population, compared to psychiatric “treatment as usual.”

Despite the lack of formal focus on the criminogenic “need” principle, it sometimes seems to *informally* infiltrate contemporary programs for offenders with mental illness. When it does, it is likely to greatly improve their effectiveness in reducing criminal behavior. That is, to the extent that staff members in mental health courts or other programs go beyond their primary focus on mental health to target factors that actually get an offender in trouble (e.g., hanging out with her drug-dealing cousin), they are intuitively applying this important evidence-based correctional principle.

Although little data are available on this issue, Eno Loudon et al. (2010) coded audiotapes of 83 interactions between specialty probation officers and supervisees with serious mental illness. They found that, although officers tended to focus heavily on general mental health issues (discussed in 66 percent of meetings), they also discussed supervisees’ criminogenic needs, including attitudes supportive of crime (36 percent of meetings). In turn, the amount of time officers spend discussing criminogenic needs is inversely related to the risk of recidivism for general offenders

(Bonta, Ruge, Scott, Bourgon and Yessine 2008). Similarly, in a survey of correctional mental health providers in state facilities, psychologists and other clinically trained respondents viewed traditional clinical issues (i.e., medication adherence, mental illness awareness) as most essential to psychotherapy with offenders with mental illness and spent the most time addressing those (Bewley and Morgan, 2011). Still, a significant minority of respondents (16 percent) reported that they folded correctional treatment principles into their work, including a focus on criminogenic needs. In addition to better implementing formal CBT programs for offenders with mental illness, we believe that the next step in research and policy for this population is to make informal or intuitive principles explicit, practice them consistently, and evaluate their effect on new crimes.

Making Evidence-Based Correctional Principles Explicit

In addition to looking beyond mental illness to general criminogenic needs, some contemporary programs may reduce new crimes because they improve core correctional practices (Dowden and Andrews 2004), which include establishing warm, respectful, and “firm but fair” relationships with offender, and modeling and reinforcing pro-social behavior. Based on a study of approximately 360 offenders with mental illness followed for over two years, Skeem, Manchak, et al. (2009) found that specialty probation reduces risk of recidivism less because of mental health service linkage or symptom reduction than because specialty officers are more likely than traditional officers to establish high-quality “controlling but caring” relationships with offenders and to apply problem-solving strategies rather than threats of incarceration. It will be crucial in the future for (1) practitioners who work with this population to recognize the power of “core correctional practices,” and (2) researchers who study this population to operationalize them and examine their impact on criminal behavior.

Reducing Stigma and Increasing Tolerance

Recall that the vast majority of offenders are supervised in the community on probation and parole. As correctional practitioners know, offenders can “fail” community supervision without committing a new crime. Offenders with mental illness may be particularly susceptible to such failures, given that mental illness is a heavily stigmatized condition. Although more research is needed, some evidence reviewed below suggests that officers and judges generally apply lower thresholds for revoking community supervision, as a function of mental illness. We suspect that some contemporary programs may reduce recidivism not by preventing new crime, but by increasing practitioners’ tolerance for minor transgressions, using revocation as a “last resort” for true criminal behavior, thereby promoting greater success in community supervision. This may be particularly true when programs involve special judicial supervision (e.g., mental health courts) or special probation/parole supervision (e.g., specialty caseloads).

Offenders with and without mental illness are about equally likely to be re-arrested for a new offense (Bonta et al. 1998; Gagliardi, Lovell, Peterson, and Jemelka 2004; cf. Baillargeon et al. 2009). However, those with mental illness are significantly more likely to commit technical violations (Baillargeon et al. 2009; Eno Louden and Skeem, 2011). This may be because those with mental illness: (1) have functional impairments that reduce their ability to adhere to such standard conditions of community release as maintaining employment or paying fines and fees (see Skeem and Eno Louden 2008); (2) are required to abide by *more* conditions of release (e.g., mandated treatment) than those without mental illness; and/or (3) are subject to increased monitoring and control, which increases the likelihood that minor infractions will be detected (Skeem, Eno Louden, et al., 2008). Regardless of the reason, those with mental illness are significantly more likely to commit technical violations and to have their community terms suspended or revoked than those without mental illness (Eno Louden and Skeem, 2011; Porporino and Motiuk 1995). This suggests that correctional officers and judges may have lower thresholds for revoking those with mental illness, compared to their relatively healthy counterparts.

These results are consistent with findings that correctional officers respond conservatively to offenders with mental illness, perhaps out of stigma-based fear or paternalism (Callahan 2004; Eno Louden 2009). Public conceptions of mental illness are “suffused with negative stereotypes, fear, and rejection” (Phelan et al. 2000, 189). Stigma of mental illness involves negative labels (e.g., “crazy”), a grossly exaggerated perception of the (weak) link between mental illness and violence, and willingness to use coercive strategies to achieve social control (e.g., Pescosolido et al. 2000). Based on an experiment conducted with 264 probation officers who read case vignettes, Eno Louden et al. (2009) found that mental illness (particularly schizophrenia) increased officers’ perceptions of violence risk and promoted plans to keep the probationer under close surveillance and on a “short leash” (see also Callahan 2004). Lynch’s (2000) ethnography suggests that reincarceration sometimes is inappropriately used for parolees in emotional crisis. In one case, a psychotic parolee who disclosed suicidal thoughts was arrested and “taken to the county jail for his safety” (p. 52). Skeem, Encandela, and Eno Louden (2003) found that probation officers perceive offenders with mental illness as atypical cases that create “problems to the system,” in that their needs are perceived as non-routine and, therefore, time and resource consuming. Some adopt the strategy of watching these offenders closely until they have an opportunity to transfer or terminate the case (e.g. “If there’s a nutso on my caseload and he’s just taking up too much of my time . . . I’ll transfer him”).

Together, these findings are consistent with the notion that some supervision “failures” reflect minor infractions, fear, and paternalism, or both, rather than a new offense. To the extent that contemporary programs include practitioners who are more tolerant of minor infractions, are less affected by stigma, and are more likely to reserve revocation for new crimes, they will return fewer offenders with mental illness to custody than traditional programs.

Conclusion

More research is needed to determine *how* contemporary programs for offenders “work,” when they actually reduce recidivism. It is not safe to assume that they work because they link offenders with psychiatric treatment, which controls their symptoms, thus preventing new offenses. To help develop more efficient and effective interventions for this population, we recommend that researchers and practitioners systematically test the three hypotheses offered here, that is, that (1) mandating and accessing psychiatric treatment reduces crime for the small subgroup of “direct relationship” offenders, (2) targeting general criminogenic needs and improving core correctional practices reduces crime for the larger group of “indirect” and “independent” relationship offenders, and (3) reducing the stigma of mental illness and increasing tolerance for minor rule infractions reduces supervision “failure” in the absence of new crimes.

To test these hypotheses, it will be necessary to: (1) differentiate between “recidivism” that does and does not occur with the commission of a new crime; (2) distinguish between offenders whose mental illness does, and does not, generally drive their criminal behavior; (3) articulate and systematically measure what practitioners are doing in a program (i.e., what explicit and implicit principles of evidence-based practice they are drawing from mental health or corrections); and (4) determine how particular aspects of what they are doing reduce recidivism, and for whom. These efforts will help us arrive at a coherent model of “what works” for offenders with mental illness. In the next section, we set these challenges aside to articulate principles of smarter sentencing and corrections for offenders with mental illness, given what we know now.

IMPLICATIONS FOR SENTENCING AND CORRECTIONS

Although little data are available, it seems that offenders with mental illness typically are mandated to mental health treatment, as part of a sentence or suspended sentence agreement. Judge’s orders tend to mandate offenders with mental illness to psychiatric treatment generically, without specifying any particular approach (Skeem and Eno Louden 2008). Although there is broad variation among contemporary programs for this population, most emphasize psychiatric service linkage.

Drawing from the literature on general offenders, there may be more effective sentencing and risk reduction alternatives to this “one size fits all,” mental health-centric approach. That is, “smarter sentencing” could be applied to make better decisions about offenders with mental illness both at the point of entry to the system and at any point of trouble within the system (see Monahan and

Steadman, in press, for a “sequential intercept model” that articulates key stages of processing).

“Front End” Sentencing and Case Planning

For general offenders, Wolff (2008) recommends that judicial discretion be embraced as an opportunity to leverage evidence-based correctional principles to reduce reoffending. Specifically, he recommends using data to inform highly individualized decisions that (1) match the intensity of an offenders’ supervision and services to his or her level of risk for reoffending (e.g., such that intensive supervision and services are reserved for medium-high risk offenders), and (2) specify particular types of programs or treatments that target his or her most prominent criminogenic *needs* (e.g., anger, antisocial cognition). The data used to make these decisions would be legally appropriate and could be based on validated “risk/needs” assessment tools used to help generate a probation officer’s pre-sentence investigation report. Space in prison would be reserved “for the most dangerous and most likely to repeat” (Wolff 2008, 1394). Specific supervision and/or treatment programs would be mandated for offenders and evaluated routinely to assess their ability to meet individuals’ criminogenic needs and reduce recidivism. Ostensibly, offenders would no longer be sentenced to programs that produced little evidence of effectiveness.

We believe that similar principles can be applied to offenders with mental illness to reduce recidivism. Below, we make practical recommendations for doing so.

Assess Offenders’ Mental Illness and Risk-Needs

The first step toward effectively sentencing and supervising offenders with mental illness is identifying that population. Although a variety of screening tools for mental illness are available, we recommend the Brief Jail Mental Health Screen (BJMHS; Steadman et al. 2005); given that it is exceptionally short, it can be made part of any standard intake process, and has been shown to perform well in identifying both incarcerated and community offenders who qualify for a diagnosis of a serious mental illness (e.g., Steadman et al. 2005; Eno Loudon, Skeem, and Blevins 2010). The relatively small proportion of offenders who “screen in” as potentially mentally ill can then be referred for a full psychological assessment to better characterize the severity and type of their disorder.

As is the case for all offenders, those with mental illness must be assessed for (1) their risk of recidivism and (2) the criminogenic needs that drive that risk. Many risk assessment tools are available, and the validated tools appear about equally effective in predicting recidivism (Kroner, Mills, and Reddon 2005). One of the best established tools is the Levels of Services Inventory (LSI; Andrews, Bonta, and Wormith 2004), which provides an indication of where the offender stands on each of eight robust risk factors for recidivism mentioned earlier (e.g., employment problems, criminal associates), and is equally predictive for offenders with and without mental illness (Girard and Wormith 2004; Skeem et al. 2008).

Tailor the Sentence to Target Risk and Be Responsive to Mental Illness

Judges can draw upon mental health and risk-needs assessments to inform an individualized approach that leverages evidence-based principles to reduce risk and maximize the possibility of safe community reentry. We have two recommendations for doing so:

- *Mandate psychiatric treatment judiciously.* When offenders have a serious mental illness, they need psychiatric treatment, even if they do not belong to the small subgroup whose symptoms actually drive criminal behavior. This is in accordance with the evidence-based correctional treatment principle of *responsivity*, that is, that services should be delivered in a manner that matches the abilities, styles, and needs of offenders (Andrews et al. 1990). For some offenders, psychiatric treatment may be necessary to control severe symptoms and organize their thinking enough that they can participate in evidence-based CBT programs that target criminal thinking and reduce recidivism. Provision of treatment is also consistent with the fact that correctional models that add treatment services (“care”) to surveillance (“control”) often are more effective in reducing recidivism than surveillance models alone (for a review, see Skeem and Manchak 2008). When offenders’ clinical needs are particularly pronounced or unresponsive to traditional care, mental health programs like ACT or IDDT (see above) may be specifically mandated to achieve important clinical outcomes like reducing repeated hospitalization or improving psychosocial functioning.
- *Tailor services and supervision to recidivism risk and criminogenic needs.* Beyond individualizing psychiatric service linkage, assessment data can also be used to tailor the intensity and focus of supervision and services to reduce an individual’s risk. Because symptoms are a criminogenic need for only a small minority of these offenders and even those with psychotic symptoms often are at relatively low risk for violence (for a review, see Skeem et al. 2010), an offenders’ risk of recidivism (whether mentally ill or not) is best captured by a well-validated risk-needs tool. These tools can be applied to achieve two ends. First, intensive services can be reserved for higher risk offenders, given that correctional treatment programs for high-risk offenders are significantly more effective than those focused on low-risk offenders ($b = .27$; Lowenkamp et al. 2006). For a variety of reasons, placing low-risk offenders in intensive programs is not simply inefficient; it can increase their risk of recidivism (Andrews et al. 1990). Thus, the most intensive rehabilitation programs should be reserved for offenders who are at high risk of recidivating. Second, surveillance and treatment should focus on monitoring and reducing an individual offenders’ most prominent criminogenic needs. For example, if an offenders’ chief needs are criminal thinking and associates, he may be mandated to a CBT program that targets risky thinking and builds problem-solving skills and, during supervision, explicit efforts may be made to reduce his contact with friends

who drink heavily, use drugs, or have a criminal history (see Andrews et al. 2006). As this example suggests, the offenders' psychiatric status or medication noncompliance should not automatically eclipse other risk factors that may relate much more strongly to risk of recidivism, like pro-criminal attitudes, an antisocial and/or impulsive-aggressive lifestyle, criminal companions, substance abuse, and poorly structured leisure time. To achieve maximum recidivism reduction, the judge and/or program staff should work toward treatment conditions and a case management plan that targets factors that have led an individual to criminal behavior in the past.

Require Programs to Demonstrate Effectiveness in Reducing Recidivism

Given the novelty and diversity of programs for offenders with mental illness, it seems crucial to evaluate in controlled studies whether local programs are effective in reducing recidivism. We learned, for example, that not all "specialty mental health probation" programs are created equal—some programs adopt the specialty label but have such large caseload sizes that they function no differently than traditional probation (Skeem et al. 2006). Wolff (2008) discusses how judges can be proactive in insisting that programs demonstrate—and maintain evidence of—their effectiveness in reducing recidivism. We add that stakeholders also should insist on knowing *why* the programs work because this will enable them to streamline programs while monitoring and protecting their most essential elements.

“Back End” Problem Solving

A variety of signs suggest that offenders with mental illness have difficulty adjusting to incarceration and community supervision. Here, we note three problem-solving points that may facilitate adjustment, prevent return to incarceration, and promote safe community re-entry.

Institutional Considerations

While incarcerated, offenders with serious mental illness are relatively prone to rule infractions, disciplinary misconducts, and suicide-related behavior (see Fellner 2006; Toch and Adams 1989). One way to prevent these adverse outcomes is to identify offenders early (with a screening tool like the BJMHS), assess whether symptoms are driving their behavior, and intervene appropriately.

Perhaps as a consequence of repeated infractions and misconducts, inmates with mental illness are nearly four times more likely than their relatively healthy counterparts to be placed on “special housing units” (SHU) or “the hole,” which is marked by solitary confinement, intensive supervision during solo exercise, and lockdown during exposure to other persons (Lovell, Johnson, and Caine 2007). Offenders who “max out” and are released directly from SHUs are significantly more likely to return to custody than those who are released from less restrictive areas in

prison (Lovell et al. 2007). At the same time, “step down” treatment programs for SHUs hold promise in reducing misconducts and violent behavior (Kupers et al. 2009). For that reason, we recommend that “step down” programs from SHUs be systematically implemented for offenders with serious mental illness prior to release to increase their likelihood of successful reentry.

An obvious prerequisite to reentering the community is being released from prison. Ideally, offenders would be released to parole, which might provide a period of “step down” supervision in the community. There are also problems at this stage of release decision-making, however. Offenders with mental illness are less likely than their relatively healthy counterparts to receive a term of parole and more likely to “max out,” moving directly from full supervision in prison to no supervision in the community (see Matejkowski, Caplan and Cullen, 2010). Because it is difficult to believe that these offenders are at much greater risk for recidivism than their relatively healthy counterparts, it would seem wise for parole boards to guard against fear, paternalism, and other signs of stigma when determining whether an inmate with mental illness should be release.

Community Considerations

In many ways, evidence-based supervision of offenders with mental illness has been the focus of this chapter. As suggested earlier, it is crucial that offenders be linked with psychiatric services, be supervised by officers who can establish “firm but fair” relationships with them, and have their criminogenic needs targeted.

It is also clear, based on the data outlined above, that case managers, supervising officers, and judges should not apply lower thresholds for revoking community supervision for this population than they do with general offenders. That is, fear (that offenders will be violent) or paternalism (around treatment compliance) seem an inappropriate basis for using incarceration to achieve social control over these individuals when they are behaving no worse than offenders without mental illness. It is important to remain mindful of our tendency to watch offenders with mental illness more closely and to respond more forcefully to their behavior. Even if we isolate and perfectly implement the ingredients of sentencing and corrections that reduce criminal behavior, these individuals will continue to “fail” as long as we maintain an unusually high threshold for their success. We hope that the models and data reviewed here foster better assessment, management, and risk reduction for offenders with mental illness.

REFERENCES

- Abram, K., and L. Teplin. 1991. “Co-occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy.” *American Psychologist* 46: 1036–1045.
- Abram, K., L. Teplin, and G. McClelland. 2003. “Co-morbidity of Severe Psychiatric Disorders and Substance Use Disorders among Women in Jail.” *American Journal of Psychiatry* 150: 1007–1010.

- American Probation and Parole Association (APPA). 2003. *Resolution: Justice System's Response to Individuals with Mental Illness*. Retrieved on February 3, 2009, from http://www.appa-net.org/eweb/DynamicPage.aspx?Site=APPA_2&WebCode=IB_Resolutions.
- Andrews, D. J., J. Bonta, and S. Wormith. 2004. *The Level of Service/Case Management Inventory (LS/CMI)*. Toronto: Multi-Health Systems.
- Andrews, D., J. Bonta, and S. Wormith. 2006. "The Recent Past and Near Future of Risk and/or Need Assessment." *Crime and Delinquency* 52: 7–27.
- Andrews, D., I. Zinger, R. Hoge, J. Bonta, P. Gendreau, and F. Cullen. 1990. "Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis." *Criminology* 28: 369–404.
- Antonowicz, D. H. 2005. "The Reasoning and Rehabilitation Programme: Outcome Evaluations with Offenders." In *Social Problem Solving and Offending: Evidence, Evaluation and Evolution*, eds. M. McMurrin and J. McGuire, 163–181. Chichester, UK: John, Wiley, and Sons.
- Baillargeon, J., B. A. Williams, J. Mellow, A. J. Harzke, H. K. Hoge, G. Baillargeon, and R. B. Griefinger. 2009. "Parole Revocation among Prison Inmates with Psychiatric and Substance Use Disorders." *Psychiatric Services* 60: 1516–1521.
- Bewley, M. T., and R. D. Morgan. 2011. "A National Survey of Mental Health Services Available to Offenders with Mental Illness: Who Is Doing What?" *Law & Human Behavior* 35: 351–363.
- Bonta, J., M. Law, and C. Hanson. 1998. "The Prediction of Criminal and Violent Recidivism among Mentally Disordered Offenders: A Meta-Analysis." *Psychological Bulletin* 123: 123–142.
- Bonta, J., T. Ruge, T. L. Scott, G. Bourgon, and A. K. Yessine. 2008. "Exploring the Black Box of Community Supervision." *Journal of Offender Rehabilitation* 47(3): 248–270.
- Bureau of Justice Assistance. 2009. *Improving Responses to People with Mental Illness: The Essentials of a Mental Health Court*. Retrieved on February 3, 2009, from <http://www.ojp.usdoj.gov/BJA/grant/mentalhealth.html>.
- Bureau of Justice Statistics. 2009. *Adult Correctional Populations, 1980–2007*. Retrieved on February 17, 2009, from <http://www.ojp.usdoj.gov/bjs/glance/corr2.htm>.
- Callahan, L. (2004). "Correctional officer attitudes toward inmates with mental disorders." *International Journal of Forensic Mental Health* 3: 37–54.
- Calsyn, R., R. Yonker, M. Lemming, G. Morse, and D. Klinkenberg. 2005. "Impact of Assertive Community Treatment and Client Characteristics on Criminal Justice Outcomes in Dual Disorder Homeless Individuals." *Criminal Behaviour and Mental Health* 15: 236–248.
- Chandler, D., and G. Spicer. 2006. "Integrated Treatment for Jail Recidivists with Co-Occurring Psychiatric and Substance Use Disorders." *Community Mental Health Journal* 42: 405–425.
- Clark, R., S. Ricketts, and G. McHugo. 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., B. Wong, S. Latimer, and J. Abarca. 2010. "Time to Prison Return for Offenders with Serious Mental Illness Released from Prison: A Survival Analysis." *Criminal Justice and Behavior* 37: 175–187.
- Council of State Governments. 2002. *Criminal Justice/Mental Health Consensus Project*. Retrieved on March 13, 2008, from <http://www.consensusproject.org>.

- Council of State Governments. 2009. *Improving Outcomes for People with Mental Illness under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice*. Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Dauphinot, L. 1996. *The Efficacy of Community Correctional Supervision for Offenders with Severe Mental Illness*. Unpublished doctoral dissertation, Department of Psychology, University of Texas at Austin.
- Dowden, C., and D. A. Andrews. 2004. "The Importance of Staff Practice in Delivering Effective Correctional Treatment: A Meta-Analytic Review of Core Correctional Practice." *International Journal of Offender Therapy and Comparative Criminology* 48: 203–214.
- Draine, J., A. Wilson, and W. Pogorzelski. 2007. "Limitations and Potential in Current Research on Services for People with Mental Illness in the Criminal Justice System." *Journal of Offender Rehabilitation* 45: 159–177.
- Drake, R., J. Morrissey, and K. Mueser. 2006. "The Challenge of Treating Forensic Dual Diagnostic Clients." *Community Mental Health Journal* 42: 427–432.
- Dupont, R., and S. Cochran. 2000. "Police Response to Mental Health Emergencies: Barriers to Change." *Journal of the American Academy of Psychiatry and the Law* 28: 338–344.
- Eno Louden, J. 2009. "Effect of Mental Disorder and Substance Abuse Stigma on Probation Officers' Case Management Decisions." Unpublished doctoral dissertation, University of California, Irvine.
- Eno Louden, J., and J. Skeem. 2011. "Parolees with Mental Disorder: Toward Evidence-Based Practice." *Bulletin of the Center for Evidence-Based Corrections*.
- Eno Louden, J., J. L. Skeem, and A. Blevins. 2010. "Identifying Probationers with Mental Disorder: Validation of a Mental Health Screening Questionnaire." Unpublished manuscript under review.
- Eno Louden, J., J. L. Skeem, J. Camp, S. Vidal, and J. Peterson. 2010. "Supervision Practices in Specialty Mental Health Probation: What Happens in Officer-Probationer Meetings?" *Law and Human Behavior*, online first: 23 Dec 2010.
- Fazel, S., and J. Danesh. 2002. "Serious Mental Disorder in 23,000 Prisoners: A Systematic Review of 62 Surveys." *Lancet* 359: 545–550.
- Fellner, J. 2006. "A Corrections Quandary: Mental Illness and Prison Rules." *Harvard Civil Rights-Civil Liberties Law Review* 41: 391–412.
- Fisher, W., E. Silver, and N. Wolff. 2006. "Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Health Policy and Services Research." *Administration and Policy in Mental Health* 33: 544–557.
- Frank, R., and S. Glied. 2006. *Mental Health Policy in the United States since 1950: Better but Not Well*. Baltimore, MD: The Johns Hopkins University Press.
- Gagliardi, G., D. Lovell, P. Peterson, and R. Jemelka. 2004. "Forecasting Recidivism in Mentally Ill Offenders Released from Prison." *Law and Human Behavior* 28: 133–155.
- Girard, L., and J. Wormith. 2004. "The Predictive Validity of the Level of Service Inventory-Ontario Revision on General and Violent Recidivism among Various Offender Groups." *Criminal Justice and Behavior* 31: 150–181.
- Glaze, L., and T. Bonczar. 2007. *Probation and Parole in the United States, 2006*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Hodgins, S. 2000. "The Etiology and Development of Offending among Persons with Major Mental Disorders." In *Violence among the Mentally Ill*, ed. S. Hodgins, 89–116. Dordrecht: Kluwer.
- Hodgins, S., and J. Carl-Gunnar. 2002. *Criminality and Violence among the Mentally Disordered*. New York: Cambridge University Press.

- Kazdin, A. E. 2007. "Mediators and Mechanisms of Change in Psychotherapy Research." *Annual Review in Clinical Psychology* 3: 1–27.
- Kim-Cohen, J., A. Caspi, T. E. Moffitt, H. L. Harrington, B. S. Milne, and R. Poulton. 2003. "Prior Juvenile Diagnoses in Adults with Mental Disorder: Developmental Follow-Back of Prospective-Longitudinal Cohort." *Archives of General Psychiatry* 60: 709–717.
- Kroner, D., J. Mills, and J. Reddon. 2005. "A Coffee Can, Factor Analysis, and Prediction of Antisocial Behavior: The Structure of Criminal Risk." *International Journal of Law and Psychiatry* 28(4): 360–374.
- Kupers, T. A., T. Dronet, M. Winter, J. Austin, L. Kelly, W. Cartier, T. J. Morris, S. F. Hanlon, E. L. Sparkman, P. Kumar, L. C. Vincent, J. Noris, K. Nagle, and J. McBride. 2009. "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs." *Criminal Justice and Behavior* 36: 1037–1050.
- Junginger, J., K. Claypoole, R. Laygo, and A. Cristiani. 2006. "Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses." *Psychiatric Services* 57: 879–882.
- Lamberti, J., R. Weisman, and D. Faden. 2004. "Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness." *Psychiatric Services* 55: 1285–1293.
- Lipsey, M. W., and N. A. Landenberger. 2006. "Cognitive-behavioral Interventions." In *Preventing Crime: What Works for Children, Offenders, Victims, and Places*, eds. B. C. Welsh and D. P. Farrington, 57–71. Dordrecht, Netherlands: Springer.
- Lovell, D. L., L. C. Johnson, and K. C. Kane. 2007. "Recidivism of Supermax Prisoners in Washington State." *Crime and Delinquency* 53: 633–656.
- Lowenkamp, C., E. Latessa, and A. Holsinger. 2006. "The Risk Principle in Action: What Have We Learned from 13,676 Offenders and 97 Correctional Programs?" *Crime and Delinquency* 52: 77–93.
- Lynch, M. (2000). "Rehabilitation as rhetoric: The reformable individual in contemporary parole discourse and practices." *Punishment and Society* 2: 40–65.
- Matejkowski, J., J. Caplan, and S. Cullen. 2010. "The Impact of Severe Mental Illness on Parole Decisions: Considering Integration Within a Prison Setting." *Criminal Justice & Behavior* 37: 1005–1029.
- McNeil, D., and R. Binder. 2007. "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence." *American Journal of Psychiatry* 164: 1395–1403.
- Monahan, J., and H. Steadman. In press. "Extending Violence Reduction Principles to Justice-Involved Persons with Mental Illness." In *Applying Social Science to Reduce Violent Offending*, eds. J. Dvoskin, J. Skeem, R. Novaco, and K. Douglas. New York: Oxford University Press.
- Morgan, R. W. Fisher, and N. Wolff. 2010, April. "Criminal Thinking: Do People with Mental Illnesses Think Differently?" Policy Brief of the Center for Behavioral Health Services & Criminal Justice Research. Accessed June 15, 2010, at www.cbhs-cjr.rutgers.edu/pdfs/Policy_Brief_April_2010.pdf.
- Morrissey, J., P. Meyer, and G. Cuddeback. 2007. "Extending Assertive Community Treatment to Criminal Justice Settings: Origins, Current Evidence, and Future Directions." *Community Mental Health Journal* 43: 527–544.
- National Institute of Corrections (NIC). 2009. *Mentally Ill Persons in Corrections*. Retrieved February 7, 2009, from <http://nicic.gov/MentalIllness>.
- Pearson, F., D. Lipton, C. Cleland, and D. Yee. 2002. "The Effects of Behavioral/Cognitive-Behavioral Programs on Recidivism." *Crime and Delinquency* 48: 476–496.

- Peterson, J. K., J. L. Skeem, E. Hart, S. Vidal, and F. Keith. 2010. "Comparing the Offense Patterns of Offenders with and without Mental Disorder: Exploring the Criminalization Hypothesis." *Psychiatric Services* 61: 1217–1222.
- Porporino, F., and L. Motiuk. 1995. "The Prison Careers of Mentally Disordered Offenders." *International Journal of Law and Psychiatry* 18: 29–44.
- Prins, S. J., and L. Draper. 2008. *Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice*. New York: Council of State Governments Justice Center.
- Sacks, S., J. Sacks, K. McKendrick, S. Banks, and J. Stommel. 2004. "Modified Therapeutic Community for MICA Offenders: Crime Outcomes." *Behavioral Sciences and the Law* 22: 477–501.
- Skeem, J., J. Encandela, and J. Eno Loudon. (2003). "Experiences of Mandated Mental Health Treatment in Traditional and Specialty Probation Programs." *Behavioral Sciences & the Law* 21: 429–458.
- Skeem, J., and J. Eno Loudon, J. 2008, March. "Mandated Treatment as a Condition of Probation: Coercion or Contract?" In *Understanding in Mandated Community Treatment*, A. Redlich (Chair), Symposium conducted at the annual meeting of the American Psychology-Law Society, Jacksonville, FL. Available at: <https://webfiles.uci.edu:443/skeem/Downloads.html>.
- Skeem, J., and S. Manchak, S. 2008. "Back to the Future: From Klockars' Model of Effective Supervision to Evidence-Based Practice in Probation." *International Journal of Offender Rehabilitation* 47: 220–247.
- Skeem, J. L., M. Manchack, and J. P. Peterson. 2010. "Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction." *Law and Human Behavior* 35: 110–126.
- Skeem, J., S. Manchak, S. Vidal, and E. Hart. 2009, March. "Probationers with Mental Disorder: What (Really) Works?" Paper presented at the American Psychology and Law Society (AP-LS) Annual Conference, San Antonio, TX. Available at: <https://webfiles.uci.edu:443/skeem/Downloads.html>.
- Skeem, J., E. Nicholson, and C. Kregg. 2008, March. "Understanding Barriers To Re-Entry For Parolees With Mental Illness." In *Mentally Disordered Offenders: A Special Population Requiring Special Attention*, D. Kroner (Chair). Symposium conducted at the meeting of the American Psychology-Law Society, Jacksonville, FL.
- Skeem, J., J. Peterson, and E. Silver. In press. "Toward Research-Informed Policy for High Risk Offenders with Serious Mental Illness." In *Managing High Risk Offenders: Policy and Practice*, eds. B. McSherrey and P. Keyser. New York: Routledge.
- Skeem, J., C. Schubert, C. Odgers, E. Mulvey, W. Gardner, and C. Lidz. 2006. "Psychiatric Symptoms and Community Violence among High-Risk Patients: A Test of the Relationship at the Weekly Level." *Journal of Consulting and Clinical Psychology* 74: 967–979.
- Solomon, P., and J. DraineJ. 1995. "One-year Outcomes of a Randomized Trial of Case Management with Seriously Mentally Ill Clients Leaving Jail." *Evaluation Review* 19: 256–273.
- Steadman, H., and M. Naples. 2005. "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders." *Behavioral Science and the Law* 23: 163–170.
- Steadman, H., S. Dupius, and L. Morris. 2009, March. "For Whom Does Jail Diversion Work? Results of a Multi-Site Longitudinal Study." Paper presented at the annual conference of the American Psychology-Law Society, San Antonio, TX.

- Steadman, H., J. Scott, F. Osher, T. Agnese, and P. Robbins. 2005. "Validation of the Brief Jail Mental Health Screen." *Psychiatric Services* 56: 816–822.
- Steadman, H. J., F. C. Osher, P. C. Robbins, B. Case, and S. Samuels. 2009. "Prevalence of Serious Mental Illness among Jail Inmates." *Psychiatric Services* 60: 761–765.
- Teplin, L. 1990. "The Prevalence of Severe Mental Disorder among Urban Male Jail Detainees: Comparison with the Epidemiologic Catchment Area Program." *American Journal of Public Health* 80: 663–669.
- Teplin, L. A., K. M. Abram, and G. M. McClelland. 1996. "Prevalence of Psychiatric Disorders among Incarcerated Women: Pretrial Jail Detainees." *Archives of General Psychiatry* 53(6): 500–512.
- Tessner, K. D., V. Mittal, and E. F. Walker. 2011. "Longitudinal Study of Stressful Life Events and Daily Stressors among Adolescents at High Risk for Psychotic Disorders." *Schizophrenia Bulletin* 37: 432–441.
- Toch, H., and K. Adams. 1989. *The Disturbed Violent Offender*. New Haven, CT: Yale University press.
- Toch, H., and K. Adams. 2002. *Acting Out: Maladaptive Behavior in Confinement*. Washington, DC: American Psychological Association.
- Walker, E., L. Kestler, A. Bollini, and K. M. Hochman. 2004. "Schizophrenia: Etiology and Course." *Annual Review of Psychology* 55: 401–430.
- Weisburd, D., C. Lum, and A. Petrosino. 2001. "Does Research Design Affect Study Outcomes in Criminal Justice?" *The Annals of the American Academy of Political and Social Sciences* 578: 50–70.
- West, H., and W. Sabol. 2009. *Prison and Jail Inmates at Midyear 2008—Statistical Tables*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Wilson, A., and J. Draine. 2006. "Collaborations Between Criminal Justice and Mental Health Systems for Prisoner Reentry." *Psychiatric Services* 57: 875–878.
- Wolff, M. 2008. "Evidence-Based Judicial Discretion: Promoting Public Safety through State Sentencing Reform." *New York University Law Review* 83: 1389–1419.
- Young, S., K. Chick, and G. Godjonsson. 2010. "A Preliminary Evaluation of Reasoning and Rehabilitation 2 in Mentally Disordered Offenders (R&R2M) Across Two Secure Forensic Settings in the United Kingdom." *The Journal of Forensic Psychiatry* 21: 336–349.
- Young, S. J., and R. R. Ross. 2007. *R&R2 for Youths and Adults with Mental Health Problems: A Prosocial Competence Training Program*. Ottawa: Cognitive Centre of Canada.