

Toward research-informed policy for
high risk offenders with serious mental illness

Jennifer Skeem, Ph.D.

Professor of Psychology & Social Behavior
University of California, Irvine
Voice: (949) 824-3782
Internet: skeem@uci.edu

Jillian Peterson, M.A.
University of California, Irvine

Eric Silver, Ph.D.
Pennsylvania State University

To appear in Bernadette McSherrey and Patrick Keyser (Eds.), *Managing High Risk Offenders: Policy and Practice*. Routledge.

People with mental illness are disproportionately represented in the criminal justice system (Fazel & Danesh, 2002). Approximately 1 in 7 men (15%) and 1 in 3 women (31%) detained in jails in the U.S. suffer from such serious and often disabling illnesses as schizophrenia, bipolar disorder, and major depression (Steadman, Osher, Robbins, Case & Samuels, 2009). The vast majority experience co-occurring substance abuse disorders (see Prins & Draper, 2009). Many of these men and women become inextricably entangled in the criminal justice system. Compared to their relatively healthy counterparts, offenders with mental illness are incarcerated longer and placed in ‘supermax’ or solitary confinement more often (Lovell, Johnson, & Kane, 2007; Toch & Adams, 2002; for a review, see Fellner, 2006). After they are released from prison, they are two times more likely to be re-incarcerated than offenders without mental illness (Eno Louden & Skeem, in press).

This problem “not only takes a toll on people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system” (Council of State Governments, 2002, p. 6). In an effort to improve the criminal justice’s response to people with mental illness, policymakers and practitioners in the U.S. have launched numerous federal initiatives and local programs for this population (see Skeem, Peterson, & Manchak, in press). Similar movements inspired by large populations of offenders with mental illness are apparent across the U.K. and Australiasia (e.g., Beyond Bars Alliance, 2007; Mullen, 2001; Rethink & Sainsbury Centre for Mental Health, 2010).

These efforts are diverse, both across- and within- countries. Nevertheless, they are united by the belief that these individuals wind up arrested and under correctional supervision because they do not receive the mental health services they need. They view criminal justice involvement as the direct product of mental illness, and linkage with mental health treatment as

the solution. Contemporary policy underlying these efforts relies heavily on the notion of diversion, seeking to replace involvement in the criminal justice system with (greater) involvement in the mental health system. In this chapter, we outline problems with the conceptual model that underpins this policy, present an alternative model that is more firmly rooted in research, and explain the implications of this alternative model for sentencing, treating, and supervising the heterogeneous group of offenders with serious mental illness.

Throughout this chapter, our primary focus is on adult offenders with serious, diverse, and numerous past offenses and a high estimated risk of repeated criminal behavior. We focus on this population because intervention programs for high risk offenders are significantly more effective in reducing recidivism than those focused on low risk offenders ($b = .27$; Lowenkamp et al., 2006). Focusing supervision and intervention efforts on high risk offenders will maximize returns in public safety. We specifically focus on high risk offenders with serious mental illness (schizophrenia spectrum disorders, bipolar disorder, or major depression) and co-occurring substance abuse problems who have been convicted of crimes or arrested and diverted from jail (rather than those deemed not guilty by reason of insanity). We emphasize the context of community corrections (probation and parole) rather than institutions (jail and prison) because most offenders are supervised in the community and the bulk of work on evidence-based corrections focuses on that context. The model we present focuses on criminal behavior; we set aside criminal justice involvement that reflects stigma, paternalism, and decision-making biases against those with mental illness (for a review, see Skeem et al., in press) that are independent of unlawful behavior.

CONTEMPORARY POLICY: THE DIRECT CAUSE MODEL

The model and programs

The perceived root of the problem is simple and literal: the widely held belief is that people with mental illness are disproportionately represented in the criminal justice system because mental illness causes criminal behavior. In theory, psychiatric services have become unavailable, fragmented, or inadequate, so individuals with mental illness are deteriorating and committing crimes that should have been prevented or managed through treatment. Sometimes, a person would be arrested for violence that is the direct “product of the person’s untreated mental illness” (Torrey et al., 2002, p. 48). A person with paranoid delusions, for example, may assault his perceived persecutor. More often, a person with mental illness would be arrested for a minor crime, perhaps in an effort to secure treatment in jail (see Lamb & Weinberger, 1998). For example, someone displaying psychotic behavior on the street may be arrested for disturbing the peace.

What types of programs have been developed for offenders with mental illness? In the U.S., there are two general classes of programs. The first class is derived from general criminal justice models and focuses on a particular stage of case processing (e.g., pre-booking jail diversion, post-booking jail diversion; specialty probation and parole caseloads; jail transition and prison re-entry). For example, mental health courts are post-booking jail diversion programs that involve a specialized court docket and ongoing judicial supervision of community-based treatment plans. Mental health courts have spread prolifically in the U.S. over recent years (BJA, 2009), with some recent uptake in Australasia but little or none in the UK. The second class of programs is derived from mental health models; Forensic Assertive Community Treatment (FACT) and Forensic Intensive Case Management. FACT and FICM are relatively intensive community treatment and service linkage models that may be used either independently or in conjunction with criminal-justice derived programs (e.g., a mental health court). FACT and

FICM were adapted from the most extensively studied and perhaps most resource-intensive mental health service, Assertive Community Treatment (ACT) (Morrissey, Meyer, & Cuddeback, 2007; Osher & Steadman, 2007). Treatment development efforts for this population, then, have involved adapting services that have been shown to improve patients' *clinical* outcomes (e.g., reduced hospitalization) rather than services that have been shown to reduce offenders' *recidivism* (e.g., reduced arrests).

Despite differences both within- and among- programs, virtually all are designed to link offenders with mental illness to community treatment services. Indeed, there has been a “proliferation of case management services as the policy response” (Draine, Wilson, & Pogorzelski, 2007, p. 161) for this population. The chief policy goal of these programs is to reduce the likelihood of recidivism. This mostly means protecting public safety by minimizing “new crimes and new victims” (Keiser, 2009). The technique for reaching that goal generally focuses on a single dimension: mental illness. Criminal justice involvement is used to mandate or link the individual to psychiatric treatment (e.g., a probationer is required to abide by a special condition to participate in treatment), and treatment is thought to reduce the risk of recidivism. Because (untreated) mental illness is perceived as the root of the problem, access to effective mental health services has been cast as the lynchpin to successful response (e.g., CSG, 2002, Policy Statement #1 & Chapter 7).

Problematic assumptions of the model

When evaluated against empirical evidence, the direct cause model is underpinned by two problematic assumptions. That is, there is little compelling evidence that (a) mental illness directly causes criminal behavior for this population, or (b) that effective mental health services meaningfully reduce new crimes and new victims. Although a comprehensive review of this

literature is beyond the scope of the present chapter, each assumption will be briefly addressed here (for more information, see Skeem et al., in press).

Mental Illness Directly Causes Criminal Behavior

Violence is a form of criminal behavior that laypeople often (erroneously) attribute to serious mental illness. A large body of research indicates that “risk of violence is modestly elevated for people with mental disorder, particularly those who misuse substances” (Silver, 2006, p. 685). Still, most people with mental illness are not violent, most violent offenders are not mentally ill, and the strongest risk factors for violence (e.g., past violence) are shared by those with- and without- mental illness. The link between psychosis and violence is particularly weak among offenders (e.g., Bonta, Law, & Hanson, 1998; Quinsey, Harris, Rice, & Cormier, 2006), perhaps because the base rate of violence is high and the strongest risk factors are well represented, leaving little room for the modest role that mental illness plays in other contexts (see Buchanan, 2008). Based on a meta-analysis of 204 diverse studies and samples, Douglas, Guy, and Hart (2009) found no meaningful correlation between psychosis and violence for offenders with mental illness ($r = .00$ or $OR = 0.91$) and general offenders ($r = .01$ or $OR = 1.27$).

Setting aside violence per se, there is little evidence that offenders with mental illness recidivate because of (uncontrolled) symptoms or other clinical factors. For example, in a meta-analysis of 58 prospective studies of offenders with mental illness (70% with schizophrenia), Bonta, Law and Hanson (1998) found that clinical variables (e.g., diagnoses, treatment history) did not meaningfully predict a new general offense ($r = -.02$) or a new violent offense ($r = -.03$). Instead, the strongest predictors of a new violent offense ($r > .20$) were antisocial personality, juvenile delinquency, criminal history, and employment problems – risk factors that this population shares with offenders who are not mentally ill.

Despite the consistency of these findings, recent evidence collected in the U.S. argues that the direct cause hypothesis should be scaled back rather than wholly discarded. Among the heterogeneous population of offenders with mental illness, a small but important subgroup may become involved in the criminal justice system as a direct result of their symptoms (Juninger et al., 2006; Peterson, Skeem et al., in press; see also Monahan et al., 2001). A handful (perhaps 1 in 10) seem to be arrested because their hallucinations or delusions lead to (seemingly irrational) violence or because they cause a public disturbance by being ‘psychotic at the wrong place at the wrong time.’ However, the rest – perhaps 9 in 10 – seem to have lifetime patterns of crime that are indistinguishable from those of general offenders.

Peterson, Skeem, et al. (in press) studied lifetime patterns of offending among a matched sample of 221 parolees with- and without serious mental illness. The modal diagnosis in the sample was schizophrenia or another psychotic disorder (52%). The pattern of offending for the vast majority of parolees – mentally ill (90%) or not (68%) – reflected trait anger and impulsivity. Only 5% of parolees with mental illness manifested a pattern that was attributable to psychotic symptoms and only 2% fell in the ‘disadvantaged’ or ‘survival crime’ group. Thus, although most had offense patterns similar to those without mental illness, a minority (7%) of the mentally ill sample fit the direct cause model. Remarkably similar findings emerged in a study of less serious offenders and in a study of violence among psychiatric patients. Based on a sample of 113 inmates deemed eligible for a jail diversion program (34% of whom had a schizophrenia spectrum disorder), Juninger et al. (2006) found that 8% had been booked for offenses that their psychiatric symptoms probably-to-definitely caused, either directly (4%) or indirectly (4%). Based on a sample of over 608 violent incidents that involved psychiatric patients enrolled in the MacArthur Violence Risk Assessment study, 11% were rated as having

occurred while patients were delusional or hallucinating (Monahan et al., 2001). Thus, in the U.S., there is evidence that mental illness directly causes violence and other crime for a small but important minority of this population (about 10%). The size of this subgroup in other countries remains to be determined. To the extent that individuals with mental illness are, for example, more likely to be acquitted by reason of insanity, this subgroup in countries outside the U.S. may be smaller.

Psychiatric Services Directly Reduce Criminal Behavior

The data reviewed above suggests that psychiatric symptoms are a direct or leading cause of criminal behavior for only a small minority of offenders with mental illness. At the group level, there is little evidence that mental illness is what got this population into jail or prison (see Juninger et al., 2006). Even so, the second assumption of the current policy model could still be correct. Is it? That is, do psychiatric services meaningfully reduce criminal behavior for this population?

Although one can never prove the null hypothesis, the answer provided by the most rigorous controlled studies is ‘probably not.’ In a review of these studies, Skeem et al. (in press) distilled evidence that contemporary programs often successfully link offenders with psychiatric treatment and sometimes reduce their symptoms and distress; but this rarely translates into fewer new crimes and new victims. This is particularly true of the mental health-based models (FACT, FICM; see Morrissey et al., 2007) and of jail diversion programs that rely heavily on case management (without judicial, probation, or other ongoing supervision). This pattern raises a question about the wisdom of prioritizing psychiatric service linkage if the chief goal is to reduce recidivism.

One might argue that the policy model is correct, but merely poorly implemented. That is, contemporary programs may be linking offenders with psychiatric services, but they will fail to meet the policy goal unless those psychiatric services are *effective*. Although intuitively appealing, this argument rests on little evidence. In rigorous experiments, even *evidence-based* mental health services that reliably affect clinical outcomes (i.e., ACT & Integrated Dual Diagnosis Treatment) do not affect criminal justice outcomes like arrest (e.g., Caslyn et al., 2005; Chandler & Spicer, 2006; Clark, Ricketts, & McHugo, 1999).

Moreover, in the few studies indicating that some contemporary programs are meeting the chief policy goal, Skeem et al. (in press) could find no evidence that recidivism reduction was mediated by mental health services or symptom improvement. For example, Skeem, Manchak, Vidal, and Hart (2009) have been studying the outcomes of 360 offenders with serious mental illness placed on either specialty mental health or traditional probation. The two samples of probationers have been rigorously matched, both methodologically and statistically, and followed for over one year. Compared to traditional probationers, specialty probationers received more treatment services, exhibited better treatment adherence, and were substantially less likely to have their probation revoked ($d=.74$). Nevertheless, trajectories of symptom change over one year were unrelated to the probability of revocation. Moreover, there were no differences between the two groups in the number of new crimes and new victims, based on within-offender changes in the number of arrests from the two years before- to the two years after probation placement. These findings resonate with others. Based on over 1,000 participants in a multi-site jail diversion study, Steadman, Dupius, and Morris (2009) found that no significant relationship between symptom reduction and the number of re-arrests over time.

Broadly, then, offenders who show symptom improvement during a program (for whatever reason) are no less likely to recidivate than those whose symptoms remain unchanged or worsen.

As a group, these studies suggest that the issue lies less in fidelity to the current policy model than in problems with the model itself. At a more fundamental level, additional research indicates that the availability, organization, and financing of psychiatric services in a given locale is unrelated to incarceration rates for individuals with mental illness (for a review, see Skeem et al., in press). In fact, there is little evidence that the risk of incarceration has uniquely increased for those with mental illness. Based on a careful analysis of living arrangements for people with serious and persistent mental illness (SPMI) in the U.S. from 1950 to 2000, Frank and Glied (2006) concluded, “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.

TOWARD A RESEARCH-INFORMED POLICY

The research reviewed above suggests that for most offenders with mental illness, the current focus on linkage with psychiatric services may poorly match the chief policy goal of reducing criminal behavior. Plausible alternatives to the direct cause model assume that the etiology of criminal behavior largely is shared by offenders with- and without-mental illness. In this section, we review evidence suggesting that these offender groups are more alike than different in their patterns of risk, and present a theory that links mental illness with criminal behavior. In the next section, we explain implications of this theory for developing policy that will better reduce recidivism for offenders with mental illness.

More Alike than Different

Particularly for offenders at high estimated risk of repeated criminal behavior, there is substantial overlap in contextual/distal risk factors and characterological/proximal risk factors between those with- and without- serious mental illness. This overlap is captured by a criminological perspective that spans sociological, economic, and psychological (including social psychological) disciplines.

Contextual/Distal Risk Factors

One dimension of similarity between offenders with- and without- mental illness involves exposure to contextual or distal risk factors. For example, individuals with a low position in the social hierarchy are at risk for crime and other deviant behavior. Poverty is an indicator of low social class. Poverty can force people to live with other marginalized citizens in settings rife with illegal substances, health problems, under- and un-employment, child abuse and neglect, domestic violence, family breakdown, and crime (Fisher & Drake, 2007). Thus, it may be that people with mental illness engage in criminal behavior “not because they have a mental disorder, but because they are poor. Their poverty situates them socially and geographically, and places them at risk of engaging in many of the same behaviors displayed by persons without mental illness who are similarly situated” (Fisher et al., 2006, p. 553).

Although poverty is but one of several distal risk factors, this contextual perspective enjoys some indirect empirical support. That is, offenders with mental illness are particularly likely to live in disadvantaged neighborhoods (Dickinger, Eno Loudon, Robinson, Troshynski, & Skeem, 2008), be under- or un-employed (see Prins & Draper, 2009), have histories of child abuse and victimization (Prins & Draper, 2009), abuse substances (Abram & Teplin, 1991; Abram et al., 2003), and associate with people who have criminal histories, drink heavily, and use drugs (Skeem, Eno Loudon, Manchak, Vidal, & Haddad, 2008).

Characterological/Proximal Risk Factors

A second dimension of shared risk is characterological or proximal risk factors for crime. From a social psychological perspective, criminal behavior largely is learned through patterns of early modeling and reinforcement, and maintained by proximate risk factors like criminal attitudes (e.g., Andrews & Bonta, 2006; Gendreau & Goggin, 1997). According to this perspective, people with mental illness engage in criminal behavior not because they are mentally ill, but because they have developed factors like “antisocial cognition, antisocial personality pattern, and substance abuse” (Andrews, Bonta, & Wormith, 2006, p. 10). Of course, one need not adopt this particular theoretical approach to recognize that there are strong individual, characterological, or “proximal” risk factors for criminal behavior. Although these factors may be caused by learning, it seems more plausible that they reflect an interaction between learning and innate tendencies or temperaments.

Painted broadly, this view enjoys some indirect support. That is, there is evidence that offenders with mental illness are at disproportionate risk of criminal behavior because they have even *more* proximal risk factors for recidivism than their relatively healthy counterparts. According to one model, the “big four” risk factors for crime are an established criminal history (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), and antisocial associates. Four additional, moderate risk factors include substance abuse, employment instability, family problems, and low engagement in prosocial leisure pursuits. Together, these risk factors have been called the “Central Eight” and are assessed in a risk-needs tool called the Levels of Services Inventory/Case Management Inventory (LS/CMI; Andrews, Bonta, & Wormith, 2004).

Based on a matched sample of 221 parolees with- and without- mental illness, Skeem et al. (2008) found that those with mental illness obtained significantly higher scores on the LS/CMI ($\eta^2 = .20$), particularly on the antisocial pattern subscale (e.g., early or diverse criminal behavior, criminal attitudes, pattern of generalized trouble). Similarly, based on a sample of 600 probationers, Girard and Wormith (2004) found that those with mental health problems ($n=169$) obtained higher scores on the LS/CMI than those without such problems. In turn, the LS/CMI predicts recidivism equally well for those with- and without mental illness (Andrews et al., 2004; Girard & Wormith, 2004), and perhaps better than risk assessment tools that reference clinical factors (Skeem et al., 2008). These LS/CMI results are in keeping with a finding 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, & Wolff, 2010).

As a more general point, when one isolates the policy-relevant group of high risk offenders, one obtains a relatively homogeneous group. This point is illustrated by Kroner, Mills, and Reddon (2005), who used a large sample of general offenders to examine their score patterns across on four alternative tools that often are applied to estimate recidivism risk. They found that (a) offenders’ scores on the alternative tools were strongly correlated (e.g., LSI-R & PCL-R, $r = .77$), and (b) new tools created by randomly selecting items from the original tools performed as well as the originals in predicting new convictions and revocations. This suggests that the instruments are interchangeable means of tapping overlapping risk factors (e.g., criminal history, antisocial lifestyle). Thus, high risk offenders (whether mentally ill or not) are likely to share robust risk factors for recidivism that can and should be targeted in supervision and intervention.

Theory: Three Pathways to Criminal Behavior

Skeem, Peterson, & Manchak (in press; see also Peterson, 2010) integrated the dominant psychiatric perspective (aka, direct cause model) with criminological perspectives to develop a provisional model to guide research and improve the effectiveness of correctional policy for offenders with mental illness. Their analysis suggests that those with serious mental illness follow one of three different pathways to criminal behavior.

For the small subgroup described earlier (appx. 1 in 10), mental illness directly causes criminal justice involvement. For example, paranoid delusions and acute feelings of threat may lead to assault of perceived persecutors. For this subgroup, the current policy focus on effective mental health services should be the solution. The vast majority, however, will fall in the two remaining subgroups. For these subgroups, mental illness does not directly cause criminal behavior. Instead, contextual and/or characterological are leading causal risk factors for crime that either fully mediate- or are independent of- the effect of mental illness. For them, the current policy focus will not effectively reduce recidivism risk. Potential foci for each subgroup are outlined below.

For the second subgroup, mental illness indirectly causes criminal behavior by exposing individuals to contextual risk factors for crime. Borrowing from the criminological perspectives outlined earlier, mental illness may lead to substance abuse and downward socioeconomic drift, exposing individuals to modeling and reinforcement patterns that establish proximal risk factors for crime like criminogenic attitudes. Similarly, the onset of psychosis during late adolescence may cause some to gravitate toward social networks and disadvantaged environments that model, reinforce, and create opportunity for criminal behavior. For the “indirect” subgroup, prevention efforts that target risk factors that lie directly downstream from mental illness (e.g., social-occupational dysfunction; substance abuse) may be most effective. If opportunities for

prevention are missed, intervention arguably should target proximate risk factors for criminal behavior. Why? The factors that caused criminal behavior may differ from those that maintain it. It seems unlikely that psychiatric services and symptom improvement will change “personal attitudes and values supportive of criminal behavior” (Bonta et al., 1998, p. 138).

For a third subgroup, mental illness is incidental to or independent of criminal behavior. Here, exposure to contextual and/or characterological risk factors would have occurred even if the individual was not mentally ill. For example, growing up in a chaotic, disadvantaged environment with an abusive parent may establish a hostile attributional style that leaves one prone to violence and other dysregulated behavior. Or, a disinhibited temperament combined with poor parenting and supervision may lead to criminal behavior. In both of these examples, criminogenic processes are independent of- and, at best, run parallel to- mental illness. For this group, evidence-based treatment for general offenders that targets criminal thinking and attitudes may be most effective for recidivism reduction.

As explained later, a major task for future research will be to identify the specific moderator(s) that differentiates the subgroup for whom the effect of mental illness on criminal behavior is direct vs. indirect/independent. A simple marker with promise is age of onset for criminal behavior. Those who begin antisocial behavior early in childhood, well before the onset of psychosis or other serious mental illness, may belong to the indirect or independent group. In contrast, those who begin criminal behavior after the onset of serious mental illness may belong to the direct group (see Hodgins, 2000). As explained by Silver (2006), “the heart of the distinction between early- and late-start offenders is that early start offenders are, from the beginning, more deeply embedded in and exposed to criminogenic risk factors both in themselves and in their social environments” (p. 700). For late starters, mental illness seems to

play a more causal role in offending. There is some support for this distinction, particularly for violent behavior (e.g., Swanson et al., 2007; for a review, see Hodgins, 2008).

IMPLICATIONS FOR SENTENCING AND PROGRAMS

Theory and evidence reviewed thus far suggest that contemporary policy for offenders with mental illness is too strongly driven by a “one size fits all” approach. Although linkage with psychiatric services is likely to reduce criminal behavior for a very small but important subgroup of offenders with mental illness, it is unlikely to do so for the vast majority. Most high risk offenders with mental illness share robust (and changeable) risk factors for crime with their relatively healthy counterparts. It may be that their most immediate pathways to criminal behavior are much the same as those without mental illness.

This raises three policy-relevant questions about this population. First, is the current “exceptionalist” approach appropriate, or should offenders with mental illness be more “mainstreamed” with other offenders? Second, what is the appropriate role of psychiatric treatment in policy for this population? Third, how can evidence-based correctional programs and principles be bridged to these offenders to reduce their risk? In this section, we address each question in turn.

To Divert or Not to Divert?

As noted earlier, many programs for this population in the US and beyond revolve around the concept of diversion. Diversion means “change,” “alteration,” or “departure.” Theoretically, diversion programs would release offenders from the criminal justice system and admit them to the mental health system. Practically, this rarely happens.

Arguably, diversion (in the true sense) is appropriate for only two small subgroups of offenders with mental illness. Legal mechanisms have long been in place to effect diversion for

the first subgroup of offenders. That is, individuals who are not criminally responsible for their actions because of mental illness are acquitted by reason of insanity and appropriately diverted from the criminal justice system. Diversion also seems appropriate for the small subgroup of offenders with mental illness who actually fit the current “direct cause” model. For these individuals, psychiatric symptoms have motivated criminal behavior (but perhaps not enough to meet the criteria for insanity) or become crimes themselves (e.g., psychotic behavior becomes ‘disturbing the peace’). Channeling these individuals out of the criminal justice system and into mental health treatment arguably amounts to correcting a system “sorting error.” Providing them with effective psychiatric treatment should ameliorate what was masquerading as criminal behavior.

For the vast majority of offenders with mental illness, however, the notion of diversion does not seem particularly appropriate. If these offenders’ criminal actions reflect risk factors that are shared with their relatively healthy counterparts and will not be effectively addressed through psychiatric treatment, then it is senseless to “divert” them from the criminal justice system to the mental health system. Here, “diversion” simply seems a misnomer for mandated treatment. Rather than signaling immediate egress from the criminal justice system, it signals that psychiatric treatment is going to be mandated within the correctional system. The goal is more to recognize that offenders are mentally ill and need appropriate treatment than to leverage them out of correctional supervision altogether. Remarkably, most “jail diversion” programs in the US are post-booking programs that mandate treatment within the correctional system. Arguably, it would make sense to stop calling these “diversion” programs.

What Role Should Psychiatric Treatment Play?

Like the direct cause model itself, the role of psychiatric treatment in policy for this population should be contextualized, not jettisoned. Although effective mental health services will reduce criminal behavior for only a small minority of offenders with serious mental illness, we believe that they all should receive such services. First, even if mental health services have no effect on recidivism, they may achieve crucial public health outcomes for this group (e.g., reducing symptoms, substance abuse, and hospitalization). For example, an ACT team may not reduce recidivism, but is quite likely to reduce repeated hospitalizations. Second, prisoners have a constitutional right to adequate health care, including mental health care (*Estelle v. Gamble*, 1976; *Ruiz v. Estelle*, 1980). For probationers and parolees, we assume that sentencing bodies will continue mandating psychiatric treatment when mental illness has been identified (see Skeem & Eno Loudon, 2008). Third, and perhaps most importantly, correctional intervention programs have been shown to be more effective in reducing recidivism when services are *responsive* to the abilities, styles, and needs of offenders (see Andrews, et al., 2006). Effective psychiatric treatment may complement correctional treatment by, for example, reducing hallucinations that interfere with an offender's ability to attend to, and benefit from, cognitive behavioral sessions that target criminal thinking. Regardless of whether the relationship between an offenders' mental illness and criminal behavior is direct, indirect, or independent, psychiatric treatment can play some role in correctional interventions.

How Can we Better Leverage (or Make Explicit) Evidence-Based Corrections?

Correctional policy for offenders with mental illness should not stop at linkage with psychiatric services because doing so will fail to meet the chief policy goal for the vast majority (perhaps 90%) of that population. Beyond sharing risk factors for criminal behavior with their relatively healthy counterparts, there is preliminary evidence that (as a group) offenders with mental illness

respond to similar principles of risk reduction. Earlier, we mentioned randomized controlled trials indicating that ACT and IDDT do not meaningfully improve criminal justice outcomes. Given such results, scholars have cautioned that positive outcomes observed for evidence-based mental 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” (Calsyn et al., 2005, p. 245).

Adapting Formal Evidence-Based Correctional Programs

Correctional principles and interventions that have been shown to reduce criminal behavior among general offenders are readily available. In particular, cognitive behavioral treatment (CBT) that explicitly targets criminal thinking is consistently ranked “in the top tier with regard to effects on recidivism” (Lipsey & Landenberger, 2006, p. 57). Although several specific brands of CBT are available (e.g., “Reasoning and Rehabilitation,” “Moral Reconnection Therapy,” “Thinking for a Change”), they all seem to be about equally effective in reducing recidivism (Aos et al., 2006; Landenberger & Lipsey, 2005).

Remarkably, Skeem et al. (in press) could locate only *one* small controlled outcome study for offenders with mental illness that included any emphasis on “criminal thinking.” Specifically, Sacks, Sacks, McKendrick, Banks, & Stommel (2004) studied a subsample of these offenders who had participated in a prison-based therapeutic community program in the U.S. Of these offenders, 43 chose to complete a residential “aftercare” program in the community and 32 did not. The aftercare program was intensive and multidimensional, targeting mental illness, substance abuse, unemployment, and criminal thinking. Over one year, those who chose the aftercare group were less likely to be reincarcerated than those who did not (5% vs. 16%). Although these results seem promising, the possibility of selection bias prevents any conclusion

that the program reduced recidivism. Moreover, the multidimensional nature of the program prevents attribution of any recidivism reduction to reduced criminal thinking.

Only one “true” or more narrowly packaged CBT program for offenders with mental illness has been systematically studied. The program is Reasoning and Rehabilitation-2 for Mentally Disordered Offenders (Young & Ross, 2007). Although it was adapted to be responsive to the cognitive limitations of some offenders with mental illness, it retains validated techniques like relapse prevention to target general criminogenic needs (e.g., criminal values, impulsivity, hostility). Although each has methodological problems, four small controlled studies conducted on inpatient forensic psychiatric units in the UK and Germany provide preliminary evidence that this program increases motivation to change and reduces criminal thinking. Antonowicz (2002) reviews the three smallest studies (treatment group, $n < 15$). In the fourth study, Young, Chick, & Gudjonsoon (2010) compared 22 offenders with mental illness who completed this CBT program (out of 34 who began the program) with 12 wait-list controls. The authors found that the CBT group showed greater reductions in both pro-violence attitudes and disruptive behavior on the unit than the control group. Sadly, the effect of this CBT treatment on the outcome of interest (i.e., recidivism) is unknown; all investigations to date have focused on inpatient forensic wards. In future research and practice, it will be vital to examine the extent to which CBT treatment reduces criminal behavior for offenders with mental illness, compared to psychiatric “treatment as usual.”

Making Evidence-Based Correctional Principles Explicit

The nature and prevalence of programs for offenders with mental illness in the US, UK, and Australasia is unclear. A survey that described these programs would be helpful. In the absence of such a survey, the literature seems to suggest that *formal CBT programs* are rarely

applied to offenders with mental illness...particularly in the US, and particularly in community settings. Nevertheless, there is evidence that *informal principles* of evidence-based corrections sometimes infiltrate programs for offenders with mental illness...even in community-based programs in the US driven by the direct cause model. 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 these principles explicit, practice them consistently, and evaluate their effect on recidivism. We suspect that existing programs work with this population— when they work -- in some of the same ways that programs for general offenders work.

What is the preliminary evidence that these principles have infiltrated programs driven by the dominant ‘direct cause’ model? In the study of 360 probationers with mental illness described above, Skeem et al. (2009) found that the effect of specialty mental health probation in reducing revocation was fully explained by the quality of officer-probationer relationships (not by symptom reduction, as the model that drives the program would assume). Specifically, “firm but fair” officer-probationer relationships characterized by caring, fairness, trust, and an authoritative (not authoritarian) style significantly protected against both re-arrest and revocation over a one-year period (see also Skeem, Eno Loudon, Polaschek, & Camp, 2007). This finding is in keeping with the general literature on offenders, where some describe such relationships as the most important component of effective correctional practice. In one meta-analysis, Dowden and Andrews (2004) found that staff behaviors that are predictive of outcome include conveying an enthusiastic, warm and personally respectful style, making program rules clear and exerting their authority without being authoritarian, frequently praising offenders for prosocial behavior,

and structuring offender learning into concrete, graded steps. Moderate to large correlations resulted when programs incorporated some of these characteristics, compared to none.

It may also be the case that some staff intuitively target criminogenic needs, or changeable risk factors that relate closely to crime, rather than focus exclusively on mental health. My encounters with practitioners across the US provide some anecdotal accounts of staff members in mental health courts and other programs who “naturally” target factors that really get an offender in trouble (e.g., hanging out with her drug dealing cousin). To the extent that they do so, they are (accidentally) applying a well-validated principle of effective correctional treatment called the “need” principle (Lowenkamp et al., 2006; Lowenkamp, Pealer, Smith, & Latessa, 2006). The effectiveness of correctional programs in reducing recidivism is positively associated with the number of criminogenic needs they target (i.e., dynamic risk factors for crime, like procriminal attitudes), relative to noncriminogenic needs (i.e., disturbances that impinge on an individual’s functioning in society, like depression; Andrews et al., 2006). Because mental illness is a criminogenic need for only about 1 in 10 offenders with serious mental illness (i.e., those in the “direct” subgroup), it seems important to target stronger risk factors for crime.

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% of meetings), they also discussed supervisees’ criminogenic needs, including attitudes supportive of crime (36% of meetings). In research with general offenders, Bonta et al. (2008) found that the amount of time officers spent discussing criminogenic needs was inversely related to the risk of recidivism.

The Message

Although there is evidence that a few programs for offenders with mental illness occasionally “work” to reduce recidivism, there is no evidence that they do so for the reasons assumed (Skeem et al., in press). An important goal for future research is to identify the mechanisms by which programs reduce recidivism. 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). The current wealth of program operationalizations only underscores the need to identify change mechanisms and bring greater parsimony to the field. This is essential for developing model programs that can be widely disseminated. At a more local level, in today’s economic environment, policymakers should insist on knowing why programs work because this will enable them to streamline programs while protecting their most essential elements.

CONCLUSION

To establish more effective policies for this population, it seems necessary to avoid approaching mental illness as the “master status” that uniformly defines it, and begin to attend to the criminogenic risk factors and needs that are shared with other high risk offenders. Serious mental illness may relate directly, indirectly, or not at all to criminal behavior. This chapter provides a theoretical model to test in future research that can help shape policy toward recidivism reduction for this group as a whole.

REFERENCES

- Abram, K., & Teplin, L. (1991). Co-occurring disorders among mentally ill jail detainees: Implications for public policy. *American Psychologist, 46*, 1036–1045.
- Abram, K., Teplin, L., & McClelland, G. (2003). Co-morbidity of severe psychiatric disorders and substance use disorders among women in jail. *American Journal of Psychiatry, 150*, 1007-1010.
- Andrews, D. A., & Bonta, J. (2006). *The psychology of criminal conduct* (4th ed.). Newark, NJ: LexisNexis.
- Andrews, D.J., Bonta, J., & Wormith, S. (2004). *The Level of Service/Case Management Inventory (LS/CMI)*. Toronto: Multi-Health Systems.
- Andrews, D., Bonta, J., & Wormith, S. (2006). The recent past and near future of risk and/or need assessment. *Crime and Delinquency, 52*, 7-27.
- Antonowicz, D.H. (2005) The reasoning and rehabilitation programme: Outcome evaluations with offenders. In M. McMurrin & J. McGuire, (Eds.), *Social problem solving and offending: Evidence, evaluation and evolution* (pp. 163-181). Chichester, UK: John, Wiley, & Sons.
- Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based adult corrections programs: What works and what does not*. Olympia: Washington State Institute for Public Policy.
- Beyond Bars Alliance (2007). *Mental illness and the criminal justice system*. Downloaded July 18, 2010 at <http://www.beyondbars.org.au/facts.htm>
- Bonta, J., Law, M., & Hanson, C. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin, 123*, 123–142.

- Bonta, J., Rugge, T., Scott, T.L., Bourgon, G., & Yessine, A.K. (2008). Exploring the black box of community supervision. *Journal of Offender Rehabilitation, 47*(3), 248-270.
- Buchanan, A. (2008). Risk of violence by psychiatric patients: Beyond the “actuarial versus clinical” assessment debate. *Psychiatric Services, 59*, 184-190.
- 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>.
- Calsyn, R., Yonker, R., Lemming, M., Morse, G., & Klinkenberg, D. (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., & Spicer, G. (2006). Integrated treatment for jail recidivists with co-occurring psychiatric and substance use disorders. *Community Mental Health Journal, 42*, 405-425.
- Clark, R., Ricketts, S., & McHugo, G. (1999). Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatric Services, 50*, 641-647.
- Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. Retrieved on March 13, 2008 from <http://www.consensusproject.org>.
- Dickinger, E., Eno Loudon, J., Robinson, J., Troshynski, E., & Skeem, J. (2008, March). The effect of individual-and neighborhood-level characteristics on recidivism for parolees with mental disorder. In S. Manchak (chair), *Offenders with mental illness in community corrections*. Symposium conducted at the annual meeting of the

American Psychology-Law Society, Jacksonville, FL. Available at:

<https://webfiles.uci.edu:443/skeem/Downloads.html>

Douglas, K., Guy, L., & Hart, S. (2009). Psychosis as a risk factor for violence to others: A meta-analysis. Unpublished manuscript under review.

Dowden, C., & Andrews, D.A. (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., Wilson, A., & Pogorzelski, W. (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.

Eno Louden, J. & Skeem, J. (in press). Parolees with mental disorder: Toward evidence-based practice. *Bulletin of the Center for Evidence-Based Corrections*.

Eno Louden, J., Skeem, J. L., Camp, J., Vidal, S., & Peterson, J. (2010). Supervision practices in specialty mental health probation: What happens in officer-probationer meetings? Manuscript under review.

Fazel, S., & Danesh, J. (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., & Drake, R. (2007). Forensic mental illness and other policy misadventures: Commentary on "extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions." *Community Mental Health Journal, 43*, 545-548.

- Fisher, W., Silver, E., & Wolff, N., (2006). Beyond criminalization: Toward a criminologically informed framework for mental health policy and services research. *Administration and Policy in Mental Health, 33*, 544-557.
- Frank, R., & Glied, S. (2006). *Mental health policy in the United States since 1950: Better but not well*. Baltimore, MD: The Johns Hopkins University Press.
- Gendreau, P., & Goggin, C. (1997). Correctional treatment: Accomplishments and realities. In P. Van Voorhis, M. Braswell, & D. Lester (Eds.), *Correctional counseling and rehabilitation (3rd Ed.)*. Cincinnati, OH: Anderson.
- Girard, L., & Wormith, J. (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
- Hodgins, S. (2000). The etiology and development of offending among persons with major mental disorders. In S. Hodgins (Ed.), *Violence among the mentally ill* (pp. 89–116). Dordrecht: Kluwer.
- Hodgins S. (2008). Violent behaviour among people with schizophrenia: A framework for investigations of causes, and effective treatment, and prevention. *Philosophical Transactions of the Royal Society of London, 363*, 2505–2518.
- Junginger, J., Claypoole, K., Laygo, R., & Cristiani, A. (2006). Effects of serious mental illness and substance abuse on criminal offenses. *Psychiatric Services, 57*, 879-882.
- Kazdin, A.E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review in Clinical Psychology, 3*, 1-27.

- Keiser, G. (2009, July). Program design elements and principles of effective community corrections responses. Invited panel presented at the Bureau of Justice Assistance Technical Assistance and Training Event for National Grantees (Washington, DC).
- Kroner, D.G., Mills, J.F., & Reddon, J.R. (2005). A coffee can, factor analysis, and prediction of antisocial behavior: The structure of criminal risk. *International Journal of Law and Psychiatry, 28*, 360-374.
- Lamb, H., & Weinberger, L. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services, 49*, 483-492.
- Landenberger, N., & Lipsey, M. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology, 1*, 451-476.
- Lipsey, M. W., & Landenberger, N. A. (2006). Cognitive-behavioral interventions. In B. C. Welsh & D. P. Farrington (Eds.). *Preventing crime: What works for children, offenders, victims, and places*. Dordrecht, Netherlands: Springer, pp. 57-71.
- Lovell, D.L., Johnson, L.C., & Kane, K.C. (2007). Recidivism of supermax prisoners in Washington State. *Crime and Delinquency, 53*, 633-656.
- Lowenkamp, C., Latessa, E., & Holsinger, A. (2006). The risk principle in action: What have we learned from 13,676 offenders and 97 correctional programs? *Crime and Delinquency, 52*, 77-93.
- Lowenkamp, C., Pealer, J., Smith, P., & Latessa, E. (2006). Adhering to the risk and need principles: Does it matter for supervision-based programs. *Federal Probation, 70*, 3-8.

- Monahan, J., Steadman, H., Appelbaum, P., Grisso, T., Mulvey, E., Silver, E., et al. (2001). *Risk assessment: Violence and mental disorder*. Oxford, UK: Oxford University Press.
- Morgan, R. Fisher, W., & Wolff, N. (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](http://www.cbhs-cjr.rutgers.edu/pdfs/Policy%20Brief%20April%202010.pdf).
- Morrissey, J., Meyer, P., & Cuddeback, G. (2007). Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal*, 43, 527-544.
- Mullen, P.E. (2001). *Mental health and criminal justice: A review of the relationship between mental disorders and offending behaviours on the management of mentally abnormal offenders in the health and criminal justice services*. Melbourne, Australia: Criminology Research Council.
- Osher, F., & Steadman, H. (2007). Adapting evidence-based practices for person with mental illness involved with the criminal justice system. *Psychiatric Services*, 58, 1472-1478.
- Peterson, J.K., Skeem, J.L., Hart, E., Vidal, S., & Keith, F. (in press). Comparing the offense patterns of offenders with and without mental disorder: Exploring the criminalization hypothesis. *Psychiatric Services*.
- Prins, S.J., & Draper, L. (2009). *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.

- Quinsey, V., Harris, G., Rice, M., & Cormier, C. (2006). *Violent Offenders: Appraising and Managing Risk (2nd Ed.)*. Washington, DC: American Psychological Association.
- Rethink & Sainsbury Centre for Mental Health (2010). *The Diversion Dividend: Interim Report*. Downloaded July 18, 2010 at http://www.scmh.org.uk/pdfs/Diversion_Dividend.pdf
- Sacks, S., Sacks, J., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified therapeutic community for MICA offenders: Crime outcomes. *Behavioral Sciences and the Law*, 22, 477-501.
- Silver, E. (2006). Understanding the relationship between mental disorder and violence: The need for a criminological perspective. *Law and Human Behavior*, 30, 685-706.
- Skeem, J., & Eno Louden, J. (2008, March). Mandated treatment as a condition of probation: Coercion or contract? In A. Redlich (Chair), *Understanding in mandated community treatment*. 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., Eno Louden, J., Manchak, S., Vidal, S., & Haddad, E. (2008). Social networks and social control of probationers with co-occurring mental and substance abuse problems. *Law and Human Behavior*, 33, 122-135.
- Skeem, J., Eno Louden, J., Polaschek, D., & Camp, J. (2007). Relationship quality in mandated treatment: Blending care with control. *Psychological Assessment*, 19, 397-410.
- Skeem, J., Manchak, S., Johnson, T., & Gillig, B. (2008, March). Comparing specialty and traditional supervision for probationers with mental illness. Paper presented at the

American Psychology and Law Society (AP-LS) Annual Conference, Jacksonville, FL.

Available at: <https://webfiles.uci.edu:443/skeem/Downloads.html>

Skeem, J. L., Manchack, M. Peterson, J.P. (in press). Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction. *Law and Human Behavior*.

Skeem, J., Manchak, S., Vidal, S., & Hart, E. (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>

Steadman, H., Dupius, S., & Morris, L. (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., Osher, F.C., Robbins, P.C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60, 761-765.

Swanson, J.W., Van Dorn, R.A., Swartz, M.S., Smith, A., Elbogen, E., Monahan, J. (2008). Alternative pathways to violence in persons with schizophrenia: The role of childhood antisocial behavior problems. *Law & Human Behavior*, 228-240.

Toch, H., & Adams, K. (2002). *Acting out: Maladaptive behavior in confinement*. Washington DC: American Psychological Association.

Torrey, W.C., Drake, R.E., Cohen, M., Fox, L., Lynde, D., Gorman, P., et al. (2002). The challenge of implementing and sustaining integrated dual disorders treatment programs. *Community Mental Health Journal*, 38, 507-521.

Young, S., Chick, K, & Godjonsson, G. (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*, 1-14

Young, S. J., & Ross, R. R. (2007) *R&R2 for youths and adults with mental health problems: A prosocial competence training program*. Ottawa: Cognitive Centre of Canada.