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Executive Summary

This executive summary reports on research and literature on adult and juvenile offenders who are diagnosed with serious mental illness. This summary highlights the most significant findings contained in the full version of the report *Treating Offenders with Mental Illness: A Review of the Literature*.

National Rates of Mental Illness

According to a Report of the Surgeon General (U.S. Department of Health and Human Services, 1999), one in five adults in the United States (U.S.) have a diagnosable mental illness over the course of one year, making the annual prevalence rate in the U.S. is approximately 20%. The report indicated 5.4% of adults have a diagnosis of a serious mental illness (Kessler, 1996, as cited in U.S. Department of Health and Human Services, 1999), where serious mental illness was defined as, “at least one 12-month DSM[III-R] disorder other than substance use disorders, and to have serious impairment” (Kessler, Berglund et al. 1996, p. 60). The report further specified individuals with a serious and persistent mental illness (SPMI) to be at an annual prevalence rate of 2.6% (National Advisory Mental Health Council, 1993, as cited in U.S. Department of Health and Human Services, 1999) and defined SPMI as, “schizophrenia, bipolar, other severe forms of depression, panic disorder, and obsessive-compulsive disorder” (p. 46). More recently, the National Survey on Drug Use and Health found approximately 5% of adults in the U.S. have a serious mental illness diagnosis (National Institute of Mental National Institute of Mental Health 2008). This survey defined serious mental illness as “a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders), diagnosable currently or within the past year, of sufficient duration to meet diagnostic criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities” (p. 1).

Rates of Adult Offenders with Mental Illness

There are variations in the reported rates of individuals with mental health disorders involved in the criminal justice system. For example, the Bureau of Justice Statistics reported 56% of inmates in state prisons, 45% of inmates in federal prison, and 64% inmates in jails had a ‘recent history’ or ‘symptoms’ of a mental health disorder (James and Glaze 2006). Steadman, Osher et al. (2009) pointed out, this report is often “mistakenly cited as evidence of an escalating problem,” despite the fact that, “the methods used in this study are not consistent with other efforts to establish the prevalence of mental illness in jails” (p. 761), as functional impairment and duration of symptoms were not assessed and symptoms as a result of a general medical condition or bereavement were included.

Steadman, Osher et al. (2009) administered the Structured Clinical Interview for DSM-IV (SCID) to 822 jail inmates and found 14.5% of males and 31.0% of females qualified for a diagnosis of a serious mental illness, which included major depressive disorder, depressive disorder not otherwise specified, schizophrenia spectrum disorder, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, delusional disorder, and psychotic disorder not otherwise specified. Steadman and colleagues asserted these findings were similar to those found by Fazel and Danesh (2002), who conducted a meta-analysis that included prisoners in 12 countries and found approximately 3.7% of male inmates and 4% of female inmates were diagnosed with a psychotic illness and 10% of male inmates and 12% of female inmates had a diagnosis of major depression. They conclude, “approximately one in seven prisoners in western countries have a psychotic illness or major depression” (p. 548).

Rates of Juvenile Offenders with Mental Illness

Studies vary significantly on estimated the rates of juvenile offenders with mental illness (Fazel, Doll et al. 2008); as with adult prevalence rates, this is likely due to methodological differences in the research studies. Recent studies have estimated the prevalence of juvenile offenders who have at least one diagnosable mental illness (including anxiety disorders, affective/mood disorders, disruptive/conduct disorders, and substance use disorders) to be between 67% to 72% (Teplin, Abram et al. 2002; Robertson, Dill et al. 2004; Wasserman, Ko et al. 2004; Shufelt and Coccozza 2006; Skowya and Coccozza 2007; Vincent, Grisso et al. 2008). Research on the severity of the mental disorders observed in juvenile offender samples is tenuous. Nevertheless, Coccozza, Skowya and Shufelt (2010) estimated 27% of youth placed in juvenile justice settings suffer from lowered levels of functioning as a result of severe mental illness and based on prevalence rates in the general population. Overall, researchers estimate the prevalence rates of mental illness found in juvenile justice involved youth is approximately two times as high as the general adolescent population (Robertson, Dill et al. 2004).

Why is the Treatment of Offenders with Mental Illness Important?

There is growing concern that offenders with mental illness are disproportionately represented in the criminal justice system (Arons 2000; Duncan, Nicol et al. 2006; Hartford, Carey et al. 2006; Epperson, Wolff et al. 2011; Scott, McGilloway et al. n.d.). In addition to disproportionate

representation, researchers have found offenders with serious mental illness transitioning out of incarceration are twice as likely to have their probation or parole revoked (Prins and Draper 2009), are at an elevated risk for rearrest, incarceration, and homelessness (Kesten, Leavitt-Smith et al. 2011), lack skills to obtain and sustain employment (Wolff, Epperson et al. 2010), and have higher rates of medical problems (Center for Substance Abuse Treatment, 1995, as cited in Kleinpeter, Deschenes et al. 2006).

Some researchers have asserted adults with serious mental illness are ‘criminalized’ due to a lack of available treatment in mental health settings (Walsh and Holt 1999; Teplin 2000; Lurigio 2001; Lamb, Weinberger et al. 2004; Hartford, Carey et al. 2006; Soderstrom 2007; Ryan, Brown et al. 2010; Lange, Rehm et al. 2011). However, others have pointed out there is insufficient empirical evidence to draw this conclusion (Morabito 2007; Epperson, Wolff et al. 2011; Prins 2011; Skeem, Manchak et al. 2011). Regardless of the process by which mentally ill adults come into contact with the criminal justice system, offenders with mental illness span the boundaries of both the criminal justice and mental health systems. For example, Buck, Brown et al. (2011) note a jail in Texas is the “largest provider of mental health beds” in the state and is one of the largest in the nation, second only to Los Angeles County Jail (p. 120). Unfortunately, problems such as this have led to a lack of clarity as to which system should be held clinically and financially responsible these individuals (Wolff 1998).

Researchers also cite a legal (Cohen 2008) and ethical responsibility (Blackburn 2004) to treat incarcerated offenders with mental illness. Citing federal court decisions and the Eighth Amendment’s ban on cruel and unusual punishment, Cohen (2008) wrote, “the duty to provide medical or psychological care is preventative and ameliorative, and emphatically includes an obligation to relieve pain, prolong life, and stabilize (if not cure) the malady” (Cohen 2008, p. 2-3). The author went on to state the “right to treatment, at least for serious disorders, would be meaningless without an additional duty to provide diagnosis. Similarly, the Juvenile Justice and Delinquency Prevention Act (as cited in Penner, Roesch et al. 2011) requires programs to meet the mental health needs for juveniles who are incarcerated to receive federal funding and avoid litigation if failure to provide such services causes serious harm.

What is the Relationship Between Mental Illness and Criminal Offending?

Research seems to suggest that there is an association between mental illness and criminal conduct given the higher arrest rates of offenders with mental illness (Hodgins 1998), particularly in violent offending (Link, Andrews et al. 1992; Hodgins, Mednick et al. 1996; Mullen, 2000 as cited in Mullen 2002; Arnold-Williams, Vail et al. 2008; Large, Smith et al. 2009). Others have proposed that the relationship between mental illness and violent offending is not as a result of simply having a mental health diagnosis, rather, having a mental health disorder with active psychotic symptoms (National Institute of Justice Research Preview, 1996, as cited in The Sentencing Project, 2002).

These conflicting findings have led some researchers to believe the answer is more complicated than a causative relationship (Hodgins, 2002; Fazel and Grann 2006; Fisher and Drake 2007; Epperson, Wolff et al. 2011). Pallone (1991) suggested, “A more moderate approach might grant that some portion of those who commit serious crimes are indeed *seriously* mentally disordered, quite apart from whether a specific mental disorder is related to the particular criminal behavior at hand in any way that can reasonably be said to be ‘causative’” (p. 6). As an example, a systematic review and meta-analysis conducted by Large, Smith et al. (2009), found the number of homicides committed by individuals with schizophrenia to be “associated with the rates of other homicides” in a geographic area (p. 127). The authors suggested there appears to be a relationship between schizophrenia and homicide; however, they posited the relationship does not appear to be causative and more likely due to social factors that influence violence in general, including substance abuse and low socio-economic status, which may disproportionately affect individuals with this diagnosis.

Bonta, Law et al. (1998), conducted a meta-analysis to greater understand what factors predicted recidivism in offenders with mental illness. The researchers found the factors that predict criminal offending in offenders with mental illness are similar to that of general offenders, including criminal history, antisocial personality, substance abuse, and family dysfunction. The results of this research has some to advocate treating offenders with mental illness similarly to non-mentally ill offenders (Harris and Rice 1997; Andrews and Bonta 2006; Skeem, Manchak et al. 2011). That is, offender treatment should always target criminogenic needs and address mental health needs as necessary. One such treatment model with a large evidence base in treating criminal offenders is the Risk-Need-Responsivity model.

Framework for the Treatment of Criminal Offenders

Psychological, social, and environmental risk factors found through research to be associated with criminal offending must be targeted in offender treatment. The Risk Need Responsivity (RNR) model is a research-based framework for treating offenders (Rice and Harris 1997; Andrews and Bonta 2006; Epperson, Wolff et al. 2011). The full RNR model has 15 principles, which can be used by agencies and practitioners in program design and treatment planning. The three core principles of RNR should underscore all elements of offender treatment.

The first core principle is the ‘Risk Principle.’ The risk principle first states that an individual’s propensity or risk to engaging in future criminal behavior can be predicted and that prediction of risk should be done using validated risk measures. These risk assessments, like the Level of Service Inventory (LSI-R), have undergone extensive research and demonstrate an acceptable level of validity. The risk principle also states the intensity of interventions and treatment should match the level of risk. This means for a low-risk offender “minimal or no intervention” is sufficient, while high-risk offenders will require “intensive and extensive services” (Andrews and Bonta 2006, p. 48). Additionally, higher-risk offenders should be given priority treatment over lower-risk offenders. It is of note, when intensive services are provided to low-risk individuals, the services are likely to have a negative effect on the individual (Rice and Harris 1997).

The second core principle is the ‘Criminogenic Need Principle.’ The authors refer to needs as “problematic circumstances” that are troubling to an individual (Andrews and Bonta 2006, p. 49). These risk and need factors are referred to as the ‘Central Eight,’ with the first four, or ‘Big Four,’ having the greatest impact on recidivism, and the second four, or ‘Moderate Four,’ have a slightly less, but still impactful relationship with future criminal behavior. These targets include:

1. History of Antisocial Behavior. For this risk factor, the dynamic need to be targeted in treatment is, “building up new noncriminal behaviors in high-risk situations and build self-efficacy beliefs supporting reform” (p. 58).
2. Antisocial Personality Pattern. This is described as “impulsive, adventurous pleasure-seeking, generalized trouble (multiple persons, multiple settings), restlessly aggressive, callous disregard for others” (p. 58). For this risk factor, the dynamic need

- to be targeted in treatment is, “weak self-control skills, weak anger management skills, and poor problem solving skills” (p. 58).
3. **Antisocial Cognition.** This includes “attitudes, values, beliefs, rationalizations, and a personal identity that is favorable to crime” (p. 59). For this risk factor, the dynamic need to be targeted in treatment is, “reduction of antisocial thinking and feeling and through building and practicing of less risky thoughts and feelings” (p. 59).
 4. **Antisocial Associates.** This includes, “both association with procriminal others and relative isolation from anticriminal others” (p. 59). For this risk factor, the dynamic need to be targeted in treatment is, “...reduce association with procriminal others and enhance association with anticriminal others” (p. 59).
 5. **Family/Marital Circumstances.** This includes, “poor-quality relationships in combination with neutral expectations with regard to crime and procriminal expectations. For this risk factor, the dynamic need to be targeted in treatment is, “Strong nurturance and caring in combination with strong monitoring and supervision” (p. 59).
 6. **School/Work.** This includes, “low levels of performance and involvement and low levels of rewards and satisfactions” (p. 59). For this risk factor, the dynamic need to be targeted in treatment is, “Enhance performance, involvement, and rewards and satisfactions” (p. 59).
 7. **Leisure/Recreation.** This includes, “Low levels of involvement and satisfaction in anti-criminal leisure pursuits” (p. 59). For this risk factor, the dynamic need to be targeted in treatment is, “Enhance involvement and rewards and satisfactions” (p. 60).
 8. **Substance Abuse.** This includes, “problems with alcohol and/or other drugs (p. 60). For this risk factor, the dynamic need to be targeted in treatment is, “Reduce substance abuse, reduce personal and interpersonal supports for substance-oriented behavior, enhance alternatives to substance abuse” (p. 60).

The final core principle is the ‘General Responsivity Principle.’ Responsivity is defined as delivering a program or curriculum in a manner that matches the learning style and ability of the target audience. General responsivity means a program should use methods of delivery that are known to be most effective. The authors wrote, “the most powerful influence strategies available are cognitive-behavioral and cognitive social learning,” which includes strategies such as,

“modeling, reinforcement, role playing, skill building, modification of thoughts and emotions through cognitive restructuring, and practicing new, low-risk alternative behaviors over and over again in a variety of high-risk situations until one gets very good at it” (Andrews and Bonta 2006, p. 50).

Closely related to general responsivity is the ‘Specific Responsivity Principle.’ Specific responsivity is a concept which means treatment should be matched to the recipients’ individual characteristics, including personality and cognitive style. For example, it may not be appropriate to put an offender with social phobia or extreme anxiety in a large group, or to put an individual with low intelligence or a learning disorder in a group that uses a high amount of didactic or written material alone. Other responsivity factors which the authors noted are important to consider when delivering treatment include interpersonal sensitivity, anxiety, verbal intelligence, cognitive maturity, and level of motivation for treatment (Andrews and Bonta 2006, pp. 50-51).

Responsivity factors specific to a mentally ill population can include mental health symptoms, if those symptoms interfere with treatment, cognitions, or motivation for change. For example, Epperson, Wolff et al. (2011), wrote, “some risks may not be addressable until others are managed through therapeutic intervention. For example, intervening to change antisocial cognitions would not make sense if an offender is actively psychotic, experiencing seizures, or intoxicated” (p. 13). Other problems that impact the severely mentally ill are homelessness, victimization, poverty, substance abuse, and unemployment. These will be an important responsivity factors to address in treating mentally ill offenders. For example, researchers have found contact with treatment providers is often disrupted in mentally ill homeless populations (Hartford, Carey et al. 2007).

Utilizing the RNR model with offenders with mental illness requires the modification of the typical offender rehabilitation program. The model offers the individualized adaptation of interventions and through responsivity factors. Responsivity factors are especially salient with the mentally ill population and require good screening and assessment of mental illness and substance abuse problems throughout the points of contact within the correctional system. Better screening and identification would allow for correctional programs to appropriately remediate mental health issues that may interfere with rehabilitation efforts and improve outcomes. For example, an offender may present to a probation officer as agitated, resistive to treatment, and

unmotivated to change. If this offender were to be screened using a validated depression screening instrument it may be found he or she is depressed and recommend cognitive behavioral therapy or medication. Once appropriately treated, it is likely the offender's agitation, motivation, and resistance (all symptoms of depression) would change making them more amenable to treatment that targets their criminogenic needs.

Best Practice Recommendations

The following best practice recommendations are derived from this review and synthesis of the literature on mentally ill offenders. These recommendations are applicable to the management and treatment of mentally ill offenders in both adult and juvenile justice systems.

1. Collaboration between criminal justice and mental health agencies is necessary to meet the needs and goals of the respective systems and to provide comprehensive treatment of offenders with serious mental illnesses. This can include working together on interdisciplinary teams, developing agreed upon roles and responsibilities, and developing complementary goals.
2. Continuity between placements and points of contact in the criminal justice and mental health system is recommended. This may include wraparound services, specialized aftercare planning, information sharing agreements, or specialized case managers as "boundary spanners" who work to transition offenders between programs and the criminal justice and the mental health system.
3. Diversion and community-based treatment should be utilized whenever possible with all criminal offenders, but it may be especially important with mentally ill offender due to the particularly adverse effects of jail and prison on the severely mentally ill. Programs that use assertive community outreach, club-house models, and specially trained probation/parole officers and case managers are especially promising for use with mentally ill offenders.
4. Staff in both criminal justice and mental health organizations should be cross-trained on the relevant needs and goals of the respective systems. This should include training on criminogenic needs, responsivity factors, signs and symptoms of serious mental illness, and strategies for working with offenders who have serious mental illness.

5. Screening and assessment of criminal risk, mental health, and substance abuse issues should be completed at each point in contact in the criminal justice system. Information gained from these screening and assessment tools should be used to inform the level and type of treatment needed for each individual.
6. Treatment should include a focus on criminogenic needs, which can reduce the risk of future criminal behavior and further penetration into the criminal justice system.
7. Mental health stabilization and treatment must be provided to mentally ill offenders throughout the criminal and juvenile justice system. This will facilitate the offenders' participation in treatment for criminogenic needs and overall rehabilitation.
8. Treatment for offenders should be comprehensive, multi-systemic, and psychotherapeutic interventions should be cognitive behavioral or cognitive social learning and include interventions such as modeling, reinforcement, role-playing, skill building, and cognitive restructuring.
9. Psychiatric medication should always be considered for mentally ill offenders in the criminal and juvenile justice system. This should include an initial psychiatric assessment, ongoing medication management, and compliance enhancement strategies. This includes proactive interventions to improve compliance, such as identifying barriers to adherence (post-release access, economics, offender resistance), and using practical aftercare planning, ongoing case management, and motivational strategies to overcome those barriers.
10. All programs serving mentally ill offenders should employ tracking, evaluation, and program improvement strategies. This should include a system-wide tracking system that identifies and tracks mentally ill offenders along with program-specific assessments of both mental health and criminal justice outcomes, ongoing process evaluations, and fidelity assessments.

Summary

The treatment and rehabilitation of offenders with serious mental illness has been a concern of both the criminal justice and mental health systems. Despite this overwhelming concern, there has been a lack of rigorous research studies to demonstrate efficacy for specific treatment programs for this population. Nevertheless, some programs have demonstrated promising

criminal justice and/or mental health outcomes and are concluded to be promising, but in need of additional empirical research. Still, numerous researchers and practitioners have pointed out treatment and best practice should be influenced by not only knowledge gained by research, but also by ethical considerations.

What is known regarding treatment of both adult and juvenile offenders with mental illness is that this population needs more than just mental health treatment to reduce their risk of recidivism. Researchers have found that, similar to non-mentally ill offenders, offenders with serious mental illness have criminogenic needs, which must be the focus of treatment when the goal is to reduce the risk of future criminal behavior. One treatment model that takes into account these factors is the Risk Need Responsivity Model. The criminogenic needs that have been found to have the largest impact on risk include the Central Eight: antisocial behavior, antisocial personality patterns, antisocial cognition, antisocial associates, family and marital circumstances, school/work performance, leisure/recreational involvement, and substance abuse. Additionally, there is some evidence that suggests offenders with serious mental illness and co-occurring substance abuse have a greater risk for future violent behaviors. Thus, a high priority should be placed on the identification and treatment of these offenders.

The research suggests that treatment for mental health needs should follow best practices for the specific disorders, which have been outlined for the general population. Generally treatment for chronic and persistent mental illness includes the use of psychoactive medications. Among mentally ill offenders, compliance with medication correlates with reduced recidivism. Unfortunately, offenders are generally non-compliant with medication, especially after leaving institutional and residential settings. Studies on improving medication compliance reveal several creative and promising strategies.

Many researchers and practitioners have highlighted the importance of collaboration between criminal justice and mental health. It is also suggested those within the two systems who work with this population be cross-trained in both criminal justice (criminogenic need) and mental health (recognizing and responding to the needs of the seriously mentally ill). Furthermore, continuity between the two systems, in addition to the various points of contact within the systems is recommended. Providing coherent transitions will facilitate continuity in treatment for

the offenders with mental illness. This may include linkages or ‘boundary spanners,’ information sharing practices, and specialized caseworkers.

The literature suggests that offenders should be screened for mental health and substance abuse at each point of contact within the criminal justice system. If indicated, further assessment should include a risk, mental health, and substance abuse assessment. These screenings and assessments will allow for the identification and timely treatment of offenders with serious mental illness. Additionally, treatment at each point of contact will allow for interventions that can assist in preventing further penetration into the criminal justice system. By addressing the unique needs of these offenders, improvements can be made to both mental health functioning and criminal justice (recidivism) outcomes. When we improve functioning and reduce recidivism we decrease costs to the taxpayers and improve the safety of our communities.

How mental health treatment needs should interface with criminogenic needs is not entirely clear and more research and evaluation of promising treatment models is needed. The extant literature does generally suggest that treatment within the criminal justice system must consider mental health needs, not as an alternative to criminogenic needs, but as a treatment responsiveness factor. This factor must be considered and remediated to allow for targeted work on the criminogenic needs that lead to the reduction of recidivism. In addition, researchers and legal scholars remind us that it is unethical for custodial and correctional systems to ignore mental health needs. There continues to be debate between the mental health and correctional systems about who is responsible, financially, and ethically, for these offenders. This debate all too frequently results in lack of coordination, leading to offenders with mental illness who are not identified or treated and who continue to struggle, fall through the cracks, and cycle in and out of both systems for decades, at a huge social and financial cost.

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