Center for
Behavioral Health Services
& Criminal Justice Research

The Next Generation of Behavioral Health and Criminal Justice Interventions: Improving Outcomes by Improving Interventions

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"Invention, it must be humbly admitted, does not consist of creating out of void, but out of chaos."

—Mary Wollstonecraft Shelley

Funded by the National Institute of Mental Health (Grant #P30 MH079920).
The Center is a major research unit within the Institute for Health, Health Care Policy, and Aging Research.

RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

September 2011

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Introduction

The over-representation of persons with serious mental illnesses (SMI)[1] in the criminal justice system has been a cause of concern for several decades. In 1972, psychiatrist David Abramson published an article in the *American Journal of Psychiatry* describing what he referred to as the "criminalization of mentally disordered behavior," meaning increasing numbers of individuals with SMI who formerly had been state hospital patients were now to be found in jails and prisons. Since that time, numerous studies have been conducted to estimate the prevalence of SMI among criminal justice populations. The first such study was conducted by Teplin and colleagues in Chicago's Cook County Jail (Teplin, 1990; Teplin, Abram, & McClelland, 1996). Using then state-of-the art epidemiologic techniques, they estimated a prevalence of SMI and co-occurring substance abuse that substantially exceeded the general population rates obtained in the Epidemiologic Catchment Area study (Robins & Regier, 1991).

Although prevalence estimates in subsequent studies have varied, a meta-analysis of 62 surveys from 12 countries indicates roughly 14% of persons in the criminal justice system suffer from one or more SMI (Fazel & Danesh, 2002). Some of the most recent research conducted confirms previous estimates; the rate of SMI in five U.S. jails was estimated at 14.5% for male inmates and 31% for female inmates (Steadman, Osher, Robbins, Case, & Samuels, 2009). Based on this body of research, it is estimated that over one million adults with SMI are under correctional supervision, and most are living in the community while being supervised (Ditton, 1999; James & Glaze, 2006).

In response to this notable shift of adults with SMI from public sector mental health services to the criminal justice system, numerous programs have been developed to serve people with SMI at many different points within the legal system. These include police training, jail diversion, drug and mental health courts, specialized probation, crisis intervention teams, and others. Although these interventions have developed over more than two decades and focus on various types of criminal justice involvement, we refer to these programs collectively as "first generation interventions." We characterize these interventions as a group because they are largely united by a singular theme: the reduction or elimination of criminal justice involvement for people with SMI is achieved primarily by providing these individuals with mental health treatment.

While some of the first generation interventions have demonstrated efficacy and several have earned recognition as evidence-based practices, a general consensus has emerged that collectively we are not maximizing the effectiveness of first generation interventions (Blitz, Wolff, Pan, & Pogorzelski, 2005; Skeem, Manchak, & Peterson, 2011). This is perhaps best illustrated by the aforementioned range of prevalence studies which, over the course of two decades, do not demonstrate any meaningful reduction in the over-representation of persons with SMI in the U.S. criminal justice system. Additionally, although several of these first generation interventions have made strides in developing collaborative efforts between mental health and criminal justice systems, these interventions tend to exist as primarily "mental health" or "criminal justice" interventions, and as such do not typically reflect integrated philosophies, services, and outcomes.

The purpose of this monograph is to suggest ways in which we can build and improve upon first generation interventions and develop the "next generation" of behavioral health and criminal justice interventions — interventions that better address the multiple and complex needs of persons with SMI who are at risk of criminal justice involvement. We begin in section one by describing a variety of first generation interventions, summarizing the literature on their strengths and weaknesses, and illustrating how these interventions are united by a common theme of connecting individuals with mental health services. In section two, we present a complex set of individual and environmental factors contributing to criminal justice involvement to be targeted in the next generation of interventions. These factors are supported by both conceptual and empirical scholarly work, much of which has

[1] In this monograph, we use several terms to describe persons with mental illnesses who are involved in the criminal justice system. We use "serious mental illnesses" (SMI) to describe major Axis I diagnoses, including schizophrenia spectrum disorders, bipolar spectrum disorders, and major depressive disorders. The term "mental illnesses" (MI) refers to a broader category of any diagnosed mental health condition. Because this monograph focuses on criminal justice populations, unless otherwise noted we will use SMI and MI as umbrella terms to refer to those populations of persons with mental illnesses who are justice-involved.

been conducted by teams represented by the authors of this monograph. Section three presents findings from a web-based survey and workshop discussions with practitioners working with justice-involved persons with SMI conducted by the authors. This section highlights the critically important, but oft-ignored, voices of those working directly with justice-involved persons with SMI, and suggests how their lived experiences in working with this population can inform the next generation of interventions. Finally, in section four, we outline a blueprint for effective change in which we present goals, unifying principles, and key components to shape the next generation of interventions.

Much progress has been made in developing a first generation of mental health and criminal justice interventions to better serve persons with SMI who are justice-involved. This first generation of interventions has surely brought a greater recognition and understanding of the disproportionate representation of people with SMI in the criminal justice system. If, however, we are to improve a range of outcomes for this population and ultimately reduce the ranks of people with SMI in the criminal justice system, it would serve us well to critically examine existing interventions, learn from their successes and failures, and use this knowledge to shape a new and improved generation of behavioral health interventions that can achieve the outcomes desired by consumers, providers, and communities. It is our hope that the work presented in this monograph will contribute to that aim.

The First Generation of Mental Health and Criminal Justice Interventions

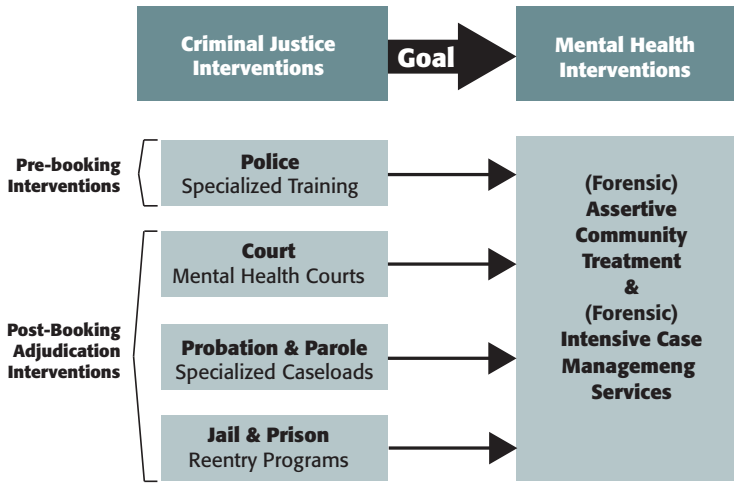
As noted in the introduction, the criminalization phenomena, as described by Abramson (1972), focused on the involvement of persons with SMI with the criminal justice system. At the time, it was thought the solution to the problem of criminalization resided within the mental health system because these individuals had SMI. As a result of this view, the first generation of services was grounded in two related beliefs. The first was that the justice system entanglement of persons with SMI was caused by their failure to access mental health services or their disconnection from those services. The second was that developing mechanisms for connecting or reconnecting persons with SMI with appropriate services would prevent further criminal justice involvement (Fisher, Silver, & Wolff, 2006).

With these beliefs in place, the first generation of services was designed and implemented primarily to accomplish treatment connection. What follows in this section is a brief overview of first generation interventions and the research evidence regarding their effectiveness.[2] This information is relevant to subsequent discussions regarding the design of the next generation of services, which if tailored to the actual needs and risks of justice-involved persons with SMI, not to beliefs about their needs, may yield better individual and social outcomes.

First Generation Interventions

Over the past 20 years, "connecting" interventions were implemented at various intercept points in the justice process (Munetz & Griffin, 2006). The broad categories of these interventions are shown in Figure 1. Note that the points of intercept begin with police, proceed through the courts, and end at the point of reentry to the community following a spell of incarceration and/or supervision. The interventions are situated in the criminal justice or mental health systems. Criminal justice interventions generally expand police, court-based, and mandatory supervision practices in ways that use the legal means at their disposal to divert persons with SMI to the mental health system. Mental health interventions, on the other hand, are traditionally case management-based services that in some instances have been altered to meet the special needs of persons with SMI entangled in the criminal justice system.

Figure 1: First Generation Mental Health and Criminal Justice Interventions



[2] See the Center for Behavioral Health Services & Criminal Justice Research website (http://*www.cbhs-cjr.rutgers.edu/intervention_fact.html*) for more detailed reviews of the research evidence by type of intervention.

Criminal Justice Interventions

Diverting non-dangerous offenders with SMI from jails to mental health treatment has been a policy priority for over a decade. In 2004, diversion policies were energized with funding from the federal government through the *Mentally Ill Offender Treatment and Crime Reduction Act*, which provided funding for collaborative efforts by local criminal justice and mental health agencies to develop diversion programs for persons with SMI who commit "low level, non-violent misdemeanors." The goal of diversion programs is to identify persons with SMI at an early phase of the justice process and then move them out of the "criminal justice line" and into the "mental health line." Where in the criminal process the movement from one line to the other occurs determines the classification of the diversion program as either "pre-booking" or "post-booking or -adjudication."

Pre-booking diversion intervention. The intercept point for pre-booking diversion is the police. These programs typically involve training police officers to recognize symptoms of SMI in persons who might be subject to arrest on low-level nuisance charges and to use their legal authority to transport these individuals to a designated mental health portal – typically a psychiatric emergency center or hospital emergency room. Once there, police involvement ends and the involvement of the local mental health system begins.

Intervention at the point of the police makes sense because police have frequent encounters with persons with SMI. By one estimate, officers spend more time managing incidents related to persons with SMI than they do responding to traffic accidents, burglaries, or assaults (Cordner, 2006).

In a recent survey of practices in the United States, Canada, the United Kingdom, and Australia, researchers identified two types of police diversion models: "police-based response," which involves training officers to respond appropriately to crises and to then link persons with SMI with local mental health services and "co-response," which entails joint responses to crises by both mental health workers and police (Wood, Swanson, Burris, & Gilbert, 2011). In the United States, the most common model is the *Crisis Intervention Team* (CIT), a police-based response. This model trains a specialized cadre of officers — the CIT — whose members receive 40 hours of training on mental illness and related topics. CIT officers are first responders to any call involving a person known or suspected to have SMI and they are expected to take command of the situation, use their specialized training and skill sets to resolve such situations without the use of hospitalization or arrest, and be familiar with local mental health resources. Police departments with CIT units typically have agreements with local mental health agencies that make services more accessible to persons with SMI referred by police (DuPont & Cochran, 2000; Cochran, Deane, & Borum, 2000).

Pre-booking diversion is controversial for two reasons. First, people with SMI who are diverted by police to treatment avoid arrest and detention. However, giving people who violated the law a "pass" because of their mental illness has been considered preferential legal treatment, creating different legal consequences for people engaging in the same illegal behavior. Second, the accuracy of police identification of a serious mental illness has been questioned. Because mental illness may be hidden intentionally or disguised by other co-occurring problems (e.g., substance use), specially trained officers may not engage all persons with SMI who are good candidates for diversion and, as a consequence, some people with SMI may unnecessarily spend time in jail.

Post-booking/adjudication diversion interventions. Post-booking diversion addresses these problems by processing the individual within the justice system up to the point of a hearing in court, at which point a judge can make a determination regarding what, if any, sanctions or supervision should be applied and the consequences for non-compliance. Non-compliance with court orders can lead to the imposition of sanctions, which may include jail time, while compliance can, in some cases, lead to dismissal of the charges altogether.

Mental health court (MHC) is a common type of post-booking diversion. MHCs, like drug and other "specialty" courts, place a priority on treatment goals over punitive sanctions. MHCs have six distinguishing features: first, MHCs are criminal courts that maintain separate dockets for persons with SMI; second, they share the goal of diverting these individuals from the justice system to community mental health programs; third, MHCs mandate community mental health treatment, requiring that defendants engage in treatment, take medications, and adhere to other conditions ordered by the court; fourth, MHCs provide continuing supervision via judicial review status; fifth, MHCs use a "carrot and stick" approach, offering praise for compliance and, ultimately, "graduation," at which point charges may be dropped or court supervision converted to probation, but can also impose sanctions, including jail, for non-compliance; and sixth, participation by defendants is voluntary (Wolff, 2003).

Since their introduction in 1997, MHCs have proliferated. As many as 100 MHCs were reported in 2006, increasing to over 250 in operation or under development in 2010 (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011). Despite their rapid growth, MHCs are not without their critics (Wolff, 2002). Among the concerns raised regarding MHCs is the requirement that a defendant enter a "guilty" or "no-contest" plea to the charges for which he or she has been arraigned, creating an arrest record. And if a misdemeanor arrest results, the defendant may prefer to pay a small fine, complete community service, or a short jail sentence as opposed to being compelled to an extended period of supervision and intensive mental health treatment (Barr, 2001).

Instead of special court supervision, some people with SMI found guilty may be sentenced to community supervision in lieu of incarceration (referred to as "probation") or as a condition of release upon completing a period of incarceration (referred to as "parole" if the person was incarcerated in prison). The protocols used to supervise the general population of offenders on probation or parole are not generally effective in meeting the needs of probationers with SMI. According to Skeem and Petrila (2004), the needs of probationers with SMI are different from probationers without SMI and, hence, require specialized supervision. Probationers with SMI typically need: mental health treatment; specialized housing and other services; extra support to comply with the basic conditions of probation (e.g., working, paying fees); extra monitoring for compliance and treatment participation; and special attention for co-occurring substance abuse problems.

In response, beginning in the late 1980s, several jurisdictions developed *specialized caseloads for probationers* with SMI. Skeem and Loudon (2006) have described five key features that distinguish these units from traditional probation models. They are: (1) specialized caseloads that include only clients with mental disorders; (2) reduced caseloads; (3) sustained officer training on behavioral health problems and their management; (4) active integration of probation and community resources; and (5) problem-solving strategies as the chief means for addressing treatment non-compliance. New Jersey is currently piloting a state-wide specialized mental health probation caseload in which probationers with SMI who are at risk of failing supervision are assigned to mental health probation officers. These officers received 40 hours of training in mental health and related issues and carry a caseload of 25 to 30 clients (Wolff, Epperson, & Fay, 2010).

After a person has completed months or years of incarceration, reentry into the community can be a difficult process. Incarceration is known to disrupt treatment, housing, employment, and family support connections in the community. Not preparing these individuals for, and assisting them with, reentry contributes to their recidivism and subsequent return to prison or jail. As a consequence, legislative action in the form of the *Second Chances Act of 2008* sought to moderate the effects of this process by providing federal support for local reentry initiatives. A recent study of "reentry readiness" of soon-to-be-released inmates from the New Jersey Department of Corrections found that one in four male and one in five female inmates reported their readiness as "poor" or "fair," and half did not know if they would be able to support themselves in the community (Wolff, Gerardi, Shi, & Schumann, 2009).

Reentry to the community can be particularly challenging for people with SMI who have chronic treatment needs, fragile community supports, and supervision requirements such as employment and treatment compliance. Several models of reentry assistance for people with SMI have developed over the past decade. An early model, the *Forensic Transition Team* (FTT) developed by the Massachusetts Department of Mental Health brings case managers into correctional settings to identify persons who might be eligible for mental health services and works with them and the providers in the community to create a seamless transition from the correctional setting to the community (Hartwell & Orr, 1999). A more recent model, *Critical Time Intervention* (CTI), uses principles that have worked well in serving persons who are homeless. As its name suggests, the basic strategy of CTI uses time-limited case management services during the "critical" transition period (Draine & Herman, 2007) during reentry. This approach is quite new and no evaluative data have yet been published, although a randomized controlled trial is underway in the New Jersey Department of Corrections.

Mental Health Interventions

As noted earlier, the mental health interventions currently in place are typically variants on existing mental health services that have been re-designed to meet the needs of justice-involved persons with SMI. Two types of services have gained prominence in this regard. These services include *Forensic Assertive Community Treatment* (FACT) based on the Assertive Community Treatment (ACT) model and *Forensic Intensive Case Management* (FICM) model, a variant of Intensive Case Management (ICM).

The non-forensic versions of these services, ACT and ICM, have been shown to be highly effective in maintaining persons with SMI in the community. Preeminent among these is ACT, a well established evidence-based practice that has achieved broad success in, among other things, reducing the use of psychiatric hospitalization (Stein & Santos, 1998). ACT services are delivered by a multidisciplinary team (inclusive of a psychiatrist, nurse, and case managers) that adheres to the following program requirements: (1) low patient to staff ratios (typically 10 to 1); (2) services are delivered directly by the ACT team and in the community on a 24 hour basis; and (3) clients are provided services on a time-unlimited basis. A relatively new development is FACT, which grafts a forensic specialty component onto ACT (Lamberti, Weisman, & Faden, 2004). Unlike ACT, which has a standardized protocol, FACTs are quite heterogeneous. A national survey of county behavioral health directors found that FACT teams differ widely with respect to referral sources (e.g., courts, corrections, forensic mental health facilities) and criminal justice admission requirements (i.e., whether clients are incarcerated, charged with felonies, have experienced a certain number of prior arrests, or committed violent crimes) (Lamberti, Deem, Weisman, & LaDuke, 2011).

Intensive Case Management (ICM), like ACT, responds to the needs of high service users and delivers assertive outreach and rehabilitative services on an indefinite basis to clients in their natural environments. But, unlike ACT, ICM programs have caseloads of less than 20 and rely on individual case managers, not a multidisciplinary team, to deliver services. Forensic Intensive Case Management (FICM) programs focus on justice-involved clients and employ case managers with specialized training in forensics. FICM programs sometimes work with local probation departments (Lamberti et al).

As an emerging literature suggests, FACT and FICM services do not appear to occupy a particular niche within the sequence of intercepts to "capture" persons with SMI. Instead, these services play a number of different roles at the criminal justice-mental health interface, with the particular role shaped by local needs and the existence and degree of cooperation of other agencies with which they can interact. FACT and FICM programs may have cases referred to them by pre- or post-booking/adjudication programs if these programs exist in the community.

Effectiveness of First Generation Interventions

The outcome research on first generation interventions is quite thin. This is particularly so for FACT, FICM, specialized supervision caseloads, and CTI, which are relatively new. Because these interventions share many similarities with respect to their finding and limitations, we focus on the effectiveness evidence for these interventions as a group.[3] In terms of limitations, the evidence base has significant methodological problems that compromise generalizability. These methodological issues include the lack of (1) a side-by-side comparison to competing alternatives; (2) randomization of clients to intervention or interventions to setting; and (3) a follow-up period that measures psychiatric and criminal justice outcomes over one-year or longer. In a recent review of first generation efforts, Dvoskin and colleagues (2011) assert that the evaluations of various interventions have not been rigorous enough to ascertain whether they are more than minimally effective. In addition, research consistently shows that these interventions by *themselves* will not be effective. There *must* be adequate, appropriate mental health services in place that can easily be accessed by the "connecting" interventions or the effort will fail.

Two recently published studies have compiled evidence on the effectiveness of a variety of first generation interventions. Martin and colleagues (2011) conducted a meta-analysis of 25 studies and found that all but one demonstrated some effectiveness in the area of reducing criminal justice involvement. However, there were no significant effects of these interventions on mental health service or medication use, and the authors note the absence of mental health outcome data in many studies. Similarly, Skeem and colleagues (2011) reviewed exemplary studies of first generation interventions. Most interesting was their finding of no relationship between the reduction of symptoms of SMI and reduced recidivism across the interventions.

These studies highlight two important deficits in first generation interventions and their evaluation. First, many studies of first generation interventions focus solely on criminal justice outcomes, such as rearrest, jail days, or injuries to officers occurring during "mental health calls" to the exclusion of mental health outcomes. Second, those studies that do evaluate both types of outcomes find little to no relationship between mental health outcomes (i.e., symptom reduction or increased service utilization) and reduced criminal justice

[3] Detailed reviews of the research evidence for the specific interventions can be found elsewhere (see: *http://www.cbhs-cjr.rutgers.edu/intervention_fact.html*).

involvement. Given that these first generation interventions are largely focused on the goal of increased mental health treatment as a means of reducing criminal justice involvement, these reviews shed considerable doubt on the assumption that treating the symptoms of SMI will address the tendency of individuals with SMI to engage in illegal or antisocial behaviors.

Conclusion

First generation interventions sought to connect justice-involved persons with SMI to mental health treatment in an effort to reduce their criminal behavior and increase their involvement in treatment. While "connecting" interventions rapidly disseminated over the past decade or so, whether they are working to achieve the dual goals of psychiatric recovery and prosocial behavior is not evident from the research evidence itself or the continued over-representation of persons with SMI in the criminal justice system. As mentioned above, the research evidence with its methodological limitations suggests minimal effectiveness in terms of criminal justice outcomes and no meaningful connection between reduced psychiatric symptoms and reduced recidivism. This result is consistent with the fact that the representation of persons with SMI in correctional settings has remained largely unchanged over the time that these interventions were implemented. A recent report by the Treatment Advocacy Center entitled *More Mentally Ill Persons in Jails and Prisons than Hospitals: A Survey of the States* (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010) shows a persistent over-representation of persons with SMI in the criminal justice system.

As noted at the beginning of this section, the first generation of interventions was premised on the belief that effective treatment engagement (i.e., the reduction in psychiatric symptoms) would eradicate criminal justice behavior for persons with SMI. In response, first generation "connecting" interventions were widely adopted on the belief that it was the "right thing to do," not because these interventions were effective in achieving the goals of reduced criminal activity and increased psychiatric well-being. Two decades later we have evidence suggesting that diversion to traditional services is not *the* solution, although treatment is part of the solution. In the next section, we review the research evidence on the needs and risks of justice-involved persons with SMI in an effort to identify the pertinent needs and risks and ways to best respond to them with targeted intervention.

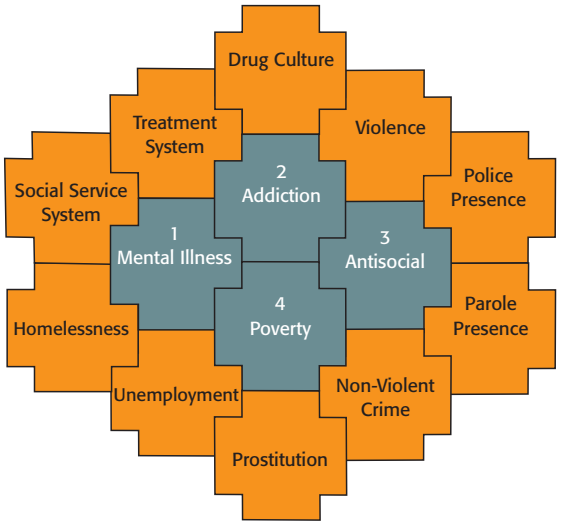
The Next Generation of Behavioral Health and Criminal Justice Interventions

The first generation of mental health and criminal justice interventions targeted participants across different stages of the criminal justice system and coalesced around a singular objective — to link offenders with mental illnesses (MI) to mental health treatment. Though a portion of people with serious mental illnesses (SMI) are tangled in the criminal justice system solely due to the symptoms of untreated mental illness, there is a growing consensus that this proportion is relatively small. In fact, a recent estimate suggests that the criminalization explanation accounts for only 1 in 10 offenders with MI (Skeem et al., 2011). Given the limited role of untreated mental illness in criminal justice involvement and the focus of first generation interventions targeting this population for linkage to the mental health system, it is not surprising that there remains a persistent over-representation of people with SMI in the criminal justice system (Fazel & Danesh, 2002; Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010).

Attributes of Criminality

Although effective and accessible mental health treatment will be an active component of any intervention for this population, research evidence is increasingly suggesting that treatment alone is not sufficient. Justice-involved people with SMI have more than just a mental illness; they are individuals with an array of challenges nested within complicated lives. For this reason, the solution to their encounters with the criminal justice system is not one of simply shifting or diverting to treatment. Finding the "right" solution, instead, begins with opening up the perspective of the problem so that it can be informed by factors that are known to contribute to criminal justice encounters. That is, we begin to solve the problem with a general understanding of factors that contribute to criminal behavior and by acknowledging that people with SMI are "normal" in many of their criminal risk factors. Towards this end, we suggest a person-place framework that is more comprehensive and inclusive of factors contributing to criminal behavior in general, as depicted in Figure 2.

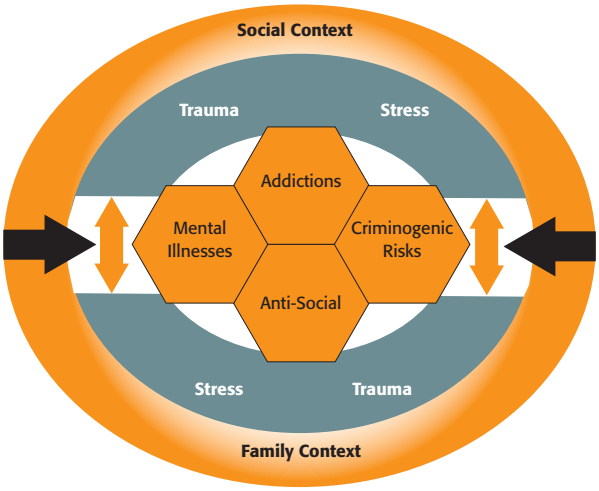
Figure 2: Factors Contributing to Justice-Involvement



In this framework, we focus on two levels of factors: person (individual) and place (environment). At the center of the figure are person-level factors emphasizing mental illness, addictions, antisocial cognitions and attitudes, and poverty. These factors work separately and interactively to affect the risk of criminal justice entanglement. In addition, individuals may live within environments that increase their risks of criminal justice involvement, as indicated by the outer edge of the "puzzle" depicting the social and community context in which many offenders with SMI reside. The environmental or "place" context includes not only the mental health treatment system, but also community characteristics including levels of violence, law enforcement presence, homelessness, unemployment, and other social disadvantages. More broadly, people with SMI who end up in the criminal justice system often lack employment and other prosocial skills, contributing to an overall sense of desperation when struggling to address their daily needs. These challenges often occur within disorganized communities, in which discrimination and stigma toward people with SMI further exacerbate risk.

In addition to these two levels, there are mediators that act as catalysts between the person and place factors contributing to justice involvement (see Figure 3). These mediators include trauma and stress. Situations within the environment may produce interpersonal trauma (e.g., sexual or physical violence) and stress associated with unemployment, poverty, violence, family dynamics, and homelessness, which intensify person-level risk factors and push people towards behaviors that are harmful to themselves and the community. This catalytic process produces environmental pressure towards criminal justice entanglement as depicted in Figure 3.

Figure 3: Catalytic Role of Trauma and Stress



As these figures illustrate, for most persons with SMI in the criminal justice system, their path to criminal involvement is not simply explained by a lack of mental health treatment, but rather by the complex interplay of individual and environmental factors and catalytic mediators. This is not to say that *all* people with SMI have the same risk or need factors. *Our point is that the full complement of the individual's relevant risk and need factors must be addressed to improve individual and social outcomes.* As such, in order for the next generation of behavioral health and criminal justice interventions to effectively reduce the over-representation of people with SMI in the criminal justice system, a broader perspective of the problem is warranted. This section will highlight driving concepts that have, to varying degrees, not been fully incorporated into first generation interventions, and begin to suggest ways in which these concepts can inform the next generation of interventions. These concepts are organized by: *person-level*, inclusive of four factors: criminogenic risk, addiction, trauma exposure, and stress exposure and *place-level*, represented by concentrated social disadvantage.

Person-Level Factors

Criminogenic risk. Over the past 20 years, researchers have identified a variety of individual-level factors that elevate risk of offending behavior. These factors have been categorized by their predictive power or ability to predict criminal behavior. Factors that are most predictive are called the "Central Eight" because when considered individually they are most likely to accurately and reliably predict the risk of criminal behavior (see Andrews & Bonta, 2006, for a more thorough review). Table 1 summarizes the "Central Eight" risk factors.

Table 1: "Central Eight" risk factors predictive of criminal behavior

1- History of Antisocial Behavior. The more extensive one's involvement in crime, the greater the risk for criminal recidivism. History of antisocial behavior emphasizes the extent of criminal involvement (extensiveness), not the seriousness of criminal offense (intensiveness). That is, a repeated pattern of unrelated minor offenses is more predictive of crime than an isolated incidence of violence or a serious criminal offense.

2- Antisocial Personality Pattern. A pattern of restlessness, aggressiveness, poor self control, adventurousness, pleasure seeking, and callousness are characteristic of an antisocial personality pattern, and having a pattern of such personality characteristics increases the risk of criminal behavior.

3- Criminal Thinking and Antisocial Attitudes. Cognitive processes and attitudes that are supportive of a criminal lifestyle predict criminal behavior.

4- Antisocial Associates. The more criminal associates (e.g., family members, friends, co-workers) an individual has, the higher the risk of criminal behavior.

5- Family and/or Relationship Circumstances. The less connected and engaged one is with family or other important support systems, the greater the risk for criminal behavior. Social connections that are more dysfunctional also predict criminal behavior.

6- School and/or Work Functioning. The greater one's commitment to academic or vocational pursuits, the lower the risk of criminal behavior. Although attaining work or involvement in school reduces the risk of criminal behavior, greater risk reduction is achieved when one gains satisfaction from academic or work activities.

7- Leisure and/or Recreational Activities. The greater the number of, and satisfaction from, prosocial leisure and recreational pursuits, the lower risk of engaging in crime

8- Substance Abuse. Alcohol and illicit drug use increases risk for criminal activity.

These risk factors are changeable and, as such, have been identified as treatment targets for interventions aimed at reducing criminal recidivism. The first generation of mental health and criminal justice interventions operated largely on the assumption that these factors were not applicable for justice-involved persons with SMI. That is, it was assumed that these risk factors were "normal" only to persons without mental illness. Or, said somewhat differently, first generation interventions assumed that offenders with SMI were not normal in their criminal behavior.

Over the past few years, researchers have investigated the validity of the non-normalization assumption as applied to justice-involved persons with SMI. One area of particular interest concerns the criminal thinking and antisocial attitudes among offenders with and without MI. Two studies based on inmate populations are noteworthy. Based on a sample of 416 inmates with SMI, Morgan and colleagues (2010) found that inmates with and without SMI demonstrated equivalent criminal thinking. More specifically, inmates with SMI, like their counterparts without SMI, possessed styles of thinking that supported a criminal lifestyle — that is, they were "normal" in their criminal thinking compared to other offenders without SMI. Similar results were found by Wolff et al. (2011) based on a sample of 3986 male inmates and 218 female inmates. In this study, inmates with SMI (i.e., schizophrenia, bipolar disorder), as well as other mental illnesses (i.e., depression, anxiety), displayed antisocial attitudes that were comparable to inmates without MI.

This emerging area of research is showing that justice-involved people, both with and without SMI are similar; they both have antisocial attitudes and criminal thinking styles that are known predictors of criminogenic risk. This evidence of normalization suggests that justice-involved persons with SMI have criminogenic needs that complement their mental health needs. This opens up the possibility that these co-occurring risks, if ignored, may interact in ways that mitigate the effectiveness of mental health treatment. More specifically, for people with SMI, ignoring their co-occurring criminogenic needs may limit treatment effectiveness in ways analogous to ignoring their co-occurring substance abuse problems. From this perspective, the challenge becomes how to address criminogenic needs within a behavioral health orientation, not simply on rerouting mechanisms that channel justice-involved persons with SMI into traditional mental health treatment.

Addictions and behavioral patterns. Substance abuse/use is a central risk factor for criminal involvement and is pervasive among justice-involved persons (Chandler, Fletcher, & Volkow, 2009; James & Glaze, 2006). According to a national survey conducted by the Bureau of Justice Statistics, about 75% of prison and jail inmates who had a mental health problem also met criteria for substance dependence or abuse, and drug use prior to arrest was more common among state prisoners with mental health problems than those without (James & Glaze, 2006). Given the co-morbidity of mental illness and substance disorders, researchers have been exploring the relative impact of these disorders on recidivism. In a large study of Texas parolees, Baillargeon et al. (2009) found that those with a dual diagnosis of SMI and a substance use disorder were at greatest risk of parole revocation. By contrast, no increased risk of parole revocation was found among parolees with singularly occurring SMI or a substance use disorder. Looking at jail detainees, Swartz and Lurigio (1999) found that detainees with co-morbid SMI and substance use disorders demonstrated increased levels of arrests for property crimes. Similarly, Wallace, Mullen, and Burgess (2004) found higher rates of criminal conviction among Australian psychiatric patients with both a diagnosis of schizophrenia and substance abuse compared to those with schizophrenia alone.

In addition, justice-involved persons with and without SMI struggle with a variety of other behavioral patterns that increase the risk of criminal justice involvement, including addictive personalities, novelty seeking, and tendencies toward instant gratification. Problematic behavioral patterns and addictions may arise in many areas including gambling (Clark & Walker, 2009), eating disorders (Messina & Grella, 2006), sexual risk behaviors (Epperson, El-Bassel, Gilbert, Orellana, & Chang, 2008), and other compulsive behaviors. To varying degrees, these thought and behavior patterns may be related to impulsivity or cost-benefit behavioral decision making, which may also contribute to criminal involvement.

Trauma exposure. Trauma exposure, specifically sexual or physical victimization, is a highly relevant issue for people with SMI who are involved in the criminal justice system. A significant association exists between trauma history and addictive behaviors and trauma history and criminal justice involvement (Wolff & Shi, 2009). While lifetime exposure to a traumatic event is fairly common, severe physical and sexual victimization are more prevalent among criminal justice populations, particularly those with MI (Teplin, McClelland, Abram, & Weiner, 2005). Incarcerated adults, especially

those with SMI, report extremely high lifetime rates of physical and sexual trauma, often occurring during their formative childhood years through adulthood (Wolff & Shi, 2010; Wolff et al., 2011). In one study, a majority of 209 female inmates interviewed reported experiencing at least one type of crime-related (58%), general disaster (98%), and/or interpersonal (87%) trauma, and most (74%) reported a childhood history of sexual or physical trauma (Wolff et al., 2011).

Being inside correctional settings can heighten the risk for further victimization. For example, Wolff and colleagues (2007) found that about 1 in 12 male inmates with MI reported at least one incident of sexual victimization by another inmate, while 1 in 32 inmates without MI reported such experiences. Similar results were also found for physical victimization (Blitz, Wolff, & Shi, 2008). These findings parallel the finding among psychiatric populations; involuntarily committed adults with SMI have been found to experience high levels of trauma as well as a wide range of indignities in controlled environments (Frueh et al., 2005).

The psychological consequences of sexual or physical trauma are potentially severe and include fear, anxiety, depression, anger, guilt, somatic symptoms (e.g. gastrointestinal symptoms), substance abuse, suicidal ideation, and post-traumatic stress disorder (Breslau, Davis, Andreski, & Peterson, 1991; Bryant, 2010). In addition to these psychological consequences, there are physical and medical consequences to trauma exposure. For example, having a history of unwanted sexual experience is associated with cigarette smoking, disability, poor physical and mental health, and less satisfaction with life (Crisanti, Frueh, Gundaya, Salvail, & Triffleman, 2011). Among those exposed to trauma, the development of post-traumatic stress disorder (PTSD) is elevated by individual risk factors, including lower social support, female gender, lower socioeconomic status, lower intelligence, lower education, and, most relevant to this discussion, prior history of social adjustment or psychiatric disorder (Andrews, Brewin, & Rose, 2003; Breslau et al., 1991; Brewin, Andrews, & Valentine, 2000; Rosen et al., 2010). For this reason, it is not surprising that while rates of PTSD have been estimated at 8% of the adult U.S. population (APA, 2000), among adults with SMI the rates of PTSD are considerably higher, ranging from 13 to 46% (Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011).

Stress exposure. Stress, while part of life, is particularly acute inside correctional settings where unrelated people live in close proximity for days, weeks, months, and years, and where the circumstances of their living situations are highly uncertain. In correctional settings, at any moment, there could be a fight, a lock down, a report of bad news from the outside, a loss of privileges, a change in housing unit or cellmate, a racial slur, a "shakedown," and so forth. The only thing that is known for certain inside correctional settings is that anything can happen at any time and that inmates have no control over the course of these events in terms of their timing, nature, or consequences. Similarly, the anticipation of release to the community or a halfway house from a correctional setting can trigger stress because the circumstances on the outside are unknown. There is uncertainty about parole, housing arrangements, employment, and family reunification, as well as about how to function in a world that requires more than standing in line to be fed.

Because criminal justice involvement (i.e., arrest, detainment, supervision, release) is stressful, it can trigger relapse of mental illness and addictive behaviors. Criminal behavior has been associated with the inability to regulate severe stress, emotional discomfort, and deprivation (Samuelson, Carmody, Kabat-Zinn, & Bratt, 2007). Negative affect may also manifest as a consequence of stress in part as a coping mechanism and in part as a response to feelings of hopelessness and helplessness (Ong, Bergeman, Bisconti, & Wallace, 2006).

Unmanaged and persistent stress exposure may also develop into serious health-related problems including diabetes, heart disease, obesity, immune system disturbances, and ulcers among others (Kabat-Zinn, 1990), as well as coping strategies that include aggression, suppression, and obsession. Chronic stress and an overactive autonomic nervous system, stimulated by the body's fight, flight, or freeze response, are consequences of the process of arrest, incarceration, supervision, and reentry and, as such, can be expected to have unintended effects on mental, physical, and emotional well-being, in addition to hindering prosocial functioning.

Place-Level Factors

Social disadvantage. As noted in Figure 2, place factors contribute to the involvement of persons with and without MI in the criminal justice system. In fact, criminologists have repeatedly highlighted the effects of environment and social class on offending. More than 80 years ago, Faris and Dunham (1939) coined the term "downward drift" to describe the process by which individuals with MI move to ever-poorer parts of the city. In a more recent study by Silver, Mulvey, and Swanson (2002), the existence of a "downward drift"

pattern was re-confirmed among a sample of people with SMI in four urban areas. Drifting into communities with higher levels of social and economic disadvantage increases exposure to crime, violence, drug use, and police supervision, and may be seen as a source of criminogenic risk. Although the relationship between MI and crime is relatively weak, issues of poverty, under-education, unemployment, and the paucity of positive social relationships typically accompany SMI and are likely to contribute more strongly to crime than psychiatric symptomatology (Draine, Salzer, Culhane, & Hadley, 2002).

In point of fact, mental illness appears to expose individuals to high crime environments. People with SMI, who are disproportionately homeless, as well as those receiving residential services from mental health agencies or local housing authorities, often reside in areas shared with other persons of low socioeconomic status (Fisher et al., 2006). The economic circumstances of persons with SMI, the limits of state mental health agency residential program budgets, and other factors work to trap many individuals in low-income, high crime areas (Lurigio, 2011). Many such neighborhoods, particularly those in inner cities, are beset with drug users and dealers as well as others who have significant criminal histories.

This kind of social environment presents numerous opportunities for people with SMI to engage in criminal and antisocial behaviors, and, in particular, to become involved in substance abuse. Moreover, data from the Massachusetts Mental Health - Criminal Justice Cohort Study, which tracked the arrest patterns of a cohort of persons with MI receiving services from state mental health agencies, indicate that many drug arrests in this cohort involve not only possession, but drug trafficking and manufacturing (Fisher et al., 2007). The fact that persons with MI take on the level of antisocial behavior that is characteristic of their surroundings is further reinforced by data from the MacArthur Risk Study, which found that the likelihood of such individuals engaging in acts of interpersonal violence was roughly the same as those of persons without MI living in the same neighborhoods (Monahan et al., 2001).

Identifying "Intervenable" Risk Factors

In this section, we offered a conceptual framework to better represent the set of factors and pressures that predict criminal behavior of people with and without SMI. One objective of this framework was to move our collective thinking away from the inaccurate notion that mental illness is the sole cause of criminal behavior. Indeed, in light of the research literature (see Bonta, Law, & Hanson, 1998), it would be naïve to argue that mental illness alone predicts the criminal behavior of people with SMI. Rather, it is increasingly clear that justice-involved people with SMI share criminal risk factors with justice-involved people without SMI. Thus, justice-involved people with SMI present with co-occurring mental health and criminal risks. This more complex framework suggests that justice-involved individuals with SMI may have multiple risk factors predicting their criminal behavior, not just one: serious mental illness.

For this reason, we endorse a more reasoned perspective of risk that focuses attention on the relative predictive effects across a set of "intervenable" risk factors. This perspective does not ignore mental illness. Rather, it puts mental illness within a set of person and place risks and addresses these risks within targeted interventions, with the full recognition that some risks are more strongly predictive of criminal behavior than others and that 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 a seizure, or intoxicated, even though criminal thinking is a stronger predictor of criminal behavior than mental illness, physical illness, or addiction.

By focusing more broadly on the constellation of risks associated with "person" and "place," we have a more realistic and informed framework for building the next generation of interventions and for sequencing the steps within these interventions to achieve better outcomes for individuals with SMI and their communities. This is not to say that some exemplary first generation interventions have not already begun to incorporate a perspective beyond mental illness in identifying targets for intervention (e.g., criminal thinking). While anecdotal examples of such programs do exist, the dominant first generation models do not target a range of risk factors, and this broader perspective is largely absent in the existing literature on first generation interventions. The degree to which the next generation of behavioral health and criminal justice interventions can address this array of person and place factors will determine their success in serving those persons with SMI who are at risk of criminal justice involvement. In the next section, we look to the experiences of the practice community to inform the perspective of "intervenable" risks.

Looking to Practice for Understanding

To inform the development of the next generation of behavioral health and criminal justice interventions, we looked to those in the practice community to guide our understanding of what is working and what needs improvement. It is the custom of researchers to focus primarily on interventions and their outcomes; it is not typically our practice to explore the experiences of those who work day to day with the people that these interventions are intended to benefit. Indeed, very little is known about how those in the practice community serving justice-involved adults with SMI perceive the successes and challenges of their work. Yet their experiences are critical to the process of knowing what is working and what is not working for individuals with SMI who are at risk of criminal involvement.

To address this omission, we invited a sample of community and corrections-based programs serving justice-involved clients with SMI to teach us about the problems they confront as they help clients overcome their challenges and achieve their goals. The perspectives of those closest to the needs of, and challenges faced by, consumers can help us to better understand what is needed to improve behavioral health and criminal justice outcomes for justice-involved persons with SMI and prevent justice involvement for people with SMI. The quantitative and qualitative data from this study provide a general view of the behavioral, economic, and programmatic challenges facing programs as they work with justice-involved persons with SMI, and the multitude of complex issues faced by their clients.

The National Survey and Workshop

As previously discussed, programs designed to engage justice-involved persons with SMI have expanded over the past decade. These programs include police and jail diversion, mental health courts, specialized probation, forensic assertive community treatment (FACT), and others. The weight of the research evidence suggests that in order for these interventions to effectively reduce recidivism rates for justice-involved clients, they need to be more inclusive of risk factors for criminal involvement, such as antisocial cognitions and attitudes, addictive behaviors, poverty, and structural disadvantages (Draine, Salzer, Culhane & Hadley, 2002; Morgan, Fisher, Duan, Mandracchia, & Murray, 2010).

The Center for Behavioral Health Services and Criminal Justice Research (referred to as "the Center") conducted a Mental Health Interventions Survey of a national sample of community-based programs serving justice-involved clients with SMI. Surveys were completed on-line by case managers or supervisors affiliated with these programs. The web-based survey was completed by staff from 85 programs (see the appendix for more details on methods). The survey collected data on the characteristics and needs of the client base; characteristics and challenges associated with difficult-to-engage clients; service needs and obstacles; and recommendations for improving program effectiveness. This survey serves both as a needs assessment tool and a blueprint for informing the development of the second generation of behavioral health and criminal justice interventions. Herein we describe responses from 53 community-based mental health programs (e.g., assertive community treatment, forensic assertive community treatment, intensive case management programs, herein referred to as CBPs) and 32 reentry, diversion, or corrections-based programs (referred to as DFPs) (details about the programs can be found in the appendix).

The Center then invited staff from the programs that completed the survey to participate in a day-long workshop at Rutgers University. Staff from 19 programs representing 18 states consented to and participated in the workshop. A large group discussion was conducted during the first half of the day and focused on the survey report, which described client profiles and the factors identified as contributing to criminal behavior and treatment compliance for all the programs that completed the survey. Smaller facilitated break-out sessions were held in the second half of the day to discuss ways to improve treatment adherence and client services. Herein the survey results (quantitative) are described followed by the perceptions (qualitative) from our national sample of key informants regarding what matters and needs to be changed for behavioral health interventions to meet the needs of justice-involved persons with SMI.

Results from the Web-Based Survey

Client Profile

The clinical characteristics, thinking styles, and life problems of clients managed by survey respondents are described in this section.

Clinical Characteristics. Respondents indicated that the majority of their clients present with schizophrenia, bipolar disorder, or major depression. Approximately 40% of community-based programs (CBP) respondents and 30% of diversion-focused programs (DFP) reported that half or more of their clients have post-traumatic stress disorder (PTSD) or antisocial personality disorders. Nearly all of respondents (93% or more) reported that half or more the clients of the CBPs and DFPs used, misused, or are dependent on alcohol or drugs.

Other common problems reported among clients included impulsivity, self neglect, suicidality, aggressiveness, violence, and sexual promiscuity. Sexual, physical, and emotional trauma was reported for half or more clients by over 50% of respondents, with over 80% reporting half or more of their clients had experienced emotional or psychological trauma in the recent or distant past. What was clear from the portrait of clients described by respondents is that their clients have a constellation of problems with different origins, etiologies, and symptoms, often crossing over the boundaries of mental illness, addictions, and antisocial pathologies. Responding effectively to these clients requires knowledge of the different problems, expertise in how to respond to them, and an understanding of how these problems interact when they co-occur. The poly-problems of these clients suggest the need for an integrated and comprehensive approach.

Criminal thinking styles. Respondents reported that most of their clients have thinking styles associated with criminality. A majority of respondents indicated that half or more of their clients used thinking styles of mollifying, impulsivity, discontinuity, cutting off, and super-optimism (see Table 1).[4] Walters (1990) describes these thinking styles in the following way:

(1) *Mollification* - rationalizing action by blaming external factors; (2) *Discontinuity* – hesitancy and unreliability in thought and behavior; (3) *Cutoff* – immediate disregard for thoughts that deter crime; and (4) *Superoptimism* – overconfidence in one's ability to avoid negative results of one's behavior.

Table 1: How many of your clients practice any of the following *thinking styles*?	Half or more of clients (%)	
	CBP (n=53)	DFP (n=32)
Rationalize their behaviors by blaming external factors	82.4	75.9
Impulsivity	80.8	79.3
Unreliability or hesitancy in thought and behavior	73.1	62.1
Disregard thoughts that could keep them out of trouble	67.3	65.5
Overconfidence in ability to avoid negative consequences that result from their behaviors	56.9	58.6
Using quick or easy cognitive "short cuts"	52.0	58.6
Sense of privileged self-regard that permits antisocial behavior	48.1	44.8
Need to control others, self, and situations	30.6	41.4
Justify doing inappropriate things for the good of others	22.9	24.1

Life problems. As shown in Table 2, the vast majority of respondents indicated that half or more of their clients have life problems that can contribute to poor treatment compliance, difficulty with supervision by the correctional system, and criminal justice involvement. When asked more specifically about problems that make clients difficult to engage, frequent responses were:

- Lack of motivation and/or insight
- Impulsive behavior
- Disorganization
- Lack of trust
- Fragile coping skills
- Hopelessness
- Antisocial attitudes and criminality

[4] Responses are grouped by the percentage of respondents indicating that 50% or more of their clients evince a particular thinking style (Table 1) or life problem (Table 2).

- Resistance to treatment
- Poor judgment
- Trauma (all types)
- Family (lack of or intrusive)
- Homelessness
- Learned behaviors
- Active substance abuse
- Addictive behavior

Factors Contributing to Criminal Behavior

There was general consistency in responses to the following question: What factors contribute to the criminal behavior of your clients? The most common response was drug and/or alcohol use or abuse. The frequency of responses, ordered from highest to lowest, is shown below:

- **Substance abuse** – use or abuse of illegal drugs or alcohol (51/85);
- **Environment** – poverty, boredom, housing, lack of opportunities, discrimination, stigma, close proximity to crime and criminal culture (45/85);
- **Mental health treatment issues** – lack of access, lack of services, compliance issues, and the illness itself (33/85);
- **Criminal thinking** – wanting things easy, "glorification of outlaw values," Axis II issues, lack of accountability, and criminal attitudes (20/85);
- **Family dynamics** – family history of criminality, family drug abuse, family culture, "parents with no boundaries," lack of family support, and learned behaviors (18/85);
- **Coping skills** – lack of coping skills, difficulty with impulse control, entitlement issues, thinking errors, difficulty managing frustration (17/85);
- **Social support** – lack of prosocial support and positive peers or role models (16/85); and
- **Victimization** – sexual, physical, emotional, and psychological trauma (10/85).

Table 2: How many of your clients have the following *life problems*?	**Half or more of clients (%)**	
	CBP (n=53)	**CBP (n=32)**
Problems contributing to poor treatment compliance and difficulty with supervision by the correctional system		
Problems managing time	94.0	89.3
Problems following through on commitments	92.3	86.2
Difficulty managing stress	92.3	93.1
Difficulty coping with mental illness	88.7	86.2
Difficulty getting housing	84.6	89.7
Problems with medication compliance	78.9	86.2
Being abusive to or neglectful of self	50.0	42.9
Problems with impulsivity	76.5	78.6
Problems contributing to criminal justice involvement		
Difficulty getting a job	100	89.7
Difficulty keeping a job	100	92.9
Problems managing money	96.1	89.3
Problems managing time	94.0	89.3
Difficulty managing stress	92.3	93.1
Developing unhealthy relationships	88.2	89.3
Getting arrested	86.8	93.3
Fighting with family members	94.3	92.9
Having nothing to do	80.4	81.5
Problems with impulsivity	76.5	78.6
Periods of homelessness	73.6	75.9
Hanging out on the streets	68.6	57.1
Being victimized	59.2	59.3
Being abusive to others	44.2	32.1

With the addition of a "Central Eight" screening tool and information …, service providers would have a "risk map" that could guide their identification of people with SMI who are at greatest risk for criminal behavior and, with additional training, begin to respond with services to decrease these risks.

It is interesting to note that the responses from the program representatives on criminal justice contributors are consistent with the "Central Eight" risk factors identified in the previous section: history of antisocial behavior; antisocial personality pattern; antisocial cognitions; antisocial associates and peer groups; family and/or relationship circumstances; school and/or work functioning; leisure and/or recreation pursuits; and substance abuse. As such, these respondents are already identifying client factors that significantly predict criminal justice involvement. With the addition of a "Central Eight" screening tool and information on the nature and consequences of these risk factors, service providers would have a "risk map" that could guide their identification of people with SMI who are at greatest risk for criminal behavior and, with additional training, begin to respond with services to decrease these risks.

Treatment Engagement

It is often thought that clients are either compliant or non-compliant. However, our respondents indicated that compliance behavior changes over time. Over 94% of CBP and DFP respondents indicated that their now compliant clients were difficult to engage at some point in the past. We asked respondents as part of the survey to reflect on clients who moved from non-compliance to compliance with treatment and to identify what contributed to the change. Responses ranged from style to form. One respondent noted that "*all clients go through a period of non-compliance. The individual and the clinician need to build rapport, trust, and understanding*." The relationship characteristics of rapport, trust, and understanding were mentioned frequently by CBP respondents. **Style of engagement** was also stressed. Many noted the importance of "*building a positive, supportive relationship*," "*consistency on the part of the treatment team*," "*empathy and non-judgmental attitude of clinician*," "*staff belief in that the consumer could change*," "*strong therapeutic alliance*," "*persistence*," "*understanding*," "*effective combination of communication and accountability*," "*caring*," "*encouragement*," "*motivational interviewing*," "*starting where the person is at*," and "*giving people a second chance*."

Other responses focused on the **client and his/her development**. Clients reportedly switched from non-compliance to compliance behavior once they "*developed insight*," "*were ready to change*," "*got physically and mentally tired of their issues*," "*accepted the illness*," "*changed their decisional balance*," "*found purpose or meaning in life*," "*gained trust in staff*," "*had personal successes with treatment and medication*," and "*wanted something different*."

According to one respondent, what is needed is *"a program that is long enough to wait through the pre-contemplative stage."*

It was also noted that particular **external circumstances** enhanced the likelihood of switching to more compliant treatment behavior. External circumstances were most frequently mentioned by DFP respondents. These circumstances included: external motivators (e.g., jail, judicial mandates, hospitalization); positive and consistent family, community, and social support; intensive wrap-around services; recovery-oriented services; and "having someone who cared about them."

Respondents were asked what could be changed to improve their program's effectiveness with clients who are difficult to engage. There was a range in responses. Some respondents focused on more external controls (e.g., "swift imposition and availability of punitive sanctions"), some focused on needing more resources and training to work effectively with these clients, and others focused on a change in philosophy that is more understanding, patient, and creative (see Table 3).

Treatment service expansion and modifications were mentioned by a majority of respondents. For greater specificity, they were asked to assess the importance of an array of treatment services for clients who are not compliant with treatment (see Table 4). In general, the treatment services identified as most important were: substance abuse treatment, intensive case management, and medication management, although there is some variation between CBP and DFP respondents.

Table 3: What could be changed to improve the program's effectiveness with clients who are difficult to engage?

External Controls	Treatment and Networking Resources	Staff Training	Philosophy
• Incentives/rewards • Pro-treatment legislation • Involuntary treatment • More assertiveness • Punitive sanctions	• Better screening tools • Better risk assessment tools • Ready access to substance abuse treatment • Smaller caseloads (more time) • Ready access to ACT, ICM • More peer supports • More and stronger relations with other agencies • More cooperation between mental health and criminal justice system • Access to meaningful jobs • More dual treatment beds • Longer programming • More safe housing • More cars for home visits • Eliminate ineffective programs	• More skills in engaging clients • Ongoing training for mental health and criminal justice staffs • Motivational interviewing training • More creative solutions	• Reduce pressure for the "quick-fix" • Patience • "Getting the client to do more" • Collaboration between systems and with community stakeholders • More empathy towards clients • Change requires hope • More assertiveness • Less judgment • Humor

Table 4: How important are the following *services* in helping your clients live successfully in the community?	Very Important %	
	CBP (n=53)	DFP (n=32)
Substance abuse treatment	86.8	84.4
Intensive case management	86.8	62.5
Medication management	84.9	84.4
Relapse prevention intervention	71.7	71.9
Dual diagnosis treatment	67.9	71.9
Individual therapy	62.3	56.3

Obstacles identified by respondents as most relevant to preventing their clients from living successfully in the community included inadequate or unsafe housing options, reductions in state and local funding for programs, difficulty getting clients covered by Medicaid, and limited availability of substance abuse treatment.

Skills Needs of Clients

Living productively and prosocially in the community requires an abundance of skills. Some skills are required simply to function (e.g., pay bills, manage money, clean a house, prioritize time, communicate with other people), while others are essential to manage the ups and downs of life (e.g., loss of a job, interpersonal conflicts, stress). We asked respondents to indicate the importance of a variety of skills and then to indicate their availability in the community. Table 5 summarizes their responses. The relative ranking of skills very important for successful community living were generally consistent among CBP and DFP respondents. However,

more DFP respondents considered motivational skills as less important and stress management, safe coping, anger management, illness management, and independent living skills as more important than CBP respondents. Also, DFP respondents reported less availability of skill services than their CBP counterparts.

Table 5: How important are the following *skills* in helping your clients live successfully in the community?	Very Important (%)		Skills Available in Community (% yes)	
	CBP (n=53)	DFP (n=32)	CBP (n=53)	DFP (n=32)
Motivational skills	79.3	59.4	81.1	50.0
Problem solving skills	71.7	81.3	88.7	68.8
Healthy relationship & boundary skills	64.2	71.9	81.1	68.8
Stress management skills	64.2	75.0	92.5	78.1
Safe coping skills	60.4	78.1	81.1	68.8
Anger management skills	60.4	71.9	98.1	90.6
Behavior modification skills	56.6	62.5	86.8	68.8
Money management skills	54.7	56.3	86.8	71.9
Social skills	54.7	53.1	83.0	78.1
Living independently skills	52.8	75.0	86.8	84.4
Positive thinking skills	52.8	56.3	73.6	56.3
Enpowerment skills	52.8	50.0	81.1	62.5
Anxiety management skills	50.9	56.3	94.3	84.4
Illness management skills	49.1	75.0	88.7	68.8
Employment skills	43.4	56.3	96.2	84.4
Health and wellness skills	43.4	46.9	86.8	84.4
Time management skills	41.5	56.3	66.0	53.1
Communication skills	35.9	53.1	79.3	59.4
Parenting skills	32.1	31.3	84.9	84.4
Literacy skills	26.4	37.5	88.7	62.5
Hygiene management skills	24.5	37.5	79.3	65.6

Results from the Workshop

The workshop discussions provided important information about perceptions of our national sample of key informants (referred to as "participants") regarding the role of behavioral health interventions for criminal justice populations with SMI. Participants spoke with passionate conviction about their purpose and many expressed concern with the dire state of behavioral health care for the clients they serve across a variety of settings. They reported feeling lonely and isolated in their work, and struggling with the perception that so many others in the criminal justice system "*don't get it*." Many spoke of the dilemmas they face in making treatment, parole, and referral decisions in the face of extremely limited resources and service options. Resources are limited at the level of the individual clients they serve and at the system and state levels charged with providing and managing behavioral health care. Our qualitative analyses of the workshop data yielded findings that clustered around four sets of solution-oriented themes, which are described in turn below.

Theme 1: Funding and resources are low, and basic needs must be met first

Participants reported in virtually unanimous fashion that the funding available to provide an array of social and behavioral health care services has dropped to dangerously low levels. They believed that state systems have for years inadequately funded the continuum of care at the level of the mental health system and related agencies within the legal system. As a consequence, there are major gaps in services at every point in the continuum, resulting in an inability to provide necessary client support through general assistance. Many of the participants found it challenging to provide treatment when the basic needs of their clients could not be satisfied. To this point, one participant said: "*It's Maslow's hierarchy. You can't help people with therapy if they don't have a ride to the clinic or don't have any money to eat.*" Drawing on lyrics on poverty by Bob Marley that "*a hungry man is an angry man,*" one participant commented that "*it's hard to give treatment to people who have no food to eat or place to live.*" Throughout the discussion, participants recounted their extra efforts to help their clients "survive" in the community. Indeed, case managers often go the extra mile literally to get their clients to treatment, as remarked by one participant, "*I'll do whatever it takes; I'll drive out into the country to pick them up if necessary.*"

Many of these comments echo to the past when persons with SMI were moved from psychiatric hospitals to the community. At that time, concerns were raised about the inadequacy of basic services, such as food, shelter, and clothing, and the underfunding of the community-based treatment system that was expected to respond to the demands of relocated individuals. Now the pressure is to reallocate funding from the criminal justice system, which has been consuming more of the public funding, to the community. "*More money needs to be ponied up that is currently used in corrections,*" according to one participant, *"to be used in the community and to provide community resources, and things that reduce recidivism like housing to put a roof over people's heads and income*." Reflecting to the future, the participants expected the gap to widen between the need for services and the ability to meet the need. "*Budgets are already being cut. Many more cuts are also coming*." There was a sense of future doom for their clients as community-based funding dries up, pushing more resources into the criminal justice system as social conditions continue to create environments that increase criminal justice activity and incarceration.

Theme 2: Services must be integrated and coordinated and clients seen holistically

Fragmentation of services has historically plagued the behavioral health and criminal justice systems (Wolff, 1998). The first generation of mental health and criminal justice interventions added specialized programming within the criminal justice system and the mental health systems, adding to the service fragmentation within each system. As a consequence, the current services for justice-involved persons with SMI are highly fragmented, with little coordination between provider agencies or between funding agencies resulting in organizational waste and piecemeal service delivery. For example, behavioral health providers inside correctional settings are often different from those delivering services in the community. Likewise, reentry programs and specialized probation and parole caseloads are often provided by programs funded within and staffed by employees of the justice system. These programs may have little connection to or involvement with community-based services, such as outpatient services (e.g., psychotherapy, case management), assertive community treatment, hospitalization, homeless outreach, and a variety of reentry services intended to help justice-involved persons with SMI adjust to the demands of civilian life. One participant indicated frustration with the chaos by noting that "*my case managers don't even know how to access all those programs, and if a case manager can't do it, how can the clients do it? It's just too complicated!*"

Participants reported that a more concerted effort to holistically engage clients by coordinating services, such as through the utilization of comprehensive service plans that outline what is expected of clients, would minimize client confusion and increase compliance. Yet they also acknowledged that the absence of accessible, integrated, and coordinated services would diminish the impact of the service plan, however, comprehensive. There was general consensus among participants that better integration and coordination of services both within and across systems, including service providers, judges, law enforcement, and parole officers, was necessary to optimize outcomes of lower recidivism and improved functioning for their clients. Here, the discussion focused on the centralization of processing and service delivery across the criminal justice, behavioral health, and social services systems. First, the merits of an integrated and centralized application process were addressed. Centralized processing was recommended whereby *"from day one when they come out, … all of their supports are in place and they know where they're going to go."* The frustration associated with securing housing led one participant to remark that "*if we could have a one-stop application process for all the housing programs, I just can't tell you how wonderful that would be.*"

There was a strong sense among the participants that "scale" inefficiencies were rampant in the community as a consequence of many different small-scale programs offering similar services. Resources, it was argued, could be used more efficiently by combining programs to achieve economies of scale. Speaking to this point, one respondent said *"a lot of community services that are out there are repeating and providing the same things in a localized area; they are doing the same thing. It would be great to be able to combine programs and services to make things more efficient and provide a better array of services. This would also reduce administrative burden across programs."*

In response, one participant suggested a "one-stop center" that would process applications for housing as part of a comprehensive approach to provision of case-management services. Said somewhat differently but speaking to the same issue, another participant said that "*We need Macy's—not the little boutiques that we all have*."

Participants also acknowledged the importance of networking and collaborating with other service programs to reduce

waste across programs and optimize the overall quality of client treatment. There was frustration among participants with the high level of staff turnover within their agencies. Here, it was noted that evidence-based practices (EBPs) required high levels of staff training and, that oft-times, after training staff in these practices, they switched agencies or jobs. Losing investments in their staff placed a significant burden on agencies, especially small-scale agencies dependent on grant funding. High turnover also compromised service quality as "*high level of turnover … leads to confusion and delays in getting benefits*."

Theme 3: Evidence-based practices are important but must be feasible and flexible

Participants were uniform in their agreement that EBPs were efficacious, valued, and necessary for the care of their clients. Yet all these programs balkanize services. One participant noted that "*there's an alphabet soup of different interventions [and it is] hard to follow them all and keep track*." There is, indeed, a virtual "alphabet soup" of specialized services (e.g., FACT, CIT, CTI, CBT, RR, MRT, START, AOD, SOAR) being implemented to respond to the needs of justice-involved persons with SMI. This is problematic in a number of ways. It can be highly confusing to sift through the numerous options and to make decisions about which services to adopt and implement. The similarities or differences among them can be obscure, and many appear to be implemented in a "*faddish*" manner—"*encouraged and funded today, and then gone tomorrow*."

> *" …there's an alphabet soup of different interventions [and it is] hard to follow them all and keep track."*
>
> ~Workshop participant

There are also concerns about training and intervention fidelity, especially when mental health care providers or case managers are responsible for implementing multiple intervention types. To this issue, one participant noted that "*the training for all these different treatments is a problem, and how can you monitor fidelity? One can't be an expert in everything!*" With frustration, another participant noted "*if it's not feasible, it won't work [or] matter. I'm all for manuals, but they have to be feasible*." As a consequence, it was often not clear whether interventions are being implemented with fidelity or in accordance with the empirical evidence behind them.

The solution that rose from the group discussion was the need for unified protocols, with flexible and integrated core principles and approaches that can be effectively applied even if clients are only able to be engaged for a short period of time. There was considerable frustration with the disorganized push to implement EBPs without any sensitivity for their disjointed philosophies and approaches, as well as specialized training requirements. To this issue, one participant said that treatment "*is very expensive…. The people who developed it are now getting rich, which is okay, but maybe there could be a more cost-effective way to provide good service. Also the service would have to be flexible*."

"Poly-programming" was raised as another significant issue. Most of the EBPs being implemented have been tested against competing alternatives, but not in the context of multiple different interventions with different philosophies, orientations, and staffing requirements. Little thought has been given to the production aspects of EBPs. In reality, each EBP often has its own manual, training requirements, philosophy, and structure, as well as fidelity requirements. If a program offers five EBPs, staff has to be trained to implement the manuals according to the philosophy and structure of each EBP. The breadth and depth, as well as the compatibility, of the production requirements of the different EBPs can challenge feasibility, especially for small scale programs. Indeed, it is not clear that it is feasible, effective, or cost-effective to simultaneously implement multiple EBPs, in the same way that it is unclear whether different medications when combined will yield the effects expected if taken independently. Yet the current practice of wholesale implementation of poly-programming assumes that the effects of the individual programs will be forthcoming; an assumption that imposes large training and staffing costs on the programs. For this reason, it was argued that practitioners and clients *"need things that don't require multiple modules over time, [but] something that can be accommodating and effective if we have people for three days or three months. Something where you can get efficient training in one-on-one sessions*." Moreover, it was thought that any unified protocol must be one that can be implemented and coordinated across the spectrum, from incarceration to reentry and beyond.

Theme 4: Philosophical approaches matter and require universal application

As part of the discussion, participants were given 10 imaginary chips, each worth one million dollars. They were asked to allocate the chips across four areas: external controls; treatment and networking resources; staff training; and philosophy, which were identified in the web-based survey as ways to improve program effectiveness (refer to Table 3). Quite surprisingly, the majority of chips were allocated to "philosophy." Participants were in marked agreement that "philosophy matters" and that the philosophical orientation towards clients and their recovery was more relevant to outcomes than any specific procedures or intervention. One particular area concerned the perception of the person. Here, there was a strong belief that justice-involved persons with SMI *should* be treated as people, first and always. There was a strong belief among participants that "*people should be treated like human beings*."

This belief, however, was variably accepted within and across programs, especially those situated in the criminal justice system. Tension in philosophical orientation toward clients was the strongest between those representing the mental health and criminal justice systems. One participant noted that "*… because I'm on the clinical side we struggle with the legal team because they are very punitive*." While consequences are important and universally supported by participants, the form of the consequences mattered. From a clinical perspective, "*with a treatment recovery orientation, [clients] are driving [their] own treatment. We help them find the motivation to actually do those things to meet their definition of success*." In contrast, the "*… law can punish them, but for us to punish them by doing things like withholding treatment, which some mental health center's do, they punish them by calling them non-compliant and then not treating [them], that doesn't work*." Punishment orientations may actually make matters worse. "*Punishment may work for somebody, but I know it does not work for the people that come through our doors*."

The workshop participants supported an interactional style and client orientation that is more relational than authoritarian. By this, they meant "*treating clients like people*," taking a collaborative problem-solving approach, developing rapport, showing concern and empathy, offering encouragement when appropriate, and maintaining a consistent firm and fair approach to each client. It also means avoiding adversarial or punitive interactions. At the same time, participants strongly agreed on the need for direct consequences to influence behaviors, including both rewards and "recovery-sensitive" punishments. Participants explained that a relational approach fosters client communication and motivation, and ultimately optimizes program resources and treatment delivery.

Integrating philosophies about style and orientation within and across programs was also seen as vital but challenging. The importance of bringing program and policy leaders on board was identified as key. Participants working in the criminal justice field saw the need to involve judges in the process. "*Judges have pretty unlimited power and where I come from if you want something done whether its housing, programs, or money, you have to get them on board first. It's been very hard to do from the bottom up*." This "buy-in" and engagement from judges is needed given that they have the authority to create policy, direct funding, determine the sentence, and mandate oversight parameters.

An integrated philosophical approach includes many elements, including a need to educate and train everyone working within the legal system (police, correctional officers, prosecutors, judges, parole officers, etc.) on the role of mental illness and co-occurring disorders in criminogenic thinking and behaviors, and the importance of high quality interventions for addressing psychiatric symptoms and improving role functioning within the community. There was near unanimous agreement among participants that the impressions of mental illness at the policy-level were critical, as policy makers establish policies and funding priorities. "*We need to train our policy makers to focus on what is really cost effective. We need them to know that mentally ill people are not bad; they do bad things, but they are not bad and they have a right to treatment*."

In terms of building a culture that reflects this philosophy, it was strongly recommended that agencies "*hire staff that has the ability to understand and empathize with our clients*." Growing this culture within agencies and systems would require hiring priorities, training on issues of philosophy, and line support of the values underpinning the philosophical approach to "person" engagement and treatment.

Conclusion

This survey and workshop discussion provided a window into the experiences and needs of community-based and diversion-focused programs serving justice-involved persons with SMI. Our objective was to learn from these program staff so that research can be focused to assist programs improve the health and well-being of their clients. What we learned from these respondents is that they are serving clients with a constellation of challenges that place them at risk for psychiatric relapse and recidivism. Their clients have psychiatric disorders that require treatment. However, a sizable proportion of their clients are resistant to treatment because of where they are in their acceptance of their illness and its treatment, and they may be similarly resistant to prosocial interventions because they have thinking styles, life situations, and/or behavioral tendencies that put them at greater risk for criminality. And, even for those clients who are accepting of intervention, the philosophy, structure, orientation, and availability of the intervention may not fit their needs in ways that are most effective. The philosophy of seeing the person within a "stages of change" model was seen as vital, as well as recognizing that getting to sustained change takes time, tolerance, and an abundance of chances.

It was also noted that many problems co-occur with mental illnesses, including poverty, urban disenfranchisement, substance abuse, criminal thinking, interpersonal trauma, stress, and underdeveloped coping and social competencies, which individually and collectively serve as risk factors for relapse and recidivism. These co-occurring problems are not simply artifacts of which to be aware; rather, they are, in and of themselves, targets of intervention because of their link to relapse and recidivism.

Responses to the survey suggest that access to services varies between the community-based and diversion-focused programs. While both groups of respondents had identified similar needs among their clients, community-based respondents, compared to their diversion-focused counterparts, reported greater availability of services in response to these needs. This may indicate that community-based staff had stronger professional networks and knowledge of community resources and, as a consequence, they are more aware of services in the community than their diversion-focused counterparts situated in the criminal justice system.

Results from the workshop affirmed and elaborated these findings. Many remedial problems were identified by workshop participants, including the need to focus on the "basics" in terms of service funding and delivery; the efficiency and effectiveness of program scale; the impairing effect of production inefficiencies on effectiveness; the effects of poly-programming on efficiency and effectiveness; and the consistent integration of philosophy into agency culture and practice.

According to study respondents, improving the next generation of behavioral health and criminal justice interventions will require adequate funding, better coordination and integration of services tied to particular problems, EBPs that are feasibly implemented across the spectrum of care (with unified protocols), and a relational and recovery-oriented approach that is coherent and integrated (i.e., with "buy-in") at all levels within and between organizations and systems. More specifically, the findings from the survey and workshop suggest the following service recommendations:

- Develop service structures and orientations that can address the co-occurrence of multiple problems that interact in ways that can impair judgment and promote harmful conduct;
- Adopt and consistently implement a "person first" value into engagement and recovery philosophies;
- Integrate evidence-based programs in ways that are sensitive to production requirements (e.g., screening tools, staffing requirements, philosophies, manualized structures, outcome measures, and fidelity measurement) and social conditions (e.g., employment, criminal justice encounters, housing); and
- Integrate service modalities that (a) address the problems (e.g., trauma, criminal thinking, substance abuse) that contribute to relapse and recidivism and (b) build the requisite skills that will support healthy and safe choices and conduct.

On the research side, the recommendations from the survey and workshop include:

- Adapt and test screening tools for the "Central Eight" risk factors and training modules for community-based providers;
- Test the effects of "poly-programming" on treatment effectiveness;

- Explore the integration of several EBP interventions focusing on different problems, e.g., integrating interventions focusing individually on trauma, stress, addictions, criminal thinking, and serious mental illnesses into one intervention, with emphasis on core constructs and synergies;
- Examine the role of program, organizational, and system philosophy on recovery and recidivism outcomes;
- Use implementation science methods to study the implementation of integrated philosophy and EBP interventions; and
- Use principles of efficiency to explore issues of program scale and production requirements in the delivery of services within and across systems.

The practice recommendations identified by respondents are consistent with emerging trends in other related fields, as well as recent evidence from the field of mental health and criminal justice. The proliferation of cognitive behavioral treatments in psychology has recently led to the development of a transdiagnostic unified treatment protocol for emotional disorders (mood and anxiety) that incorporates empirical evidence from the domains of learning, emotional development and regulation, and cognitive science (Wilamowska et al., 2010). Moreover, empirical data indicate that correctional officers can be most effective in reducing recidivism when relying on a relational approach rather than an authoritarian approach (Skeem, Eno Louden, Polaschek, & Camp, 2007; Skeem, Eno Louden, Manchak, Vidal, & Haddad, 2009).

While results from this study are consistent with emerging trends in the behavioral health field, this research effort has several limitations. Our findings represent only the perceptions and opinions, with a range of possible biases inherent, of a nationally-representative group of key informants consisting of administrators, advocates, and practitioners working on behalf of justice-involved persons with SMI. Findings are also limited by our inability to recruit representatives from all of the eligible programs. Overall, for the web-based survey, we achieved a 77% program participation rate and for the in-person workshop, a 42% program participation rate (reasons for not participating appear in the appendix), which likely introduces unknown bias into the results. Nevertheless, according to these key informants, the current status quo does not represent an optimal utilization of resources, either for individuals with SMI, the criminal justice systems they are involved with, or society at large.

Often the focus of research is on individual change, specifically getting individuals (i.e., persons with SMI) with unhealthy or harmful behaviors to change their cognitions and behaviors in ways that will yield healthier or less harmful behaviors. Our findings suggest the need to also get systems, agencies, programs, and staff to change in order to improve behavioral and cost outcomes. Some of the changes recommended by our respondents are relatively inexpensive (e.g., changing the values or philosophy of an organization), while others are more expensive (e.g., consolidating and integrating programs). It is important to note, however, that, independent of the relative cost of these changes, there is likely to be enormous resistance to change. System, agency, and program changes will be resisted for the same reasons that individuals resist change — fear of the unknown, lack of skills, habit persistence, constitutional orientation, and desire to maintain autonomy, structural rigidities, and so forth.

As in the case of individuals, system-wide change usually requires crisis and it is not clear whether the recent health care reforms and fiscal issues across the states will motivate enough "crisis" for these changes to emerge. The status quo of first generation interventions, however, is likely on its own to generate pressures for change, as scale and production inefficiencies in combination with fiscal constraints will likely lead to internal pressures for EBPs to be scaled back, modified, or eliminated altogether to save costs. The next generation of interventions, if they are successful in integrating problems, philosophies, and approaches, may provide an alternative to "cheapening" extant EBPs by lowering their budgetary costs by scaling back, eliminating, or modifying their components.

Certainly there are significant humanitarian goals guiding the provision of treatment for justice-involved persons with SMI. But, to achieve these goals, practical issues will dominate. How treatment is delivered must be sensitive to the implementation and production aspects of EBPs, as these issues influence costs and, ultimately, sustainability. For positive change to emerge within the behavioral health and criminal justice arena, cost savings will have to be assured by developing programs that are sensitive to the staffing and protocol requirements of interventions adopted in real world settings. The alternative: cheapening extant EBPs, can be expected to be penny-wise but pound-foolish as such changes are likely to increase costs related to crime, law enforcement, criminal justice proceedings, and incarceration.

Blueprint for Effective Change: Moving to the Next Generation of Interventions

Improving outcomes for justice-involved people with SMI begins with an unbiased and rich understanding of the challenges facing these individuals and follows with the designing of interventions that address these challenges within the context of the environments where individuals live and interventions are set. In earlier sections, we reviewed the limitations of first generation interventions and their inability to reduce the prevalence of people with SMI entangled with the justice system. We also presented a more "normal" view of the risks that contribute to the justice involvement of people with and without MI. This view was confirmed and elaborated upon by practitioners in this field who participated in our survey and workshop. With this as a foundation, we describe the process of building more effective interventions; interventions with a better chance of reducing the ranks of people with SMI in the justice system. In this section, we present a blueprint and recommendations for modifying first generation interventions and building the next generation of interventions to achieve the twin goals of psychiatric stabilization and recovery and reduced criminal justice involvement.

Effective Change

"Effective change" is the goal of the blueprint to be described in this section. Change will be deemed effective if interventions are designed to improve behavioral health ***and*** criminal justice outcomes for people with SMI. Our blueprint for effective change has a set of unifying principles and a conceptual framework supported by these principles and targeted towards measureable outcomes. The outcomes, principles, and framework are informed by and integrate the evidence presented in earlier sections.

Goal for Effective Change

The two outcomes of focus in our blueprint for effective change are: (1) to improve psychiatric outcomes (i.e., stabilization, functioning, recovery) in the least restrictive setting ***and*** (2) decrease recidivism. Trans-institutionalization is not seen as an effective outcome. That is, neither incarcerating people with SMI to stabilize them psychiatrically nor hospitalizing them to avoid harm to self or others is seen as a successful or preferred outcome. The goal of effective intervention is to engage people with SMI in timely and respectful ways that avoid the need to unnecessarily use restrictive institutional modes of intervention. Ultimately, effective interventions should both increase the quality of life for people with SMI and enhance the safety of the communities where they reside.

Unifying Principles

At the foundation of any intervention are principles. These principles support our framework of intervention and guide it towards the outcomes of interest. We propose the following seven unifying principles for the next generation of behavioral health and criminal justice interventions:

1. The "person" is the focus of intervention.
2. Mental health treatment is a necessary component of any intervention and should be delivered in the least restrictive setting and with the least intrusion on individual choice.
3. Recovery from mental illness includes relapses.
4. Many person and place factors contribute to criminal behavior.
5. People with SMI who engage in criminal behavior have competing and interacting risk factors in addition to their mental illness.
6. Many risk factors that predict criminal behavior are "intervenable."
7. Change is a process and any movement forward on this continuum should be interpreted as some measure of progress.

Conceptual Framework for Effective Intervention

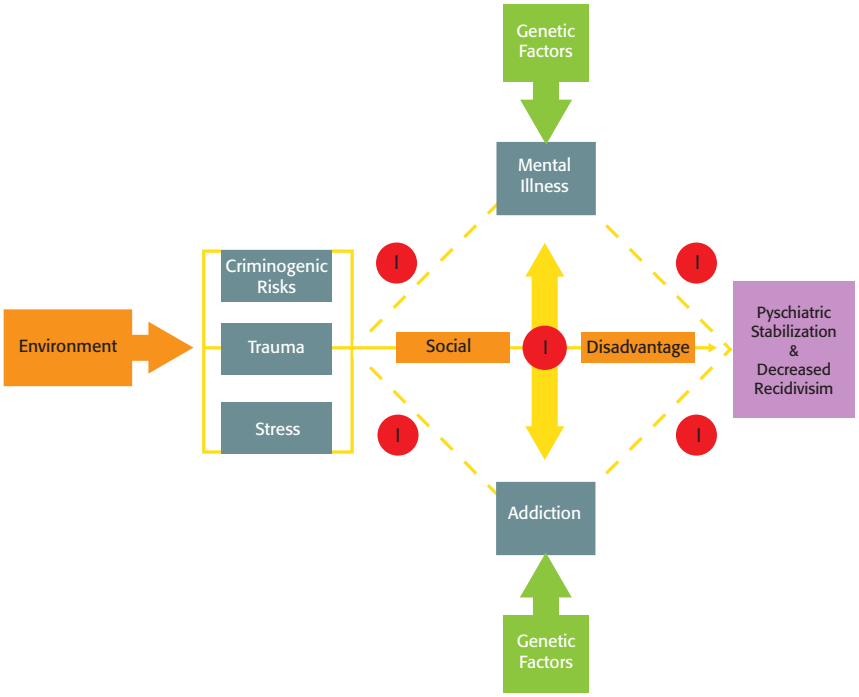
Our framework for intervention focuses on the person- and place-level risk factors discussed in section two, and reflects the seven unifying principles identified above. The purpose of this framework is to both highlight and integrate the risk factors predicting criminal behavior and to identify points of intervention to achieve the goals of promoting psychiatric wellness and reducing criminal behavior.

As shown in Figure 4, psychiatric stabilization and recovery and decreased recidivism are predicted by person-level factors: criminogenic risks, trauma, stress, mental illness, and addiction (blue boxes); and place-level factors: social disadvantage and environmental conditions (orange boxes). Person-level factors can be triggered by historical or current experiences in the environment (e.g., community, institution) or genetic predispositions (green boxes). The dynamic interactions among the person-level factors are shown by the gold lines that are associated with psychiatric symptoms and criminal behavior. Content areas for intervention are indicated by the red circles, which indicate needs and risks that can be targeted for intervention.

Key Components of Effective Intervention

Overlapping risks. Risk factors for psychiatric relapse and crime overlap with each other. The "Central Eight" risk factors, represented in the box labeled criminogenic risks, directly predict criminal behavior. Although mental illness (as measured by specific symptoms of psychopathology such as psychosis and depressed mood) does predict criminal behavior, it does so to a lesser degree than the "Central Eight" risk factors (Andrews & Bonta, 2006). Yet, as we know, mental illness and criminal risk co-occur and, as such, when presented together can interact and jointly predict criminal behavior. A recent study by Walters (2011) shows criminal thinking as a mediator for inmates with SMI who engage in violence inside prison. Likewise, factors associated with social disadvantage (i.e., unemployment, lack of education, lack of housing, and economic difficulties) increase the risk for re-hospitalization (Mgustshini, 2010) and are also known risk factors for criminal behavior. Similarly, substance abuse, a prominent risk factor for criminal behavior, contributes to mental illness relapse (Lyons et al, 1997). In fact, the link between mental illness and violence is weak without co-morbid

Figure 4: Conceptual Framework for Effective Intervention



substance abuse issues (Elbogen & Johnson, 2009; Swartz et al., 1998). An effective intervention adopts an overlapping risks perspective that identifies and responds to the collection of risks that predict relapse and recidivism (Lurigio, 2011).

Service orientation of intervention. Historically, services for justice-involved people with SMI have emphasized one of two service orientations: basic mental health services or criminal rehabilitation (Morgan, 2003; Morgan, Steffan, Shaw, & Wilson, 2007; Morgan, Winterowd, & Ferrell, 1999). The focus of basic mental health services has been on symptom reduction, adjustment difficulties (e.g., coping with incarceration), crisis management, and impaired daily functioning (Fagan, 2003). By contrast, criminal rehabilitation has focused specifically — and most often exclusively — on reducing criminal behavior and criminal recidivism (Morgan, 2003). While interventions for persons with SMI have been traditionally categorized as either basic mental health or criminal rehabilitation service, this view is inconsistent with the evidence of co-occurring risks. Interventions are designed for ineffectiveness if they focus on one risk factor, instead of the "person" who is likely to have a range of co-occurring risks. For interventions to be effective for persons with SMI, they will need to be sensitive to and tailored for the co-occurring mental health and criminal rehabilitation risks and needs of people with SMI. The next generation of interventions, in all likelihood, will be housed in criminal justice and mental health specific settings. Their setting, however, should not restrict, constrain, or limit the intervention components of philosophy, approach, or outcomes.

Philosophy of intervention. Interventions designed as solely mental health or criminal justice assume particular engagement philosophies that are unique to their service systems. It is customary for the mental health system to adopt a person-centered treatment philosophy, where the focus is on providing mental health treatment for Axis I mental disorders in ways that stabilize the person's mental illness. Treatment emphasizes medication compliance for persons with SMI. Compliance, however, is set within a recovery framework that understands relapse as part of the recovery process. In the criminal justice system, the engagement philosophy typically emphasizes the label of "offender" and the system's responsibility to protect the public by holding the individual accountable to conditions set forth by the court. Compliance, in the criminal justice context, is framed more rigidly because it is viewed through a dual public safety and rehabilitation lens that interprets non-compliance as evidence of manipulation and continued deviance on behalf of the "offender," which puts the public at risk.

These disparate and competing engagement philosophies create strain and tensions between the staff of the mental health and justice systems with mental health staff seeing the person primarily as an illness and justice staff (i.e., judges, prosecutors, officers of the police, corrections, probation, and parole) seeing an offender who is deviant. If criminal justice staff becomes more flexible (or recovery-oriented) in their management and supervision of persons with SMI, they are open to accusations from supervisors or peers of being "soft on crime," "a hug-a-thug," or "not being a 'real' cop." These social pressures encourage staff compliance with the system's "tough on crime" philosophy. Mental health professionals who routinely interface with criminal justice professionals may internalize the "officer" mentality of the criminal justice system, seeing their clients more as offenders and becoming more confrontational and rigid in their compliance expectations and liberal in the use of negative sanctions for lack of treatment participation (Lamb, Weinberger, & Gross, 2004).

Neither an extreme (i.e., illness- or criminal-oriented) nor a blended engagement philosophy is part of effective intervention. More consistent with effective intervention is the recognition that the person, while both having a serious mental illness and entanglements with the justice system, is more than an illness or an offender. These individuals are human beings and, as such, they respond best when treated respectfully, civilly, and professionally. Like most people, they will respond more openly if shown concern and empathy, offered encouragement and support, treated with fairness and consistency, provided with clear expectations for behavior, and engaged by a problem-solving approach. And, when positive change is observed, no matter how incremental, it should be acknowledged as progress towards wellness and prosocial living. An effective intervention will assume a humanistic engagement philosophy that sees the person as a human being, capable of change, facing a collection of challenges, and who responds best when treated respectfully, civilly, and professionally.

Getting from Here to There

Our recommendations for building effective interventions are organized around issues of structure, process, and outcomes. These recommendations are informed by the blueprint and by the issues of scale, production, duplication, and poly-programming inefficiencies raised by practitioners in section three.

Structural Recommendations

Fragmentation of effort across multiple systems and agencies creates the mistaken impression of effective action. When fragmentation results in duplication of effort, redundancies, and production inefficiencies due to small scale or under-used specialization, the dominant result is implementation inefficiencies, not program effectiveness. As a consequence, relapse and recidivism outcomes are foregone because resources are wasted in the production and distribution of incremental interventions that are not integrated, coordinated, or centralized. The fragmented nature of the first generation of intervention was highlighted as a significant problem by practitioners in the field, as illustrated by the following quote: "*We need Macy's — not the little boutiques that we all have.*" We recognize that bundling all needed services for this population into one program or setting is, for most localities, infeasible.

> *"A lot of community services that are out there are repeating and providing the same things in a localized area, they are doing the same thing. It would be great to be able to combine programs and services to make things more efficient and provide a better array of services. This would also reduce administrative burden across programs."*
>
> ~Workshop participant

However, the next generation of interventions would benefit from adopting a unified and complementary approach. To enhance the effectiveness and efficiency of the next generation of interventions, we recommend:

- **Integrate Interventions.** We recommend the modularization of interventions for justice-involved persons with SMI, regardless of whether the intervention is delivered in a criminal justice, mental health, a hybrid setting, or multiple service locations. Problem-specific modules would reflect evidence of what works for people with and without mental illness who are justice-involved. There is research evidence to guide module development. Morgan and colleagues (2011), using meta-analytic techniques, found that a variety of treatments addressing trauma, stress, medication compliance, and skill building were effective in reducing criminal justice involvement of justice-involved persons with SMI. These interventions were also found to reduce distress, improve coping, and reduce behavioral problems. Drawing on this evidence and with a unified protocol, problem-specific modules would be structured to incorporate the seven unifying principles and the key components of effective interventions. In addition to learning objectives, interactive exercises, and homework assignments for each module, there would be design recommendations in terms of group size and composition; length of intervention; sequence of topics; staff training; and staff, process, and outcome assessment. The modules would draw heavily on psycho-educational approaches and would be developed for particular risk areas but would integrate other risks into skill building exercises and discussions, and would include a:

  - **Medication adherence module**. The *Medication Adherence* module seeks to build an understanding of how medications regulate and improve the body's functioning. This module recognizes the presence of co-occurring medical (e.g., diabetes, hypertension, HIV, asthma) and psychiatric disorders. Medication treatment would be oriented first to chronic medical conditions and then to psychiatric conditions. The effects of substance use would be addressed as part of this discussion. The focus of this module is on educating people with SMI on the biological mechanisms of schizophrenia, bipolar disorder, and major depressive disorder, why treating these disorders pharmacologically is necessary, and the benefits and side effects of various types of medications. Skill building exercises would address how to communicate with physicians regarding medications, specifically side-effects encountered, as well as coping strategies for undesirable side-effects.

- **Criminogenic risks module**. The *Criminogenic Risks* module seeks to help justice-involved persons with SMI develop an understanding of factors contributing to their criminal behavior (including antecedents to crime) and promote skill development such as social and problem-solving skills, as well as anger management to counter personality attributes of impulsivity and weak self-control. The goal of this module is to reduce criminal thinking and connections with criminal associates. This criminogenic risk module would be informed by and coordinated with modules seeking to increase psychiatric stabilization and recovery, decrease addictive behaviors, build environmental supports for prosocial living, improve skills that support healthy interpersonal relationships, and increase participation in prosocial activities such as employment, education achievement, volunteering, and recreational activities.

- **Addiction risk module.** The *Addiction Risk* module focuses on all forms of addictive behavior. Addictive behaviors may be (a) caused by genetic predispositions triggered by environmental circumstances or (b) a coping response to environmental circumstances that cannot be tolerated in healthy ways. In either case, addictive behavior is connected to experiences in the environment. Focusing only on substance use and addiction is problematic in correctional settings because it is often assumed that without the availability of substances, the substance abuse problem is addressed. However, when substance use is a coping strategy for feelings that are intolerable, people will substitute other forms of addiction to manage these feelings in correctional settings, such as gambling and romantic relationships. For this reason, the addiction risk module would assess type and level of addiction, examine antecedents to addictive behavior, and identify the circumstances (including thoughts and feelings) that trigger addictive behavior. This module would examine the client's life goals and how reducing addictive behavior can assist the client in obtaining his/her goals. It would also develop knowledge and build healthy coping skills for changing addictive patterns. The addictive risks module would reinforce skills and connections developed in the criminogenic risks, trauma, stress, and social disadvantage modules. Mindfulness-based relapse prevention for addictive behaviors is a promising intervention for this module (Bowen, Chawla, & Marlatt, 2011).

- **Trauma risk module.** The *Trauma Risk* module would incorporate a "trauma-informed" care approach. This approach focuses on increasing staff awareness of trauma exposure prevalence and its consequences, and how best to engage clients who have experienced trauma. Staff would be trained to ask clients about "what happened to them" and to respond to their clients in ways that are respectful, reassuring, and hopeful about the possibility of recovery. Clients would be guided through a process of understanding how trauma has impacted them and about the connection between trauma and trauma-related responses (e.g., depression, anxiety, addictions, criminal behavior). Two promising interventions that could provide content for this module are Seeking Safety (Najavits, 2002) and Trauma Recovery and Empowerment Model (Fallot & Harris, 2002).

- **Stress risk module.** The *Stress Risk* module would build skills for managing stress in healthy ways. It would focus on building an understanding of how stress accumulates in life and decision-making skills can decrease the accumulation of stress and increase healthier responses to stress. A growing body of evidence shows mindfulness-based techniques to be effective in reducing levels of stress, anxiety, and depression (Baer, 2003). Mindfulness-based stress reduction approaches use meditation practices to build the ability to concentrate on an object (usually the breath) and then expand the focus to the emotions, thoughts, and sensations associated with an experience. Mindfulness-based approaches have been increasingly incorporated into treatment for a range of medical and psychological

disorders, including chronic pain, depression, anxiety, eating disorders, substance abuse, and smoking cessation (see: http://www.mindful-net.org). This module holds promise both for managing the stress associated with the effects of incarceration or correctional supervision and living in socially disadvantaged communities, as well as the management of thought and emotional processing that can trigger relapse of mental illness, addiction, and criminal behavior.

- **Social disadvantage risk module.** Interventions geared towards the individual are not effective at changing systemic layers of social disadvantage. The *Social Disadvantage Risk* module would build skills on how to identify and avoid high risk situations, to distinguish between "good friends" and persons who are interested in causing harm, to establish intra- and interpersonal boundaries to avoid being manipulated by others, and to avoid people and places that increase the risk of victimization or criminalization (Drake, Wallach, & McGovern, 2005; Drake & Wallach, 1989). Additionally, this module would entail an assessment of needs related to social disadvantage, including housing, education, and job training, and would provide linkages to services to address these needs.

- **Centralize Interventions.** Although it is unrealistic to have a "one stop" center for justice-involved people with SMI in every community, it is feasible to develop and implement an internet-based "one-stop" intervention site that centralizes information on screening tools, intervention modules, and training related to these modules. This site would provide universal access to practitioners located around the country through a web portal that would support a virtual "community of practice." Communities of practice (CoP) are "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (Wenger, 2000). The goal of these communities is to advance a specific knowledge base and to diffuse it, effectively and efficiently, though a social (knowledge) network. Through a CoP portal, practitioners would be able to download module materials, participate in on-line training on each module, attend webcasts on particular risk areas, and communicate problems and experiences with other practitioners and researchers through an interactive discussion venue. The Center is currently piloting a virtual CoP with practitioners. Additionally, local or regional services could be organized into geographically tailored CoP's, in which service providers can coordinate the delivery of interventions in a way that incorporates the recommended targets and modules without unnecessary redundancies or omissions. The goal here is to centralize and standardize the dissemination of screening tools, intervention modules, and the related training for tools and modules in an effort to minimize production inefficiencies and maximize intervention effectiveness.

Process Recommendations

Targeting interventions for effectiveness requires identifying "intervenable" risks efficiently and reliably among justice-involved persons with SMI. This is particularly problematic when the different risk areas have developed specialized screening tools that require specialized training for administration and/or have not been disseminated broadly across service systems managing clients with these risks. Similar compartmentalization occurs with techniques for engaging clients in the process of behavioral change. Those who work in the risk areas of substance abuse and mental illness understand that the process of change is not linear or binary. People adapt to change through stages where periodic and episodic relapse is part of the change process. In general, people do not change from not complying with treatment to compliance with a single dose of an intervention or in a straight line. They approach change over time and circuitously. For this reason, our process recommendations are:

- Identify valid, reliable, and cost effective screening tools for each of the risk areas and distribute the instruments along with scoring training to practitioners through the web-based community of practice portal.

- Customize motivational interviewing (Miller & Rollnick, 2002) and relational approaches for the supervision of persons with SMI in justice settings and provide training on the use of these approaches to engage clients in the process of change.

- Develop training on effective engagement of justice-involved people with SMI for justice and mental health staff. Trainings for justice staff would address the relative advantages of a relational approach rather than an authoritarian approach in terms of recidivism outcomes, as well as how authoritarian styles exacerbate psychiatric systems and trigger trauma flashbacks and unhealthy coping strategies. Training for mental health staff would focus on criminogenic risks and behaviors and their triggers, as well as the difference between antisocial cognitions and antisocial personality disorder.

Outcome Recommendations

Interventions situated at the intersection of the behavioral health and criminal justice systems address outcomes of greatest interest to the systems that fund the interventions. As such, interventions situated in justice settings (e.g., courts, probation or parole offices, prisons) often measure changes in recidivism with specificity and changes in psychiatric relapse generally. By contrast, interventions located in the behavioral health system reverse the order of specificity, with more rigorous measurement of treatment outcomes than recidivism outcomes. Global outcomes of recidivism, relapse, and treatment compliance, however, assume that change occurs either as a linear or binary process, which it does not. For this reason, we recommend the:

- Standardization of outcome measurement for psychiatric relapse and recidivism across interventions for justice-involved people with SMI independent of the placement of the intervention and its funding source.
- Development of outcome measures that are specific to areas of risk and that capture the *process of change* towards outcomes associated with prosocial living, including symptom and harm reduction, healthy relationships, stable housing, vocational and avocation activities, community living, compliance with treatment and supervision conditions, and improvements in quality of life.
- Calculation of outcome to cost ratios that measure the change in risk to program expenditures to evaluate the cost effectiveness of interventions.

Conclusion

The development of first generation interventions for justice-involved persons with SMI spans over two decades and resulted in the vast expenditure of resources. However, to advance the ultimate goal of these interventions, which is to alleviate the over-representation of people with SMI in the criminal justice system, significant changes are required in the process and design of these interventions. The necessary changes entail more than simple modifications to or tweaking of existing interventions.

In this blueprint for effective change, we advance unifying principles, a conceptual framework, and key components of effective interventions as well as recommendations for the structure, process, and outcomes of these interventions. The comprehensive changes that we suggest will prefigure the next generation of behavioral health and criminal justice interventions that, we believe, will yield significantly improved individual and social outcomes.

Building the next generation of interventions will not be an easy task. There are many individual, organizational, and structural factors that resist change. But just as we advocate for an orientation that sees individual change as a process or continuum, so must we expect a similar process of change within systems, organizations, programs, and interventions. Change, at any level, is a process that moves in small, often non-linear increments, not in leaps, bounds or straight lines. It is time, however, to actively engage in this process; there is simply too much at stake to continue to rely solely on first generation interventions. The framework presented herein is a step in that process and, hopefully, it will inspire additional steps toward better outcomes for all.

Appendix

Mental Health Interventions Survey and Workshop Methods

Sampling

The study population was comprised of all programs that were part of the Building Interventions Database created and maintained by the Center for Behavioral Health Services & Criminal Justice Research. The Building Interventions Database included programs from across the United States that (1) provide direct treatment services or brokered services; (2) have clients/patients with mental illnesses involved with the criminal justice system as the target population; and (3) operate for the specific purpose of improving community-living outcomes, such as reduced hospitalization and criminal justice encounters. The programs in the Building Interventions Database were compiled from a variety of sources including; the Justice Center's Criminal Justice/Mental Health Consensus Project's local program database, a general internet keyword search, and state and national government and non-governmental entities such as the National Association of State Mental Health Program Directors website, National Institute of Correction, National Criminal Justice Reference Service, National Institute of Justice, National Institutes of Health, Bureau of Justice Statistics, Policy Research Associates, The Bazelon Center, and the Substance Abuse and Mental Health Services Administration.

Survey data were collected from October 12, 2010 to January 25, 2011. All programs in the Building Interventions Database were invited to participate in the survey, as well as those programs referred by respondents. In all, 153 programs were eligible and 111 programs consented to participate in the survey. A total of 86 programs completed the survey. The response rate was 56.2% of eligible programs and 77.4% of programs agreeing to participate. One program was excluded from data analysis because they served individuals with sexual offenses and not mental illness.

Procedure

The consent procedures were approved by the appropriate Institutional Review Boards. Subjects were compensated with a $10 gift card to Barnes & Noble for their participation in the study. The survey was conducted on-line in a web-based format that required subjects to log in using a unique access code.

Unique access codes were generated using random string generator for up to three contacts in every program of the Building Interventions Database. Up to three contacts per program were emailed in September 2010 to request their participation in the survey. If a contact declined to participate, additional contacts for the program were emailed until either three contacts in the program agreed to participate, or no contacts remained for the program in the Building Interventions Database. Contacts who did not respond were sent an email in October 2010 to remind them that the survey was taking place and were asked if they were interested in completing the survey.

Contacts who agreed to participate were emailed a survey link, an individual access code, and instructions to access the survey. Supervisors in programs with less than three contacts were emailed up to two additional access codes with instructions to distribute the access codes and survey instructions to other individuals in their program who may be interested in completing the survey, such as case workers, coordinators, and social workers. Subjects were also asked to refer programs that they believed would be interested in participating in the survey.

All contacts who agreed to participate in the survey were sent emails in October, November and December 2010 reminding them to complete the survey. The survey was completed on January 25, 2011. In all, 86 programs and 110 subjects completed the survey.

Variables and Measures

The survey was divided into four parts: (1) program organization; (2) characteristics and needs of program clients; (3) needs and obstacles of program services; and (4) professional and demographic background of subject. It took approximately 30 minutes to complete the survey.

Analysis

Programs were separated into two categories for analysis: (1) those that provided direct community-based services (n=53) and (2) those that provided either correction-based services or reentry case management/diversion services (i.e., no direct treatment services) (n=32). One respondent was selected from each participating program. Preference was given to respondents with more client contact and experience. If subjects had an equal amount of client contact and experience, they were chosen randomly.

Workshop Methods

The workshop population was a subset of individuals from programs that participated in the survey. Subjects were not compensated for their participation in the workshop, although they were reimbursed for their travel expenses and provided overnight accommodations.

Of the 86 programs that participated in the survey, 45 were invited to participate in the workshop. At least 1 program from every participating state (n=33) was invited to participate in the workshop for regional representation. Priority was given in selection to programs that provided direct community treatment services (ACT, FACT, Intensive Case Management, etc.). Other factors given priority were length of program existence, range of services provided, and selecting multiple programs from states that had multiple programs participate in the survey.

One individual from each of the 45 programs was invited to participate in the workshop. For programs that had more than one individual who completed the survey, priority was given to the individual who spent the most amount of time working directly with clients. If individuals had an equal amount of direct client contact, the individual invited to participate in the workshop was selected randomly. Of the 45 contacted programs, 33 expressed interest in participating in the workshop. Information packets were mailed to those interested in participating in the workshop during January and February 2011 which provided detailed information on the venue, dates, agenda, and the travel reimbursement policy.

In all, staff from 19 programs in 18 states (AK, AR, CO, CT, DE, GA, ID, IN, KY, MN, MO, NC, NJ, NY, TN, UT, VA, and WA) consented to participate in the workshop. Reasons provided for not participating in the workshop included work and personal scheduling conflicts, unable to receive approval from their employer to attend, staff and budget cuts, and not wanting to travel. Of the 19 participants, 74% were female, 79% were white, 42% were actively involved in providing case management services, and 84% had supervisory responsibilities. Participants were also highly experienced in working with study-relevant populations, with 58% having more than ten years of experience, 16% having between five and ten years of experience, and all having at least two years of experience. The workshop was held on the Rutgers University campus on April 14, 2011.

Qualitative Research Procedures

A large group discussion was used in the first half of the day to discuss the survey results, client profiles, and the factors identified as contributing to criminal behavior and treatment compliance. Discussion of client profiles included the frequency of client clinical characteristics (mental illness, substance abuse, antisocial behavior, etc.), client criminal thinking styles, and life problems that clients face (financial difficulties, lack of employment, interpersonal challenges, etc.). Smaller break-out sessions were used in the second half of the day to discuss methods to improve treatment adherence and identify ways to improve client services. Discussion facilitation throughout the day was conducted collaboratively by four of the authors (NW, WF, RM, and BCF). Our semi-structured discussion guide was flexible, including optional follow-up questions. Discussion facilitators could explore, probe, and ask relevant follow-up questions as needed or to clarify participants' responses (Greenbaum, 1987). This approach was chosen because it is more systematic than conversational interview approaches and is more appropriate for group discussions, but allows for more flexibility to elicit individual perspectives than a fully standardized interview approach.

Data Recording and Management

The large group discussion was professionally videotaped, while the smaller break-out sessions were recorded on MP3 compatible recording devices and recordings for both were professionally transcribed. Transcriptions were carefully compared to the audiotapes by one of the authors (JH) to correct errors and omissions.

Qualitative Analyses and Interpretation

To appropriately focus analyses, study personnel convened on a regular basis to review and reevaluate initial research questions. Although there is no exact rule for sample size estimates for community-based participatory research, discussion experiences and our qualitative data analyses support that the point of theoretical saturation was reached (Greenbaum, 1987). A series of narrative analyses (Patton, 1987) were performed to identify salient thematic categories regarding programs for criminally involved adults with SMI. In a research conference, each author identified a list of thematic categories and subcategories. These themes were then further developed and ordered by the first author and edited by the others. The authors then met in a final consensus conference to discuss the categories, resolve questions, and refine the thematic categories. After additional on-line discussion to review and refine categories and resolve questions, the final thematic categories were completed and higher order categories were developed.

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