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Reconceptualizing Criminal Justice Reform For Offenders With Serious Mental Illness

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RECONCEPTUALIZING CRIMINAL JUSTICE REFORM FOR OFFENDERS WITH SERIOUS MENTAL ILLNESS

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Abstract

Roughly 14% of male inmates and 31% of female inmates suffer from one or more serious mental illnesses, such as schizophrenia, bipolar disorder, and major depressive disorder. Policymakers and the public widely ascribe the overrepresentation of offenders with serious mental illness in the justice system to the "criminalization" of the symptoms of this afflicted population. The criminalization theory posits that the criminal justice system has served as the primary agent of social control over symptomatic individuals since the closure of state psychiatric hospitals in the 1950s and the tightening of civil commitment laws. The theory identifies untreated mental illness as the origin of individuals' criminal justice involvement and mental health treatment as the clear solution to breaking their cycle of recidivism. This Article evaluates the three main bodies of evidence offered in support of the criminalization theory: individuals' movement from psychiatric hospitals to jails and prisons ("transinstitutionalization"), the heightened policing of individuals with serious mental illness, and the science linking mental illness and crime. This evaluation reveals that the criminalization theory—the understanding that animates most current policies aimed at offenders with serious mental illness—rests largely on intuitive assumptions that are often unverified and sometimes false.

A growing body of behavioral sciences literature constructs an alternative account of the relationship between mental illness and crime. Coined the "normalization theory," it relies upon decades of research that demonstrate that clinical factors, such as diagnosis and treatment history, are not predictive of criminal activity. Instead, the same risks and needs that motivate individuals without mental illness also drive those with mental disorders to commit crimes. These "criminogenic risks" include, among others, substance abuse, employment instability, family problems, and poorly structured leisure time. Behavioral science researchers reject

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the premise that individuals with serious mental illness are overrepresented in the justice system because these individuals' illnesses directly lead to criminal behavior. Instead, they theorize that serious mental illnesses fuel the greater accumulation and concentration of typical criminogenic risk factors.

This recognition holds dramatic potential for the redesign of criminal justice programs. Programs that target the criminal behavior of offenders with mental illness should principally focus on addressing criminogenic risk factors that can be mitigated. Officials should also address mental health needs, but only to the extent necessary to facilitate a better criminogenic risk profile and fulfill constitutional obligations. Moreover, correctional experience suggests that institutions should allocate their scarce programmatic resources according to offenders' risk of reoffending and potential to achieve programmatic goals. These insights, which federal agencies are beginning to recognize, hold radical implications for the redesign—and possibly the existence—of jail diversion programs, mental health courts, specialized probation and parole, and reentry programs for offenders with serious mental illness.

INTRODUCTION

The relationship between mental illness and criminal behavior is elusive and complex. Understanding this relationship is key to the design of effective interventions for offenders with serious mental illness. The efficient allocation of scarce correctional and community resources depends on an accurate understanding of whether, and to what extent, the relationship between mental illness and crime is direct or is mediated by other variables.[1] Indeed, such an understanding will be critical for eradicating stigma related to mental illness and, ultimately, for ending mass incarceration.

Reducing the involvement of individuals with serious mental illness in the criminal justice system is of paramount importance. Prevalence estimates vary, but researchers estimate that roughly 14% of male inmates and as many as 31% of female inmates suffer from one or more serious mental illnesses,[2] such as schizophrenia, bipolar disorder, and major depressive disorder.[3] These rates are two to three times higher than those of the general population.[4] Inmates with serious mental illness are

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1. *See* Jennifer L. Skeem et al., *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 LAW & HUM. BEHAV. 110, 118–19 (2011).

2. *See* FRED OSHER ET AL., ADULTS WITH BEHAVIORAL HEALTH NEEDS UNDER CORRECTIONAL SUPERVISION: A SHARED FRAMEWORK FOR REDUCING RECIDIVISM AND PROMOTING RECOVERY 3–4 (2012), https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf [http://perma.cc/RY6W-3HLQ]. The concern in this Article is individuals with serious mental illness who are involved in the criminal justice process. The term "serious mental illness" is used in this Article to refer to mental disorders, other than substance abuse disorder, that satisfy criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revised, have lasted for at least a year, and are related to a significant functional impairment. *Id.* at 3 (adopting this definition).

3. HOLLY HILLS ET AL., EFFECTIVE PRISON MENTAL HEALTH SERVICES: GUIDELINES TO EXPAND AND IMPROVE TREATMENT 3 (2004), https://info.nicic.gov/nicrp/system/files/018604.pdf [https://perma.cc/989J-6BTK] (discussing the prevalence of mental illness in prison systems); Kenneth Adams & Joseph Ferrandino, *Managing Mentally Ill Inmates in Prisons*, 35 CRIM. JUST. & BEHAV. 913, 913 (2008) (discussing studies about the prevalence of mental illness in state and federal prisons); Matthew W. Epperson et al., *Envisioning the Next Generation of Behavioral Health and Criminal Justice Interventions*, 37 INT'L J.L. & PSYCHIATRY 427, 428 (2014); Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 764 (2009) (discussing the prevalence of serious mental illness among jail inmates).

4. *See* Nahama Broner et al., *Effects of Diversion on Adults with Co-Occurring Mental Illness and Substance Use: Outcomes from a National Multi-Site Study*, 22 BEHAV. SCI. & L. 519, 519 (2004); *see also* Ronald C. Kessler et al., *The Prevalence and Correlates of Serious Mental Illness (SMI) in the National Comorbidity Survey Replication (NCS-R)*, *in* MENTAL HEALTH, UNITED STATES, 2004, at 134, 137 (Ronald W. Manderscheid & Joyce T. Berry eds., 2006) (referring to women); Linda A. Teplin, *The Prevalence of Severe Mental Disorder Among Male*

significantly more costly to house and treat than those without mental illness for a variety of reasons, including increased staffing needs, psychiatric medications, and psychiatric evaluations.[5] Some studies have found that offenders with serious mental illness have higher rates of recidivism[6] and probation revocation[7] than those without such illness.[8] The likelihood of recidivism is even higher for the majority of offenders with serious mental illness who have co-occurring substance abuse disorders.[9] Moreover, jails and prisons are ill-equipped to safely house

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Urban Jail Detainees: Comparison with the Epidemiologic Catchment Area Program, 80 AM. J. PUB. HEALTH 663, 663 (1990) (referring to men).

5. *See* OSHER ET AL., *supra* note 2, at 8; E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 9–10 (2010); *infra* note 291 and accompanying text.

6. *See* Jacques Baillargeon et al., *Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door*, 166 AM. J. PSYCHIATRY 103, 105 (2009) [hereinafter Baillargeon et al., *Psychiatric Disorders*]; Kristin G. Cloyes et al., *Time to Prison Return for Offenders with Serious Mental Illness Released from Prison: A Survival Analysis*, 37 CRIM. JUST. & BEHAV. 175, 183 (2010). However, "[a] number of studies have shown that inmates with mental disorders exhibit reincarceration rates that are either comparable to or lower than rates for inmates without psychiatric disorders." Jacques Baillargeon et al., *Parole Revocation Among Prison Inmates with Psychiatric and Substance Use Disorders*, 60 PSYCHIATRIC SERVS. 1516, 1516–17 (2009) [hereinafter Baillargeon et al., *Parole Revocation*] (endnotes omitted) (collecting studies).

7. *See* Jennifer Eno Louden et al., *Applying the Sequential Intercept Model to Reduce Recidivism Among Probationers and Parolees with Mental Illness*, *in* THE SEQUENTIAL INTERCEPT MODEL AND CRIMINAL JUSTICE: PROMOTING COMMUNITY ALTERNATIVES FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS 118, 120 (Patricia A. Griffin et al. eds., 2015) (summarizing studies); Jennifer L. Skeem & Jennifer Eno Louden, *Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment*, 57 PSYCHIATRIC SERVS. 333, 333 (2006) (citing research showing that the revocation of probation was much more likely for probationers with mental illness than those without mental illness (37% versus 24%), as was rearrest (54% versus 30%)); *see also* Frank J. Porporino & Laurence L. Motiuk, *The Prison Careers of Mentally Disordered Offenders*, 18 INT'L J.L. & PSYCHIATRY 29, 40–41 (1995) (finding, in a study of seventy-two Canadian parolees, that those with a major mental illness were more likely to be reincarcerated for parole violations but less likely to be reincarcerated for committing a new criminal offense than parolees without such a condition). *But see* Baillargeon et al., *Parole Revocation*, *supra* note 6, at 1516 (finding that neither parolees with a psychotic nor a major mood disorder had a statistically significant increased risk of parole revocation for a technical violation or commission of a new offense than non-disordered parolees).

8. *See* Baillargeon et al., *Parole Revocation*, *supra* note 6, at 1519 (discussing possible contributors to high reincarceration rates).

9. *See, e.g.*, DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISONS AND JAIL INMATES 1 (2006) (finding that 74% of state prisoners with mental illness and 76% of local jail inmates with mental illness "met criteria for substance dependence or abuse"); Baillargeon et al., *Parole Revocation*, *supra* note 6, at 1519 (finding that parolees with comorbid serious mental illness and substance abuse disorders were nearly twice as likely to experience revocation as a result of a parole violation than offenders with only a serious mental illness); Stephanie W. Hartwell, *Comparison of Offenders with Mental Illness Only and Offenders with Dual Diagnoses*, 55 PSYCHIATRIC SERVS. 145, 145 (2004) (finding that released

and care for these inmates.[10] This inadequacy can result in the victimization of inmates, the deterioration of their mental health, and costly lawsuits alleging violations of inmates' Eighth Amendment right to be free from cruel and unusual punishment.[11] Therefore, correctly identifying the origin of this population's offending behavior—and, more importantly, understanding how to reduce it—is crucial to decreasing the use of incarceration, bringing correctional costs under control, and addressing a growing humanitarian crisis.

The legal community generally assumes that mental illness drives criminal behavior and that the provision of mental health treatment will reduce recidivism.[12] These beliefs are an outgrowth of the popular criminalization theory, which posits that individuals with serious mental illness have become enmeshed in the criminal justice system because the mental health system has failed.[13] According to this theory, the closure of psychiatric hospitals released a flood of individuals with mental illness into communities.[14] Without adequate community treatment or broad civil commitment laws, these individuals were then arrested for behavior

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inmates with dual diagnoses had higher rates of reincarceration than inmates with severe mental illness alone).

10. *See* E. Lea Johnston, *Conditions of Confinement at Sentencing: The Case of Seriously Disordered Offenders*, 63 CATH. U. L. REV. 625, 630–36 (2014) (detailing shortcomings in mental screening procedures); E. Lea Johnston, *Vulnerability and Just Desert: A Theory of Sentencing and Mental Illness*, 103 J. CRIM. L. & CRIMINOLOGY 147, 158–83 (2013) [hereinafter Johnston, *Vulnerability*] (discussing the likelihood of physical and sexual assaults, housing in solitary confinement, and psychological deterioration during incarceration).

11. *See, e.g.*, Braggs v. Dunn, 257 F. Supp. 3d 1171, 1267 (M.D. Ala. 2017) (finding that the Alabama Department of Corrections and the Associate Commissioner of Health Services violated an individual's Eighth Amendment right regarding accommodation for serious mental-health needs); Madrid v. Gomez, 889 F. Supp. 1146, 1265–66 (N.D. Cal. 1995) (explaining that plaintiffs must show a sufficiently serious injury and satisfy the subjective component of the Eighth Amendment in order to show a violation of objective Eighth Amendment standards).

12. *See, e.g.*, Risdon N. Slate, *Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence*, 26 S. CAL. INTERDISC. L.J. 341, 354 (2017) ("Ideally, if appropriate and sufficient treatment were available in the community, there would be no need to have protocols in place to divert persons with mental illnesses from the criminal justice system."); Chris Gautz, *Mental Health Court a Year Old*, JACKSON CITIZEN PATRIOT (MI), Nov. 14, 2009, at A1 (quoting the judge of the mental health court in Jackson County, Michigan, as explaining that mental health courts provide treatment to offenders with mental illness because "[t]hey're just going to recidivate if you don't address the underlying pathology"); Kathleen Brady Shea, *Mental Health Courts on Horizon – Local Counties*, PHILA. INQUIRER, June 30, 2008, at B1 (quoting Delaware County Court Judge Frank T. Hazel as expressing that offenders with mental illness often reoffend because they do not receive adequate treatment for their mental illnesses).

13. *See* William H. Fisher et al., *Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Health Policy and Services Research*, 33 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RES. 544, 546 (2006); *see also infra* Part I (discussing the criminalization theory).

14. Fisher et al., *supra* note 13, at 545.

deriving from their illnesses, either for violent crimes or for minor offenses as a means of securing needed treatment or enforcing social control.[15] The implications of this theory are clear: symptomatic mental illness is the root cause of these offenders' criminal involvement, so access to and participation in treatment should reduce recidivism. Most current programs tailored to offenders with serious mental illness—including jail diversion programs, mental health courts, specialized probation and parole dockets, and reentry programs—emanate from this theory of criminal behavior and center around the leveraged provision of community treatment.[16] Some direct evidence supports the criminalization theory,[17] and an older body of clinical literature has contributed to its dominance.[18]

This account of the criminal justice involvement of individuals with serious mental illness has yielded several effects. Positively, the narrative has called national attention to the severe shortage of community mental health resources and the need for an immediate and substantial influx of funding.[19] It has also revived useful conversations about the proper scope of civil commitment laws and the important role of insurance in providing and utilizing mental health care.[20] Additionally, the account has sparked outrage at the transformation of prisons and jails into "asylums,"[21] and it

15. *Id.* at 545–46.

16. *See* Skeem et al., *supra* note 1, at 112 ("[C]riminal justice-derived programs for this population are united by their emphasis on linkage with mental health services in the community as an essential component of their mission."); *see also infra* notes 33–38 and accompanying text (discussing this theory).

17. *See infra* Part I.

18. *See* Sarah McCormick et al., *Mental Health and Justice System Involvement: A Conceptual Analysis of the Literature*, 21 PSYCHOL. PUB. POL'Y & L. 213, 219 (2015) (exploring the aims, implicit assumptions, scope, and terminology of the clinical literature concerning mental health and criminal offending and comparing this to the independent and somewhat conflicting approach to the same topic by the literature focused on forensic rehabilitation).

19. *See, e.g.*, HUM. RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 23–25 (2003), http://www.hrw.org/reports/2003/usa1003/ [https://perma.cc/UA4Z-NQS3]; MILTON L. MACK, JR., CONFERENCE OF STATE COURT ADMINS., DECRIMINALIZATION OF MENTAL ILLNESS: FIXING A BROKEN SYSTEM 3, 9–10 (2017), http://cosca.ncsc.org/~/media/Microsites/Files/COSCA/Policy%20Papers/2016-2017-Decriminalization-of-Mental-Illness-Fixing-a-Broken-System.ashx [https://perma.cc/429K-UCF3]; Michele Nealon, *Decriminalizing Mental Illness*, HUFFPOST (May 12, 2016, 6:51 PM), https://www.huffingtonpost.com/michele-nealonwoods/decriminalizing-mental-il_b_9913256.html [https://perma.cc/XR3T-ZQUH].

20. *See, e.g.*, Rachel A. Scherer, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 413–15 (2007) (using evidence of criminalization to argue on behalf of preventative outpatient treatment civil commitment).

21. *See generally, e.g.*, ALISA ROTH, INSANE: AMERICA'S CRIMINAL TREATMENT OF MENTAL ILLNESS (2018) (discussing this phenomenon).

has prompted the funding and creation of diversion programs to shunt individuals with mental illness out of the justice system and into community treatment.[22]

However, the theory of criminalization has a dark underside. Most importantly, the theory fuels a simplistic understanding of criminal behavior—reminiscent of the "medical model" of rehabilitation dominant until the 1970s[23]—that germinates from and reinforces false causal associations between mental illness, violence, and crime. Moreover, the premise that serious mental illness holds a direct, causal relationship to crime is largely wrong, so policies based on this understanding are destined to fail.[24] This failure then further cements the false and damaging stereotype that offenders with serious mental illness are incorrigible and dangerous, necessarily dominated and defined by their illness, and fundamentally different from the rest of us.[25]

Recently, social scientists have proposed an alternative theory to account for the disproportionate justice involvement of individuals with serious mental illness.[26] Coined the "normalization hypothesis," this explanation understands the phenomenon as reflective of the greater concentration of criminogenic risks and needs among this population.[27]

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22. *See, e.g.*, CITY OF ALEXANDRIA, DECRIMINALIZING MENTAL ILLNESS: DIVERSION FROM JAIL TO TREATMENT 1 (2009), https://www.alexandriava.gov/uploadedFiles/dchs/adultservices/DecriminalizingMI.pdf [https://perma.cc/6PFC-Y3TF] (discussing initiatives "to effectively address the problem of incarcerating people for behaviors that resulted from a mental illness and lack of access to treatment"); COMMONWEALTH OF MASS. DEP'T OF MENTAL HEALTH FORENSIC SERVS. & NAMI MASS., DECRIMINALIZATION OF MENTAL ILLNESS: A SNAPSHOT LOOK AT DIVERSION MODELS IN THE COMMONWEALTH 2–9 (2011), https://namimass.org/wp-content/uploads/DecriminalizationofMentalIllness-ASnapshotLookatDiversionModelsinMass.pdf [https://perma.cc/5MZC-TDDS] (describing mental health diversion efforts in Massachusetts); TREATMENT ADVOCACY CTR., 21ST CENTURY CURES ACT 1–2 (2016), http://www.treatmentadvocacycenter.org/fixing-the-system/21st-century-cures-act [https://perma.cc/78NW-3QV3] (praising the 21st Century Cures Act for its efforts to decriminalize mental illness); Epperson et al., *supra* note 3, at 428–29 (discussing initiatives at the federal and state level).

23. *See* E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 547–51 (2012).

24. *See* Skeem et al., *supra* note 1, at 114.

25. *See* Fisher et al., *supra* note 13, at 549 (observing that the current practice of focusing "almost exclusively on mental health problems and solutions . . . reinforces the label of 'person with mental illness' as a 'master status'—that status which above all others defines the individual's position within the mental health system, the criminal justice system and society in general").

26. *See* Skeem et al., *supra* note 1, at 116 (arguing that "[w]hat is needed to shape more informative research and more effective interventions is an explicit conceptual framework that looks beyond mental illness as the principal cause of and solution to the problem of criminal justice involvement" and exploring plausible alternatives).

27. Nancy Wolff, *Are Mental Health Courts Target Efficient?*, 57 INT'L J.L. & PSYCHIATRY 67, 68 (2018) (citing Skeem et al., *supra* note 1, at 116–17) (defining the "normalization

Criminogenic risks and needs are factors empirically demonstrated to predict criminal behavior, such as antisocial personality pattern, substance abuse, employment instability, and family problems.[28] Studies demonstrate that these factors motivate the criminal activity of those with and without mental disorders alike.[29] In the majority of cases, the effect of mental illness on criminal behavior appears to be "fully mediated" by these general risk factors.[30] The normalization theory thus suggests that the overrepresentation of mentally disordered offenders is best addressed by treating those criminogenic needs that are capable of change.[31] Crucially, this theory dictates that, so long as the goal is to reduce recidivism,[32] the criminal justice system should only provide mental health treatment to the extent necessary to allow for the effective treatment of criminogenic needs and to comply with constitutional obligations. Accepting this empirically informed framework has dramatic implications for major programs for offenders with mental illness in the United States. It would necessitate the reform of virtually all such programs and may require that some be eliminated completely.

This Article proceeds in the following manner. Part I critically evaluates evidence underlying the criminalization theory. In particular, it assesses evidence of individuals' transinstitutionalization from psychiatric hospitals to jails and prisons, the differential policing of individuals with mental illness, and the direct relationship of mental illness to criminal offending. This analysis suggests that the theory of criminalization, while intuitive, lacks robust evidentiary support.

Drawing from behavioral sciences literature, Part II presents evidence undergirding the normalization theory. This Part discusses the importance of criminogenic needs in motivating criminal behavior and how these needs contribute to the overrepresentation of individuals with serious mental illness in the justice system. Part III explores the dominant correctional model for assessment and treatment, the Risk-Need-Responsivity (RNR) model, to suggest how these insights might apply to contemporary justice programs. It also chronicles the fledgling efforts to

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hypothesis" as "offenders with mental illness are 'normal' in their criminal behavior insofar as the same criminogenic risk factors that motivate offenders without mental illness also motivate those with mental illness").

28. *See infra* notes 128–32 and accompanying text.

29. *See, e.g.*, Wolff, *supra* note 27.

30. *See* Skeem et al., *supra* note 1.

31. "Criminogenic needs" are defined as dynamic risk factors for criminal behavior that, consequently, should serve as intermediate targets of change in rehabilitation treatment. D. A. Andrews & James Bonta, *Rehabilitating Criminal Justice Policy and Practice*, 16 PSYCHOL. PUB. POL'Y & L. 39, 45–46 (2010).

32. *But see infra* Subsection IV.B.2 (asking whether the criminal justice system should expend resources in the pursuit of goals beyond public safety).

apply this model to offenders with serious mental illness and shows that substantial reform of specialized programs has yet to occur.

Part IV charts a new path forward. It argues that taking the normalization hypothesis and the RNR model seriously calls for a radical shift in the way the criminal justice system treats offenders with serious mental illness. It posits that the four major programs specially designed for these individuals—jail diversion programs, mental health courts, specialized probation and parole, and community reentry—should be abandoned unless a scientifically sound justification linked to public safety can be offered for their existence. It then proposes four potential justifications for these programs, all involving varying relationships between mental illness, criminogenic risks, and recidivism. If none of these justifications is availing, the correctional system should reallocate its scarce resources to programs that achieve better programmatic outcomes and focus on fulfilling its constitutional obligation to provide reasonably adequate mental health care to all inmates in need.

I. CRIMINALIZATION THEORY

The core of criminalization theory is that faulty mental health policy and inadequate service delivery have resulted in the inappropriate involvement of persons with serious mental illness with the criminal justice system.[33] As the Council of State Governments stated in 2002:

> Law enforcement officers, prosecutors, defenders, and judges—people on the front lines every day—believe too many people with mental illness become involved in the criminal justice system because the mental health system has somehow failed. They believe that if many of the people with mental illness received the services they needed, they

33. *See, e.g.*, Robert Bernstein & Tammy Seltzer, *Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform*, 7 UDC/DCSL L. REV. 143, 143 (2003) ("For most [offenders with mental illness], the underlying issue is their need for basic services and supports that public systems have failed to deliver in meaningful ways."); Fisher et al., *supra* note 13, at 545–46 (discussing the evolution of the criminalization theory); H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVS. 483, 485 (1998) ("[M]any uncared-for mentally ill persons may be arrested for minor criminal acts that are really manifestations of their illness, their lack of treatment, and the lack of structure in their lives."). Marc F. Abramson first suggested the criminalization theory. *See* Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 101, 104–05 (1972).

> would not end up under arrest, in jail, or facing charges in court.[34]

Criminalization theory thus posits that mental illness lies at the root of an offender's criminal behavior and that with effective mental health treatment, the criminal behavior will stop.[35] Forensic psychologists, criminologists, and legal scholars have argued that the criminalization theory lacks a strong evidentiary basis.[36] Recently, federal government agencies have cautiously acknowledged this argument.[37] However, this theory continues to dominate public discourse and serves as the underlying rationale for all major justice programs directed at people with serious mental illness who are involved with the criminal justice system.[38]

Criminalization proponents often make three assertions when defending this theory: that individuals with serious mental illness migrated to jails and prisons upon the closure of state mental hospitals, that law enforcement officers arrest individuals with serious mental illness at a higher rate than individuals without perceived illness in an effort to provide needed treatment or to ease public discomfort, and that individuals' offenses are simply manifestations of their illnesses.[39] Close

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34. COUNCIL OF STATE GOV'TS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 26 (2002), https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf [https://perma.cc/X8G6-7GXU].

35. *See id.*; *see also* John Junginger et al., *Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses*, 57 PSYCHIATRIC SERVS. 879, 879 (2006) (explaining that adherents of the criminalization theory apparently believe that "symptoms of serious mental illness motivate or otherwise cause actual criminal offenses").

36. *See, e.g.*, Fisher et al., *supra* note 13, at 547–48 (marshalling evidence both in support of and challenging the criminalization theory and concluding that the body of evidence is "at best equivocal in its support of the 'criminalization due to inadequate mental health services' model"); Junginger et al., *supra* note 35 ("In fact, what little empirical research exists on this particular interpretation of the criminalization hypothesis has produced no consensus."); Skeem et al., *supra* note 1, at 116 ("There is no evidence for the basic criminalization premise that decreased psychiatric services explain the disproportionate risk of incarceration for individuals with mental illness."). *See generally* Fredrick E. Vars & Shelby B. Calambokidis, *From Hospitals to Prisons: A New Explanation*, 102 CORNELL L. REV. ONLINE 101 (2017) (critiquing modern criminalization explanations and offering a novel one, based on involuntary medication of prisoners, to explain the disproportionate incarceration of persons with mental illness).

37. *See* OSHER ET AL., *supra* note 2, at 5 ("Recent studies . . . have demonstrated that the relationship of mental illness to criminal activity is . . . nuanced and complex. . . . [C]hanges in an individual's psychiatric symptoms do not necessarily relate to whether or not he or she is rearrested or revoked from community supervision.").

38. Jennifer L. Skeem et al., *Offenders with Mental Illness Have Criminogenic Needs, Too: Toward Recidivism Reduction*, 38 LAW & HUM. BEHAV. 212, 212 (2014) ("Most policy recommendations for this population reflect an implicit assumption that mental illness is the direct cause of criminal justice involvement, and psychiatric treatment is the principal solution . . . .").

39. *See infra* Sections I.A–C. Another perceived contributor to criminalization has been the narrowing of civil commitment laws, which has reduced the ability of law enforcement to forcibly

examination demonstrates that these assertions, while certainly true in some cases, do not individually or collectively explain the justice involvement of most individuals with serious mental illness. Moreover, they do not provide a sound prescription to end that involvement.

A. *Transinstitutionalization*

Advocates of criminalization theory contend that the phenomenon of criminalization began with the closure of state-run psychiatric facilities in the 1950s.[40] According to this theory, deinstitutionalization—the movement to treat individuals in the community rather than in institutional settings—resulted in a deluge of patients into communities with inadequate outpatient services and thereby led to a surge in apparent deviant behavior.[41] Narrower civil commitment laws and decreased institutional capacity meant that mental hospitals exerted less authority over these individuals.[42] Instead, law enforcement officers became the primary agents of social control.[43] This account assumes a reciprocity and functional interdependence between the mental health and criminal justice systems whereby a decrease in capacity in one results in the expanded use of the other for individuals requiring institutional care.[44]

Upon first glance, data seem to support this hypothesis.[45] From the 1920s through the 1950s, the United States institutionalized those deemed "mentally defective" at staggering rates. At the peak of institutionalization in the 1940s and 1950s, the United States

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treat symptomatic individuals in the civil mental health system. For a summary of the legal evolution of civil commitment laws and the rise of due process protections for individuals facing commitment, see generally Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, 43 ISR. J. PSYCHIATRY & RELATED SCI. 209 (2006).

40. Skeem et al., *supra* note 1, at 111. For a detailed yet pithy recitation of the history of deinstitutionalization, see CHRIS KOYANAGI, LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM 4–10 (2007), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7684.pdf [https://perma.cc/2ZN6-749T].

41. *See* Henry J. Steadman et al., *The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968-1978*, 75 J. CRIM. L. & CRIMINOLOGY 474, 475 (1984).

42. *See supra* note 39 and accompanying text.

43. *See* Abramson, *supra* note 33, at 102–03; Carole Morgan, *Developing Mental Health Services for Local Jails*, 8 CRIM. JUST. & BEHAV. 259, 261 (1981).

44. *See generally* L. S. Penrose, *Mental Disease and Crime: Outline of a Comparative Study of European Statistics*, 18 BRIT. J. MED. PSYCHOL. 1 (1939) (advancing the "balloon theory").

45. *See* Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 58–64 (2011) (tracing the rise and fall of institutional populations over time).

institutionalized approximately 625 of every 100,000 adults.[46] From the end of the 1950s through the 1980s, however, the rate of institutionalization at mental hospitals dropped precipitously.[47] After 1980, the population of individuals institutionalized at mental hospitals dropped to "negligible" levels.[48]

As institutionalization rates fell dramatically, the national prison and jail populations exploded. During the 1980s and 1990s, incarceration rates increased by nearly 500%.[49] Whereas the inpatient rate was approximately three times the prison incarceration rate in the 1950s and 1960s, the inverse was true by the 1980s.[50] Considering these trends, commentators have speculated that deinstitutionalization resulted in the migration of individuals with serious mental illness from psychiatric hospitals to carceral facilities.[51] Currently, levels of serious mental illness are disproportionately high in carceral institutions,[52] but it is unclear whether this phenomenon is more acute now than it was in the past.[53]

Researchers have questioned the assumptions embedded in this theory.[54] In an early investigation of the reciprocity between the mental health and criminal justice systems, Henry Steadman and his colleagues

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46. *See* Bernard E. Harcourt, *An Institutionalization Effect: The Impact of Mental Hospitalization and Imprisonment on Homicide in the United States, 1934-2001*, 40 J. LEGAL STUD. 39, 41 (2011).

47. *Id.* The advent of Medicaid and Medicare, medical advances in symptom control, public awareness and intolerance of the abuses within mental hospitals, and the 1963 Community Mental Health Act all served to shift mental health treatment from institutional to community-based care. *See* Dae-Young Kim, *Psychiatric Deinstitutionalization and Prison Population Growth: A Critical Literature Review and Its Implications*, 27 CRIM. JUST. POL'Y REV. 3, 4–5 (2014); Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 J. LEGAL STUD. 187, 190 (2013).

48. Harcourt, *supra* note 46.

49. Raphael & Stoll, *supra* note 47, at 189.

50. *See* Harcourt, *supra* note 46, at 43 fig.2; Raphael & Stoll, *supra* note 47, at 188.

51. *See, e.g.*, Lamb & Weinberger, *supra* note 33, at 484 (discussing the thesis advanced by Penrose, *supra* note 44, "that a relatively stable number of persons are confined in any industrial society" so, if either institutionalization or incarceration is reduced, the other will increase, and surmising that deinstitutionalization has significantly contributed to the incarceration of individuals with mental illness); Linda A. Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 AM. PSYCHOLOGIST 794, 794 (1984) (collecting sources).

52. *See supra* notes 2–4 and accompanying text.

53. Steadman et al., *supra* note 41, at 477 ("Unfortunately, there is no available reliable baseline data from psychological interviews and tests on the prevalence of mental disorder in prison populations for the period before the deinstitutionalization of mental hospitals."); *id.* at 488 ("[T]he clientele of prisons, based on their state hospitalization histories, appeared not to be appreciably more disordered in 1978 than in 1968 . . . .").

54. *See, e.g.*, Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?*, 47 COMMUNITY MENTAL HEALTH J. 716, 717–19 (2011).

observed that, "[a]lthough the *census* of state mental hospitals fell dramatically between 1968 and 1978, the number of *admissions* declined only slightly. . . . Almost as many persons were admitted . . .; they just did not stay as long."[55] The development of effective antipsychotic medications, including chlorpromazine (Thorazine), permitted outpatient treatment for psychotic disorders and shorter inpatient stays.[56] Thus—although the identity of admitted individuals did not factor into Steadman et al.'s analysis—it is possible that roughly the same number of individuals were receiving institutional care before as during the period of deinstitutionalization.

In addition, a number of scholars have noted that the advent of Medicaid in 1965 incentivized states to transfer patients from mental hospitals to general hospitals and nursing homes.[57] The daily spending for nursing home care was lower than for an inpatient stay in a mental hospital, and, under Medicaid, states bore 100% of state mental hospital costs but only 20% to 50% of the costs for care in a nursing home.[58] This economic reality carried predictable and swift effects: Between 1963 and 1969, the percentage of institutional care for elderly people with mental disorders in nursing homes grew from 53% to almost 75%.[59] When the daily costs of general hospital psychiatric units were less than double those of state hospitals, states had a similar incentive to shift mental hospital patients to general hospitals.[60] Thus, criminalization proponents' assumption that exits from state mental hospitals resulted in entry to communities' streets is, at least for many individuals who required

55. Steadman et al., *supra* note 41, at 479 ("In 1968, there were 66,077 male admissions to the six states' mental hospitals; in 1978, there were still 60,161 male admissions."); *see also* Jeffrey L. Geller, *The Last Half-Century of Psychiatric Services as Reflected in* Psychiatric Services, 51 PSYCHIATRIC SERVS. 41, 45 (2000) ("Much of this decrease in the size of state hospitals is attributable to shortening lengths of stay.").

56. *See* Harcourt, *supra* note 45, at 65–66. However, studies show that the advent of psychotropic drugs was not a significant contributor to deinstitutionalization. *See* Joni Lee Pow et al., *Deinstitutionalization of American Public Hospitals for the Mentally Ill Before and After the Introduction of Antipsychotic Medications*, 23 HARV. REV. PSYCHIATRY 176, 185 (2015). *See generally* William Gronfein, *Psychotropic Drugs and the Origins of Deinstitutionalization*, 32 SOC. PROBS. 437 (1985) (discussing the effects of psychotic drugs on institutionalization).

57. *See, e.g.*, RICHARD G. FRANK & SHERRY A. GLIED, BETTER BUT NOT WELL: MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950, at 54–55, 94–95 (2006); KOYANAGI, *supra* note 40, at 1; Harcourt, *supra* note 45, at 67–68; Prins, *supra* note 54, at 717–18.

58. FRANK & GLIED, *supra* note 57, at 54.

59. *Id.* at 55; *see also* KOYANAGI, *supra* note 40, at 6 ("[B]y 1980, 750,000 people with serious mental illness lived in nursing homes, representing 44 percent of the nursing home population.").

60. FRANK & GLIED, *supra* note 57, at 54; *see* KOYANAGI, *supra* note 40, at 6 ("General hospitals more than doubled their psychiatric patient-care episodes from 1955 to 1977, as state hospital use declined by 30 percent over the same time.").

institutionalized care, false. Moreover, while their populations began winnowing decades before, whole state institutions did not begin to close in significant numbers until the 1990s.[61]

Studies on deinstitutionalization's effect on incarceration rates have reached varying conclusions,[62] but the most rigorous study to date has found that transinstitutionalization accounts for perhaps a quarter of the population of incarcerated individuals with severe mental illness.[63] In a 2013 study using a panel data set, Professors Stephen Raphael and Michael A. Stoll found that those who would have been institutionalized in 1950 were much less likely to be institutionalized (in either mental hospitals or prisons) in 2000, "both absolutely and relative to overall trends."[64] They found no evidence of transinstitutionalization for any demographic group between 1950 and 1980, the period when state-run mental hospitals were closing.[65] Nevertheless, between 1980 and 2000, Raphael and Stoll found significant transinstitutionalization rates for men and women, with the largest transinstitutionalization rate for white men.[66] For nonwhite men after 1980, the effect of transinstitutionalization was insignificant or absent altogether,[67] a finding of increased significance in light of the disproportionate incarceration rate of this population.[68] Raphael and Stoll concluded that, for the year 2000, deinstitutionalization may have accounted for between 14% to 26% of the incarcerated severely

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61. KOYANAGI, *supra* note 40, at 1.

62. *See, e.g.*, Kim, *supra* note 47, at 3–11 (reviewing empirical literature examining the impact of mental hospitalization on imprisonment and concluding that, overall, empirical findings are equivocal at the aggregate level); Ashley Primeau et al., *Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions*, 2 COMPREHENSIVE PSYCHOL. 1, 7 (2013) (finding that 7% of the changes in Pennsylvania's incarceration rate between 1970 and 2010 could be attributed to a decrease in hospital beds).

63. *See* Raphael & Stoll, *supra* note 47, at 192 (defining "severe mental illness" as including "manic depression, bipolar disorder, or a psychotic disorder").

64. *Id.* at 203.

65. *Id.* at 211–12; *see also* Steadman et al., *supra* note 41, at 483 ("During the period of maximum deinstitutionalization of mental hospitals [between 1968 and 1978], the percentage of former patients among the ranks of prison admittees decreased in as many study states as it increased.").

66. Raphael & Stoll, *supra* note 47, at 215–16 (finding a near one-for-one transinstitutionalization rate for white men between 1980 and 2000).

67. *Id.* at 216.

68. Important demographic distinctions exist between formerly institutionalized individuals and currently incarcerated people with serious mental illness. Fred Osher & Yu Ling Han, *Jails as Housing for Persons with Serious Mental Illnesses*, 16 AM. JAILS 36, 38–39 (2002); Prins, *supra* note 54, at 719. Whereas "prison and jail inmates in the United States are overwhelmingly male, disproportionately minority, and relatively young," Raphael & Stoll, *supra* note 47, at 198, the mental hospital population at midcentury was considerably older and more likely to be white and female. *Id.* at 200.

ill population.[69] As an explanation for the delayed effects of transinstitutionalization, the authors hypothesized that "it is likely that deinstitutionalization followed a chronologically selective path, with the least ill and perhaps the least prone to felonious behavior deinstitutionalized first."[70] However, Raphael and Stoll noted that they could not control for changes in sentencing law and suspected such changes to be a relevant factor in their analysis.[71]

Harsh drug laws and the frequent co-occurrence of mental disorder and substance abuse likely account, at least partially, for the disproportionate justice involvement of individuals with serious mental illness.[72] Legislatures imposed a number of severe sentencing policies in the mid-1980s through the mid-1990s, including three strikes, truth-in-sentencing, life without possibility of parole, and mandatory minimum sentencing laws.[73] The War on Drugs and "tough on crime" sentencing policies increased incarceration rates for the entire population,[74] including individuals with mental illness.[75] Offenders with mental illness have extremely high rates of substance abuse disorders, exceeding those of the non-disordered offending population.[76] Notably, studies have found that, upon controlling for substance abuse, offenders with serious mental illness are no more likely than offenders without psychiatric illness to commit drug-related offenses.[77] Thus, individuals' involvement in these offenses appears to be due to their substance abuse disorder, not their serious mental illness. Moreover, system-level studies show that neither the decrease of psychiatric inpatient capacity nor changes in the

69. Raphael & Stoll, *supra* note 47, at 219.

70. *Id.* at 209.

71. *See id.* at 217.

72. *See* Arthur J. Lurigio, *People with Serious Mental Illness in the Criminal Justice System: Causes, Consequences, and Correctives*, 91 PRISON J. 66, 73–74 (2011).

73. THE GROWTH OF INCARCERATION IN THE UNITED STATES: EXPLORING CAUSES AND CONSEQUENCES 73 (Jeremy Travis et al. eds., 2014).

74. *See* Jon Sorenson & Don Stemen, *The Effect of State Sentencing Policies on Incarceration Rates*, 48 CRIME & DELINQ. 456, 456 (2002); Susan Turner et al., *The Impact of Truth-in-Sentencing and Three Strikes Legislation: Prison Populations, State Budgets, and Crime Rates*, 11 STAN. L. & POL'Y REV. 75, 77 (1999).

75. *See* Baillargeon et al., *Psychiatric Disorders*, *supra* note 6, at 103; Steven K. Hoge et al., *Outpatient Services for the Mentally Ill Involved in the Criminal Justice System*, AM. PSYCHIATRIC ASS'N 1, 2 (2009); Edward P. Mulvey & Carol A. Schubert, *Mentally Ill Individuals in Jails and Prisons*, 46 CRIME & JUST. 231, 235–36 (2017).

76. *See* JAMES & GLAZE, *supra* note 9, at 6 (finding that 74% of state prisoners with a mental problem met criteria for substance dependence or abuse, while 56% of those without a mental problem did, and finding that 76% of jail inmates with a mental problem met criteria for substance dependence or abuse, while 53% of those without a mental problem did).

77. *See* James A. Swartz & Arthur J. Lurigio, *Serious Mental Illness and Arrest: The Generalized Mediating Effect of Substance Use*, 53 CRIME & DELINQ. 581, 593 (2007).

financing of community services affects the probability of incarceration for individuals with mental illness.[78] Researchers have concluded that "there is little evidence that the risk of incarceration has uniquely increased for those with mental illness."[79]

B. *Differential Policing*

Criminalization proponents have also offered differential policing as an explanation for the overrepresentation of offenders with serious mental illness under correctional supervision. Police officers frequently interact with persons who have serious mental illness: A 2000 study found that 89% of officers in a large metropolitan center had contact with such persons in the previous year.[80] Commentators theorize that—in light of a lack of community treatment options, bureaucratic hurdles to emergency hospitalization, and narrow civil commitment criteria—officers may opt to arrest individuals with mental illness for minor offenses as a means of securing treatment, an act that has been called "mercy booking."[81] Collections of case studies and anecdotal evidence indicate the existence of this practice in certain localities.[82] Given that arrest for minor offenses is discretionary and somewhat arbitrary,[83] such a tendency could result in the disproportionate arrest of individuals with serious mental illness.

The primary support for differential policing as a systemic trend is a 1984 observational study by Professor Linda Teplin involving 1,382 police-citizen encounters.[84] In observing 506 suspects—30 of whom had

78. Skeem et al., *supra* note 1, at 116; Fisher et al., *supra* note 13, at 547–48.

79. Skeem et al., *supra* note 1, at 116; *see also* FRANK & GLIED, *supra* note 57, at 124–28 (observing that, between 1990 and 2000, the share of people with mental illness in jails and prisons rose, but the proportion of people with serious mental illness living with family or in the community remained relatively stable at around 80% and arguing that, while incarceration rates of people with serious mental illness have remained relatively stable, the share of incarcerated people with mental illness has varied primarily with increases in the overall incarceration rate).

80. Teresa LaGrange, Distinguishing Between the Criminal and the "Crazy": Decisions to Arrest in Police Encounters with Mentally Disordered, Presentation at the American Society of Criminology, San Francisco, California (Nov. 15–18, 2000); *cf.* Martha W. Deane et al., *Emerging Partnerships Between Mental Health and Law Enforcement*, 50 PSYCHIATRIC SERVS. 99, 100 (1999) ("Among the 174 police departments in our study, 7 percent of all police contacts, both investigations and complaints, involved persons believed to be mentally ill.").

81. Lamb & Weinberger, *supra* note 33, at 488; *see* Teplin, *supra* note 51, at 795.

82. *See* EDWIN FULLER TORREY ET AL., CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS 46–48 (1992).

83. *See* Robin Shepard Engel & Eric Silver, *Policing Mentally Disordered Suspects: A Reexamination of the Criminalization Hypothesis*, 39 CRIMINOLOGY 225, 226 (2001).

84. Teplin, *supra* note 51. Proponents also point to the simple overrepresentation of individuals with mental illness in jails and prisons and arrest rates of former mental patients. *See* Engel & Silver, *supra* note 83, at 227–28. However, this evidence does not establish that law

a mental illness—Teplin found that arrest rates for mentally disordered suspects were 46.7% compared with 27.9% for non-mentally disordered suspects.[85] After disaggregating arrest rates by seriousness of offense, Teplin concluded: "[W]ithin similar types of situations, persons exhibiting signs of mental disorder have a higher probability of being arrested than those who do not show such signs. Clearly, the way we treat our mentally ill is criminal."[86] Subsequent research has found that several clinical factors—including diagnosis, nature and severity of symptoms, medication noncompliance, and impaired functioning—increase the likelihood of arrest.[87]

However, researchers have found that once studies control for legally relevant and encounter-level factors, clinical factors lose their salience, and individuals with mental disorder are not more likely to be arrested than their non-disordered counterparts.[88] A 2001 study that used multivariate statistical techniques to analyze data from two large-scale, multi-site field studies of police behavior found that, after controlling for variables known to affect police decision-making,[89] police officers were not more likely to arrest suspects with mental disorder.[90] In addition, the study found that the factors most relevant to arrest decisions for individuals with mental disorder similarly predicted arrest for non-disordered individuals.[91] Moreover, a 2005 observational study of 617 police-suspect encounters by Professors Kenneth J. Novak and Robin S. Engel found that "mentally disordered suspects were . . . significantly *less*

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enforcement officers are disproportionately or inappropriately arresting individuals with mental disorders when they would not so treat non-disordered individuals.

85. Teplin, *supra* note 51, at 798.

86. *Id.* at 799.

87. *See* Ellen Ballard & Brent Teasdale, *Reconsidering the Criminalization Debate: An Examination of the Predictors of Arrest Among People with Major Mental Disorders*, 27 CRIM. JUST. POL'Y REV. 22, 25–26 (2016).

88. *See infra* notes 89–94 and accompanying text. Prior research also reached this conclusion. *See* Egon Bittner, *Police Discretion in Emergency Apprehension of Mentally Ill Persons*, 14 SOC. PROBS. 278, 279 (1967); Jennifer Caldwell Bonovitz & Jay S. Bonovitz, *Diversion of the Mentally Ill into the Criminal Justice System: The Police Intervention Perspective*, 138 AM. J. PSYCHIATRY 973, 975–76 (1981).

89. The study factored in sex, race, age, homelessness, alcohol and drug use, disrespect to officers, noncompliance with officers' requests or commands, whether the victim knew the suspect previously, whether the suspect was known to the police officer(s) prior to the encounter, whether the victim(s) requested that police take official action, whether the encounter was proactive or reactive, whether the location of the encounter was public or private, the number of bystanders, suspect threat or assault of another citizen during the encounter, threat or assault of a police officer during the encounter, evidence of disorderly or illegal conduct, presence of a weapon, and the seriousness of the offense. Engel & Silver, *supra* note 83, at 237, 239 tbl.1.

90. *Id.* at 242, 245.

91. *Id.* at 242.

likely to be arrested compared to non-disordered suspects," even though suspects with mental disorder "were significantly more likely to be disrespectful" and to resist arrest than non-disordered suspects.[92] These authors surmised that officers are less likely to arrest individuals with mental disorder because officers perceive them as less culpable and less deserving of arrest.[93] Additional research has confirmed that relevant legal and situational factors—including nature and severity of offense, prior criminal history, criminal thinking patterns, demeanor, intoxication, public location of encounter, and victim requests for arrest—predict the arrest of suspects both with and without mental illness.[94]

C. *Symptom-Driven Crime*

A fundamental assumption underlying the criminalization hypothesis is that the criminal behavior of individuals with serious mental illness stems from, or is a manifestation of, their illness.[95] Criminalization proponents believe that individuals with serious mental illness who cannot access care in the community "are arrested for psychosis-induced violence, disturbed behavior on the street, or 'survival-type' crimes (for example, 'dine and dash' from a restaurant)."[96] This notion is intuitive, reflects the commonly held stigma that links mental disorders to dangerousness, and reifies assumed differences between "mentally disordered" and "normal" individuals. Importantly, it also suggests a solution to end the cycling of individuals with mental disorder through the criminal justice system: address the underlying cause of criminal behavior by providing needed mental health treatment.

92. Kenneth J. Novak & Robin S. Engel, *Disentangling the Influence of Suspects' Demeanor and Mental Disorder on Arrest*, 28 POLICING: INT'L J. POLICE STRATEGIES & MGMT. 493, 506 (2005) (emphasis added). Prior research had established that, generally, these behaviors increase likelihood of arrest. *Id.* at 494–95. This finding was replicated by Novak and Engel. *Id.* at 506.

93. *See id.* at 507 (drawing upon a theory advanced in John Van Maanen, *The Asshole*, *in* POLICING: A VIEW FROM THE STREET 221, 223–24 (Peter K. Manning & John Van Maanen eds., 1978)).

94. Ballard & Teasdale, *supra* note 87, at 27–28.

95. Jillian Peterson et al., *Analyzing Offense Patterns as a Function of Mental Illness to Test the Criminalization Hypothesis*, 61 PSYCHIATRIC SERVS. 1217, 1217 (2010).

96. *Id.*

However, research across jail,[97] parole,[98] and psychiatric samples[99] demonstrates that only a small minority of crimes—perhaps around 5% to 12%—committed by individuals with serious mental illness are the direct result of delusions or hallucinations.[100] An additional subset may be motivated by anger, impulsivity, or confusion stemming from a serious mood disorder.[101] For example, in a 2014 study of 143 offenders with mental illness, Professor Jillian Peterson and colleagues found that 4% of crimes had a mostly or completely direct relationship to psychosis, 3% had a mostly or completely direct relationship to depression, and 10% had a mostly or completely direct relationship to bipolar disorder.[102] Critically, the study authors employed broad definitions of mental illness that included the possibly normative personality traits of anger and impulsivity.[103] Yet, even with these broad—and potentially problematic—definitions of symptoms, only approximately one-fifth of crimes had at least a "mostly . . . direct" relationship to symptoms.[104] Approximately 82% of crimes were held to be completely (64.7%) or mostly (17.2%) independent of offenders' psychiatric illnesses.[105] This conclusion coheres with other research on the subject.[106]

Importantly, recent research has found that "there is no subgroup of offenders with mental illness who only engage in criminal behavior when their symptoms directly cause such behavior."[107] In the 2014 study by

97. *See* Junginger et al., *supra* note 35, at 880–81 (finding, in interviews of 113 offenders with co-occurring mental and substance abuse disorders shortly after their arrest, that delusions or hallucinations occurred concurrently with the index offense in 4% (n=4) of offenses).

98. *See* Peterson et al., *supra* note 95 (finding, in a retrospective study of 111 parolees with a serious mental illness, that 7% of mentally disordered offenders' criminal behavior was a direct result of psychosis (5%, n=6) or constituted survival crimes related to poverty (2%, n=2)).

99. *See* JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL ILLNESS AND VIOLENCE (2001) (finding, in a study of over 608 violent incidents involving psychiatric patients, that psychosis immediately preceded violent incidents in 11% (n=67) of violent and aggressive incidents detected).

100. *See* Jennifer L. Skeem et al., *Applicability of the Risk-Need-Responsivity Model to Persons with Mental Illness Involved in the Criminal Justice System*, 66 PSYCHIATRIC SERVS. 916, 919 (2015) (collecting studies).

101. *See* Junginger et al., *supra* note 35, at 880–81 (finding that 4% (n=4) of crimes were related to "any other symptom-based influence, such as confusion, depression, thought disorder, or irritability"); *see also* Jillian K. Peterson et. al., *How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders with Mental Illness?*, 38 LAW & HUM. BEHAV. 439, 446 (2014).

102. Peterson et. al., *supra* note 101.

103. *Id.* at 440 (noting that categorizing anger and impulsivity as symptoms of mental illness risks "pathologizing a normal emotional state").

104. *Id.* at 446.

105. *Id.* at 444 fig.3.

106. *See supra* notes 97–99 (detailing studies).

107. Peterson et. al., *supra* note 101.

Peterson and colleagues, "[t]he 18% of crimes coded as mostly or completely related . . . to symptoms were scattered among 38% of offenders" with mental illness.[108] "Of the 38% of offenders with at least one direct crime[] . . . [67%] also committed at least one crime that was coded 'mostly or completely' independent" of symptoms.[109] This finding suggests that, if an offender is one who commits crimes reflecting her psychiatric symptoms, over time she will also commit crimes unrelated to her symptoms. Overall, the research suggests that many offenders with serious mental illness commit no symptom-based offenses, while others commit symptom-based crimes among other, more generally-motivated crimes.

Indeed, decades of research have found that clinical factors are, at most, weak predictors of criminal behavior. A landmark 1998 meta-analysis conducted by Dr. James Bonta, Professor Moira Law, and Professor Karl Hanson found that the effect of clinical variables—such as diagnosis, intellectual dysfunction, and treatment history[110]—on recidivism[111] was largely insignificant and paled in comparison to dozens of other factors.[112] The meta-analysis of 58 studies between 1959 and 1995 revealed that intellectual dysfunction, diagnosis of a mood disorder, and treatment history were nonsignificant variables, while psychosis and schizophrenia were negatively related to recidivism.[113] Risk factors that applied to offenders both with and without mental illness, such as criminal history, juvenile delinquency, antisocial personality, family problems, and substance abuse, were more predictive of criminal behavior.[114] The study's authors concluded that many of the clinical factors emphasized within the mental health community "have little relevance to the assessment of long-term risk for recidivism."[115] In subsequent work, Bonta and Professor D.A. Andrews identified major mental disorder as a "minor" risk factor[116] but posited that its predictive

108. *Id.* at 445.

109. *Id.*

110. James Bonta et al., *The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis*, 123 PSYCHOL. BULL. 123, 125 (1998).

111. Recidivism was defined as including "any evidence of a new criminal offence" (like an arrest or conviction), "including a recommitment to a psychiatric hospital because of law-breaking behavior." *Id.* at 125–26.

112. *See id.* at 127–28 (general recidivism); *see also id.* at 132 (violent recidivism).

113. *See id.* at 128, 132, 136. These researchers found that major mental disorder was at least unrelated to violent and nonviolent recidivism and, in some cases, may have even been negatively associated with reoffending. *See id.* at 135, 136, 139.

114. *See id.* at 135–36.

115. *Id.* at 135; *see also id.* at 137 ("Clinical variables and clinical judgments contribute minimally in the prediction of recidivism.").

116. D.A. Andrews et al., *The Recent Past and Near Future of Risk and/or Need Assessment*, 52 CRIME & DELINQ. 7, 11 (2006).

validity is mediated by the general risk factors of antisocial cognition and antisocial personality pattern, as well as substance abuse.[117]

A large 2014 meta-analysis of the relative predictive validity of general and clinical risk factors confirmed the insignificance of clinical factors for recidivism.[118] This meta-analysis of 126 studies representing 96 unique samples concluded that, "for offenders, having a mental disorder was no more predictive of recidivism than not having a mental disorder."[119] For both general[120] and violent[121] recidivism, the clinical variables of psychosis, schizophrenia (which was analyzed separately due to recent attention in the literature), mood disorder, prior admissions, length of hospitalization, psychiatric treatment history, and personality disorder were all insignificant predictors.[122] The only exceptions were antisocial personality and psychopathy, which were significant predictors of both general and violent reoffending.[123] This predictive relationship is not surprising. Antisocial personality and psychopathy are closely aligned with and include aspects of antisocial personality pattern (for example, criminal history and personality features such as impulsivity, hostility, and lack of empathy), which is a strong risk factor for criminal activity in individuals with and without mental disorder.[124]

In summary, little hard evidence supports the criminalization hypothesis. It is doubtlessly true that components of this theory—including the closure of state psychiatric institutions, "mercy bookings," and arrests for symptomatic behavior—have contributed to the justice involvement of some individuals with serious mental illness.[125] However, as a broad explanatory theory for the disproportionate justice involvement of this population, the criminalization theory is unsupported by strong evidence. Instead, the narrative seems reliant on uncritical and stigma-driven assumptions involving the dominance of mental illness in individuals' lives and assumed causal connections between mental illness and crime.

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117. *Id.* at 10.

118. James Bonta et al., *A Theoretically Informed Meta-Analysis of the Risk for General and Violent Recidivism for Mentally Disordered Offenders*, 19 AGGRESSION & VIOLENT BEHAV. 278, 278 (2014).

119. *Id.* at 286. *See generally id.* at 281 (defining recidivism as any evidence of reoffending, such as arrests or convictions, and including recommitment to a psychiatric facility due to a new general or violent criminal offense).

120. *Id.* at 281 (defining general recidivism as any recidivism, including violent recidivism).

121. *Id.* (stating that violent recidivism includes sexual offenses).

122. *See id.* at 282, 285.

123. *Id.* at 285.

124. *See infra* notes 129–30 and accompanying text.

125. TORREY ET AL., *supra* note 82, at 49.

Crucially, the fact that insufficient treatment has contributed to a population's criminal justice involvement does not mean that adequate treatment will reduce its overrepresentation. The behavioral sciences literature documents a more complicated relationship between mental health features and crime.

II. NORMALIZATION THEORY

Normalization theory identifies criminogenic needs, as opposed to clinical factors, as driving criminal behavior.[126] This theory hypothesizes that "offenders with mental illness are 'normal' in their criminal behavior insofar as the same criminogenic risk factors that motivate offenders without mental illness also motivate those with mental illness."[127] Over the last twenty years, researchers have identified eight criminogenic risk and need factors—the "Central Eight"—that accurately and reliably predict the risk of criminal behavior.[128] The first four factors include a history of antisocial behavior, antisocial personality pattern, antisocial cognition, and antisocial attitudes.[129] These variables involve poor socialization, restless energy, risk-taking, impulsivity, egocentrism, poor problem-solving skills, hostility, and a disregard for responsibilities and others.[130] The remaining four risk/need factors include marital or family problems (or both), low levels of social or work performance (or both), low levels of involvement and satisfaction in anti-criminal leisure pursuits, and substance abuse.[131] A number of studies, including large-scale meta-analyses, have confirmed the importance of criminogenic risk

126. *See* Wolff, *supra* note 27, at 68. Earlier articles referred to the "normalization" theory as the "criminality" theory. *See generally* Ballard & Teasdale, *supra* note 87, at 23–29 (describing arguments advanced for the competing theories of criminalization and criminality). The normalization approach is consistent with several criminological theories, including social learning theory. *See* Skeem et al., *supra* note 1, at 116; *see also infra* notes 146–51 and accompanying text (discussing social learning theory in the context of the RNR model).

127. Wolff, *supra* note 27 (citation omitted); *see* Skeem et al., *supra* note 1, at 116 ("[T]he etiology of criminal behavior largely is shared by offenders with- and without-mental illness.").

128. *See* Bonta et al., *supra* note 118, at 280, 282 (listing and discussing the predictive validity of each criminogenic risk/need factor); *see also* JAMES BONTA & D.A. ANDREWS, THE PSYCHOLOGY OF CRIMINAL CONDUCT 45–46 tbl.3.1 (6th ed. 2017) (describing each factor in detail).

129. Andrews et al., *supra* note 116. Early prediction studies found these four factors—known colloquially as the "Big Four"—to be more predictive of criminal behavior than the four remaining factors that comprise the "Central Eight" criminogenic risks/needs. *See* BONTA & ANDREWS, *supra* note 128, at 44. Recent research, however, has found no clear demarcation in the predictive weight of the eight factors for mentally disordered offenders, general offenders, youthful offenders, mentally disordered offenders, racial minorities, or drug offenders. *See id.* (listing studies).

130. *See* BONTA & ANDREWS, *supra* note 128, at 45.

131. Andrews et al., *supra* note 116.

factors in predicting recidivism among disordered and non-disordered offenders alike.[132] Clinical variables, such as diagnosis or treatment history, do not improve predictive accuracy.[133]

Some research suggests that, on average, offenders with mental illness enter the criminal justice system with a higher concentration of criminogenic risk factors than offenders without mental illness. In a 2014 study assessing a matched sample of 221 parolees with and without mental illness, Professor Jennifer Skeem and colleagues found that offenders with mental illness had significantly higher scores for the general risk factors of antisocial pattern, family or marital problems, low educational or employment success, and procriminal attitude orientation than their non-disordered counterparts.[134] The largest difference in the risk profiles of the two samples lay in antisocial personality pattern.[135] Other studies have also found that offenders with mental illness tend to be "riskier" than those without mental illness.[136] The reasons for this phenomenon are unclear, but contributing factors may be that individuals with mental illness are more likely to live in poverty, be homeless, live in disadvantaged neighborhoods, be victimized, and possibly have more criminal associates.[137]

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132. *See, e.g.*, BONTA & ANDREWS, *supra* note 128, at 44; Bonta et al., *supra* note 110, at 135; Bonta et al., *supra* note 118, at 282.

133. *See* Skeem et al., *supra* note 38; *supra* notes 110–23 and accompanying text.

134. *See* Skeem et al., *supra* note 38, at 218.

135. *Id.* at 221 (concluding that offenders with mental illness "were more likely to manifest early and diverse criminal behavior, a generalized pattern of trouble (e.g., financial instability, few prosocial friends), and procriminal attitudes" than their non-disordered counterparts).

136. *See* Lina Girard & J. Stephen Wormith, *The Predictive Validity of the Level of Service Inventory-Ontario Revision on General and Violent Recidivism Among Various Offender Groups*, 31 CRIM. JUST. & BEHAV. 150, 164 (2004) (finding, in a sample of 600 probationers, that those with mental health problems (n=169) had significantly more general risk factors than those without mental illness); Nancy Wolff et al., *Thinking Styles and Emotional States of Male and Female Prison Inmates by Mental Disorder Status*, 62 PSYCHIATRIC SERVS. 1485, 1490–91 (2011) (finding that inmates who reported a mental disorder scored significantly higher on measures of aggression and hopelessness and showed antisocial attitudes similar to or greater than those who did not report a mental disorder); *infra* notes 255–59 and text accompanying; *cf.* Robert D. Morgan et al., *Prevalence of Criminal Thinking Among State Prison Inmates with Serious Mental Illness*, 34 LAW & HUM. BEHAV. 324, 332 (2010) (finding that offenders with mental illness exhibit criminal thinking patterns and content comparable to non-ill inmates).

137. *See* William H. Fisher et al., *Community Mental Health Services and Criminal Justice Involvement Among Persons with Mental Illness*, *in* COMMUNITY-BASED INTERVENTIONS FOR CRIMINAL OFFENDERS WITH SEVERE MENTAL ILLNESS 25, 38–41 (William H. Fisher ed., 2003) (exploring the role of poverty and social environments as risk factors for criminal justice involvement among persons with mental illness); Epperson et al., *supra* note 3, at 433–34 (identifying the tendency to move into high-crime neighborhoods with high levels of social and economic disadvantage, poverty, under-education, unemployment, paucity of positive social relationships, discrimination and stigma, and stress in meeting daily needs as exacerbating the

Vitally important to calls for the adoption of the normalization theory is evidence that demonstrates that all of the Central Eight criminogenic risk factors—with the exception of established criminal history—are dynamic or capable of change.[138] Studies show that the most effective programs for reducing recidivism are those that target these dynamic risks.[139] Evidence demonstrates that appropriate offender rehabilitation programs that address criminogenic variables can reduce recidivism by 30%.[140] In light of this evidence, Bonta and Andrews issued this opinion in relation to programs directed at offenders with mental illness:

> Our argument is that if [mental health] treatment services are offered with the intention of reducing recidivism, changes must be encouraged on criminogenic need factors. Offenders also have a right to the highest quality service for other needs, but that is not the focus of correctional rehabilitation. Striving to change noncriminologic needs is unlikely to alter future recidivism significantly unless it indirectly impacts on a criminogenic need. We may make an offender feel better, which is important and valued, but this may not necessarily reduce recidivism.[141]

In summary, normalization theory holds, and empirical evidence demonstrates, that reducing recidivism necessitates prioritizing the

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criminogenic risk of individuals with serious mental illness); Fisher et al., *supra* note 13, at 552–54 (discussing the impact of life circumstances and features of environments associated with serious mental illness within criminological frameworks).

138. *See* BONTA & ANDREWS, *supra* note 128, at 44, 46.

139. *See, e.g.*, JAMES BONTA & D.A. ANDREWS, RISK-NEED-RESPONSIVITY MODEL FOR OFFENDER ASSESSMENT AND REHABILITATION 12 (2007) (concluding that, when the principles of risk, need, and responsivity are followed in a rehabilitation program, "then we see average recidivism differences between the treated and non-treated offenders of 17% when delivered in residential/custodial settings and 35% when delivered in community settings"); Andrews & Bonta, *supra* note 31, at 47–48 (summarizing the empirical base for the RNR model); Craig Dowden & D.A. Andrews, *Effective Correctional Treatment and Violent Reoffending: A Meta-Analysis*, 42 CANADIAN J. CRIMINOLOGY 449, 459 (2000).

140. *See* Andrews & Bonta, *supra* note 31, at 47–48; Craig Dowden & D.A. Andrews, *The Importance of Staff Practice in Delivering Effective Correctional Treatment: A Meta-Analytic Review of Core Correctional Practice*, 48 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 203, 212 (2004); Craig Dowden et al., *The Effectiveness of Relapse Prevention with Offenders: A Meta-Analysis*, 47 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 516, 522 (2003); A. Murray Ferguson et al., *Predicting Recidivism by Mentally Disordered Offenders Using the LSI-R:SV*, 36 CRIM. JUST. & BEHAV. 5, 8 (2009).

141. D.A. ANDREWS & JAMES BONTA, THE PSYCHOLOGY OF CRIMINAL CONDUCT 244 (2d ed. 1998); *see also* Eric Silver, *Understanding the Relationship Between Mental Disorder and Violence: The Need for a Criminological Perspective*, 30 LAW & HUM. BEHAV. 685, 689 (2006) ("If mental disorder is only a small part of the problem, services aimed at its control can only be a small part of the solution.").

treatment of criminogenic risk factors, not prioritizing the treatment of the non-criminogenic factor of serious mental illness.

III. THEORY IN PRACTICE

Effective interventions for offenders with serious mental illness require adopting a treatment framework that spans beyond mental health to address the broader set of criminogenic needs proven to drive criminal behavior.[142] Recently, some social scientists and policy advocates have suggested that the Risk-Need-Responsivity (RNR) model, a highly influential correctional model that targets criminogenic needs and reflects a normalization approach, should guide the treatment of this population.[143] This Part recounts the principles inherent in the RNR model and elucidates current research regarding how mental illness may factor into this framework. This Part then highlights the federal government's recent promotion of this model for justice-involved individuals with mental illness and current efforts to apply the model to this group.

A. *Risk-Need-Responsivity Correctional Model*

The RNR model is the leading evidence-based offender assessment and treatment model in the world.[144] In 1990, Andrews, Bonta, and Professor Robert Hoge generated the first iteration of this model, which is derived from a personality and social learning theory of criminal behavior.[145] A key premise of social learning theory is that criminal behavior is learned through social interaction and operant conditioning.[146] According to one notable advocate of this theory,

142. *See* Skeem et al., *supra* note 1, at 116.

143. *See, e.g.*, Carol Fisler, *When Research Challenges Policy and Practice: Toward a New Understanding of Mental Health Courts*, 54 JUDGES J. 8, 11 (2015) (suggesting the RNR model for mental health courts); Skeem et al., *supra* note 1, at 121; *cf.* Evan R. Seamone et. al., *Veteran* Non Grata*: Veteran Sex Offenders with Service-Related Mental Health Conditions and the Need to Mitigate Risk*, 6 VA. J. CRIM. L. 182, 221–23 (2018) (suggesting the application of the RNR model to the treatment of sex offenders).

144. BONTA & ANDREWS, *supra* note 128, at 175.

145. *See* D.A. Andrews et al., *Classification for Effective Rehabilitation: Rediscovering Psychology*, 17 CRIM. JUST. & BEHAV. 19, 33 (1990); *see also* BONTA & ANDREWS, *supra* note 128, at 43–52 (outlining principles of general personality and cognitive social learning theory).

146. *See* Ronald L. Akers et al., *Social Learning and Deviant Behavior: A Specific Test of a General Theory*, 44 AM. SOC. REV. 636, 637–38 (1979) (explaining core constituents of social learning theory); Andrews & Bonta, *supra* note 31, at 44. Key elements of social learning theory include differential association (group influence on behavior), definitions (an individual's attitudes and beliefs, learned and reinforced through differential association), differential reinforcement (the balance of actual and anticipated consequences for engaging in criminal behavior), and imitation or modeling (learning by observing others). Silver, *supra* note 141, at 691–92 (describing social learning theory in the context of violence); *see also* Ronald L. Akers,

Professor Ronald Akers, interaction and association with others' behavioral and normative patterns shapes "one's own attitudes or meanings that one attaches to given behavior."[147] Key factors in the initiation and maintenance of criminal behavior are social support for that behavior and antisocial cognitions, as well as antisocial personality features such as anger, impulsivity, and recklessness.[148] Other relevant factors include substance abuse and indicators of social achievement, such as educational and employment status.[149] Social learning theory posits that criminal behavior can be influenced by imitation and by differential reinforcement, or, in other words, "the balance of anticipated or actual rewards and punishments that follow or are consequences of behavior."[150] Treatment "thus largely involves interventions that create learning experiences for offenders in which antisocial cognitions and behaviors are replaced with prosocial cognitions and behaviors," addressing the problems or deficits that contribute to criminal offending, and increasing rewards and satisfaction for alternatives to criminal behavior.[151]

1. Risk, Need, and Responsivity

Within this theoretical structure, the RNR model provides a blueprint for effective correctional treatment. The treatment framework involves three core principles: risk, need, and responsivity. The risk principle holds that the intensity of treatment services should match the offender's risk level.[152] Effectuating this principle requires designing and properly using reliable and valid evidence-based risk assessment instruments and then appropriately matching the level of service to an offender's risk level.[153] On the latter point, offenders at the highest risk levels should receive the most intensive services in order to yield the greatest reductions in recidivism.[154] Low-level offenders, on the other hand, should receive minimal or no services.[155] Indeed, some studies have found that the intensive treatment of low-risk offenders can make them

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Social Learning Theory, *in* EXPLAINING CRIMINALS AND CRIME: ESSAYS IN CONTEMPORARY CRIMINOLOGICAL THEORY 192, 192–210 (R. Paternoster & R. Bachman eds., 2001) [hereinafter Akers, *Social Learning Theory*] (detailing elements of theory).

147. Akers, *Social Learning Theory*, *supra* note 146, at 195.

148. *See* Andrews & Bonta, *supra* note 31, at 44.

149. *Id.*

150. Akers, *Social Learning Theory*, *supra* note 146, at 195.

151. Francis T. Cullen, *Rehabilitation: Beyond Nothing Works*, 42 CRIME & JUST. 299, 341 (2013); *accord* BONTA & ANDREWS, *supra* note 128, at 48.

152. BONTA & ANDREWS, *supra* note 128, at 176 tbl.9.1.

153. BONTA & ANDREWS, *supra* note 139, at 9.

154. BONTA & ANDREWS, *supra* note 128, at 190–91.

155. *Id.*

more likely to recidivate, probably because of their association with higher risk offenders and increased surveillance.[156]

The need principle dictates that, to reduce risk of recidivism, treatment must focus on addressing an offender's set of dynamic criminogenic needs—those psycho-social-biological factors proven to influence and maintain criminal behavior—as opposed to focusing on other needs that are more distally related to offending.[157] According to Andrews and colleagues:

> The most promising intermediate targets include changing antisocial attitudes, feelings, and peer associations; promoting familial affection in combination with enhanced parental monitoring and supervision; promoting identification with anticriminal role models; increasing self-control and self-management skills; replacing the skills of lying, stealing, and aggression with other, more prosocial skills; reducing chemical dependencies; and generally shifting the density of rewards and costs for criminal and noncriminal activities in familial, academic, vocational, and other behavioral settings.[158]

The responsivity principle, which consists of general and specific components, focuses on effective service delivery. General responsivity dictates that interventions should target the right variables and be capable of addressing those variables.[159] Consistent with the criminological theory underlying RNR, general responsivity calls for the use of cognitive-behavioral and cognitive-social learning strategies to influence behavior.[160] Appropriate strategies include modeling and skill development, rehearsal, role playing, reinforcement, resource provision, detailed verbal guidance and explanations, and "practicing new, low-risk alternative behaviors repeatedly in a variety of high-risk situations until one gets very good at it."[161] Applications of these practices involve the utilization of certain core correctional skills, including effective use of authority (a "firm but fair" approach), prosocial (anti-criminal) modeling

156. *See* BONTA & ANDREWS, *supra* note 139, at 10 (collecting studies).

157. *See* BONTA & ANDREWS, *supra* note 128, at 191–92; *see supra* notes 128–32 and accompanying text (discussing the Central Eight criminogenic needs).

158. D.A. Andrews et al., *Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis*, 28 CRIMINOLOGY 369, 375 (1990).

159. *See* Cullen, *supra* note 151, at 342–43.

160. BONTA & ANDREWS, *supra* note 128, at 180, 182.

161. *Id.* at 182.

and positive reinforcement, problem-solving, brokerage of community resources, and high quality relationships between staff and offenders.[162]

The principle of specific responsivity, on the other hand, holds that service providers should tailor intervention strategies to match the setting of service and an offender's relevant characteristics.[163] Of the core RNR principles, specific responsivity is the least developed or understood.[164] In 1995, Bonta stated that specific responsivity "focuses on personal characteristics that regulate an individual's ability and motivation to learn."[165] To facilitate effective treatment, programs should build on an individual's strengths and reduce barriers to participation.[166]

Researchers differ in how they define and measure the variables contained within the concept of specific responsivity.[167] Responsivity factors may be internal to the individual (that is, motivation, interpersonal anxiety, depression, cognitive deficits, personality characteristics, gender, age, or ethnicity) or external (that is, language barriers, lack of stable housing, or therapist characteristics).[168] Many responsivity factors appear unrelated to recidivism but require amelioration before the effective treatment of criminogenic needs can commence;[169] other factors may also function as risk factors and therefore require a more sustained treatment approach.[170] Because many responsivity factors must be addressed before correctional treatment begins, addressing these factors is often a short-term goal, while decreasing recidivism (through the

162. *See* Andrews et al., *supra* note 158, at 375–76; Dowden & Andrews, *supra* note 140, at 204.

163. *See* BONTA & ANDREWS, *supra* note 128, at 180.

164. *See* Thomas H. Cohen & Jay Whetzel, *The Neglected "R"—Responsivity and the Federal Offender*, 78 FED. PROB. 11, 12 (2014); Sarah McCormick et al., *The Role of Mental Health and Specific Responsivity in Juvenile Justice Rehabilitation*, 41 LAW & HUM. BEHAV. 55, 56 (2017).

165. James Bonta, *The Responsivity Principle and Offender Rehabilitation*, 7 F. CORRECTIONS RES. 34, 35 (1995).

166. D.A. Andrews, *The Risk-Need-Responsivity (RNR) Model of Correctional Assessment and Treatment*, *in* USING SOCIAL SCIENCE TO REDUCE VIOLENT OFFENDING 127, 139 (Joel A. Dvoskin et al. eds., 2011).

167. *See* Tracey A. Vieira et al., *Matching Court-Ordered Services with Treatment Needs: Predicting Treatment Success with Young Offenders*, 36 CRIM. JUST. & BEHAV. 385, 399 (2009); *see also* Cohen & Whetzel, *supra* note 164, at 11 (describing various ways in which specific responsivity may be conceived).

168. *See* Jan Looman et al., *Responsivity Issues in the Treatment of Sexual Offenders*, 6 TRAUMA, VIOLENCE & ABUSE 330, 336–37 (2005) (discussing internal and external factors).

169. *See* Bonta, *supra* note 165, at 37 (noting that anxiety, depression, and some severe forms of mental disorder are responsivity factors that are not significantly predictive of recidivism).

170. *See id.* (noting that antisocial personality or psychopathy is an example of a responsivity factor that also functions as a risk factor).

treatment of criminogenic needs) is the ultimate long-term goal.[171] Appropriate responses to responsivity concerns include adapting the delivery or composition of an intervention directed at criminogenic needs and the "targeting of noncriminogenic needs for purposes of enhancing motivation, the reduction of distracting factors, and for reasons having to do with humanitarian and entitlement issues."[172] "Despite the intuitive appeal of [the specific responsivity] principle," little empirical research has investigated its applicability to correctional rehabilitation.[173]

2. Mental Illness and Specific Responsivity

Social scientists have conceptualized mental health features, such as anxiety and depression, as specific responsivity factors that may impede the treatment of criminogenic needs.[174] Mental illness is a destabilizer that increases life's demands, affects decision-making, and generates stress.[175] As Andrews and Bonta pithily explained, "[o]ne cannot successfully deal with a substance addiction if the client is psychotic; one cannot deal with employment problems if the person is suicidal."[176] Numerous meta-analyses establish that mental health factors (and the treatment thereof) are largely unrelated to recidivism,[177] but scholars have hypothesized that an individual's mental illness may need to be stabilized so that she will be willing and able to participate in criminogenic-focused interventions.[178] However, little empirical research has questioned the

171. *See* Faye S. Taxman, *Second Generation of RNR: The Importance of Systemic Responsivity in Expanding Core Principles of Responsivity*, 78 FED. PROB. 32, 33 (2014).

172. BONTA & ANDREWS, *supra* note 128, at 177.

173. Dowden & Andrews, *supra* note 139, at 453; *see also* BONTA & ANDREWS, *supra* note 128, at 176 tbl.9.1 ("The evidence in regard to specific responsivity is generally favorable but very scattered, and it has yet to be subjected to a comprehensive meta-analysis."); Cohen & Whetzel, *supra* note 164, at 17 ("Responsivity is an important but under-investigated component of the RNR framework. Indeed, beyond a few succinct descriptions of the principle itself, there is minimal extant research.").

174. *See, e.g.*, BONTA & ANDREWS, *supra* note 139, at 7; Bonta, *supra* note 165, at 36 tbl.1; Taxman, *supra* note 171, at 33, 35. Importantly, the RNR model does not opine on the responsivity effect of particular diagnostic categories of mental illnesses but rather speaks to "particular features" of mental health and functioning. *See* McCormick et al., *supra* note 18, at 217–18; *see, e.g.*, BONTA & ANDREWS, *supra* note 128, at 345 tbl.15.4 (including "[c]ognitive/[i]nterpersonal [s]kill [l]evel," "[i]nterpersonal [a]nxiety," and "[a]ntisocial [p]ersonality [p]attern" factors, as well as "[m]ental [d]isorder," under the specific responsivity principle).

175. *See* Taxman, *supra* note 171, at 35–36 (discussing the importance of stabilizers and destabilizers to specific responsivity).

176. BONTA & ANDREWS, *supra* note 128, at 192.

177. *See supra* Section I.C.

178. *See, e.g.*, Bonta, *supra* note 165, at 36 ("Anxiety, depression and perhaps even some severe forms of mental disorder are key responsivity factors. . . . [B]efore targeting criminogenic needs such as antisocial attitudes, responsivity factors may need to be addressed to prepare the offender to learn prosocial behaviour.").

import of various aspects of mental health or mental health treatment for effective correctional treatment.[179] Because "responsivity variables have received little empirical attention in the RNR literature . . . this classification of mental health variables contributes little clarification as to their role, either in terms of risk assessment or rehabilitative programming."[180]

Thus, it is currently unclear whether the treatment of mental health features facilitates or enhances the treatment of criminogenic needs.[181] One recent study, published by clinical psychologist Sarah McCormick and colleagues in 2016, sought to address this question.[182] The study "investigated the relationships among mental health status, criminogenic needs treatment, and recidivism" of 232 youths who were referred for court-ordered assessments to inform sentencing.[183] The researchers found that the youths who received mental health treatment were more likely to have their criminogenic needs addressed—and to have a greater proportion of their criminogenic needs addressed—than those youths whose mental health needs were not addressed.[184] This finding suggested that mental health may be best conceptualized as a specific responsivity variable of "relevance to treatment engagement and success," with "influence . . . at the intermediate stage of completion of criminogenic needs treatment."[185] Particularly noteworthy is that McCormick et al.'s study did not support the hypothesis that mental health treatment functioned as a responsivity factor (that is, as a moderator of the effect of criminogenic needs treatment on recidivism).[186] The study found that "whether or not youths' mental health needs were treated did not predict recidivism, nor did it moderate the effect of treating criminogenic needs on the outcome."[187] Specific responsivity is a topic of growing interest in the behavioral health science community, so our understanding of this important principle should evolve as research continues.[188]

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179. *See* Skeem et al., *supra* note 100, at 920 ("We are aware of no empirical support for the responsivity principle among persons with mental illness.").

180. McCormick et al., *supra* note 18, at 218.

181. *Id.* at 220.

182. *See* McCormick et al., *supra* note 164, at 55.

183. *Id.*

184. *Id.* at 60, 63.

185. *Id.* at 63.

186. *Id.* at 61, 63 ("The alternative conceptualization of responsivity—that of mental health treatment as a moderator of the success of intervention targeted to criminogenic needs—was not supported; youth who had more of their criminogenic needs addressed through intervention were less likely to reoffend *regardless of* mental health functioning.").

187. *Id.* at 61.

188. *See* McCormick et al., *supra* note 18, at 218 (listing researchers examining issues around RNR model implementation).

B. *Current Implementation of RNR Model*

Even though "there is as yet no direct support for the applicability of the three core RNR principles to treat this population,"[189] a groundswell is building to apply the RNR model to offenders with serious mental illness. This chorus consists of federal agencies, policy advocates, and social scientists and has resulted in the development of new risk assessment instruments and adapted cognitive-behavioral interventions.[190] Few, if any, however, recognize that the normalization theory and the RNR model may call for a radical shift in the relationship of criminal justice to mental health. Indeed, the logic of this theory and correctional model call into question the very existence of current, popular criminal justice programs such as jail diversion programs, mental health courts, specialized probation and parole, and specialized reentry programs.

The federal government now endorses the RNR model for allocation of services to individuals with mental illness in correctional institutions or on parole or probation.[191] In 2012, the Council of State Governments Justice Center, in partnership with a number of federal agencies,[192] published a white paper that introduced a framework coordinating the activities of correctional and behavioral health service providers for this population.[193] The paper notes that "[r]ecent studies" undermine the criminalization theory and "suggest[] that interventions to reduce recidivism among people with mental illnesses in the criminal justice system need to not only include traditional mental health treatment, but also incorporate new multifaceted strategies."[194] The framework for resource allocation includes three dimensions: criminogenic risk, need

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189. Skeem et al., *supra* note 100, at 916. Skeem and colleagues warn that, before the criminal justice and behavioral health systems prioritize correctional services to reduce recidivism over psychiatric services to improve clinical outcomes,

> [t]here must be explicit recognition that these services are being applied to a new population with unique characteristics (mental illness combined with justice system involvement), such that generalizability from the general offender population is uncertain and must be tested. . . . Services may not be effective if we shortcut studying how the unique features of this group affect the process and outcome of treatment.

Id. at 917.

190. *See infra* notes 201–07 and accompanying text.

191. *See* OSHER ET AL., *supra* note 2, at 45.

192. These agencies include the Department of Justice's National Institute of Corrections and Bureau of Justice Assistance and the Department of Health and Human Service's Substance Abuse and Mental Health Services Administration (SAMSA). *See id.* at iii.

193. *See id.*

194. *Id.* at 5.

for mental health treatment, and need for substance abuse treatment.[195] In accordance with RNR principles, the framework dictates that institutions and practitioners prioritize those offenders at higher risk of recidivism to receive scarce correctional programming, services, and treatment resources.[196] Providers should only address offenders' mental health needs to the extent necessary to allow for the successful treatment of criminogenic needs and to satisfy constitutional obligations.[197]

The federal government has promoted the operationalization of this framework through funding and guidance. In 2013 and 2017, it issued guidelines to assist mental health, correctional, and community stakeholders in assessing criminological and clinical needs, planning appropriate treatment in custody and upon reentry, identifying post-release services, and coordinating with community-based providers to avoid gaps in treatment.[198] Since fiscal year 2011,[199] the Bureau of Justice Assistance has prioritized applications which include the "use of criminogenic and violence risk assessments to identify and prioritize treatment and case management services for individuals at risk for committing future violence."[200] Federal agencies have also publicized examples of state and local programs that assess criminogenic and clinical needs, identify criminogenic needs as treatment targets, and favor those offenders with the highest risk of recidivism for treatment.[201]

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195. *See id.* at 32, 33 fig.5.

196. *See id.* at 24, 36.

197. *See id.* at 7, 24, 35–36. The white paper stresses that low-risk inmates with high clinical needs should not be prioritized for the receipt of scarce mental health services, programming, or other correctional resources such as monitoring and supervision on probation. *See id.* at 21. Such inmates, if incarcerated, should have their needs addressed to the extent necessary to satisfy correctional institutions' duties to provide health care under the Eighth Amendment. *See id.* at 7. On probation or at reentry, "these low-risk/high-need individuals should be linked to effective treatments for which they are eligible and that can be paid for by existing behavioral health financing mechanisms, such as Medicaid and other local, state, and federal funding sources." *Id.* at 35.

198. *See* ALEX M. BLANDFORD & FRED OSHER, GUIDELINES FOR THE SUCCESSFUL TRANSITION OF PEOPLE WITH BEHAVIORAL HEALTH DISORDERS FROM JAIL AND PRISON 5 (2013), https://csgjusticecenter.org/wp-content/uploads/2013/12/Guidelines-for-Successful-Transition.pdf [https://perma.cc/R47S-G6DF]; POLICY RESEARCH ASSOCS., GUIDELINES FOR SUCCESSFUL TRANSITION OF PEOPLE WITH MENTAL OR SUBSTANCE USE DISORDERS FROM JAIL AND PRISON: IMPLEMENTATION GUIDE 8–19 (2017), https://store.samhsa.gov/shin/content/SMA16-4998/SMA16-4998.pdf [https://perma.cc/HJZ7-XNNH].

199. *See* OSHER ET AL., *supra* note 2, at 47.

200. U.S. DEP'T OF JUSTICE, OMB NO. 1121-0329, JUSTICE AND MENTAL HEALTH COLLABORATION PROGRAM FY 2018 COMPETITIVE GRANT ANNOUNCEMENT 8 (2018), https://www.bja.gov/funding/JMHCP18.pdf [https://perma.cc/9WCV-DGLX].

201. *See, e.g.*, *id.* at 1; *see also* POLICY RESEARCH ASSOCS., *supra* note 198, at 4–5; U.S. GOV'T ACCOUNTABILITY OFFICE, FEDERAL PRISONS: INFORMATION ON INMATES WITH SERIOUS MENTAL ILLNESS AND STRATEGIES TO REDUCE RECIDIVISM 24, 29 (2018).

In response to this call to action and the decades of science preceding it, social scientists have begun to create or adapt evidence-based assessment tools and interventions for use with offenders with mental illness. Empirical studies support the use of general risk assessment tools—including the leading correctional tool, the Levels of Service/Case Management Inventory (LS/CMI)—to measure this group's risk of recidivism.[202] On the treatment front, Robert Morgan and colleagues created the Changing Lives and Changing Outcomes program, an evidence-based intervention that addresses mental health and criminogenic needs.[203] When adapting general risk reduction interventions, scholars have emphasized that modifications may be necessary to address the treatment needs of offenders with serious mental illness, accommodate their particular cognitive and emotional impairments, and deliver the intervention in a community mental health setting.[204] To date, one popular structured cognitive-behavioral intervention for criminogenic risk factors—the "Reasoning and Rehabilitation" (R&R) program—has been modified to accommodate the learning abilities of offenders with mental illness.[205] Several controlled studies have shown that this modified version can improve coping skills and reduce antisocial attitudes, violent thoughts, disruptive behavior, and substance abuse among forensic patients.[206] Other programs—including Thinking for a Change, Options, Moral Reconation Therapy, and Interactive Journaling—have also been applied to offenders with mental illness.[207] In addition, structural mental health interventions that "emphasize clinical features associated with criminality, such as frustration intolerance, social skills deficits, and misperceptions of the

202. *See* Skeem et al., *supra* note 100, at 917–18.

203. Robert D. Morgan et al., *Treating Justice Involved Persons with Mental Illness: Preliminary Evaluation of a Comprehensive Treatment Program*, 41 CRIM. JUST. & BEHAV. 902, 904 (2014). While a preliminary evaluation showed reductions in psychological symptoms and criminal thinking, the program's effect on recidivism is unknown. *See* BONTA & ANDREWS, *supra* note 128, at 330.

204. *See* Morgan et al., *supra* note 136, at 334–36; Merrill Rotter & W. Amory Carr, *Targeting Criminal Recidivism in Mentally Ill Offenders: Structured Clinical Approaches*, 47 COMMUNITY MENTAL HEALTH J. 723, 724–25 (2011); Skeem et al., *supra* note 1, at 120–21; Amy Blank Wilson et al., *Translating Interventions that Target Criminogenic Risk Factors for use in Community Based Mental Health Settings*, 53 COMMUNITY MENTAL HEALTH J. 893, 894 (2017).

205. *See* Skeem et al., *supra* note 100.

206. *See* BONTA & ANDREWS, *supra* note 128, at 328–29; Skeem et al., *supra* note 100 (collecting studies).

207. *See* MERRILL ROTTER & W. AMORY CARR, REDUCING CRIMINAL RECIDIVISM FOR JUSTICE-INVOLVED PERSONS WITH MENTAL ILLNESS: RISK/NEEDS/RESPONSIVITY AND COGNITIVE-BEHAVIORAL INTERVENTIONS 2–3 (2013), http://forensiccounselor.org/images/file/ReduceCrimRecidMIRiskNeedsResponCogBehavInter.pdf [https://perma.cc/KCV5-G65B].

environment" have been modified for justice-involved individuals.[208] These efforts are nascent, however, and it appears that very little treatment currently offered to offenders with mental illness coheres with the RNR model.[209]

Social scientists also argue that "first generation" specialized justice programs—such as jail diversion programs, mental health courts, specialized probation and parole, and reentry programs—should adapt to reflect RNR principles.[210] Currently, these programs reflect the criminalization notions that mental illness drives criminal behavior, and mental health treatment will reduce reoffending.[211] Although working at different points in the justice process,[212] they are unified in their approach of using the justice system to leverage engagement with community mental health treatment.[213] Consistent with the RNR framework, social scientists and policy advocates contend that these specialized programs should be modified to address criminogenic needs and to allocate resources by risk level. For example, researchers have urged mental health courts to increase attention to participants' criminogenic needs.[214]

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208. *See id.* at 3 (discussing the use of Dialectical Behavioral Therapy and Schema Focused Therapy).

209. *See* BONTA & ANDREWS, *supra* note 128, at 321 ("Clinical interventions with the MDO [mentally disordered offender] usually involve treating psychological complaints or the behaviors that are disruptive to the functioning of the institution."); Marshall T. Bewley & Robert D. Morgan, *A National Survey of Mental Health Services Available to Offenders with Mental Illness: Who Is Doing What?*, 35 LAW & HUM. BEHAV. 351, 360 (2011) (finding, in a survey of 230 mental health service providers in 165 state correctional facilities, that only 15.7% reported incorporating each of the three RNR principles into their work with offenders with mental illness).

210. *See* Epperson et al., *supra* note 3, at 427 (defining "first generation" interventions as those that (a) "are united by a common philosophy and theme: criminal justice involvement of people with SMI [serious mental illness] is reduced primarily by providing mental health treatment to these individuals" and (b) have as a "principal objective . . . to create or strengthen linkages to effective mental health services"); Skeem et al., *supra* note 1, at 112 (identifying the "most common types of contemporary programs for offenders with mental illness" as falling into four categories: "jail diversion programs, problem-solving courts, specialty probation or parole caseloads, and jail transition or prison re-entry programs").

211. *See* BONTA & ANDREWS, *supra* note 128, at 328–31; Epperson et al., *supra* note 3, at 434 ("While anecdotal examples of such programs [incorporating a broader perspective beyond mental illness in identifying targets for intervention] do exist, the preponderance of first generation models do not systematically target the range of risk factors discussed in our person–place framework."); Skeem et al., *supra* note 38.

212. *See* Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCHIATRIC SERVS. 544, 544–45 (2006).

213. *See* Peterson et al., *supra* note 95, at 1218.

214. *See, e.g.*, Natalie Bonfine et al., *Exploring the Relationship Between Criminogenic Risk Assessment and Mental Health Court Program Completion*, 45 INT'L J.L. & PSYCHIATRY 9, 15 (2016); Mary Ann Campbell et al., *Multidimensional Evaluation of a Mental Health Court:*

Several scholars have also suggested limiting these courts to high-risk individuals at high clinical need,[215] or, alternatively, accepting all individuals with high clinical needs but adopting multiple supervision tracks to address different levels of criminogenic risk.[216] In addition, researchers have urged specialized mental health probation officers to focus more on criminogenic needs in client meetings.[217] Others have urged consideration of RNR principles in reentry[218] and jail diversion programs.[219] However, recent commentary on the state of correctional programs reflects that these programs largely remain focused on clinical—not criminogenic—needs.[220]

Although calls for reform are increasingly common, few individuals have questioned the existence of these "first generation" programs altogether.[221] Scholars' allegiance to these programs and their continued focus on mental health treatment may be explained by their confidence in the status of mental illness as a major responsivity factor.[222] Despite the

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Adherence to the Risk-Need-Responsivity Model, 39 LAW & HUM. BEHAV. 489, 490 (2015); Fisler, *supra* note 143.

215. *See* Skeem et al., *supra* note 1, at 122 (advancing a model that would reserve intensive supervision and psychiatric treatment for those with the greatest criminogenic risk and clinical need and merely provide "good enough" supervision and community treatment for low-risk, low-need individuals).

216. *See* Bonfine et al., *supra* note 214, at 14 (suggesting this approach).

217. *See* Jennifer Eno Louden et al., *Supervision Practices in Specialty Mental Health Probation: What Happens in Officer-Probationer Meetings?*, 36 LAW & HUM. BEHAV. 109, 116–18 (2012).

218. *See* Cheryl Lero Jonson & Francis T. Cullen, *Prisoner Reentry Programs*, 44 CRIME & JUST. 517, 553–57 (2015).

219. *See* Virginia Barber-Rioja et al., *Diversion Evaluations: A Specialized Forensic Examination*, 35 BEHAV. SCI. & L. 418, 421, 423 (2017) (calling for diversion evaluations to include assessment and consideration of both clinical and criminogenic needs).

220. *See* Debra A. Pinals, *Jail Diversion, Specialty Court, and Reentry Services: Partnerships between Behavioral Health and Justice Systems*, *in* PRINCIPLES & PRACTICE OF FORENSIC PSYCHIATRY 237, 239 (Richard Rosner & Charles Scott eds., 3d ed. 2017) (reviewing the evolution of jail diversion and reentry programs and stating that, while RNR "is an increasingly emphasized sorting approach to help determine who can benefit most from particular diversion strategies," "[t]raditional clinical services have not embraced or incorporated these [RNR] concepts yet"); *see also* Epperson et al., *supra* note 3, at 427 (pointing out the emphasis certain interventions place on clinical and mental health services).

221. *See, e.g.*, Epperson et al., *supra* note 3, at 436 (observing that "[w]hile some existing first generation interventions may be amenable to adaptation, the need for second-generation philosophical and practical approaches will also likely require entirely new and innovative intervention models," and suggesting a module-based approach).

222. *See, e.g.*, MARGARET SEVERSON & JASON MATEJKOWSKI, REVIEW OF THE LITERATURE ON JAIL DIVERSION PROGRAMS AND SUMMARY RECOMMENDATIONS FOR THE ESTABLISHMENT OF A MENTAL HEALTH COURT AND CRISIS CENTER WITHIN DOUGLAS COUNTY, KANSAS 7 (2014) (noting, in a literature review of mental health diversion programs, that "the presence of a mental illness is a personal characteristic to which programs targeting criminogenic needs must be responsive"

lack of empirical support for the responsivity principle,[223] scholars and advocates appear to view mental health's status as a responsivity factor as "largely settled."[224] This uncritical stance could lead to the unjustified and inefficient continuation of programs that yield sub-maximal recidivism reductions and, in segregating individuals with mental illness and treating them specially, reinforce stigma and harmful stereotypes. Andrews has warned:

> Sometimes, . . . specific responsivity concerns are misused as a way to keep doing what has always been done. For example, a focus on relieving mental illness . . . may be treated as even more important than adherence with the core RNR principles. Noncriminogenic needs that clinicians enjoy addressing may be declared mistakenly to be specific responsivity factors that demand special attention.[225]

Furthermore, Andrews has observed that "once the targeting of noncriminogenic needs becomes dominant, . . . programs are virtually never adherent to other RNR principles."[226] These service providers also tend to prioritize low-risk individuals and often fail to offer the most effective interventions.[227] Hence, dogmatic adherence to the notion that mental illness is a major responsivity factor "constitutes crime prevention programming that is decidedly less than 'smart.'"[228]

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and concluding that "[t]here is nothing fundamentally at odds with providing needed mental health services while adopting an RNR approach with those clients who are engaging in criminal behaviors"); Fisler, *supra* note 143 ("Mental illness still plays a role in the RNR framework, but as a *responsivity* factor that affects a person's ability to participate in and learn from interventions designed to address criminogenic needs. . . . In this context, treatment for mental illness remains crucial for mental health court participants, not because improvements in symptoms or functioning will have a direct impact on criminal behavior but because treatment will improve their ability to respond to interventions to change criminal behavior.").

223. *See supra* notes 163–73 and accompanying text (citing to literature exploring the principles of specific responsivity); *supra* Subsection III.A.2 (identifying mental illness as a specific responsivity factor).

224. McCormick et al., *supra* note 18, at 218; *see also* Skeem et al., *supra* note 100, at 920 ("We are aware of no empirical support for the responsivity principle among persons with mental illness. Nevertheless, in contemporary discourse about applying the RNR model to this group, mental illness is often asserted to be a (specific) responsivity issue." (endnote omitted)).

225. Andrews, *supra* note 166.

226. *Id.*

227. *Id.*

228. *Id.* (citation omitted).

IV. RECONCEPTUALIZING CRIMINAL JUSTICE REFORM FOR OFFENDERS WITH SERIOUS MENTAL ILLNESS

The sizeable body of evidence supporting the normalization hypothesis undercuts the basis of "first generation" programs for offenders with mental illness and calls into question their utility.[229] Taking the normalization realization seriously means starting from the premise that offenders with mental illness are more similar to than different from offenders without mental illness. The RNR framework leads to the necessary inquiry of whether specialized justice programs for this population are even warranted. A correctional system in accord with RNR principles would prioritize treating the criminogenic needs of those offenders who are at the highest risk of reoffending, regardless of their noncriminogenic needs. Social scientists and criminal justice institutions should consider the extent to which individuals with serious mental illness fall within this priority group and—consistent with the legal norm of accommodating individuals with mental illness within the least restrictive environment[230]—weigh whether they can be treated in integrated settings such that they are rendered amenable to correctional intervention. This inquiry is made even more urgent by the scarcity of correctional and behavioral health resources.[231]

The criminalization myth and the pernicious stereotype of mental illness as dominant and violence-inducing contribute to the unblinking assumption that specialized criminal justice programs that emphasize mental health treatment make sense. Also, conceptualizing mental illness as a major driver of crime helps to rationalize the consolidation of mental health treatment in the criminal justice realm. If most seriously ill individuals will encounter the justice system as their health deteriorates,[232] providing mental health treatment in that space may be an efficient means of providing treatment to those most in need. Understanding the actual, largely indirect relationship between mental illness and crime, however, counsels providing mental health treatment

229. *See* Epperson et al., *supra* note 3, at 427 (defining "first generation" programs).

230. *See, e.g.*, Americans with Disabilities Act, 42 U.S.C. § 12132 (2012); 28 C.F.R. § 35.130(d) (2018); 34 C.F.R. § 300.114(a)(2) (2018).

231. *See* OSHER ET AL., *supra* note 2, at vii, 10.

232. *See* William H. Fisher et al., *Patterns and Prevalence of Arrest in a Statewide Cohort of Mental Health Care Consumers*, 57 PSYCHIATRIC SERVS. 1623, 1625 (2006) (finding, in study of a statewide cohort of individuals who received public mental health services in a given year (n=13,816), that 27.9% were arrested at least once over the roughly ten-year follow-up period); *id.* at 1626 (noting that the population studied "consisted of individuals whose psychiatric illnesses were sufficiently serious and disabling that they had been deemed eligible for services under the relatively stringent eligibility criteria typical of state mental health agencies in the early 1990s").

earlier and more broadly. Privileging those who commit criminal offenses with scarce mental health resources simply as a response to misbehavior and subsequent state control is perverse. Instead, these resources should be delivered via systematic efforts to achieve public safety benefits. Moreover, in the absence of a compelling public safety rationale,[233] it is discriminatory to use the criminal justice system to coerce medical treatment for a discrete class of individuals—those with serious mental illness—without a finding of incompetency to make treatment decisions.[234] This state action overrides the fundamental liberty right of individuals to choose (or decline) medical treatment.[235]

This observation should not detract attention from the urgent need to address existing, insufferable deficiencies in correctional mental health care. Correctional institutions have a constitutional duty to provide reasonably adequate mental health care to inmates.[236] Despite this obligation, nationwide studies consistently reveal that 30% to 60% of inmates with serious mental health needs receive no form of mental

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233. *See* Washington v. Harper, 494 U.S. 210, 227 (1990) ("We hold that, given the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.").

234. *See* Jennifer Eno Louden & Jennifer L. Skeem, *How Do Probation Officers Assess and Manage Recidivism and Violence Risk for Probationers with Mental Disorder? An Experimental Investigation*, 37 LAW & HUM. BEHAV. 22, 32 (2013) ("Requiring individuals who are involved in the criminal justice system through no direct cause of their mental disorder to accept mental health treatment is a form of structural stigma.").

235. *See* Cruzan v. Dir., Mo. Dep't. of Health, 497 U.S. 261, 270 (1990) ("The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."); Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891) ("No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. . . .").

236. *See* Estelle v. Gamble, 429 U.S. 97, 103–04 (1976) (establishing "the government's obligation to provide medical care for those whom it is punishing by incarceration" and concluding "that deliberate indifference to serious medical needs of prisoners" is prohibited by the Eighth Amendment); *see also* DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 200 (1989) ("[W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—*e.g.*, food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause."). Circuit courts of appeals have extended this principle to psychiatric and psychological care. *See, e.g.*, Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977) (holding that an inmate is "entitled to psychological or psychiatric treatment if a physician or other health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial").

health treatment while incarcerated.[237] Jails, in particular, do a poor job of providing necessary medication and therapy.[238] For instance, a 2017 study by the Bureau of Justice Statistics found that, among inmates who had previously been told they had a mental disorder, 37% of prisoners and 56% of jail inmates reported not having received any form of mental health treatment since admission.[239] Perhaps even more alarming, 64% of prisoners and 70% of jail inmates who met the threshold for serious psychological distress said they were not currently receiving mental health treatment.[240] This failure to provide needed health care causes unconscionable suffering to persons with serious mental illness.[241] Failing to respond to acute and chronic mental health needs predictably leads to mental deterioration, psychotic break, victimization by staff and inmates, inability to comply with institutional rules, and housing in isolation, all of which compound suffering.[242]

Considering the important (and currently neglected) duty to provide adequate mental health care to inmates, the normalization realization should call into question the allocation of resources for specialized justice programs—such as mental health courts, jail diversion programs, specialized probation and parole, and reentry programs—that provide mental health services to select individuals under the guise of reducing recidivism. These programs—which currently effect minimal recidivism

237. *See* PAULA M. DITTON, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 9 (1999), http://bjs.gov./content/pub/pdf/mhtip.pdf [https://perma.cc/N3E5-JV86] (finding, in nationwide surveys and interviews of inmates, that—of those identified as having a mental health condition—59% of jail inmates, 39% of state prisoners, and 40% of federal prisoners reported having not received any form of mental health services since admission); Jennifer M. Reingle Gonzalez & Nadine M. Connell, *Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity*, 104 AM. J. PUB. HEALTH, 2328, 2330–32 (2014) (finding, in a study of interview data from 18,185 prisoners, that 48% of inmates in federal prison—and 58% of inmates in state prisons—who were medicated for mental health conditions at admission did not receive medication during their prison sentence); Andrew P. Wilper et al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 668–70 (2009) (finding, in interviews of 25,167 inmates, that—among inmates with a mental condition ever treated with psychiatric medication—31% of federal, 31% of state, and 54% of local jail inmates were not receiving psychiatric medication after admission). Mental health treatment in correctional settings is often limited to psychiatric medications due to fiscal, space, and temporal constraints. Adams & Ferrandino, *supra* note 3, at 922; *see* JENNIFER BRONSON & MARCUS BERZOFSKY, INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS AND JAIL INMATES, 2011–12, at 8–9 (2017), https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf [https://perma.cc/22RD-EQ2S].

238. *See, e.g.*, HUM. RIGHTS WATCH, *supra* note 19, at 16 ("By all accounts, jails across the country are even less able to care for mentally ill prisoners than prisons.").

239. *See* BRONSON & BERZOFSKY, *supra* note 237, at 8.

240. *See id.*

241. *See* HUM. RIGHTS WATCH, *supra* note 19, at 53–69.

242. *See* Johnston, *Vulnerability*, *supra* note 10.

reductions and may be highly resource-intensive[243]—should be eliminated and the resources used elsewhere unless new, supportable justifications can be established. At least four possible justifications exist and are outlined below.

A. *Possible Justifications for Specialized Programs*

1. Mental Illness as a Barrier

The first possible justification for the existence of specialized justice programs is often posited as established:[244] Serious mental illness is a significant responsivity obstacle that requires redress before the effective treatment of criminogenic needs is possible.[245] The "barrier" conceptualization implies that treatment may be provided sequentially (that is, treatment to stabilize the mental illness, then treatment of a criminogenic need).[246] This theory has considerable intuitive power. For example, the treatment for antisocial attitudes involves learning, but before an individual with schizophrenia can learn new ways of reacting to problematic situations, her psychosis must be effectively treated.[247] Hence, stabilizing mental illness might be necessary to effectively treat some key criminogenic needs—such as antisocial attitudes[248]—or some combination of dynamic needs.[249] This model, where mental illness serves as a barrier that must be overcome prior to treatment, may be particularly suitable for certain mental disorders such as major

243. *See* Skeem et al., *supra* note 1, at 114 ("[T]here is, at best, mixed evidence that these programs as a whole reduce recidivism.").

244. *See, e.g.*, Cohen & Whetzel, *supra* note 164, at 11 ("Even more broadly, . . . responsivity factors are conceived by various community corrections scholars as barriers to offenders' successful supervision and reintegration. A responsivity factor may preclude an offender from participating in an intervention (e.g., CBT group), thus leaving the underlying risk factors unaddressed. This requires officers to first mitigate responsivity factors so that the work of risk reduction can begin." (citation omitted)).

245. *See supra* Subsection III.A.2.

246. *See* Epperson et al., *supra* note 3, at 434 ("For example, intervening to change antisocial cognitions would not make sense if the justice-involved person 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.").

247. *See id.*

248. *See infra* note 254 and accompanying text.

249. *See* Faye S. Taxman et al., *Risk-Need-Responsivity (RNR): Leading Towards Another Generation of the Model*, *in* SIMULATION STRATEGIES TO REDUCE RECIDIVISM 285, 287 (Faye S. Taxman & April Pattavina eds., 2013) ("The consideration of a spectrum of dynamic needs alters the emphasis of the model and allows the RNR model to be more directly tied to responsivity (appropriate correctional programming).").

depression, schizophrenia, schizoaffective disorders, and bipolar disorder.[250]

According to this model, as Sarah McCormick and colleagues have observed, mental illness functions as a moderator of intervention effectiveness, such that successfully addressing the mental illness increases the effectiveness of interventions targeting criminogenic needs.[251] However, as previously discussed,[252] it is currently unclear how—and whether—mental illness may function in this way, either by allowing for the identification and treatment of more criminogenic needs or by increasing that treatment's effectiveness at reducing recidivism.[253] As of yet, there is no evidence to support the latter hypothesis, and only nascent evidence to support the former.

2. Mental Illness as a Reinforcing Factor

A second possible justification for specialized programs is that mental illness and criminogenic needs may be reinforcing or even synergistic, such that they must be simultaneously addressed in order to reduce recidivism. This theory also has yet to be established by rigorous testing.

Certain mental illnesses may reinforce or coexist with aspects of antisocial personality that function as criminogenic risk factors.[254] Research indicates that antisocial attitudes may be a top risk factor for recidivism[255] and that offenders with mental illness may be particularly likely to have high levels of criminogenic cognitions.[256] For example, in a 2011 study, Dr. Jon Mandracchia and Professor Robert Morgan found that the presence of a psychological disorder was associated with more

250. *See supra* Subsection III.A.2; *supra* notes 176–78 and accompanying text.

251. McCormick et al., *supra* note 164.

252. *See supra* notes 182–87 and accompanying text (discussing findings in McCormick et al., *supra* note 164).

253. McCormick et al., *supra* note 164, at 63.

254. *See* Bonta, *supra* note 165, at 36–37 ("A diagnosis of antisocial personality or psychopathy are examples of the ways risk, criminogenic needs and responsivity may operate together. Not only are such individuals more likely to recidivate (risk), but therapists may attempt to target aspects of the antisocial personality, such as impulsivity (criminogenic need).").

255. *See* BONTA & ANDREWS, *supra* note 128, at 65–66; Travis C. Pratt et al., *The Empirical Status of Social Learning Theory: A Meta-Analysis*, 27 JUST. Q. 765, 788–90 (2010).

256. *See* Jon T. Mandracchia & Robert D. Morgan, *The Relationship Between Status Variables and Criminal Thinking in an Offender Population*, 7 PSYCHOL. SERVS. 27, 32 (2010) (finding that, among general-population inmates, those who reported not currently receiving mental health services endorsed higher levels of criminogenic cognitions than inmates who reported receiving mental health services). In the risk literature, criminogenic or antisocial cognitions refer to the "attitudes, beliefs, and thoughts that support crime." Glenn D. Walters & Matt DeLisi, *Antisocial Cognition and Crime Continuity: Cognitive Mediation of the Past Crime-Future Crime Relationship*, 41 J. CRIM. JUST. 135, 135 (2013) (citing Andrews et al., *supra* note 116).

criminogenic thinking, "whereas reception of mental health services was associated with lower levels of criminal attitudes."[257] They suggested this association was because "many psychological problems [including depression and anxiety] consist of immature thinking patterns marked by impulsivity, overgeneralizations, extreme judging, and self-pity."[258] Antisocial personality traits are inherent in the definitions of some mental disorders—such as antisocial personality disorder, conduct disorder, and attention deficit disorder—which indicates conceptual overlap whereby antisocial cognitions or behaviors could be identified as a symptom of mental illness or as a criminological factor.[259] However, antisocial personality traits may tend to associate with, but not be eclipsed by, other disorders.[260]

In addition, Skeem and colleagues have noted the possibility that mental disorders and criminogenic risk factors may act synergistically to intensify overall risk of reoffending.[261] Citing the research of Professor Arthur Lurigio and associates,[262] Skeem and colleagues observe that individuals with mental disorders are much more likely to abuse substances—one of the Central Eight general risk factors for crime—than those without a mental disorder.[263] In addition, studies demonstrate that individuals with both a psychiatric and substance abuse disorder are much more likely to commit a crime—and to be violent—than those with a

257. Jon T. Mandracchia & Robert D. Morgan, *Predicting Offenders' Criminogenic Cognitions with Status Variables*, 39 CRIM. JUST. & BEHAV. 5, 19 (2012). The study, which involved 595 adult male incarcerated offenders, did not include data on particular diagnoses. *See id.* at 8 (describing the methodology).

258. *Id.* at 20.

259. Skeem and colleagues have noted that "some 'normative' risk factors for crime (for example, externalizing features such as anger and impulsivity) are also defined as symptoms of some mental disorders." Skeem et al., *supra* note 100.

260. *See* McCormick et al., *supra* note 164, at 62 ("[S]everal features assessed by the personality/behavior domain may also be features of clinical diagnoses such as ADHD (e.g., poor frustration tolerance, impulsivity) . . . [and] are frequently comorbid with mental health problems such as anxiety and depression . . . .").

261. Skeem et al., *supra* note 100, at 920; *see also* Ainslie M. McDougall, Understanding Factors that Impact Responsivity Within Case Management Plans of Community-Based Offenders with and Without Mental Health Needs 37–38 (June 2014) (unpublished Ph.D dissertation, University of New Brunswick), https://unbscholar.lib.unb.ca/islandora/object/unbscholar%3A6504/datastream/PDF/view [https://perma.cc/3EWF-DUVY] ("[M]ental illness may be best conceptualized as a potential destabilizing factor that can elevate the influence of other criminal risk factors and reduce that of protective factors.").

262. *See* Arthur J. Lurigio et al., *Standardized Assessment of Substance-Related, Other Psychiatric, and Comorbid Disorders Among Probationers*, 47 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 630, 644 (2003) (finding, in a random sample of 627 adult probationers in Illinois, that "55% of probationers with one or more current psychiatric disorders were dependent on one or more substances, compared with 37% of those without any psychiatric disorders").

263. Skeem et al., *supra* note 100, at 920.

psychiatric diagnosis alone.[264] These findings, observe Skeem and colleagues, suggest that the noncriminogenic risk factor of mental illness may both attract and exaggerate the effect of the criminogenic risk factor of substance abuse.[265] These researchers also suggest that "mental illness can become 'criminogenic' when paired with other risk factors," such as a history of violence.[266] Illustrating this possibility, Glenn Water and Gregory Crawford found in a 2014 study that "[major mental illness] or [violence history] in isolation were of questionable utility in predicting aggressive and nonaggressive institutional infractions[,] but . . . when combined, [major mental illness] and [violence history] demonstrated an ability to predict future disciplinary problems."[267] In light of this research, Skeem and colleagues observe:

> [One] reason to avoid focusing services too exclusively on general risk factors is that these variables may sometimes interact with mental illness to exponentially increase risk. When clinical factors potentiate general risk factors, they become part of the criminogenic story that should be assessed and targeted with services that are "wise" to their interaction.[268]

Perhaps, then, the continued treatment of certain mental illnesses is necessary to allow for the effective or efficient amelioration of certain criminogenic needs.[269] So long as that mental health treatment is best provided in a specialized environment, "first-generation" programs that address both the mental health and criminogenic needs of high-risk individuals could be appropriate.

3. Alteration of Intervention

A third possible justification for specialized programs could be that offenders with and without serious mental illness require different interventions to effectively and efficiently treat their criminogenic needs,

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264. *See id.* at 920–21 (first citing Junginger et al., *supra* note 35, at 879–82; then citing Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 393–401 (1998)).

265. *Id.* at 920.

266. *Id.*

267. Glenn D. Walters & Gregory Crawford, *Major Mental Illness and Violence History as Predictors of Institutional Misconduct and Recidivism: Main and Interaction Effects*, 38 LAW & HUM. BEHAV. 238, 243–44 (2014) (involving a sample of 2,627 male prison inmates).

268. Skeem et al., *supra* note 100, at 920.

269. *See* McCormick et al., *supra* note 164, at 62.

and these interventions are best delivered in segregated environments.[270] As mentioned previously, social scientists have posited that modifications to general correctional interventions may be necessary to address the particular treatment needs, cognitive and emotional impairments, and delivery requirements of offenders with serious mental illness.[271] Researchers have begun to create and adapt evidence-based, cognitive-behavioral interventions for use with this population,[272] but the effects of these specialized interventions on recidivism are unclear.[273] As Professor Faye Taxman and colleagues note, the RNR emphasis on tailoring programming to offender profiles "is still being explored in studies of correctional programming and offender outcomes."[274]

4. Mental Illness as a Causal Factor

A fourth possibility is that these specialized justice programs are necessary to deliver mental health treatment to the subgroup of offenders "who are influenced primarily by mental health needs—and on whom RNR-identified criminogenic needs have little influence."[275] As previously discussed, studies suggest that symptoms directly precede violence and other criminal behavior in a small subset of offenses.[276] However, because research indicates that symptom-based crimes do not cluster by person, it appears impossible to identify a reliable, symptom-driven subgroup.[277] According to Skeem and colleagues, this research suggests that, as a policy matter, "symptoms should be routinely treated among justice-involved people with mental illness, with the understanding that this may prevent a small but important minority of (unpredictable) symptom-preceded crimes."[278] However, it is unclear how "important"—or likely to be violent or particularly impactful—this subset of crimes committed by offenders with serious mental illness is and whether their relative import justifies this investment of resources.

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270. *See* Bonta, *supra* note 165, at 37; Kirk Heilbrun et al., *Risk-Reducing Interventions for Justice-Involved Individuals: A Critical Review*, *in* 2 ADVANCES IN PSYCHOLOGY AND LAW 271, 274 (Brian H. Bornstein & Monica K. Miller eds., 2016).

271. *See* Morgan et al., *supra* note 203.

272. *See supra* notes 202–07 and accompanying text.

273. *See* BONTA & ANDREWS, *supra* note 128, at 330.

274. *See* Taxman et al., *supra* note 249, at 288.

275. *See* Heilbrun et al., *supra* note 270.

276. *See supra* notes 97–106 and accompanying text.

277. *See supra* notes 107–09 and accompanying text.

278. Skeem et al., *supra* note 100.

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Serious mental illness is not a single conglomerate with a uniform set of features.[279] Indeed, no single mental illness has stable or uniform aspects. Therefore, different mental illnesses may fall within the ambit of different justifications and may satisfy multiple justifications simultaneously or across time. To justify a specialized criminal justice program, it may be unnecessary to scientifically verify a particular justification for a particular diagnosis or set of individuals. Indeed, establishing the scientific validity of some of these justifications—particularly those involving mental illness as a responsivity factor—in isolation would be very difficult given pragmatic data availability and clinical control feasibility.[280] This is especially the case considering that serious mental illness and criminogenic risk factors, if they are related, may interact as part of an emergent system that does not lend itself to reductive efforts to test individual variables independently.[281] Given the likely limits of testing, behavioral health science researchers should continue along the path charted by McCormick and colleagues, who, in 2017, began to investigate the extent to which mental illness and its treatment may function as a moderator of intervention effectiveness.[282]

In the meantime, criminal justice programs should treat individuals with serious mental illness with "next generation" programs that prioritize criminogenic needs.[283] These programs should be implemented in a way that allows researchers to validly test whether these programs can achieve recidivism outcomes that are at least as great as those yielded by first generation programs among similar mentally disordered offender populations. If so, this evidence would seem to demonstrate that the

279. *See* OSHER ET AL., *supra* note 2 (defining "serious mental illness").

280. I appreciate this insight offered by my research assistant, John Hood.

281. *See supra* Subsection IV.A.2.

282. McCormick et al., *supra* note 164; *see supra* notes 182–87 and accompanying text.

283. *See* Epperson et al., *supra* note 3, at 428–29 (casting a vision for the next generation of behavioral health and criminal justice interventions that would attend to the "empirically informed individual and environmental factors that directly and indirectly contribute to criminal justice involvement for individuals with SMI" as well as the "unique stressors attributable to their mental illness," which should improve their ability to reduce recidivism and psychiatric relapse); Skeem et al., *supra* note 1, at 121; Wolff, *supra* note 27, at 74 (arguing that court systems could "adopt rehabilitation harm reduction in the application of the law" and defining "rehabilitation harm" as "the social and individual welfare interest loss associated with not identifying criminogenic risks and needs, and harm is reduced by providing appropriate supervision, rehabilitation, and treatment in response to these risks and needs"); *cf.* WILLIAM R. KELLY ET AL., FROM RETRIBUTION TO PUBLIC SAFETY: DISRUPTIVE INNOVATION OF AMERICAN CRIMINAL JUSTICE 127 (2017) ("We propose a diversion process on a scale unimagined in U.S. history . . . that has as the primary goal the reduction of recidivism by means of a balance between risk management/supervision, on the one hand, and evidence-based clinical intervention and rehabilitation, on the other.").

specialized environments of (currently composed) first-generation programs that prioritize mental health are not the best way to address this population. Thus, given the limited empirical support for the criminalization justification of first generation programs and their inherently discriminatory nature,[284] these programs should be defunded in favor of next generation programs that principally address criminogenic risk factors.

B. *Larger Foundational Questions*

The determination of whether offenders with serious mental illness warrant specialized programs should not turn solely on whether evidence establishes some link between the treatment of mental illness and criminogenic needs or recidivism. In addition to those crucial questions, other questions that pertain to the overall allocation of resources in, and purposes of, the criminal justice system must be answered.

1. Necessary Empirical Information

Specialized justice programs for offenders with serious mental illness should exist only to the extent that their public safety benefits exceed those that could be realized through a different allocation of resources.[285] Many considerations are relevant in this equation. Understanding what percentage of high-risk offenders have a serious mental illness would provide useful context for determining the extent to which this population should be a focus of special intervention.[286] A more directly pertinent question is the percentage of that group that can be serviced by a particular specialized program. For instance, mental health courts, given their intensive nature, can only ever serve a small fraction of offenders with serious mental illness.[287] Finally, it is crucial to understand the effectiveness of these programs—ideally, when focused on treating the criminogenic needs of higher risk individuals—at reducing recidivism and the likelihood they can be administered faithfully such that expected gains can be realized.[288]

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284. *See supra* notes 233–34 and accompanying text.

285. *But see infra* Subsection IV.B.2 (questioning whether criminal justice resources should be allocated to achieve goals other than public safety).

286. *See infra* notes 304–08, 320 and accompanying text.

287. *See* Alene Kennedy-Hendricks et al., *Improving Access to Care and Reducing Involvement in the Criminal Justice System for People with Mental Illness*, 35 HEALTH AFF. 1076, 1080 (2016).

288. *See supra* note 242 and accompanying text; *see also* Jodi L. Viljeon et al., *Do Risk Assessment Tools Help Manage and Reduce Risk of Violence and Reoffending? A Systematic Review*, 42 LAW & HUM. BEHAV. 181, 181 (2018) (concluding, from a systematic review of 73 published and unpublished studies, that "despite some promising findings, professionals do not

To develop a complete picture of the possible benefit these specialized programs may yield, it is necessary to understand the cost these offenders pose to the justice system in these programs' absence. In addition to information on the recidivism rate of higher risk offenders with serious mental illness,[289] it would be useful to understand any likelihood of their committing particularly violent or impactful crimes.[290] Policymakers, in addressing these concerns, must also consider expenses related to the management of these offenders, including the costs to house, treat, transport, supervise, deal with disciplinary infractions, and protect them from victimization or self-harm.[291]

To understand whether resources allocated to special programs could be better spent, it is necessary to gather information pertaining to higher risk offenders without serious mental illness. In particular, it is important to ascertain the percentage of the high- and moderate-risk general population that has unmet criminogenic and responsivity needs beyond mental illness, as well as the frequency, and ideally the potency, of each need.[292] The cost and effectiveness of treating each of these needs (as well as common sets of criminogenic needs) is also significant. Another key issue is the malleability of each criminogenic and responsivity variable, and how much of an impediment each responsivity factor is (compared to mental health features) to the effective treatment of criminogenic needs.[293] These questions are beyond the scope of this Article.

Researchers have developed an RNR Simulation Tool to assist justice agencies in better allocating resources "to reduce recidivism through responsivity to the primary treatment needs of their offender populations."[294] The tool utilizes a reconceptualized RNR model that

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consistently adhere to tools or apply them to guide their risk management efforts; [and,] following the use of a tool, match to the risk principle is moderate and match to the needs principle is limited, as many needs remained unaddressed").

289. *See supra* notes 6–9 and accompanying text.

290. *Cf. supra* notes 110–22 and accompanying text (discussing meta-analyses showing that clinical variables are, at most, weak predictors of risk).

291. *See supra* note 5 and accompanying text. It is difficult to determine these costs at the systemic level. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 201, at 17–21 (finding that the Bureau of Prisons does not track the cost of inmates with serious mental illness and selected states track only a subset of these costs).

292. *See* Taxman et al., *supra* note 249, at 295–96 (estimating that only 10% of offenders currently have access to treatment services).

293. *See* Cohen & Whetzel, *supra* note 164, at 17 ("When and how to provide assistance in overcoming responsivity factors will depend on the offender's overall risk level and the malleability of the responsivity factor being targeted. . . . [M]ental health[] may change only very slowly.").

294. Taxman et al., *supra* note 249, at 298; *see* Erin L. Crites & Faye S. Taxman, *The Responsivity Principle: Determining the Appropriate Program and Dosage to Match Risk and Needs*, *in* SIMULATION STRATEGIES TO REDUCE RECIDIVISM, *supra* note 249, at 143, 143–63

reflects the demonstrated relationship of individual needs to recidivism and an expanded list of psychosocial and lifestyle factors that affect an individual's stability and amenability to services and control.[295] The researchers created a synthetic, nationally representative data set with key variables of risk, needs, demographic characteristics, and recidivism from publicly available data sets of various offender populations.[296] The model creates "a taxonomy of correctional programming" that reflects the range of services typically needed in a correctional setting, based on targets of intervention and the features of programs likely to affect recidivism.[297] A jurisdiction's actual programming distribution will reflect its actual offender population and trove of available resources.[298]

The model also recommends distributions of programming that are informed by the prevalence of criminogenic needs within the national offender population.[299] It suggests allocating the greatest share of resources (40% to 45%) to programs that use cognitive-behavioral interventions to target criminal thinking, criminal lifestyles, or both.[300] Next, the model recommends allocating the second largest share (25% to 30%) to treating offenders with "clinical destabilizers," including substance abuse and mental health disorders.[301] Finally, the model would allocate the third largest share (15% to 20%) of treatment resources to

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(describing the rationale for matching risk-need configurations to appropriate programming and the process used to develop individual program-group assignment and classification criteria for programs).

295. *See* Stephanie A. Ainsworth & Faye S. Taxman, *Creating Simulation Parameter Inputs with Existing Data Sources: Estimating Offender Risks, Needs, and Recidivism*, *in* SIMULATION STRATEGIES TO REDUCE RECIDIVISM, *supra* note 249, at 115, 115–19; *id.* at 117 tbl.5.1 (listing the static risk factors, dynamic criminogenic risks, criminally relevant destabilizers, and lifestyle factors (stabilizers, destabilizers) included in the simulation tool); Faye S. Taxman et al., *The Empirical Basis for the RNR Model with an Updated RNR Conceptual Framework*, *in* SIMULATION STRATEGIES TO REDUCE RECIDIVISM, *supra* note 249, at 73, 73–106 (prioritizing offender needs based on their direct impact on recidivism and the clinical relevance of non-criminogenic factors).

296. These datasets, each created by the Bureau of Justice Assistance, included the Survey of Inmates in State and Federal Correctional Facilities, 2004; the Survey of Inmates in Local Jails, 2002; the State Court Processing Statistics; and the Recidivism of Inmates Released in 1994. *See* Ainsworth & Taxman, *supra* note 295, at 120; *see also id.* at 120–40 (describing the assumptions and data elements of the RNR Simulation Tool and Model).

297. Taxman et al., *supra* note 249, at 297.

298. *See id.*; *see* Avinash Bhati et al., *RNR Simulation Tool: A Synthetic Datasets and Its Uses for Policy Simulations*, *in* SIMULATION STRATEGIES TO REDUCE RECIDIVISM, *supra* note 249, at 197, 198–220 (describing a synthetic dataset development and re-weighting methodology that will allow small and under-resourced jurisdictions or agencies to generate a synthetic dataset that can be analyzed as if it were a localized data collection effort).

299. Taxman et al., *supra* note 249, at 298; *see* Ainsworth & Taxman, *supra* note 295.

300. *See* Taxman et al., *supra* note 249, at 298.

301. *See id.*

improve social and interpersonal stability with programs involving anger management, services to increase education and employment opportunities, and other initiatives.[302] Programming types requiring fewer resources include those for substance dependence (not abuse), life skills programs, and absolute punishment.[303]

Researchers have also used this simulation tool to identify the proportion of correctional populations at each risk level that are recommended for each RNR program type.[304] Overall, the simulation tool recommends that a high percentage of total offenders in each correctional modality (prison, jail, community corrections) should receive treatment for substance abuse or mental disorders (25% to 28%).[305] Disaggregated by risk level, however, it only recommends that a small percentage (3% to 5%) of high-risk offenders in each modality receive this treatment.[306] A much higher percentage of moderate-risk offenders is recommended for substance abuse or mental health treatment: 40% of moderate-risk prisoners,[307] 31% of jail inmates,[308] and 36% of those on community supervision.[309]

The simulation model recommends that the highest percentage of offenders should receive cognitive-behavioral treatment for criminal thinking and lifestyle—overall, among high-risk offenders, and among moderate-risk offenders. On a systems level, the model recommends that 43% of prisoners, and 42% of jail inmates and individuals on community supervision, should receive cognitive-behavioral treatment for criminal thinking and lifestyle.[310] Crucially, it recommends that the vast majority (75%) of high-risk offenders in each modality receive this intervention.[311] Substantial percentages of moderate-risk offenders are recommended for treatment for criminal thinking and lifestyle: 35% of moderate-risk prisoners,[312] 42% of jail inmates,[313] and 38% of those on community supervision.[314] It is also useful to remember that offenders with mental illness appear to have criminal cognition levels at or above those of

302. *See id.*
303. *See id.*
304. *See id.* at 299 tbls.11.1–11.3.
305. *See id.*
306. *See id.*
307. *Id.* at 299 tbl.11.1.
308. *Id.* at 299 tbl.11.2.
309. *Id.* at 299 tbl.11.3.
310. *See id.* at 299 tbls.11.1–11.3.
311. *See id.*
312. *Id.* at 299 tbl.11.1.
313. *Id.* at 299 tbl.11.2.
314. *Id.* at 299 tbl.11.3.

general offenders,[315] and that the extent to which treatment of mental illness facilitates the treatment of criminogenic needs is still unclear.[316]

Currently, the programming resources allocated to treating major criminogenic needs in correctional settings are woefully inadequate.[317] Although the greatest rehabilitative needs are for interventions that target criminal cognitions and lifestyles, these are the least available types of programming.[318] There is often no direct funding for these programs, and few correctional agencies regularly offer them.[319] Given the importance of these criminogenic needs and their frequency among the offending population,[320] perhaps criminal justice institutions should prioritize investing in treatment programs that address these needs (depending on the relative cost and effectiveness of these programs), as well as proper risk assessment instruments and sorting procedures to ensure that individuals at higher risk of recidivism are prioritized for services.[321]

2. Proper Goals of Correctional Treatment

This Article has assessed the propriety of maintaining specialized justice programs for offenders with serious mental illness in a correctional system whose aim in providing mental health services—beyond satisfying constitutional obligations[322]—is to maximize public safety. However, it is necessary to ask whether public safety is the right goal in this context, or whether it should be one of several aims to pursue. On one hand, as Professor Kirk Heilbrun and colleagues have observed, "[s]ervices to justice-involved individuals are almost entirely publicly funded, and society has a substantial interest in supporting rehabilitative

315. *See supra* notes 255–59 and accompanying text.

316. *See supra* Subsections III.A.2, IV.A.1–2.

317. *See* BONTA & ANDREWS, *supra* note 128, at 321 ("It is almost nonexistent to find the MDO [mentally disordered offender] undergoing treatment that targets, for example, procriminal attitudes and associates. Even targeting the criminogenic need of substance abuse is relatively rare."). Inadequate programs also exist for treating substance abuse, with the result that most offenders with substance abuse disorder do not receive these services. *See* Taxman et al., *supra* note 249, at 292–93.

318. *See* Taxman, *supra* note 171, at 38.

319. Taxman et al., *supra* note 249, at 292–93.

320. *See supra* notes 254, 309–13 and accompanying text.

321. In addition, to the extent that a jurisdiction chooses to allocate resources to address a responsivity barrier, mental illness may not be the most appropriate factor to address. *See* Cohen & Whetzel, *supra* note 164, at 12–13, 14 tbl.1 (finding, in a descriptive analysis of the presence of responsivity factors for 19,753 offenders placed on federal supervision over a four-month period, that inadequate transportation was a more commonly flagged responsivity obstacle than mental illness for high-risk (22% versus 18%) and moderate-risk (17% versus 12%) offenders, yet many more resources were allocated to mental health than to transportation).

322. *See supra* note 235 and accompanying text.

services that reduce the risk of further offending."[323] A reduced likelihood of reoffending likely signals improved individual stability.[324] On the other hand, it is clear that this population has dire health needs that require more than a minimal level of attention to allow for recovery, personal flourishing, and the avoidance of suffering.[325] Thus, some have argued that the clinical needs of all offenders must be addressed for humanitarian reasons.[326]

An alternative argument, which might be more appealing to policymakers in a tight fiscal climate,[327] would involve concern for the overall societal cost exacted by offenders with serious mental illness. These individuals tend to be large consumers of public health resources, including emergency and inpatient psychiatric services.[328] Criminal justice programs that address mental health needs—even when they do not reduce recidivism—may be cost-effective when they reduce the use of these other services.[329] For instance, Professors Skeem and Sarah M. Manchak found, in a matched sample of 367 probationers with serious mental illness who were followed for two years, that specialty probation was cost-effective compared with traditional probation (average cost per probationer of approximately $15,000 versus $20,000, respectively), largely through reduced expenditures on emergency and inpatient psychiatric services.[330] As Skeem and colleagues later observed, "the

323. Heilbrun et al., *supra* note 270, at 273.

324. *See* ROTTER & CARR, *supra* note 207, at 1.

325. SAMHSA defines "recovery" from mental disorder or substance abuse disorder as "[a] process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." *SAMHSA's Working Definition of Recovery Updated*, SAMHSA BLOG (Mar. 23, 2012), https://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.W2oCOVVKjIU [https://perma.cc/CS82-8CQH]. This conception of recovery includes four main dimensions, including health, a stable and safe home, the ability to lead a purposeful life, and being in "relationships and social networks that provide support, friendship, love, and hope." *Id.*

326. *See* BONTA & ANDREWS, *supra* note 128, at 177–78; Skeem et al., *supra* note 100, at 918 ("The target population has pressing behavioral health needs. If policy goals reach beyond reducing recidivism—as we believe they should—then strict adherence to the risk principle may have costs.").

327. *See* ROTTER & CARR, *supra* note 207, at 1 ("Decreased criminal recidivism, particularly resulting from new crimes with new victims, is the measure most consistently desired by programs, policymakers, and funding agencies for justice-involved individuals with mental illness. This one measure captures both improved client stability and public safety, while providing support for the promised decreased jail-day cost savings required to sustain continued financial resources.").

328. *See* Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1, 15, 19, 28 (2012) (discussing research).

329. Skeem et al., *supra* note 100, at 918–19.

330. *Id.* at 918 (discussing Jennifer L. Skeem & Sarah M. Manchak, Does Specialty Mental Health Probation "Fight Crime and Save Money"? A Cost-Benefit Analysis, Presentation at the

results [of this study] raise the possibility that addressing clinical needs could net large returns in other domains, even if symptom control rarely translates into reduced recidivism."[331]

However, the overall cost-effectiveness of such a return would depend on whether the individuals in these specialized programs—of all individuals with serious mental illness who could be receiving mental health treatment and stabilization—are the ones most likely to exact the highest cost on society if untreated. If not, then public health resources should be used in a way that benefits persons who have not committed criminal offenses. On the other hand, given that persons with serious mental illness are often unwilling to identify a treatment need or accept treatment, it is possible that the leveraging power of the criminal justice system offers a useful, and perhaps necessary, way to supply and engage individuals in treatment[332] such that only through leveraging the justice system can a net savings occur. If this is the case, then a strong utilitarian argument exists for including broader societal costs in the cost-benefit analysis of whether to invest in specialized criminal justice programs for offenders with mental illness. Such consideration would be particularly appropriate when considering specialized programs for higher risk offenders with serious mental illness, a programmatic configuration that strong evidence suggests would maximize public safety benefits.

CONCLUSION

Robust evidence demonstrates that offenders with serious mental illness are driven by the same set of criminogenic needs that motivate those without mental illness. Therefore, these offenders are more similar to than different from the general offending population, and rehabilitative strategies should be similar for both populations. Given deeply embedded stigma and a long history of discrimination against individuals with serious mental illness, specialized, segregated criminal justice programs should not exist unless they are justified by a scientifically supportable rationale. Such justifications are possible, but they are currently largely unsupported by data. Much more research is needed on the relationship of mental illness (and the treatment of mental illness) to the treatment of criminogenic needs. In the meantime, correctional institutions should focus on treating the criminogenic needs of higher risk individuals and

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American Psychology-Law Society (AP-LS) Annual Conference, San Juan, Puerto Rico (Mar. 14–17, 2012)).

331. *Id.* (endnote omitted).

332. *See* Michael Allen, *Round Pegs, Square Holes*, 22 HEALTH AFF. 280, 280–81 (2003) (debating the role that lack of insight into illness and coercion should play in provision of mental health treatment).

begin to take seriously their constitutional obligation to provide reasonably adequate mental health care to all inmates in need.[333]

One consequence of the normalization realization should be to highlight what should already have been apparent: The criminal justice system should not and cannot be society's primary source of mental health care. The goals of the justice system—to punish and reduce recidivism—are largely unserved by mental health care. Moreover, the punitive and security focus of the criminal justice system makes the system, and those who choose to serve in it, particularly ill-equipped to render effective care.[334] Instead, the justice system must be a secondary stopgap, supplying the minimum amount of mental health care necessary to meet constitutional obligations and permit the effective treatment of criminogenic needs in higher risk offenders. The primary source of care must reside in community mental health services, which are woefully underfunded and in desperate need of resources and attention.

333. *See supra* note 235 and accompanying text.

334. *See* HUM. RIGHTS WATCH, *supra* note 19.