



## Parolees with Mental Disorder: Toward Evidence-Based Practice

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In the U.S., the rate of such serious mental disorders as major depression, bipolar disorder, and schizophrenia is about two times higher among incarcerated men and three times higher in incarcerated women than in the general population (Teplin, 1994; Teplin, Abram, & McClelland, 1996). Estimates suggest that approximately 14.5% of prison inmates have a serious mental disorder (Diamond, Wang, Holzer, Thomas, & Cruzer, 2001; Fazel & Danesh, 2002; Steadman, Osher, Robbins, Case, & Samuels, 2009). As the number of persons supervised by the criminal justice system in the United States grows—it is now at an all-time high of 7.2 million (Glaze & Bonczar, 2007)—so will the number of offenders with serious mental disorder.

Although the criminal justice system was not designed to meet the needs of offenders with mental disorder, it has become an integral component of the “*de facto*” mental health care system. For example, Los Angeles County jail, Riker’s Island jail in New York, and Cook County jail in Chicago each hold more people with mental illness than the largest psychiatric inpatient facilities in the United States (Torrey, 1995). As noted by the Council of State Governments (2002), “the current situation not only exacts a significant toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system” (p. 6).

Community supervision is a crucial context for beginning to address this problem. Most offenders are supervised in the community on probation or parole<sup>1</sup> rather than being incarcerated in

prisons or jails (Glaze & Bonczar, 2007). Compared to their relatively healthy counterparts, probationers and parolees with mental disorders (PMDs) are more likely to have their community term revoked, often for committing a technical violation (breaking of the rules of community supervision, such as associating with known criminals; Cloyes, Wong, Latimer, & Abarca, 2010; Porporino & Motiuk, 1995). This deepens their involvement in the criminal justice system.

Understanding parole and mental health is particularly important in California. First, California has the largest parole population in the nation (Petersilia, 2006), in part because every individual released from prison in the state serves at least one year of parole. Second, California’s rate of return to prison for parolees is notoriously high (Grattet, Petersilia, & Lin, 2008). Third, California has long had a system in place for addressing the needs of parolees with mental disorder. The Mental Health Services Continuum Program (MHSCP) is a prison “in-reach” program designed to identify the most seriously ill parolees and refer them to Parole Outpatient Clinics (POCs) for mental health treatment. MHSCP social workers conduct pre-release needs assessments of paroling inmates with mental disorder, assist with applications for social service assistance, and refer them to the outpatient clinics. The focus is on two classes of inmates with major mental disorders identified in the prison: (a) Correctional Clinical Case Management System (CCCMS) inmates who are determined to be stable and have minimal treatment needs, and (b) Enhanced Outpatient Program (EOP) who are characterized by active psychotic symptoms and substantial treatment needs. The most recent available evaluation of the MHSCP program suggests that it has strengths and weaknesses: parolees who

<sup>1</sup> Probation and parole are both mechanisms for community supervision, but differ in a meaningful way: probation is a sentence in itself (in lieu of jail), whereas parole is a period of supervision that occurs after a prison term (Abadinsky, 2000). Thus, parolees are generally more serious offenders than probationers.

receive the evaluation are more likely to receive psychiatric services, but many eligible parolees do not receive the services intended and many return to prison (Farabee, Bennett, Garcia, Warda, & Yang, 2006). Even with these enhanced services, a detailed analysis of all California parolees reported that EOP and CCCMS parolees were at 36% higher risk of committing a new offense than non-disordered parolees, and had an even higher rate of technical violations (70% higher risk; Grattet et al., 2008). To effect change in the recidivism rate of California's PMDs, this group must be better understood so that recommendations can be tailored to meet their unique needs.

### **What do we need to know?**

Because little is known about California's PMDs other than their high rates of returns to custody, we focused on addressing three basic, but key questions about this population in California. First, what types of disorders are most prevalent among California's PMDs? To make meaningful recommendations, we must understand what types of mental disorders are most prevalent. Do these offenders most often have depression or other mood disorders, or psychotic disorders like schizophrenia? Second, how do these PMDs differ demographically from non-disordered parolees? Demographic characteristics including young age, male gender and minority ethnicity are commonly related to recidivism risk, as are criminal justice characteristics such as number of prior offenses (Gendreau, Little, & Goggin, 1996). Mental disorder itself is a weak predictor of recidivism (Bonta, Law, & Hanson, 1998), but parolees with mental disorder tend to be 'riskier' than non-disordered parolees as measured by general risk factors (Skeem, Nicholson, & Kregg, 2008). Thus, interventions for addressing returns to custody for PMDs must address factors other than mental disorder to include risk factors related directly to offending for this group.

Third, and perhaps most importantly, what are the primary reasons that PMDs return to custody? Do they commit more new crimes than non-disordered offenders, more technical violations, or both? Some research has suggested that PMDs are more likely than non-disordered parolees to return to custody without committing a new offense (Porporino & Motiuk, 1995). To tailor policies and practices to better reduce returns to custody for PMDs in California, we must know what kinds of infractions are being committed. It is possible that PMDs are simply riskier than non-disordered parolees—if this is true, we would expect to see a pattern of consistently higher rates of return to custody for all types of offenses (e.g., violence, property crimes, technical violations). On the other hand, if PMDs are more likely to commit technical violations

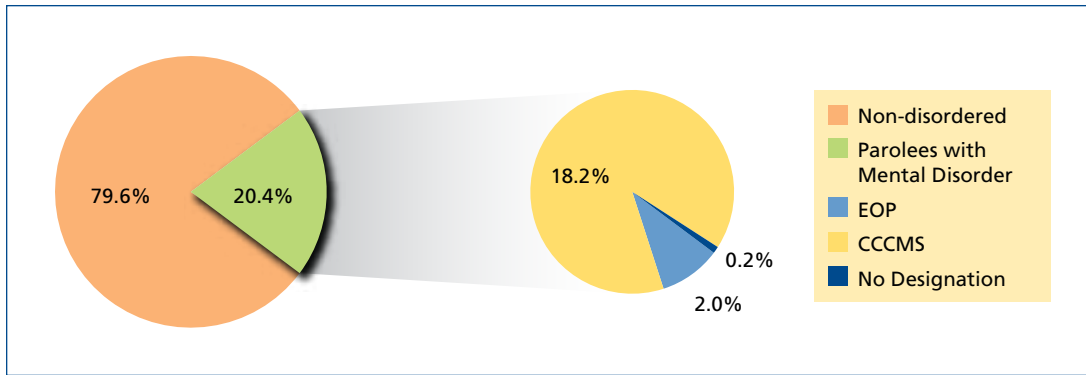
than other types of offenses, this may indicate other pathways to offense. For example, PMDs may be watched more carefully by parole agents who perceive them as high risk, and this closer monitoring would by definition lead to discovery of more infractions. This closer monitoring could be a function of California's mechanisms for supervising PMDs: parolees classified as EOP are monitored more closely than non-disordered or even CCCMS parolees because EOP parolees are supervised by officers with smaller caseloads, allowing the officer more time to supervise each parolee (Farabee et al., 2006). Beyond this closer monitoring, parole agents may be less willing to ignore minor technical violations committed by PMDs (EOP and CCCMS alike) than by non-disordered parolees if they perceive these minor violations as being indicative of decompensation and impending serious offenses. Knowing *how* PMDs return to custody will lead to more effective interventions for preventing returns for this group.

### **METHOD**

To address these aims, we obtained and integrated three databases from the California Department of Corrections and Rehabilitation (CDCR). At the most basic level, CDCR collects general demographic descriptors of each inmate, including gender, date of birth, and ethnic background. While the inmate is housed at a CDCR facility, CDCR records any movements within or between facilities or departments, such as intake to a prison or release to a parole unit. Movements and demographic data are tracked in the Offender Based Information System (OBIS). In addition, the facility records any mental health evaluations or treatment contacts with mental health providers (Parole Automated Tracking System; PATS). After an inmate is released to parole, CDCR records any violation of the terms of parole, including commission of new crimes (which result in hearings tracked in the Revocation Scheduling and Tracking System; RSTS). If an inmate had been housed at a CDCR institution prior to the current term, the number and type of prior offenses is also included in OBIS.

### **Sample**

Participants were all 44,987 persons released to a *new term* of adult parole in California within one calendar year—from January 1, 2004 to December 31, 2004. Although 105,430 persons were released to parole during this calendar year, we exclude the 60,443 persons who were being re-released to parole after having already served prison time for an earlier parole revocation. These "re-releasees" had by definition already recidivated, so we excluded them to focus on the likelihood of return to custody (rather than the likelihood of repeated returns to custody).



**Figure 1:**  
**Prevalence**  
**of mental**  
**disorder**  
**and specific**  
**designations**

These parolees were mostly male (87.5%), with a mean age of 33.7 ( $sd = 10.0$ ) at the time they were released to parole. Parolees' ethnicity was as follows: Caucasian (31.3%), African-American (21.6%) and Hispanic/Latino (42.2%). We used this sample to answer our three primary research questions—(a) determining the types of mental disorder most prevalent in California's parole population, (b) describing how the characteristics of these parolees with mental disorder differ from those of non-disordered parolees, and (c) examining the relative nature of return to custody for parolees with and without mental disorder.

### Definition of variables of interest

**Mental disorder.** Parolees with identified mental disorder were defined based on diagnoses and designations issued by CDCR clinicians and entered into the computer system. The vast majority of PMDs were identified in prison because they received mental health services and/or were assessed as mentally ill during an assessment prior to release; less often, the supervising parole agent notices signs of potential mental disorder and refers the parolee for further evaluation. For the present study, we included in our PMD group (a) those designated as EOP or CCCMS and (b) those provided with a clinical diagnosis but no treatment designation.

The data on mental disorder came from two CDCR sources: (1) the Distributed Data Processing Service (DDPS) for all releasees, which includes a continuously updated variable (mhcode) denoting whether each releasee was designated as EOP or CCCMS during their most recent incarceration, and (2) the Parole Automated Tracking System (PATS) for releasees linked with the Parole Outpatient Clinics, which includes variables that are fed by DDPS, but provides more time-anchored and detailed mental health data, including specific diagnoses. Each data source has strengths and weaknesses. That is, although DDPS denotes a mental health status for every releasee, it reflects his or her mental health designation at the time our database was captured (2006), rather at the time of actual release to parole (2004). Although our sample is comprised of new releases, it is highly likely that some parolees' designations changed by the time our database was captured (e.g., 2004 parolees who recidivated and were re-released could have a new designation by

2006). Similarly, although PATS captures releasees' designation at the time of actual release to parole and provides detailed diagnostic information, it captures only the subset of releasees who were reached by the MHSCP and linked with the outpatient clinics. Approximately 55% of releasees designated as mentally ill in DDPS appear in PATS, largely because offenders are often not released on the expected date and/or the MHSCP social workers did not assess them in time prior to release (see Farabee et al., 2006). We defined a parolee as having a mental disorder if he or she had an EOP or CCCMS designation in either DDPS or PATS, or had a diagnosis of an Axis I disorder other than substance abuse listed in PATS. If a parolee had different designations in DDPS and PATS, we relied on the PATS designation as we judged these to be more accurate.

**Return to custody.** We obtained return to custody variables from two sources. The first source was a database containing the details of all parole revocation hearings (Revocation Scheduling and Tracking System (RSTS)). Here, we defined return to custody as a determination via parole revocation hearing that the parolee had committed either a new crime or a technical violation. In virtually all cases (95%), this determination resulted in a return to prison. The second source was a database describing entrances to, and exits from, CDCR facilities (Offender Based Information System (OBIS)). Here, return to custody was defined as a return to prison. We used these two indices both individually and in combination, as described later, to capture all returns to custody captured by CDCR. Each parolee was followed one year from their index date of release from prison. For 1,727 parolees who recidivated (approximately 12%), the type of charge was not available due to missing data—these parolees are excluded from analyses of types of returns.

## RESULTS & DISCUSSION

### How widespread is identified mental disorder in California parolees?

First, we determined the percentage of parolees in our sample who met criteria for mental disorder. As depicted in Figure 1, 20.4% of parolees were identified as having a mental disorder, either by their mental health designation or diagnosis. Estimates from similar criminal justice

	All PMDs	EOP	CCCMS	Non-designated
Any psychotic disorder	21.3	39.6	17.1	30.7
Any mood disorder	40.8	25.4	38.5	61.4
Any anxiety disorder	7.0	4.1	6.5	11.3

**Table 1: Diagnostic categories for California PMDs (n = 5,342)**

populations have suggested that approximately 14.5% of men and 30% of women in prisons have serious mental disorder (i.e., major depression, schizophrenia, or bipolar disorder; Diamond et al., 2001; Fazel & Danesh, 2002; Steadman et al., 2009). Examining California’s parolees separately by gender, 29.7% of women and 19.1% of men have an identified mental disorder. It should be noted that mental disorder classifications in California are based on functioning impairments and symptoms, such that a parolee could be classified as EOP or CCCMS with a diagnosis other than the those commonly used in prevalence estimates.

**How serious are these mental disorders?** Next, we examined the diagnoses that best characterized each subgroup with mental disorder. Here, by necessity, we limited our analyses to parolees who appeared in the PATS database. As shown in Table 1, psychotic disorders are the most common type of diagnoses among parolees with an EOP designation, while other PMDs are most likely to have mood disorders. This is not surprising, given that the EOP designation is reserved for parolees with acute symptoms and serious functioning impairments, while the CCCMS designation is reserved for parolees with comparatively less serious impairments.

**What types of diagnoses are most common within diagnostic categories?** Next, we examined the specific diagnoses among parolees in each diagnostic category. As shown in Table 2, parolees who have a mood disorder are most

likely to have a diagnosis of major depressive disorder, whereas parolees who have a psychotic disorder are most likely to have a diagnosis of psychotic disorder not otherwise specified (NOS), meaning they have serious psychotic symptoms and functioning impairment, but do not meet the criteria for schizophrenia or another psychotic disorder (see American Psychiatric Association, 2000). These results indicate that PMDs in California more often than not have serious mental disorders—primarily serious mood and psychotic disorders. Research in other locations has reported similar results, as major depression, schizophrenia, and bipolar disorder are usually the most common disorders reported in prevalence studies (see Diamond et al., 2001 for a review). Although we did not find a high prevalence of anxiety disorders, PMDs who have such disorders are particularly likely to have a diagnosis of Post-Traumatic Stress Disorder, which is consistent with other research, particularly studies of incarcerated women (Teplin, Abram, & McClelland, 1996).

**How do parolees with identified mental disorder differ from non-disordered parolees?**

Our second aim was to identify any differences between parolees with and without mental disorder in their demographic and criminal justice history characteristics. A comparison of PMDs and non-disordered parolees indicated that the two groups differ across all three demographic

Category	Diagnosis	Percent within diagnostic category
Psychotic disorders (n = 1,138)	Schizophrenia	49.8
	Psychotic disorder not otherwise specified (NOS)	49.8
	Schizoaffective disorder	29.9
Mood disorders (n = 2,177)	Major depression	32.4
	Depressive disorder NOS	26.2
	Bipolar disorder	22.2
	Mood disorder NOS	18.1
Anxiety disorders (n = 375)	Post Traumatic Stress Disorder	60.4
	Anxiety disorder NOS	52.1
	Panic disorder	31.9
	Generalized anxiety disorder	9.2
	Obsessive compulsive disorder	4.3

**Table 2: Specific diagnoses for California PMDs**

Characteristic	Parolees with mental disorder	Parolees without mental disorder	Statistical comparisons
Average age***	35.5 ( <i>sd</i> = 10.3)	33.2 ( <i>sd</i> = 9.8)	$t(44,985) = -19.74$ $p < .001, d = .23$
Percent female***	18.2	11.0	$\chi^2(1) = 339.2, p < .001$
Ethnicity ***			
Caucasian	41.0%	28.9%	$\chi^2(3) = 1389.3, p < .001$
African American	29.0%	19.7%	
Hispanic	25.9%	46.4%	
Other	4.1%	5.1%	
Number of prior charges+			
Violent	0.15	0.08	
Serious	0.13	0.08	
Any	0.99	0.71	

\*\*\*comparisons significant at  $p < .001$ . + significant at  $p < .001$ , but effect size ( $d = 0$ ).

**Table 3: Comparison of parolees with and without mental disorder.**

characteristics we analyzed. PMDs are slightly older than non-disordered parolees (35.5 years versus 33.2 years of age on average), and are significantly more likely to be female (18.2% versus 11.0%). As shown in Table 2, PMDs are more likely to be Caucasian or African-American, and less likely to be Hispanic than non-disordered parolees. To determine whether there were differences in PMDs designated via PATS and those designated via DDPS, we computed these analyses again, this time comparing PMDs identified in PATS to those not designated in PATS as mentally ill, and the pattern of results was the same. Although our comparison of the number of prior offenses for PMDs and non-disordered parolees was statistically significant, this difference was likely due to the large sample size rather than real differences between the two groups, as both groups had approximately one prior offense (0.99 and 0.71, respectively).

These findings raise questions about “cherry picking” of relatively low risk offenders for psychiatric intervention. On one hand, investigators have found that, among offenders with mental disorder, those referred to treatment were more likely than those *not* referred to treatment to have such “low risk” demographic features as older age, Caucasian ethnicity, and female gender (Naples, Morris, & Steadman, 2007). On the other hand, prevalence studies indicate that female jail detainees are more likely to meet criteria for mental disorder than male detainees (appx. 30% vs. 15%, respectively, Steadman et al., 2009; Teplin, 1994; Teplin et al., 1996), as are Caucasian detainees compared to African-American detainees (appx. 11% versus 6%, respectively, Teplin, 1994, although the Caucasian sample in this study was particularly small). The data available in the present study do not allow us to definitely resolve the “cherry picking” issue.

Nevertheless, it is clear that the demographic makeup of California’s PMDs suggests that they should be at *lower* risk for returns to custody than parolees without mental disorder, since women, Caucasians, and older offenders are

less likely to recidivate than men, ethnic minorities, and younger offenders (Gendreau et al., 1996). Therefore, the fact that PMDs are reportedly at higher risk of return leads to the question of why these relatively low risk offenders return to custody so much more often.

### **Are parolees with mental disorder more likely to return to custody than those without mental disorder?**

Next, we compared rates of return to custody for parolees with and without mental disorder. First, we examined the proportion of parolees who returned to custody within one year of their release to parole, regardless of reason (new crime or technical violation). We found that PMDs are substantially more likely to return to custody than non-disordered parolees (52.8% versus 29.7%). Focusing within the PMD group, parolees designated as EOP are at greater risk of returning to custody than those designated as CCCMS or non-designated (62.0% versus 51.2% and 33.0%, respectively).

Because demographic characteristics are important risk factors and PMDs differ from non-disordered parolees on the variables we examined (i.e., age, gender, and ethnicity), we next performed logistic regression analyses to determine if PMDs are still at higher risk of returning to custody than non-disordered parolees after controlling for these variables. We found that in terms of odds ratio, PMDs have 3.28 times the odds of returning to custody as non-disordered parolees after controlling for age, gender, ethnicity, and number of prior convictions. Because of the high proportion of incomplete diagnosis data, it is not possible for us to parse out the effects of severity of mental disorder from intensity of monitoring. Thus, it is not clear the extent to which the higher rates of return to custody for EOP versus CCCMS parolees is due to symptom severity or closer monitoring by parole agents.

Type of offense	% of PMDs	% of non-disordered parolees	Statistical comparisons
<b>Any return to custody</b>	<b>52.9</b>	<b>29.7</b>	$\chi^2(1)= 1738.9, p < .001$
Violent offense	14.3	8.0	$\chi^2(1)= 316.5, p < .001$
Property offense	14.5	9.7	$\chi^2(1)= 161.5, p < .001$
Drug offense	23.0	14.4	$\chi^2(1)= 370.1, p < .001$
Minor offense	9.6	6.0	$\chi^2(1)= 142.7, p < .001$
Technical violation	23.8	11.2	$\chi^2(1)= 906.7, p < .001$

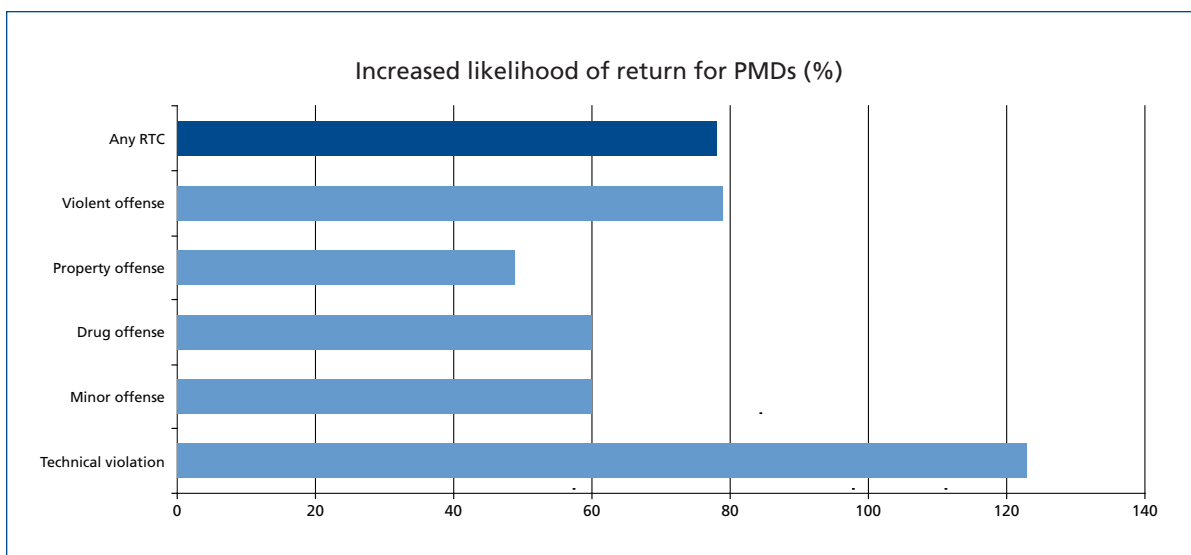
**Table 4: Types of returns to custody (one year) for PMDs and non-disordered parolees.**

Next, we examined parolees’ charges. Relative rates of return for each type of charge are presented in Table 4. As shown, PMDs were more likely to return for each type of charge. The large sample size means that even small differences were statistically significant (e.g., 9.6% of PMDs versus 6.0% of non-disordered parolees returns for minor offenses). Thus, we also present risk ratios of return for PMDs compared to non-disordered offenders in Figure 2 to draw comparisons in the magnitude of differences in these relative rates of return. As shown in Figure 2, overall PMDs were 78% more likely to return to custody (for any reason) than their relatively healthy counterparts (without controlling for variables listed earlier).

**Understanding risk for violence.** As shown in Table 4, PMDs’ risk of violence was consistent with their overall rate of return, where PMDs were more likely to return for violence (14.3 versus 8.0%, respectively). In comparison, PMDs were 123% more likely to return for technical violations than non-disordered parolees. Thus, although PMDs were more likely to return for violence than non-disordered parolees, this difference was not as large as the difference in their rates of return for relatively minor technical violations. This is consistent with previous research suggesting

that mental disorder is only a weak predictor of violence (Bonta et al., 1998). Importantly, in their review of risk factors for offense, Andrews, Bonta, and Wormith (2006) concluded that “the predictive validity of mental disorder most likely reflects antisocial cognition, antisocial personality pattern, and substance abuse” (p. 10). So, it is not clear whether mental disorder itself is driving such acts, or if it is merely a proxy for other known risk factors (see Skeem, Manchak, & Peterson, 2010). It is likely that PMDs’ returns for violence were related to such risk factors that we were not able to address with the current data; it is crucial to bear this in mind when drawing any conclusions regarding the rates of violence among California’s PMDs. Finally, it is important to note that our figures only represent returns to custody for violence. Rates of violence and other offenses that did not result in returns to custody (e.g., acts that were not discovered) are not known.

**Drilling down on risk for technical violations.** In California, a wide range of behaviors including serious new offenses have been processed through the parole board rather than through criminal court because the burden of proof is lower in parole hearings. Thus, parolees often can be returned to custody for parole violations, even when they allegedly have also



**Figure 2: Increased risk of returning for PMDs compared to non-disordered parolees.**

Type of violation	% of PMDs	% of non-disordered parolees
Failure to attend Parole Outpatient Clinic (POC)	7.6	0.4***
Failure to report to officer	10.3	9.2
Absconding	48.5	46.0
Drug use	10.3	10.4
Possession of weapons	10.1	15.9***
Other	45.3	45.6

\*\*\*significant at  $p < .001$ .

**Table 5: Types of technical violations for parolees who committed them (n = 5,761).**

committed a new offense (Petersilia, 2006). For this reason, it is crucial to “drill down” on technical violations to interpret the finding that those with mental disorder are at disproportionate risk for this type of failure. Here, we isolated all 5,761 parolees who committed a technical violation within one year of release to parole. To determine if there were particular types of violations that PMDs were more likely to commit, we compared the rates of the types of violations for PMDs versus non-disordered parolees. As shown in Table 5, there are no significant differences between the groups in the most common forms of technical violations, including general technical violations, drug use, absconding, and failure to report to the parole agent. However, non-disordered parolees are more likely than PMDs to incur a technical violation for weapons access than PMDs (15.9% versus 10.1%). Conversely, PMDs are more likely than non-disordered parolees to incur technical violations for failing to attend treatment. In fact, PMDs were 15.6 times more likely to return to prison for this reason.

Next, we examined subgroups of those with identified mental disorder to shed further light on the relation between mental disorder and technical violations. This examination reveals that the most seriously ill parolees – those with an EOP designation – are significantly (though marginally) more likely to incur a technical violation than those with a CCCMS designation (52.8% versus 47.0%). As described earlier, it is not possible to determine from the data available the extent to which the increased risk of technical violations for EOP parolees is due to severity of symptoms or increased monitoring by parole agents.

Finally, we compared PMDs and non-disordered parolees to determine whether PMDs are more likely to return to custody purely or exclusively for technical violations. We found that most parolees (PMDs and non-disordered alike) are charged with a new offense (86.6% and 89.4%, respectively). Thus, PMDs are not more likely to return purely for technical violations than non-disordered parolees.

## CONCLUSIONS & IMPLICATIONS

The primary results of this study may be organized into three points. First, a significant proportion of parolees in California are identified as having severe mental disorders—about

twenty percent of male and thirty percent of female parolees. Parolees with mental disorder primarily have diagnoses of serious mood and psychotic disorders. Second, these parolees with identified mental disorder (PMDs) have demographic characteristics that generally relate to lower rates of recidivism—they are older and more likely to be female and Caucasian than non-disordered parolees. Third, and most importantly, PMDs are more likely to return to custody than their non-disordered counterparts, and commit a disproportionate number of technical violations, often for failing to attend psychiatric treatment.

As with any research, this study has limitations. First, we are unable to determine the charge associated with return to custody for a sizeable minority of parolees (about 12% of those who returned). It is unclear if the proportions of each type of offense would differ if this data were available. Second, our mental health data came from different data sources with different systems for entering this data. The missing diagnosis data for a large proportion of PMDs limits our ability to make inferences regarding diagnosis. Further, there may be variability in the diagnoses rendered by different clinicians; such variability could affect the reliability of the analyses we conducted focused on specific diagnoses. The strengths of this research, including the large sample size, only partially mitigate these limitations.

This study’s key finding – that PMDs are substantially more likely to be returned to custody than non-disordered parolees – has direct implications for practice. First, it is important for judges and parole agents alike to be mindful of PMDs’ functional impairments when assigning and enforcing conditions of parole. When rules of parole are particularly difficult for PMDs to meet (e.g., numerous conditions, including both standard and special treatment conditions; conditions that require unimpaired daily functioning), the rules themselves may set PMDs up for failure. Although non-disordered parolees are occasionally mandated to treatment (e.g., substance abuse treatment), PMDs routinely are required to participate in psychiatric treatment. Even though PMDs were less likely to commit relatively serious technical offenses (e.g., weapons possession), they were markedly more likely to commit treatment non-compliance than non-disordered parolees. Policymakers

and practitioners must consider whether this is appropriate, given research indicating that (a) mental illness *per se* is a relatively weak risk factor for rearrest, and (b) psychiatric treatment rarely reduces the risk of rearrest among PMDs (see Skeem, Manchak, & Peterson, 2010, for a review).

Second, it is imperative that decision-makers are mindful that parolees often commit technical violations and other offenses for reasons other than symptoms and functional impairments. Spurious causes of supervision failure—such as poverty, poor social networks, and neighborhood disadvantage—may account for a large number of cases of recidivism for offenders with mental disorder (Skeem & Eno Louden, 2006). Although one characteristic that we controlled for—ethnicity—may serve as a proxy for poverty or neighborhood disadvantage, more sophisticated analyses must be done to parse out the effects of such characteristics. Measuring and addressing such spurious causes can help reduce recidivism for this group. For example, officers generally expect PMDs to be more likely to fail on community supervision and seek to monitor them more closely (Eno Louden, 2009)—indeed, EOP parolees, who had the highest rate of returns to custody in this study, are in practice monitored more closely than CCCMS parolees and non-disordered parolees (Farabee et al., 2006). The fact that PMDs are disproportionately likely to return for relatively minor technical violations suggests that the increased level of supervision these parolees receive may account partly for the high rate of technical violations for this group.

Third, it seems that California's POC program for *preventing* PMDs' violations is not sufficiently addressing the problem; it may also be necessary to reinvigorate California's program for *intervening* with PMDs, once a violation has occurred. An intervention program called the "Psychiatric Return Process" (PRP) has been in place for years in California, but rarely is used properly. If the PRP was properly applied, PMDs who committed a technical violation sufficient to warrant parole revocation would be referred for an assessment to determine (a) the extent to which their mental disorder caused the technical violation, and (b) an appropriate disposition, which could include an in-prison treatment program focused on improving community adjustment. At present, most PMDs who are referred for the PRP are returned to prison for the full one-year maximum revocation period, with no reassessment period, and little re-entry focused treatment. The results of this study suggest that a reinvigoration of the PRP process is needed to improve the likelihood of successful community re-entry for PMDs.

Beyond California, the results of this study have implications for the supervision of PMDs. The data presented here add support to the notion that PMDs are more likely to return to custody than their non-disordered counterparts,

even though they have demographic characteristics that should make them at lower risk. More importantly, our data point to the fact that PMDs are disproportionately likely to commit relatively minor technical violations. Given that the detection and processing of these technical violations are generally the responsibility of parole agents who often have lowered thresholds for violations committed by PMDs (Porporino & Motiuk, 1995), training parole agents in effectively handling non-compliance with PMDs without incarceration is a potential first step towards keeping this group out of already overcrowded correctional facilities.

## REFERENCES

- Abadinsky, H. (2000). *Probation and parole: Theory & Practice* (7th ed.). Upper Saddle River, NJ: Prentice Hall.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR)*. Washington, DC: Author.
- Andrews, D. A., Bonta, J. L., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency, 52*(1), 7-27.
- Bonta, J., & Andrews, D. A. (2007). Risk-need-responsivity model for offender assessment and rehabilitation (Corrections Research User Report No. 2007-06). Ottawa, ON: Public Safety Canada.
- Bonta, J., Law, M., & Hanson, K. (1998). The prediction of violent and non-violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin, 123*, 123-142.
- Cloyes, K. G., Wong, B., Latimer, S., & Abarca, J. (2010). Time to prison return for offenders with serious mental illness released from prison: A survival analysis. *Criminal Justice and Behavior, 37*, 175-187.
- Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. Retrieved from <http://www.consensusproject.org>.
- Diamond, P.M., Wang, E.W., Holzer, C.E., Thomas, C., & Cruser, A. (2001). The prevalence of mental illness in prison. *Administration and Policy in Mental Health, 29*, 21-40.
- Eno Louden, J. (2009). *Effect of mental disorder and substance abuse stigma on probation officers' case management decisions*. Unpublished doctoral dissertation, University of California, Irvine.
- Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet, 359*, 545-550.
- Farabee, D., Bennett, D., Garcia, D., Warda, U., & Yang, J. (2006). *Final report on the Mental Health Services Continuum Program of the California Department of Corrections and Rehabilitation—Parole Division*. Sacramento, CA: CDCR Division of Adult Parole Operations.
- Gendreau, P., Little, T., & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: what works. *Criminology, 34*, 575-607.
- Glaze, L.E., & Bonczar, T.P. (2007). Probation and parole in the United States, 2006. *Bureau of Justice Statistics*, Washington D.C.



Grattet, R., Petersilia, J., & Lin, J. (2008). *Parole violations and revocations in California*. Final grant report to the National Institute of Justice.

Naples, M., Morris, L.S., & Steadman, H.J. (2007). Factors in disproportionate representation among persons recommended by programs and accepted by courts for jail diversion. *Psychiatric Services*, 58, 1095-1101.

Petersilia, J. (2006). *Understanding California corrections: A policy research program report*. Berkeley, CA: California Policy Research Center.

Porporino, F.J., & Motiuk, L.L. (1995). The prison careers of mentally disordered offenders. *International Journal of Law and Psychiatry*, 18, 29-44.

Skeem, J., & Eno Louden, J. (2006). Toward evidence-based practice for probationers and parolees mandated to mental health treatment. *Psychiatric Services*, 57(3), 333-342.

Skeem, J. L., Manchack, M., & Peterson, J. P. (2010). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior*.

Skeem, J., Nicholson, E., & Kregg, C. (2008, March). Understanding barriers to re-entry for parolees with mental disorder. In D. Kroner (Chair), *Mentally disordered offenders: A special population requiring special attention*. Symposium conducted at the meeting of the American Psychology-Law Society (Jacksonville, FL).

Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., Roth, L. H., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, 55, 393-401.

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

Teplin, L. A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health*, 84, 290-293.

Teplin, L. A., Abram, K. M., & McClelland, G. M. (1996). Prevalence of psychiatric disorders among incarcerated women: Pretrial jail detainees. *Archives of General Psychiatry*, 53, 505-512.

Torrey, E. (1995). Editorial: Jails and prisons—America's new mental hospitals. *American Journal of Public Health*, 85, 1611-1613.