“What Works” to Reduce Recidivism in General and Among Mentally Ill Offenders

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“What works” to reduce recidivism-in general and among mentally ill offenders.

Statement of the Problem

Historically, research has proven that during the 1960s mental ill offenders were struggling within the criminal justice system within the prison system as well as in society because resources were not available to them. Criminals with mental illnesses who were serving a prison term and/or being supervised were not separated from those offenders who were not suffering from mental illnesses. Since offenders suffering from mental illnesses went untreated within the prison system, it was very common that these offenders found themselves back and forth within the criminal justice system after they were released or during their terms of incarceration. A review of literature that addresses challenges the mentally ill face within the prison systems in the United States was examined for this paper. It is very apparent that many offenders within state and local federal prisons are indeed diagnosed with mental health illness. Not only were these offenders in the prison system diagnosed with mental illnesses, but many individuals within local jails were also diagnosed as well.

Research has proven that rates of offenders suffering from mental illnesses that are diagnosed are four to eight times higher in the criminal justice system than in the general population in our society today. The research has demonstrated that mentally ill offenders are twice as likely to fail on supervision than offenders that are not suffering from any mental illnesses. Statistics has also shown that mentally ill offenders are 30 % more likely to be re-incarcerated within one year of their release date.

Purpose of the Study

The purpose of this research is to discuss the debates on whether or not there are any solutions that can reduce recidivism among the mentally ill offenders within the prison systems. Even with the vast research that is continuing on this topic, more resources will need to made accessible to the public of those who suffer from mental illnesses to prevent from criminal behavior to happen, continue, and prevention. Constant debates and research studies will need to be done periodically to stay current with research and keep society educated on mental illnesses within the criminal justice system.

Unfortunately, mentally ill offenders are a significant population within the criminal justice system in the prisons throughout our country and their treatment plans are going unrecognized and/or diagnosed. In some cases, some inmates will confess to crimes they did not commit because of their mental state of mind. For example, these individuals may confess for reasons such as fear of law enforcement, or appeasing authority. (Debbaudt & Rothman, 2001) In most cases, these individuals do not have the mental capacity to understand the interrogation questions, which in return results in false confessions and/or unreliable testimony. (Debbaudt & Rothman, 2001) With proper sources for programs within the criminal justice system, it will show that the mentally ill offenders' criminal behavior will decrease. The research and findings in regards to mentally ill offenders will demonstrate to the criminal justice system that there are ways to reduce recidivism and among mentally ill offenders. Research findings for this paper will address deterrents to reduce recidivism by offering resources for law enforcement professionals. For example, adequate training for law enforcement officials, financial conflicts resolution plans for funding for correctional facilities, and treatment programs for the mentally ill offenders.

Significance of the Study

Research has demonstrated there is a remarkable unnecessary prison population of mentally ill offenders within our society today and this is a very concerning issue for society today.With mental health evaluations by psychologists and the treatments in place for those offenders suffering from mental illnesses requested by doctors, the criminal justice system will be able to more accurately assess the offender’s past, present, and future when dealing with criminal behavior. Through resources available to the mentally ill, the criminal justice system will be able to provide effective and ideal treatment for these individuals, rather than place them in an environment that is not appropriate for them (prison), but have these mentally ill offenders being beneficial to society.

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Introduction

Historically, rehabilitative efforts were at the forefront of correctional programming; however, in 1974, an attack on rehabilitation was generated on the basis of Martinson's (1974) "nothing works" essay. At the time, Martinson (1974) had conducted the most in-depth review of rehabilitative programming and his conclusion was that there is no research to indicate that rehabilitation reduced recidivism. The interpretation of Martinson's conclusion was that rehabilitation had no palpable effect on recidivism and, given the social unrest of the time (Cullen & Jonson, 2012); Martinson's conclusion was readily accepted. The rehabilitative ideal was attacked (Cullen & Gilbert, 1982) and consequently, the focus of correctional programming became sanction based (Cullen & Gendreau, 2001).

However, what Martinson (1974) was actually stating was that the quality of the research being conducted was so inadequate it was impossible to draw any substantial conclusions. What Martinson (1974) cited was a list of studies that failed to exclude for confounding variables, that were not replicable, and that lacked consistently defined outcome measures. Rehabilitation may have appeared to suffer a setback; Martinson's (1974) article actually generated a renewed interest in rehabilitative efforts with a focus on evaluating the empirical effectiveness of interventions (Cullen & Jonson, 2012). The debate became focused on empirical evidence and provided an opportunity for researchers to rebut Martinson's findings and develop a framework for effective correctional programming. (Bourgon, Bonta, Rugge, Scott, & Yessine, 2010) The result of subsequent research has yielded an overwhelming consensus: rehabilitation works (MacKenzie, 2000). The importance of understanding the mental health personnel and criminal justice system personnel is idealistic for a successful reentry experience for offenders into their communities. In order for a program to be successful, the criminal justice system personnel and

the mental health personnel need to work together and coincide with one another to have a successful treatment plan for the offender.

Risk Needs Responsivity Paradigm

The RNR paradigm is an overarching theme, which provides the basis for effective rehabilitative programming. Specifically, for rehabilitative efforts to be effective they need to be based on the risk needs responsivity paradigm (RNR), to include core correctional practices, and to be correctly implemented. The RNR paradigm consists of three equally important principles that help identify not only which offenders to target for rehabilitative programming, as well as aspects of offender behavior are most important. The RNR paradigm is a premier model for guiding offender assessment and treatment. The RNR paradigm provides a hierarchal order for pinpointing which offender needs should be addressed first, thus helping to generate an empirically based case plan for rehabilitation. The hierarchal order would be established to address the offender in a series in which the offender needs assessments and treatment plans in a structured order. Lastly, the RNR paradigm attempts to match interventions to individual offender's abilities, motivational level, and personality traits (Andrews & Dowden, 2007). Thus far, research on the RNR paradigm has been highly favorable with estimates of predictive validity ranging from 0.15 to 0.40 (Andrews, D.A., Donta, J., & Wormith, J.S. (2011) Though there is variability in these validity estimates, adhering to the RNR paradigm is associated with reduced recidivism, while non-adherence, is associated with no discernible effect on recidivism, or worse, increased recidivism (Andrews & Dowden, 2007).

Risk Principle

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The risk principle, the first principle of the RNR paradigm, is two-fold (Lowenkamp & Latessa, 2005). The risk principle states that correctional interventions should be matched to an offender's assessed risk level (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990). For instance, high-risk offenders should receive the greatest amount of correctional intervention or programming while low-risk offenders should receive the least amount (Lowenkamp, Pealer, Smith, & Latessa, 2006). Essentially, the risk principle helps to target the "who" of correctional intervention (Latessa, 2004).

The first step in applying the risk principle is assessing offender risk level; the probability that the offender will recidivate or be re-incarcerated. Evaluating offender risk level is not new; however, the earliest form of assessment was based on clinical interviewing and provided a subjective assessment of offender risk based on clinical interpretation of informal and inconsistent criteria (Andrews & Bonta, 2003). Research findings show evidence, which indicated that the prediction of risk based solely on clinical assessment was wrong two thirds of the time (Andrews & Bonta, 2003). The risk principle calls for greater reliability in risk assessment; therefore risk assessment is no longer based on professional opinion, but is instead the result of a sophisticated and validated risk assessment tool. Risk assessments are very credible with evidence of successful or unsuccessful strategies. The risk assessments will be completed to determine the qualitative value of risk for the mental state of mind and address a concrete treatment plan for the offenders.

Risk assessment tools evaluate individual offender characteristics that are predictive of future criminal conduct and provide an actuarial analysis of risk level (Andrews, Bonta, & Hoge, 1990). Sophisticated risk assessment tools include, both static and dynamic risk factors. Static

factors are historical aspects that are immutable; such as: age at first arrest, number of arrests at the time of conviction, or history of a violent offense.

Conversely, dynamic risk factors are characteristics, such as: associating with antisocial peers, having a negative attitude, or using illicit substances, which can be addressed through intervention (Latessa & Lowenkamp, 2005). Changes in dynamic risk factors subsequently correlate with changes in offender risk level (Andrews, Zinger, et al., 1990). For example, risk assessment tools are integral in the assessment of offender risk level and are the first step in following the RNR paradigm.

While risk assessment provides a mechanism for offender evaluation, it is necessary for correctional staff to individualize interventions and programming based on an offender's assessed risk level (Andrews & Bonta, 2003). Matching increases the likelihood that interventions will be effective at reducing recidivism (Adrews et al,. 1990) and research supports reductions in recidivism when intensive interventions are tailored to high-risk offenders (Andrews et al., 1990). Although, research within the criminal justices changed throughout history, this area has stayed unchanged. Too often, correctional interventions are applied to all offenders equally regardless of risk level. Apparently, the necessity of intervention is disregarded under the pretext that intervention should, at least, not make things worse; however, research has indicated when intensive interventions are provided to low-risk offenders the result is often an increase in recidivism (Andrews et al., 1990; Lowenkamp & Latessa, 2005; Andrews & Bonta, 2003). The goal of correctional programming that is solely based on the risk principle of the offender, is to keep low-risk offenders low-risk and to target high-risk offenders in such a way that their risk level decreases (Andrews & Dowden, 2007).

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According to Lowenkamp and Latessa's (2005) evaluation of residential programming, treatment interventions provided to high-risk offenders reduced recidivism by an average of 5% with some programs showing reductions as high as 25%. However, when low-risk offenders were admitted to residential programming, there was an average of 4% increase in recidivism (Lowenkamp & Latessa, 2005). Lowenkamp et al. (2006) conducted an evaluation of adherence to the risk principle as quantified by having a high-risk sample, utilizing risk supervision, and referring to risk treatment. Results indicate reductions in recidivism ranging from 5% to 11% by adhering to the risk principle. Conversely, programs that did not adhere to the risk principle increased recidivism by an average of 13% (Lowenkamp at el., 2006). Interestingly, the more broadly programs adhered to the risk principle the higher the reduction in recidivism, for instance, programs that met one or two factors, decreased recidivism by 3%, but programs that adhered to three or more factors decreased recidivism by 15% (Lowenkamp et al., 2006).

Needs Principle

The needs principle states that correctional interventions should target criminogenic needs (Lowenkamp et al., 2006). Criminogenic needs are dynamic risk factors that are highly predictive of recidivism; such as: antisocial attitudes, association with antisocial peers, pro-criminal personality characteristics, weak family support, low educational or vocational achievement, substance abuse, (Gendreau, Little, & Goggin, 1996 quoted in Lowenkamp et al., 2006), a lack of pro-social recreation, and limited financial resources (Andrews & Dowden, 2007). All of these factors are dynamic, indicating they can be targeted for improvement, and improvement can result in the reduction of recidivism. The needs principle helps to determine the "what" of correctional intervention (Latessa, 2004).

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Again, criminogenic needs are identified through the completion of sophisticated assessment tools such as screening, pre-booking, post-booking, re-entry programs and comprehensive diversion programs. While some needs may appear to be obvious, such as substance abuse, others, such as antisocial attitudes, may be more difficult to discern from a political standpoint. Funding is a huge source for reducing recidivism within the criminal justice system for mentally ill offenders. Many believe these individuals should just be incarcerated and not be addressed in a medical field aspect. Additionally, having a particular risk factor does not make an offender high-risk; it is the combination of multiple risk factors that results in a high-risk designation. Given the multitude of risk factors, needs should be prioritized and focus should be placed on the highest risk areas, which are those most highly correlated with recidivism (Latessa & Lowenkamp, 2005). The dynamic risk factors found to be most closely correlated with offender risk are: anti-social peers, anti-social attitudes, and anti-social personality (Andrews & Bonta, 2003) and, therefore, those criminogenic needs are the most urgent to address.

Criminogenic needs are the intermediate targets of correctional intervention (Andrews & Dowden, 2007). It is important to understand that the best results for successful rehabilitation will come from implanting programs based upon cognitive behaviors. While a reduction in recidivism is the ultimate outcome measure, in the short term, a reduction in the severity or quantity of criminogenic needs is just as useful of an indicator of correctional effectiveness (Andrews & Dowden, 2007). In order to recognize changes in criminogenic needs, it is necessary for offenders to be periodically reassessed. Risk/need assessment tools should be regularly re-administered to determine if the correctional interventions that have been introduced have had any positive effect (Andrews & Bonta, 2003).

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It is important that correctional staff do not get distracted by non-criminogenic needs, such as: self-esteem, physical conditioning, cultural awareness, assertiveness, or creativity (Andrews, Zinger, et al., 1990; Latessa & Lowenkamp, 2005; Dowden & Andrews, 2004). While these areas may be important for the offender to work on, evidence indicates that non-crimonogenic needs will not reduce recidivism, and therefore are not an effective correctional interventions (Latessa & Lowenkamp, 2005). Evidence suggests that programs that target four to six criminogenic risk factors tend to decrease recidivism by 30% while programs that do not target criminogenic risk factors have no effect on recidivism (Latessa & Lowenkamp, 2005).

Responsivity Principle

The responsivity principle states that the mode of treatment intervention should be matched with offender learning styles and personal characteristics (Andrews et al., 1990). Evidence indicates that offenders respond more positively to correctional interventions when service style is matched to an offender's learning ability, motivational level, and personality (Andrews & Dowden, 2007). So, the responsivity principle dictates the "how" of correctional intervention (Latessa, 2004).

Responsivity is characterized as general or specific (Andrews & Dowden, 2007). General responsivity outlines that treatment approaches should be based on cognitive-behavioral techniques (CBT) (Paparozzi & Gendreau, 2005; Lowenkamp, Hubbard, Makarios, & Latessa, 2009) to be the most effective. Cognitive behavioral programming focuses on targeting behaviors, feelings, and thoughts that contribute to deviancy so offenders are aware of the thinking patterns that perpetuate criminality (Rotter & Carr, 2011). Cognitive behavioral techniques consist of three attributes that have been proven effective for correctional

intervention: a focus on the present, an insistence on action, and an emphasis on teaching new skills (Latessa, 2004).

While correctional focus has a tendency to be historical, cognitive-behavioral programming places substantial weight on current risk and responsivity factors (Latessa, 2004). While prior criminal history is a static factor highly correlated with offender risk, it is irreversible, and highly unbeneficial to focus on. Working instead on current offender behavior, attitudes, or values will prove to be more successful at reducing recidivism (Lowenkamp et al., 2009). Secondly, instead of employing a conventional talk based regimen CBT programs are action-oriented (Latessa, 2004). Emphasis is placed on guiding offenders through exercises and role playing to aid in comprehension and application. Lastly, offenders are taught new pro-social skills to replace the pro-criminal ones they previously employed (Latessa, 2004). The main modes of this instruction are through pro-social modeling, role-playing, and reinforcement (Latessa, 2004).

Many CBT programs have been designed for correctional intervention; such as: Thinking for a Change (T4C), Moral Recognition Theory (MRT), Lifestyle Change, Options, or Reasoning and Rehabilitation (R&R) (Rotter & Carr, 2011). These programs all focus on modeling pro-social behavior, challenging cognitive distortions, enhancing offender problem-solving skills, and increasing self-control (Latessa, 2004). Andrews, et al. (1990) found that employing behavioral techniques yielded an effect size of .29, which is far greater than the .04 effect size generated by non-behavioral techniques. Additionally, Lowenkamp et al. (2009) reported that offenders placed in the control group were 57% more likely to be arrested during the follow-up period than offenders who participated in CBT programming. A meta-analysis refers to methods focused on contrasting and combing results from different studies, in hope of identifying patterns

among those study results. (Merriam-webster.com, 2013) With that being said, lastly, a meta-analysis, which is…. of CBT programming exhibited an 8.2% reduction in future felony convictions for individuals who completed CBT programming (Rotter & Carr, 2011). Specific responsivity focuses on targeting the individual needs of offenders and customizing treatment interventions to their learning abilities and interests (Andrews & Dowden, 2007). In order for a correctional professional to target responsivity factors, he/she he or she must first develop a rapport with offenders to determine their particular abilities, motivation levels, and personality factors. While specific responsivity factors may not be directly correlated with risk, they do indirectly affect risk by decreasing the benefit of treatment or preventing offenders from participating in programming (Latessa, 2004). For example, a highly motivated high-risk offender may exhibit greater compliance than a poorly motivated moderate-risk offender. Conversely, a low-risk offender who is plagued by personal struggles, such as: a language barrier, poor education, illiteracy, a learning disability, or detrimental personal factors (lack of child care, transportation, or housing) may have a higher likelihood of recidivism if correctional professionals cannot respond or adjust intervention based on these factors. (Loveland & Boyle, 2007)

Applying the RNR Paradigm to Mentally Ill Offenders

Historically, it was widely accepted that the prevalence of mentally ill offenders within the criminal justice system was because mental illness had been criminalized (Lurigio, 2011). Essentially, psychiatric patients just happened to end up in the criminal justice system due to their symptoms instead of purposeful criminal conduct (Morgan, Fisher, Duan, Mandracchia, & Murry, 2009). It was often thought that if mental illness was appropriately treated, if more mental health facilities were available, or if more cost-effective services were offered then these

offenders would not end up in the criminal justice system at all (Skeem, Manchak, & Peterson, 2011).

Rates of mental illness are four to eight times higher in the criminal justice system than in the general population (Skeem & Manchak, 2008), mentally ill offenders are twice as likely to fail on supervision than are non-mentally ill offenders (Skeem & Manchak, 2008), and mentally ill offenders are 30% more likely to be re-incarcerated within one year of release (Skeem et al., 2011). These statistics proves the study of "what works" with mentally ill offenders has become more prominent within the criminal justice system (Skeem et al., 2011). At first, several theories abounded as to why so many mentally ill offenders were incarcerated, the most prominent being: deinstitutionalization, restrictive involuntary commitment laws, and the inadequacy of community-based treatment options (Skeem et al., 2011). Crisis Intervention Teams is a diversion program which involve the mentally ill offenders that have come into contact with law enforcement officials. Sentence mechanics…. In some cases, instead of these offenders being charged with a crime, they are diverted to a program that addresses their mental health needs, rather than process these individuals through the criminal justice system. All of these theories focused on external factors that purportedly resulted in high rates of recidivism among mentally ill offenders; however, what was lacking was an evaluation of mentally ill offenders and an empirical basis for risk.

Modern research indicates that clinical factors (such as depression or bi-polar disorder) do not always solely account for recidivism among mentally ill offenders (Dooley, 2010). Instead, the strongest predictors of a new violent offense (>.20) were antisocial personality, juvenile delinquency, criminal history, and employment issues; all factors shared with general offenders (Skeem et al., 2011). Additionally, mentally ill offenders produced criminal thinking

scores similar to those of healthy offenders (Morgan et al., 2009), with 66% of mentally ill offenders adopting pro-criminal values (Morgan et al., 2009). It is becoming obvious that the main mode of addressing recidivism among mentally ill offenders, simply treating mental illness, is not enough to reduce recidivism (Morgan et al., 2009).

Predominantly, the chief objective for treating mentally ill offenders has been to generate an exit from the criminal justice system, which, logically, has been attempted through mental health treatment (Skeem et al., 2011). However, research suggests that mentally ill offenders who exhibit clinical symptom improvement are no less likely to recidivate or be re-incarcerated (Skeem et al., 2011). It is not mental illness that results in incarceration; instead, it is the possession of a combination of risk factors and mental illness (Skeem et al., 2011). It is speculated that the disproportionate amount of mentally ill offenders in the criminal justice system results from mentally ill offenders possessing more dynamic risk factors than the general population (Skeem et al., 2011). Given that mentally ill offenders share similar risk and needs factors with the general offender population, treatment interventions that follow the RNR paradigm can reduce recidivism for mentally ill offenders (Morgan et al., 2009).

While risk and need factors are identical for both general offender and mentally disordered populations (Bonta et al., 1998), responsivity factors on the other hand, become all the more important with the mentally ill population. Mentally ill offenders are more likely to incur technical violations, often times; this is a result of impaired functioning, which reduces their ability to effectively follow their rules of community supervision (Skeem et al., 2011). Maintaining a high base for success will often result in more failure (Skeem et al., 2011). Correctional professionals need to respond to the abilities of mentally ill offenders by being more sensitive to their impaired functioning, looking at removing unnecessary or overly burdensome

conditions, and ensuring an appropriate level of mental health treatment is obtained (Skeem et al., 2011).

While mental health treatment alone does not reduce recidivism, it is an important responsivity factor that can help to reduce clinical symptoms that may be interfering with effective correctional interventions (Skeem et al., 2011). Furthermore, treating mental illness may help to target criminogenic needs by reducing clinical symptoms that may: prevent employment, encourage substance abuse, or diminish social support (Lurigio, 2011). Lastly, correctional professionals have an ethical, if not a legal, obligation to continue mental health treatment for mentally ill offenders (Lurigio, 2011). So, while mental illness is not a criminogenic need, it has been effective at achieving positive patient outcomes (Skeem et al., 2011) and will always play a large role in the supervision of mentally ill offenders.

Lastly, evidence indicates that CBT may be effective for mentally ill offenders (Rotter & Carr, 2010). While CBT programming was developed for a general offender population, the structure of CBT programming is particularly suited to match the learning style of mentally ill offenders (Rosenfeld, Galietta, Ivanoff, Garcia-Mansilla, Martinez, Fava, et al., 2007 cited in Rotter & Carr, 2010). Evaluations of MRT and Lifestyle Change have been completed for mentally ill populations and reveal increased problem solving skills (Donnelly & Scott, 1999 cited in Rotter & Carr, 2010), increased social adjustment (Donnelly & Scott, 1999 cited in Rotter & Carr, 2010), and a reduction in re-arrest (Robinson, 1995 cited in Rotter & Carr, 2010).

Core Correctional Practices

Historically, correctional staff has tended to utilize a law enforcement or surveillance model of supervision, which includes programs including intensive supervision, boot camp, and case management; all interventions which research has now indicated were

ineffective (Taxman, 2002). Modern research has indicated that a more balanced approach between law enforcement and social work is highly successful (Kennealy, Skeem, Manchak, & Louden, 2012; Whetzel, Paparozzi, Alexander, & Lowenkamp, 2011). Additionally, research has been able to pinpoint core correctional practices (CCP) that make the implementation of the RNR paradigm more successful.

Core Correctional Practices are procedures of interacting with offenders that aid in the development of therapeutic potential, thus increasing the likelihood of rehabilitation (Dowden & Andrews, 2004). CCPs are based on the tenets of social learning theory and were designed to exhibit the most effective correctional approaches for nurturing positive change within offenders (Dowden & Andrews, 2004).

Topic sentence Within the criminal justice system, it is important to understand the reasoning as to why some offenders commit acts of crimes. Robert Akers (1994) adds to Sutherlands Differential Association Theory by working in aspects of behavioral learning principles. Akers focuses on four main concepts of differential association, definitions, differential reinforcement, and imitation. Akers posits that when individuals associate with other people who conform to deviant behavior those individuals will be more inclined to conform to the deviant behavior because that is what the "norm" is for those individuals. On the other hand, when individuals associate with people who are more likely to conform to the norms of society, those individuals will be more inclined to conform to society's norms over deviant behavior.

The premise of Akers theory is that individuals will conform to whatever the norm is that they are most exposed to, good norms or bad norms. Much research over the years has supported the social learning theory but according to Akers the demographics and community variables on behavior still needs to be researched. The following brings in some community variables, which

show support for Akers social learning theory combined with Sutherland Differential Association Theory.

The concept of social norms fits naturally with the social learning theory, as Ward et al. (2009) points out. There is also evidence to suggest that an individuals' placement in the community and demographic adds to the social learning theory and differential association.

Overall, the people who individuals associate with are related to where they live, either neighborhood, community, household, or dorm. In addition, those individuals will learn the social norms of that community or neighborhood based on the differential association theory and those individuals will learn the behaviors of others based on their association and proximity to either norm, good or bad.

Adhering to core correctional practices helps to manage short-term offender risk and promote long-term behavioral change (Whetzel et al., 2011). The core correctional practices consist of the following: the effective use of authority, anti-criminal modeling and reinforcement, problem solving, use of community resources, and quality of interpersonal relationships with offenders.

The effective use of authority requires that correctional professionals clearly delineate the rules while focusing on providing positive reinforcement . Correctional professionals need to be direct and specific while providing offenders with the ability to evaluate consequences and make decisions. The goal of effective authority is to respectfully guide offenders into compliance - not to authoritatively demand compliance of them. Secondly, correctional professionals need to clearly model pro-social attitudes and behaviors and provide positive or negative reinforcement . The goal of this strategist approach is that offenders will begin to learn pro-social behavior from

their frequent contacts with correctional professionals. Additionally, professionals that do not thoroughly counteract pro-criminal thoughts or behaviors may be reinforcing recidivism (Dowden & Andrews, 2004).

The third core correctional practice involves teaching problem solving skills (Dowden & Andrews, 2004). Offenders with a greater ability to problem solve are more likely to engage in non-criminal behaviors to remedy obstacles in their lives, such as financial or medical struggles (Dowden & Andrews, 2004). Fourth, correctional professionals need to make quality community referrals for needed services (Dowden & Andrews, 2004). Lastly, relationship factors are especially important. Correctional professionals that are open and engaging, while effectively using authority, develop the most mutually beneficial relationships with their clients (Dowden & Andrews, 2004). This is generally achieved through a human service approach.

Research in this area has been quite favorable, indicating effect sizes of 40% to 80% (Andrews et al., 1990) for correctional professionals who engage in CCP. Kennealy et al. (2012) reported that a dual role relationship with offenders actually reduces the likelihood of re-arrest; additionally, the quality of the dual role relationship predicted the probability of re-arrest regardless of offender risk level. Paparozzi and Gendreau (2005) also determined that the dual role orientation of officers successfully reduced recidivism much more than either the law enforcement orientation or the social work orientation alone, whileSkeem & Manchak (2008) identified that probation officers who were both highly caring and highly directive had higher quality relationships with the offenders on their caseloads, which resulted in improved probationer attitudes and lower rates of new convictions. Additionally, Robinson, VanBenschoten, Alexander, and Lownkamp (2011) reported a 50 % reduction in supervision failure rates for moderate-risk clients that were supervised by correctional staff that engaged in

CCP. Lastly, one important aspect of CCP is that it may make ineffective correctional interventions effective (Paparozzi & Gendreau, 2005). Research that has been reviewed periodically over time has indicated that intensive supervision programs (ISP) are ineffective at reducing recidivism (Taxman, 2002; Skeem & Manchak, 2008); however, a study of the use of CCP in ISP reported a reduction in recidivism of 20% to 30% (Paparozzi & Gendreau, 2005). Indicating that CCP can be beneficial regardless of the effectiveness of the intervention utilized.

Individually, the majority of core correctional practices have significant effect successful outcomes when utilized (Dowden & Andrews, 2004), for example, solely participating in treatment referrals reduces recidivism by 13% (Lowenkamp et al., 2006). Additionally, the effectiveness of CCP is greatly increased when used in combination with the RNR paradigm (Dowden & Andrews, 2004). Downed and Andrews (2004) conducted a meta-analysis of the effectiveness of using core correctional practices and determined that they were rarely utilized in correctional programming. They found that even the most commonly used techniques were present in only 16% of the studies examined (Dowden & Andrews, 2004).

Utilizing Core Correctional Practices with Mentally Ill Offenders

Persons with mental illness are not only disproportionately represented in the criminal justice system; they are more likely to fail in the community (Skeem et al., 2011). Eno Louden and Skeem (in press; cited in Skeem et al., 2011) cited that parolees with mental illness were two times more likely to return to prison within one year of release than were parolees without a mental illness. Given the complexity of working with offenders that are struggling with not only marked risk factors but mental illness as well, the quality of the relationship with the offender becomes all the more important.

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Kennealy et al. (2012) report relationships that are characterized by trust, caring, fairness, and an effective use of authority are just as beneficial for mentally ill offenders as for a general offender population. Conversely, harmful relationships are those that are authoritarian, demanding, lack flexibility, and are overly controlling (Skeem, Eno Louden, Polaschek, & Camp, 2007). While authoritarian orientations and a reliance on threats of incarceration are negative for all offenders, those tactics are particularly harmful to mentally ill patients who are highly susceptible to the effects of a harmful relationship (Skeem et al., 2011). Threats of sanctions can result in poor treatment compliance or a complete inability to further participate in treatment due to the high levels of anxiety and stress these threats cause (Skeem & Manchak, 2008) Further, Skeem et al., (2011) indicate that a permissive orientation with mentally ill offenders may also undermine the effects of treatment. In circumstances where probation has been found to reduce the recidivism of mentally ill offenders, it has more to do with a high quality dual role relationship with the probation officer, than the punishment imposed (Skeem et al., 2011). Even among involuntary clients, who are prevalent within the criminal justice system, a high quality dual role relationship was able to predict future compliance (Skeem et al., 2007).

One of the main methods of specifically providing CCP to mental health offenders that has generated some interest is specialized caseloads. Specialized caseloads are those consisting solely of mentally ill offenders, with a reduced caseload number, that offer ongoing mental health care, by utilizing both internal and external resources of offender support, and focusing primarily on problem solving (Skeem & Manchak, 2008; Skeem, Emke-Francis, & Eno Louden., 2006). The use of specialized caseloads appear promising; however, evidence has not indicated a reduction in recidivism (Skeem & Manchak, 2008). Specialized caseloads may be too narrowly

focused on the tenets of effective treatment with limited focus on the RNR paradigm (Skeem & Manchak, 2008) thus not effectively targeting factors that could reduce recidivism.

Mental health courts are also very valuable to research with mentally ill. Professionals within mental health courts are very dedicated and the process is a court-based jail diversion program. Within mental health courts, it consists of a presiding judge, a probation officer that specializes in mental health, a mental health professional, the prosecutor and the public defender. The sole purpose of mental health courts is to improve the overall social functioning of mentally ill offenders while providing him/her with support services, housing, employment, and treatment programs.

Implementing core correctional practices are beneficial for all offenders; however, are highly beneficial for correctional personnel working with mentally ill offenders for future instances of criminal behavior.. Poor relationship quality between can negatively impact a mentally ill offender's already compromised mental state, thus reducing their ability to maintain compliance with their conditions of release (Skeem et al., 2007). The sensitivity and complexity of mentally ill offenders mandates an adherence to core correctional practices to help achieve reduced recidivism and effective treatment (Skeem et al., 2011).

IV. Implementation

Currently, in the United States, 1 in every 99 adults is incarcerated, which is higher than any other country in the world (Pew, 2008). The United States has 7.3 million adults currently incarcerated or on some type of community supervision (Bureau of Justice Statistics, 2010). Many of those incarcerated have been returned to prison due to revocation for repeated drug use, repeat sexual behavior, or frequent missed urine screens or medical appointments. Based on these staggering numbers, many correctional agencies are attempting to implement evidence-

based practices to enhance the effectiveness of correctional intervention (Lerch, Viglione, Eley, James-Andrews, & Taxman, 2011).

However, implementing a whole new correctional ideal can be difficult and wrought with staff resistance (Latessa, 2004). Large scale organizations involve several different strata of personnel and with each layer of the organization is another set of people who must be convinced on the intervention (Latessa, 2004). Additionally, implementation is a timely process requiring years of investment prior to success (Alexander, 2011). Lastly, once implementation is attempted in the "real world" it is possible for the results to be different than those obtained in a controlled clinical study (Bourgon et al., 2010). What "doesn't work" for implementation often consists of the most commonly practiced procedures: mandating change, simply providing the information, and conducting training (Alexander, 2011).

In order to implement a new correctional ideal, organizations need to step beyond the ordinary modes of implementation and instead make changes for sustained progress. Prior to the implementation process beginning, there are several important factors that need to be assessed, including: organizational readiness, jurisdictional prerequisites, and program design. Organizational readiness is the extent to which the organization is prepared to change (Lerch et al., 2011).

Organizational readiness is quantified by organizational climate, commitment to the organization, and resource availability (Lerch et al., 2011). Organizational climate refers to the openness of staff to change and their willingness to support new initiatives. Additionally, strong leadership is extremely important to organizational climate, particularly, during what could be a turbulent transition (Alexander, 2011). Commitment to the organization outlines how attached staff is to the organization and how willing they will be to stay with the organization during the

change process (Lerch et al., 2011). Lastly, resources to support change need to be available to staff, including but not limited to, supplies, training, and time (Lerch et al., 2011). High levels of organizational readiness are associated with increased effectiveness of organizational change and improved implementation (Lerch et al., 2011). These attributes can also be referred to as drivers, which are components that interact to promote change (Alexander, 2011).

Jurisdictional prerequisites include the use of a validated risk/needs assessment tools, organizational policies congruent with the RNR paradigm, and managerial support (Bourgon et al., 2010). Prior to the implementation process it is necessary for organizations to be able to address the RNR paradigm, with the first necessary step being the ability to assess offender risk level and criminogenic needs (Bourgon et al., 2010). Next, existing policies regarding the supervision of offenders need to be revised to ensure compliance and congruence with the RNR paradigm (Bourgon et al., 2010). Incongruent policies will inhibit successful implementation and increase staff frustration or resistance. Lastly, managers must exhibit support for change and lead by example (Bourgon et al., 2010). All managers should be trained on the change initiatives and strive to effectively practice the new initiatives in order to promote staff support (Bourgon et al., 2010). Additionally, managers need to be sensitive to the new requirements placed on staff and allow appropriate time for learning (Bourgon et al., 2010).

Lastly, the program design consists of the actual program to be implemented, the targets of the program, the intervention strategies, and the empirical background supporting the intervention (Bourgon et al., 2010). The program design is an important first step in actualizing empirical information, such as: the risk principle, the need principle, and the responsivity principle into intervention (Bourgon et al., 2010). When devising a program design it is necessary to consider the principles of: fidelity, sufficient scale, and sustained progress

(Alexander, 2011). The fidelity principle states that interventions or programs should be implemented based on their original design so they are conducted as near to that design as possible. Basically, fidelity is implementing the program correctly. Ensuring that everyone is participating in the implementation of the intervention is what is meant by sufficient scale (Alexander, 2011). It is not merely enough to have some people participating; everyone needs to "buy in" to the intervention (Lastessa, 2004). Lastly, sustained progress is needed otherwise the intervention could fizzle (Alexander, 2011). Staff turnover or decreased interest can greatly diminish sustained progress (Alexander, 2011).

Once a program design is complete, the next step is training (Bourgon et al., 2010). The effectiveness of training can be increased by providing an explanation for the change, focusing on necessary behavioral change, and having a formal training structure (Bourgon et al., 2010). As previously indicated, staff support is necessary to implement change. Staff resistance to change can be successfully counteracted by providing staff with a rational explanation of the need for change (Bourgon et al., 2010). Additionally, appealing to the effectiveness of the proposed change may help to increase staff support (Bourgon et al., 2010). Lastly, a good working relationship between the trainers and the staff being trained is imperative (Bourgon et al., 2010). The ability for the trainers to cite real life experiences and incorporate the new skills into actual job performance will go a long way in promoting behavioral change (Bourgon et al., 2010). Promoting change can also be completed by selecting staff more willing to embrace and support the change (Alexander, 2011). Lastly, creating a formal training manual or regimen covering all aspects of the training will allow for continuity in training as well as an additional resource for staff (Bourgon et al., 2011).

Once staff complete the formal training, it is necessary to establish skill maintenance protocols (Bourgon et al., 2010). In order for skills to be retained, it is necessary to implement new skills into job performance and receive feedback (Alexander, 2011). Periodic meetings to discuss the new skills or the implementation of these skills can provide a forum for this feedback (Bourgon et al., 2010). Additionally, providing staff with training exercises or asking staff to audiotape their interactions with clients can provide further opportunity to receive feedback (Bourgon et al., 2010). Lastly, periodic refresher training can help in the maintenance and indoctrination of new skills (Bourgon et al., 2010).

The last step of implementation is evaluation (Bourgon et al., 2010). Any program or intervention implemented needs to be evaluated to determine program effectiveness and limitations (Bourgon et al., 2010). This evaluation also helps to ensure fidelity and integrity to the program design (Andrews & Dowden, 2005). It is necessary to evaluate both the use of the interventions by staff and also the effects of the intervention on clients (Bourgon et al., 2010). This will allow for an indication of how well the skills are being utilized by staff and for an evaluation of how effective the skills have been in reducing criminogenic needs or recidivism (Bourgon et al., 2010).

Implementation is a continuous process and progresses through many stages (Alexander, 2011). The exploration stage is where options are just beginning to be explored and administration can begin to discuss change with staff (Alexander, 2011). Next, is the installation stage where the organization should begin to prepare for implementation by planning, training, making policy changes, and identifying agency wide issues that would be barriers to implementation (Alexander, 2011). Once staff training has begun and staff is expected to begin using the new intervention, the stage of initial implementation has been reached (Alexander,

2011). Lastly, is full implementation (Alexander, 2011). At full implementation, the majority of staff is using the new intervention and the majority of clients are receiving the intervention (Alexander, 2011). Implementation is a continuous process and just because the stage of full implementation has been obtained does not mean that the process stops there, programming should be continuously assessed, evaluated, and improved (Alexander, 2011).

Several implementation issues can arise, any of which can result in diminished treatment effects (Gendreau, Goggin, & Smith, 1999). Programs that are not properly implemented suffer decreased effectiveness (Gendreau et al., 1999). Further, high quality of implementation is correlated with reductions in recidivism (Gendreau et al., 1999) and enhancements in the effects core correctional practices (Andrews and Dowden, 2005). So the proper implementation of programming results not only in increased staff acceptance and indoctrination but also has important effects on outcome measures. Lastly, just because an intervention has been proven effective and implementable, does not mean that it will be actualized (Latessa, 2004). There are several other barriers to implementation that are external to the intervention, which can impede success at many different levels, including: political pressure, funding, and a lack of support (Latessa, 2004).

Barriers to Implementation While Working with Mentally Ill Offenders

Implementing correctional practices that are based on the RNR paradigm, through utilization of CCP can be much more difficult for a caseload of mentally ill offenders as correctional professionals need to target criminogenic needs, while being sensitive and responsive to mental health concerns (Morgan et al., 2009). Criminality and mental illness are not usually regarded as co-occurring conditions and thus specialized programming has been formulated (Morgan et al., 2009). Additionally, appropriate referral sources may not be

available, either geographically or given the special needs of mentally ill offenders; such as: specialized housing or treatment programs (Morgan et al., 2009).

Morgan et al. (2009) suggests a two pronged approach to the implementation of correctional interventions for mentally ill offenders. First, appropriate identification of mentally ill offenders through risk assessment and psychiatric assessment (Morgan et al., 2009). Second, to determine the severity of criminal thinking patterns and determine if they can be targeted by interventions developed for non-mentally ill offenders (Morgan et al., 2009). Interventions targeting criminal thinking patterns should be integrated with psychiatric treatment similarly to how co-occurring criminality and substance abuse have been treated (Morgan et al., 2009). Morgan et al. (2009) stresses the need for simultaneous and integrated intervention as opposed to sequential; therefore, it is not beneficial to try and target solely mental health concerns or criminogenic needs to the exclusion of the other.

Summary and Concluding Statements

The focus of the criminal justice system became sanction based resulting in an explosion of adults who are under correctional incarceration or supervision (Cullen & Gendreau, 2001). The criminal justice system will always include a punitive component; however, resurgence on the effectiveness of rehabilitation has yielded a more successful approach to the punishment and reintegration of offenders. Given the number of people under the control of the criminal justice system and the tightening of governmental budgets, it is necessary to make correctional programming as effective and accessible as possible.

Through the process of improvement cycles, correctional intervention has gone from "nothing works" to being able to specify exactly "what works" (Alexander, 2011). This information has led to not only increased effectiveness of correctional programming but

increased efficiency. Correctional staff now has a blueprint of where to focus their efforts. Governments are looking for tangible results (success stories) and agencies are looking for a conceivable way to function with limited staff and resources. Observing the RNR paradigm would allow correctional agencies to reduce time and resources inappropriately aimed at low-risk offenders or on non-crininogenic needs and instead focus efforts and resources on offenders who need them, by addressing dynamic risk factors, and increasing efficacy by targeting an offender's specific learning styles. Additionally, it is inexpensive and effective to train staff on core correctional practices. Lastly, implementation and evaluation, though not easy or inexpensive, will prove to be cost-efficient if interventions are documented as effective and appreciable effects are recognized.

The future of correctional programming should include a proactive model of community supervision which would allow the correctional professional to develop a positive relationship with the offender, to focus on offender change and compliance, to utilize case planning to monitor responsivity factors, and to adhere to the ground rules of supervision (Taxman, 2002). Contact with offenders has become the basis for defining the relationship between the offender and the correctional professional (Taxman, 2002). Contacts are easily quantifiable and have therefore become the benchmark of supervision; however, the essence of a contact that produces social control is far different than the essence of the surveillance-oriented contact (Taxman 2002). The correctional professional is no longer an enforcer but instead an agent of change (Taxman, 2002) and in order for that transformation to take place, correctional professionals need to improve their technical skills, modify their philosophies on supervision, increase their communication skills, and have a management team that will oversee successful implementation

(Taxman, 2002). This is a recipe for sustained long term change not only for the offender but for the correctional professional as well (Taxman, 2002).

References

Alexander, M. (2011). Applying implementation research to improve community corrections: Making sure that "new" things sticks. Federal Probation, 75, 47-51.

Andrews, D., & Bonta, J. (2003). Prediction of Criminal Behavior and Classification of Offenders. The Psychology of Criminal Conduct. Chapter 6. New Providence: Matthew Bender & Company, Inc.

Andrews, D., Bonta, J., & Hoge, R. (1990). Classification for effective rehabilitation: Rediscovering psychology. Criminal Justice and Behavior, 17, 19-52.

Andrews, D., & Dowden, C. (2005). Managing correctional treatment for reduced recidivism: A meta-analytic review of programme integrity. Legal & Criminological Psychology, 10, 173-187.

Andrews, D. & Dowden, C. (2007). The risk needs responsivity of assessment and human service in prevention and corrections: Crime prevention and jurisprudence. Canadian Journal of Criminology & Criminal Justice, 49, 439-464.

Andrews, D., Zinger, I., Hoge, R., Bonta, J., Gendreau, P., & Cullen, F. (1990). Criminology, 28, No. 3, 369- 404.

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. Psychological Bulletin, 123, 123-142.

Bourgoun, G., Bonta, J., Rugge, T., & Yessine, A. (2010). The role of program design, implementation, and evaluation in evidence based "real world" community supervision. Federal Probation, 74, 2-15.

Bureau of Justice Statistics (2010). Total Correctional Population. http://bjs.ojp.usdoj.gov/index.cfm? ty=tp&tid=11

Cullen, F. & Gendreau, P. (2001). From nothing works to what works: Changing professional ideology in the 21st century. The Prison Journal, 81, 313-338.

Cullen, F. & Gilbert, K. (1982) The Rise of Rehabilitation. Reaffirming Rehabilitation (Chapter 3). Cincinnati: Anderson.

Cullen, F. & Jonson, C. (2012). Correctional Theory in Crisis. Correctional Theory Context and Consequences (23-36). Thousand Oaks: Sage Publications.

Dowden, C., & Andrews, D. (2004). The importance of staff practice in delivering effective correctional treatment: A meta-analytic review of core correctional practices. International Journal of Offender Therapy and Comparative Criminology, 48, 203-214.

Gendreau, P., Goggin, C., & Smith, P. (1999). The forgotten issue in effective correctional treatment: Program implementation. International Journal of Offender Therapy and Comparative Criminology, 43, 180-187.

Kennealy, P., Skeem, J., Manchak, S., & Eno Louden, J. (2012). Firm, fair, and caring officer-offender relationships protect against supervision failure. Law and Human Behavior (in press).

Latessa, E. (2004). The challenge of change: Correctional programs and evidence-based practices. Criminology & Public Policy, 3, 547-560.

Latessa, E. (2004) From Theory to Practice: What works in reducing recidivism? State of Crime andJustice in Ohio.

Latessa, E. & Lowenkamp, C. (2005). Community Corrections: Research and Best Practices. What are criminogenic needs and why are they important? Ohio Judicial Conference.

Lerch, M., Viglione, M., Eley, E,. James-Andrews, S., & Taxman, F. (2011). Organizational readiness in corrections. Federal Probation, 75, 5-10.

Lowenkamp, C., Hubbard, D., Makarios, M., & Latessa, E. (2009) A quais-experimental evaluation of thinking for a change. A real world application. Criminal Justice and Behavior, 36, 137-146.

Lowenkamp, C., & Latessa, E. (2005). Increasing the effectiveness of correctional programming through the risk principle: identifying offenders for residential placement. Criminology & Public Policy, 4, 263-289.

Lowenkamp, C., Pealer, J., Smith, P., & Latessa, E. (2006) Adhering to the risk and need principles: Does it matter for supervision-based programs? Federal Probation, 70, 3-8.

Lurigio, A. (2011). Examining prevailing beliefs about people with serious mental illness in the criminal justice system. Federal Probation, 75, 11-18.

Martinson, R. (1974). What works?-questions and answers about prison reform. Public Interest, 35, 22- 54.

Mackenzie, D. (2000). Evidence-based corrections: Identifying "what works". Crime and Delinquency, 46, 457-471.

Morgan, R., Fisher, W., Duan, N., Mandracchia, J., & Murray, D. (2010). Prevalence of criminal thinking among state prison inmates with serious mental illness. Law of Human Behavior, 34, 324-336.

Paparozzi, M. & Gendreau, P. (2005). An intensive supervision program that worked: Service delivery, professional orientation, and organizational supportiveness. The Prison Journal, 85, 445-466.

Pew Charitable Trusts. (2008). One in 100: Behind bars in America 2008.

Robinson, C., VanBenschoten, S., Alexander, M., & Lowenkamp, C. (2011). A random (almost) study of staff training aimed at reducing re-arrest (STARR): Reducing recidivism through intentional design. Federal Probation, 75, 57- 63.

Rotter, M. & Carr, W. (2011). Targeting criminal recidivism in mentally ill offenders: structured clinical approaches. Community Mental Health Journal, 47, 723-726.

Skeem, J., Emke-Francis, P., & Eno Louden, j. (2006) Probation, mental health, and mandated treatment. A national survey. Criminal Justice and Behavior, 33, 158-184.

Skeem, J., Eno Louden, J., Polaschek, D., & Camp, J. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. Psychological Assessment, 19, 397-410.

Skeem, J., & Manchak, S. (2008). Back to the future: From Klockars' model of effective supervision to evidence-based practice in probation. Journal of Offender Rehabilitation, 47, 220-227.

Skeem, J., Manchak, S., & Peterson, J. (2011) Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. Law of Human Behavior, 35, 110-126.

Taxman, F. (2002). Supervision: Exploring the dimensions of effectiveness. Federal Probation, 66, 14-27.

Whetzel, J., Paparozzi, M., Alexander, M., & Lowenkamp, C. (2011). Goodbye to a worn-out dichotomy: Law enforcement, social work, and a balanced approach (A survey of federal probation officer attitudes). Federal Probation, 75, 7-12.