

# *The Criminologist*

The Official Newsletter of the American Society of Criminology

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**Editor's Note:** Once again, your ASC colleagues are bringing you an issue of *the Criminologist* filled with current information, challenging ideas, suggestions for action, and overviews of parts of the field that may be new to you. I continue to be overwhelmed by the "corner" editors and essay authors who are so knowledgeable and who take the time to share their expertise with all of us! A prime example of that is this issue's lead article, in which Art Lurigio fills us in on current evidence about the criminalization of the mentally ill in the US. Also, please don't fail to take a look at the letter from Alvin W. Cohn, who tells us what the ASC and *the Criminologist* were like 38 years ago. Featured articles by Howard Snyder, Charles Wellford and Ed Maguire let us know what's happening with the National Crime Statistics Exchange (NCS-X), and with the new government relations effort of the ASC and the ACJS. Ed Muñoz gives us a thought-provoking essay based on *Gang Life in Two Cities: An Insider's Journey*, by Robert Durán. The corner editors, Jay Albanese (Criminology around the World), Charisse Coston (Teaching Tips) and Bianca Bersani (Doctoral Student Forum) outdo themselves this issue. And we can always depend on the ASC Policy Committee and the journal editors to let us know the latest. Please join me in thanking these people for bringing you an issue that you can really sink your teeth into.

By ASC policy, it is the Vice-President who edits *the Criminologist*, and at the November meeting, our new Vice-President, Karen Heimer, will take office. That means that Karen will become the new editor of *the Criminologist*. I want to wish her, and the new Associate Editor, Susan Sharp, all the best in 2014. I also want to tell 2013 authors, editors and ASC staff that it has been an honor and a privilege – and a lot of fun – to be able to work with you this year. I learned a lot. Thank you all. Karen and Susan – enjoy the experience!

Carolyn Rebecca Block, Editor, *the Criminologist*

## **CRIMINALIZATION of the MENTALLY ILL Exploring Causes and Current Evidence in the United States**

**Arthur J. Lurigio, Loyola University Chicago<sup>1</sup>**

In the early 1970s, Dr. Marc Abramson, a jail psychiatrist in California, was the first to report in the scholarly literature that people with serious mental illnesses (PSMI) (e.g., schizophrenia, bipolar disorder, major depression) were being criminalized: being processed through the criminal justice system instead of the mental health system (Abramson, 1972). Since that time, studies have suggested that the mentally ill are arrested and incarcerated at levels that exceed both their representation in the general population and their tendency to commit serious crimes (Council of State Governments [CSG], 2002; Teplin, Abram, & McClelland, 1996). Estimates suggest that 14% of offenders (more than one million people) in the criminal justice system in the United States suffer from serious mental illnesses (Fazel & Danesh, 2002). This phenomenon has come to be known as the "criminalization" of the mentally ill.

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## UPCOMING CONFERENCES AND WORKSHOPS

For a complete listing see [www.asc41.com/caw.html](http://www.asc41.com/caw.html)

**IV ANNUAL CONFERENCE OF THE VICTIMOLOGY SOCIETY OF SERBIA** *Victims and contemporary responses to crime: between protection and misuse*, November, 28 – 29, 2013 Belgrade, Serbia. For more information, visit [www.vds.org.rs](http://www.vds.org.rs) or contact: [infovds@eunet.rs](mailto:infovds@eunet.rs).

**3rd INTERNATIONAL CONFERENCE ON NANOTEK AND EXPO**, December 2 - 4, 2013, Hampton Inn Tropicana, Las Vegas, NV. For more information, visit <http://www.omicsgroup.com/conferences/nanotek-nanotechnology-2013/>.

**5th INTERNATIONAL SYMPOSIUM ON TERRORISM AND TRANSNATIONAL CRIME (USAS 2013)**, December 6 - 8, 2013, Antalya, Turkey. For more information, visit <http://www.utsam.org/>.

**1st ANNUAL INTERNATIONAL CONFERENCE ON FORENSIC SCIENCE & CRIMINALISTICS RESEARCH (FSCR 2013)**, December 9 -10, 2013, Hotel Fort Canning, Singapore. For more information, visit <http://forensi-conf.org/>.

**THE 28th ANNUAL SAN DIEGO INTERNATIONAL CONFERENCE ON CHILD AND FAMILY MALTREATMENT**, January 26 - 27, 2014 (Preconference Institutes/Trainings), January 28 - 31, 2014 (San Diego Conference), Sheraton San Diego Hotel and Marina, San Diego, CA. For more information for questions or learning more about the conference, visit <http://www.sandiegoconference.org/>, contact [sdconference@rchsd.org](mailto:sdconference@rchsd.org) or phone (858) 966-7972.

**INTERNATIONAL POLICE EXECUTIVE SYMPOSIUM 24th ANNUAL MEETING**, March 16 - 21, 2014, Trivandrum (Kerala), India, Theme: "Policing by Consent: Theoretical Problems and Operational Issues".

**THE SOCIETY FOR PREVENTION RESEARCH (SPR) 2014 ANNUAL MEETING**, May 27 - 30, 2014, Washington, D.C. Theme: Comprehensive and Coordinated Prevention Systems: Building Partnerships and Transcending Boundaries. Conference website: <http://www.preventionresearch.org/>

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Criminalization of the mentally ill arose from a confluence of factors in our country, which appeared in the decades around the time of Abramson's seminal paper. Among these factors were the deinstitutionalization of PSMI, which depopulated state hospitals; more stringent commitment laws, which prohibited the involuntary hospitalization of PSMI unless they were deemed an imminent threat to themselves or others; and the failed community mental health movement, which never established a comprehensive infrastructure of care for psychiatric patients released from state hospitals (Grob, 1991).

The criminal courts have become the instrumentality for the mandatory treatment of people with substance use and psychiatric disorders and their comorbidities. Similarly, jails and prisons have become the leading sites for the delivery of behavioral healthcare services (Council of State Governments, 2002). Mental health courts for the treatment of PSMI have burgeoned since the creation of drug courts. Such courts are predicated on the philosophy of therapeutic jurisprudence and use a team approach to address the multiplicity and complexity of clients' problems. However, the effectiveness of mental health courts and other programs for criminally involved PSMI is still being investigated (Epperson, Canada, & Lurigio, 2013).

This essay examines four common beliefs about the criminalization of PSMI – that criminally involved PSMI are a homogeneous group, that deinstitutionalization is responsible for the purported increase of PSMI in correctional populations, that treatment is the key to reducing crime and recidivism among criminally involved PSMI, and that the enforcement of drug laws has contributed to the growing numbers of PSMI in the criminal justice system.

### **Heterogeneity of PSMI**

Although many people believe that criminally involved PSMI are a homogeneous group, a closer inspection of their characteristics and pathways into the criminal justice system proves otherwise. PSMI can enter the criminal justice system through criminalization and standard criminal justice processing. Criminalization occurs only when PSMI are arrested for displaying the signs and symptoms of serious mental illness, especially in public. They are typically arrested for public-order violations that stem not from a criminal intent to harm others but from an uncontrollable expression of signs and symptoms of mental illness. These arrests usually are for public order offenses (e.g., disorderly conduct, minor property damage, and trespassing) that arise mostly from psychiatric symptoms (e.g., auditory hallucinations, delusions, and impaired executive function), from intoxication, or from the combination thereof, rather than from intentional or deliberate threats to others or their property. Specific examples of such "offenses" include shouting obscenities in a restaurant for no apparent reason; engaging in heated arguments with unseen, imaginary enemies on a busy street corner; and urinating while a passenger on a bus. The mentally ill who exhibit these types of behaviors have no criminal intent and, thus, would be better served in a hospital than in a police lockup. Under such circumstances, PSMI should be diverted from the criminal justice and into the mental health system where they can receive treatment in an emergency room, drop-in center, or community mental health facility.

Instances of true criminalization occur when PSMI are arrested and punished instead of treated for public manifestations of severe mental illness. Nonetheless, if PSMI commit serious crimes (e.g., violent felonies, such battery or sexual abuse), whether prompted by their symptoms or not, their behaviors warrant processing through the criminal justice system (Rotter, Larkin & Schare, 1999). Most individuals, including PSMI who are charged with felony crimes, usually are ineligible for diversion programs (Epperson, Canada, & Lurigio, 2013). Therefore, their entry into the criminal justice system does not constitute actual criminalization (Lurigio & Rodriguez, 2004).

Heightened awareness of the problem of PSMI in the criminal justice system has resulted in a flurry of legal, policy, and programmatic initiatives at the federal, state, and local levels. Such actions include the implementation of diversionary police (crisis intervention teams) and court (misdemeanor bond courts) programs, all of which probably have decreased the chances of the mentally ill being criminalized (CSG, 2002; National Institute of Corrections [NIC], 2009). Indeed, recent estimates suggest no more than 10% of the PSMI who enter the criminal justice system are there because of criminalization (Claypoole, Laygo, & Cristiani, 2006).

Research has found that the police are no more likely to arrest PSMI than non-PSMI for similar types of behaviors (Engel & Silver, 2001). Furthermore, the criminalization of the seriously mentally ill rarely leads to a prison sentence, which can be imposed for only felony convictions, not for public-order crimes, misdemeanors, or ordinance violations. For example, in Chicago, the overwhelming majority of PSMI in jail, on specialized probation, or under mental health court supervision had been arrested for felonies (Lurigio, 2004). Nevertheless, PSMI can still be criminalized when contacts with the police are mishandled and end in charges for assaulting a police officer or when aggressive public-order policing initiatives sweep into the court or jail people who are homeless, publicly intoxicated, or panhandling (Lurigio, Snowden, & Watson, 2006).

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Other distinctions among criminally involved PSMI include differences with respect to psychiatric symptoms and treatment needs as well as the risk of crime, violence, and recidivism. Nearly 30 years ago, using a longitudinal research design and archival analyses, I studied a large sample of PSMI released from state hospitals in Chicago and found that an appreciable subsample were engaged (presently and historically) in criminal activities for a variety of reasons and at varying levels of frequency and seriousness. The data revealed a typology of arrested PSMI: 40% were criminalized (i.e., arrested for disorderly, symptom-driven conduct); 28% were arrested for low-level survival crimes (e.g., shoplifting, prostitution, selling small amounts of drugs); and 30% were arrested for serious crimes (e.g., burglary, robbery, battery) (Lewis & Lurigio, 1994). Many of the former patients in the third group had served prison sentences. Other studies have reported similar typologies, underscoring the diversity of criminally involved PSMI (Hiday, 1999; Hartwell, 2004).

### **Deinstitutionalization and Crime**

The second common belief is that deinstitutionalization is responsible for the purported increase of PSMI in correctional populations. This belief is partially true. Deinstitutionalization began in the mid-1950s with the advent of psychotropic medications. The downsizing of hospitals was hastened by the passage of federal entitlement laws that shifted costs for psychiatric care from the states to the federal government and led to trans-institutionalization—the placement of PSMI in nursing homes, institutes of mental diseases, and board-and-care facilities (Lurigio, & Harris, 2007). The lack of community-based care sent floods of PSMI into the streets, often without treatment or housing. Deinstitutionalization coincided with an unprecedented 30-year rise in crime and punishment, the war on drugs, and the disintegration of urban communities—all of which became a recipe for the escalating numbers of the mentally ill entering the criminal justice system (Lurigio & Swartz, 2000).

The prison explosion came 25 years after deinstitutionalization. Although changes in mental health and correctional policies overlapped, they were not coterminous or causally related as the literature has suggested. Furthermore, the notion that patients simply moved *en bloc* from the hospital to the jail is based on the faulty assumption that these patients had serious criminal propensities. The broadening criminalization of PSMI was probably less dramatic than discussions have suggested. For example, the earliest cohorts released from the state hospital were at low risk for crime (e.g., they were more likely to be comprised of older, middle class, and female patients than were later cohorts). These former psychiatric patients were destined to spend many years in nursing homes and homeless shelters rather than in prisons and jails. Growth in the proportion of PSMI in the criminal justice system was to be expected, given the general rise in the numbers of people under correctional supervision as well as the rise of those defined in the general population as psychiatrically disabled (Draine, Wilson, & Pogorzelski, 2007; Fazel & Danesh, 2002).

During the 1960s, the mental health system became bifurcated, with greater racial and economic disparities between public and private hospital populations. The population of the former became significantly poorer, younger, male, drug-using, and from crime-infested communities (Lurigio & Swartz, 2000). Hence, PSMI released from state hospitals in the 1970s had higher arrest rates than did members of the general population. The increase in arrest rates upon patients' release from state psychiatric hospitals was due to changes in their demographic characteristics and their origination from criminogenic neighborhoods. Their increasing estrangement from family members and greater use of illicit drugs were also risk factors for criminal involvement and arrest. Previous generations of those released from state hospitals had similar or lower arrest rates than did members of the general population (Lewis & Lurigio, 1994). Moreover, state patient cohorts in the 1970s began to accumulate arrest histories that led to more future arrests and greater penetration into the criminal justice system (Steadman, Cocozza, & Melick, 1978).

An egregious shortcoming of deinstitutionalization was its failure to treat chronic patients adequately, as these patients are less likely to comply with or respond to medication regimes and are more likely to suffer from intractable social and economic deficits (Shadish, Lurigio, & Lewis, 1989). In other words, the failed transition to community mental health care had the most tragic effects on those patients who were the least able to perform the basic tasks of daily life (Grob, 1991). Public psychiatric hospitals became the primary treatment settings for poor persons, and patients became younger because of the shorter length of hospital stays. These shorter stays were attributable to new medications and changes in hospital policies. Such policies were intended to save money by shifting the costs of care from state to federal budgets. The former paid for hospitalization, whereas the latter paid for community mental health services (Lewis & Lurigio, 1994). Reductions in federal expenditures for social welfare programs in the 1990s left even more PSMI with fewer treatment options or ancillary services for essentials such as food, clothing, shelter, and medical attention (Thomas, 1998). As a tragic result of their persistent economic hardships and political disfranchisement, the chronically mentally ill became a permanent part of the underclass (Auletta, 1982; Thomas, 1998).

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The commonalities between the patient and arrestee populations were based less on shared mental illness and more on similar demographic characteristics and environments, which are correlates of criminal involvement (Fisher, Sliver, & Wolff, 2006). PSMI have been over-represented among the poorest populations in the United States. Furthermore, severe mental illness can cause people to drift down the socioeconomic ladder because of the disabling effects of brain diseases, which undermine their educational and employment success. Continued exposure to violence and poverty can precipitate or exacerbate psychiatric symptoms among people already predisposed to them (Fisher et al., 2006).

In short, unlike earlier generations of state mental patients, those hospitalized since the 1970s have been more likely to have criminal histories, to misuse drugs and alcohol, and to tax the capacities of families and friends to care for their needs (Lurigio & Swartz, 2000). Therefore, the characteristics of the mentally ill have begun to resemble those of people involved in the criminal justice system; they are increasingly poor, young, and estranged from the community (Steadman, Cocozza, & Melick, 1978).

### **Treatment and Crime Reduction**

Related to the preceding point, the third common belief is that treatment is the key to reducing crime and recidivism among criminally involved PSMI. Contemporary thinking on the issue is evolving and reflective of recent research on the relationship between crime and severe mental illness (Skeem, Manchak, & Peterson, 2010). No clear pathogenesis has ever been established between severe mental illness and criminal predilections or actions. In fact, individuals with schizophrenia are at a lower risk for the commission of crimes as the result of negative symptoms and cognitive impairments. Furthermore, individuals with depression lack the energy, concentration, motivation, and agency to commit crimes. Although bipolar disorder can elevate the risk of committing a crime (during a manic phase) because the disorder shares transcendent features with criminality—namely, impulsivity and behavioral dysregulation—for those with no criminal history or intention, the display of recklessness during a manic episode is not indicative of criminality (Lurigio, 2011).

As suggested above, mental illness alone generally does not cause criminal behaviors; therefore, the treatment of mental illness alone cannot be expected to reduce criminal behavior and recidivism. In particular, research has shown that the provision of evidence-based mental health services has no effect on criminal justice outcomes (e.g., Clark, Ricketts, & McHugo, 1999), nor is the paucity of such services correlated with a growth in local correctional populations (e.g., Erickson, Rosenheck, Trestment, Ford, & Desai, 2008; Geller, Fisher, Wirth-Cahon, & Simon, 1990).

Psychiatric treatment is a necessary, but not a sufficient, condition for the prevention of crime and violence. Notwithstanding the weak relationship between psychiatric treatment and criminal behavior, such interventions can cause PSMI to become more stable and more amenable to evidence-based programming that attend to criminogenic needs. The “Big 8” risk factors (Andrews, Bonta, & Wormith, 2006) (e.g., criminal thinking, educational and employment failure, substance use disorder, antisocial associates, lack of prosocial leisure pursuits) enhance criminal propensities among PSMI and non-PSMI. These problems must be alleviated in order to lower crime and recidivism rates (Skeem, Nicholson, & Kregg, 2008). Thus, psychiatric treatment alone is unlikely to reduce criminal risk in the absence of changes in these other factors (Fisher et al., 2006).

The criminal justice system has moral, legal, and ethical obligations to provide mental health services to PSMI in jails and prisons and those on probation and parole supervision. PSMI who commit low-level crimes and public order violations should be diverted from punishment and confinement, placed into care, and protected from victimization. In addition, treatments that alleviate psychiatric symptoms could render PSMI more amenable to interventions that focus on the primary correlates of crime and recidivism and that are steeped in core correctional practices (Skeem & Manchak, 2011).

### **Co-Occurring Disorders**

The fourth common belief is that the enforcement of drug laws has contributed to the growing numbers of PSMI in the criminal justice system. Much evidence supports this belief. Since the late 1980s, individuals convicted of drug-law violations have been among the fastest-growing subgroups of the correctional population in the United States (Beck, 2000). A high proportion of PSMI have co-occurring substance use disorders. Co-occurrence is the expectation not the exception among PSMI in the general population and especially among those in correctional populations (Lurigio, 2009).

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Substance use is common among arrestees. For example, in Chicago, at least 70% of the detainees in the Cook County Jail test positive for one or more illicit substances (Office of National Drug Control Policy [ONDCP], 2013). Research in the jail also has shown that a large proportion of detainees who are currently abusing and dependent on drugs have histories of psychiatric illnesses and vice versa (Swartz & Lurigio, 1999). Drug use among PSMI and non-PSMI populations is a crime accelerator. The possession of drugs is the gateway through which a substantial number of PSMI enter the criminal justice system. Specifically, the majority of those convicted have comorbid psychiatric and substance use disorders, which has increased the presence of mentally ill offenders in the nation's criminal justice system (Lurigio, 2004; Swartz & Lurigio, 1999).

Like dolphins among tuna, many mentally ill and drug-using persons have been caught in the net of rigorous drug enforcement policies (Lurigio & Swartz, 2000). Several studies have shown that PSMI who use illicit drugs are more prone to violence and more likely to be arrested and incarcerated than PSMI who do not (Clear, Byrne, & Dvoskin, 1993; Swanson, Estroff, Swartz, Borum, Lachinotte, Zimmer, & Wagner, 1997; Swartz, Swanson, Hiday, Borum, Wagner, & Burns, 1998). Hence, the vigorous enforcement of drug laws and harsh sentences for those convicted of violating drug laws, as well as the high rate of comorbidity between drug use and psychiatric disorders, can partially explain the large numbers of PSMI in the nation's jails and prisons. Unfortunately, fragmented drug and psychiatric treatment programs fail to provide fully integrated care for persons with co-occurring disorders, which compounds their problems in both areas and elevates their risk for arrest and incarceration (Lurigio & Swartz, 2000).

## Summary

PSMI in the criminal justice system are a diverse group. The criminalization of this population has appeared to decline. Deinstitutionalization was a contributing, but not a determining, force behind the purported increase of PSMI in the criminal justice system. Shared demographic characteristics and criminogenic environments account for the intersection between the mentally ill and criminally involved, and people with severe mental illness can also be criminally inclined as these are not mutually exclusive categories. Criminogenic needs explain criminal behavior among both the PSMI and non-PSMI populations. Because mental illness alone generally does not cause criminal behaviors, the treatment of mental illness alone cannot be expected to reduce criminal behavior and recidivism. However, treatments that alleviate psychiatric symptoms could render PSMI more amenable to interventions that focus on the primary correlates of crime and recidivism and that are steeped in core correctional practices. Finally, much evidence supports the common belief that the enforcement of drug laws has contributed to the growing numbers of PSMI in the criminal justice system. High rates of co-occurring psychiatric and substance use disorders are critical variables in explaining the representation of PSMI at every point of interception in the criminal justice process.

PSMIs in the criminal justice system present many challenges to mental health and criminal justice professionals. The care of the mentally ill in court and correctional settings must be improved in at least four general areas.

- The first lies in our ability to construct and administer more efficient and precise tools and strategies for screening and assessing psychiatric disorders, which will enhance our ability to keep pace with the steady and often torrential flow of PSMIs entering our courts, jails, and prisons.
- The second lies in our ability to adopt treatment approaches that are expressly designed to respond to the complex and multifarious problems that afflict criminally involved PSMIs.
- The third lies in our ability to create and support legislation that will allocate the necessary dollars to fund adequately the services that are needed to respond to the mental health needs of criminally involved PSMIs (e.g., the Law Enforcement and Mental Health Project Bill).
- The fourth lies in our ability to study and evaluate what works most effectively in treating the problems of PSMIs in the criminal justice system. We must use methodological and statistical skills to identify and refine evidence-based practices for treating the mentally ill in the criminal justice system.

## References

- Abramson, M.F. (1972). The criminalization of mentally disordered behavior: Possible side-effect of a new mental health law. *Hospital and Community Psychiatry*, 23, 101-107.
- Andrews, D., Bonta, L., & Wormith, J.S. (2006). The recent past and new future of risk and/or need assessment. *Crime and Delinquency*, 52, 7-27.
- Auletta, K. (1982). *The underclass*. New York: Random House.
- Beck, A.J. (2000). *Prisoners in 1999*. Washington, DC: Bureau of Statistics.
- Clark, R., Ricketts, S., & McHugo, G. (1999). Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatric Services*, 50, 641-647.

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- Clear, T., Byrne, J., & Dvoskin, J. (1993). The transition from being an inmate: Discharge planning, parole and community-based services for offenders with mental illness. In H. J. Steadman & J.J. Coccozza (Eds.) *Mental Illness in America's prisons* (pp. 47-63). Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System.
- Council of State Governments (2002). Criminal Justice/Mental Health Consensus Project. New York: Author.
- Draine, J., Wilson, A., & Pogorzelski, W. (2007). Limitations and potential in current research on services for people with mental illness in the criminal justice system. *Journal of Offender Rehabilitation*, 45, 159-177.
- Engel, R.S., & Silver, E. (2001). Policing mentally disordered suspects: A reexamination of the criminalization hypothesis. *Criminology*, 39, 225-252.
- Epperson, M.W., Canada, K.E., & Lurigio, A.J. (2013). Mental health court: One approach for addressing the problems of persons with serious mental illnesses in the criminal justice system. In J. B. Helfgott (Ed.), *Criminal psychology* (pp. 367-392). Haverhill MA: Praeger Press.
- Erickson, S., Rosenheck, R., Trestment, R., Ford, J., & Desai, R. (2008). Risk of incarceration between cohorts of veterans with and without mental illness discharged from inpatient units. *Psychiatric Services*, 59, 178-183.
- Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet*, 359, 545-550.
- Fisher, W. H., Silver, E., & Wolff, N. (2006). Beyond criminalization: Toward a criminologically-informed mental health policy and services research. *Administration and Policy in Mental Health and Mental Health Services Research*, 33, 544-557.
- Geller, J.L., Fisher, W.H., Wirth-Cahon, J.L., & Simon, L.J. (1990). Second-generation deinstitutionalization I: Brewster v. Dukakis's impact on state hospital care mix. *American Journal of Psychiatry*, 147, 982-987.
- Grob, G.N. (1991). *From asylum to community: Mental health policy in modern America*. Princeton, NJ: Princeton University Press.
- Hartwell S.W. (2004). Comparison of offenders with mental illness only and offenders with dual diagnoses. *Psychiatric Services*, 55, 145-50.
- Hiday, V. A. (1999). Mental illness and the criminal justice system. In A. Horwitz & T. Scheid (Eds.), *The handbook for the study of mental health: Social contexts, theories, and systems* (pp. 508-525). Cambridge, MA: Cambridge University Press.
- Lewis, D. A., Lurigio, A. J., & others (1994). *The state mental patient and urban life: Moving in and out of the institution*. Springfield, IL: Charles C. Thomas.
- Lurigio, A.J. (2009). Comorbidity. In Nancy A. Piotrowski (Ed.), *Encyclopedia of psychology and mental health* (pp. 439-442). Pasadena, CA: Salem Press.
- Lurigio, A.J. (2011, September). *Responding to the needs of people with mental illness in the criminal justice system: An area ripe for research and community partnerships*. Keynote address presented at the annual meeting of the Midwest Criminal Justice Association. Chicago, IL.
- Lurigio, A. J. (2004). *Transinstitutionalization and the mentally ill in the criminal justice system*. Lecture presented at the Corrections and Public Health Task Force Steering Committee Meeting. Cook County Department of Corrections, Chicago, IL.
- Lurigio, A.J., & Harris, A. (2007). The mentally ill in the criminal justice system: An overview of historical causes and suggested remedies. *Professional Issues in Criminal Justice*, 2, 145-169.
- Lurigio, A. J., & Rodriguez, P. (2004, April). *A court system's approach to responding to the mentally ill*. Paper presented at the annual Mental Health in Corrections Consortium, Kansas City, MO.
- Lurigio, A.J., Snowden, J., & Watson, A. (2006). Police handling of the mentally ill: Historical and research perspectives. *Law Enforcement Executive Forum*, 6, 87-110.
- Lurigio, A. J., & Swartz, J. A. (2000). Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness. In J. Horney (Ed.), *NIJ 2000 Series: Policies, processes, and decisions of the criminal justice system* (Volume 3) (pp. 45-108). Washington, DC: National Institute of Justice.
- National Institute of Corrections (2009). Mentally ill persons on corrections. Retrieved May 15, 2013. <http://nicic.gov/MentalIllness>.
- Office of National Drug Control Policy (2013). *Arrestee Drug Abuse Monitoring Program II (ADAM II): 2012 annual report*. Washington, DC: Author.
- Rotter, M., Larkin, S., Schare, M., et al. (1999). *The clinical impact of doing time: Mental illness and incarceration*. Albany, NY: Research Foundation for Mental Hygiene.
- Shadish, W. R., Lurigio, A. J., & Lewis, D. A. (1989). After deinstitutionalization: The present and future of mental health long-term care policy. *Journal of Social Issues*, 45, 1-15.
- Skeem, J., Manchak, S., & Peterson, J. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior*, 35, 110-126.
- Skeem, J., Nicholson, E. & Kregg, C. (2008, March). Understanding barriers to re-entry for parolees with mental illness. *Mentally disordered offenders: A special population requiring special attention*. Symposium held at the Annual Meeting of the American Psychology-Law Society.

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- Steadman, H., Coccozaa, J., & Melick, M. F. (1978). Explaining the increased arrest rate among mental patients: The changing clientele of state hospitals. *American Journal of Psychiatry*, 35, 816-820.
- Swanson, J., Estroff, S., Swartz, M., Borum, R., Lachiotte, W., Zimmer, C., & Wagner, R. (1997). Violence and severe mental disorder in clinical and community populations: The effects of psychotic symptoms, comorbidity, and lack of treatment. *Psychiatry*, 60, 1-22.
- Swartz, J. A., & Lurigio, A. J. (1999). Psychiatric illness and comorbidity among adult male jail detainees in drug treatment. *Psychiatric Services*, 50, 1628-1630.
- Swartz, M. S., Swanson, J. W., Hiday, V. A., Borum, R., Wagner, R., & Burns, B. J. (1998). Violence and severe mental illness: The effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry*, 155, 226-231.
- Teplin, L., Abram, K., McClelland, G. (1996). Prevalence of psychiatric disorders among incarcerated women: Pretrial detainees. *Archives of General Psychiatry*, 53, 500-512.
- Thomas, T. (1998). Ronald Reagan and the commitment of the mentally ill: Capital, interest groups, and the eclipse of social policy. *Electronic Journal of Sociology*, 003.004, 1-13. ([www.sociology.org](http://www.sociology.org)).

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