

THE IMPACT OF SEVERE MENTAL ILLNESS ON PAROLE DECISIONS

Social Integration Within a Prison Setting

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This study examined the extent to which severe mental illness (SMI) affects parole release decisions either directly or indirectly through its association with other factors considered in the parole release decision-making process. A random sample of 407 inmates with parole release decisions in 2007 (200 with SMI and 207 without SMI) was selected from the New Jersey State Parole Board. Data on inmates' program participation, misconduct, and job assignments while incarcerated along with levels of community support and other pertinent release factors were collected. Differences between the SMI and non-SMI groups as well as the relationships among study variables, SMI, and release decisions were examined. Findings indicate that persons with SMI were released to parole at a rate similar to that of persons without SMI. However, the presence of SMI was associated with disciplinary infractions while incarcerated, which in turn negatively affected parole release decisions. Policy implications are discussed.

Keywords: severe mental illness; parole; social integration; prison behavior; prison programs

Parole—the conditional release of prisoners—operates in 30 states in the United States. The parole release decision-making process is based on a statutory or administrative determination of eligibility as well as a subsequent assessment of risk to public safety. This process generally includes consideration of an inmate's chances of remaining crime-free in the community, based on assessment of a number of pertinent risk factors for criminal behavior and recidivism (Bonta, 2002, p. 18; Heilbrun, 1997) encompassing many life domains, including the mental and emotional health of inmates. These latter clinical factors are often included in assessments for parole release regardless of research showing that mental health status, in itself, has little relation to long-term criminal recidivism (Bonta, Law, & Hanson, 1998; Gendreau, Little, & Goggin, 1996; Quinsey, Harris, Rice, & Cormier, 1998). Despite the weak relationship between mental health and recidivism, inmates with mental illness tend to fare worse in risk assessments (Carroll, Weiner, Coates, Galegher, &

AUTHORS' NOTE: *This research was supported by Grant H133-B03-1109 for the University of Pennsylvania Collaborative on Community Integration of Individuals With Psychiatric Disabilities (RRTC) from the National Institute on Disability and Rehabilitation Research (Salzer, principal investigator). Correspondence concerning this article should be addressed to Jason Matejkowski, School of Social Policy and Practice, University of Pennsylvania, 3815 Walnut Street, Philadelphia, PA 19104-6179; e-mail: matejkow@sp2.upenn.edu.*

CRIMINAL JUSTICE AND BEHAVIOR, Vol. 37 No. 9, September 2010 1005-1029

DOI: 10.1177/0093854810372898

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Alibrio, 1982; Hannah-Moffat, 2004) and are less likely to be paroled than inmates without mental illness (Feder, 1994; Fields, 2006; Hannah-Moffat, 2004), extending their time behind bars (Ditton, 1999; Porporino & Motiuk, 1995).

Stigma associated with mental illness may explain why a parole board would deny parole on the basis of mental health status. Link and Phelan (2001) describe stigma as occurring when individuals are labeled as different and when these differences are undesirable and serve to separate labeled from nonlabeled individuals conceptually and through discriminatory practices that place labeled individuals in less favorable circumstances. In general, the public perceives persons with mental illness as dangerous (Link, 2008; Rabkin, 1980). Research on how persons with mental illness are portrayed in newspapers, film, and children's programs consistently shows that such persons are portrayed as violent and, thus, to be reacted to with fear (Signorielli, 1989; Wahl, 1992; Wahl, Hanrahan, Karl, Lasher, & Swaye, 2007; Wahl, Wood, & Richards, 2002; Wahl, Wood, Zaveri, Drapalski, & Mann, 2003). Indeed, research has suggested that mental illness is seen as a predictor of violent behavior among potential parolees (Hannah-Moffat, 2004) and an indicator of inability to comply with parole supervision requirements (Carroll et al., 1982). That is, stigma associated with psychiatric disabilities and, in this case, perceptions of dangerousness and instability may result in denial of parole.

Although Feder (1994) attributed parole denial to "differential treatment" (p. 408) of mentally ill inmates (i.e., inmates who had a psychiatric hospitalization while incarcerated), it is possible that other variables associated with mental illness, along with the presence of mental illness itself, increases assessed risk. Mental illness affects many domains of social functioning considered in parole release decisions (Factors Considered at Parole Hearings, 2005), including supportive social networks (Albert, Becker, McCrone, & Thornicroft, 1998; Furukawa, Harai, Hirai, Kitamura, & Takahashi, 1999; Link, Cullen, Frank, & Wozniak, 1987), employment (Anthony & Blanch, 1987; Mueser, Salyers, & Mueser, 2001), institutional misconduct (Toch & Adams, 1986), and housing (Martell, Rosner, & Harmon, 1995; Michaels, Zoloth, Alcabes, Braslow, & Safyer, 1992). Thus, having a mental illness may have a cumulative negative impact on an inmate's parole eligibility, reducing his or her chances of being granted parole above and beyond concerns about mental or emotional health alone.

Research on the social functioning and integration of persons with mental illness in the community has often highlighted discrimination and stigma (Link, 2008; Link et al., 1987; Satcher, 1999; Stuart, 2006), low employment and treatment participation (Kessler et al., 2001; Messias, Eaton, Nestadt, Bienvenu, & Samuels, 2007; Mueser et al., 2001), and impoverished social networks (Albert et al., 1998). Such research also has provided mixed evidence of the potential for violence (Bonta et al., 1998; Link, Andrews, & Cullen, 1992; Monahan, 1992; Mulvey, 1994) among persons with mental illness, and it is relevant to understanding the mechanisms through which mental illness influences the assessment of risk and parole release decisions. The current study used these indicators, couched within a social integration framework (Wong & Solomon, 2002), to examine how factors that have been shown to be characteristic of this population's participation in the community may or may not translate to the prison setting and, in turn, affect how inmates with the most debilitating forms of mental illness (severe mental illness [SMI]) are evaluated with regard to parole.

SMI, defined for this study, refers to a clinical diagnosis of a major mood or psychotic disorder (i.e., mania, bipolar or mood disorder not otherwise specified (NOS), major depression, schizophrenia, schizoaffective disorder, or psychotic disorder NOS). The diagnoses used in

this study are presented in mental health parole evaluations that are conducted on all inmates in New Jersey—as well as in other states—prior to their parole release hearing. The results of these evaluations are readily available to parole board members as part of every inmate's case file. This diagnostic criterion alone has been used extensively in the literature to define serious mental illness or SMI (e.g., McAlpine & Mechanic, 2000; Swanson et al., 2002; Wolff, Maschi, & Bjerklie, 2004) and indicates a high level of interference with social and occupational functioning. In addition, SMI diagnoses include those in which perceptions of unpredictability and dangerousness to others predominate (Crisp, Gelder, Goddard, & Meltzer, 2005). Thus, this definition, which is based on an easily accessible and visible indicator of psychiatric pathology, allows for a strong test of whether differential treatment (Feder, 1994) of inmates with mental illness continues to play a role in the parole release decision-making process. The definition, by focusing on the most debilitating forms of mental illness, also allows for testing of whether social performance intervenes between SMI and parole release decisions.

The goal of the study was to test whether indicators of social integration mediate the relationship between SMI and release decisions. The study targeted three primary questions for inquiry: (a) To what extent is SMI related to release decisions? (b) To what extent do prisoners with SMI differ from other prisoners in their degree of participation in work and programming, rates of institutional misconduct while incarcerated, and social network characteristics just prior to their parole release hearings? (c) To what extent are these factors related to parole release decisions? Identifying specific factors that are negatively affected by an inmate's mental health status allows the prison system to strategically address the needs of its mentally ill prisoners. Targeting existing resources to these areas may safely reduce prison populations and promote the successful integration of mentally ill inmates back into the community via discretionary parole.

The following review uses a definition of social integration that includes a social network and a social interaction dimension as a framework to present research examining network (i.e., size of social networks) and interactional (i.e., involvement in work, education, and negative interactions) dimensions among persons with SMI in the community. Parallel indicators of these social integration dimensions within the prison setting are offered, and hypotheses among SMI, these indicators, and parole release decisions are presented.

SOCIAL INTEGRATION

Social integration, as defined by Wong and Solomon (2002), consists of two dimensions: an interactional and a social network component. The interactional component of social integration is defined as “the extent to which an individual engages in social interactions with community members that are culturally normative both in quantity and quality, and that take place within normative contexts” (Wong & Solomon, 2002, p. 18). This dimension of social integration is characterized by participation in social activities that are available in an individual's environment. In the prison environment, then, social integration would be characterized by participation with other inmates in work and rehabilitation programs and avoidance of disciplinary infractions that restrict social contact. The network dimension of social integration includes an adequately sized network of persons from whom one can receive and provide various kinds of support (Wong & Solomon, 2002). These

personal supports can be crucial for obtaining employment, housing, and social services during an inmate's transition from prison to the community (Wolff & Draine, 2004). In the community, people with SMI tend to fare worse on both the interactional and network dimensions of social integration. However, little is known about whether these social patterns persist for persons with SMI while in prison and how this social integration may influence the release decisions of a parole board that takes into consideration factors reflecting the network and interactional dimensions of social integration.

SOCIAL NETWORKS AND RELEASE DECISIONS

The network dimension of social integration refers to the group of people with whom individuals interact (termed a *social network*). Social networks tend to be smaller among persons with a wide range of mental illnesses (Albert et al., 1998; Furukawa et al., 1999) and are more likely to include relatives, other mental health consumers, and mental health professionals than are networks of persons without a psychiatric disability (Albert et al., 1998; Froland, Brodsky, Olson, & Stewart, 2000; Goering et al., 1992; Macdonald, Hayes, & Baglioni, 2000; Meeks & Murrell, 1994). As a result, many persons with mental illness feel isolated and lack desired relationships with community members (Perese & Wolf, 2005). For example, community studies have shown persons with SMI are less likely to get married (Dickerson et al., 2004) and persons with more broadly defined forms of mental illness are more likely to get divorced (Kessler, Walters, & Forthofer, 1998) than persons without mental illness. Among those incarcerated, inmates with a mental illness were more likely to victimize a relative or intimate relation compared to a non-mentally ill offender (Ditton, 1999), possibly leading to increased dissolution of familial relationships among inmates with a mental illness. As a result, inmates with SMI may have fewer people in the community from whom they can access needed resources to ease their transition from prison than inmates without SMI. As the parole board under study considers sources of support in the community in their release decisions (Factors Considered at Parole Hearings, 2005), the social isolation typical of many persons with SMI may hinder their release to parole. In addition to negative associations with network size, SMI may be related to lower levels of social interactions and higher levels of negative interactions in the prison setting.

SOCIAL INTERACTIONS AND RELEASE DECISIONS

Institutional misconduct and release decisions. Although only a small percentage of persons with mental illness are violent, community studies have found that the presence of SMI is associated with characteristics and behaviors that have been implicated in an increased risk of violent behavior (Link et al., 1992; Monahan, 1992; Mulvey, 1994; Swanson, Holzer, Ganju, & Jono, 1990). These factors can include delusional or psychotic symptoms (e.g., Fresan et al., 2005; Hodgins, Hiscoke, & Freese, 2003; Nordström, Dahlgren, & Kullgren, 2006; Swanson et al., 2006; Teasdale, Silver, & Monahan, 2006), substance use (e.g., Fulwiler, Grossman, Forbes, & Ruthazer, 1997; Langevin, Paitich, Orchard, Handy, & Russon, 1982; Monahan et al., 2001), homelessness (Swanson et al., 2002), and lack of treatment adherence (Swanson et al., 1997).

The potential for violent behavior by persons with mental illness may be exhibited in prison as well, particularly given that many receive no or minimal mental health treatment

while incarcerated (Human Rights Watch, 2003). In addition, a lack of training for correctional officers on how to respond to inmates exhibiting symptoms of mental illness may lead to stressful or negative interactions between correctional officers and inmates that end in violence (Callahan, 2004; Parker, 2009). Inmates with mental illness generally have shown higher rates of disciplinary infractions than inmates without mental illness (Adams, 1986; Ditton, 1999; Feder, 1994; Jemelka, Lovell, & Wilson, 1996, as cited by Lovell & Jemelka, 1996; D. W. Morgan, Edwards, & Faulkner, 1993; Toch, Adams, & Grant, 1989), and the severity of infractions appears to increase with the severity of mental illness (Toch & Adams, 1986). Therefore, we expected parole-eligible inmates with SMI in this study to have higher rates of disciplinary infractions while incarcerated than similarly situated offenders without SMI. As New Jersey parole granting authorities take into consideration an inmate's disciplinary history while incarcerated (Factors Considered at Parole Hearings, 2005), prisoners with SMI may be less likely than others to be approved for parole. Higher rates of disciplinary infractions among mentally ill inmates may also negate the opportunity to participate in institutional programming (Jemelka, Trupin, & Chiles, 1989), further reducing chances at parole.

Program participation and release decisions. When considering whether to release an inmate to parole supervision, a parole board will consider an inmate's participation in institutional programming aimed at reducing problems that have been identified as likely contributing to his or her incarceration (Factors Considered at Parole Hearings, 2005). Although there may be overlap with regard to the areas in need of attention with inmates who do not have a mental illness (Bonta et al., 1998), inmates with SMI may require additional training in activities of daily living, psychoeducation aimed at informing inmates about their illness and the need to comply with medication regimes (Human Rights Watch, 2003), and specialized substance abuse treatment programs (Drake & Osher, 1997; Rice & Harris, 1997).

In the community, a majority of persons with mental illness do not seek professional assistance for their disabilities (Kessler et al., 2001; Messias et al., 2007; Regier et al., 1993). Stigma has been identified as an obstacle to seeking treatment (Satcher, 1999), as have practical obstacles, such as insurance, transportation, and time to make a mental health visit (Leaf, Bruce, Tischler, & Holzer, 1987; Takeuchi, Leaf, & Kuo, 1988). Although instrumental factors such as these may be inconsequential behind bars, stigma associated with mental illness does exist and may influence treatment acceptance; program understaffing and prescription of sedative medications also can preclude treatment program participation (Human Rights Watch, 2003).

Past experiences with discrimination in educational institutions in the community may deter inmates with SMI from participating in educational programs while incarcerated. Low educational attainment has been well documented among persons with mental illness (Kessler, Foster, Saunders, & Stang, 1995) and may be attributed, in part, to negative experiences related to their psychiatric conditions while in an academic setting. According to the Substance Abuse and Mental Health Services Administration (SAMHSA),

Grade-school children with serious emotional disturbances have the highest rates of school failure because of the discrimination and stigma associated with these disorders. Fifty percent of these students drop out of high school, compared to 30 percent of all students with disabilities. The situation gets worse as the students get older. (SAMHSA's ADS Center, 2007)

As among the general public, students with mental illnesses are reacted to with fear and social distance by their peers (Beltran, Scanlan, Hancock, & Lockett, 2007; Chung, Chen, & Liu, 2001; Martin, Pescosolido, Olafsdottir, & McLeod, 2007; Mukherjee, Fialho, Wijetunge, Checinski, & Surgenor, 2002) and teachers (Amada, 1986; Becker, Martin, Wajeeh, Ward, & Shern, 2002; DiPietro & Wolf, 1992; Javed et al., 2006). Becker and colleagues (2002) report on research that suggests that at the college level, psychiatric symptoms have been cited as grounds for dismissal even when the student was performing adequately (p. 360), indicating further that discrimination in educational settings can occur at all levels. The possibility that these past negative experiences would deter inmates with SMI from pursuing educational programs while incarcerated is reflected in the expectation that inmates with SMI would have lower levels of educational program participation while incarcerated than inmates without SMI.

In addition, older-generation medications are often used in prison settings as a cost-saving measure (Baillargeon, Black, Contreras, Grady, & Pulvino, 2001; Koson, 1998). The effects of these medications, such as oversedation and tardive dyskinesia, can result in lower program participation, and an inmate's avoidance of these medications can lead to exacerbation of symptoms that interfere with program participation (e.g., avolition) or can result in disciplinary infractions, which, again, may interfere with program participation. As such, it was expected that inmates with SMI would have lower levels of overall participation in institutional programming than inmates without SMI and that this, in turn, would be associated with unfavorable parole release decisions.

Work participation and release decisions. Although many desire employment (Macias, DeCarlo, Wang, Frey, & Barreira, 2001; Rogers, Walsh, Masotta, & Danley, 1991), employment rates among persons with SMI in the community are much lower than those among persons without SMI (Ridgway & Rapp, 1999). Research has shown the employment rate to be less than 15% among this population (Anthony & Blanch, 1987; Mueser et al., 2001). Stigma attached to persons with mental illness is the most common factor cited for low employment rates (Stuart, 2006); employers are often reluctant to hire an individual who they know has a psychiatric disability (Manning & White, 1995; Scheid, 1999; Spitzmueller & Angell, 2009). In prison, however, these circumstances are likely to differ, given the meaning assigned to work within these confines.

Keeping inmates busy and occupied in meaningful pursuits during their incarceration contributes to the ease with which a correctional facility is run. Prison administrators usually attempt to keep inmates occupied in education programs, working at menial jobs, or involved in some type of job training program (Batchelder & Pippert, 2002, p. 269).

In New Jersey, inmates are assigned work unless jobs are unavailable or a medical condition prohibits it; refusal to work results in disciplinary charges (Exceptions; Time in Custody; Failure to Work, 2008). As such, work participation among inmates with SMI is likely not to differ from those inmates without SMI with regard to time "unemployed." However, as inmates with SMI may be more susceptible to accumulating punishment from disciplinary charges and sent to segregation units (where job assignments are likely to change), job turnover among this population may be high. This turnover may preclude the development of valuable job skills that could be obtained from more stable work tenure. Given that the development and implementation of such skills are taken into consideration in parole release decisions (Factors Considered at Parole Hearings, 2005), inmates with mental illness may be at a significant disadvantage for being paroled.

HYPOTHESES

On the basis of the review, it was expected that many of the characteristics and behaviors that are common to persons with mental illness in the community would persevere in the prison setting. To summarize, it was hypothesized that the negative relationship between SMI and parole release would be mediated by indicators of social integration within the prison setting: (a) Inmates with SMI will less likely be granted parole than inmates without SMI. (b) Inmates with SMI will display higher rates of disciplinary infractions and job turnover and lower program participation and less adequate social networks. (c) These factors will predict negative parole release decisions. We expect these relationships to hold when controlling for other factors that have been shown to have an impact on parole release decisions, such as incarceration length, severity of current offense, and criminal history (Caplan, 2007) as well as offender demographics that have been controlled for in prior research on parole release decisions (e.g., Feder, 1994; K. D. Morgan & Smith, 2005), including age (Huebner & Bynum, 2006), gender (Hannah-Moffat, 2004), race (Bynum & Paternoster, 1984; Myers, 1993; Petersilia, 1985), education (Feder, 1994; Proctor, 1999), and marital status (Morgan & Smith, 2005).

METHOD

PARTICIPANTS

The sampling frame for this study was provided by the New Jersey State Parole Board's Information System (PBIS). Data were collected from inmate case files and New Jersey State Parole Board and Department of Corrections administrative databases. PBIS provided a list of all New Jersey inmates who had parole release decisions in 2007. Each of these 11,181 cases was assigned a unique random number, and this sampling frame was sorted in ascending order based on this number. Inmate case files were then screened sequentially, as listed in this randomly sorted sampling frame, to identify parolees with and without SMI. The resulting study sample includes the first 200 inmates who screened positive for SMI and the first 207 inmates who screened negative for SMI.

The authors received approval for this study from the University of Pennsylvania institutional review board.

To allow results from this stratified sample to reflect the total population of inmates receiving a parole decision during the study period, we weighted each sample case according to its probability of inclusion in the sample. The weights were created by calculating the sampling fraction of both inmates with and without SMI. The inverse of this probability, normalized to sum to the sample size of 407, was taken as the weight for each case in the study sample. Results contain weighted percentages for categorical variables and weighted means and standard deviations for continuous variables.

MEASURES: STUDY VARIABLES

SMI. A mental health parole evaluation (MHPE) is completed by a trained mental health clinician (i.e., PsyD, PhD, or LSW) for every inmate typically within 3 months prior to his or her parole release hearing (median number of days between most current MHPE and parole hearing was 77). The evaluation includes assessments of an inmate's current mental

TABLE 1: Diagnoses Counts and Percentages of Parole-Eligible Inmates With Severe Mental Illness

<i>Disorder</i>	<i>n</i>	<i>%</i>
Mood disorders		6.0
Bipolar disorder	74	3.0
Major depressive disorder	57	2.3
Mood disorder NOS	15	0.6
Psychotic disorders		2.7
Schizoaffective disorder	28	1.1
Psychotic disorder NOS	22	0.9
Schizophrenia	17	0.7

Note. Percentages based on screening of 2,447 inmates. More than one diagnosis per inmate possible. NOS = not otherwise specified.

health status, persons from whom the inmate can receive support following release, risk for reoffending, and summaries of substance abuse, mental health, and history of compliance with community supervision. Included in the MHPE are multi-axial diagnoses for parolees with mental illness. Results of the MHPE are included in all inmates' case files, regardless of mental health status. In addition, the most recent copy of the inmate's electronic medical record (EMR) from the New Jersey Department of Corrections (NJDOC) provides a list of all medical problems with accompanying International Classification of Diseases (ICD) or *Diagnostic and Statistical Manual of Mental Disorders* codes, medications currently prescribed, medical directives (e.g., orders to be seen monthly in a chronic care clinic), and work restrictions. The EMR is included in all inmates' case files and is typically updated within 3 months prior to the release hearing (median number of days between most current EMR and parole hearing was 79). The presence in either the MHPE or EMR of a current or historical diagnosis of schizophrenia, schizoaffective disorder, psychotic disorder NOS, major depression, mania, or bipolar or mood disorder NOS was used to identify inmates with SMI. Inmates without any record of a current or historical diagnosis of SMI in both the MHPE and the EMR were identified as the comparison group. According to risk assessments conducted at the time of the MHPE, 75% of inmates identified as having SMI were receiving mental health treatment at the time of their evaluation, whereas only 5% of inmates identified as not having an SMI were receiving some form of mental health treatment.

The screening of inmate case files identified 8.1% of parole-eligible inmates as meeting the criteria for SMI. With the exception of lower rates of major depression among male inmates in this study, prevalence rates are comparable to those others have reported (Fazel & Danesh, 2002; Haney, 2006). Table 1 provides a breakdown of psychiatric diagnoses among the individuals in the SMI group. Bipolar disorder was the most frequent diagnosis, and mood disorders overall were more common than psychotic disorders. The most common psychotic disorder was schizoaffective disorder.

Incarceration length, program participation, work history, disciplinary infractions. Although used as a control variable in the current study, length of incarceration is described here to explain how program participation, work history, and disciplinary infraction rates were calculated. Length of incarceration was calculated from data provided by PBIS and was defined as the time between the dates an inmate began serving time for the offense(s) for

which he or she is being considered for parole and the identified (2007) parole hearing date. Information on inmates' program participation, work history, and disciplinary infractions while incarcerated was collected from the NJDOC's inmate management system (iTag). Activities while incarcerated that were analyzed for this study included those that occurred during an inmate's length of incarceration.

Program participation data included referral date, start date, completion status, and indication of program type according to mutually exclusive NJDOC categories: therapeutic (e.g., anger management, substance abuse treatment), academic (e.g., general equivalency diploma [GED], Adult Basic Education), enrichment (e.g., financial life skills, parenting skills), vocational, religious, or college. Average numbers of program types that each inmate was referred to, that each inmate started, and that each inmate completed are reported. Total number of programs referred to, started, and completed annually was calculated by summing all programs, regardless of type, that an inmate was referred to, had started, and had completed and then dividing each value by length of incarceration. This rate controlled for an inmate's opportunity to participate in programs given his or her time served in prison.

The NJDOC categorizes disciplinary infractions as *nonasterisk*, *asterisk*, or *violent asterisk* charges. Nonasterisk charges include offenses such as smoking where prohibited, refusing a work assignment, or tattooing. Asterisk charges are considered more severe than nonasterisk charges and include offenses such as escape and use of drugs. Examples of violent asterisk charges include assault and threatening with bodily harm. Counts of total disciplinary charges while incarcerated (including nonasterisk, asterisk, and violent asterisk charges) were divided by an inmate's number of years of incarceration prior to his or her release hearing to provide annual total infraction rates for each inmate. Annual rates of asterisk charges and annual rates of violent asterisk charges were also calculated in a similar manner.

Data were collected on all inmates' work history during their incarceration along with the type of job, rate of pay, and length in each job. As all inmates were employed during their length of incarceration, per NJDOC protocol, unemployment rates could not be analyzed. Analyses are limited here to the annual rate of job turnover as indicated by the number of job details an inmate had during his or her length of incarceration divided by length of incarceration.

Social network. Each inmate's MHPE provided clinician evaluations of an inmate's sources of support in the community or planned residence that indicated sources of support (e.g., plans to live with a spouse). These assessments identified people (e.g., family members, friends) that the inmate could rely on for support in transitioning back to the community. Two of the authors performed a content analysis of these comments to categorize whether each offender's social network contained family members (other than a spouse or partner), a spouse or partner, and other members (e.g., Alcoholics Anonymous sponsor, friends). The two authors independently coded comments as indicating the absence or presence of each of the three types of network members. Results were compared (with more than 95% initial agreement on all three categories), and discrepancies were reconciled through an open discussion process to make the final determination of a specific type of community support. In addition, to assess the adequacy of inmates' social networks, data

were collected on whether inmates had a residence to which they could return or, instead, needed to rely on parole to locate a shelter in which to reside after release (termed a *placement*). Case summary sheets served as the source of data on whether the inmate would require placement after release to parole. A board hearing officer completes case summary sheets while conducting a preliminary review of the inmate's case. The purpose of the review is to evaluate whether the inmate meets the appropriate standard for parole release.

MEASURES: CONTROL VARIABLES

Current offense information. Information on inmates' current offense(s) was collected from PBIS and the presentence investigation reports (PSI) related to the offense(s) for which the inmate was currently incarcerated. PBIS provided the offense name, counts of offense, and offense degree, categorized 1 to 5, with a first-degree offense being the most serious and a fifth-degree offense the least serious (termed a *disorderly person offense* in New Jersey). An inmate's number of current offenses refers to the total number of counts of charges for which the inmate was incarcerated. Severity of offense was dichotomized as less severe than a second-degree offense or either a first- or second-degree offense. Crimes were also categorized as either nonviolent or violent. Violent offenses included crimes and attempted crimes that involved an assault (e.g., manslaughter, rape, simple assault) or threatened assault (e.g., terroristic threats, armed robbery, carjacking). The analysis also used information from the offender's PSI to identify whether any crime for which the inmate was currently incarcerated was perpetrated on a victim (e.g., a drug or vice crime). Data from PBIS were used to identify whether the current offense(s) were committed while under community supervision (i.e., a probation or parole violation).

Criminal history. Criminal history data were collected via NJDOC's iTag system and the state parole board's case summary sheets. Case summary sheets provided a count of prior adult convictions and a count of juvenile adjudications. The iTAG system provided a no-yes indicator of whether the inmate had a sex offense history, history of escape from a correctional facility, or history of gang involvement.

Risk assessment. The New Jersey State Parole Board uses the Level of Service Inventory-Revised (LSI-R; Andrews & Bonta, 1995) to assess risk for recidivism among potential parolees. The LSI-R is administered by the same trained clinicians who complete the MHPE and scores individuals' risk in many life domains, including criminal history, leisure and recreation, and alcohol or drug problems. LSI-R scores (higher score indicates higher risk) were collected for each inmate. The LSI-R has been shown to be a reliable risk assessment tool ($\alpha = .77$) and a significant predictor of reconviction among the New Jersey community corrections population (Schlager, 2005).

Demographics. Age at time of hearing, gender, and race were provided via PBIS. PBIS uses mutually exclusive categories to identify race. The categories in the sample included White, Black, Asian, and Hispanic. Marital status was collected from iTAG in five mutually exclusive categories: single (never married), widowed, separated, divorced, and married. Education level was provided by the MHPE completed prior to each parole hearing. Education level was dichotomized as less than a high school graduate or high school graduate (including GED) or higher.

ANALYSES

Analyses compared study and control variables between those persons with and without SMI. These bivariate comparisons used *t* tests for continuous variables and chi-square tests for categorical variables. Using logistic regression, we examined the effect of SMI on parole release decisions in the presence of control variables. Separate multivariate analyses were then conducted to examine the impact of SMI (independent variable) on each of the variables significant in the bivariate analyses (dependent variables). We used linear regression for continuous factors and logistic regression for categorical dependent variables. These models controlled for all other characteristics that were statistically significant at the .05 level in the bivariate analyses. We then conducted logistic regression to assess relations among study and control variables and parole release decision.

RESULTS

PARTICIPANT DEMOGRAPHICS

Table 2 compares demographic and other control variables among inmates with and without mental illness. Inmates with SMI were slightly older at the time of their parole hearing and more likely to be female and White than inmates without SMI. Although female inmates made up only 9% of the total study sample, females composed nearly a quarter of the SMI group. A significantly higher percentage of persons with SMI were currently incarcerated and eligible for parole for a crime that involved a victim and that included some form of violence, compared with persons without SMI. Persons with SMI received higher risk assessment scores prior to their parole hearings. This finding was attributable, in most part, to inmates with SMI who scored significantly higher on two items assessing past and present mental health treatment (both at $p < .001$) and two items assessing moderate and severe interference in ability to function attributable to psychiatric problems (both at $p < .01$). To a lesser extent, inmates with SMI had significantly higher rates of reliance on social assistance and medical problems attributable to substance abuse (both at $p < .05$).

BIVARIATE ANALYSES

Inmates with SMI were not granted parole at lower rates than non-mentally ill inmates. Approximately half the inmates from both groups received favorable release decisions (see Table 3). There were no statistically significant differences between the inmates with and without SMI with regard to any measure of level of community support. Both groups had substantial support from family members who could assist in transitioning back to the community. Inmates with SMI had similar levels of support from other members of the community; however, this level was low for both groups.

Contrary to our hypothesis, there were no statistically significant differences between the two groups on any measure of program participation while incarcerated (see Table 3). In general, inmates were referred to between three and three-and-a-half programs annually. Although there is a pattern that inmates with SMI tended to complete a lower proportion of programs they were referred to, completion rates were low for both groups, and the difference in completion rates did not reach statistical significance.

TABLE 2: Cross-Tabs Comparing Personal Variables Among Persons With and Without Severe Mental Illness (SMI)

<i>Variable</i>	<i>With SMI</i>	<i>Without SMI</i>	χ^2	df	p
<i>Age, gender, race-ethnicity</i>					
Age at hearing	36.8 (9.8)	33.0 (9.0)	-2.3(<i>t</i>)	405	0.020
% Male	75.8	92.7	11.1	1	0.001
% Black	42.4	59.9	3.8	1	0.051
% Hispanic	12.1	23.3	2.2	1	0.141
% White	42.4	16.0	14.2	1	<0.001
<i>Education</i>					
% High school graduate or higher	53.3	50.3	0.1	1	0.748
<i>Marital status</i>					
% Married	3.0	3.5	<0.1	1	1.0-F
% Widowed	0.0	1.3	0.4	1	1.0-F
% Divorced	12.1	6.7	1.4	1	0.278-F
% Separated	3.0	1.1	1.0	1	0.346-F
% Never married	72.7	79.1	0.7	1	0.389
Missing marital status	6.1	8.3	0.2	1	1.0-F
<i>Criminal history</i>					
Number of prior adult convictions	8.5 (7.7)	6.9 (7.4)	-1.2(<i>t</i>)	399	0.235
Number of prior adjudications	1.5 (2.9)	2.3 (3.0)	1.3(<i>t</i>)	397	0.180
% Prior sex offense	12.1	9.1	0.3	1	0.533-F
% History of escape	12.1	13.1	<0.1	1	1.0-F
% Known gang member	6.1	18.8	3.4	1	0.067
<i>Current offense</i>					
Number of offenses	2.7 (2.4)	2.6 (4.0)	-0.4(<i>t</i>)	405	0.699
% Violent offense	33.3	18.8	4.0	1	0.045
% Violation of parole or probation	39.4	31.0	1.0	1	0.321
% First- or second-degree offense	27.3	24.1	0.2	1	0.680
% Victim present	63.3	43.3	4.5	1	0.034
<i>Risk assessment score</i>					
LSI-R score	29.4 (6.6)	25.8 (6.0)	-3.2(<i>t</i>)	392	0.001
<i>Length of incarceration</i>					
Years incarcerated at hearing	2.50 (5.40)	2.36 (4.00)	-0.2(<i>t</i>)	405	0.849

Note. F = Fisher's exact test; LSI-R = Level of Service Inventory-Revised (Andrews & Bonta, 1995). Weighted percentages with standard deviations in parentheses are presented for continuous variables.

The hypothesis that inmates with mental illness would have higher rates of disciplinary infractions than inmates without mental illness was partly confirmed. Institutional misconduct overall was slightly higher for inmates with SMI. Given their average length of incarceration, the typical inmate with SMI could expect to be disciplined once for some form of institutional misconduct. The most severe misconduct was more common in the SMI group, with the difference in rates of violent charges reaching statistical significance (see Table 3).

The hypothesis that turnover in job duties would be positively related to SMI was not supported. Although inmates were consistently employed, findings indicate that during their stay, all inmates were assigned approximately nine different jobs annually, indicating no differences in job turnover rate (see Table 3).

TABLE 3: Cross-Tabs and *t* Tests Comparing Inmates With and Without Severe Mental Illness (SMI)

<i>Variable</i>	<i>With SMI</i>	<i>Without SMI</i>	χ^2	df	p
Parole release decision					
% Parole granted	45.5	50.3	0.3	1	.596
Social network					
% Supportive family member	86.7	89.0	0.1	1	.761-F
% Supportive spouse/partner	16.7	28.5	2.0	1	.163
% Supportive others	16.7	14.4	0.1	1	.787-F
% Needs placement	29.0	18.9	1.8	1	.174
	<i>With SMI</i>	<i>Without SMI</i>	t	df	p
Program participation					
Annual rate of all program referrals	3.55 (5.40)	3.06 (4.71)	-0.6	405	.573
Annual rate of all program starts	1.29 (2.78)	1.70 (3.67)	0.6	405	.529
Annual rate of all program completes	0.35 (1.32)	0.61 (1.81)	-0.8	405	.424
Proportion of programs completed among those referred to programs	0.11 (0.24)	0.21 (0.30)	1.7	268	.092
Therapeutic programming					
Total number of referrals	1.18 (1.92)	1.06 (1.78)	-0.4	405	.695
Total number of starts	0.49 (1.12)	0.44 (1.03)	-0.3	405	.788
Total number of completes	0.16 (0.59)	0.15 (0.59)	-0.1	405	.887
Academic programming					
Total number of referrals	0.58 (1.34)	0.62 (1.27)	0.2	405	.853
Total number of starts	0.39 (1.24)	0.53 (1.23)	0.6	405	.554
Total number of completes	0.08 (0.40)	0.16 (0.63)	0.7	405	.505
Enrichment programming					
Total number of referrals	0.29 (0.61)	0.43 (0.91)	0.8	405	.403
Total number of starts	0.13 (0.43)	0.28 (0.58)	1.4	405	.161
Total number of completes	0.08 (0.32)	0.30 (1.45)	0.8	405	.396
Vocational programming					
Total number of referrals	0.93 (1.52)	0.50 (1.30)	-1.8	405	.071
Total number of starts	0.33 (0.87)	0.22 (0.61)	-1.0	405	.330
Total number of completes	0.04 (0.23)	0.09 (0.37)	0.6	405	.523
Religious programming					
Total number of referrals	0.03 (0.26)	0.04 (0.24)	<0.1	405	.933
Total number of starts	0.03 (0.26)	0.02 (0.17)	-0.5	405	.627
Total number of completes	0.00 (0.00)	0.01 (0.10)	0.6	405	.571

(continued)

TABLE 3: (continued)

<i>Variable</i>	<i>With SMI</i>	<i>Without SMI</i>	χ^2	df	p
College programming					
Total number of referrals	0.02 (0.18)	0.03 (0.23)	0.4	405	.735
Total number of starts	0.01 (0.14)	0.02 (0.21)	0.4	405	.701
Total number of completes	0.01 (0.14)	0.01 (0.07)	-0.4	405	.715
Disciplinary charges					
Annual rate of all charges	0.45 (1.07)	0.37 (1.59)	-0.3	403	.763
Annual rate of asterisk charges	0.20 (0.58)	0.12 (0.33)	-1.2	403	.244
Annual rate of violent charges	0.14 (0.53)	0.03 (0.14)	-2.9	403	.004
Work history					
Jobs worked per year	9.12 (9.44)	8.97 (11.27)	<0.1	405	.940

Note. F = Fisher's exact test.

MULTIVARIATE ANALYSES

Model A in Table 4 presents the regression of release decision on SMI along with control variables. The presence of SMI did not significantly predict release decisions. Assessing the direct effect of serious mental illness on parole release decisions can be considered the first step in testing whether risk factors considered in the parole release decision-making process mediate the relationship between mental illness and release decisions (Baron & Kenny, 1986). However, more recent thoughts on the subject of mediation suggest that the absence of a statistically significant relationship between the presence of a serious mental illness and parole release does not preclude testing of mediation (Kenny, 2009; MacKinnon, Krull, & Lockwood, 2000; Shrout & Bolger, 2002). Thus, analyses continued with examination of the relationships among SMI, potential mediators, and release decisions.

Results of regressing each variable that significantly differentiated the two groups in the bivariate analyses along with the other significant variables in the bivariate analyses on SMI indicate that the presence of SMI was associated with an increase in violent infractions while incarcerated, with being a White female, and with higher risk assessment scores (see Table 5).

Model B in Table 4 presents the results of a logistic regression of parole release decision on factors that significantly differentiated the groups of mentally ill and non-mentally ill inmates as well as factors from prior literature that have been shown to affect release decisions, such as severity of current offense, criminal history, and certain offender demographics (Caplan, 2007). A nonsignificant finding from the Hosmer and Lemeshow test indicate that the model has adequate fit to the data, $\chi^2(8, N = 353) = 12.62, p = .13$. Overall, the model correctly predicts nearly 69% of release decisions (69% of those who were released and 69% of those who were denied parole). The variables in this model account for nearly a quarter of the variance in decision to release inmates to parole (Nagelkerke $R^2 = .278$). Findings comport with prior research in that education level, (adult) criminal history, length of incarceration, and (severe) institutional misconduct were all significantly associated with release decisions. However, race, the presence of a mental illness, program participation,

TABLE 4: Logistic Regression Results: Factors Associated With Parole Release

Variable	Model A (n = 355)	Model B (n = 345)
	AOR (p)	AOR (p)
Sociodemographic characteristics		
Severe mental illness	0.726 (.500)	0.899 (.833)
Male	0.447 (.102)	0.405 (.085)
White	1.200 (.596)	0.786 (.516)
Education >12th grade	2.006 (.007)	2.703 (.001)
Age at time of hearing	0.973 (.108)	0.979 (.286)
Years incarcerated	1.136 (.012)	1.115 (.035)
Criminal history		
Number of prior adult convictions	0.954 (.048)	0.937 (.017)
Number of prior juvenile adjudications	0.925 (.081)	0.930 (.143)
Sex offense history	1.022 (.964)	1.320 (.624)
History of escape	0.668 (.294)	0.737 (.453)
Known gang member	0.366 (.003)	0.438 (.022)
Current offense		
Number of offenses	0.747 (<.001)	0.746 (<.001)
Violent offense	0.582 (.188)	0.520 (.136)
Victim present	1.168 (.595)	1.513 (.195)
First- or second-degree offense	0.914 (.798)	0.914 (.805)
Violation of parole or probation	0.683 (.143)	0.789 (.395)
LSI-R score	0.975 (.301)	0.961 (.137)
Social network		
Supportive family member		0.574 (.223)
Supportive spouse/partner		1.423 (.221)
Supportive others		0.600 (.185)
Needs placement		1.292 (.468)
Program participation		
Annual number of program referrals		0.977 (.566)
Annual number of programs started		0.983 (.868)
Annual number of program completed		1.080 (.409)
Institutional misconduct		
Annual disciplinary charges		1.240 (.154)
Annual asterisk charges		0.379 (.035)
Annual violent asterisk charges		1.159 (.854)
Nagelkerke <i>R</i> ²	0.212	0.278

Note. AOR = Adjusted Odds Ratio; LSI-R = Level of Service Inventory–Revised (Andrews & Bonta, 1995).

TABLE 5: Linear and Logistic Regression of Factors Significant in Bivariate Analyses (Dependent Variables) on Severe Mental Illness (SMI; Independent Variable)

Categorical Dependent Variable	SMI		
	AOR	95% CI	p
Male	0.241	0.076, 0.761	.015
White	3.962	1.647, 9.531	.002
Violent offense	1.491	0.530, 4.196	.449
Victim present	1.348	0.496, 3.661	.558
Continuous Dependent Variable	B	95% CI	p
Age at hearing	3.098	−0.329, 6.525	.076
LSI-R score	2.689	0.305, 5.074	.027
Annual rate of violent charges	0.120	0.040, 0.200	.003

Note. AOR = Adjusted Odds Ratio; CI = confidence interval; LSI-R = Level of Service Inventory–Revised (Andrews & Bonta, 1995).

severity of current offense, and risk assessment scores were not significant predictors of release decisions.

The weight of SMI in predicting release decisions was reduced with the addition of hypothesized mediators in Model B compared with Model A, suggesting mediation; however, the lack of relationships among SMI and hypothesized mediators and the relationship between those factors and parole release decisions do not support our mediation hypothesis.

It should be noted that the large number of tests conducted could have resulted in Type I errors. However, on the basis of recommendations of Rothman (1990) and Perneger (1998), Bonferroni adjustments were not made. The reason for this is threefold: First, Bonferroni adjustments are highly conservative, and their application risks missing important differences that exist between the two groups being compared. Second, examining parole release decision making is a complicated endeavor. Even focusing on just a few of the many factors the parole board considers in its release decisions requires the inclusion of numerous relevant variables. The application of Bonferroni adjustments reduces statistical power and would necessitate sample sizes that would make this type of research infeasible. Third, in cases where statistical significance was identified, the effect size was large. The average rate of violent infractions among inmates with SMI while incarcerated was nearly 5 times that of non-mentally ill inmates. In the multivariate analyses, the odds ratio with the smallest magnitude but still identified as significant (number of prior adult convictions; Table 4, Model B) indicated substantial effects of that variable on release decisions. Thus, foregoing alpha adjustments did not result in the identification of trivial effects.

DISCUSSION

The findings indicate that there are few differences between parole-eligible persons with and without SMI among the integration factors assessed. Among study variables, rate of violent disciplinary infractions while incarcerated was the only difference between the two groups. Although the presence of SMI itself accounted for some differences between inmates with and without SMI (i.e., annual rate of violent charges while incarcerated, risk assessment scores, and being a White female), these factors were not significant in predicting parole release decisions. Thus, our hypotheses that the presence of SMI would be related to release decision and that this relationship would be mediated by social integration factors while incarcerated were not supported. Results indicate that release decisions were significantly associated with some of the factors identified in prior research on parole decision making (e.g., criminal history, institutional misconduct); however, several factors shown in the literature to have an impact on early release to parole (e.g., mental illness, age, gender) were not observed to do so in the current study. Given the sampling frame, along with the likelihood that other releasing authorities consider different risk factors or that correctional programming in other areas are more or less developed than those in New Jersey, findings may not generalize to other jurisdictions.

RELEASE DECISIONS

The finding of no significant association between SMI and parole release decisions was most surprising. Prior research examining the impact of mental illness on parole release

decisions has shown enormous detrimental effects of a psychiatric history on release decisions. In a study by Feder (1994), 79% of inmates without a history of psychiatric hospitalization while incarcerated received favorable parole release decisions, whereas only 21% with a psychiatric hospitalization were paroled. Although inmates with SMI in this study were approximately 14% less likely to receive a favorable release decision, this estimate neither neared the effect size found by Feder nor reached statistical significance. It is possible that the more broad definition of mental illness used in the present study, although limited to the severest forms of mental illness, did not signal to the parole board a heightened risk to the community in the same way as Feder's criterion of having had a psychiatric hospitalization during incarceration. Feder's operationalization included an indication of active psychiatric symptoms, whereas ours did not, reflecting a limitation of our study.

A less dramatic effect of mental illness on parole decisions was reported in Hannah-Moffat's (2004) study, which found that 94% of inmates without a mental illness were paroled compared to 71% of inmates with a mental illness. Although the operationalization of mental illness in the Hannah-Moffat study is similar to that in the current study (based on diagnoses, although the diagnoses in Hannah-Moffat were unspecified), the release rates appeared extremely high. It is unlikely that such high release rates would be observed in New Jersey, which has annually paroled approximately 50% of inmates receiving a parole hearing between 2002 and 2006 (Corzine & D'amico, 2007). The high release rates may be related to the fact that the sample in the Hannah-Moffat study included only females. However, although approaching significance, gender did not predict release decisions in the current study.

On the basis of prior research examining parole release decisions (Feder, 1994; K. D. Morgan & Smith, 2005), we controlled for the influence of criminal history, current offense, education, length of incarceration, age, race, and gender. Similar to prior research, indicators of criminal history (Carroll et al., 1982; Proctor, 1999), length of incarceration (Carroll et al., 1982; Turpin-Petrosino, 1999), and educational attainment (Proctor, 1999) were significant predictors of release decisions. Although age (Huebner & Bynum, 2006), gender (Hannah-Moffat, 2004), and race (Petersilia, 1985) of inmates have been suggested to influence release decision, their associations with release decisions in this study were negligible. This result, along with the findings related to psychiatric diagnosis, could reflect a disregard by the parole board of offender characteristics that in the past have been criticized for undue influence in the release decision-making process. As most of the research that prompted inclusion of these variables in the current study was conducted several years ago, it could be that training of parole board members on empirically based risk factors has reduced the influence of offender demographics in parole release decisions.

No measure of community support or program or work participation predicted release decisions, and one indicator of institutional misconduct (annual asterisk charges) predicted release decisions. Taken together with offense and criminal history predictors, this study supports findings by others that have shown release decisions to be most strongly predicted by past criminal behavior and prison infractions, suggesting that assessment of future misconduct of inmates by the parole board is based primarily on indicators of past misconduct (Carroll & Burke, 1990). In addition to parole release decisions, this study aimed to examine the social participation of inmates with SMI while in prison and their levels of community support. These findings and their implications are discussed next.

NETWORK DIMENSION OF SOCIAL INTEGRATION

Prior research has shown that persons with SMI tend to have smaller networks of persons with whom they interact socially than persons without a psychiatric disability (Albert et al., 1998; Furukawa et al., 1999; Link et al., 1987; Macdonald et al., 2000). However, the current study found no statistically significant differences on any measure of social networks reported by inmates with and without mental illness. The finding that 86.7% of inmates with SMI report a family member among their social network is encouraging and supports community studies that suggest that families are highly supportive of persons with SMI (Albert et al., 1998; Froland et al., 2000; Goering et al., 1992; Macdonald et al., 2000). Nonetheless, it appears that the quality or extent of support may vary. For instance, research has shown that many people coming out of prison and jail live, at least initially, with family members or friends (McMurray, 1993) and that families are usually a positive source of support, influencing whether people violate probation or parole (Shapiro, 1999). However, in examining available housing as an indicator of community support (and as an indicator of stable parole plans, which the parole board considers in release decisions), the current study found that almost one third of inmates with SMI will need housing placement services from the parole board. Although not significantly different from non-mentally ill inmates, it suggests that many inmates with SMI will end up in homeless shelters after release from prison. This may reflect the fact that although the friends and families of persons with SMI offer these inmates some forms of support, they may not be as willing to supply housing or shelter. As a result, it is clear that inmates with SMI will face housing problems after release to the community. It should be noted that although housing is an important type of support and indicator of stable parole plans, it is limited in the extent that it can proxy for the myriad types of support network members could offer parolees (e.g., access to employment, financial resources, linkages to formal supports). Future research could examine whether differential access to these types of support exists and whether this access influences parole release decisions.

INTERACTIONAL DIMENSION OF SOCIAL INTEGRATION

Work and program participation. Although inmates with SMI were given work assignments during the duration of their incarceration, it should be noted that the data collected for this study did not measure the extent of an inmate's engagement in work activities. Informal conversations that one of the authors has had with NJDOC inmates with SMI suggest that being assigned a job does not necessarily equate to performing a job. In those informal discussions, some inmates reported that they are rarely called on to perform their assigned job or are assigned tasks, such as cleaning their own cells, that are not supervised and involve no contact with others. As such, the data presented here may overrepresent inmates' work involvement.

Low educational attainment and treatment engagement among persons with SMI in the community suggested that a similar pattern might carry over to the prison setting. In addition, we believed that stigma associated with mental health treatment programs behind bars may also reduce participation in programming. Findings did not support this hypothesis; there were no differences observed in rates of annual program referrals, starts, and completions or in the proportion of programs completed among those referred to programs; however, they

were uniformly low among both groups. Less than a quarter of all inmates participated in any therapeutic, academic, or vocational programming. Among inmates with SMI, fewer than a quarter began a therapeutic program during their average 2.5-year stay in prison. The paucity of therapeutic programming among SMI inmates is surprising, given that this type of program (e.g., anger management, substance abuse counseling) has become more prevalent in prisons at the expense of costlier and lengthier vocational and educational programming (LoBuglio, 2001). This suggests that inmates with SMI leave prison no better equipped to deal with the symptoms and manifestations of their mental illness than when they were originally incarcerated, which does not bode well for a successful community reentry and reintegration.

The finding that so few inmates in both groups participated in academic or vocational programming, at rates lower than those reported nationally (Travis, Solomon, & Waul, 2001), is particularly troubling, considering that only half of the inmates in this study had a high school education. This appears to be another missed opportunity for providing inmates with the skills and tools necessary to improve their chances at successful community reintegration and may doubly hinder the transition of inmates with SMI.

Finally, we had suggested that higher rates of prison misconduct among inmates with mental illness may result in lower rates of institutional programming. This did not appear to be the case. Persons with SMI had higher rates of violent disciplinary charges than inmates without mental illness but similar rates of program participation. Given that this study did not evaluate the causal mechanisms between disciplinary infractions and program participation, either promoting or hindering it, future research could examine the extent to which institutional misconduct promotes or deters referral to programs.

Institutional misconduct. Inmates with SMI had higher rates of violent infractions but similar rates of other nonviolent but severe and less severe infractions. Given our focus on the population with the most severe forms of mental illness, results are similar to those reported 20 years earlier that the severity of infractions increases with severity of mental illness (Toch & Adams, 1986). Among inmates with SMI, the rate of committing a violent offense while incarcerated was 3 times higher when the inmate had been incarcerated for a violent offense than when incarcerated for a nonviolent offense (27.3% and 9.1%, respectively), $\chi^2(1, N = 33) = 1.9, p = .17$, suggesting that there is a subgroup of persons with SMI whose violent behavior transcends community and institutional living (Rabkin, 1979). If this subgroup can be identified, it could help the NJDOC and the parole board target scarce programming resources on the most serious and risky offenders. Although it was not possible for us to determine the context of the violent offenses in which inmates with mental illness engaged, it is likely that some of this violence targeted correctional staff during interventions with inmates experiencing a psychiatric crisis. It is likely that improved methods of crisis intervention, along with additional training and education, would lower the incidence of violence among this population.

POLICY IMPLICATIONS

Corrections. Inmates with SMI committed more violent infractions than those without mental illness. The presence of SMI was associated with these violent charges, which in terms of more broadly defined asterisk charges were significantly related to release decisions.

Frequency of institutional misconduct may be considered a static risk factor (i.e., a risk factor that cannot be changed) at the time of parole release hearings in that there is no way to alter the behaviors that have occurred in the past. However, for correctional officials, institutional misconduct can be considered more dynamic in the sense that efforts can be made to prevent these incidents. The NJDOC does offer therapeutic programming that may serve to reduce violent acting out by inmates. Anger management, moral reconnection, and other cognitive behavioral treatment programs are targeted at these types of behaviors. Again, however, referral to and engagement in these therapeutic programs is rare among all inmates. Providing more opportunities, and possibly incentives, for engagement in these programs may reduce incidents of violence behind bars and has the potential to carry over into the community after release.

More training for correctional staff could reduce violent incidents involving inmates with SMI. In the community, crisis intervention teams (CITs) have been developed among many of the nation's police forces to respond to the needs of citizens in a mental health emergency. The purpose of these teams is to reduce arrest and use of force and promote psychiatric referrals for those persons in need. Research suggests that CITs have been effective in achieving these goals (Dupont & Cochran, 2000; Steadman, Deane, Borum, & Morrissey, 2000). The expansion of similar teams in correctional settings could improve interactions between, and reduce injury incurred by, inmates and staff, particularly when responding to inmates in psychiatric crisis.

Parole and reentry. Without formal or informal relationships to obtain support, a high proportion of released mentally ill offenders will quickly be rearrested and returned to the correctional system (Feder, 1991a, 1991b; Jacoby & Kozie-Peak, 1997). Mentally ill offenders released from prison who fail to establish connections with formal support services are likely to decompensate, which in turn will likely result in further criminal behavior (Council of State Governments, 2002; Walsh & Holt, 1999). Parole services can be designed to alter this pattern.

The use of specialized mental health caseloads has been identified as "on the cusp of qualifying as a 'promising practice' in the supervision of parolees with mental illness" (Skeem & Loudon, 2006, p. 340). The limited research on these specialty supervision programs indicates that specially trained parole officers may work with treatment providers or have mental health clinics solely for parolees, may use intermediate sanctions and a therapeutic philosophy, and may reduce short-term recidivism (Skeem & Loudon, 2006). On the other hand, adherence to rigid sanctions for violating treatment requirements may result in increased incarcerations (Veysey, 1996). Technical violations could be viewed as "opportunities to build closer alliances with parolees with SMI and assist them avoiding future, and more serious, problems" (Lurigio, 2001, p. 457). Although the leverage parole officers have with parolees may promote adherence with needed mental health and substance abuse treatment, this leverage must be tempered with consideration of the impact SMI may have on compliance with treatment demands and the availability of community-based services.

CONCLUSION

The findings suggest that inmates with mental illness may not be discriminated against in parole release decisions as much as prior studies have suggested. Moreover, inmates with

mental illness appear to exhibit only a slightly heightened risk for criminal behavior, on the basis of the factors examined. Although inmates with mental illness also appeared to be able to access prison programming at rates similar to those of non-mentally ill inmates, these rates were universally low. Improving access to needed therapeutic, educational, and vocational programs could go a long way in addressing criminogenic needs among inmates both with and without mental illness.

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