

Appendix A. Search Strategy

Literature Search Methods

Electronic Database Searches

The following databases were searched for relevant information:

Name	Date Limits	Platform/Provider
ClinicalTrials.gov	April 30, 2012	www.clinicaltrials.gov
The Cochrane Central Register of Controlled Trials (CENTRAL)	1990 through 2012, Issue 3	www.thecochranelibrary.com
The Cochrane Database of Methodology Reviews (Methodology Reviews)	1990 through 2012, Issue 3	www.thecochranelibrary.com
The Cochrane Database of Systematic Reviews (Cochrane Reviews)	1990 through 2012, Issue 3	www.thecochranelibrary.com
Database of Abstracts of Reviews of Effects (DARE)	1990 through 2012, Issue 3	www.thecochranelibrary.com
EMBASE (Excerpta Medica)	1990 through April 17, 2012	OVID
Health Technology Assessment Database (HTA)	1990 through 2012, Issue 3	www.thecochranelibrary.com
Healthcare Standards Directory (ECRI Institute)	April 18, 2012	www.ecri.org
MEDLINE/PreMEDLINE	1990 through February 20, 2012	OVID
National Criminal Justice Reference Service (NCJRS)	1990 through April 17, 2012	www.ncjrs.gov
ProQuest Criminal Justice	1990 through April 11, 2012	ProQuest
PsycINFO	1990 through April 17, 2012	OVID
PubMed (In-process and Publisher records)	1990 through February 20, 2012	www.pubmed.gov
U.K. National Health Service Economic Evaluation Database (NHS EED)	1990 through 2012, Issue 3	www.thecochranelibrary.com
U.S. National Guideline Clearinghouse™ (NGC)	April 18, 2012	www.ngc.gov

Detailed search strategies are presented below.

Hand Searches of Journal and Nonjournal Literature

Journals and supplements maintained in our collections were routinely reviewed. Nonjournal publications and conference proceedings from professional organizations, private agencies, and government agencies were also screened. Other mechanisms used to retrieve additional relevant information included review of bibliographies/reference lists from peer-reviewed and gray literature. (Gray literature consists of reports, studies, articles, and monographs produced by Federal and local government agencies, private organizations, educational facilities, consulting firms, and corporations. These documents do not appear in the peer-reviewed journal literature.)

Medical Subject Headings (MeSH), Emtree, PsycINFO, and Keywords

The search strategies employed combinations of freetext keywords as well as controlled vocabulary terms including (but not limited to) the concepts shown in the Topic-specific Search Terms table.

Topic-specific search terms

Concept	Controlled Vocabulary	Keywords
Serious mental illness and dual diagnosis	MEDLINE (MeSH)	Affective disorder/s
	Depression/	Bipolar
	Diagnoses dual/	Co-occurring
	Exp mood disorders/	Depression
	Exp schizophrenia and disorders with psychotic features/	Depressive
	Mental disorders/	Dual diagnosis/es
	Mentally ill persons/	Dual disorder/s
		Dually diagnosed
		MDD
		Mental disorder/s
		Mental illness/es
		Mentally disordered
		Mentally ill
		MICA
		Mood disorder/s
		Psychiatric disorder/s
		Psychosis/es
		Psychotic
		Schizoaffective
		Schizophren*
	SMI	
	SPMI	
	EMBASE (EMTREE)	
	((Exp addiction/ OR Exp substance abuse/ AND comorbidity/)	
	Exp mood disorder/	
	Exp psychosis/	
	Mental disease/	
	PsycINFO	
	Dual diagnosis/	
	Exp affective disorders/	
	Exp chronic mental illness/	
	Exp psychosis/	
	Mental disorders/	
	Schizoaffective disorder/	

Concept	Controlled Vocabulary	Keywords
Criminal justice system	<p>MEDLINE Criminals/ Prisoners/ Prisons/</p> <p>EMBASE Offender/ Prison/ Prisoner/</p> <p>PsycINFO Correctional institutions/ Exp criminals/ Incarceration/ Mentally ill offenders/ Prisoners/</p>	Correctional Criminal* Forensic hospital/s Forensic setting/s High secure/ity Incarcerated Incarceration Inmate* Jail* Low secure/ity Medium secure/ity Offender* Parole* Prison/s Prisoner/s Probation*
Re-entry		Discharge planning Reentering Re-entering Reentrance Re-entrance Reentry Re-entry Reintegrating Re-integrating Reintegration Re-integration Releas* Return to society

Concept	Controlled Vocabulary	Keywords
Psychiatric interventions and delivery of services	<p>MEDLINE Case management/ Community mental health services/ Exp forensic psychiatry/ Exp mandatory programs/ Exp medical assistance/ Exp program evaluation/ Exp psychotherapy Exp self-help groups/ Mental health services/ *Psychiatry/ Voluntary programs/</p> <p>EMBASE Case management/ Community based rehabilitation/ OR Community care/ Community program/ Counseling/ Exp psychotherapy/ Forensic psychiatry/ Medicaid/ Medicare/ Mental health service/ Program development/ Psychiatric treatment/ *Psychiatry/ Social psychiatry/ Support group/ Voluntary program/</p>	Aftercare After-care Assertive community treatment Case management Cognitive behavior/al therapy Cognitive behavior/al treatment Cognitive behaviour/al therapy Cognitive behaviour/al treatment Cognitive therapy Community-based program Community-based treatment Complementary Counseling Criminal thinking curricula Critical time intervention Dialectical Forensic psychiatry Group intervention Group support IDDT Integrated dual disorders treatment Intensive community treatment Meditat* Mental health team/s Modified therapeutic community Motivational interviewing Outpatient commitment Outpatient treatment Psychiatric treatment Psychoeducation* Psychotherapy Seeking safety Strengths-based care management Support group/s Trauma informed interventions Trauma recovery and empowerment model Trauma-informed services Treatment alternatives for safer communities

Concept	Controlled Vocabulary	Keywords
Psychiatric interventions and delivery of services (Continued)	PsycINFO Cognitive therapy/ Community mental health centers/ Community mental health services/ Counseling/ Crisis intervention/ Exp *intervention/ Exp case management/ Exp program development/ Exp program evaluation/ Exp psychotherapy/ Forensic psychiatry/ Involuntary treatment/ Medicaid/ OR medicare/ Mental health programs/ Motivational interviewing/ Outpatient commitment/ Outpatient treatment/ *Psychiatry/ Support groups/	<u>Broad terms:</u> Intervention* Medicaid Medical assistance Medical benefits Medicare Program* Rehabilitation Service* Social security disability insurance SSI Supplemental security income Therap* Treatment*

Concept	Controlled Vocabulary	Keywords
Pharmacologic interventions	<p>MEDLINE Anti-anxiety agents/ Antimanic agents/ Antipsychotic agents/ Drug therapy.fs. Drug therapy/ Exp antidepressive agents/ Psychotropic drugs/ Therapeutic use.fs.</p> <p>EMBASE Drug therapy.fs. Drug therapy/ Exp antidepressant agent/ Exp anxiolytic agent/ Exp benzodiazepine derivative/ Exp neuroleptic agent/ Psychopharmacotherapy/ Psychotropic agent/</p> <p>PsycINFO Benzodiazepines/ Drug therapy/ Exp antidepressant drugs/ Exp neuroleptic drugs/</p>	Antidepressant* Anti-depressant/s Antipsychotic* Anti-psychotic/s Benzodiazepine* Drug counseling Drug therapy Drug treatment/s Drug-based Incarceration-based drug treatment Mood stabiliser/s Mood stabilizer/s Pharmacologic* Psychopharmacologic* Psychotropic/s Risperidone Serotonin reuptake inhibitor/s SSRIs Substance abuse treatment

Search Strategies

The strategy below is presented in OVID syntax; the search was simultaneously conducted across EMBASE, MEDLINE, and PsycINFO. A similar strategy was used to search the databases comprising the Cochrane Library, ProQuest Criminal Justice, and NCJRS.

OVID Conventions:

- * = when appearing before a search term requires the term to be a "major" heading
- * = when appearing at the end of a search term signifies truncation (wildcard)
- ADJ*n* = search terms within a specified number (*n*) of words from each other in any order
- exp = "explodes" controlled vocabulary term (e.g., expands search to all more specific related terms in the vocabulary's hierarchy)
- .de. = limit controlled vocabulary heading
- .fs. = floating subheading
- .hw. = limit to heading word
- .md. = type of methodology (PsycINFO)
- .mp. = combined search fields (default if no fields are specified)
- .pt. = publication type
- .ti. = limit to title
- .tw. = limit to title and abstract fields

EMBASE/MEDLINE/PsycINFO: OVID syntax

Set #	Concept	Search Statement
1	Mentally ill population	Mental disease/ OR mental disorders/ OR mentally ill persons/ OR exp chronic mental illness/ OR exp affective disorders/ OR depression/ OR exp mood disorder/ OR exp mood disorders/ OR exp psychosis/ OR schizoaffective disorder/ OR exp schizophrenia and disorders with psychotic features/ OR ((mental* OR psychiatric) ADJ (disorder* OR health OR ill OR illness*)) OR SMI OR SPMI OR (affective ADJ disorder*) OR bipolar OR depress* OR MDD OR (mood ADJ disorder*) OR psychosis OR psychoses OR psychotic OR schizoaffective OR schizophreni*
2	Dually diagnosed population	Diagnosis dual/ OR ((exp addiction/ OR exp substance abuse/) AND comorbidity/) OR dual diagnosis/ OR (co ADJ occurring) OR comorbid* OR (dual* ADJ (diagnos* OR disorder*)) OR MICA.ti,ab.
3	Criminal justice population	Exp criminals/ OR exp correctional institutions/ OR incarceration/ OR offender/ OR exp prison/ OR exp prisons/ OR prisoner/ OR prisoners/ OR correctional OR criminal* OR incarcerat* OR inmate* OR (offender* NOT sex*.ti.) OR high secure OR low secure OR medium secure OR jail* OR parole* OR prison OR prisons OR (prisoner* NOT (political* OR war).ti.) OR probation*
4	Concepts that cover both populations	mentally ill offenders/ OR (forensic ADJ (hospital* OR patients OR setting* OR unit OR units))
5	Psychiatric interventions Subject headings	Exp forensic psychiatry/ OR *psychiatry/ OR psychiatric treatment/ OR exp psychotherapy/ OR cognitive therapy/ OR exp complementary therapies/ OR counseling/ OR exp case management/ OR crisis intervention/ OR *intervention/ OR group intervention/ OR self help/ OR exp self-help groups/ OR self help techniques/ OR social psychiatry/ OR support group/ OR support groups/ OR group intervention/ OR mental health programs/ OR mental health services/ OR motivational interviewing/ OR involuntary treatment/ OR exp mandatory programs/ OR voluntary program/ OR voluntary programs/OR exp program development/ OR exp program evaluation/ OR community based rehabilitation/ OR community care/ OR community mental health centers/ OR community mental health services/ OR community program/ OR outpatient treatment/ OR telepsychiatry/
6	Psychiatric interventions Text words	Aftercare OR after care OR assertive case management OR assertive community treatment OR (case management).ti. OR cognitive therapy OR (cognitive ADJ behav* ADJ (therapy OR treatment)) OR CBT OR (community based).ti. OR community treatment OR complementary OR counseling OR (crisis ADJ intervention ADJ team*) OR critical thinking curricula OR critical time intervention OR dialectical.ti. OR forensic psychiatry OR (group* ADJ (intervention* OR support* OR therapy)) OR (support ADJ group*) OR integrated dual disorders treatment OR IDDT OR (intensive ADJ community ADJ treatment*) OR intensive supervision OR meditat* OR mindfulness based relapse prevention OR modified therapeutic community OR motivational interviewing OR psychoeducation* OR psychotherap* OR psychiatry.ti. OR self help OR seeking safety OR strengths based case management OR trauma informed OR (trauma ADJ recovery ADJ2 empowerment) OR TREM OR outpatient commitment OR outpatient treatment OR (treatment ADJ alternatives ADJ2 safer ADJ communities) OR telemental OR telepsychiatry OR telepsychology OR (intervention* OR program* OR rehabilitat* OR service* OR treat* OR therap*).ti.
7	Pharmacologic interventions Subject headings	Exp anxiolytic agent/ OR exp anticonvulsants/ OR exp anticonvulsive agent/ OR exp anticonvulsive drugs/ OR exp antidepressant agent/ OR exp antidepressive agents/ OR exp antidepressant drugs/ OR anti-anxiety agents/ OR antimanic agents/ OR antipsychotic agents/ OR exp benzodiazepine derivative/ OR benzodiazepines/ OR drug therapy/ OR drug therapy.fs. OR exp neuroleptic agent/ OR exp neuroleptic drugs/ OR psychopharmacotherapy/ OR psychotropic agent/ OR psychotropic drugs/

Set #	Concept	Search Statement
8	Pharmacologic interventions Text words	(drug ADJ (based OR counseling OR therapy OR treatment*)) OR formular* OR medication* OR pharmac* OR psychopharmacologic* OR psychopharmacotherap* OR (substance ADJ abuse ADJ treatment*) OR agonist* OR anticonvulsant* OR anticonvulsive* OR antidepress* OR (anti ADJ depress*) OR antipsychotic* OR (anti ADJ psychotic*) OR benzodiazepine* OR (mood ADJ (stabiliser* OR stabilizer*)) OR psychotropic* OR risperidone OR (serotonin ADJ reuptake ADJ inhibitor*) OR SSRI*
9	Benefits	Exp medical assistance/ OR medicaid OR medicare/ OR medical assistance OR medical benefits OR medicaid OR medicare OR supplemental security income OR SSI OR social security disability insurance
10	Combine intervention and benefits sets	OR/5-9
11	Community re-entry population	Discharge planning OR reentry OR re entry OR reentering OR re entering OR reentrance OR re entrance OR reintegration OR re integration OR releas* OR (return ADJ2 society)
12	Key Question 1	((1 OR 2) AND 3) OR 4) AND 10
13	Key Question 2	((1 OR 2) AND 3) OR 4) AND 11
14	Combine	12 OR 13
15	Limit to english language	limit 14 to english language
16	Limit to journals (excludes dissertations, etc. from PsycINFO)	limit 15 to all journals
17	Limit by publication type	16 NOT (book/ OR edited book OR case report/ OR case reports/ OR comment/ OR conference abstract/ OR conference paper/ OR conference review/ OR editorial/ OR letter/ OR news/ OR note/ OR proceeding/ OR (book OR edited book OR case report OR case reports OR comment OR conference abstract OR conference paper OR conference review OR editorial OR letter OR news OR note OR proceeding).pt. OR ("comment/reply" OR editorial OR letter OR review-book).dt.)
18	Limit by publication date	Limit 17 to yr="1990-Current"
19	Limit to Adults in MEDLINE and EMBASE	18 AND (adolescent/ OR child/ OR infant/ OR (adolescen* OR juvenile* OR teen* OR young* OR youth*).ti.)
20		18 AND (Exp adult/ OR adult.ti.)
21		19 NOT 20
22		18 NOT 21
23		22 use EMEZ
24		22 use MESD
25		23 OR 24
26	Limit to Adults in PsycINFO using Empirical Population Limits	Limit 25 to (childhood <birth to 12 years> or adolescence <13 to 17 years>)
27		Limit 25 to adulthood <18+ years>
28		26 NOT 27
29		25 NOT 28
30		29 use PSYF
31	Total Adult studies sets	25 OR 30

Set #	Concept	Search Statement
32	Limit to studies performed in the United States, Canada, the United Kingdom, Australia, and New Zealand	31 AND (exp africa/ OR exp asia/ OR exp central america/ OR exp eastern hemisphere/ OR exp europe/ OR exp latin america/ OR mexico/ OR exp south america/ OR exp south and central america/ OR (china OR finland OR france OR germany OR india OR iran OR ireland OR italy OR japan OR malaysia OR mexico OR portugal OR singapore OR spain OR sweden OR taiwan OR thailand OR turkey).ti,in.)
33		31 AND (exp united states/ OR exp canada/ OR exp australasia/ OR exp australia/ and new zealand/ OR exp great britain/ OR exp united kingdom/ OR (america* OR united states OR US OR USA OR canada* OR australia OR new zealand OR england OR great britain OR united kingdom OR UK OR wales OR scotland).ti,in.)
34		32 NOT 33
35		31 NOT 34
36	Eliminate overlap	Remove duplicates from 35*

*Note that weeding for desired study types will be done by hand rather than with search limits.

Additional Conventions:

PubMed

[tiab] = limit to title or abstract

Cochrane Library

Menu-driven

ProQuest Criminal Justice

* = truncation character (wildcard)

NEAR/*n* = search terms within a specified number (*n*) of words from each other in any order

[SU] = ProQuest subject heading

[TI] = limit to title

[AB] = limit to abstract

[STYPE] = source type (i.e., scholarly journal)

NCJRS

Menu-driven, thesaurus selections also available

Appendix B. Forms Used for Title, Abstract, and Full-Length Article Review

Table 19. Questions used for title, abstract, and full-length article review

Review Level	Questions	Answer Choices
Title Screening	Does the title of the article address the topic of the report?	Yes
		No
Abstract Screening	Does the abstract meet any of the following exclusion criteria?	Off-topic
		Non- English language
		Not a full length article
		Case report (<5 subjects)
		Study of Children
		None of the above
	Was the study conducted in a country of interest?	Yes
		No
		Unsure
	Is this a nonclinical study (narrative or systematic review) but looks like it might be useful anyway?	Yes
		No
		Unsure
		Clinical study
	Is the study a comparative trial with an independent control group?	Yes
		No
		Unsure
		Not applicable
	Does the study consider the efficacy/effectiveness of a treatment/intervention/program?	Yes
		No
		Unsure
		Not applicable
	Is the study population primarily SMI (schizophrenia, schizoaffective disorder, bipolar disorder, or major depression) with or without a dual diagnosis of substance abuse?	Yes
		No
		Unsure
Not applicable		
Does the study appear to be conducted in one of the CJ settings of interest?	Yes	
	No	
	Unsure	
	Not applicable	
Does the study follow patients for at least 3 months?	Yes	
	No	
	Unsure	
	Not applicable	

Review Level	Questions	Answer Choices
Article Screening	Is the study published in English?	Yes
		No
	Is the study a peer-reviewed full-length article or from an important gray literature agency?	Yes
		No
	Was the study conducted in a country of interest?	Yes
		No
	Is the study population 18 years or older?	Yes
		No
	Is the study population SMI or SMI plus substance abuse/use disorder?	Yes
		No
	Is the study a comparative trial with an independent control group?	Yes
		No
	Does the study include 5 patients per treatment arm?	Yes
		No
	Does the study consider the efficacy/effectiveness of a treatment/intervention/program?	Yes
		No
		Unsure
	If not randomized, does the study use an analytic method (i.e., baseline matching, propensity scoring, etc.) to address selection bias?	Yes
		No
	Does the study appear to be conducted in one of the CJ settings of interest?	Yes
		No
	Does the study follow patients for at least 3 months?	Yes
		No
	Does the study report on at least one mental health outcome?	Yes
		No
	Are subjective outcomes measured using validated instruments?	Yes
		No
	Other reason for exclusion?	Duplicate
		Out of publication date range
		Other (specify)
	Which Key Question does the study answer?	Key Question 1
		Key Question 2
	What is the primary study population?	SMI
		Dual Diagnosed
		Mixed Population

Appendix C. Full-Length Review Excluded Studies

Not a comparative trial with independent control group of interest

Prevention of jail and hospital recidivism among persons with severe mental illness. *Psychiatr Serv* 1999 Nov;50(11):1477-80.

A model prison diversion program. *Psychiatr Serv* 2000 Nov;51(11):1440-2.

Alcock D, White T. Study of the clinical and forensic outcome of admission to a forensic psychiatry day hospital at one, two, and three years. *J Forensic Psychiatry Psychol* 2009;20(1):107-119.

Arnold EM, Stewart JC, McNeece CA. Enhancing services for offenders: the impact on treatment completion. *J Psychoactive Drugs* 2001 Jul-Sep;33(3):255-62. PMID: 11718318

Baillargeon J, Black SA, Contreras S, et al. Anti-depressant prescribing patterns for prison inmates with depressive disorders. *J Affect Disord* 2001 Mar;63(1-3):225-31. PMID: 11246100

Baillargeon J, Penn JV, Knight K, et al. Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorders. *Admin Policy Ment Health* 2010 Jul;37(4):367-74.

Bartels SJ, Teague GB, Drake RE, et al. Substance abuse in schizophrenia: service utilization and costs. *J Nerv Ment Dis* 1993 Apr;181(4):227-32. PMID: 8473874

Boothroyd RA, Poythress NG, McGaha A, et al. The Broward Mental Health Court: process, outcomes, and service utilization. *Int J Law Psychiatry* 2003 Jan-Feb;26(1):55-71.

Citrome L, Volavka J. Pharmacological management of acute and persistent aggression in forensic psychiatry settings. *CNS Drugs* 2011;25(12):1009-1021.

Constantine R, Andel R, Pettila J, et al. Characteristics and experiences of adults with a serious mental illness who were involved in the criminal justice system. *Psychiatr Serv* 2010 May;61(5):451-57.

Cusack KJ, Steadman HJ, Herring AH. Perceived coercion among jail diversion participants in a multisite study. *Psychiatr Serv* 2010 Sep;61(9):911-6. PMID: 20810590

Daniel C, Jackson J, Watkins J. Utility of an intensive behavior therapy unit in a maximum security female prison. *Behav Ther* 2003 Jan;26(1):211-2.

Draine J, Solomon P. Jail recidivism and the intensity of case management services among homeless persons with mental illness leaving jail. *J Psychiatr Law* 1994;22(2):245-61.

Draine J, Solomon P. Threats of incarceration in a psychiatric probation and parole service. *Am J Orthopsychiatry* 2001 Apr;71(2):262-7. PMID: 11347368

Drapalski AL, Youman K, Stuewig J, et al. Gender differences in jail inmates' symptoms of mental illness, treatment history and treatment seeking. *Crim Behav Ment Health* 2009;19(3):193-206. PMID: 19533597

Dvoskin JA, Steadman HJ. "Using intensive case management to reduce violence by mentally ill persons in the community": Correction. *Hosp Community Psychiatry* 1994 Oct;45(10):1004.

Feldman HS. Loxapine succinate as initial treatment of hostile and aggressive schizophrenic criminal offenders. *J Clin Pharmacol* 1982 Aug-Sep;22(8-9):366-70. PMID: 7130427

Felthous AR, Weaver D, Evans R, et al. Assessment of impulsive aggression in patients with severe mental disorders and demonstrated violence: inter-rater reliability of rating instrument. *J Forensic Sci* 2009 Nov;54(6):1470-1474.

Foley TR, Goldenberg EE, Bartley F, et al. The development of a clozapine treatment program for offenders in a correctional mental health prison. *Int J Offender Ther Comp Criminol* 1995;39:353-58.

Friedmann PD, Melnick G, Jiang L, et al. Violent and disruptive behavior among drug-involved prisoners: Relationship with psychiatric symptoms. *Behav Sci Law* 2008;26(4):389-401.

Geelan SD, Campbell MJ, Bartlett A. What happens afterwards? A follow-up study of those diverted from custody to hospital in the first 2.5 years of a metropolitan diversion scheme. *Med Sci Law* 2001 Apr;41(2):122-8. PMID: 11368392

Gilbert AR, Moser LL, Van Dorn RA, et al. Reductions in arrest under assisted outpatient treatment in New York. *Psychiatr Serv* 2010 Oct;61(10):996-9. PMID: 20889637

Godley SH, Finch M, Dougan L, et al. Case management for dually diagnosed individuals involved in the criminal justice system. *J Subst Abuse Treat* 2000 Mar;18(2):137-48. PMID: 10716097

Goodness KR, Renfro NS. Changing a culture: a brief program analysis of a social learning program on a maximum-security forensic unit. *Behav Sci Law* 2002;20(5):495-506. PMID: 12239708

Goss JR, Peterson K, Smith LW, et al. Characteristics of suicide attempts in a large urban jail system with an established suicide prevention program. *Psychiatr Serv* 2002 May;53(5):574-9. PMID: 11986506

Greenberg G, Rosenheck RA, Erickson SK, et al. Criminal justice system involvement among people with schizophrenia. *Community Ment Health J* 2011 Dec;47(6):727-36. PMID: 21113799

Grella CE, Greenwell L, Prendergast M, et al. Diagnostic profiles of offenders in substance abuse treatment programs. *Behav Sci Law* 2008;26(4):369-88.

Gunter TD, Philibert R, Hollenbeck N. Medical and psychiatric problems among men and women in a community corrections residential setting. *Behav Sci Law* 2009 Sep-Oct;27(5):695-711.

Gussak D. Effects of art therapy with prison inmates: a follow-up study. *Arts Psychother* 2006;33(3):188-98.

Gussak D. The effectiveness of art therapy in reducing depression in prison populations. *Int J Offender Ther Comp Criminol* 2007 Aug;51(4):444-60. PMID: 17652148

Heap M. Differences in the progress of discharged and undischarged patients in a medium secure unit: a pilot study. *J Psychiatr Ment Health Nurs* 2003 Oct 1;10(5):534-42.

Heilbrun K, Lawson K, Spier S, et al. Community placement for insanity acquittees: a preliminary study of residential programs and person-situation fit. *Bull Am Acad Psychiatry Law* 1994;22(4):551-60. PMID: 7718928

Herinckx HA, Swart SC, Ama SM, et al. Rearrest and linkage to mental health services among clients of the Clark County mental health court program. *Psychiatr Serv* 2005 Jul;56(7):853-7. PMID: 16020819

Hodgins S, Muller-Isberner R, Freese R, et al. A comparison of general adult and forensic patients with schizophrenia living in the community. *Int J Forensic Ment Health* 2007;6:63-75.

Hodgins S, Tengstrom AN, Eriksson A, et al. A multisite study of community treatment programs for mentally ill offenders with major mental disorders: design, measures, and the forensic sample. *Crim Justice Behav* 2007 Feb;34(2):211-28.

Holcomb WR, Ahr PR. Arrest rates among young adult psychiatric patients treated in inpatient and outpatient settings. *Hosp Community Psychiatry* 1988 Jan;39(1):52-7. PMID: 3338728

Hornsveld RH, Nijman HL. Evaluation of a cognitive-behavioral program for chronically psychotic forensic inpatients. *Int J Law Psychiatry* 2005 May-Jun;28(3):246-54. PMID: 15950282

Humber N, Hayes A, Wright S, et al. A comparative study of forensic and general community psychiatric patients with integrated and parallel models of care in the UK. *J Forensic Psychiatry Psychol* 2011 Apr;22(2):183-202.

Jerrell JM, Ridgely MS. Evaluating changes in symptoms and functioning of dually diagnosed clients in specialized treatment. *Psychiatr Serv* 1995 Mar;46(3):233-8. PMID: 7796208

Johnson J, Hickey S. Arrests and incarcerations after psychosocial program involvement: clubhouse vs. jailhouse. *Psychiatr Rehabil J* 1999;23(1):66-9.

Johnstone P, Zolese G. Systematic review of the effectiveness of planned short hospital stays for mental health care. *BMJ* 1999 May 22;318(7195):1387-90.

Johnson J. Cost-effectiveness of mental health services for persons with a dual diagnosis: A literature review and the CCMHCP. *J Subst Abuse Treat* 2000 Mar;18(2):119-27.

Kamath J, Temporini H, Quarti S, et al. Best practices: disseminating best practices for bipolar disorder treatment in a correctional population. *Psychiatr Serv* 2010 Sep;61(9):865-7.
PMID: 20810582

Kamath J, Temporini HD, Quarti S, et al. Psychiatric use and utility of divalproex sodium in Connecticut prisons. *Int J Offender Ther Comp Criminol* 2008 Jun;52(3):358-70.
PMID: 17893206

Kamath J, Zhang W, Kesten K, et al. Algorithm-driven pharmacological management of bipolar disorder in connecticut prisons. *Int J Offender Ther Comp Criminol* 2011 Nov 24.
PMID: 22116961

Kinzie DJ, Hancey J, Wilson W, et al. Paroxetine and offenders: a pilot study. *Int J Offender Ther Comp Criminol* 1996;40:285-92.

Kleinpeter C, Deschenes EP, Blanks J, et al. Providing recovery services for offenders with co-occurring disorders. *J Dual Diagn* 2006 Dec 18;3(1):59-85.

Kubiak SP, Zeoli AM, Essenmacher L, et al. Transitions between jail and community-based treatment for individuals with co-occurring disorders. *Psychiatr Serv* 2011 Jun;62(6):679-81.
PMID: 21632740

Ladds B, Convit A, Zito J, et al. Involuntary medication of patients who are incompetent to stand trial: a descriptive study of the New York experience with judicial review. *Bull Am Acad Psychiatry Law* 1993;21(4):529-45. PMID: 7914440

Loveland D, Boyle M. Intensive case management as a jail diversion program for people with a serious mental illness: a review of the literature. *Int J Offender Ther Comp Criminol* 2007 Apr;51(2):130-50. PMID: 17412820

Lovell D, Allen D, Johnson C, et al. Evaluating the effectiveness of residential treatment for prisoners with mental illness. *Crim Justice Behav* 2001;28:83-104.

Lovell D, Johnson C, Jemelka R, et al. Living in prison after residential mental health treatment: a program follow-up. *Prison J* 2001;81:473-90.

Luetzgen J, Chrapko WE, Reddon JR. Preventing violent re-offending in not criminally responsible patients: an evaluation of a continuity of treatment program. *Int J Law Psychiatry* 1998 Dec;21(1):89-98.

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MacKain SJ, Streveler A. Social and independent living skills for psychiatric patients in a prison setting: innovations and challenges. *Behav Modif* 1990 Oct;14(4):490-518. PMID: 2252469

McCoy ML, Roberts DL, Hanrahan P, et al. Jail linkage assertive community treatment services for individuals with mental illnesses. *Psychiatr Rehabil J* 2004 Winter;27(3):243-50. PMID: 14982331

McMurran M, Egan V, Ahmadi S. A retrospective evaluation of a therapeutic community for mentally disordered offenders. *J Forensic Psychiatry* 1998;9(1):103-13.

Metraux S. Examining relationships between receiving mental health services in the Pennsylvania prison system and time served. *Psychiatr Serv* 2008 Jul;59(7):800-2. PMID: 18586999

Morgan RD, Fisher WH, Duan N, et al. Prevalence of criminal thinking among state prison inmates with serious mental illness. *Law Hum Behav* 2010 Aug;34(4):324-36. PMID: 19551496

Morgan RD, Steffan J, Shaw LB, et al. Needs for and barriers to correctional mental health services: inmate perceptions. *Psychiatr Serv* 2007 Sep;58(9):1181-6. PMID: 17766563

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Appendix D. Risk-of-Bias Assessment for Key Question 1 and Key Question 2

Table 20. Risk-of-bias assessment for Key Question 1

Outcome	Study	Q1. Were pts. randomly assigned to study groups?	Q2. Was the process of assigning patients to groups made independently from physician/mental health care provider and patient preference?	Q3. For nonrandomized trials, did the study employ any other methods to enhance group comparability?	Q4. Was comparison of interest prospectively planned?	Q5. Were all study groups concurrently treated?	Q6. Were those who assessed the patients' outcomes blinded to the group to which the patients were assigned?	Q7. Was the outcome measure of interest objective and was it objectively measured?	Q8. Was the treatment applied consistently across study subjects and over time?	Q9. Was there a ≤ 5 difference between groups in ancillary treatment(s)?	Q10. Was there $\leq 15\%$ difference in the length of followup for the two groups?	Q11. Did $\geq 85\%$ of enrolled patients provide data at the time point of interest?	Q12. Was there a $\leq 15\%$ difference between groups in the percentage of patients who provided data at the time point of interest?	Q13. Was funding free of financial interest?	Overall Quality Category
Psychiatric symptoms	Cullen et al., 2011 ⁴⁹	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	No	Yes	Moderate
	Balbuena et al., 2010 ⁵⁰	No	No	Yes	No	Yes	No	No	Yes	NR	Yes	Yes	Yes	Yes	Moderate
	Martin et al., 2008 ⁵¹	No	No	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Moderate
	Sacks et al., 2008 ⁵²	Yes	Yes	Yes	Yes	Yes	NR	No	Yes	NR	Yes	No	Yes	NR	Moderate
	Sullivan et al., 2007 ⁴⁸¹	Yes	Yes	Yes	Yes	Yes	NR	No	Yes	NR	Yes	No	Yes	NR	Moderate
	Tavernor et al., 2000 ⁵³	No	No	Yes	Yes	Yes	NR	No	Yes	Yes	Yes	Yes	Yes	Yes	Moderate

Outcome	Study	Q1. Were pts. randomly assigned to study groups?	Q2. Was the process of assigning patients to groups made independently from physician/mental health care provider and patient preference?	Q3 For nonrandomized trials, did the study employ any other methods to enhance group comparability?	Q4. Was comparison of interest prospectively planned?	Q5. Were all study groups concurrently treated?	Q6 Were those who assessed the patients' outcomes blinded to the group to which the patients were assigned?	Q7 Was the outcome measure of interest objective and was it objectively measured?	Q8 Was the treatment applied consistently across study subjects and over time?	Q9. Was there a ≤5 difference between groups in ancillary treatment(s)?	Q10 Was there ≤15% difference in the length of followup for the two groups?	Q11 Did ≥85% of enrolled patients provide data at the time point of interest?	Q12 Was there a ≤15% difference between groups in the percentage of patients who provided data at the time point of interest?	Q13 Was funding free of financial interest?	Overall Quality Category
Psychiatric symptoms (Continued)	Beck et al., 1997 ⁵⁴	No	NR	Yes	Yes	No	NR	No	Yes	Yes	Yes	Yes	Yes	NR	Moderate
	Wilson, G., 1990 ⁵⁵	Yes	Yes	Yes	Yes	Yes	No	No	Yes	NR	Yes	Yes	Yes	Yes	Moderate
Substance use/abuse	Sacks et al., 2008 ⁵²	Yes	Yes	Yes	Yes	Yes	NR	No	Yes	NR	Yes	No	Yes	NR	Moderate
	Sullivan et al., 2007 ⁴⁷¹	Yes	Yes	Yes	Yes	Yes	NR	No	Yes	NR	Yes	No	Yes	NR	Moderate
Infractions	Balbuena et al., 2010 ⁵⁰	No	No	Yes	Yes	Yes	No	Yes	Yes	NR	Yes	Yes	Yes	Yes	Moderate
Dangerousness/Aggression Toward Others	Beck et al., 1997 ⁵⁴	No	NR	Yes	Yes	No	NR	No	Yes	Yes	Yes	Yes	Yes	NR	Moderate
Recidivism or Re-incarceration	Sacks et al., 2004 ⁴⁶	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes	NR	Yes	No	No	Yes	Moderate

Outcome	Study	Q1. Were pts. randomly assigned to study groups?	Q2. Was the process of assigning patients to groups made independently from physician/mental health care provider and patient preference?	Q3 For nonrandomized trials, did the study employ any other methods to enhance group comparability?	Q4. Was comparison of interest prospectively planned?	Q5. Were all study groups concurrently treated?	Q6 Were those who assessed the patients' outcomes blinded to the group to which the patients were assigned?	Q7 Was the outcome measure of interest objective and was it objectively measured?	Q8 Was the treatment applied consistently across study subjects and over time?	Q9. Was there a ≤ 5 difference between groups in ancillary treatment(s)?	Q10 Was there $\leq 15\%$ difference in the length of followup for the two groups?	Q11 Did $\geq 85\%$ of enrolled patients provide data at the time point of interest?	Q12 Was there a $\leq 15\%$ difference between groups in the percentage of patients who provided data at the time point of interest?	Q13 Was funding free of financial interest?	Overall Quality Category
Other Criminal Activity (e.g., self-reported criminal behavior)	Sacks et al., 2008 ⁵²	Yes	Yes	Yes	Yes	Yes	NR	No	Yes	NR	Yes	No	Yes	NR	Moderate
	Sacks et al., 2004 ⁴⁶	Yes	Yes	Yes	Yes	Yes	NR	No	Yes	NR	Yes	No	No	Yes	Moderate

Table 21. Risk-of-bias assessment Key Question 2

Outcome	Study	Q1. Were pts. randomly assigned to study groups?	Q2. Was the process of assigning patients to groups made independently from physician/mental health care provider and patient preference?	Q3 For nonrandomized trials, did the study employ any other methods to enhance group comparability?	Q4. Was comparison of interest prospectively planned?	Q5. Were all study groups concurrently treated?	Q6 Were those who assessed the patients' outcomes blinded to the group to which the patients were assigned?	Q7 Was the outcome measure of interest objective and was it objectively measured?	Q8 Was the treatment applied consistently across study subjects and over time?	Q9. Was there a ≤5 difference between groups in ancillary treatment(s)?	Q10 Was there ≤15% difference in the length of followup for the two groups?	Q11 Did ≥85% of enrolled patients provide data at the time point of interest?	Q12 Was there a ≤15% difference between groups in the percentage of patients who provided data at the time point of interest?	Q13 Was funding free of financial interest?	Overall Quality Category
Psychiatric symptoms	Chandler and Spicer, 2006 ⁶⁴	Yes	Yes	Yes	Yes	Yes	NR	No	Yes	Yes	Yes	No	NR	Yes	Moderate
	Solomon and Draine, 1995 ⁶⁶	Yes	Yes	Yes	Yes	Yes	NR	No	No	No	Yes	No	No	Yes	Moderate
Psychiatric hospitalization	Coid et al., 2007 ⁶³	No	Yes	Yes	No	Yes	NR	Yes	NR	NR	Yes	Yes	Yes	No	Moderate
	Chandler and Spicer, 2006 ⁶⁴	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes	Yes	Yes	No	NR	Yes	Moderate
	Van Stelle and Moberg, 2004 ⁶⁵	No	Yes	Yes	No	Yes	NR	Yes	NR	NR	Yes	No	No	Yes	Moderate

Outcome	Study	Q1. Were pts. randomly assigned to study groups?	Q2. Was the process of assigning patients to groups made independently from physician/mental health care provider and patient preference?	Q3 For nonrandomized trials, did the study employ any other methods to enhance group comparability?	Q4. Was comparison of interest prospectively planned?	Q5. Were all study groups concurrently treated?	Q6 Were those who assessed the patients' outcomes blinded to the group to which the patients were assigned?	Q7 Was the outcome measure of interest objective and was it objectively measured?	Q8 Was the treatment applied consistently across study subjects and over time?	Q9. Was there a ≤ 5 difference between groups in ancillary treatment(s)?	Q10 Was there $\leq 15\%$ difference in the length of followup for the two groups?	Q11 Did $\geq 85\%$ of enrolled patients provide data at the time point of interest?	Q12 Was there a $\leq 15\%$ difference between groups in the percentage of patients who provided data at the time point of interest?	Q13 Was funding free of financial interest?	Overall Quality Category
Substance use/abuse	Van Stelle and Moberg, 2004 ⁶⁵	No	Yes	Yes	No	Yes	NR	Yes	NR	NR	Yes	No	No	Yes	Moderate
	Solomon and Draine, 1995 ⁶⁶	Yes	Yes	Yes	Yes	Yes	NR	No	No	No	Yes	No	No	Yes	Moderate
Quality of Life	Solomon and Draine, 1995 ⁶⁶	Yes	Yes	Yes	Yes	Yes	NR	No	No	No	Yes	No	No	Yes	Moderate
Completed Suicide	Coid et al., 2007 ⁶³	No	Yes	Yes	No	Yes	NR	Yes	NR	NR	Yes	Yes	Yes	No	Moderate
Service utilization	Chandler and Spicer, 2006 ⁶⁴	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes	Yes	Yes	No	NR	Yes	Moderate
	Van Stelle and Moberg, 2004 ⁶⁵	No	Yes	Yes	No	Yes	NR	Yes	NR	NR	Yes	No	No	Yes	Moderate

Outcome	Study	Q1. Were pts. randomly assigned to study groups?	Q2. Was the process of assigning patients to groups made independently from physician/mental health care provider and patient preference?	Q3 For nonrandomized trials, did the study employ any other methods to enhance group comparability?	Q4. Was comparison of interest prospectively planned?	Q5. Were all study groups concurrently treated?	Q6 Were those who assessed the patients' outcomes blinded to the group to which the patients were assigned?	Q7 Was the outcome measure of interest objective and was it objectively measured?	Q8 Was the treatment applied consistently across study subjects and over time?	Q9. Was there a ≤5 difference between groups in ancillary treatment(s)?	Q10 Was there ≤15% difference in the length of followup for the two groups?	Q11 Did ≥85% of enrolled patients provide data at the time point of interest?	Q12 Was there a ≤15% difference between groups in the percentage of patients who provided data at the time point of interest?	Q13 Was funding free of financial interest?	Overall Quality Category
Service utilization (Continued)	Theurer and Lovell, 2008 ⁶¹	No	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Moderate
	Wenzlow et al., 2011 ⁶²	No	Yes	Yes	No	Yes	NR	Yes	No	No	Yes	Yes	Yes	Yes	Moderate
	Solomon and Draine, 1995 ⁶⁶	Yes	Yes	Yes	Yes	Yes	NR	Yes	No	No	Yes	No	No	Yes	Moderate
Infractions	Van Stelle and Moberg, 2004 ⁶⁵	No	Yes	Yes	No	Yes	NR	Yes	NR	NR	Yes	No	No	Yes	Moderate
Recidivism or Re-incarceration	Chandler and Spicer, 2006 ⁶⁴	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes	Yes	Yes	No	NR	Yes	Moderate
	Solomon and Draine. 1995 ⁶⁶	Yes	Yes	Yes	Yes	Yes	NR	Yes	No	No	Yes	No	No	Yes	Moderate

Outcome	Study	Q1. Were pts. randomly assigned to study groups?	Q2. Was the process of assigning patients to groups made independently from physician/mental health care provider and patient preference?	Q3 For nonrandomized trials, did the study employ any other methods to enhance group comparability?	Q4. Was comparison of interest prospectively planned?	Q5. Were all study groups concurrently treated?	Q6 Were those who assessed the patients' outcomes blinded to the group to which the patients were assigned?	Q7 Was the outcome measure of interest objective and was it objectively measured?	Q8 Was the treatment applied consistently across study subjects and over time?	Q9. Was there a ≤ 5 difference between groups in ancillary treatment(s)?	Q10 Was there $\leq 15\%$ difference in the length of followup for the two groups?	Q11 Did $\geq 85\%$ of enrolled patients provide data at the time point of interest?	Q12 Was there a $\leq 15\%$ difference between groups in the percentage of patients who provided data at the time point of interest?	Q13 Was funding free of financial interest?	Overall Quality Category
Recidivism or Re-incarceration (Continued)	Van Stelle and Moberg, 2004 ⁶⁵	No	Yes	Yes	No	Yes	NR	Yes	NR	NR	Yes	No	No	Yes	Moderate
	Coid et al., 2007 ⁶³	No	Yes	Yes	No	Yes	NR	Yes	NR	NR	Yes	Yes	Yes	No	Moderate
	Theurer and Lovell, 2008 ⁶¹	No	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Moderate

Appendix E. Key Question 1: Study, Treatment, and Patient Characteristics

Table 22. Key Question 1: general study characteristics

Types of Therapies	Study	Study Design	Number of Participants/Facilities	State/Country	*Rural/Urban	Treatment Setting
Psychopharmacological Therapies	Balbuena et al., 2010 ⁵⁰	Nonrandomized comparative trial that employed matching	98 federally sentenced, high needs, high-risk mentally disordered offenders in a forensic hospital	Saskatoon, Canada	Urban	Forensic hospital
	Martin et al., 2008 ⁵¹	Nonrandomized comparative trial that employed matching	73 admitted to forensic psychiatric hospital	New South Wales, Australia	Urban	Acute unit of forensic hospital
	Tavernor et al., 2000 ⁵³	Nonrandomized comparative trial that employed matching	50 adults detained in an English Special Hospital	London, UK	Urban	Maximum security hospital for patients considered to be a “grave and immediate danger.”
	Beck et al., 1997 ⁵⁴	Nonrandomized comparative trial that employed matching	20 adults from hospitalized on 3 forensic treatment wards at a State mental hospital	Fulton, Missouri	Rural	Maximum security unit of State mental hospital
Psychological Therapies	Cullen et al., 2011 ⁴⁹	Multisite RCT	84 men from six medium-secure forensic units	London, UK	Urban	Medium-secure forensic units
	Wilson, G., 1990 ⁵⁵	RCT	10 inmates at a large maximum security prison	NR	NR	Maximum security prison
Dual Disorders Treatment	Sacks et al., 2008 ⁵²	RCT	314 at Denver Women’s Correctional Facility	Denver, Colorado	Urban	Medium security prison
	Sacks et al., 2004 ⁴⁶ & Sullivan et al., 2007 ⁴⁸ & Sullivan et al., 2007 ⁴⁷ <i>Each publication reports on same patient population</i>	RCT	139 at San Carlos correctional facility, which was specifically constructed for male offenders with psychiatric disorders	Pueblo, Colorado	Urban	Maximum security forensic prison

* Urban areas include all urbanized areas (over 50,000 population) and Urban Clusters (2,500 to 49,999 population) as defined by the Bureau of the Census in the 2000 Decennial Census.

NR = Not reported; RCT = randomized control trial

Table 23. Key Question 1: treatment characteristics

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Psycho-pharmacological Therapies	Balbuena et al. 2010 ⁵⁰	Clozapine (65)	Psychiatrist in a forensic hospital	Clozapine Dosage not reported	Department of Corrections (Canada)	NR	Minimum of 6 weeks	6 months to 3 years	65	NR
		Other antipsychotics (33, quetiapine n=14; olanzapine n=10, risperidone n=9, methotrimeprazine n=2; and chlorpromazine n=2) ^a	Psychiatrist in a forensic hospital	Antipsychotic medications other than clozapine Dosage not reported	Department of Corrections (Canada)	NR	Minimum of 6 weeks	6 months to 3 years	33	NR
Psycho-pharmacological Therapies	Martin et al. 2008 ⁵¹	Clozapine (47)	Psychiatrist in a forensic hospital	Clozapine The mean highest dose was 514 mg daily (range 200 to 900 mg)	NR	NR	Mean length on clozapine was 18 months	Up to 5 years	37	Mood stabilizers 11 (23%), antidepressants: 21 (45%), benzodiazepine 10 (21%), other antipsychotic 12 (26%), methadone 9 (19%)
		Other antipsychotics (26)	Psychiatrist in a forensic hospital	Antipsychotic medications other than clozapine Dosage not reported The average number of antipsychotics prescribed was 4 (range 1 to 8)	NR	NR	NR	Up to 5 years	NR	Mood stabilizers 4 (15%), antidepressants 5 (19%), benzodiazepine 9 (35%), other antipsychotic 8 (27%), methadone 0 (0%)

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Psycho-pharmacological Therapies	Tavernor et al. 2000 ⁵³	High dose chlorpromazine (>1,400 mg, 32)	Psychiatrist in English Special Hospital	>1,400 mg chlorpromazine	NR	Total daily equivalent dose was 2533.1 mg (standard deviation 1101.7 mg)	NR	Up to 8 years	32	14 (44%) on more than 2 antipsychotics, 18 (56) on 2 or fewer antipsychotics, 21 (66%) on procyclidine, and 5 (15%) Authors report that there was not statistically significant difference between the treatment and control group for use of antidepressants, benzodiazepines, or hypnotic use.
		Standard dose chlorpromazine (<1,000 mg, 32)	Psychiatrist in English Special Hospital	<1,000 mg chlorpromazine	NR	Total daily equivalent was 538.1 mg (standard deviation 980.8 mg)	NR	Up to 8 years	32	32 (100%) on 2 or fewer antipsychotics, 19 (59%) on procyclidine, 2 (6.0%) on benzhexol, and 2 (6.0%) on mood stabilizers

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Psycho-pharmacological Therapies	Beck et al. 1997 ⁵⁴	Risperidone (10)	Psychiatrist in forensic hospital	6 mg of risperidone daily	NR	6 mg once daily	NR	6 months	10	All participated in psychosocial rehabilitation program
		Traditional neuroleptics (10)	Psychiatrist in forensic hospital	Authors report that this group got "traditional neuroleptics," but do not report type or dosage. They do indicate that the average patient was on 2,000 chlorpromazine units (milligrams).	NR	NR	NR	6 months	10	All participated in psychosocial rehabilitation program

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Psychological Therapies	Cullen et al. 2011 ⁴⁹	Cognitive skills program— Reasoning and Rehabilitation (R & R, 36)	Therapist trained in the program	The program covered the following 8 treatment modules: problem solving, assertiveness skills, social skills, negotiation skills, creative thinking, emotion management, values reasoning, and critical reasoning.	NR	36 two-hour sessions	Treatment completers completed 30 or more sessions	12 months	35	Typical antipsychotic 12 (27.3%), atypical antipsychotic 36 (81.8%), CBT10 (23.8%), other psychotherapy 13 (32.5%), group therapy 10 (23.8%)
		Treatment as usual (36)	NR	Participants were free to receive any interventions considered to be part of their usual treatment	NR	NR	NR	12 months	34	Typical antipsychotic 10 (25%), atypical antipsychotic 31 (77.5%), CBT 6 (15.0%), other psychotherapy 13 (32.5%), group therapy 6 (15.0%)

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Psychological Therapies	Wilson, G. 1990 ⁵⁵	Group cognitive therapy (5)	Trained therapist (author of study) in prison setting	Group sessions were problem-oriented and focused on specific techniques, such as activity planning, recording dysfunctional and functional thoughts, and group interaction. Inmates were given homework assignments to improve mood and teach adaptive skills.	NR	14, 90 minute sessions	14 weeks	9 months	5	NR
		Individual supportive therapy (5)	Trained therapist (author of study) in prison setting	The objective of the individual sessions was to provide a general therapy format and clarify problematic issues via personal reflection. The therapy was designed to be brief and avoided specific cognitive/behavioral techniques and homework.	NR	4, 30 minute sessions plus weekly check-ins by the therapist or cellblock counselors	Checks continued for 14 weeks	9 months	5	NR

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Dual Disorders Treatment	Sacks et al. 2008 ⁵²	Therapeutic community (TC, 163)	Mental health, addictions counselors, and peer counselors. Program takes place in a single floor residential building that is separated from the general prison population.	The <i>Challenge to Change</i> TC is a comprehensive program that addresses issues of substance abuse, mental health, criminal behavior, trauma and abuse, parenting, relationships, and employment. Women participate in three facility-wide services: mental health, education, and health care.	Department of corrections (Colorado)	Program activities take place 5 days a week for 4 hours per day. The remaining 4 hours/day during the week is spent working within the prison.	Study participants remained in the program for on average 6.5 months.	6 months	163	NR

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Dual Disorders Treatment	Sacks et al. 2008 ⁵² (Continued)	Intensive outpatient program (IOP, 151)	Mental health, addictions counselors, and vocational counselors. Most of the services took place in a classroom setting within the correctional facility.	The IOP program was designed to address substance abuse and criminality, with a focus on prevention and relapse. The substance abuse component consisted of a 90-hour course (provided over the course of 15 weeks) that utilized elements of cognitive behavioral therapy. Women participated in a number of other services, including mental health assessment and counseling, medication, educational and vocational training, and counseling to address trauma, parenting skills, and community re-integration.		Classroom activities took place 2 days per week for 2 hours each day. Inmates participated in work in the correctional industries when not attending class.	Services were received over the course of 6 to 9 months	6 months	151	NR

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Dual Disorders Treatment	Sacks et al. 2004 ⁴⁶ & Sullivan et al. 2007 ⁴⁸ & Sullivan et al. 2007 ⁴⁷ <i>Each publication reports same patient population</i>	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	Mental health, addictions counselors, and peer counselors in the prison setting and in the community residential aftercare program	The MTC program is a prison-based residential program that includes psycho-educational classes, cognitive-behavioral protocols, medications and therapeutic interventions directed at both mental health and substance abuse problems. It also involves reliance of mutual peer self-help and uses "community" as a healing agent. The aftercare program is a residential program that focuses on building skills to facilitate integration back into the community.	Department of corrections (Colorado)	Inmates attend the formal MTC program 5 days per week for 4 to 5 hours each day. The average inmate attends formal program activities at the aftercare program 3 to 7 days per week for 3 to 5 hours each during the 6 month tenure.	Planned duration of the MTC program is 12 months, but varies depending on offender's progress in treatment, time required for approval to be placed in a community corrections facility, and available space in the program. The aftercare program lasted 6 months.	12 months	43	NR

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Dual Disorders Treatment	Sacks et al. 2004 ⁴⁶ & Sullivan et al. 2007 ⁴⁸ & Sullivan et al. 2007 ⁴⁷ <i>Each publication reports same patient population (Continued)</i>	Prison MTC only (32)	Mental health and addictions counselors in the prison setting	The MTC program is a prison-based residential program that includes psycho-educational classes, cognitive-behavioral protocols, medications and therapeutic interventions directed at both mental health and substance abuse problems. It also involves reliance of mutual peer self-help and uses "community" as a healing agent.	Department of corrections (Colorado)	Inmates attend the formal MTC program 5 days per week for 4 to 5 hours each day.	Planned duration of the MTC program is 12 months, but varies depending on offender's progress in treatment, time required for approval to be placed in a community corrections facility, and available space in the program.	12 months	32	NR

Types of Therapies	Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Follow up	N at Follow up	N (%) Receiving Ancillary Treatment
Dual Disorders Treatment	Sacks et al. 2004 ⁴⁶ & Sullivan et al. 2007 ⁴⁸ & Sullivan et al. 2007 ⁴⁷ <i>Each publication reports same patient population (Continued)</i>	Standard mental health interventions (MH, 64)	Mental health and addictions counselors in the prison setting and in community in an outpatient post-prison community mental health facility	The prison based mental health program provides psychiatric services that include medication, weekly individual therapy and counseling, and specialized groups. Services focus on treating both mental health and substance abuse problems. The MH program also includes a range of aftercare services that are provided by a community-based mental health agency.	Department of corrections (Colorado)	Individual therapy is provided weekly and substance abuse services consist of a 72 hour CBT educational program. MH aftercare in the form of case management is provided twice per week for a total of 4 hours.	Duration of MH services not reported. Duration of substance abuse services is 72 hours and duration of aftercare is not reported.	12 months	64	NR

^a Some patients on more than one medication, so numbers do not add to 33.

DOC = Department of Corrections; MH = mental health; NR = not reported

Table 24. Key Question 1: additional treatment characteristics

Types of Therapies	Study	Treatment Group	Treatment Creator	Provider	Fidelity Rating
Psychopharmacological therapies	Balbuena et al. 2010 ⁵⁰	Clozapine (65)	NR	NR	NR
		Other antipsychotics (33, quetiapine n=14; olanzapine n=10, risperidone n=9, methotrimeprazine n=2; and chlorpromazine n=2) ^a	NR	NR	NR
Psychopharmacological therapies	Martin et al. 2008 ⁵¹	Clozapine (47)	NR	NR	NR
		Other antipsychotics (26)	NR	NR	NR
Psychopharmacological therapies	Tavernor et al. 2000 ⁵³	High dose chlorpromazine (>1,400 mg, 32)	NR	NR	NR
		Standard dose chlorpromazine (<1,000 mg, 32)	NR	NR	NR
Psychopharmacological therapies	Beck et al. 1997 ⁵⁴	Risperidone (10)	NR	NR	NR
		Traditional neuroleptics (10)	NR	NR	NR
Psychological Therapies	Cullen et al. 2011 ⁴⁹	Cognitive skills program— Reasoning and Rehabilitation (R & R, 36)	Developed in Canada by Ross and Fabiano (1985)	Staff providing treatment received training from program developers during intensive 3 to 5 day workshops.	Treatment fidelity was monitored throughout the study by one of the study authors and treatment sessions were recorded and assessed using an objective rating scale provided by the Cognitive Center Foundation in the UK.
		Treatment as usual (36)	NR	NR	NR
Psychological Therapies	Wilson, G. 1990 ⁵⁵	Group cognitive therapy (5)	Followed framework developed by Hollon and Shaw (1979)	Doctoral student	NR
		Individual supportive therapy (5)	NR	Doctoral student	NR

Types of Therapies	Study	Treatment Group	Treatment Creator	Provider	Fidelity Rating
Dual Disorders Treatment	Sacks et al. 2008 ⁵²	Therapeutic community (TC, 163)	Therapeutic community programs tailored to the needs of inmates with dual diagnoses were developed by DeLeon and colleges (1995). The author of the present study modified the program to more specifically address the needs of female participants.	Clinically trained mental health and peer counselors	NR
		Intensive outpatient program (IOP, 151)	Utilized the framework developed by Wanburg & Milkman described in <i>Strategies for Self-Improvement and Change</i> .	Clinically trained mental health and peer counselors	NR
Dual Disorders Treatment	Sacks et al. 2004 ⁴⁶ & Sullivan et al. 2007 ⁴⁸ & Sullivan et al. 2007 ⁴⁷ <i>Each publication reports same patient population</i>	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	Therapeutic community programs tailored to the needs of inmates with dual diagnoses were developed by Wexler and colleagues (1995). The author of the present study modified the program to more specifically address the needs of female participants.	Clinically trained mental health and peer counselors	NR
		Prison MTC only (32)	Therapeutic community programs tailored to the needs of inmates with dual diagnoses were developed by Wexler and colleagues (1995). The author of the present study modified the program to more specifically address the needs of female participants.	Clinically trained mental health and peer counselors	NR
		Standard mental health interventions (MH, 64)	NR	Clinically trained mental health and peer counselors	NR

NR = Not reported

Table 25. Key Question 1: participant characteristics

Types of Therapies	Study	Treatment Group (n)	Mean Age (Standard Deviation)	Number (% White)	Number (% Female)	N (% Basic Literacy Skills)	Number (%) Prior/ Current Felony Conviction	Number (%) Prior/ Current Violent Conviction	Number (%) Incarcerated ≥5 Years	Number (%) Enrolled in Medicaid at Entry
Psycho-pharmacological Therapies	Balbuena et al. 2010 ⁵⁰	Clozapine (65)	Mean age at medication start: 34.3 (9.03)	Aboriginal: 37 (57%)	2 (3.1%)	Minimum elementary school: 40 (61.5%)	NR	NR Life sentence: 19 (29.2%)	NR Mean. length of current incarceration: 2.5 years (SD 3.5)	NR
		Other antipsychotics (33)	Mean age at medication start: 37.0 (10.3)	Aboriginal: 16 (48.5%)	2 (6.1%)	Minimum elementary school: 20 (60.1%)	NR	NR Life sentence: 8 (24.2%)	NR Mean. length of current incarceration: 1.7 years (SD 1.8)	NR
Psycho-pharmacological therapies	Martin et al. 2008 ⁵¹	Clozapine (47)	Mean age at diagnosis: 22.31 (range 14 to 37 years) and mean age at medication start: 30.74 (range 20 to 46 years)	NR	0	NR	NR	Murder: 15 (32%), sexual assault: 4 (9.0%)	NR	NR
		Other antipsychotics (26)	Mean age at diagnosis: 32 (range 20 to 49 years)	NR	0	NR	NR	Murder: 9 (35%), sexual assault: 1 (4.0%)	NR	NR

Types of Therapies	Study	Treatment Group (n)	Mean Age (Standard Deviation)	Number (%) White	Number (%) Female	N (%) Basic Literacy Skills	Number (%) Prior/Current Felony Conviction	Number (%) Prior/Current Violent Conviction	Number (%) Incarcerated ≥5 Years	Number (%) Enrolled in Medicaid at Entry
Psycho-pharmacological therapies	Tavernor et al. 2000 ⁵³	High dose chlorpromazine (>1,400 mg, 32)	38.6 years (9.0)	NR	NR	NR	NR	NR	Average length of hospital stay 8 years	NR
		Standard dose chlorpromazine (<1,000 mg, 32)	38.1 years (9.7)	NR	NR	NR	NR	NR	Average length of hospital stay 8 years	NR
Psycho-pharmacological Therapies	Beck et al. 1997 ⁵⁴	Risperidone (10)	39.30 (4.50)	7 (70%)	0	Years: 10.10 (SD 2.28)	NR	NR	NR Length of hospitalization: 8.49 years	NR
		Traditional neuroleptics (10)	40.20 (8.39)	3 (30%)	0	Years: 10.70 (SD 1.64)	NR	NR	NR Length of hospitalization: 12.6 years	NR
Psychological Therapies	Cullen et al. 2011 ⁴⁹	Cognitive skills program—Reasoning and Rehabilitation (R & R, 36)	35.4 (11.4)	15 (34.1%)	0	Obtained school-leaving qualifications: 17 (39.5%)	Median number criminal convictions: 5 (range 0 to 31)	NR	NR	NR
		Treatment as usual (36)	35.4 (8.4)	12 (30.0%)	0	Obtained school-leaving qualifications: 16 (40%)	Median number of criminal convictions: 6 (range 0 to 30)	NR	NR	NR
Psychological Therapies	Wilson, G. 1990 ⁵⁵	Group cognitive therapy (5)	33.1 (8.0)	NR	NR	NR	NR	NR	NR Mean length of current incarceration 28.1 years (SD 45.4)	NR
		Individual supportive therapy (5)								

Types of Therapies	Study	Treatment Group (n)	Mean Age (Standard Deviation)	Number (%) White	Number (%) Female	N (%) Basic Literacy Skills	Number (%) Prior/ Current Felony Conviction	Number (%) Prior/ Current Violent Conviction	Number (%) Incarcerated ≥5 Years	Number (%) Enrolled in Medicaid at Entry
Dual Disorders Treatment	Sacks et al. 2008 ⁵²	Therapeutic community (TC, 163)	35.8 (7.5)	47.9%	100%	67.3% high school/GED	100% committed a drug-related crime 30.7% committed a sex crime	37.7% committed a violent crime	NR Lifetime years incarcerated : 1.01 (SD 1.68)	NR
		Intensive outpatient program (IOP, 151)	35.4 (7.6)	47.7%	100%	57.6% high school/GED	100% committed a drug-related crime 27.8% committed a sex crime	29.9% committed a violent crime	NR Lifetime years incarcerated: 1.22 (2.3)	NR
Dual Disorders Treatment	Sacks et al. 2004 ⁴⁶ & Sullivan et al. 2007 ⁴⁸ & Sullivan et al. 2007 ⁴⁷ <i>Each publication reports same patient population</i>	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	35.99 (8.33)	29 (51%)	0 All males	Years: 10.58 (SD 1.87)	32 (74%) committed a drug related crime in the year prior to incarceration	22 (52%) committed a violent offense in the year prior to incarceration	NR Mean length of current incarceration 6.1 years (SD 6.4)	NR
		Prison MTC only (32)	35.56 (8.83)	17 (53%)	0 All males	Years: 11.03 (2.04)	17 (53%) committed a drug related crime in the year prior to incarceration	14 (44%) committed a violent offense in the year prior to incarceration	NR Mean length of current incarceration 3.04 years (3.5)	NR
		Standard mental health interventions (MH, 64)	32.51 (8.92)	45	0 All males	Years: 10.45 (1.69)	31 (48%) committed a drug related crime in the year prior to incarceration	37 (58%) committed a drug related crime in the year prior to incarceration	NR Mean length of current incarceration 4.5 years (4.4)	NR

NR = Not reported; SD = standard deviation

Table 26. Key Question 1: additional participant characteristics

Types of Therapies	Study	Treatment Group (n)	Mental Health Diagnosis	Method of Mental Health Diagnosis	Number (%) With Substance Use Dependence Diagnosis	Number (%) With Substance Abuse Diagnosis	Method of Substance Use Diagnosis	Number (%) with Co-occurring Personality Disorder or PTSD
Psycho-pharmacological therapies	Balbuena et al. 2010 ⁵⁰	Clozapine (65)	Psychosis or related disorders	Two research psychiatrists reviewing the clinical chart and agreeing on the final diagnosis. Diagnosis was based on DSM-IV.	NR	51 (78.5%)	Documented in patient chart	NR
		Other antipsychotics (33)	Psychosis or related disorders	Two research psychiatrists reviewing the clinical chart and agreeing on the final diagnosis. Diagnosis was based on DSM-IV.	NR	30 (91.0%)	Documented in patient chart	NR
Psycho-pharmacological therapies	Martin et al. 2008 ⁵¹	Clozapine (47)	Schizophrenia: 41 (87%) Schizoaffective disorder: 6 (13%)	Documented in patient chart	Substance use/dependence: 47 (100%)	NR	Documented in patient chart	19 (40%) personality disorder
		Other antipsychotics (26)	Schizophrenia: 22 (85%) Schizoaffective disorder: 4 (15%)	Documented in patient chart	Substance use/dependence: 20 (77%)	NR	Documented in patient chart	7 (27%) personality
Psycho-pharmacological therapies	Tavernor et al. 2000 ⁵³	High dose chlorpromazine (>1,400 mg, 32)	Schizophrenia: 30 (94%) Schizoaffective disorder: 2 (6.2%)	International Classification of Diseases (ICD) classification from patient chart	The authors reported that there were no significant difference between cases and controls for presence of previous substance abuse	NR	Documented in patient chart	NR
		Control does chlorpromazine (<1,000 mg, 32)	Schizophrenia: 32 (100%)	ICD classification from patient chart		NR	Documented in patient chart	NR

Types of Therapies	Study	Treatment Group (n)	Mental Health Diagnosis	Method of Mental Health Diagnosis	Number (%) With Substance Use Dependence Diagnosis	Number (%) With Substance Abuse Diagnosis	Method of Substance Use Diagnosis	Number (%) with Co-occurring Personality Disorder or PTSD
Psycho-pharmacological therapies	Beck et al. 1997 ⁵⁴	Risperidone (10)	Schizophrenia: 7 (70%) Schizoaffective disorder: 3 (30%)	Diagnosis was based on DSM-IV	NR	NR	NR	NR
		Traditional neuroleptics (10)	Schizophrenia: 6 (60%) Schizoaffective disorder 4 (40%)	Diagnosis was based on DSM-IV	NR	NR	NR	NR
Psychological therapies	Cullen et al. 2011 ⁴⁹	Cognitive skills program— Reasoning and Rehabilitation (R & R, 36)	Schizophrenia: 35 (79.5%) Schizo-affective disorder: 6 (13.6%) Other psychotic disorder: 3 (6.8%)	Diagnosis was based on DSM IV or ICD-10	NR	NR	NR	20 (45.5%)
		Treatment as usual (36)	Schizophrenia: 34 (85.0%) Schizo-affective disorder: 4 (10.0%) Other psychotic disorder: 2 (5.0%)	Diagnosis was based on DSM IV or ICD-10	NR	NR	NR	17 (42.5%)
Psychological therapies	Wilson, G. 1990 ⁵⁵	Group cognitive therapy (5)	Major depression	Structured interview and judgment by trained interviewer (author of study)	NR	NR	NR	NR
		Individual supportive therapy (5)		Structured interview and judgment by trained interviewer (author of study)				

Types of Therapies	Study	Treatment Group (n)	Mental Health Diagnosis	Method of Mental Health Diagnosis	Number (%) With Substance Use Dependence Diagnosis	Number (%) With Substance Abuse Diagnosis	Method of Substance Use Diagnosis	Number (%) with Co-occurring Personality Disorder or PTSD
Dual disorders treatment	Sacks et al. 2008 ⁵²	Therapeutic community (TC, 163)	LT Dx any Axis I mental disorder: 70.6% LT Dx severe Axis I mental disorder: 66.2% LT Dx major depression: 61.2% LT Dx bipolar: 27.9% LT Dx manic/hypomanic: 30.9% LT Dx generalized anxiety disorder: 24.2% LT Number of Dx: 1.9 (SD 1.8)	Diagnostic Interview Schedule	NR	LT alcohol use: 98 (60%) LT substance use: 99 (61%)	Items from Center for Therapeutic Community Research (CTCR) Baseline Protocol	LT Dx PTSD: 36.8% LT ADHD: 11.8%
		Intensive outpatient program (IOP, 151)	LT Dx any Axis I mental disorder: 82.2% LT Dx severe Axis I mental disorder: 73.3% LT Dx major depression: 71.1% LT Dx bipolar: 26.7% LT Dx manic/hypomanic: 26.7% LT Dx generalized anxiety disorder: 37.8% LT Number of Dx: 2.2 (SD 1.6)	Diagnostic Interview Schedule	NR	LT alcohol use: 97 (64%) LT substance use: 100 (66%)	Items from Center for Therapeutic Community Research (CTCR) Baseline Protocol	LT Dx PTSD: 52.3% LT ADHD: 6.7%

Types of Therapies	Study	Treatment Group (n)	Mental Health Diagnosis	Method of Mental Health Diagnosis	Number (%) With Substance Use Dependence Diagnosis	Number (%) With Substance Abuse Diagnosis	Method of Substance Use Diagnosis	Number (%) with Co-occurring Personality Disorder or PTSD
Dual disorders treatment	Sacks et al. 2004 ⁴⁶ & Sullivan et al. 2007 ⁴⁸ & Sullivan et al. 2007 ⁴⁷ <i>Each publication reports same patient population</i>	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	Axis I or Axis II disorder: 42 (97%) Axis I mental illness: 35 (81%) Axis I serious mental illness: 29 (67%)	Based on <i>Diagnostic Interview Schedule</i>	NR	39 (90%)	Based on <i>Diagnostic Interview Schedule</i>	17 (39.5%) with antisocial personality disorder
		Prison MTC only (32)	Axis I or Axis II: 30 (94%) Axis I mental illness: 26 (81%) Axis I serious mental illness: 22 (69%)	Based on <i>Diagnostic Interview Schedule</i>	NR	28 (87.5%)	Based on <i>Diagnostic Interview Schedule</i>	7 (22%)
		Standard mental health interventions (MH, 64)	Axis I or Axis II: 62 (97%) Axis I mental illness: 48 (75%) Axis I serious mental illness: 36 (56%)	Based on <i>Diagnostic Interview Schedule</i>	NR	58 (91%)	Based on <i>Diagnostic Interview Schedule</i>	28 (44%)

Dx = Diagnosis; LT = lifetime; NR = not reported; SD = standard deviation

Appendix E. (Continued): Key Question 2: Study, Treatment, and Patient Characteristics

Table 27. Key Question 2: general study characteristics

Study	Study Design	Number of Participants/Facilities	State/Country	Rural/Urban	Treatment Setting
Wenzlow et al., 2011 ⁶²	Non-randomized comparative study using administrative data	686 inmates released from Oklahoma State prisons between 2004 and 2008	Oklahoma/United States	NR	Prison to community
Theurer and Lovell, 2008 ⁶¹	Non-randomized comparative study using matching	64 State prisoners with SMI and 64 matched controls, and a larger control group of offenders released at a prior time point with serious mental illness	Washington/United States	Urban	Prison to community
Coid et al., 2007 ⁶³	Non-randomized comparative study using administrative data	1,061 patients treated in medium-security forensic unit of a psychiatric hospital followed by psychiatric service upon release. The services were either provided by forensic specialists or by generalist MH care providers.	England and Wales/United Kingdom	Both	Forensic unit of a psychiatric hospital to community
Chandler and Spicer, 2006 ⁶⁴	RCT	Jail followed by high-fidelity IDDT (N=103) vs. jail followed by TAU	California/United States	Urban	Jail -to-community
Van Stelle and Moberg, 2004 ⁶⁵	Non-randomized comparative study using administrative data; all subjects were eligible for the treatment being studied.	212 prisoners with dual diagnoses were enrolled in the therapeutic community and from October 1997 through September 2001. 66 prisoners with dual diagnoses who had less than 18 months left on their sentence, but who qualified for therapeutic community acted as a comparison group. All prisoners were felons.	Wisconsin/United States	NR	Prison to community
Solomon and Draine, 1995 ⁶⁶	RCT	200 inmates of a large urban city jail were randomized. 176 of these were eligible to participate in this RCT.	Pennsylvania/USA	Urban	Jail to community

IDDT = Intensive dual disorders treatment; TAU = treatment as usual

Table 28. Key Question 2: treatment characteristics

Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Followup	n at Followup	N (%) Receiving Ancillary Treatment
Wenzlow et al., 2011 ⁶²	Medicaid enrolled (77)	Three discharge managers in 3 different Oklahoma correctional facilities (one medium security for men, one maximum security for women, and the State Penitentiary) each with a large mental health unit. Inmates were released in 2007–2008	Discharge managers identify prisoners with an SMI who are likely to be Medicaid eligible; obtain consent for application assistance; and assist with application completion.	Discharge managers are employed by the State MH agency to work in correctional facilities	Obtained consent at 6-9 months pre-release; application for Federal disability benefits 4 months pre-release and Medicaid application 2 month pre-release.	9 month process	3 months	54 (but author analysis based on all 77)	21 (27) Reentry Intensive Care Coordination Team (RICCT) program
	Medicaid eligible (195)	Same facilities as above but inmates released in 2004–2006	Prisoner must reapply upon discharge	NA	NA	NA	3 months	195	0 (0)
	Other Oklahoma correctional facilities (130)	Other comparable facilities, inmates released 2007–2008	Prisoner must reapply upon discharge	NA	NA	NA	3 months	130	15 (12) Reentry Intensive Care Coordination Team (RICCT) program
	Other Oklahoma correctional facilities (284)	Other comparable facilities, inmates released 2004–2006	Prisoner must reapply upon discharge	NA	NA	NA	3 months	284	0 (0)

Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Followup	n at Followup	N (%) Receiving Ancillary Treatment
Theurer and Lovell, 2008 ⁶¹	Mentally Ill Offender Community transition Program (MIOCTP)	Multidisciplinary staff including: MH case manager, psychiatrist, nurse practitioner, registered nurse, substance abuse counselor, community corrections officer, and residential house manager.	Pre-release planning including entitlement application; post-release case management, including individual and group services with MH and correction specialists; close coordination with community corrections officers; housing assistance; co-occurring disorders treatment.	Both	Daily contact if needed, regular bi-monthly home visits.	NR	2 years	64	NR
	Residential MH program residency while in prison; TAU upon release	No description of staff qualifications was provided.	Residential MH program residency while in prison; TAU upon release	Both	Residential MH treatment in prison; as needed in post-release period	NR	2 years	64	NR

Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Followup	n at Followup	N (%) Receiving Ancillary Treatment
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison	In prison and in community after release or in the general population if followup occurs there	Group meetings throughout the day to cover community-level issues; individual sessions; mental illness and substance abuse treatment groups; structured social activities; daily living skills groups; and health, anger management and relapse prevention groups. Prisoners are isolated from the general prison population. Outreach included monitoring medication compliance; monthly meeting with a staff member; and obtaining community services.	NR	Daily meetings; segregation from general population and treatment as needed in community along with monthly meetings	4 – 2 month residential phases followed by community outreach or institutional outreach if prisoner is not released after completing the incarceration portion of the program.	12 months	130 for intermediate outcome points	NR
	Treatment as usual	Not clearly reported but subjects did receive treatment in the community	Not clearly reported but subjects did receive treatment in the community	NR	As needed	9 to 12 months	12 months	59 for intermediate outcome points	NR

Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Followup	n at Followup	N (%) Receiving Ancillary Treatment
Chandler and Spicer, 2006 ⁶⁴	Jail followed by high-fidelity IDDT (103)	Substance abuse or DD experienced staff in California.	Jail component: intensive assessment, medication, discharge planning consultation with jail staff, one-on-one counseling, and crisis intervention.	Advisory committee including MH and CJ administrators	continuous	Maximum of 2.5 years	Maximum of 2.5 years	61 (59%)	NR
	Jail followed by TAU (79)		Jail component: intensive assessment, medication, discharge planning consultation with jail staff, one-on-one counseling, and crisis intervention. Post-jail component: usual services (referral to county-operated service team for case management and medications) plus the availability of up to 60 days post-release grant funded case management and housing assistance.		continuous	Maximum of 2.5 years	Maximum of 2.5 years	NR	

Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Followup	n at Followup	N (%) Receiving Ancillary Treatment
Coid et al., 2007 ⁶³	Forensic specialist psychiatric services (409)	Mental health professionals with forensic specialty background.	Standard of care treatment in a medium secure unit of a psychiatric hospital followed by forensic specialist MH services in community.	Forensic specialist	NR	Mean 6.2 years (Range: 1 month to 9.9 years)	Mean 6.2 years (Range: 1 month to 9.9 years)	409	NR
	General adult psychiatric services (652)	Mental health generalist psychiatric services	Standard of care treatment in a medium secure unit of a psychiatric hospital followed by general MH services in community.	MH generalist	NR	Mean 6.2 years (Range: 1 month to 9.9 years)	Mean 6.2 years (Range: 1 month to 9.9 years)	652	NR

Study	Treatment Group (n)	Provider and Setting	Description of Treatment	MH or DOC Provided Treatment	Number and Time of Treatment	Duration of Treatment	Length of Followup	n at Followup	N (%) Receiving Ancillary Treatment
Solomon and Draine, 1995 ⁶⁶	Mental health services in jail followed by ACT in community	A leader, 3 case managers, a psychiatric resident and supervising psychiatrist made up the ACT team. The ACT team provided and coordinated services in the community.	ACT intensive case management provides services to clients 24 hours a day, 7 days a week, including: locating resources, assisting clients in daily living, taught coping skills, developed peer support, assisted in reducing reliance on institutions, provided support to family members, and assisted with housing.	NR	24 hours per day/7 day week	1 year	1 year	94	NR
	Forensic mental health services in jail followed by Intensive case management	Experienced forensic specialist case managers brokered services in the community.	Forensic case managers worked independently with a forensic caseload.	NR	As needed	1 year	1 year		NR
	Mental health services in jail followed by referral to a community mental health center (TAU)	Intensive case managers brokered services in the community mental health centers where they were employed.	Individual case managers work for community mental health centers and their role was to broker services for the client at their respective center.	NR	As needed	Minimum 1 year	1 year		NR

NR = Not reported; TAU = treatment as usual

Table 29. Key Question 2: additional treatment characteristics

Study	Treatment Group (n)	Treatment Creator	Provider Education	Fidelity Rating
Wenzlow et al., 2011 ⁶²	Medicaid enrolled (77)	Oklahoma Stakeholder agencies (including corrections, MH, Medicaid, human services, disability determination, and Social Security)	NR	Authors report that discharge managers had addressed many program implementation issues and the program's effectiveness seemed to be increasing.
	Medicaid eligible (195)	NA	NA	NA
	Other Oklahoma correctional facilities (130)	NA	NA	NA
	Other Oklahoma correctional facilities (284)	NA	NA	NA
Theurer and Lovell, 2008 ⁶¹	Mentally Ill Offender Community transition Program (MIOCTP)	Interagency MH/DOC collaboration	Variable, including: BA/BS, nursing, and MD.	Authors note that program outcomes are more impressive if first-year participants are excluded from analysis and that the first year of implementation was one of institutional and clinical adaptation.
	Residential MH program residency while in prison; TAU upon release	NR	NR	NR
Coid et al., 2007 ⁶³	Forensic specialist psychiatric services (409)	NR	NR	NA
	General adult psychiatric services (652)	NR	NR	NA
Chandler and Spicer, 2006 ⁶⁴	Jail followed by high-fidelity IDDT (103)	New Hampshire Psychiatric Institute	All team members had experience in substance abuse or dual diagnosis programs	Mean SAMSHA "Fidelity Scale" Rating 4.1 and 4.0 (two raters)
	Jail followed by TAU (79)	NA	NR	
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison	NR	NR	NR
	Treatment as usual	NR	NR	NR

Study	Treatment Group (n)	Treatment Creator	Provider Education	Fidelity Rating
Solomon and Draine, 1995 ⁶⁶	ACT	Model based on the Program of Assertive Community Treatment (PSCT) implemented in Madison, Wisconsin.	Treatment team led by a psychiatrist.	Author notes there were implementation problems resulting in a lack of fidelity to the experimental model.
	Forensic intensive case management	NR	NR	NR
	TAU	NR	NR	NR

ACT = Assertive community treatment; NR = not reported; TAU = treatment as usual

Table 30. Key Question 2: participant characteristics

Study	Treatment Group (n)	Age	Number (%) White	Number (%) Female	Number (%) with Basic Literacy Skills	Number (%) Prior/Current Felony Conviction	Number (%) Prior/Current Violent Conviction	Number (%) Incarcerated ≥5 years	Number (%) Enrolled in Medicaid at Entry
Wenzlow et al., 2011 ⁶²	Medicaid enrolled (77)	Age ≥45: 22 (29%)	39/77 (51)	30/77 (39)	42/77 (67)	55/77 (71)	20/77 (26)	20/77 (26)	7/77 (9.0)
	Medicaid eligible (195)	Age ≥45: 39 (20%)	115/195 (59)	57/195 (29)	122/195 (67)	136/195 (70)	54/195 (28)	51/195 (26)	7/195 (4.0)
	Other comparable facilities, inmates released 2007-2008 (130)	Age ≥45: 31 (24%)	77/130 (59)	29/130 (22)	57/130 (47)	103/130 (79)	41/130 (32)	27/130 (21)	8/130 (6.0)
	Other comparable facilities, inmates released 2004-2006 (284)	Age ≥45: 56 (20%)	173/284 (61)	18/284 (6.0)	148/284 (56)	227/284 (80)	72/284 (25)	55/284 (19)	9/284 (3.0)
Theurer and Lovell, 2008 ⁶¹	Mentally Ill Offender Community transition Program (MIOCTP) (64)	35.9 (NR)	33/64 (51%)	2/64 (42%)	NR	NR	Homicide/ manslaughter: 1 (1.6%) Sex: 5 (8%) Robbery/ other violent: 17 (27%)	NR	NR
	Residential MH program residency while in prison; TAU upon release (64 matched subjects)	36.1 (NR)	NR	23/64 (36%)	NR	NR	NR	NR	NR

Study	Treatment Group (n)	Age	Number (%) White	Number (%) Female	Number (%) with Basic Literacy Skills	Number (%) Prior/Current Felony Conviction	Number (%) Prior/Current Violent Conviction	Number (%) Incarcerated ≥5 years	Number (%) Enrolled in Medicaid at Entry
Coid et al., 2007 ⁶³	Forensic specialist psychiatric services (409)	Mean: 32.0 (11.2)	NR	55/409 (13.4)	NR	NR	Prior violent: 175/409 (42.8) Index offense violent: 216/409 (52.9)	NR	NA
	General adult psychiatric services (652)	Mean: 29.0 (9.9)	NR	97/652 (14.9)	NR	NR	Prior violent: 250/652 (38.3) Index offense violent: 249/652 (38.2)	NR	NA
Chandler and Spicer, 2006 ⁶⁴	Jail followed by high-fidelity IDDT (103)	18-25: (12.6%) 26-35: (26.2%) 36-50: (51.5%) 51-78: 9.7	24/103 (23.3)	29/103 (28.2)	NR	≥2 jail episodes in the past two years or having spent 90 days in jail	NR	NR	NR
	Jail followed by TAU (79)	18-25: (7.6%) 26-35: (21.5%) 36-50: (60.8%) 51-78: (10.1%)	15/79 (19.0)	22/79 (28.2)	NR	≥2 jail episodes in the past two years or having spent 90 days in jail	NR	NR	NR

Study	Treatment Group (n)	Age	Number (%) White	Number (%) Female	Number (%) with Basic Literacy Skills	Number (%) Prior/Current Felony Conviction	Number (%) Prior/Current Violent Conviction	Number (%) Incarcerated ≥5 years	Number (%) Enrolled in Medicaid at Entry
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison (212)	Mean: 36.4 (NR)	91/212 (43)	0	Mean reading level (TABE): 6.6	212/212 (100%)	Violent/aggressive: 33% Sexual assault: 11%	Mean: 7.6 years	NR
	Treatment as usual (66)	Mean: 36.0 (NR)	NR	0	reading level (TABE): 6.6	66/66 (100%)	The primary offense was usually a property or violent crime per authors.	NR	NR
Solomon and Draine, 1995 ⁶⁶	ACT	Mean:35.2 (9.4)	30 (15%)	27 (13.5%)	Non- HS graduate: 118 (62.6%)	NR	NR	9.53 months (9.8 months) Range: 13 days to 5 years	NR
	Forensic intensive case management								
	TAU								

ACT = Assertive community treatment; MICA = mentally ill chemical abuser; NR= not reported; TAU = treatment as usual

Table 31. Key Question 2: additional participant characteristics

Study	Treatment Group (n)	Mental Health Diagnosis	Method of Mental Health Diagnosis	Number (%) With Substance Use Dependence Diagnosis	Number (%) With Substance Abuse Diagnosis	Method of Substance Use Diagnosis	Number (%) with Co-occurring Personality Disorder or PTSD
Wenzlow et al., 2011 ⁶²	Medicaid enrolled (77)	Major depression, bipolar disorder, or a psychotic illness: 100%	C1 mental health service classification	NR	NR	NA	NR
	Medicaid eligible (195)	Major depression, bipolar disorder, or a psychotic illness: 100%	C1 mental health service classification	NR	NR	NA	NR
	Other comparable facilities, inmates released 2007–2008 (130)	Major depression, bipolar disorder, or a psychotic illness: 100%	C1 mental health service classification	NR	NR	NA	NR
	Other comparable facilities, inmates released 2004–2006 (284)	Major depression, bipolar disorder, or a psychotic illness: 100%	C1 mental health service classification	NR	NR	NA	NR
Theurer and Lovell, 2008 ⁶¹	Mentally Ill Offender Community transition Program (MIOCTP)	Psychotic disorder: 36 (56%) Depression: 13 (20%) Bipolar disorder: 13 (20%) Other: 2 (3%)	Mental health risk management specialist assessed each candidate	Co-occurring chemical dependence/abuse: 57 (89%)	Co-occurring chemical dependence/abuse: 57 (89%)	Mental health risk management specialist assessed each candidate	Personality disorder: 33 (52%)
	Residential MH program residency while in prison; TAU upon release	NR	Administrative records	NR	NR	Administrative records	NR

Study	Treatment Group (n)	Mental Health Diagnosis	Method of Mental Health Diagnosis	Number (%) With Substance Use Dependence Diagnosis	Number (%) With Substance Abuse Diagnosis	Method of Substance Use Diagnosis	Number (%) with Co-occurring Personality Disorder or PTSD
Coid et al., 2007 ⁶³	Forensic specialist psychiatric services (409)	Upon admission to medium secure unit: Schizophrenia/schizoaffective disorder: 252 (63.2) Personality disorder: 54 (13.5) Mania/hypomania: 24 (6.0) Paranoid delusion: 23 (5.8) Depression: 30 (7.5) Organic brain disorder: 16 (4.0)	Case notes were assessed by a trained psychiatrist using ICD-10 criteria	Alcohol dependence: 105 (25.8) Drug dependence: 117 (28.7)	NR	Case notes	54 (13.5) had a personality disorder as either their primary or co-occurring disorder based on case notes and DSM-III-R Axis II criteria Antisocial personality disorder: 87 (21.3)
	General adult psychiatric services (652)	Upon admission to medium secure unit: Schizophrenia/schizoaffective disorder: 452 (71.4) Personality disorder: 30 (4.7) Mania/hypomania: 72 (11.4) Paranoid delusion: 32 (5.1) Depression: 33 (5.2) Organic brain disorder: 14 (2.2)	Case notes were assessed by a trained psychiatrist using ICD-10 criteria	Alcohol dependence: 140 (21.5) Substance dependence: 192 (29.5)	NR	Case notes	30 (4.7) had a personality disorder as either their primary or co-occurring disorder based on case notes and DSM-III-R Axis II criteria Antisocial personality disorder: 83 (12.7)

Study	Treatment Group (n)	Mental Health Diagnosis	Method of Mental Health Diagnosis	Number (%) With Substance Use Dependence Diagnosis	Number (%) With Substance Abuse Diagnosis	Method of Substance Use Diagnosis	Number (%) with Co-occurring Personality Disorder or PTSD
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison (212)	No axis I: 4% Schizophrenia: 32% Schizoaffective: 12% Bipolar: 14% Psychotic disorder: 13% Drug-related psychotic disorder; 11% Depressive disorder: 8% Anxiety/mood: 1% Personality disorder: 0% Dementia: 0% Other: 5%	Clinical chart review including complete medical examination by nurse clinician; psychologist administered the Diagnostic Interview Schedule; BSI; Psychiatric Symptom assessment Scale; Hare Psychopathy checklist; among other tools.	Alcohol: 33%: Cocaine: 46% Marijuana: 2% Opiate: 4% Sedative: 1% Hallucinogen: 1% Poly-substance: 1%	Alcohol: 2%: Marijuana: 5% Cocaine: 1% Other diagnoses: 4%	Addiction Severity Index	Personality disorder: 0 PTSD: not reported
	Treatment as usual (60)	Majority were schizophrenia, schizoaffective, psychotic disorder, or bipolar disorder. 89% were on psychotropic medication.	Administrative record	Majority were alcohol or poly-substance dependent	NR	Administrative records	Personality disorder: NR PTSD:NR

Study	Treatment Group (n)	Mental Health Diagnosis	Method of Mental Health Diagnosis	Number (%) With Substance Use Dependence Diagnosis	Number (%) With Substance Abuse Diagnosis	Method of Substance Use Diagnosis	Number (%) with Co-occurring Personality Disorder or PTSD
Chandler and Spicer, 1995 ^{64a}	Jail followed by high-fidelity IDDT (103)	Major depressive or other depressive disorder: 28.2% Schizophrenia: 25.2% Schizoaffective disorder: 5.8% Bipolar disorder: 11.6% Psychotic disorder NOS: 23.3%	Staff assigned Axis I. The research associate administered the PRISM for use in a dual diagnosis.	Alcohol and/or substance: 61.2% Any substance: 46.4% Alcohol: 31.1 Cocaine: 30.1 Heroin: 9.7% Cannabis: 11.7% Hallucinogen: 0% Sedative: 1.0 Stimulant: 14.7 Opiate: 3.9	Alcohol and/or substance: 59.2% Alcohol: 34.9% Any substance: 45.6%	The research associate administered a PRISM 12 month substance use disorder diagnosis.	Other (PTSD and anxiety disorders): 5.8% Personality disorders: NR
	Jail followed by TAU (79)	Major depressive or other depressive disorder: 22.8% Schizophrenia: 17.7% Schizoaffective disorder: 5.1% Bipolar disorder: 8.9% Psychotic disorder NOS: 34.2%	Staff assigned Axis I. The research associate administered the PRISM for use in a dual diagnosis.	Alcohol and/or substance: 64.6 Any substance: 48.1% Alcohol: 36.7% Cocaine: 31.6% Heroin: 5.1% Cannabis: 8.9% Hallucinogen: 2.5% Sedative: 2.5% Stimulant: 13.9% Opiate: 6.3%	Alcohol and/or substance: 58.2% Alcohol: 35.4% Any substance: 43.0%	The research associate administered a PRISM 12 month substance use disorder diagnosis.	Other (PTSD and anxiety disorders): 11.4% Personality disorders: NR
Solomon and Draine, 1995 ⁶⁶	ACT	Schizophrenia: 82.5% Major affective disorder: 10.0%	DSM III R diagnosis obtained from clinical files at the jail.	52.0% had substance use involvement		Substance use information taken from clinical files at jail	NR
	Forensic intensive case management						
	TAU						

^a Author-described population and SMI.

ACT = Assertive community treatment; DSM = Diagnostic and Statistical Manual; NR = not reported; PTSD = post-traumatic stress disorder; TAU = treatment as usual

Appendix F. Evidence Tables: Key Question 1

Table 32. Key Question 1: psychiatric symptoms

Types of Therapies	Study	Group	Outcome	Baseline Score Mean (Standard Deviation)	Post-Treatment Score Mean (Standard Deviation)	Followup Score Mean (Standard Deviation)	EPC Calculated Between Group Effect Size SMD (95% CI), p-Value	Authors' Reported Results
Psycho-pharmacological Therapies	Balbuena et al., 2010 ⁵⁰	Clozapine (65)	Brief Psychiatric Rating Scale (BPRS) total score	42.0 (14.8)	NR	6 months: 38.5 (14.6)	SDM: 0.287 (0.134 to 0.707), p=0.182	BPRS scores decreased significantly for both groups after drug treatment, but significantly more so for the non-clozapine group.
		Other antipsychotics (33)		37.8 (12.8)	NR	6 months: 30.4 (5.8)		
Psycho-pharmacological Therapies	Martin et al., 2008 ⁵¹	Clozapine (47)	Clinical Global Impression Scale	NR	NR	NR	Odds ratio (very much plus much improved) 0.55 (0.20 to 1.514), p=0.247	12 (25%) very much improved, 14 (29%) much improved, 17 (36%) minimally improved, 3 (6.0%) unchanged, and 1 (2.0%) worse
		Other antipsychotics (26)		NR	NR	NR		
Psycho-pharmacological Therapies	Tavernor et al., 2000 ⁵³	High dose chlorpromazine (>1,400 mg, 32)	BPRS total score (number of patients in each group was 25 for this outcome)	NR	NR	36 (9)	0.744 (0.171 to 1.317), p=0.011	The total BPRS score was significantly higher for the high dose group than the standard dose group (p=0.013)
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	30 (7)		

Types of Therapies	Study	Group	Outcome	Baseline Score Mean (Standard Deviation)	Post-Treatment Score Mean (Standard Deviation)	Followup Score Mean (Standard Deviation)	EPC Calculated Between Group Effect Size SMD (95% CI), p-Value	Authors' Reported Results
Psycho-pharmacological Therapies (Continued)	Tavernor et al., 2000 ⁵³ (Continued)	High dose chlorpromazine (>1,400 mg, 32)	Nurses Observation Scale for Inpatient Evaluation (NOSIE) social interest	NR	NR	29 (10)	0.631 (0.129 to 1.133), p=0.014	The NOSIE score for social interest was significantly higher for the high dose group than the standard group (p=0.035)
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	23 (9)		
		High dose chlorpromazine (>1,400 mg, 32)	NOSIE social competence	NR	NR	45 (11)	0.299 (-0.194 to 0.791), p=0.235	No significant difference between groups on the NOSIE social competence score.
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	48 (9)		
		High dose chlorpromazine (>1,400 mg, 32)	NOSIE personal neatness	NR	NR	8 (5)	0.200 (-0.291 to 0.691), p=0.425	No significant difference between groups on the NOSIE personal neatness score.
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	9 (5)		
		High dose chlorpromazine (>1,400 mg, 32)	NOSIE psychotic depression	NR	NR	8 (4)	0.750 (0.243 to 1.257), p=0.004	The NOSIE score for psychotic depression was significantly higher for the high dose group than the standard group (p=0.023)
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	5 (4)		
		High dose chlorpromazine (>1,400 mg, 32)	NOSIE manifest psychosis	NR	NR	8 (5)	0.883 (0.370 to 1.397), p=0.001	The NOSIE score for manifest psychosis was significantly higher for the high dose group than the standard group (p=0.004)
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	4 (4)		

Types of Therapies	Study	Group	Outcome	Baseline Score Mean (Standard Deviation)	Post-Treatment Score Mean (Standard Deviation)	Followup Score Mean (Standard Deviation)	EPC Calculated Between Group Effect Size SMD (95% CI), p-Value	Authors' Reported Results
Psycho-pharmacological Therapies (Continued)	Tavernor et al., 2000 ⁵³ (Continued)	High dose chlorpromazine (>1,400 mg, 32)	NOSIE irritability	NR	NR	13 (8)	0.587 (0.087 to 1.088), p=0.021	The NOSIE score for irritability was significantly higher for the high dose group than the standard group (p=0.039)
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	8 (9)		
		High dose chlorpromazine (>1,400 mg, 32)	NOSIE cooperation	NR	NR	8 (4)	0.250 (-0.242 to 0.742), p=0.319	No significant difference between groups on the NOSIE cooperation score.
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	9 (4)		
		High dose chlorpromazine (>1,400 mg, 32)	Global Assessment Scale (GAS)	NR	NR	36 (15)	0.664 (0.161 to 1.167), p=0.010	The mean score on the GAS was significantly lower for the high dose group than the standard dose group (p=0.006)
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	47 (18)		
		High dose chlorpromazine (>1,400 mg, 32)	Social Dysfunction and Aggression Scale (SDAS) general	NR	NR	10 (8)	0.532 (0.034 to 1.031), p=0.036	The general and peak levels of aggression were higher for the high dose group than for the low dose group.
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	6 (7)		
		High dose chlorpromazine (>1,400 mg, 32)	SDAS peak	NR	NR	18 (9)	0.631 (0.125 to 1.137), p=0.014	The general and peak levels of aggression were higher for the high dose group than for the low dose group.
		Standard dose chlorpromazine (<1,000 mg, 32)		NR	NR	12 (10)		

Types of Therapies	Study	Group	Outcome	Baseline Score Mean (Standard Deviation)	Post-Treatment Score Mean (Standard Deviation)	Followup Score Mean (Standard Deviation)	EPC Calculated Between Group Effect Size SMD (95% CI), p-Value	Authors' Reported Results														
Psycho-pharmacological Therapies	Beck et al., 1997 ⁵⁴	Risperidone (10)	Time-Sample Behavioral Checklist (TSBC)	NR	NR	NR	NR	MANOVA analysis indicated that the group main effect failed to achieve significance ($F=1.77$, $df=16,139$, $p<0.18$), as did the interaction between group and time ($F=0.48$, $df=18,139$, $p<0.96$). The main effect of time was significant ($F=3.55$, $df=18,139$, $p<0.001$).														
		Traditional neuroleptics (10)		NR	NR	NR			Psychological Therapies	Cullen et al., 2011 ⁴⁹	Cognitive skills program— Reasoning and Rehabilitation (R & R, 36)	Social Problem-Solving Inventory (SPSI) total score	12.6 (2.7)	13.4 (2.2)	13.2 (2.5)	Pre to posttreatment: 0.409 (-0.058 to 0.875), $p=0.086$ Pre to followup: 0.281 (-0.183 to 0.746), $p=0.235$	Results of regression analysis indicated statistically significant larger improvement in the R & R group compared with the TAU group on the total SPSI score and on the impulsive/carelessness style and avoidant style subscales at posttreatment. At 12 months followup, the R & R group demonstrated significant improvements on the SPSI impulsive/carelessness style and avoidant style subscale.	Treatment as usual (36)	13.6 (2.5)	13.4 (2.3)	13.5 (2.2)	Cognitive skills program— Reasoning and Rehabilitation (R & R, 36)
Psychological Therapies	Cullen et al., 2011 ⁴⁹	Cognitive skills program— Reasoning and Rehabilitation (R & R, 36)	Social Problem-Solving Inventory (SPSI) total score	12.6 (2.7)	13.4 (2.2)	13.2 (2.5)	Pre to posttreatment: 0.409 (-0.058 to 0.875), $p=0.086$ Pre to followup: 0.281 (-0.183 to 0.746), $p=0.235$	Results of regression analysis indicated statistically significant larger improvement in the R & R group compared with the TAU group on the total SPSI score and on the impulsive/carelessness style and avoidant style subscales at posttreatment. At 12 months followup, the R & R group demonstrated significant improvements on the SPSI impulsive/carelessness style and avoidant style subscale.														
		Treatment as usual (36)		13.6 (2.5)	13.4 (2.3)	13.5 (2.2)																
		Cognitive skills program— Reasoning and Rehabilitation (R & R, 36)	Social Problem-Solving Inventory (SPSI): positive problem orientation	12.4 (3.9)	11.9 (3.4)	12.2 (3.6)	Pre to posttreatment: 0.166 (-0.297 to 0.629), $p=0.482$															

Types of Therapies	Study	Group	Outcome	Baseline Score Mean (Standard Deviation)	Post-Treatment Score Mean (Standard Deviation)	Followup Score Mean (Standard Deviation)	EPC Calculated Between Group Effect Size SMD (95% CI), p-Value	Authors' Reported Results
Psychological Therapies (Continued)	Cullen et al., 2011 ⁴⁹ (Continued)	Treatment as usual (36)		11.5 (3.4)	11.6 (3.7)	11.3 (3.6)	Pre to followup: 0.00 (-0.462 to 0.462), p=1.000	
		Cognitive skills program— Reasoning and Rehabilitation (R & R, 36)	Social Problem-Solving Inventory (SPSI): negative problem orientation	5.8 (5.3)	5.8 (4.2)	6.4 (4.4)	Pre to posttreatment: 0.00 (-0.462 to 0.462), p=1.000	
		Treatment as usual (36)		4.8 (4.1)	4.8 (4.0)	4.3 (3.4)	Pre to followup: 0.251 (-0.213 to 0.714), p=0.290	
		Cognitive skills program— Reasoning and Rehabilitation (R & R, 36)	Social Problem-Solving Inventory (SPSI): rational problem solving	10.6 (4.3)	11.1 (4.5)	11.6 (4.0)	Pre to posttreatment: 0.351 (-0.114 to 0.817), p=0.139	
		Treatment as usual (36)		10.9 (3.8)	9.9 (4.4)	10.9 (4.2)	Pre to followup: 0.245 (-0.219 to 0.708), p=0.3011	

Types of Therapies	Study	Group	Outcome	Baseline Score Mean (Standard Deviation)	Post-Treatment Score Mean (Standard Deviation)	Followup Score Mean (Standard Deviation)	EPC Calculated Between Group Effect Size SMD (95% CI), p-Value	Authors' Reported Results
Psychological Therapies (Continued)	Cullen et al., 2011 ⁴⁹ (Continued)	Cognitive skills program—Reasoning and Rehabilitation (R & R, 36)	Social Problem-Solving Inventory (SPSI): impulsive/careless style	7.0 (4.3)	4.7 (3.4)	5.4 (4.0)	Pre to posttreatment: 0.612 (0.140 to 1.085), p=0.011	
		Treatment as usual (36)		5.0 (3.8)	5.0 (3.3)	5.5 (3.9)	Pre to followup: 0.524 (0.054 to 0.994), p=0.029	
		Cognitive skills program—Reasoning and Rehabilitation (R & R, 36)	Social Problem-Solving Inventory (SPSI): avoidant style	4.5 (4.5)	5.0 (3.8)	5.9 (4.3)	Pre to posttreatment: 0.557 (0.086 to 1.028), p=0.020	
		Treatment as usual (36)		7.0 (4.5)	5.2 (3.4)	4.8 (3.9)	Pre to followup: 0.834 (0.352 to 1.315), p=0.001	

Types of Therapies	Study	Group	Outcome	Baseline Score Mean (Standard Deviation)	Post-Treatment Score Mean (Standard Deviation)	Followup Score Mean (Standard Deviation)	EPC Calculated Between Group Effect Size SMD (95% CI), p-Value	Authors' Reported Results
Psychological Therapies	Wilson, G., 1990 ^{55*}	Group cognitive therapy (5)	Beck Depression Inventory	26.60 (12.30)	13.00 (9.69)	NR	0.956 (-0.353 to 2.264), p=0.152	Both groups improved from pre to post-treatment. "A significant main effect for time was obtained across the repeated measures on the [BDI] and a trend towards significance was noted on the Hopelessness Scale." Further analysis indicated significant improvement in depression ratings from pre- to midtreatment assessments on the BDI and between mid- and posttreatment on the MMPI D. No significant change was observed for assessments using the MAACL-D. ECRI's analysis does not include midtreatment assessment scores.
		Individual supportive therapy (5)		21.20 (4.66)	16.20 (6.76)	NR		
		Group cognitive therapy (5)	Multiple Affect Adjective Check List D Scale (MAACL D)	14.00 (7.42)	8.80 (5.26)	NR	0.812 (-0.478 to 2.102), p=0.217	
		Individual supportive therapy (5)		8.40 (6.54)	8.20 (3.49)	NR		
		Group cognitive therapy (5)	Hopelessness Scale	10.00 (6.71)	6.80 (7.59)	NR	0.032 (-1.207 to 1.272), p=0.959	
		Individual supportive therapy (5)		7.20 (5.54)	4.20 (4.14)	NR		
		Group cognitive therapy (5)	MMPI D Scale	82.00 (13.69)	69.80 (14.56)	At 9 months: 61.20 (8.41)	Baseline to post: 0.344 (-0.905 to 1.593), p=0.589 Baseline to followup: 0.200 (-1.043 to 1.443), p=0.753	
		Individual supportive therapy (5)		74.40 (16.99)	57.20 (10.98)	At 9 months: 56.40 (14.22)		

Types of Therapies	Study	Group	Outcome	Baseline Score Mean (Standard Deviation)	Post-Treatment Score Mean (Standard Deviation)	Followup Score Mean (Standard Deviation)	EPC Calculated Between Group Effect Size SMD (95% CI), p-Value	Authors' Reported Results
Dual Disorders Treatment	Sacks et al., 2008 ⁵²	Therapeutic community (TC, 163)	Beck Depression Inventory (BDI) total score	17.40 (10.74)	NR	At 6 months: 11.84 (11.53)	0.204 (-0.018 to 0.426), p=0.071	Scores for all three measures of psychological symptoms (BDI, BSI, and PSS) showed statistically significant improvement for both the TC and IOP group from pretreatment to 6 month follow-up. The authors' calculations show significant differential improvement favoring the TC group in the BDI total score and PSS score.
		Intensive outpatient program (IOP, 151)		17.74 (11.19)	NR	At 6 months: 14.48 (12.11)		
		Therapeutic community (TC, 163)	Brief Symptom Inventory (BSI) global severity index	58.77 (10.83)	NR	At 6 months: 53.47 (12.64)	0.145 (-0.077 to 0.366), p=0.201	
		Intensive outpatient program (IOP, 151)		58.64 (12.17)	NR	At 6 months: 55.10 (12.84)		
		Therapeutic community (TC, 163)	Posttraumatic Symptom Severity (PSS) Score total score	16.6 (13.01)	NR	At 6 months: 10.22 (11.10)	0.246 (0.024 to 0.468), p=0.030	
		Intensive outpatient program (IOP, 151)		16.29 (14.10)	NR	At 6 month: 13.12 (13.81)		

Types of Therapies	Study	Group	Outcome	Baseline Score Mean (Standard Deviation)	Post-Treatment Score Mean (Standard Deviation)	Followup Score Mean (Standard Deviation)	EPC Calculated Between Group Effect Size SMD (95% CI), p-Value	Authors' Reported Results
Dual Disorders Treatment	Sullivan et al., 2007 ⁴⁸	Modified Therapeutic Community (MTC, 75) vs. Standard Mental Health Program (MH, 64)	Brief Symptom Inventory global severity index	Combined for both groups: 44.7 (11.1)	NR	At 12 months Combined for both groups: 40.9 (10.1)	NR	Both groups demonstrated a statistically significant decrease in BDI scores from baseline to 12 month followup. But not between group difference was observed at 12 months: Odds ratio (p-value): 0.760 (0.47)
			Beck Depression Inventory (BDI) total score	Combined for both groups: 12.8 (10.2)	NR	At 12 months Combined for both groups: 12.7 (12.5)	NR	No significant change in BDI scores were observed for either group from baseline to 12-month followup. Between group difference at 12 months was also not significant: Odds ratio (p-value): 0.615 (0.37)
			Manifest Anxiety Scale (MAS)	Combined for both groups: 9.4 (5.0)	NR	At 12 months Combined for both groups: 8.7 (5.2)	NR	No significant change in MAS scores were observed for either group from baseline to 12-month followup. Between group difference at 12 months was also not significant: Odds ratio (p-value): 0.770 (0.54)

*Author-reported change in daily mood rating. However, mood was rated using an instrument that had not been validated. Thus, these results are not reported in this report.

CI = Confidence interval; NR = not reported; SMD = standardized mean difference

Table 33. Key Question 1: improvement status

Types of Therapies	Study	Group	Pre to Post Improvement Number (%)	Pre to Post Unchanged Number (%)	Pre to Post Deterioration Number (%)	Pre to Post Non-Depressed	Pre to Post Alleviation Number (%)
Psychological Therapies	Wilson, G., 1990 ⁵⁵	Group cognitive therapy (5)	4 (80%)	1 (20%)	0	2 (40%)	2 (40%)
		Individual supportive therapy (5)	1 (20%)	4 (80%)	0	2 (40%)	1 (20%)

* Improvement status was based on the reliable change index score (RC) of the Beck Depression Inventory. The RC index is equivalent to the difference score (e.g., posttest minus pretest) divided by the standard error of difference between the two test scores.⁵⁵ Patients were classified as improved if the RC index was ≥ 1.96 , unchanged if it was between -1.96 and +1.96, and deteriorated if the RC index was less than -1.96. Patients were classified as non-depressed if they scored below the clinical cut-off of 13 on the Beck inventory. Alleviation was defined as a statistically reliable movement from depressed into the non-depressed range as “measured by a clear pattern of greater improvement among clients receiving group cognitive treatment.”⁵⁵

Table 34. Key Question 1: independent functioning

Study	Group	Outcome	Number at Pre-Treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author's Reported Results
Balbuena et al., 2010 ⁵⁰	Clozapine (65)	Increase in pay in institutional employment as a measure independent functioning	NR	38/65 (58.5%) Number with increase in pay	OR: 3.24 (1.33 to 7.89) p=0.01	OR: 3.13 (95% CI, 1.3 to 7.5), p=0.01
	Other antipsychotics (33)	Increase in pay in institutional employment as a measure independent functioning	NR	10/33 (30.3%) Number with increase in pay		

OR = Odds ratio

Table 35. Key Question 1: institutional infractions

Study	Group	Outcome	Number at Pre-Treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Authors' Reported Results
Balbuena et al., 2010 ⁵⁰	Clozapine	Percent offense free	22/55 (40.0%)	One year: 32/47 (68.1%)	(using follow-up Ns only) OR: 1.98 (0.75 to 5.24) p=0.17	Among 19 offenders with life sentences, 11 (58%) on clozapine and 2 (25%) on other medication remained infraction free.
	Other antipsychotics	Percent offense free	6/24 (25.0%)	One year: 14/27 (51.9%)		
Beck et al., 1997 ⁵⁴	Risperidone (10)	Aggressive incidents	NR	NR	NR	Wilcoxon rank sum and signed rank tests indicated that neither the risperidone nor the traditional neuroleptic group changed significantly in terms of aggression levels during the course of the study, nor did the groups differ significantly when compared at any time during the study.
	Traditional neuroleptics (10)	Aggressive incidents	NR	NR	NR	

Table 36. Key Question 1: mental health and substance abuse service use

Study	Group	Outcome	Number (%) Receiving Treatment at Baseline	Number (%) Receiving Treatment at Followup	EPC Calculated Effect Size Odds Ratio (95% CI), p-Value	Authors' Reported Results
Sacks et al., 2008 ⁵²	Therapeutic community (TC, 163)	Mental health treatment	36 (22%)	At 6 months: 65 (40%)	0.926 (0.590 to 1.454), p=0.740	Individuals in the "[IOP] group were more likely to receive substance abuse treatment in the six months following their release from prison (p=0.03)."
	Intensive outpatient program (IOP, 151)		50 (33%)	At 6 months: 63 (42%)		
	Therapeutic community (TC, 153) ¹	Currently using psychiatric medication(s)	NR	At 6 months: 50 (33%)	1.023 (0.630 to 1.66), p=0.928	
	Intensive outpatient program (IOP, 146) ¹		NR	At 6 months: 47 (32%)		
	Therapeutic community (TC, 163)	Substance abuse treatment	72 (44%)	At 6 months: 109 (67%)	0.565 (0.341 to 0.936), p=0.027	
	Intensive outpatient program (IOP, 151)		69 (46%)	At 6 months: 118 (78%)		
Sullivan et al., 2007 ⁴⁸	Modified Therapeutic Community (MTC, 75) vs. Standard Mental Health Program (MH, 64)	Psychiatric medication	Combined percent of both groups: 47.5%	At 12 months Combined percent of both groups: 82.7%	NR	Both groups demonstrated significant increase in medication use from baseline to 12 month followup. But, no significant between group difference was observed at 12 months: Odds ratio (p-value): 0.487 (0.09)
		Psychiatric treatment	Combined percent of both groups: 36.7%	At 12 months Combined percent of both groups: 66.2%	NR	

¹Sample size is based on consumers' prescribed medication at time of followup.

CI = Confidence interval; NR = not reported; SD = standard deviation

Table 37. Key Question 1: substance use

Study	Group	Outcome	Number (%) Receiving Treatment at Baseline	Number (%) Receiving Treatment at Followup	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Authors' Reported Results
Sacks et al., 2008 ⁵²	Therapeutic community (TC, 163)	Alcohol use	86 (53%)	At 6 months: 41 (25%)	1.414 (0.826 to 2.421), p=0.207	Both the TC and IOP group showed significant reductions in on all measures of substance abuse from baseline to 6 months (p<0.001), with no significant differences between the groups. Further, the magnitude of the reported improvement appears similar for both groups.
	Intensive outpatient program (IOP, 151)		75 (50%)	At 6 months: 29 (19%)		
	Therapeutic community (TC, 163)	Substance use	111 (68%)	At 6 months: 36 (22%)	0.814 (0.484 to 1.368), p=0.438	
	Intensive outpatient program (IOP, 151)		95 (63%)	At 6 months: 39 (26%)		
	Therapeutic community (TC, 163)	Frequency of alcohol use: 0=none; 8=more than once/day	Mean (SD)		0.072 (-0.150 to 0.293), p=0.524	----
	Intensive outpatient program (IOP, 151)		4.25 (2.52)	1.22 (2.33)		
	Therapeutic community (TC, 163)	High frequency substance use	5.66 (2.56)	1.09 (2.44)	0.221 (-0.001 to 0.443), p=0.051	Both the TC and IOP group showed significant reductions in on all measures of substance abuse from baseline to 6 months (p<0.001), with no significant differences between the groups. Further, the magnitude of the reported improvement appears similar for both groups.
	Intensive outpatient program (IOP, 151)		5.511 (2.55)	1.51 (2.76)		

Study	Group	Outcome	Number (%) Receiving Treatment at Baseline	Number (%) Receiving Treatment at Followup	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Authors' Reported Results
Sullivan et al., 2007 ⁴⁷	Modified Therapeutic Community (75, MTC)	Any substance use	65 (87%)	At 12 months: 23 (31%)	0.344 (0.171 to 0.690), p=0.003	Results of multivariate logistic regression MTC vs. MH controlling for the following several sample characteristics (see table footnote). Log odds: 0.34 (p=0.01)
	Standard Mental Health Program (64, MH)		58 (91%)	At 12 months: 36 (56%)		
	Modified Therapeutic Community (75, MTC)	Any illegal substance use	59 (79%)	At 12 months: 19 (25%)	0.436 (0.213 to 0.894), p=0.023	Results of multivariate logistic regression MTC vs. MH controlling for the following several sample characteristics (see table footnote). Log odds: 0.43 (p=0.05)
	Standard Mental Health Program (64, MH)		55 (86%)	At 12 months: 28 (44%)		
	Modified Therapeutic Community (75, MTC)	Any alcohol use	43 (57%)	At 12 months: 16 (21%)	0.518 (0.243 to 1.102), p=0.088	Results of multivariate logistic regression MTC vs. MH controlling for the following several sample characteristics (see table footnote). Log odds: 0.34 (p=0.02)
	Standard Mental Health Program (64, MH)		35 (55%)	At 12 months: 22 (39%)		

Note: Sullivan et al. (2007) used the following control variables in their regression model: age at baseline, age of first illegal activity, months incarcerated, any employment, stable housing (prior to baseline), attempted suicide, and living with non-parental relative while growing up.

CI = Confidence interval; SD = standard deviation

Table 38. Key Question 1: criminal justice

Study	Group	Outcome	Number (%) at Pretreatment	Number (%) at Posttreatment	Number (%) at Followup	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Authors' Reported Results
Sacks et al., 2008 ⁵²	Therapeutic community (TC, 163)	Any arrest	150 (92%)	NR	At 6 months post prison: 42 (26%)	0.642 (0.395 to 1.042), p=0.073	The women in the TC condition showed significantly greater reductions in arrests for crimes other than parole violation as compared with women in the IOP group (Log odds -0.95, p=0.01).
	Intensive outpatient program (IOP, 151)		131 (87%)	NR	At 6 months post prison: 53 (35%)		
	Therapeutic community (TC, 163)	Arrest (not a parole violation)	73 (45%)	NR	At 6 months post prison: 15 (9%)	0.377 (0.195 to 0.729), p=0.004	
	Intensive outpatient program (IOP, 151)		68 (45%)	NR	At 6 months post prison: 32 (21%)		
	Therapeutic community (TC, 163)	Criminal activity upon release	150 (92%)	NR	At 6 months post prison: 65 (40%)	0.655 (0.418 to 1.024), p=0.063	
	Intensive outpatient program (IOP, 151)		133 (88%)	NR	At 6 months post prison: 76 (50%)		
Sacks et al., 2004 ⁴⁶	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	Reincarceration	NR	NR	At 12 months post prison: 2 (5.0%)	MTC plus vs. MTC: 0.263 (0.048 to 1.457), p=0.126 MTC plus vs. Standard MH: 0.100 (0.022 to 0.453), p=0.003 MTC vs. Standard MH: 0.379 (0.128 to 1.125) p=0.081	The MTC plus aftercare group showed significantly lower reincarceration rates than the standard MH group (5% vs. 33%, p<0.02).
	Prison MTC only (32)		NR	NR	At 12 months post prison: 5 (16%)		
	Standard mental health interventions (MH, 64)		NR	NR	At 12 months post prison: 21 (33%)		

Study	Group	Outcome	Number (%) at Pretreatment	Number (%) at Posttreatment	Number (%) at Followup	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Authors' Reported Results
Sacks et al., 2004 ⁴⁶ (Continued)	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	Criminal activity upon release	NR	NR	At 12 months post prison: 18 (42%)	MTC plus vs. MTC: 0.635 (0.253 to 1.597), p=0.335 MTC plus vs. Standard MH: 0.352 (0.158 to 0.782), p=0.010 MTC vs. Standard MH: 0.553 (0.232 to 1.319), p=0.182	The MTC plus aftercare group showed significantly lower rates of other criminal activity than the standard MH group (42% vs. 67%, p<0.05).
	Prison MTC only (32)		NR	NR	At 12 months post prison: 17 (53%)		
	Standard mental health interventions (MH, 64)		NR	NR	At 12 months post prison: 43 (67%)		
	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	Alcohol or substance offence	NR	NR	At 12 months post prison: 13 (30%)	MTC plus vs. MTC: 0.557 (0.214 to 1.447), p=0.230 MTC plus vs. Standard MH: 0.316 (0.140 to 0.717), p=0.006 MTC vs. Standard MH: 0.568 (0.241 to 1.337), p=0.195	The MTC plus aftercare group showed significantly lower rates of alcohol and substance related offences than the standard MH group (30% versus 58%, p<0.03).
	Prison MTC only (32)		NR	NR	At 12 months post prison: 14 (44%)		
	Standard mental health interventions (MH, 64)		NR	NR	At 12 months post prison: 37 (58%)		
	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	Other type of offence	NR	NR	At 12 months post prison: 9 (21%)	MTC plus vs. MTC: 0.505 (0.179 to 1.423), p=0.196 MTC plus vs. Standard MH: 0.441 (0.181 to 1.077), p=0.072 MTC vs. Standard MH: 0.873 (0.359 to 2.121), p=0.764	No further results reported
	Prison MTC only (32)		NR	NR	At 12 months post prison: 11 (34%)		
	Standard mental health interventions (MH, 64)		NR	NR	At 12 months post prison: 24 (37.5%)		

CI = Confidence interval; SD = standard deviation

Table 39. Key Question 1: time to reincarceration or recidivism

Study	Group	Outcome	Followup Mean (SD)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Authors' Reported Results
Sacks et al., 2004 ⁴⁶	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	Number of days until re-incarceration	169.5 (60.10)	MTC plus vs. MTC: 0.514 (0.049 to 0.979), p=0.030	The pattern for incarceration showed that MH clients were incarcerated earliest (108 days), followed by MTC only (125 days) and MTC + aftercare (170 days)
	Prison MTC only (32)		124.8 (113.56)	MTC plus vs. Standard MH: 0.78 (0.383 to 1.184), p <0.01	
	Standard mental health interventions (MH, 64)		108.43 (87.80)	MTC vs. Standard MH: 0.169 (-0.256 to 0.594), p=0.437	
	Prison Modified Therapeutic Community (MTC) plus aftercare (43)	Number of days until first crime	67.11 (67.99)	MTC plus vs. MTC: 0.206 (-0.253 to 0.664), p=0.380	No further results reported.
	Prison MTC only (32)		84.06 (98.76)	MTC plus vs. Standard MH: 0.012 (-0.375 vs. 0.398), p=0.958	
	Standard mental health interventions (MH, 64)		66.19 (85.33)	MTC vs. Standard MH: 0.199 (-0.227 vs. 0.624), p=0.360	

CI = Confidence interval; SD = standard deviation

Table 40. Key Question 1: adverse events

Study	Group (Number of Patients)	Adverse Event
Martin et al., 2008 ⁵¹	Clozapine (47)	2 (4%) patients developed neutropenia, 3 (6%) had seizures
	Other antipsychotics (26)	NR
Tavernor et al., 2000 ⁵³	High dose chlorpromazine (>1,400 mg, 32)	The authors reported that the high dose group experienced significantly more total (autonomic and neurological) side-effects than the standard dose group (mean score for the high dose group was 6.96, mean for standard group was 4.84, p=0.048).
	Standard dose chlorpromazine (<1,000 mg, 32)	

Appendix F. (Continued) – Evidence Tables: Key Question 2

Table 41. Key Question 2: increase in psychiatric symptoms

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size (95% CI), p-Value	Author Reported Results
Chandler and Spicer, 2006 ⁶⁴	Jail followed by high-fidelity IDDT (103)	Crisis visits	Mean: 1.62 (3.56)	Mean: 2.10 (4.59)	SMD: 0.43 (0.13 to 0.73) 0.004	Sign rank test: p<0.654
	Jail followed by TAU (79)	Crisis visits	Mean: 0.58 (1.29)	Mean: 3.32 (6.95)		Sign rank test: p<0.001
	Jail followed by high-fidelity IDDT (103)	Patients with any crisis (%)	NR	46/103 (45%)	OR: 0.79 (0.44 to 1.42) 0.42	Logistic multiple regression: z=-0.64, p<0.034
	Jail followed by TAU (79)	Patients with any crisis (%)	NR	40/79 (51%)		
Solomon and Draine, 1995 ⁶⁶	ACT	BPRS	30	NR	Could not be calculated.	BPRS was dropped from the discriminant analysis as it added very little to the model's predictive power.
	Forensic intensive case management	BPRS	23			
	TAU	BPRS	41			

BPRS = Brief Psychiatric Rating Scale; IDDT = intensive dual disorders treatment; OR = odds ratio; SMD = standardized mean difference; TAU = treatment as usual

Table 42. Key Question 2: psychiatric hospitalization

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size (95% CI), p-Value	Author Reported Results
Coid et al., 2007 ⁶³	Forensic specialist psychiatric services (409)	Any psychiatric hospital readmission	NA	564/2454 person years of followup	OR: 0.84 (0.75 to 0.95) p=0.005	Regression analysis, with potential confounders adjusted for, Incidence Rate Ratio 1.12 (95% CI, 0.90 to 1.38)
	General adult psychiatric services (652)	Any psychiatric hospital readmission	NA	1076/4121 person-years of followup		
Chandler and Spicer, 2006 ⁶⁴	Jail followed by high-fidelity IDDT (103)	Psychiatric hospitalization	Mean: 1.54 (4.59)	1.25 (3.27)	SMD: 0.54 (0.24 to 0.84) p=0.000	Sign rank test: p<0.667
	Jail followed by TAU (79)	Psychiatric hospitalization	Mean: 0.34 (1.40)	5.03 (13.88)		Sign rank test: p<0.001
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison: (39 graduates and 91 terminators)	Institutional transfer to a MH facility	NR	Graduates: 4 (9%) Terminators: 23 (25%) Total: 27	OR:0.13 (0.07 to 0.26) p=0.000	MICA graduates were more likely to be transferred to a minimum security facility, while terminators and comparison inmates were more likely to be transferred to a medium security facility, a mental health facility, or a maximum security facility.
	Treatment as usual (59)	Institutional transfer to a MH facility	NR	25 (43%)		

MICA = Mentally ill chemical abuser; OR =odds ratio; SMD = standardized mean difference; TAU = treatment as usual

Table 43. Key Question 2: function

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size (95% CI), p-Value	Author Reported Results
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison: (103)	Appropriate housing at 3 months based on agent reports	NA	85/103 (83%)	OR: 1.41 (0.62 to 3.22) p=0.41	Sign rank test: p<0.001
	TAU (55)	Appropriate housing at 3 months based on agent reports	NA	43/55 (79%)		
	MICA therapeutic community in prison and in community following release from prison: (103)	Social support system at 3 months based on agent report	NA	78/103 (76%)	OR: 0.97 (0.45 to 2.08) p=0.93	NR
	TAU (55)	Social support system at 3 months based on agent report	NA	42/55 (76%)		
	MICA therapeutic community in prison and in community following release from prison: (103)	Rated as stable	NA	60/103 (58%)	OR: 1.80 (0.93 to 3.49) p=0.08	NR
	TAU (55)	Rated as stable	NA	24/55 (44%)		

MICA = Mentally ill chemical abuser; NA=not applicable; OR = odds ratio; SMD = standardized mean difference; TAU = treatment as usual

Table 44. Key Question 2: medication adherence

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size (95% CI), p-Value	Author Reported Results
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison: (103)	Took medication consistently based on agent reports	NA	60/103 (58%)	OR 2.64 (1.34 to 5.22) p=0.005	Chi-square or one-way ANOVA significant at p<0.05
	Jail followed by TAU (55)	Took medication consistently based on agent reports	NA	19/55 (34%)		

MICA = Mentally ill chemical abuser; OR = odds ratio; TAU = treatment as usual

Table 45. Key Question 2: substance use

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison: (103)	Abstinence 3 months post release	NA	65/103 (63%)	OR 1.77 (0.91 to 3.44) p=0.09	Chi-square or one-way ANOVA significant at p<0.01
	TAU (55)	Abstinence 3 months post release	NA	27/55 (49%)		
	MICA therapeutic community in prison and in community following release from prison: (103)	Positive urinalysis within 3 months post release	NA	12/103 (12%)	OR: 0.78 (.30 to 2.03) p=0.60	NR
	TAU (55)	Positive urinalysis within 3 months post release	NA	8/55 (15%)		
Solomon and Draine, 1995 ⁶⁶	ACT	Alcohol scale of the Addiction Severity Index	NA	Not reported	Could not be calculated	Alcohol scale of the Addiction Severity Index was dropped from the discriminant analysis as it added very little to the model's predictive power.
	Forensic intensive case management	Alcohol scale of the Addiction Severity Index	NA			
	TAU	Alcohol scale of the Addiction Severity Index	NA			

ACT = Assertive community treatment; MICA = mentally ill chemical abuser; NA=not applicable; OR = odds ratio; TAU = treatment as usual

Table 46. Key Question 2: quality of life

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Solomon and Draine, 1995 ⁶⁶	ACT	Subjective Quality of Life measure, Lehman's Quality of Life Interview	NA	Not reported	Could not be calculated.	The subjective quality of life variables were dropped from the discriminant analysis as they added very little to the model's predictive power.
	Forensic intensive case management	Subjective Quality of Life measure, Lehman's Quality of Life Interview	NA			
	TAU	Subjective Quality of Life measure, Lehman's Quality of Life Interview	NA			

ACT = Assertive community treatment; NA=not applicable; TAU = treatment as usual

Table 47. Key Question 2: completed suicide

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Coid et al., 2007 ⁶³	Forensic specialist psychiatric services (409)	Suicide	NA	10/409 (2.4%)	OR: 0.79 (0.37 to 1.71) p=0.552	Regression analysis, with potential confounders adjusted for, OR: 1.25 (95% CI, 0.50 to 3.12)
	General adult psychiatric services (652)	Suicide	NA	20/652 (3.1%)		

OR = Odds ratio

Table 48. Key Question 2: service use during incarceration

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Theurer and Lovell, 2008 ⁶¹	MIOCTP (64)	Total hours in prison	NA	20 hours	Comparison was to larger control group so no effect size was calculated.	MIOCTP participants generally received pre-release services, whereas pre-release services were rare for control subjects.
	Residential mental health program residency while in prison; TAU upon release (287)		NA	0.7 hours		
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison (39 graduates and 91 terminators)	Institutional mental health service	NA	Graduates: 35 (89%) Terminators: 24 (26%)	OR: 2.05 (1.06 to 3.98) p=0.03	MICA graduates were more likely to receive mental health services through the ITC outreach component, while only one-quarter of terminators and comparison group members received some type of additional mental health service.
	TAU (59)	Institutional mental health service	NA	17 (29%)		
	MICA therapeutic community in prison and in community following release from prison (39 graduates and 91 terminators)	Medication monitoring	NA	Graduates: 35 (89%) Terminators: 90 (99%) Total: 125	OR: 1.82 (0.47 to 7.03) p=0.39	MICA graduates were more likely to receive mental health services through the ITC outreach component, while terminators and comparison group members received only periodic medication monitoring by a psychiatrist.
	TAU (59)	Medication monitoring	NA	55 (94%)		

MICA = Mentally ill chemical abuser; MIOCTP = mentally ill offender community transition program; TAU = treatment as usual

Table 49. Key Question 2: institutional infractions

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison (39 graduates and 91 terminators)	% put in segregation	NA	Graduates: 4 (9%) Terminators: 45 (49%) Total: 49	OR: 0.63 (0.34 to 1.17) p=0.14	MICA graduates were significantly less likely to receive segregation time than either terminations or members of the comparison group.
	TAU (59)	% put in segregation	NA	29 (49%)		
	MICA therapeutic community in prison and in community following release from prison (39 graduates and 91 terminators)	Average Days in segregation	NA	Graduates: 3 (NR) Terminators: 55 (NR)	Could not be calculated.	MICA graduates were significantly less likely to receive segregation time than either terminations or members of the comparison group.
	TAU (59)	Average Days in segregation	NA	57 (NR)		
	MICA therapeutic community in prison and in community following release from prison (39 graduates and 91 terminators)	% with minor conduct reports	NA	Graduates: 19 (48%) Terminators: 78 (86%) Total: 97	OR: 1.00 (0.49 to 2.03) p=1.00	MICA graduates were significantly less likely to receive conduct reports than either

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Van Stelle and Moberg, 2004 ⁶⁵ (Continued)	TAU (59)	% with minor conduct reports	NA	44 (75%)		
	MICA therapeutic community in prison and in community following release from prison (39 graduates and 91 terminators)	Average number of minor conduct reports	NA	Graduates:1.6(NR) Terminators:7.7 (NR)	Could not be calculated.	MICA graduates who did receive a conduct report received significantly fewer than the other two groups.
	TAU (59)	Average number of minor conduct reports	NA	3.9 (NR)		
	MICA therapeutic community in prison and in community following release from prison (39 graduates and 91 terminators)	% with major conduct reports	NA	Graduates: 7 (17%) Terminators: 57 (63%) Total: 97	OR: 2.02 (1.05 to 3.87) p=0.04	MICA graduates were significantly less likely to receive conduct reports than either terminations or members of the comparison group.
	TAU (59)	% with major conduct reports	NA	35 (60%)		
	MICA therapeutic community in prison and in community following release from prison (39 graduates and 91 terminators)	Average number of major conduct reports	NA	Graduates: 0.2 (NR) Terminators: 2.9 (NR)	Could not be calculated.	MICA graduates who did receive a conduct report received significantly fewer than the other two groups.
	TAU (59)	Average number of major conduct reports	NA	2.5 (NR)		

MICA = Mentally ill chemical abuser; NA=not applicable; OR = odds ratio; TAU = treatment as usual

Table 50. Key Question 2: criminal justice outcomes

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Theurer and Lovell, 2008 ⁶¹	MIOCTP (64)	New felony	NA	15/64 (23%)	OR 0.42 (95% CI 0.20 to 0.90) p=0.03	McNemar Test:, chi-square=5.5, p=0.01, OR 0.3, 3.4
	Residential mental health program residency while in prison; TAU upon release (64)		NA	27/64 (42%)		
	MIOCTP (64)	Any new offense	NA	25/64 (39%)	OR: 0.41 (0.20 to 0.84) p=0.01	McNemar Test:, p =0.003, OR 0.22, 4.5
	Residential mental health program residency while in prison; TAU upon release (64)		NA	39/64 (61%)		
Chandler and Spicer, 2006 ⁶⁴	Jail followed by high-fidelity IDDT (103)	Time to first rearrest and percent rearrested	NA	Data presented in survival graph form.	Could not be calculated.	RR: 0.94, (95% CI 0.67 to 1.35) p=0.75
	Jail followed by TAU (79)	Time to first rearrest and percent rearrested	NA	Data presented in survival graph form.		
	Jail followed by high-fidelity IDDT (103)	Total arrests at 20 months	NA	Data presented in graph form.	Could not be calculated.	IDDT participants had a non-significant lower sum of arrests than did control participants (z=1.131, p<0.189)
	Jail followed by TAU (79)	Total arrests at 20 months	NA	Data presented in graph form.		
	Jail followed by high-fidelity IDDT (103)	Arrests (per person year)	2.89	2.21	Could not be calculated.	IDDT: Sign rank test of difference within group: -0.68, p<0.01 TAU: Sign rank test of difference within group: -0.23, p≥0.05 Non-significant difference between groups
	Jail followed by TAU (79)	Arrests (per person year)	2.84	2.61		

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Chandler and Spicer , 2006 ⁶⁴ (Continued)	Jail followed by high-fidelity IDDT (103)	Any conviction (per person years)	0.69	0.59	Could not be calculated.	IDDT: Sign rank test of difference within group: -0.10, p<0.05 Non-significant difference between groups TAU: Sign rank test of difference within group:0.12, p≥0.05
	Jail followed by TAU (79)	Any conviction (per person years)	0.61	0.73		
	Jail followed by high-fidelity IDDT (103)	Felony conviction (per person years)	0.29	0.31	Could not be calculated.	IDDT: Sign rank test of difference within group: 0.02, p≥0.05 TAU: Sign rank test of difference within group: 0.03, p≥0.05 Non-significant difference between groups
	Jail followed by TAU (79)	Felony conviction (per person years)	0.25	0.28		
	Jail followed by high-fidelity IDDT (103)	Jail days (per person years)	96.74	60.71	Could not be calculated.	IDDT: Sign rank test of difference within group: -36.03, p<0.01 TAU: Sign rank test of difference within group: -20.05, p<0.01 Non-significant between group difference
	Jail followed by TAU (79)	Jail days (per person years)	79.43	59.39		
	Jail followed by high-fidelity IDDT (103)	Mean incarcerations	NA	Mean: 2.2 (NR)	Could not be calculated.	Author statistics: z=1.97, p<0.049
	Jail followed by TAU (79)	Mean incarcerations	NA	Mean: 2.8 (NR)		
	Jail followed by high-fidelity IDDT (103)	Mean jail stay (days)	NA	Mean: 59.4 (NR)	Could not be calculated.	Author statistics: z=1.97, p<0.051
	Jail followed by TAU (79)	Mean jail stay (days)	NA	Mean: 43.3 (NR)		

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at Final Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Solomon and Draine, 1995 ⁶⁶	ACT (37)	Return to jail within one year	NA	22 (60.0%)	Forensic ICM vs. ACT: 0.46 (0.18 to 1.17) p=0.10	No statistically significant difference
	Forensic intensive case management (35)	Return to jail within one year	NA	14 (40.0%)		
	TAU (22)	Return to jail within one year	NA	8 (36.0%)	Forensic ICM vs. TAU: 1.17 (0.39 to 3.51) p=0.78	
Coid et al., 2007 ⁶³	Forensic specialist psychiatric services (409)	Any re-offense	NA	477/2078	OR: 0.79 (0.70 to 0.90) p <0.000	Regression analysis, with potential confounders adjusted for, Incidence Rate Ratio 1.16 (95% CI, 0.94 to 1.43)
	General adult psychiatric services (652)	Any re-offense	NA	845/3086		
Van Stelle and Moberg, 2004 ⁶⁵	MICA therapeutic community in prison and in community following release from prison: (103)	Arrest within 3 months	NA	29/103 (28%)	OR: 0.63 (0.32 to 1.27) p=0.20	Not significant.
	TAU (55)	Arrest within 3 months	NA	21/55 (38%)		
	MICA therapeutic community in prison and in community following release from prison: (103)	Returned to prison within 3 months of release	NA	21/103 (22%)	OR: 0.49 (0.37 to 0.88) p=0.01	Chi-square or one-way ANOVA significant at p<0.05.
	TAU (55)	Returned to prison within 3 months of release	NA	19/55 (34%)		

TAU = Treatment as usual

Table 51. Key Question 2: mental health service use upon release

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at 3-month Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Theurer and Lovell, 2008 ⁶¹	MIOCTP (64)	MH service use in first 90 days post-release (total hours)	NA	92 hours	Comparison was to larger control group so no effect size was calculated.	MIOCTP participants generally received pre-release services and continued service upon release, whereas pre-release services were rare and long delays were common for control subjects.
	Residential MH program residency while in prison; TAU upon release (287)		NA	5.5 hours		
	MIOCTP (64)	Average hours per service month in the first year post-prison	NA	25 hours	Comparison was to larger control group so no effect size was calculated.	
	Residential MH program residency while in prison; TAU upon release (287)		NA	2.5 hours		
	MIOCTP (64)	Mean days from release date to first community MH service receipt	NA	2.3 days	Comparison was to larger control group so no effect size was calculated.	
	Residential MH program residency while in prison; TAU upon release (2,870)		NA	185 days		
Wenzlow et al., 2011 ⁶²	Medicaid enrollment on day of discharge or soon thereafter	% using any Medicaid MH service ≤90 days of release (calculations are based on intent-to-treat analysis)	NA	18/77(23%)	Comparison was between pre- and post-intervention periods within the same facilities: 4.27 (1.98 to 9.24) p<0.000	Authors' calculation: program was associated with a 16% increase in service use, p=0.009; adjusting for age, race, ethnicity, gender, Test of Adult Basic Education score (TABE), length of incarceration, and Medicaid status at entry.
	Pre-Medicaid program, same facilities		NA	13/195 (7%)		
	Medicaid enrollment on day of discharge or soon thereafter		13/195 (7)	18/77 (23%)		
	Comparison facilities at same point in time		11/284 (4)	3/130 (2%)		

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at 3-month Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Wenzlow et al., 2011 ⁶²	Medicaid enrollment on day of discharge or soon thereafter	% using outpatient Medicaid MH service ≤90 days of release	NA	15/77 (20%)	Comparison was between pre- and post-intervention periods within the same facilities: 5.00 (2.08 to 11.99) p<0.000	Authors' calculation: program was associated with a 14% increase in service use, p=0.015; adjusting for age, race, ethnicity, gender, Test of Adult Basic Education score (TABE), length of incarceration, and Medicaid status at entry.
	Pre-Medicaid program	(calculations are based on intent-to-treat analysis)	NA	9/195 (5%)		
	Medicaid enrollment on day of discharge or soon thereafter		9/195 (5%)	15/77 (20%)		
	Comparison facilities at same point in time		10/284 (4%)	3/130 (2%)		
Wenzlow et al., 2011 ⁶²	Medicaid enrollment on day of discharge or soon thereafter	% using prescription drug Medicaid MH service ≤90 days of release (calculations are based on intent-to-treat analysis)	NA	11/77 (14%)	Comparison was between pre- and post-intervention periods within the same facilities: 5.25 (1.87 to 14.76) p=0.002	Authors' calculation: program was associated with a 10% increase in service use, p=0.041; adjusting for age, race, ethnicity, gender, Test of Adult Basic Education score (TABE), length of incarceration, and Medicaid status at entry.
	Pre-Medicaid program		NA	6/195 (3%)		
	Medicaid enrollment on day of discharge or soon thereafter		6/195 (3%)	11/77 (14%)		
	Comparison facilities at same point in time		5/284 (2%)	2/130 (2%)		

Study	Group	Outcome	Number at Pre-treatment/ Total Number in Group (%)	Number at 3-month Followup/ Total Number in Group (%)	EPC Calculated Between Group Effect Size Odds Ratio (95% CI), p-Value	Author Reported Results
Chandler and Spicer, 2006 ⁶⁴	Jail followed by high-fidelity IDDT (103)	Received engagement related services within 60 days of release	NA	80/103 (77%)	16.15 (7.70 to 33.87) p=0.000	NR
	Jail followed by TAU (79)	Received engagement related services within 60 days of release	NA	14/79 (18%)		
	Jail followed by high-fidelity IDDT (103)	Outpatient medication service received	NA	82/103 (83%) Schizophrenia: 81.0% Major depression: 79.0%	2.39 (1.24 to 4.63) p=0.01	Chi-square=10.76, p<0.001
	Jail followed by TAU (79)	Outpatient medication service received	NA	49/79 (62.0%) Schizophrenia: 64.0% Major depression: 33.0%		

TAU = Treatment as usual

Appendix G. Guidelines

Table 52. Relevant guidelines

Reference	Scope	Recommendations to Improve Mental Health Outcomes	Recommendations to Reduce Recidivism
<p>National Commission on Correctional Health Care and Applied Clinical Education, 2009⁷¹</p>	<p>To provide guidance on treating individuals with schizophrenia in correctional facilities.</p>	<p>Treatments should be tailored to the three phases of schizophrenia: acute phase, stabilization phase and stable phase. Jails are likely to see individuals who are in the acute stage. The goals at this phase are to control disturbed behavior, suppress psychotic symptoms, and reduce anxiety/unrealistic fears, prevent harm to self or others, reintroduce function, ADL, appropriate hygiene and develop a therapeutic alliance. In phase 2, stabilization, the goal is to provide a supportive environment, manage stress, foster social skills, maintain symptom control, and promote psychosocial rehabilitation. In phase 3, stable phase, continue with progress achieved in phase 2 and medication monitoring.</p> <p>Medication is key for symptom control. The principles of drug selection for patients with schizophrenia are the same in the correctional facility as in the community. Generally, no definitive efficacy advantage has been found for atypical antipsychotics over typical agents as a class or for any individual atypical agent over another. However, clozapine is more effective than other antipsychotic in treatment resistant schizophrenia but requires regular blood monitoring to prevent adverse events. Atypical antipsychotics are often chosen over conventional agents as there is some evidence that they are better at reducing negative symptoms, for relapse prevention, and lower incidence of certain serious adverse events. Psychosocial support, in the form of group sessions, is an important adjunct to medication and should provide the patient with motivation, problem-solving skills, adherence, interpersonal communication, improving cognitive deficits, relapse prevention, treatment of comorbid disorders.</p>	<p>NR</p>

Reference	Scope	Recommendations to Improve Mental Health Outcomes	Recommendations to Reduce Recidivism
Federal Bureau of Prisons, 2009 ⁷²	To provide guidelines for identifying and treating Federal inmates with major depressive disorder.	<p>Regarding treatment: Pharmacotherapy (including ECT) is the first line treatment with psychotherapy as an adjunctive treatment only. A physician experienced in treating major depressive disorder should initiate treatment.</p> <p>Treatment occurs in three phases: acute, continuation and maintenance.</p>	NR
Prins and Draper, 2009 ⁷³	To assist policymakers in identify the best strategies for individuals with mental illness under community corrections supervision.	<p>The following six mental health treatment practices have been shown to effectively improve mental health outcomes for individuals with SMI, although their effectiveness for the SMI under community corrections has not been established: ACT, illness self-management and recovery, integrated mental health and substance abuse services, supported employment, psychopharmacology, and family psychoeducation.</p> <p>Other promising mental health interventions for individuals with SMI and community corrections supervision include supported housing and trauma interventions. These interventions are particularly relevant to this population. Additionally, the evidence for programs that combine community corrections with mental health supervision, such as specialized mental health probation caseloads, looks promising.</p>	For people with mental illness under community corrections supervision, the following strategies have been found to reduce recidivism and/or increase the use of services: “firm but fair” relationships between the community corrections officer and individuals with mental illness; problem-solving and positive pressure strategies to increase adherence to treatment; and boundary-spanning skills.

NR = Not reported

Appendix H. Previous Systematic Reviews

Table 53. Previous systematic reviews

Reference	Search Strategy/ Evidence Base	Key Inclusion/ Exclusion Criteria	Participant Characteristics	Outcomes Reported	Method of Assessing Quality	Method of Synthesizing Evidence	Results and/or Authors' Conclusions
Griffiths et al., 2012 ²⁰	AMED, AMI, APAIS Health, CINAHL, CINCH-Health, Cochrane Library, DRUG, emedicine clinical knowledge database, EMBASE, International Pharmaceutical Abstracts, MEDLINE, Proquest 5000 International, PsycINFO, Scopus and Web of Science for qualitative and quantitative studies discussing the use of psychotropic medication in prisoners. Eight Australian State and territorial government correctional services websites and one specialized journal, Journal of Correctional Health Care, were searched as well.	Study population was adult prisoners on a psychotropic medication of interest with full text available in English published between January 1999 and October 2009. Article had to be available in full text format.	32 articles were included.	Review reported in a qualitative manner authors opinions on the following five themes: polypharmacy, high dosing, duration of treatment, documentation and monitoring, and environment.	Checklist by Liberati was used for qualitative and quantitative studies and risk of bias was assessed with the Cochrane risk of bias assessment.	Qualitative	Five themes emerged from the included articles: polypharmacy (use of more than one antipsychotic is strongly discouraged but was widespread); high doses (dosages above the maximum recommended daily dose is discouraged as very high doses are no more efficacious and lead to more side effects); duration of treatment (insufficient time is given to initial monotherapy with one antipsychotic before a second supplementary drug was prescribed and therapy with hypnotics and benzodiazepines was too long); documentation and monitoring (generally found to be inadequate); environment (lack of consistency between prescribers and across sites).

Reference	Search Strategy/ Evidence Base	Key Inclusion/ Exclusion Criteria	Participant Characteristics	Outcomes Reported	Method of Assessing Quality	Method of Synthesizing Evidence	Results and/or Authors' Conclusions
Martin et al., 2011 ¹⁹	Searched PsycINFO and Web of Science for articles published no later than 2008. Evidence base consisted of 25 studies published between 1989 and 2008.	Inclusion criteria: 1) article published in peer review journal or have gone through some other peer review process; 2) included comparison group; 3) tested the hypothesis that intervention improves mental health or reduces re-involvement in CJS; 4) had a sample size of at least 5; 5) reported necessary statistics to compute an effect size; and 6) had a sample of adults with mental disorders who were involved in the CJS. Exclusion criteria: 1) substance use, intellectual/cognitive, and/or antisocial personality disorders as sole mental health diagnosis; 2) study considered a sex offender program; 3) comparison group made up of treatment refusal or dropouts; and 4) study included only subjective mental health measures.	Not reported	CJS outcomes included: number of arrests, violent arrests, jail days, and breach of conditions Mental health outcomes included: functioning, symptoms, service utilization, and medication use Moderator outcomes included: study design characteristics (e.g., sample size, quality rating, randomized), intervention characteristics (e.g., treatment location, duration, and whether voluntary), and mental health outcomes (if mental health outcomes were measured).	Quality was assessed by modifying a coding tool developed for sex offender treatment outcome research (Beech et al., 2007). The scale assesses 20 items falling within 7 categories: administrative control of the independent variable, experimenter expectancies, sample size, attrition, equivalence of groups, outcome variables, and correct comparison conducted.	Quantitative The authors used meta-analysis to derive an overall effect of interventions provided to adults with SMI in the CJS on CJS outcomes and mental health outcomes.	The results indicated that combined effect sizes from 25 studies support the effectiveness of interventions for reductions in any CJS involvement. However, interventions had no significant on an aggregate mental health outcome, but demonstrated significant improvement on some distinct mental health outcomes, such as functioning. The authors concluded that the "results suggested some relationship between intervention effects on mental health and criminal justice reinvolvement, although future research is needed in this area, especially given the absence of mental health outcome data."

Reference	Search Strategy/ Evidence Base	Key Inclusion/ Exclusion Criteria	Participant Characteristics	Outcomes Reported	Method of Assessing Quality	Method of Synthesizing Evidence	Results and/or Authors' Conclusions
Mitchell and Braham, 2011 ⁷⁴	PsycINFO and MEDLINE through present date were searched for psychological treatment needs of deaf mentally disordered offenders residing in high secure settings.	Due to a lack of direct evidence on this topic the authors expanded the inclusion criteria to include low-, medium-secure and prison settings. Any type of article was included (e.g., narrative reviews).	Mentally disordered offenders with all types of hearing loss were included except when combined with blindness. Child studies and non-psychotherapeutics (e.g., psychopharmacological) were also excluded.	A literature synthesis was presented, no predefined outcomes.	NR	Qualitative	When delivering treatment to the deaf mentally disordered offender expectation have to be adjusted, group interventions with deaf peers works best, and extra time and visual aids are required. There is a lack of evidence on effective treatments for deaf sex offenders.
Morgan et al., 2011 ¹⁸	Searched PsycINFO, MEDLINE, and SocialSciAbs. Evidence base consisted of 26 articles published between 1973 and 2004. Settings represented in articles include 64% sanction-oriented facilities and 28% treatment-oriented facilities.	Inclusion criteria: 1) study published in English; 2) study evaluated an intervention provided in CJS; 3) participants suffered from a major DSM Axis 1 disorder; 4) the study included some form of control procedure or used a repeated measures design, and 5) study included sufficient data or summary statistics that allowed calculation of an effect size. No exclusion criteria reported.	The total sample across studies included 1,649 offenders, with 1,369 participants in treatment groups and 280 participants in control groups. 42% of the studies included participants with schizophrenia, 15.4% with a mood disorder, and 19.2% with multiple Axis 1 disorders.	Mental health symptoms, coping, institutional adjustment, behavioral functioning, criminal recidivism, psychiatric recidivism, treatment-related factors, and financial benefit.	Used a portion of the Maryland Scale of Scientific Rigor to evaluate studies on the presence and composition of a comparison group relative to the treatment group.	Calculated individual study effect sizes and conducted meta-analysis on each treatment outcome.	The main findings from the review were that interventions for offenders with mental disorders reduced mental health symptoms, improved ability to cope with problems, and improved behavioral markers including institutional adjustment and behavioral functioning. Results of meta-analysis were statistically inconclusive about the effects of intervention on recidivism.

Reference	Search Strategy/ Evidence Base	Key Inclusion/ Exclusion Criteria	Participant Characteristics	Outcomes Reported	Method of Assessing Quality	Method of Synthesizing Evidence	Results and/or Authors' Conclusions
Huband et al., 2010 ²¹	CENTRAL, MEDLINE, EMBASE, CINAHL, and PsycINFO, metaRegister of Controlled Trials and ClinicalTrials.gov through April 2009. Cochrane Schizophrenia Group register of trials on aggression, National Research Record and hand searched.	Prospective, placebo controlled trials of antiepileptic drugs taken regularly by individuals with recurrent aggression to reduce the frequency or intensity of aggressive outbursts.	Studies included a wide array of subjects in a variety of settings, including but not limited to: children and adolescent with conduct disorder or pervasive developmental disorder, outpatient adult males with impulsive aggression, impulsively aggressive adults with cluster B personality disorder, women with borderline personality disorder, male prisoners with personality disorders	Aggression, impulsivity, hostility, anger, anger- hostility, non- compliance, and adverse events.	Two authors independently completed The Cochrane Collaborations' tool for assessing risk of bias.	Quantitative when possible	One study included in this systematic review found diphenylhydantoin 300 mg/day to be superior to diphenylhydantoin 24 mg/day for treating aggression and associated impulsivity in male prisoners at an institution for dangerous and emotionally unstable recidivists.

Reference	Search Strategy/ Evidence Base	Key Inclusion/ Exclusion Criteria	Participant Characteristics	Outcomes Reported	Method of Assessing Quality	Method of Synthesizing Evidence	Results and/or Authors' Conclusions
Nagi and Davies, 2010 ²²	To describe and present evidence for psychological interventions intended to address offending behavior in individuals with offending histories cared for in low secure forensic mental health services.	Articles (reviews, systematic reviews) on what works including gray literature (reports on the Home Office website, papers and posters at conferences); hand searches; and prominent author searches published in English since 1990 were included. Articles specific to women or learning disabled populations were excluded.	Varied offender groups	Reoffending	NR	Qualitative	CBT is most effective and is the dominant treatment category being offered internationally, based on consensus opinion. Risks, needs and responsivity principles are only now starting to influence the treatments being offered. More research is needed in the low secure forensic mental health service area.
Sacks et al., 2010 ²³	Single-investigator meta-analysis	Studies performed by one investigator which assessed the effectiveness of modified therapeutic community versus standard of care for clients with co-occurring substance use and mental disorders to determine the consistency of effect across studies.	Adults with co-occurring substance abuse and mental disorders in the following settings: homeless population, offenders, outpatients or with HIV/AIDS.	Substance abuse, mental health, crime, HIV-risk behavior, employment and housing	NR	Quantitative when possible	Modified Therapeutic community was superior to standard of care in reducing substance abuse and crime and improving mental health, employment and housing across a variety of settings.

Reference	Search Strategy/ Evidence Base	Key Inclusion/ Exclusion Criteria	Participant Characteristics	Outcomes Reported	Method of Assessing Quality	Method of Synthesizing Evidence	Results and/or Authors' Conclusions
Khalifa et al., 2008 ²⁴	MEDLINE, EMBASE, PsycINFO, Association of Telehealth Service Providers (ATSP online) and Telemedicine Information Exchange (TIE) from published between 1998 to 2006 were searched for the use of videoconferencing in forensic settings. This search was supplemented by hand searches.	24 articles of any design were included. Videoconferencing was broken down into three categories: for clinical and forensic applications, including determining competence to stand trial; for use in court; and for legal and ethical issues.	Those involved in the criminal justice system including youth, rural victims of domestic violence, prison inmates with and without an SMI	Cost, inmate preference, number of hospital referrals, telemedicine utilization in prison	NR	Qualitative	There is preliminary evidence that videoconferencing is effective in forensic settings. However, the available evidence is limited by lack of control group, small sample size, and limited outcome reporting.

Reference	Search Strategy/ Evidence Base	Key Inclusion/ Exclusion Criteria	Participant Characteristics	Outcomes Reported	Method of Assessing Quality	Method of Synthesizing Evidence	Results and/or Authors' Conclusions
Duncan et al., 2006 ⁷⁵	<p>Searched CINAHL, EMBASE, MEDLINE, and Psych Info for articles published between 1980 and 2002.</p> <p>Evidence base consisted of 20 studies that met inclusion criteria (8 used a control or comparison group design), 10 studies conducted in British high security hospital, 6 in British medium security hospital, and 4 in Canada or the U.S. (security level not specified).</p>	<p>Inclusion criteria: 1) study evaluated the efficacy/effectiveness of structured single-form group interventions specifically for offenders with mental disorders; 2) study evaluated the efficacy/effectiveness of structured complex group interventions specifically for offenders with mental disorders; and 3) published in English.</p> <p>No exclusion criteria reported.</p>	<p>19 studies included only males and 1 included only females.</p> <p>Patient diagnoses: Not specified (6 studies), Axis I (3 studies), personality disorder (4 studies), psychotic disorder (1 study), borderline personality disorder (1 study), sex offender (1 study), mentally ill (1 study), antisocial (1 study), and schizophrenia (1 study).</p>	<p>Studies were categorized by the focus of the intervention: problem solving skills, anger/aggression management, deliberate self-harm, or other.</p> <p>Outcomes focused on improvements in those categories (e.g., improved problem solving skills, anger management, etc.).</p>	Not reported	<p>When possible, individual study effect sizes calculated.</p> <p>Meta-analysis was not possible due to heterogeneity of study population, small sample size and lack of comparable data.</p>	<p>Individual effect size calculations indicate positive effects, with a moderate to high effect observed for self-harm interventions.</p> <p>The authors conclude that more rigorous and consistent research be applied, including an agreement on common outcome measures and development of networks to improve sample size.</p>

Appendix I: Ongoing Clinical Trials

Table 54. Ongoing clinical trials

Clinicaltrials.gov Identifier or Other Identifier	Sponsor	Design	Purpose	Start Date (month/year)	Expected Completion Date (month/year)	Estimated Enrollment
NCT00249756	National Institute on Drug Abuse	RCT	To examine the transition from prison to community for offenders with both mental illness and chemical abuse (MICA). Modified therapeutic community (reentry MTC) will be compared with case management and parole supervision.	08/2005	07/2011 Ongoing but not recruiting	332
NCT00606996	National Institute of Drug Abuse	RCT	To determine if interpersonal psychotherapy is effective for treating co-occurring depression and substance use among women prisoners.	07/2006	06/2011 Recruitment status unknown	80
NCT01313052	University of Rochester	RCT	To compare the efficacy of FACT with enhanced outpatient treatment (close outpatient followup without judicial monitoring) for individuals with a psychotic disorder who are facing charges but who have not yet been sentenced.	05/2008	05/2013 Enrollment is by invitation only	70
NCT01157351	Janssen Scientific Affairs, LLC	RCT	To compare the efficacy of paliperidone palmitate to oral antipsychotic treatments in delaying time to treatment failure for individuals with schizophrenia who have been incarcerated.	4/2010	10/2013 Currently recruiting participants	442

RCT = Randomized control trial