Social Support Among People With Mental Illnesses on Probation

Connie Longmate
University of North Carolina at Chapel Hill

Evan Lowder
George Mason University

Ashley Givens
University of Missouri

Tonya B. Van Deinse, Marilyn Ghezzi,
Stacey Burgin, and Gary S. Cuddeback
University of North Carolina at Chapel Hill

Objective: Justice-involved people with mental illnesses, in general, experience poor criminal justice outcomes (i.e., high rates of recidivism and probation revocations) and are at increased risk of homelessness, unemployment, stigma, trauma, and poor physical health. Low social support is repeatedly associated with worse mental health outcomes in the general population but little is known about social support among probationers with serious mental illnesses. *Method:* To address these gaps in the literature, we used an observational cross-sectional study design and data from a large, randomized controlled trial of specialty mental health probation to examine self-reported social support and its relationships with mental health functioning and other outcomes for individuals with serious mental illnesses on supervised probation. *Results:* Probationers who self-reported lower levels of social support also reported greater mental health symptomatology and reported lower quality relationships with their probation officers. *Conclusions and Implications for Practice:* Low social support among probationers with mental illnesses has important implications for mental health and criminal justice practice and policy. Coordinating services between the criminal justice and mental health systems to offer opportunities for social support and meaningful community engagement for those with mental illnesses who are on probation could improve a number of mental health and criminal justice outcomes for this population. Peer support and supported employment services, for example, in addition to outpatient mental health services, could be two strategies that could address social isolation and help individuals living with mental illnesses optimize their recovery and rehabilitation.

Impact and Implications
Among individuals with serious mental illnesses on probation, low levels of social support were associated with greater symptoms of depression and posttraumatic stress disorder, poor mental health functioning, and poor relationships with probation officers. Justice-involved individuals with mental illnesses would benefit from prosocial supports and meaningful community engagement opportunities to reduce social isolation, optimize recovery, and improve outcomes.

Keywords: social support, mental illnesses, probation

The U.S. is home to almost 7 million people who are under correctional supervision at any given time and individuals with mental illnesses are overrepresented in the criminal justice system

(Kaeble & Cowhig, 2018; Morrissey, Domino, & Cuddeback, 2016). In general, people with mental illnesses receive and serve longer sentences for the same crimes than those without mental illnesses and fare more poorly with regard to parole release decisions (Council of State Governments Justice Center, 2012; Hartwell, 2004; Matejkowski, Caplan, & Cullen, 2010; Skeem & Louden, 2006). To exacerbate matters, justice-involved people with mental illnesses experience high rates of substance use, homelessness, social isolation, and stigma (Hartwell, 2004; Mallik-Kane & Visher, 2008; Skeem & Louden, 2006).

Mental health is shaped by many of the same social determinants that affect physical health (Allen, Balfour, Bell, & Marmot, 2014), including education, unemployment, income, and the built environment. Social support, and conversely social isolation, has increasingly gained attention as a social determinant of health and there is a well-established protective effect of social ties on mental health (Allen et al., 2014; Chou, Liang, &

Sareen, 2011; Kawachi & Berkman, 2001; Sias & Bartoo, 2007). There is, however, limited research on the relationship between social support and mental health and prosocial personal and agency supports among justice-involved individuals with mental illnesses.

Johnson et al. (2011) examined the effects of social support on depression for incarcerated adolescents and found that higher levels of social support predicted lower depression scores. In a study of probationers with co-occurring mental illnesses and substance use disorders, Skeem, Louden, Manchak, Vidal, and Haddad (2009) found that probationers had relatively small social networks limited mostly to professionals, such as probation officers and health care providers. In addition, probationers who reported low relationship quality with their probation officers and their core social networks—defined as the five individuals with whom a probationer spent the most time—were more likely to receive a greater number of probation violations (Skeem et al., 2009).

Beyond the absence of positive social support networks, antisocial associates have been identified as one of eight criminogenic risk factors widely believed to have the strongest associations with criminal behavior (Andrews & Bonta, 2010; Andrews, Bonta, & Wormith, 2006). There is limited evidence regarding the extent to which the lack of prosocial supports, in contrast to having antisocial associates, is modifiable and amenable to change for justice-involved people with mental illnesses. This is of concern because, as a dynamic criminogenic need, facilitating prosocial supports in treatment has the potential to reduce the likelihood that a person will engage in future criminal activities (Andrews et al., 2006).

Other than the important exploratory work conducted by Skeem et al. (2009), little is known about social support among probationers with serious mental illnesses and its impact on mental health functioning, which is a significant gap in the mental health services literature, especially given the large and growing number of individuals with serious mental illnesses who are on community supervision arrangements (i.e., probation and parole). To address these gaps and inform practice and policy at the nexus of the behavioral health and criminal justice systems, we used data from a large randomized study of specialty mental health probation for probationers with serious mental illnesses to examine the relationships between social support, mental health functioning, and prosocial personal and agency supports.

Method

Design

An observational cross-sectional study design, using data from a large, randomized controlled trial (RCT) of specialty mental health probation in a large southeastern state was used to examine the relationships between social support and mental health functioning and other outcomes among a sample of 204 probationers with serious mental illnesses. In the parent RCT, probationers identified as high-risk for recidivism according to the state probation agency's recidivism risk classification system who also screened positive for mental health problems were referred to meet with the research team to assess eligibility for study participation.

Eligibility criteria included the following: (a) aged 18 or older; (b) high risk for recidivism; (c) met diagnostic criteria for at least one of the following: psychotic disorder, bipolar disorder, major depression, and/or posttraumatic stress disorder; and (d) competent to provide informed consent. Trained research staff used the Mini-International Neuropsychiatric Interview (MINI) to confirm a qualifying diagnosis (Lecrubier et al., 1997).

Baseline interviews with study participants included the collection of demographic information, the administration of standardized measures of mental health functioning, social support, personal and agency supports (researcher-created), and each subject's relationship with his or her probation officer.

The study was reviewed and approved by the Institutional Review Board at the University of North Carolina at Chapel Hill.

Sample

Between January 2017 and August 2018, 204 probationers with serious mental illnesses were consented and enrolled in the study. The characteristics of the study sample are shown in Table 1. The average age of those in the sample was 33.48 years ($SD = 10.95$) and 59% ($n = 120$) were male. The sample was mostly African American (51%, $n = 104$) or White (41%, $n = 83$) and 5% ($n = 10$) identified as Hispanic. Only 7% ($n = 15$) were married and 93% ($n = 89$) were single, divorced, or otherwise not partnered, and 25% ($n = 51$) reported having less than or equal to a high school education and 35% ($n = 70$) reported having a high school diploma or GED. About a third (35%, $n = 72$) of the probationers were unemployed at the time of baseline data collection, 27% ($n = 55$) reported full-time employment, 25% ($n = 52$) reported part-time employment, and 10% ($n = 21$) reported being disabled and unable to work.

Also, 48% ($n = 97$) of the sample did not have health insurance. At the time of the baseline interview, 46% ($n = 93$) of study participants were on probation for the first time. For those who had prior probation sentences, 27% ($n = 55$) had one prior sentence, 13% ($n = 26$) had two prior sentences, and 12% ($n = 24$) had three or more prior probation sentences. The average sentence length for the sample of probationers was 22.07 months ($SD = 12.48$). At the time of baseline interview, only 53% ($n = 109$) of the sample were receiving mental health services, such as counseling or medication management.

Measures

To assess social support among study participants, we used the Duke-UNC Functional Social Support Questionnaire (FSSQ; Broadhead, Gehlbach, de Gruy, & Kaplan, 1988). The FSSQ is an eight-item instrument using a 5-point Likert response scale with higher scores indicating greater perceptions of social support. The FSSQ has marginal test–retest reliability ($r = .66$) as well as evidence of concurrent criterion validity and discriminant validity (Broadhead et al., 1988).

Symptomatology and psychological distress was assessed using the Symptom Checklist-10-Revised (SCL-10-R), a 10-item measure based on the longer Symptom Checklist-90-Revised (Derogatis, Lipman, & Covi, 1973; Derogatis, Rickels, & Rock, 1976; Rosen et al., 2000). The SCL-10-R uses items from each of the nine subscales included in the SCL-90–R. The SCL-10-R has

Table 1

Demographic, Mental Health, and Criminal Justice Characteristics of Probationers With Mental Illnesses Who Report High Versus Low Social Support

Indicator	Total sample (n = 204) % (n)	High social support (n = 87) % (n)	Low social support (n = 117) % (n)
Gender			
Male	58.82 (120)	59.77 (52)	58.12 (68)
Female	41.18 (84)	40.23 (35)	41.88 (49)
Race			
White	41.09 (83)	48.84 (42)	35.34 (41)
African American	51.49 (104)	45.35 (39)	56.03 (65)
Hispanic	4.90 (10)	5.75 (5)	4.27 (5)
Age M (SD)	33.48 (10.46)	33.82 (11.03)	33.23 (10.94)
Education			
<High school	25.0 (51)	26.44 (23)	23.93 (28)
≥High school	75.0 (153)	73.56 (64)	76.07 (89)
Marital status			
Not married	92.65 (189)	90.80 (79)	94.02 (110)
Married	7.35 (15)	9.20 (8)	5.97 (7)
Health insurance	52.22 (106)	54.65 (47)	50.43 (59)
Employed	52.45 (107)	55.17 (48)	50.43 (59)
Diagnosis			
Psychotic disorder	23.04 (47)	18.39 (16)	26.50 (31)
Bipolar disorder	62.25 (127)	62.07 (54)	62.39 (73)
Depression	12.75 (26)	17.24 (15)	9.40 (11)
PTSD[***]	50.49 (103)	36.78 (32)	60.68 (71)
Mental health service	53.43 (109)	58.62 (51)	49.57 (58)
Prior probation	51.72 (105)	93.39 (94.75)	90.84 (62.75)
Probation months M (SD)	23.27 (11.58)	23.02 (12.11)	23.46 (11.20)
FSSQ total M (SD)	24.29 (8.60)	32.61 (4.39)	17.94 (4.69)
SCL-10-R total M (SD)[***]	19.68 (8.64)	15.98 (7.77)	22.43 (8.25)
DRI-R total M (SD)[**]	145.18 (33.65)	152.80 (31.30)	139.30 (34.34)
Agency supports M (SD)	1.25 (1.11)	1.37 (1.11)	1.16 (1.11)
Personal supports M (SD)	2.69 (1.62)	2.86 (1.61)	2.57 (1.63)

[**] $p < .01$.   [***] $p < .001$.

good internal consistency reliability ($\alpha = .87$) and has demonstrated convergent validity as evidenced by strong and positive correlations with scores on the SCL-90 ($r = .91$) and the Beck Depression Inventory ($r = .66$; Muller, Postert, Beyer, Furniss, & Achtergarde, 2010; Rosen et al., 2000). Higher scores indicate greater levels of psychological distress.

To assess the quality of the relationship between a probationer and his or her probation officer, we used the Dual Role Relationship Inventory: Revised (DRI-R), a 30-question instrument, which uses a 7-point Likert scale to assess how a person on probation feels about his or her probation officer (Skeem, Louden, Polaschek, & Camp, 2007). DRI-R total scores have excellent internal consistency reliability ($\alpha = .95$) and convergent validity as evidenced by strong and positive correlations with scores on the measures of therapeutic alliance ($r = .54$; Skeem et al., 2007). Higher scores indicate better relationship quality between the probationer and the officer.

A researcher-created measure was administered such that subjects were asked to enumerate up to five prosocial personal supports (e.g., mother, brother, girlfriend, pastor) and up to five agency supports (e.g., probation, mental health agency, church). The total number of personal and agency supports were summed separately for each subject and ranged from 0 to 5.

Data Analysis

We used descriptive statistics to describe the sample's demographics and baseline functioning with respect to the standardized measures enumerated above. Of the 204 probationers who were enrolled, 194 completed the Duke-UNC Functional Social Support Questionnaire (FSSQ; Broadhead, Gehlbach, de Gruy, & Kaplan, 1988) at their baseline interview, representing the final analytic sample used here. The sample was separated into those probationers who self-reported high versus low social support, where high social support was a FSSQ score ≥ 26 and low social support is an FSSQ score < 26.

We used bivariate inferential statistics to examine the relationship between group status (high vs. low social support) and demographic variables and scores on standardized measures. Independent groups t tests were used to examine the relationship between group status and continuous measures and chi-square tests were used to examine the relationship between group status and categorical measures.

The distribution, skew, and kurtosis of scores on the FSSQ were evaluated and normality was assessed using the Kolmogorov–Smirnov Test (K-S Test). A histogram with a normal curve overlay suggested scores on the FSSQ were normally distributed, kurtosis was -0.95, skew was 0.09 and the K-S test was not significant,

indicating the null hypothesis that the distribution was not normal was rejected. Next, we regressed total FSSQ scores on race (white as reference group), gender (male as reference group), age, diagnosis, educational level (less than high school as reference group), employment status (unemployed as reference group), marital status (single as reference group), receipt of mental health services (no services as reference group), number of prior probation sentences, length of current probation sentence, psychiatric functioning (as measured by the SCL-10-R), relationship with probationer officer (as measured by the DRI-R), personal contacts, and agency contacts.

All variables were examined for multicollinearity and were excluded if variance inflation factors (VIF) were greater than 10. Statistical analyses were conducted using StataSE 16 and SAS 9.2 (SAS Institute, Cary, NC; StataCorp, College Station, TX). In all bivariate statistical tests, two-tailed tests were used and alpha was set at .05.

Results

As shown in Table 1, the average score on the FSSQ for the total sample ($n = 204$) was 24.29 ($SD = 8.60$), the average score on the SCL-10-R was 19.68 ($SD = 8.64$), and the average score on the DRI-R was 145.18 ($SD = 33.65$). The average number of individuals identified as supports among the total sample was 2.69 ($SD = 1.62$) and the average number of agency supports identified was 1.25 ($SD = 1.11$). Among the analytic sample of 201 participants who completed the FSSQ, 57% ($n = 117$) were in the low social support group (i.e., FSSQ scores < 26) and 43% ($n = 87$) were in the high social support group (i.e., FSSQ scores ≥ 26).

The average FSSQ score for the high social support group ($n = 87$) was 32.62 ($SD = 4.35$) and the average FSSQ score for the low social support group ($n = 117$) was 17.94 (SD = 4.68). Compared with probationers who self-reported high levels of social support, probationers who reported low social support were more likely to be diagnosed with posttraumatic stress disorder (37% vs. 61%, respectively; $\chi^2(1) = 11.40$, $p < .001$). There were no other statistically significant differences between groups on any other demographic or clinical variables.

Also shown in Table 1, compared with those who self-reported high social support, probationers with low social support had higher scores on the SCL-10-R indicating greater mental health symptoms (15.98 vs. 22.43 for the high and low social support groups, respectively; $t(202) = 5.66$, $p < .001$). Compared with those who reported high social support, those who reported low social support had lower scores, on average, on the DRI-R indicating poorer relationships with their probation officers (152.80 vs. 139.30, respectively; $t(193) = -2.85$, $p < .01$).

There were no differences with respect to the number of personal supports or agency supports identified by the high and low social support groups. With regard to the top three types of agency supports identified by the sample, among those who identified agency supports, 26% ($n = 37$) identified a mental health provider as a source of support, 24% ($n = 35$) identified a church or charity as a source of support, and 12% ($n = 17$) identified a substance abuse treatment provider as a source of support.

As shown in Table 2, results of the multivariate regression model indicate that, when holding all other variables constant, the regression coefficient for scores on the SCL-10-R is negative ($\beta = -.40$), which suggests an increase in scores on the SCL-10-R is associated with a decrease in scores on the FSSQ decrease ($p < .001$). Also shown in Table 2, the regression coefficient for scores on the DRI-R is positive ($\beta = .04$), which suggests an increase in scores on the DRI-R is associated with an increase in scores on the FSSQ ($p < .01$).

Table 2

FSSQ Scores Regressed on Demographic, Clinical, Criminal Justice, and Scores on Standardized Measures

Predictor	β	SE β	t value	p
Constant	23.50	4.38	5.36	.001
Female (ref: male)	1.28	1.24	1.03	ns
Black (ref: White)	−.57	1.03	−.55	ns
Hispanic	2.45	2.95	.83	ns
Age	.03	.06	.50	ns
Marital status (ref: single)	1.76	2.06	.85	ns
Education (ref: < HS/GED)	−2.75	1.36	−2.02	.05
Employment (ref: unemployed)	1.14	1.18	.97	ns
Insurance (ref: no insurance)	1.52	1.13	1.33	ns
Depression	2.90	1.75	1.66	ns
Schizophrenia	1.59	1.46	1.09	ns
PTSD	−2.26	1.23	−1.83	ns
Prior probation (ref: none)	−.02	.05	−.49	ns
Current mental health services (ref: none)	−.50	1.23	−.41	ns
SCL-10-R	−.40	.07	−5.47	.001
DRI-R	.04	.02	2.47	.01
Person supports	.62	.36	1.69	ns
Agency supports	.69	.25	1.25	ns

Note. SAS programming code = [**proc reg** model FSSQ = gender race hispanic age marry educ employ insurance depression schizophrenia ptsd mhserv prior_probation prob_sent_months SCL_DRI_agency-support person-support/vif collin tol; **run**;]. MSQ = 267.32; *F* value (18) = 4.91; *p* < .0001; R-square = .34; ns indicates nonsignificant result. Bipolar disorder was removed from the model due to collinearity.

Discussion

We examined social support among a population of probationers with mental illnesses and used bivariate and multivariate models to examine the relationship between group status (high vs. low social support), scores on the FSSQ, and demographic and mental health functioning for this population. Our findings suggest that probationers who self-reported low levels of social support also reported more mental health symptoms and were more likely to meet diagnostic criteria for PTSD (as determined by trained research staff using the MINI). Although causation cannot be established in this study given the observational design, low social support could be an indication of untreated trauma and has implications for trauma-informed mental health and criminal justice interventions. Namely, individuals with histories of trauma, particularly childhood trauma have increased fear, anxiety, and mistrust (Charuvastra & Cloitre, 2008). These sequelae of trauma, especially when coupled with the stigma of being justice involved and having a serious mental illness, could significantly impact the ability to meet probation requirements, the ability to form and maintain relationships with probation officers and other supports, the ability to engage in mental health services, and inhibit the realization of important recovery and rehabilitation milestones.

Probationers who self-reported low social support also reported poorer relationships with their probation officers, and these findings are aligned with prior studies that report less depression among justice-involved adolescents who report higher social support (Johnson et al., 2011) and relatively small social networks among probationers with mental illnesses (Skeem et al., 2009). There is a well-established protective effect of social connections on mental health and evidence that social isolation is connected to poorer mental health outcomes (Allen et al., 2014; Chou et al., 2011; Kawachi & Berkman, 2001; Sias & Bartoo, 2007). Our findings extend this knowledge to justice-involved people with mental illnesses and further our understanding of the relationships between social support, mental health functioning, and connections with supportive individuals and agencies for probationers with mental illnesses.

For justice-involved individuals with mental illnesses, assessing social isolation and addressing prosocial support needs should be a routine practice for criminal justice and mental health providers. These findings highlight the importance of connecting people socially and helping them integrate meaningfully with their communities, because those with mental illnesses are particularly likely to face stigma and isolation, which may be exacerbated by the complexities of mental illness and involvement with the justice system (Hartwell, 2004).

Compared with those self-reporting high social support, probationers in the low social support group reported poorer relationships with their probation officers. This is an important finding given probation officers take on a "dual role," acting both as law enforcement officers and as supportive figures and resources for the probationers under their supervision (Skeem, Kennealy, & Manchak, 2014). Although this study did not assess the relationship between social support and criminal justice outcomes, the work of Skeem and colleagues suggests that future probation violations are more likely when probation-

ers have poor relationship quality with their officers (Skeem et al., 2009).

Limitations

Limitations of the study include the use of self-report measures, the cross-sectional design and the omission of a number of variables from our models, such as quality of housing, community integration, and others that likely impact social support. This study is observational such that causality or the direction of the relationships between social support and mental health and other outcomes cannot be determined. Furthermore, there may be other characteristics that impact both level of social support, mental health functioning, and relationships with probation officers that were unmeasured in this study.

The FSSQ is a well-validated measure but there is limited information about the reliability and validity of the measure for justice-involved populations and or individuals with serious mental illnesses. Given there was no guidance in the literature regarding FSSQ cutoff scores, we examined the distribution of scores in our sample and selected a reasonable midpoint to stratify our sample as low versus high support. It is important to note that the bivariate relationships between group status and SCL-10-R and DRI-R scores were confirmed in our multivariate model. In addition, the SCL-10-R was the only measure of psychiatric functioning used in the study. In future work, it would be informative to assess psychiatric functioning using several measures to ensure this construct is fully assessed.

The extent to which findings from a probation population in a southeastern state can be generalized to other probation populations in other settings is not clear. Specifically, the high-risk probationers in our sample were those classified as high risk for recidivism as indicated by the state probation agency's recidivism risk assessment tool. Thus, our findings may not generalize to probationers with mental illnesses who were at low risk for recidivism. Furthermore, we did not have access to data about probationers with mental illnesses who were at low risk for recidivism, and, thus, cannot speak to the differences in demographic and/or psychosocial differences among low- versus high-risk probationers with serious mental illnesses.

Moreover, as in many studies like ours, our sample consists of volunteers who were interested in participating in our research and were competent to provide informed consent. Caution in generalizing our findings to other probationers is warranted given that our sample most likely excludes those with especially acute or profoundly severe mental health symptoms (i.e., those who are least likely to participate in a research study). Given the limitations in the design of our study, it was not possible to infer causality (i.e., lower social support caused poor mental health functioning). Alternatively, it is also plausible that poor mental health functioning caused lower levels of social support.

Though there are several limitations, this study also has a number of strengths. Our analysis was conducted on a relatively large sample of people on probation experiencing mental illnesses and is the first study of its kind to investigate social support and mental health functioning in this way. Additionally, the use of standardized measures to assess social support, mental health functioning, and relationship quality with probation officers im-

proves our understanding of these constructs within this population.

Although our data do not speak directly to how peer supports and supported employment services improve social support outcomes, it is reasonable that interventions designed to engage probationers with severe mental illnesses in prosocial relationships, such as those with peer support workers or coworkers, could improve perceptions of social support and reduce feelings of isolation and stigma. These issues warrant investigation in future research.

Finally, this work contributes to the field and highlights the importance of connecting justice-involved people living with mental illnesses with prosocial supports and other community resources. Future research should be focused on the role of prosocial support in improving mental health and criminal justice outcomes for justice-involved people with mental illnesses. Moreover, future research should examine the role of other factors on social support for probationers with mental illnesses, especially social determinants of health, including employment, food insecurity, socioeconomic status, and housing. In addition, it is paramount to connect probationers with mental illnesses to prosocial support and other community resources and future research should examine the effectiveness of interventions at the interface of the criminal justice and mental health systems that engage this population with meaningful and supportive relationships.

Conclusion

Individuals living with mental illnesses who are under community supervision and who report low levels of social support also report poor mental health functioning and poor relationships with their probation officers. Mental health and criminal justice providers need access to evidence-based interventions proven to facilitate prosocial contacts and improve mental health and criminal justice outcomes for justice-involved people with mental illnesses.

References

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26,* 392–407. http://dx.doi.org/10.3109/09540261.2014.928270

Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law, 16,* 39–55. http://dx.doi.org/10.1037/a0018362

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime and Delinquency, 52,* 7–27. http://dx.doi.org/10.1177/0011128705281756

Broadhead, W. E., Gehlbach, S. H., de Gruy, F. V., & Kaplan, B. H. (1988). The Duke-UNC Functional Social Support Questionnaire. Measurement of social support in family medicine patients. *Medical Care, 26,* 709–723. http://dx.doi.org/10.1097/00005650-198807000-00006

Charuvastra, A., & Cloitre, M. (2008). Social bonds and posttraumatic stress disorder. *Annual Review of Psychology, 59,* 301–328. http://dx.doi.org/10.1146/annurev.psych.58.110405.085650

Chou, K.-L., Liang, K., & Sareen, J. (2011). The association between social isolation and *DSM–IV* mood, anxiety, and substance use disorders: Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of Clinical Psychiatry, 72,* 1468–1476. http://dx.doi.org/10.4088/JCP.10m06019gry

Council of State Governments Justice Center. (2012). *Improving outcomes for people with mental illnesses involved with New York City's criminal court and correction systems.* New York, NY: Author. Retrieved from http://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf

Derogatis, L. R., Lipman, R. S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale—Preliminary report. *Psychopharmacology Bulletin, 9,* 13–28.

Derogatis, L. R., Rickels, K., & Rock, A. F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. *The British Journal of Psychiatry, 128,* 280–289. http://dx.doi.org/10.1192/bjp.128.3.280

Hartwell, S. (2004). Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system. *Criminal Justice Policy Review, 15,* 84–99. http://dx.doi.org/10.1177/0887403403255064

Johnson, J. E., Esposito-Smythers, C., Miranda, R., Jr., Rizzo, C. J., Justus, A. N., & Clum, G. (2011). Gender, social support, and depression in criminal justice-involved adolescents. *International Journal of Offender Therapy and Comparative Criminology, 55,* 1096–1109. http://dx.doi.org/10.1177/0306624X10382637

Kaeble, D., & Cowhig, M. (2018). *Correctional populations in the United States, 2016.* Washington, DC: Bureau of Justice Statistics. Retrieved from https://www.bjs.gov/content/pub/pdf/cpus16.pdf

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health, 78,* 458–467. http://dx.doi.org/10.1093/jurban/78.3.458

Lecrubier, Y., Sheehan, D. V., Weiller, E., Amorim, P., Bonora, I., Harnett Sheehan, K., . . . Dunbar, G. C. (1997). The Mini International Neuropsychiatric Interview (MINI). A short diagnostic structured interview: Reliability and validity according to the CIDI. *European Psychiatry, 12,* 224–231. http://dx.doi.org/10.1016/S0924-9338(97)83296-8

Mallik-Kane, K., & Visher, C. A. (2008). *Health and prisoner reentry: How physical, mental, and substance abuse conditions shape the process of reintegration.* Washington, DC: Urban Institute Justice Policy Center.

Matejkowski, J., Caplan, J. M., & Cullen, S. W. (2010). The impact of severe mental illness on parole decisions: Social integration within a prison setting. *Criminal Justice and Behavior, 37,* 1005–1029. http://dx.doi.org/10.1177/0093854810372898

Morrissey, J. P., Domino, M. E., & Cuddeback, G. S. (2016). Expedited Medicaid enrollment, mental health service use, and criminal recidivism among released prisoners with severe mental illness. *Psychiatric Services, 67,* 842–849. http://dx.doi.org/10.1176/appi.ps.201500305

Muller, M. J., Postert, C., Beyer, T., Furniss, T., & Achtergarde, S. (2010). Comparison of eleven short versions of the Symptom Checklist 90-Revised for use in the assessment of general psychopathology. *Journal of Psychopathology and Behavioral Assessment, 32,* 246–254. http://dx.doi.org/10.1007/s10862-009-9141-5

Rosen, C. S., Drescher, K. D., Moos, R. H., Finney, J. W., Murphy, R. T., & Gusman, F. (2000). Six- and ten-item indexes of psychological distress based on the Symptom Checklist-90. *Assessment, 7,* 103–111. http://dx.doi.org/10.1177/107319110000700201

Sias, P. M., & Bartoo, H. (2007). Friendship, social support, and health. In L. L'Abate (Ed.), *Low-cost approaches to promote physical and mental health* (pp. 455–472). New York, NY: Springer New York. http://dx.doi.org/10.1007/0-387-36899-X_23

Skeem, J., Louden, J. E., Manchak, S., Vidal, S., & Haddad, E. (2009). Social networks and social control of probationers with co-occurring mental and substance abuse problems. *Law and Human Behavior, 33,* 122–135. http://dx.doi.org/10.1007/s10979-008-9140-1

Skeem, J. L., Kennealy, P. J., & Manchak, S. M. (2014). Officer-offender relationship quality matters: Supervision process as evidence-based

practice. *The Journal of the American Probation and Parole Association, 38,* 57–70.

Skeem, J. L., & Louden, J. E. (2006). Toward evidence-based practice for probationers and parolees mandated to mental health treatment. *Psychiatric Services, 57,* 333–342. http://dx.doi.org/10.1176/appi.ps.57.3.333

Skeem, J. L., Louden, J. E., Polaschek, D., & Camp, J. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment, 19,* 397–410. http://dx.doi.org/10.1037/1040-3590.19.4.397