

AARIN

Arizona Arrestee Reporting Information Network

Co-Occurring Mental Health and Substance Use
Disorders Among Recently Booked Arrestees

September 2008

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Co-Occurring Mental Health and Substance Use Disorders Among Recently Booked Arrestees

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Background

The prevalence of co-occurring substance use (or misuse) and psychiatric disorders, particularly among the arrestee population, has been well documented.¹ Research on co-occurring disorders indicates that the effect of being dually diagnosed can exacerbate either of the existing conditions or can manifest new ones.² Compared with other arrestees, the dual-diagnosed arrestee presents a complicated and expensive problem for the criminal justice system, demanding vital resources in a disproportional manner.³

Understanding the prevalence and particular characteristics of the dual-diagnosed arrestee population in Maricopa County is an important part of assessing demands on behavioral health and substance use treatment resources. Additionally, examining some of the current defining characteristics of this population relative to arrestees not dually diagnosed can serve as an indicator of future demand. The AARIN research platform, its core instrument and the Dual Diagnosis Addendum, is intended to inform practitioners and policy makers to this end.

Methodology used in present study

In the present study, researchers used interview data obtained from 1,426 recently booked adult male and female arrestees at three booking facilities in Maricopa County, Arizona as part of the Arizona Arrestee Reporting Information Network (AARIN). The Maricopa County Board of Supervisors sponsored research at Arizona State University and established AARIN in January 2007 to monitor drug use trends, treatment needs, and at-risk behavior among recently booked arrestees in Maricopa County. Each calendar quarter, professionally trained local staff conducted voluntary and anonymous interviews with adult males and females and juvenile boys and girls who had been arrested within the past 48 hours.

The interviews included the core instrument for the AARIN project, as well as a detailed 35-question Dual Diagnosis Addendum.⁴ The Dual Diagnosis Addendum was originally designed and used as part of the National Institute of Justice's Arrestee Drug Abuse Monitoring (ADAM) Program, and thus had been used in a similar data collection setting with an arrestee population, using the same sampling strategy. The Dual Diagnosis Addendum included questions about medical problems, treatment, and medications; psychiatric diagnoses, treatment, medications, and hospitalizations; and psychiatric symptoms, as well as questions related to diagnostic criteria for substance abuse and dependence. Additionally, we used several indicators from the core instrument including such socio-demographic, substance use, and crime-related variables as age, race/ethnicity, educational attainment, employment status, current housing arrangement, prior arrests, recent incarceration, and the severity and type of current arrest.

Analysis for this report relied on our adult sample from 2007, specifically limited to quarters two, three, and four during which the Dual Diagnosis Addendum was administered. Researchers initially contacted 1,896 adult arrestees, of whom 1,690 were interviewed and 1,427 provided valid urine samples. One case was removed due to missing data, leaving 1,426 cases for analysis. (For a complete description of methodology, see Rodriguez, 2008.⁵)

Definition of dual diagnosis and co-occurring disorders in the present study

Co-occurring disorder and dual diagnosis each can be loosely defined as a condition when an individual presents with both a mental illness and a substance abuse or substance dependence disorder. For the purposes of this report, we use the terms co-occurring disorder and dual diagnosis interchangeably. We do not use other commonly used mental health terms associated with mental illnesses and dual diagnosis; specifically, we do not use the term serious mental illness (SMI) to describe the sample due to the limitation of the Dual Diagnosis Addendum as a diagnostic tool.

The dual diagnosis instrument used in this study was comprised of two parts, the first specific to substance use and the second to mental health. In the following section, we detail the structure of each part and of the analysis used to classify respondents by the presence or absence of substance abuse/dependency and a mental health problem. Following the details for each part, we discuss the method of classification used to categorize a respondent as having a co-occurring disorder.

Substance abuse and substance dependence

The first part of the Dual Diagnosis Addendum included 18 substance abuse/dependence items: four designated to assess substance abuse; ten to assess substance dependence; and four additional items related to intravenous drug use, prior substance abuse/dependence diagnosis, and family history of substance misuse. The diagnostic criteria from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Revision (DSM-IV) for substance abuse and dependence provided the outline for the substance abuse and dependence screening questions.

Per DSM-IV guidelines, an affirmative response to one of four questions related to substance abuse would classify the respondent as a substance abuser, and three or more affirmative responses to ten questions related to the criteria for substance dependence would classify the respondent as dependent. Based on the self-reported data for these 14 items, each respondent was classified as satisfying the criteria for substance abuse, sub-

stance dependence, or neither. The remaining four items were used for comparative analysis only, and were not included as part of the substance abuse/dependence classification process.

The DSM-IV describes substance abuse and substance dependence as separate and distinct conditions⁶ substance dependence represents a higher level of impairment than substance abuse. For the analyses conducted for this report, respondents were classified into one of two substance misuse categories. Respondents who did not satisfy either substance abuse or dependence criteria (n=338) were assigned to the non-risk group, described as not at risk for substance misuse. Respondents who satisfied the substance abuse or dependence criteria (n=1,088) were combined and assigned to the substance misuse risk category.

Mental health disorders.

The second part of the Dual Diagnosis Addendum focused on mental health problems. Specifically, the instrument included four items related to the respondent's history of professional mental health assistance, nine items related to psychiatric symptoms, and one item related to family history of mental illness. The first four items concerned the respondent's history of professional help, asking whether the respondent had ever been (a) diagnosed by a mental health professional with a mental illness or emotional problem; (b) treated for a mental health problem; (c) prescribed medication for a mental health, emotional, or psychiatric problem; and (d) hospitalized for a mental health problem.

Respondents were assigned to one of two categories for mental health risk based on their responses to these four items. Respondents who answered "no" to all four items (n=962) were classified as not having any mental health problem. Respondents answering yes to any one of the four items (n=464) were classified as at risk for a mental health problem. Any respondent answering yes to one of the above questions was also asked whether he or she had experienced the problem within the past 6 months and within the past 30 days.

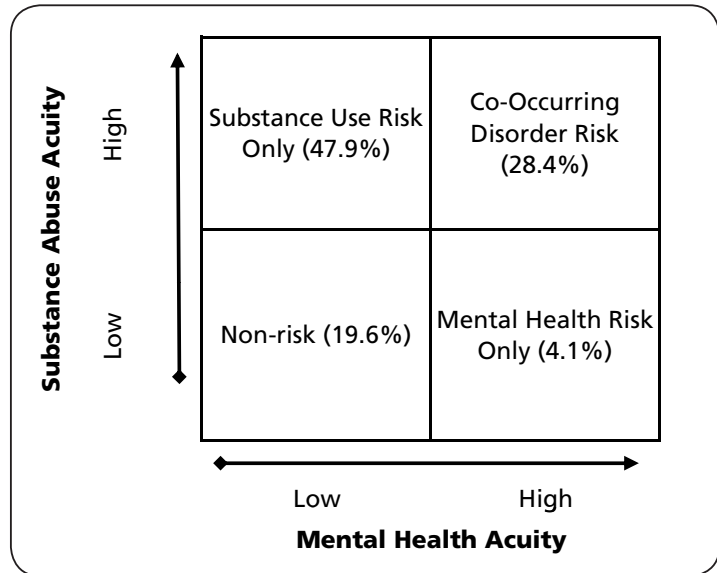
Additionally, respondents were asked about other psychiatric symptoms that they might have experienced. Presence of those psychiatric symptoms was indicative of a possible presence of various common mental illnesses or disorders. Although probative of psychiatric symptoms indicative of a variety of mental illnesses, the instrument was not designed nor intended to be used as a diagnostic tool for mental illness. We emphasize that our assignment of a respondent to the group having a mental health problem was not a clinically based diagnosis; it was based on a likelihood of a mental health problems given a self-reported history of professional mental health assistance.

Dual diagnosis criteria.

Researchers used the two independent substance abuse/dependence and mental health problem classifications to determine eligibility for the possible presence of a co-occurring disorder. Using the model of co-occurring disorder matrix of mental and addiction disorders developed by Richard Ries,⁷ respondents were assigned to one of four quadrants based on their relative risk for substance abuse/dependence and mental health problems (see Exhibit 1).

Respondents classified as not at risk for substance abuse/dependence and not at risk for a mental health problem were assigned to the non-risk quadrant. Respondents categorized as at risk for either substance abuse/dependence or a mental health problem, but not both, were assigned to the appropriate singular disorder risk quadrant. Respondents assigned to the fourth quadrant were those classified as at risk for both substance abuse/dependence and mental health problems, i.e., those at risk for a co-occurring disorder.

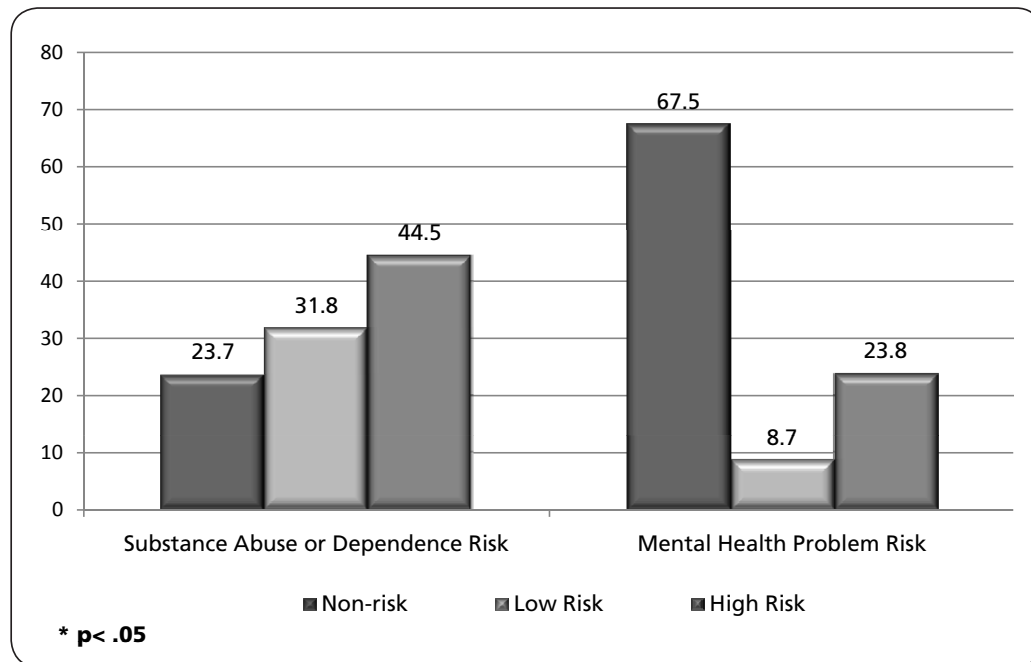
Exhibit 1: The Four Quadrants of Care Model



Proportion of arrestees at risk for substance abuse or dependence and mental health problems

Exhibit 2 shows the proportion of respondents who qualified as being at risk for substance abuse or dependence, and not at risk for substance misuse. The exhibit also shows the proportion of respondents who satisfied the criteria for being at no, low, or high risk for a mental health disorder. We found that 31.8% of respondents abused a substance and an additional 44.5% were dependent on a substance. Thus, 76.3% of all respondents satisfied criteria for a serious substance misuse problem. Additionally, Exhibit 2 shows that 8.7% of respondents reported being at low risk for a mental health disorder and 23.8% reported being at high risk for a mental health disorder. The above findings indicated that for both mental health and substance abuse/dependence problems, when a respondent reported a problem, he or she was more likely to report that the problem was severe.

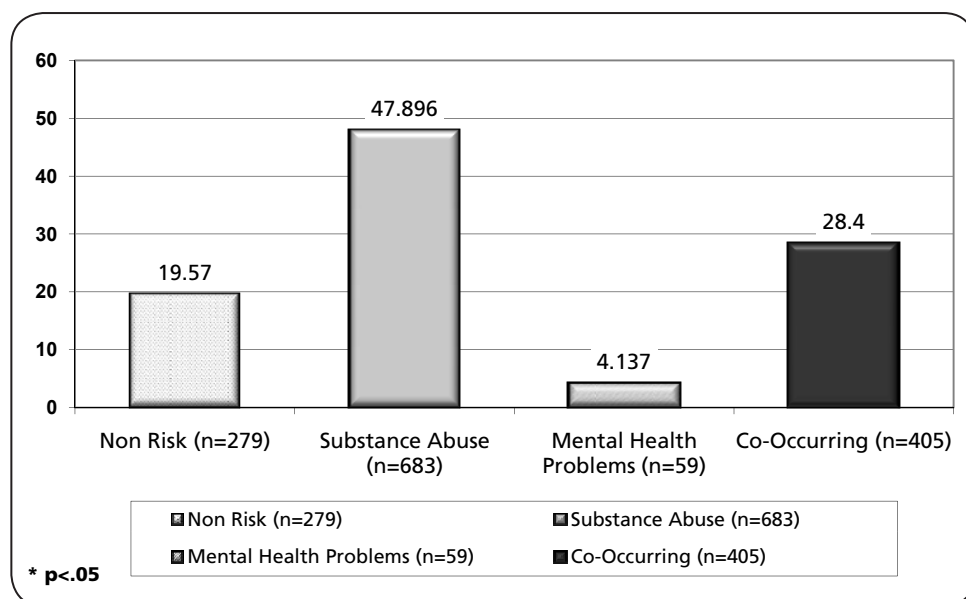
Exhibit 2: Proportion of Arrestees at Risk for Substance Abuse or Dependence and Mental Health Problems



Proportion of arrestees with co-occurring substance use and mental health problems

Exhibit 3 presents the distribution of the sample into the four co-occurring disorder risk categories. About one-fifth of the sample arrestees (19.6%)

Exhibit 3: Distribution of AARIN Sample by Co-occurring Disorder Categories



were not at risk for either substance abuse/dependence or mental health problems, 47.9% were at risk for substance abuse/dependence only, 4.1% were at risk for mental health problems only, and 28.4% were at risk for a co-occurring disorder.

Demographic characteristics of AARIN sample

Exhibit 4 displays the demographic characteristics of respondents by co-occurring disorder risk category. Analysis of differences between the groups by sex revealed significant differences, specifically in disproportionately high rates of females in the mental health problem only category.

Further analysis indicated significant differences between the groups in ethnic background. For example, although White respondents comprised about 38% of the sample, they represented 54.6% of co-occurring arrestees. The analysis also revealed that Hispanic respondents were the most likely to report neither a substance abuse problem nor a mental health problem (52.7%) compared with Whites (19.0%), African Americans (16.1%), and those from an "Other" ethnic group (12.2%).

Educational attainment was significantly different across groups. Respondents in the non-risk category were the least educated. For example, 46.5% of those in the non-risk group did not complete high school compared with 34-39% of arrestees in the other groups. Conversely, those

Exhibit 4: Demographic Characteristics of AARIN Sample by Co-occurring Disorder Category

	Co-Occurring Category				
	Non-risk	Substance Abuse	Mental Health	Co-Occurring	Total
<i>n</i> =	279	683	59	405	1,426
	%	%	%	%	%
Sex *					
Male	74.6	82.4	54.2	72.1	76.8
Female	25.4	17.6	45.8	27.9	23.3
Age					
Mean	29.6 years	31.9 years	30.4 years	32.0 years	31.4 years
SD	9.73	10.32	10.87	10.53	10.32
Race *					
White	19.0	35.3	44.1	54.6	37.9
African-American	16.1	10.8	22.0	10.9	12.3
Hispanic / Latino	52.7	37.3	23.7	20.2	34.9
Other	12.2	16.5	10.2	14.3	14.8
Education *					
Did Not Graduate HS	46.5	38.3	34.5	34.4	38.6
HS Diploma or GED	35.3	34.9	27.3	33.7	34.3
Post HS Education	18.2	26.8	38.2	31.9	27.1
Housing *					
Private residence	95.3	89.8	96.6	81.2	88.7
Public or group housing	0.0	0.9	0.0	2.7	1.2
Hospital or care facility	0.0	0.0	0.0	0.2	0.1
Incarcerated	0.0	0.6	0.0	0.7	0.5
No fixed residence / Other	4.7	8.8	3.4	15.0	9.5
Main Source of Income *					
None	3.3	9.1	8.5	11.4	8.6
Working - full or part-time	84.1	69.3	52.5	46.0	64.9
Other Legal Source	10.5	14.8	35.6	27.1	18.3
Illegal Source	2.2	6.8	3.4	15.4	8.2

* $p \leq .05$

who reported receiving post-high-school education were significantly more likely to be categorized as having a mental health problem only or a co-occurring disorder. This finding should be viewed with caution; it could be that arrestees with higher educational levels were either more willing or more able to seek professional help, and therefore met our criteria more readily than those without the same quality of access to professional mental health care.

Housing and income were also significantly different across groups. Co-occurring respondents were significantly more likely to have been homeless or to have had no fixed residence in the past 30 days. Specifically, 15% of co-occurring arrestees reported having no fixed residence compared with 4.7% of non-risk respondents, 3.4% of mental health only respondents, and 8.8% of substance abuse only respondents. Co-occurring arrestees were also significantly less likely to be employed at least part time. For instance, only 46% of co-occurring respondents were working compared with 84.1% of those in the non-risk group. Related, 15.4% of co-occurring arrestees reported illegal sources of income as their main source of income in the past 30 days, compared with 6.8% of those in the substance abuse only group, 3.4% of those in the mental health only group, and 2.2% of those in the non-risk group.

Criminal justice system involvement

Our analysis indicated that co-occurring disorder status was significantly related to the respondent's criminal justice system involvement. More than 56% of co-occurring disorder respondents reported having been arrested within the past 12 months, averaging 1.3 arrests during that period, compared with 29.6% of non-risk arrestees, who averaged .45 arrests over the prior 12 months. Arrestees in the substance abuse and mental health problem only categories were also more likely to have been arrested than those in the non-risk group (46.8% and 36.2% respectively). The analysis indicated that arrestees in the co-occurring category were the most likely to have been incarcerated within the past 12 months, with almost 57% reporting that they had spent time in jail or prison. Respondents who were categorized as having a co-occurring disorder reported having been in jail or prison 1.03 times in the past 12 months compared with .49 times for respondents who were not at risk.

Last, analysis of arrest charges revealed significant differences between arrestees at risk for a co-occurring disorder and other offenders. As shown in Exhibit 5, co-occurring arrestees were the least likely to have been arrested for a violent offense – 14.6%, compared with 16.5% of those categorized as substance abuse only, 16.9% of those categorized as mental health only, and 18.6% of those categorized as not being at risk.

Exhibit 5: Criminal Justice System Involvement by Co-occurring Disorder Category

	Co-Occurring Category				
	Non-risk	Substance Abuse	Mental Health	Co-occurring	Total
<i>n</i> =	279	683	59	405	1,426
	%	%	%	%	%
Arrested (past 12 months) *					
None	70.5	53.2	63.8	43.4	54.2
1 to 2	26.3	35.8	29.3	38.7	34.5
3 to 5	2.9	8.5	5.2	14.5	9.0
6 or more	0.4	2.5	1.7	3.5	2.3
Mean	0.45	0.95	0.81	1.30	0.94
SD	0.96	1.61	2.34	1.88	1.65
Incarcerated (past 12 months) *					
None	46.4	49.3	62.5	43.1	47.3
1 to 2	46.4	40.9	32.5	41.6	41.6
3 to 5	5.7	8.2	2.5	12.4	9.1
6 or more	1.4	1.6	2.5	2.9	2.0
Mean	0.49	0.73	0.59	1.03	0.76
SD	1.38	1.70	2.26	1.75	1.70
Current Offense					
Violent *	18.6	16.5	16.9	14.6	16.4
Drug-Related *	9.3	21.4	3.4	15.3	16.5
Property *	25.1	16.1	23.7	20.0	19.3
Miscellaneous *	47.0	46.0	55.9	50.1	47.8
Felony	52.0	59.0	52.5	57.8	57.0

* $p \leq .05$

Gangs, guns, and victimization

Exhibit 6 displays analyses of the relationship between co-occurring disorder risk status and gangs, guns, and victimization. Analysis revealed that gang affiliation, prior victimization, and gun possession were significantly related to the co-occurring disorder categories. For example, fewer than 10% of arrestees in the non-risk and mental health only groups and about 14% of substance abuse only arrestees reported any gang involvement, compared with 22.7% of co-occurring respondents. Likewise, 17.5% of those in the co-occurring group had possessed a gun within the past 12 months compared with 15.7% of those in the substance abuse only group, 10.4% of those in the non-risk group, and 6.8% of those in the mental health only group.

Analysis also revealed significant differences in frequency of violent victimization across the groups. The co-occurring group experienced victimization more frequently in every category analyzed. Respondents were

asked whether they had been victimized in the past 12 months for seven different types of violent victimization: threatened with a gun, shot at, shot, threatened with a weapon (other than a gun), injured with a weapon (other than a gun), assaulted or attacked without a weapon, and robbed. Co-occurring disorder respondents reported the highest rates of victimization in every category, some at alarmingly high rates. Specifically, arrestees at risk for a co-occurring disorder were nearly twice as likely to have been threatened with a weapon and three times as likely to have been injured with a weapon. Overall, 62.7% of co-occurring disorder respondents reported having experienced at least one of the seven types of violent victimization, followed by 41.1% of substance abuse only respondents, 40.7% of mental health only respondents, and 25.8% of non-risk respondents.

Exhibit 6: Gangs, Guns, and Victimization of Respondents by Co-occurring Disorder Category

	Co-occurring Category				
	Non-risk	Substance Abuse	Mental Health	Co-occurring	Total
<i>n</i> =	279	683	59	405	1,426
	%	%	%	%	%
Gang Membership Status *					
Non-Gang Member	90.7	85.9	91.5	77.3	84.6
Gang Associate	2.2	4.4	3.4	8.1	5.0
Current Gang Member	2.9	4.1	3.4	7.7	4.8
Former Gang Member	4.3	5.6	1.7	6.9	5.5
Firearms *					
Possessed gun in past 12 months	10.4	15.7	6.8	17.5	14.8
Victimized in past 12 months					
Threatened with a gun *	10.0	17.7	16.9	27.2	18.9
Shot at *	6.8	10.7	6.8	16.0	11.3
Shot *	2.9	0.9	3.4	3.5	2.1
Threatened with a weapon *	6.8	17.7	13.8	33.9	20.0
Injured with a weapon *	3.6	6.6	5.1	19.8	9.7
Assaulted w/o a weapon *	11.1	23.1	20.3	41.7	25.9
Robbed *	11.5	12.7	13.6	20.0	14.6
Any *	25.8	41.1	40.7	62.7	44.4

* $p \leq .05$

Psychiatric symptoms of arrestees

Respondents were asked whether they had experienced any of a variety of psychiatric symptoms. The frequencies with which respondents reported experiencing each of these symptoms are presented in Exhibit 7, by co-occurring disorder risk category. We questioned respondents about symptoms typically contained within psychometric screening instruments, diagnostic interviews, and mental health assessments for determining the presence and type of a mental health problem. We therefore expected those respondents classified as having either a mental health problem independent of substance use or a co-occurring disorder to have higher rates of psychiatric symptoms.

Comparing the respondents in the mental health problem only category with those at risk for co-occurring disorders, we observed consistently higher rates of symptoms among the co-occurring sample for all nine symptoms queried. Remarkable differences were seen in the rates of disorganized thought, hallucinations, and suicidal ideation: Almost 55% of co-occurring respondents reported that their thoughts sometimes go so fast that they are unable to think clearly or plan activities, compared with 39% of mental health only and 25.6% of substance abuse only respondents. Co-occurring respondents also reported hallucinations at nearly twice the rate of mental health only respondents (23.3% vs. 11.9%) and at almost four times the rate of substance abuse only respondents (5.9%).

Thoughts and attempts of suicide or self-injury were significantly higher among the co-occurring respondents. Specifically, nearly half of co-occurring respondents reported that they had thought about hurting or killing themselves, compared with about 38% of mental health only respondents, 12.7% of substance abuse only respondents, and 3.2% of non-risk respondents. The rates for having attempted suicide or self-injury were more striking. One in three of the 405 respondents classified as at risk for a co-occurring disorder reported having attempted suicide or engaged in self-injury. Comparatively, among the non-risk arrestees, 2.9% reported that they had attempted suicide or self-injury, followed by 8.8% of substance abuse only respondents and 27.6% of mental health only respondents.

Exhibit 7: Psychiatric Symptoms of Respondents by Co-occurring Disorder Category

	Co-Occurring Category				Total
	Non-Risk	Substance Abuse	Mental Health	Co-Occurring	
<i>n</i> =	279	683	59	405	1,426
	%	%	%	%	%
Do you think people are watching, spying, or following you? *	5.4	9.5	22.0	23.5	13.2
Do you think people are trying to kill you? *	2.9	5.6	8.5	12.6	7.2
Do your thoughts go so fast you are unable to think clearly or plan activities? *	11.5	25.6	39.0	54.5	31.6
Do people tell you that they can't understand you, even though it makes sense to you? *	16.8	26.0	32.2	45.4	30.0
Are you hearing or seeing things that people say they can't see or hear? *	4.3	5.9	11.9	23.3	10.8
Do your emotions/feelings make it hard for you to do normal day to day activities that you need or want to do? *	10.0	23.2	44.8	57.4	31.2
Do you feel depressed and hopeless, thinking that your life will not improve? *	16.1	35.5	53.4	67.2	41.4
Have you ever thought about hurting yourself or committing suicide? *	3.2	12.7	37.9	49.9	22.5
Have you ever tried to hurt or kill yourself? *	2.9	8.8	27.6	36.5	16.3

* $p \leq .05$

Substance abuse and public health factors

As seen in Exhibit 8, the last series of analyses looked at the substance abuse treatment and intravenous (IV) drug use history of respondents by co-occurring disorder status. Specifically, we examined the rates at which respondents had ever (a) sought help for a substance use problem, (b) received treatment or detoxification for a substance use problem, (c) received outpatient care for substance use, and (d) used needles to shoot drugs.

Comparing the substance abuse only group with the co-occurring group, analysis showed significant differences across substance treatment variables and intravenous drug use. Specifically, 30.4% of co-occurring respondents reported having used needles to shoot drugs compared with 14.2% of substance abusing respondents. Almost 62% of the co-occurring group had sought help for substance use problems, compared with fewer than 36% of respondents in the substance abuse group. Similarly, analyses revealed that co-occurring arrestees were significantly more likely to have received prior outpatient care, treatment, or detoxification for substance use than those in all other groups.

Exhibit 8: Substance Abuse and Public Health Factors by Co-occurring Disorder Category

	Co-Occurring Category				
	Non-Risk	Substance Abuse	Mental Health	Co-Occurring	Total
<i>n</i> =	279	683	59	405	1,426
	%	%	%	%	%
Have you ever used needles to shoot drugs? *	1.4	14.2	5.1	30.4	15.9
Have you ever gone to anyone for help because of your drinking or drug abuse? *	3.2	35.9	8.5	61.9	35.7
Have you ever received treatment for alcohol or drug abuse, or for detoxification? *	3.9	27.2	1.7	54.1	29.2
Have you ever received outpatient care for alcohol or drug abuse? *	2.2	17.0	0.0	37.1	19.1

* $p \leq .05$

Policy implications

Using data collected from more than 1,400 arrestees, this report provides insight into the nature and extent of co-occurring disorder problems among recently booked arrestees in Maricopa County, Arizona. The findings suggest that the proportion of arrestees with a co-occurring disorder is sufficiently large to justify attention and that certain socio-demographic and criminal justice characteristics of this subpopulation may require innovative strategies to adequately address the challenges.

We identified two important indicators that describe the extent of co-occurring disorder problems in the criminal justice system. First, we found that county jail intake facilities frequently deal with arrestees with co-occurring substance use and mental health problems; 28.4% of our respondents satisfied criteria for a co-occurring disorder. Notably, of the 32.5% of the sample arrestees who were categorized as having a mental health problem, the vast majority (87.3%) also satisfied the criteria for a co-occurring disorder. This finding suggests that the majority of those within the criminal justice system who are identified as having a mental health problem need to receive treatment for substance misuse along with treatment for mental health problems.

Second, co-occurring respondents were significantly more likely to be recidivists. On average, an arrestee at risk for a co-occurring disorder was arrested, booked, and incarcerated significantly more often than other arrestees, thus demanding more resources from local criminal justice agencies. Moreover, further examination of the problem suggested that the co-occurring disorder population has a disproportionate impact on the criminal justice system beyond mere frequency of interaction. For instance, co-occurring disorder arrestees were found to be at greater risk for homelessness and lack of sufficient employment, either of which can be a critical factor in the decision-making process for pretrial release and subsequent compliance with release conditions.

These findings combined suggest that employing an effective treatment strategy with this subpopulation might have a significant impact on reducing criminal justice expenses. Diversion programming specifically designed for the co-occurring disorder arrestee subpopulation could have a far-reaching economic impact on the criminal justice system by reducing the number of times these individuals are booked and processed through the system.⁸

We also found that co-occurring disorder arrestees were more likely to be affiliated with a gang and were at significantly greater risk for violent victimization. These findings suggest that although this subpopulation of arrestees is less likely to be arrested for a violent crime, as indicated by their arrest charges, they are more frequently involved in violence than official records indicate. Future research examining the relationship between co-occurring disorders and violence should further examine their disproportionate representation as victims of violent crimes and other potentially unidentified involvement with violence. Additionally, our findings suggest that these individuals may pose a greater risk to the

community, criminal justice practitioners, and themselves than might otherwise be indicated by official records.

Given the significant number of arrestees at risk for a co-occurring disorder, and given that this subpopulation presents distinctly more severe impairment to functioning (unstable housing and employment) and a greater burden to the system as a whole (recidivism and victimization), early identification and intervention would be beneficial to the cost-effectiveness and efficiency of the criminal justice system and would improve the quality of life and delivery of justice for those severely disadvantaged persons.

In summary, the scope and nature of arrestees at risk for a co-occurring disorder and the impact they have on the criminal justice system at each stage requires the examination, development, and implementation of appropriate strategies to more quickly identify arrestees at risk, to intervene with appropriate and sufficient services to serve justice, and to provide meaningful alternatives to recidivism within this special population.

Endnotes

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About the Center for Violence Prevention and Community Safety

Arizona State University, in order to deepen its commitment to the communities of Arizona and to society as a whole, has set a new standard for research universities, as modeled by the New American University. Accordingly, ASU is measured not by whom we exclude, but by whom we include.

The University is pursuing research that considers the public good, and is assuming a greater responsibility to our communities for their economic, social, and cultural vitality. Social embeddedness – university-wide, interactive, and mutually supportive partnerships with Arizona communities – is at the core of our development as a New American University.

Toward the goal of social embeddedness, in response to the growing need of our communities to improve the public's safety and well-being, in July 2005 ASU established the Center for Violence Prevention and Community Safety. The Center's mission is to generate, share, and apply quality research and knowledge to create "best practice" standards.

Specifically, the center evaluates policies and programs; analyzes and evaluates patterns and causes of violence; develops strategies and programs; develops a clearinghouse of research reports and "best practice" models; educates, trains, and provides technical assistance; and facilitates the development and construction of databases.

For more information about the Center for Violence Prevention and Community Safety, please contact us using the information provided below.

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