

Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision:

A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE

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POLICY AND PRACTICE**

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Executive Summary

OVERVIEW

The number of people under correctional supervision has reached unprecedented levels, and the vast majority of these individuals are supervised in the community by probation or parole agencies.¹ Within the context of this overall growth, probation and parole officers are coming into contact with high numbers of people with mental illnesses (most of whom have co-occurring substance use disorders). Facing staggeringly large caseloads, traditional probation and parole agencies are often unable to meet the broad treatment, service, and supervision needs this population requires.² Perhaps as a result, people with mental illnesses are more likely than others under community supervision to have their community sentences revoked,³ deepening their involvement in the criminal justice system in a manner that has implications for public safety, public health, and public spending.

Community corrections officials and their counterparts in the mental health system understand that their target populations are increasingly overlapping and that the need for new approaches has never been greater. Across the country, probation and parole officials are working with jail and prison administrators, judges, prosecutors, defense attorneys, and community-based treatment providers to develop strategies that maintain public safety while improving outcomes for people with mental illnesses under community corrections supervision. But all too often, these responses are not backed by research, and as a result, may be less successful than initiatives that incorporate empirically sound interventions. This in turn limits the political support for and sustainability of these efforts.

Corrections and mental health professionals need to design and implement interventions that are informed by the latest evidence about what works, for whom, and under what circumstances. Toward that end, this guide draws on three different literatures—research on community corrections supervision strategies, mental health treatment strategies, and integrated supervision and treatment strategies.

METHODOLOGY

The authors of this guide conducted an extensive literature review, in close consultation with nationally recognized experts, on community corrections and mental health responses to people with mental illnesses. The literature review was designed to address common questions that policymakers have about these issues. The authors then submitted a draft of this guide to members of an advisory group comprising leading researchers, practitioners, and policymakers.

In May 2008, the advisory group convened for a day-long meeting to review the research cited in this guide, develop consensus about the conclusions that could be drawn from this research, and discuss the implications of these conclusions for policy, practice, and future research. Feedback from the meeting was incorporated into this document.

CONCLUSIONS

Distilling conclusions from multiple research efforts in disparate fields is challenging. In this instance, the community corrections literature contained an abundance of research on general community corrections strategies, but not on community corrections strategies specifically for people with mental illnesses. The mental health treatment literature contained an abundance of research on general treatment strategies, but not on treatment strategies specifically for people with mental illnesses under community corrections supervision. Only a small body of research on coordinated/integrated community corrections/mental health strategies for this population exists. With these limitations in mind, the authors and advisory group drew the following conclusions:

...about the extent and nature of the problem...

People with mental illnesses, most of whom have co-occurring substance use disorders and face significant clinical, legal, and socioeconomic challenges, are **overrepresented among probation and parole populations**.

These individuals are **twice as likely** as people without mental illnesses to have their **community supervision revoked**.

The **best predictors of probation or parole revocation for people with mental illnesses are similar to predictors of revocation for people without mental illnesses** (for example, criminal history, substance use, problematic circumstances at home), **but people with mental illnesses have more of these risk factors**. In addition, people with mental illnesses face unique risk factors related to their clinical conditions (for example, some may have functional impairments).

Traditional community corrections agencies have limited resources to effectively respond to people with mental illnesses as a result of large caseload size and the time-consuming needs of this population. Certain traditional officer strategies, such as threats of incarceration and other negative pressures to enforce compliance, may be related to higher rates of probation and parole revocation for this population.

...about strategies to improve outcomes for people with mental illnesses under community corrections supervision...

A number of **evidence-based programs have been shown to reduce recidivism** for the general population under community corrections supervision, but the effectiveness of these programs has not been examined for people with mental illnesses. Features of these programs include:

- Adherence to the risk-needs-responsivity model, a set of principles designed to maximize the effectiveness of community corrections interventions. Programs that focus on the dynamic risk factors associated with criminal behavior (that is, criminogenic risks) are particularly effective.
- Cognitive-behavioral treatment interventions, which involve a type of therapy that addresses the irrational thoughts and beliefs that can lead to anti-social behavior.
- Drug treatment in the community.

A number of **general officer strategies and techniques show promise in reducing the recidivism, or increasing the use of services**, of people with mental illnesses under community corrections supervision. These include:

- “Firm but fair” relationships, or relationships between community corrections officers and the people under their supervision that are characterized by caring, fairness, trust, and an authoritative (not authoritarian) style. These types of relationships reduce supervisees’ risk of recidivism.
- Problem-solving strategies and positive pressures to encourage compliance with the terms of community supervision, which involve officers working with the people under their supervision to identify obstacles to compliance, resolve these problems, and agree on compliance plans. Using these strategies and avoiding threats of incarcerations or other negative pressures reduces supervisees’ risk of recidivism.
- Boundary-spanning skills, in which officers actively coordinate and work on teams with treatment and service providers. Use of these skills increases supervisees’ use of services.

Six evidence-based mental health treatment practices have been shown to improve clinical outcomes for people with serious mental illnesses, but the effectiveness of these practices has not been examined for people with mental illnesses under community corrections supervision. These include:

- Assertive community treatment (ACT), a service delivery model in which a multidisciplinary team of mental health professionals provides individualized treatment.*
- Illness self-management and recovery, in which people learn skills to monitor and control their own well-being.
- Integrated mental health and substance use services, in which specific treatment strategies and therapeutic techniques are combined to address mental illnesses and substance use disorders in a single contact or series of contacts over time.⁴
- Supported employment, in which people with mental illnesses are employed in competitive, integrated work settings with follow-along supports.
- Psychopharmacology, in which medications are used to treat mental illnesses.
- Family psychoeducation, in which people with mental illnesses and their families learn about mental illnesses, symptom management techniques, and stress reduction.

* It is important to note that ACT is one treatment modality that *has* been studied for people with mental illnesses under community corrections supervision, often in the form of Forensic Assertive Community Treatment, or FACT. Although ACT and FACT have been associated

with reductions in psychiatric hospitalizations and symptoms and increases in functionality, community corrections outcomes have not always been positive when ACT or FACT is employed, as the program does not seem to have an impact on recidivism.

Two promising mental health treatment practices may improve clinical outcomes for people with mental illnesses and, though untested for people with mental illnesses under community corrections supervision, are particularly relevant to the challenges this population faces:

- Supported housing, such as “Housing First,” in which people with mental illnesses gain quick access to housing in addition to case management and other supports.
- Trauma interventions, in which people with mental illnesses and extensive histories of trauma (especially among women), including physical and sexual abuse, receive targeted interventions.

A variety of program models integrate, to varying degrees, community corrections supervision with mental health treatment, and preliminary evidence suggests that these programs may reduce the risk of arrest and revocation and improve linkages to treatment and other services. One of these models, specialized mental health probation caseloads, is a promising practice for improving clinical and legal outcomes for people with mental illnesses under probation supervision.

...about the implications of current research on policy and practice...

Although promising strategies to improve the response to people with mental illnesses under community corrections supervision exist, **important questions remain that should form a research agenda on these issues.**

In order to achieve the outcomes demonstrated by the existing body of research, **policymakers must consider a number of key implementation issues:**

- Screening and assessment
- Cross-agency collaboration
- Program implementation
- Performance-based contracting and funding
- Organizational culture and leadership

Federal, state, and local policymakers are focused on improving outcomes for people with mental illnesses under community corrections supervision. Program models and principles are being developed, refined, and evaluated. **With sustained attention to these issues, a wide range of strategies that improve public health and public safety outcomes for this population is within reach.**

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† Advisory group members' titles and agency affiliations reflect the positions they held at the time of their involvement with this project.

Introduction

The number of people under local, state, and federal correctional supervision is at an all-time high, and most of these individuals are supervised in the community by probation or parole agencies.⁵ Within the context of this overall growth in community corrections populations, probation and parole officers are coming into contact with a disproportionately high number of people with mental illnesses (most of whom have co-occurring substance use disorders).⁶ This group can be among the most complex to supervise. They have broad treatment and service needs, and require supervision strategies that traditional probation and parole agencies—already facing staggeringly large case-loads—were not designed to provide. Perhaps as a result, people with mental illnesses are twice as likely to have their community sentences revoked as others under community supervision,⁷ which deepens their involvement in the criminal justice system.

Community corrections officials and their counterparts in the mental health system typically agree that inappropriate or inadequate responses to this population can have implications not only for public safety, but also public health and public spending. They also agree that many people with mental illnesses are better served in community-based treatment, rather than criminal justice settings. With the largest jails and prisons holding more people with mental illnesses than many inpatient psychiatric facilities,⁸ officials recognize that their target populations increasingly are overlapping and that the need for new approaches has never been greater.

Across the country, probation and parole officials are working with jail and prison administrators, judges, prosecutors, defense attorneys, and community-based treatment providers to develop strategies that maintain public safety while improving outcomes for people with mental illnesses under community corrections supervision. But all too often, these responses are not backed by research or data, and as a result, may be less sustainable, politically potent, efficient, and successful than those that incorporate empirically sound interventions.

The purpose of this guide, broadly speaking, is to help policymakers bring current science to bear on policy and practice, as illustrated in Figure 1. The body of research on strategies to improve outcomes for people with mental illnesses under community corrections supervision is growing, but many important questions remain unanswered; it is often

A Note on the Scope of this Guide

IN AN EFFORT TO MAXIMIZE the usefulness of this guide, the authors and advisory group identified three issues that are largely beyond the scope of this document. These issues, pre-trial release, sex offenses, and specific conditions of release/supervision, are referenced in sidebars only to the extent that they naturally arise in the discussions below.

difficult to translate current research findings into obvious policy recommendations. This guide summarizes existing research in a clear, easy-to-read format that provides policymakers with the information they need to promote, develop, and/or fund such efforts.

UNDERSTANDING THE SPECTRUM OF NEEDS AND RESPONSES

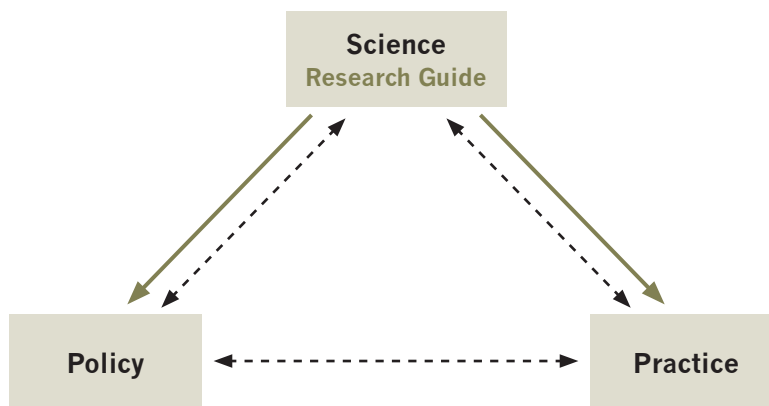
Individuals with mental illnesses under community corrections supervision are not a homogenous group. They face clinical conditions, functional impairments, socioeconomic challenges, and criminal charges or convictions of varying severity, and present varying degrees of risk on both clinical and criminogenic* dimensions.

Strategies and interventions designed to improve outcomes for this diverse population are therefore wide-ranging and can occur in a variety of settings:

Community corrections systems, where evidence-based supervision and intervention programs have been shown to decrease people’s likelihood of revocation and reincarceration. The community corrections system includes:

- Probation, where more than 4 million people may be at risk of penetrating further into the criminal justice system. Probation is a period of sentenced correctional supervision in the community, generally in lieu of incarceration,⁹ during which courts maintain jurisdiction over cases.
- Parole, where nearly 800,000 people have become more deeply entrenched in the criminal justice system and may require significant intervention to successfully reenter the community. Parole is a period of conditional release to correctional supervision in the community following a prison term,¹⁰ during which conditions are set and compliance is monitored by a state releasing authority.

Fig. 1: Bringing current science to bear on policy and practice



* That is, the dynamic risk factors associated with criminal behavior.

Community-based mental health systems, where evidence-based treatment programs have been shown to improve general clinical outcomes for people with mental illnesses.

Collaborative efforts between community corrections and mental health systems, where supervision strategies and treatment strategies are coordinated or integrated to respond to the complex needs of people with mental illnesses under probation and parole supervision.

This framework is important for understanding the state of research on these issues. The community corrections literature contains an abundance of research on general community corrections strategies, but not specifically for people with mental illnesses. The mental health treatment literature contains a wealth of research on general treatment strategies, but not specifically for people with mental illnesses under community corrections supervision. A small number of studies have been conducted on coordinated/integrated strategies specifically for

this population. Nevertheless, the research that does exist can and should be used more fully to inform the development of improved policies and initiatives.

HOW THIS GUIDE IS ORGANIZED

This guide is organized around policymakers' common questions about people with mental illnesses under community corrections supervision and the type and effectiveness of strategies designed to respond to this population. Each question is followed by a brief response, under which research summaries supporting those responses are bulleted. This guide is divided into three sections:

1. *The Extent and Nature of the Problem* explores the extent to which people with mental illnesses become involved with the community corrections system, and why traditional supervision strategies are less effective for people with mental illnesses than those without

Generalizing from Probation to Parole

THOUGH FAR LESS RESEARCH EXISTS on outcomes for people with mental illnesses on parole, both parole and probation are covered in this guide. Some research findings about probation populations may apply to parole populations, given that both groups are under community corrections supervision, share common challenges to reentry, and may be competing for the same limited resources. Still, readers should generalize research findings from probation to parole with caution, given that parole may involve a higher-risk subset of individuals.

Notably, the size of parole populations varies widely from state to state. For example, in Arkansas, there are 863 people on parole per 100,000 adult residents; in neighboring Mississippi, there are 88 per 100,000.¹¹ Sixteen states have abolished all discretionary parole; four states have abolished discretionary parole for certain offenses.¹² These differences are due in large part to sentencing and parole eligibility statutes; but even where discretionary parole is eliminated or reduced, some form of structured, supervised release typically continues to exist.

Pre-Trial Release

IN CONSIDERING THE FULL SPECTRUM of needs and potential responses to this diverse population, it is important to note that there are a variety of pre-trial interventions that avoid sentenced supervision for people with mental illnesses. In these circumstances, the criminal justice and mental health systems can collaborate before an individual with mental illness is convicted of an offense, so that conviction and sentencing are not the mechanisms that trigger linkage to appropriate treatments and services. Successful adherence to the terms of these pre-trial interventions (which often include mandated treatment) can then result in charges being reduced or dismissed. For example, police-based responses can link people with mental illnesses to treatment without arrest. Mental health courts can supervise conditions of release without corrections involvement. In some cases, probation agencies may also be involved with pre-trial services. Probation officers may help monitor the conditions of pre-trial release for people with mental illnesses who have been charged with minor offenses and who prosecutors, attorneys, and judges agree should not become further involved with the criminal justice system. Research on pre-trial programs is beyond the scope of this document, but policymakers should consider these and other “front-end” interventions that prevent an appropriate subset of individuals from becoming entrenched in the criminal justice system altogether.

such illnesses. The research summarized in this section demonstrates the scope of the problem and the challenges and risks associated with traditional supervision strategies. This section can inform policymakers’ assessments of their own communities’ experiences, and provides context for considering different approaches.

2. *Strategies to Improve Outcomes for People with Mental Illnesses under Community Corrections Supervision* explores the strategies that the community corrections system, the mental health system, and both systems working collaboratively can employ to better respond to people with mental illnesses. The research summarized in this section identifies the types of strategies that have been developed and the potential impact they can have on outcomes for this population.
3. *Future Research Questions and Implications for Policy and Practice* identifies key research questions that should be investigated to expand

the evidence base of community corrections strategies to improve outcomes for people with mental illnesses. It also explores how the current body of knowledge on these strategies is related to agency operations and program design and implementation.

HOW THIS GUIDE WAS DEVELOPED

The authors, in consultation with an advisory group comprising leading researchers, policymakers, and practitioners, conducted an extensive review of the existing literature to distill answers to the questions that policymakers typically have about these issues. The advisory group reviewed the questions, answers, summaries of research findings, and bibliography; determined the appropriate scope of the document; and provided input on which studies to include, how to interpret findings based on varying methodological rigor, and implications for policy development.

This document draws on a range of studies and is meant to bridge the gaps between research, policy, and practice, and act as a springboard for policymakers interested in developing research-based policies and interventions for people with

mental illnesses under community corrections supervision. It is not an exhaustive research inventory or meta-analysis.*

A Note on Research Limitations

THE AUTHORS AND ADVISORY GROUP selected the research summarized in this document because it represents some of the field's best thinking on these issues. There was no rigid rubric for including or excluding research based on a specific methodological standard; instead, selections include data derived from a variety of research designs, some more robust than others, that demonstrate findings of value to policymakers. Although studies with large sample sizes tend to be more rigorous than those with a small number of subjects, and studies with randomly selected comparison groups tend to be stronger than those without, other types of studies were included in this guide. As a result, findings vary in terms of validity and generalizability. In general, the following three phrases are used to convey the advisory group's assessment of the strength of evidence behind a given finding: "research strongly suggests...", "there is some research to suggest...", and "there is some empirical evidence to support the belief that..."

Complete citations for referenced research are in the bibliography.

* A meta-analysis employs systematic methods and statistical techniques to combine results from different studies to obtain a quantitative estimate of the overall effect of a particular intervention or variable on a defined outcome. This combination may produce a stronger

conclusion than any individual study can provide. (It is also known as data synthesis or quantitative overview.) Source: National Library of Medicine: <http://www.nlm.nih.gov/nichsr/hta101/ta101014.html>.

SECTION ONE

The Extent and Nature of the Problem

People with mental illnesses (most of whom have co-occurring substance use disorders) are overrepresented on community corrections caseloads. They are more likely than individuals without mental illnesses to have common risk factors for reincarceration. They also face unique clinical risk factors and socio-economic challenges to successful community reintegration. Traditional community corrections agencies cannot always respond to people with mental illnesses effectively, due to both limited community resources and internal competencies and capacity, which creates a difficult situation for this population and the officers charged with their supervision.

Increasingly high numbers of people with mental illnesses are coming into contact with law enforcement agencies, courts, and corrections agencies. The underlying reasons for this phenomenon are complex, but there are a number of common explanations for the high prevalence of mental illnesses among people within these settings compared to the general population, and why community corrections agencies are seeing more and more individuals with mental illnesses on their caseloads.

One reason people with mental illnesses become involved in the criminal justice system is that they are disproportionately likely to come into contact with law enforcement officers. This may happen for a number of reasons. First, people with mental illnesses may behave publicly in ways that are symptomatic of an untreated mental illness or substance use disorder (for example, public disturbance, public intoxication, or other “nuisance” offenses). Second, people with mental illnesses are at an increased risk of developing a substance use

disorder over the course of their lifetimes,¹³ and arrests for drug offenses have skyrocketed since 1980.¹⁴ Finally, nearly a third of people who experience homelessness have serious mental illnesses, and their homelessness makes them highly visible to law enforcement officers.¹⁵

The reasons for which people with mental illnesses become further entrenched in the criminal justice system after their initial contact with law enforcement are also complex; however, it is clear that people with mental illnesses tend to stay in jail or prison longer and are less likely to be approved for parole than others charged with similar offenses.*¹⁶ Limited access to overburdened community-based treatment and other services may increase delays in release to the community from jail and prison.¹⁷ Parole board members may lack confidence in community resources for individuals serving prison sentences, have misconceptions about mental illness, or fear negative public reactions. As a result, they may be more likely to let people with mental illnesses serve the maximum sentence allowed by law.¹⁸

* For example, in Pennsylvania, a study conducted by the Pennsylvania Board of Probation and Parole found that offenders on Department of Corrections “Psychiatric Review Team Roster” received parole approval upon meeting their minimum sentence date at a rate of 21 percent, individuals on the “Mental Health Active Roster” received

parole approval at a rate of 37 percent, and individuals on the “Mental Health Inactive Roster” received parole approval at a rate of 44 percent, compared with a rate of 61 percent for offenders in the general population. Pennsylvania Board of Probation and Parole. (2007). Internal Data.

Once people with mental illnesses are finally released, it is often extremely difficult for them to successfully transition from incarceration to the community. Their mental illnesses may be linked to community corrections supervision failure in a number of ways. Skeem and Loudon have characterized these links as being direct, indirect, or spurious.¹⁹

First, mental illnesses may *directly* result in probation or parole revocation. For example, an individual may not access treatment, leading him or her to decompensate, behave in a bizarre or dangerous manner in public, get arrested for this behavior, and have his or her probation revoked.

Defining Severe and Persistent Mental Illness, Co-occurring Disorders, “Mental Health Problems,” and Personality Disorders

What is mental illness?

According to the Department of Health and Human Services and the National Institute of Mental Health, *mental illness* is a term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.²⁰ A mental illness diagnosis is made only when particular clusters of symptoms are present for a specified period of time, other clusters of symptoms are not present, and the symptoms that are present cause significant distress or impairment in social, occupational, or other areas of functioning.

Federal and state regulations use the following classifications in determining eligibility for publicly funded mental health treatment services:

- **Serious mental illness (SMI)** generally applies to mental disorders that interfere with some area of social functioning (for example, work, school, family, leisure).²¹
- **Severe mental illness or severe and persistent mental illness (SPMI)** apply to more seriously affected individuals. This category includes schizophrenia, bipolar disorder, and other severe forms of depression, panic disorder, and obsessive-compulsive disorder. These terms are often used to describe individuals with a high level of functional impairment.²²

In this document, references to improving outcomes for people with mental illnesses under community corrections supervision pertain primarily to people with SMI or SPMI. Although substance use disorders are a type of mental illness, in this document they will be considered as part of the target population only when they co-occur with a non-addictive mental illness.

What are co-occurring disorders?

The authors use the term *co-occurring disorders* to refer to co-occurring substance-related and mental disorders. Co-occurring disorders are diagnosed when “at least one disorder of each type can be established independently of the other and is not simply a cluster of symptoms resulting from a single disorder.”²³

What are “mental health problems”?

It is particularly important to distinguish the definition and classification of mental illnesses from the term “*mental health problems*,” which has been used in some reports to characterize the

Second, mental illnesses may *indirectly* result in revocation. For example, an individual with clinical depression may have impaired functioning that prevents him or her from maintaining employment and paying court-ordered fines, which are standard conditions of release. Notably, many people with mental illnesses

returning to the community from jail or prison lack financial or social supports. Some were receiving Medicaid and other forms of public assistance at the time of their arrest, and these benefits are typically terminated rather than suspended during incarceration, and rarely reinstated immediately upon release. In short, there is

scope of the problem that criminal justice and mental health systems are working to address. The descriptive category to which this term refers includes people who have self-reported any symptom associated with a diagnosable mental disorder (e.g., feeling depressed at intake to a jail). The number of people who fit this description is extremely high—roughly 60 percent of jail and prison inmates.²⁴ This descriptive category is not used in this guide because it overestimates the size of the population that requires targeted, collaborative interventions and does not clarify treatment or programmatic needs and priorities.

What are personality disorders?

Personality disorders are enduring styles of thought, emotion, or behavior that usually appear in childhood or early adolescence and involve maladaptive and rigid patterns of perceiving and relating to other people.²⁵ Although personality disorders are a type of mental disorder, the authors distinguish them from SMI and SPMI to draw attention to the characteristic attitudes, traits, and impulse-control problems that may relate to socially deviant behaviors.

One such disorder, antisocial personality disorder (ASPD), is defined by a pervasive pattern of disregard for, and violation of, the rights of others.²⁶ Because the diagnostic criteria for ASPD includes acts of criminal and socially deviant behavior, the majority of people involved with the criminal justice system (50–75 percent) qualify for this diagnosis.²⁷ Thus, many people with SMI and SPMI involved with the criminal justice system are likely to have co-occurring ASPD, even though such diagnoses are typically excluded from the target populations of collaborative community corrections and mental health system interventions. The authors draw attention to this issue throughout the document by discussing the criminogenic risk factors that must be targeted in the treatment of people under community corrections supervision to reduce their risk of recidivism.

What disorders are not considered in this document?

Several conditions that affect mood, thinking, and behavior are beyond the scope of this guide. Developmental disabilities, traumatic brain injuries, and substance use disorders without co-occurring mental illness require different clinical interventions studied and validated by distinct bodies of research. Responses to people charged with sexual offenses and meeting criteria for paraphilia (pathological sexual behavior) are also addressed under a separate body of research.

A note on the terminology used throughout this document

Researchers apply terminology in different ways, and the authors often preserved the original language found in a given primary source to remain consistent with the researchers' reports. For example, mental illnesses are sometimes referred to as "psychiatric disorders."

often no safety net to compensate for functional impairments that may place individuals with mental illnesses at risk for revocation.

Third, mental illnesses may not result in revocation. Instead, the relationship between the two may be *spurious*—that is, more apparent than real—because a third variable associated with mental illness causes revocation. For example, an individual with bipolar disorder may be at risk of committing a new offense not because of his or her mental illness, but because of criminogenic attitudes or affiliation with antisocial peers. Alternatively, an individual with psychosis may be monitored exceptionally closely and revoked readily by his or her probation officer, given that traditional supervision strategies often reflect misconceptions about (and stigma associated with) mental illness.

From the perspective of over-burdened community corrections officers, the complicated circumstances and comprehensive needs of people with mental illnesses can represent a nearly insurmountable challenge. Officers' caseloads can reach into the hundreds, and they have limited resources to collaborate with community-based treatment providers, monitor individuals' compliance with treatment, and observe potentially harmful/dangerous behavior.²⁸ Coupled with the pressure officers may feel in meeting their agencies' public safety mission, they may determine that their safest recourse is to submit reports on any and every technical violation.

This section highlights research that explores the scope and scale of the problem and the reasons why traditional community corrections supervision practices do not achieve successful outcomes for people with mental illnesses.

Trends in Mental Health Policy

FEW SYSTEMS HAVE UNDERGONE so complete a transformation over the past 40 years as the nation's mental health treatment and service delivery apparatus. Once based exclusively on institutional care and segregation, the system has shifted its emphasis almost entirely to the provision of community-based support for individuals with mental illnesses. This shift—driven in part by fiscal reality, political and philosophical realignment, and medical advances—has resulted in successful community integration for many people who receive services.²⁹ In 1955, there were 339 state psychiatric beds for every 100,000 people in this population, and, by 2001, the number had dropped to 22 per 100,000.³⁰ This shift is referred to as “deinstitutionalization.”

Some observers have suggested a causal relationship between deinstitutionalization and the increased number of people with mental illnesses in contact with the criminal justice system—a phenomenon that has been described as “transinstitutionalization.” In fact, no study has definitively shown a transition of this population from mental health institutions into jails and prisons, and other trends in criminal justice, mental health, and social policy—for example, higher arrest rates for drug offenses, underfunded community-based treatment, and lack of affordable housing—are likely to account for this population's increasing contact with law enforcement, court, and corrections systems.³¹

Research Findings

1. What is the prevalence of people with mental illnesses under community corrections supervision?

a. Research strongly suggests that people with mental illnesses are overrepresented in probation and parole populations at estimated rates ranging from two to four times the general population.

- A 1999 study estimated that **5 percent** of people in the general population have a serious mental illness at any given time.³²
- In a study published in 2003, researchers interviewed 627 adults under probation supervision in Illinois, and using a brief, structured psychiatric interview, found that **19 percent** had “psychotic disorders” (i.e., schizophrenia, delusional disorder, and not otherwise specified psychotic disorder) at that time.³³
- In a 2008 study, researchers screened nearly 5,000 people under probation supervision. Results indicated that approximately **11 percent** of individuals in the sample were likely to have a serious mental illness.³⁴
- Using integrated databases from the California Department of Corrections and Rehabilitation, researchers identified all adults who were released to parole during 2004. During the release screening process, prison staff classified about **13 percent** of these people as having a “mental disorder.”³⁵
- In a 1999 Bureau of Justice Statistics (BJS) report, researchers estimated that **16 percent** of people under probation supervision were “mentally ill” based on self-report from a national survey.³⁶

b. Research strongly suggests that many people with mental illnesses under community corrections supervision also have a co-occurring substance use disorder.

- In a study published in 2003, researchers interviewed 627 adults under probation supervision in Illinois, and using diagnostic criteria for substance use and dependence disorders from the Diagnostic and Statistical Manual of Mental Disorders-III-R, found that **55 percent** of individuals with one or more current “psychiatric disorders” were dependent on one or more substances, compared with 37 percent of people without any “psychiatric disorders.”³⁷
- A 2008 study designed to examine risk factors that predict recidivism for people with and without mental illnesses included 221 participants on parole, 112 of whom had a “mental disorder.” Of the 112 with a mental disorder, **52 percent** had a co-occurring substance use disorder.³⁸

Prevalence of Mental Illnesses among Incarcerated Populations

THE PREVALENCE OF MENTAL ILLNESSES in both jails and prisons is relatively well documented.³⁹ Prevalence estimates of serious mental illnesses in jails range from 7 to 16 percent, or rates four times higher for men and eight times higher for women than rates found in the general population.⁴⁰ This body of literature is important to the discussion of community corrections for two main reasons.

First, although there is not much research on the prevalence of mental illnesses in community corrections populations, the figures available are consistent with this larger body of research on the prevalence of mental illnesses within correctional facilities, which lends support to those claims. It is logical to infer that the rates of mental illnesses for populations in jail are correlated with those under probation supervision, and for populations in prison with parole.

Second, studies that address the disproportionately high rate of mental illnesses in correctional facilities provide a larger context for understanding the scope of the problem. These estimates may be helpful in forecasting the number of justice-involved people with mental illnesses who will reenter the community over the next several years as they are released from jails and prisons.

2. What are the typical challenges that people with mental illnesses under community corrections supervision face?*

a. People with mental illnesses under community corrections supervision face an array of challenges. First and foremost, they have been diagnosed with mental illnesses or have presented with a variety of clinical issues.

The estimates listed below are illustrative of some of these challenges. Referenced are several studies that use different samples and methods. As a result, the percentages cited may not be directly comparable with one another and do not indicate the representation of these features in the community corrections population at large.

Of adults under probation supervision:

- **7 percent** have a lifetime history of recurrent, major depression.⁴¹
- **8 percent** have a lifetime history of manic episodes.⁴²
- **8 percent** were currently at risk of suicide.⁴³
- **8 percent** reported an overnight stay in a mental hospital at some point in their lifetimes.

Of adults participating in a mental health jail linkage program:

- **18 percent** reported hospitalization for a mental illness.⁴⁴

* Most of the research summarized in part 2a-d is drawn from Ditton, Mental health and treatment of inmates and probationers, 1999. Endnotes appear only when information is not cited from that source.

b. In addition to these clinical challenges, people with mental illnesses are more likely than those without mental illnesses to report prior traumatic experiences such as physical and sexual abuse. Victimization rates are especially high for women with mental illnesses who are under probation supervision.

- Of people under probation supervision, **39 percent** with mental illnesses, compared with 12 percent of people without mental illnesses, reported ever being abused before their arrest.
 - **31 percent** of men with mental illnesses on probation reported ever being abused before their arrest compared with 7 percent of men without mental illnesses.
 - **59 percent** of women with mental illnesses reported ever being abused before their arrest compared with 36 percent of women without mental illnesses.
- Of those who reported ever being abused before their arrest, **28 percent** of people with mental illnesses reported physical abuse compared with 10 percent of people without mental illnesses.
 - **21 percent** of men with mental illnesses reported physical abuse compared with 5 percent of men without mental illnesses.
 - **47 percent** of women with mental illnesses reported physical abuse compared with 30 percent of women without mental illnesses.
- Of those who reported ever being abused before arrest, **22 percent** of people with mental illnesses reported sexual abuse compared with 6 percent of people without mental illnesses.
 - **14 percent** of men with mental illnesses reported sexual abuse compared with 2 percent of men without mental illnesses.
 - **42 percent** of women with mental illnesses reported sexual abuse compared with 20 percent of women without mental illnesses.

c. People with mental illnesses under community corrections supervision are likely to face socioeconomic challenges such as homelessness, unemployment, and reliance on public assistance.

- Of local jail detainees, **30 percent** with mental illnesses, compared with 17 percent without mental illnesses, had been homeless in the year before their arrest.

Of people under probation supervision:

- **44 percent** with mental illnesses were unemployed compared with 24 percent of people without mental illnesses.
- **26 percent** with mental illnesses received welfare compared with 16 percent without mental illnesses.
- **25 percent** with mental illnesses received pension benefits, including Supplemental Security Income and Social Security, compared with 8 percent without mental illnesses.

d. People with mental illnesses under community corrections supervision have complex histories with the criminal justice system.

Of people with mental illnesses under probation supervision:

- **25 percent** committed a public-order offense.
- **16 percent** committed a drug offense (including both trafficking and possession).
- **30 percent** committed a property offense (including burglary, larceny/theft, and fraud).
- **28 percent** committed a violent offense.
- **57 percent** had a prior criminal history (compared with 46 percent of people under probation supervision without mental illnesses).

3. What are typical outcomes for people with mental illnesses under traditional community corrections supervision?

a. Research strongly suggests that people with mental illnesses under traditional community corrections supervision are more likely than people without mental illnesses to be re-arrested and to have their community sentence suspended or revoked.

- In a study that examined data on all people released to parole in California during 2004 (more than 100,000 people), researchers found that people on parole with mental illnesses were more likely to return to prison for a parole violation within one year of release (33 percent), compared to people without mental illnesses (20 percent).⁴⁵

b. There is some research to suggest that people with co-occurring mental illnesses and substance use disorders are more likely to return to jail or prison than people with only substance use disorders.

- In a study of more than 8,000 individuals released to parole by the California Department of Corrections in 2004, “parolees with co-occurring disorders” were more likely than parolees with substance use disorders only to return to custody.⁴⁶

4. What risk factors increase the likelihood of probation and parole revocation for people with mental illnesses?

The “Central Eight” Risk Factors Predicting Recidivism

EIGHT RISK FACTORS HAVE BEEN SHOWN to robustly predict recidivism among all individuals under community corrections supervision. Andrews and Bonta summarize these risk factors as follows:⁴⁷

- History of criminal behavior (prior interactions with the criminal justice system)
- Anti-social personality pattern (for example, antagonism, impulsivity, and risk-taking)
- Pro-criminal attitudes (for example, negative expressions about the law, conventional institutions, values, rules, procedures, etc.)
- Anti-social associates
- Poor use of leisure/recreational time
- Substance use
- Problematic circumstances at home (for example, low caring or supervision, high neglect or abuse, homelessness)
- Problematic circumstances at school or work (for example, limited education, unstable employment history)

These risk factors are the strongest predictors of recidivism, regardless of whether people have mental illnesses or not. Some evidence suggests, however, that people with mental illnesses may be at greater risk than those without mental illnesses for these general predictors of recidivism.

a. Research strongly suggests that the best predictors of probation and parole revocation for people with mental illnesses are the same as those for people without mental illnesses, but people with mental illnesses may have more of these risk factors.

- A meta-analysis of 64 unique samples, gathered from studies that dated between 1959 and 1995, indicated that the major predictors of recidivism were the same for “mentally disordered offenders” as for non-disordered offenders. The strongest predictors for both populations included criminal history and juvenile delinquency.⁴⁸
- In a 2008 study of 221 people on parole “with and without mental disorder,” researchers administered leading risk assessment tools to participants and then followed them in the community for an average of nine months. Those with mental disorder obtained significantly higher scores on a measure of the “big eight” general risk factors for recidivism (see sidebar) than those without mental disorder. These scores significantly predicted parolees’ recidivism during the follow-up period. Authors concluded that parolees with mental disorder are at a greater risk of community corrections supervision failure than parolees without mental disorder partly because they have more of these general risk factors.⁴⁹

b. There is some research to suggest that in addition to the general risk factors for revocation that all people on parole or probation share, people with mental illnesses face unique risk factors related to their clinical conditions.

- In the meta-analysis of 64 unique samples described above, the results indicated that the strongest predictors of recidivism were the same for “mentally disordered offenders” as for non-disordered offenders, and that the majority of “clinical” risk factors (e.g., intelligence, mood disorder, treatment history) were either non-significant predictors or negatively related to recidivism. However, some “clinical” risk factors unique to people with mental illnesses (e.g., prior psychiatric hospital admission) were significant, though fairly weak, predictors of recidivism.⁵⁰
- In the 2008 study of 221 people on parole with and without mental disorders described earlier, parolees with mental disorders obtained significantly higher scores on a risk assessment measure designed for clinical populations (e.g., active psychiatric symptoms). Scores on this measure weakly predicted their recidivism during an average nine-month follow-up period. Authors concluded that parolees with mental disorders are at greater risk than parolees without mental disorders mostly because of general risk factors shared between populations, but also because of risk factors that are unique to mental illness.⁵¹

5. How might traditional community corrections supervision strategies relate to higher revocation rates for people with mental illnesses?

a. Large caseload size limits the time and resources agencies can dedicate to people (with and without mental illnesses) under their supervision, and it is a widely held belief, supported by some empirical evidence, that these limitations are especially challenging for officers who supervise people with mental illnesses.

- A series of focus group discussions held separately with 32 probation officers and 20 probationers with mental illnesses explored perceptions of common supervision challenges and how best to address them. Probation officers who supervised people with mental illnesses on traditional caseloads reported that they had little or no time, training, or guidelines on how to supervise people with mental illnesses differently than the general probation population.⁵²

b. Probation officers are aware of the myriad challenges that people with mental illnesses face, and believe that people with mental illnesses may have more time-consuming needs than those without mental illnesses.

- In the focus group described above, officers reported that probationers with mental illnesses had a limited ability to comply with standard probation conditions (e.g., maintaining a job). They also had a pronounced need for a range of “social welfare benefits.” Probation officers perceived these probationers as “needy and time-consuming” because of their mental illnesses and related issues.⁵³
- In the same series of focus groups, the probationers with mental illnesses felt they required substantially more time and attention from, and became more dependent on, their probation officers than other probationers.⁵⁴

c. Research moderately to strongly supports the widely held belief that community corrections officers have a lower threshold for revoking the sentences of people with mental illnesses than people without mental illnesses.

- In a small matched sample of 36 people released to parole in Canada in 1988 and followed for two years, “mentally disordered offenders” were more likely to have their parole suspended or revoked without committing a new offense, than “non-disordered offenders.”⁵⁵
- In the focus group of 32 probation officers described above, some officers in traditional agencies perceived individuals with mental illnesses as “problem cases” and sought to 1) transfer the case to another officer’s caseload, or 2) terminate the case from probation (e.g., completion, dishonorable discharge, revocation).⁵⁶
- In a study that examined data on all people released to parole in California during 2004 (more than 100,000 people), researchers found that of those people who recidivated during the time period studied, people with mental illnesses were more likely to have determinations involving technical offenses (58 percent) than people without mental illnesses (49 percent).⁵⁷

d. Research moderately to strongly suggests that officers’ use of threats of incarceration and other negative pressures predict re-arrests and revocation for people with mental illnesses under probation supervision.

- In the focus group of 32 probation officers described above, officers on traditional caseloads reported:
 - Most often depending on threats of incarceration to enforce treatment compliance for all probationers, including those with mental illnesses.
 - Feelings of frustration at the limitations of punitive measures to enforce compliance and felt these measures were insufficient.⁵⁸
- In a study of 360 probationers that compared traditional with specialty probation agencies, use of “negative pressures” by the probation officer predicted revocation and re-arrest for people with mental illnesses after six months.⁵⁹

Conditions of Release/Supervision

THERE IS LITTLE RESEARCH REGARDING THE IMPACT of specific release/supervision conditions on outcomes for people with mental illnesses under community corrections supervision. Best practices or guidelines for judges, probation officials, or parole boards developing policies around release/supervision conditions are beyond the scope of this document, but there is general agreement that these conditions should be clearly enumerated and accurately conveyed, promote public safety, and facilitate engagement in treatment. Conditions should reflect individualized assessments of criminogenic risk and functional impairment and be flexible based on changing circumstances. There is also general agreement that highly restrictive conditions increase the likelihood of minor violations that might result in probation or parole revocation. Research shows that individual characteristics of supervisees in the general population influence their responsiveness to different types of interventions, suggesting that targeted conditions of supervision work best.⁶⁰

SECTION TWO

Strategies to Improve Outcomes for People with Mental Illnesses under Community Corrections Supervision

Strategies to reduce recidivism for people under community corrections supervision, and strategies to improve clinical outcomes for people with mental illnesses, have each been well-documented and widely supported by respective bodies of research. Despite their promise, the effectiveness of these community corrections supervision and mental health treatment strategies have not been studied in depth for people who represent an overlap in populations—those with mental illnesses under community corrections supervision. Preliminary research does show that integrating supervision and treatment strategies for this group may reduce the risk of revocation and increase linkages to mental health treatment.

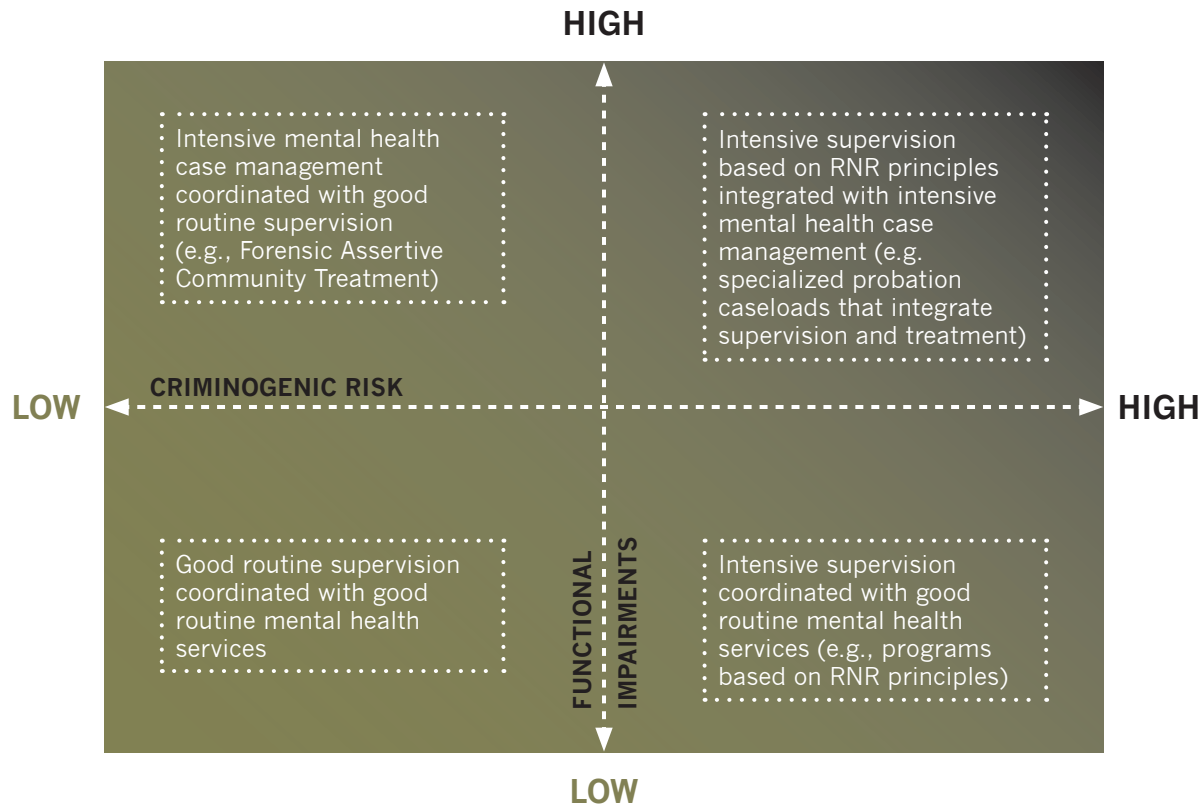
Community corrections officers are aware of the complex issues facing people with mental illnesses on probation and parole, and while their supervision responses are guided by risk, need, and responsivity principles (see Research Finding 1.a–b below), adaptations to standard practice are required to achieve positive outcomes for people with mental illnesses. Likewise, mental health providers' treatment responses are guided by a biopsychosocial model, which considers biological, psychological, and social influences on health and mental health, but adaptations to traditional treatments and supports are needed for people under community corrections supervision (see Research Finding 2.a–b below). Independently and jointly, community corrections and mental health officials have begun to develop new approaches for this population.

It is necessary to consider these new approaches within the full spectrum of needs and potential responses discussed at the outset of this guide. People with mental illnesses under community corrections supervision pose different degrees of criminogenic risk, determined by the nature of their criminal offense and

dynamic factors associated with their attitudes, circumstances, and patterns of thinking. This degree of criminogenic risk is a core component in the design of supervision strategies. So too, these individuals have a wide range of functional impairments, determined in part by diagnoses, disabilities, and socioeconomic circumstances. This degree of functional impairment is a core component in the design of traditional treatment interventions. As such, it follows that the menu of supervision and treatment options for this population should be derived from an assessment of these two basic dimensions: criminogenic risk and functional impairment.

The two-by-two matrix below illustrates this concept. Although it has not been validated, the matrix provides a conceptual approach for matching supervision and treatment options to varying degrees of criminogenic risk and functional impairment. The matrix, derived from similar efforts to organize responses to people with co-occurring mental illnesses and substance use disorders, highlights the central considerations that drive criminal justice and mental health system responses.⁶¹ It provides a framework for understanding the research

Fig. 2: Tailoring evidence-based practices to the specific criminogenic risks and functional impairments of people with mental illnesses to improve public safety and public health outcomes



presented in this guide and may be useful in deciding how to allocate the scarce resources within both mental health and community corrections systems.

In addition to the degree of criminogenic risk and functional impairment, both of which can range from low (or minor) to high (or severe), two other critical features of potential

interventions for this population are the level of response intensity, which can range from low to high, and the degree to which community corrections and mental health agencies coordinate or integrate their responses (See Research Finding 3.a below).^{*} The matrix proposes that the level of response intensity and the degree of coordination/integration should increase as both

^{*} *Coordination* exists when each agency is aware of the other's activities and occasionally shares clinical or corrections information—within legal parameters—about particular individuals in contact with both agencies. *Integration* exists when community corrections and mental health agencies develop and implement a single supervision and treatment plan in which both have an active role, such as sharing

staff and other resources, and participating in each other's case staffing. (Adapted from Center for Substance Abuse Treatment. Definitions and Terms Relating to Co-occurring Disorders. COCE Overview Paper 1. DHHS Publication No. (SMA) 06-4163 Rockville, MD: Substance Abuse and Mental Health Administration, and Center for Mental Health Services, 2006.)

criminogenic risk and functional impairment increase. The matrix assumes that “good routine supervision” includes evidence-based practices specific to community corrections supervision (see Research Finding 1.a-b below) and that “good routine treatment” includes evidence-based practices specific to mental health treatment (see Research Finding 2.a-b below). The matrix also assumes that supervision and treatment avoid “bad practice,”—such as use of sanction threats or authoritarian relationships in supervision—with all individuals under community corrections supervision regardless of where they fall on the matrix.⁶² Finally, the matrix assumes that program packages requiring intensive resources are reserved for those with the highest level of criminogenic risk and functional impairment, that is, the highest risk of recidivism.

For example, people with low criminogenic risk and low functional impairment may require little supervision and less intense outpatient mental health treatment. Community corrections and mental health staff may not need to coordinate extensively or dedicate additional resources if both systems are implementing good, routine practices. Individuals who fall into the upper left and bottom right corners of the matrix—people with high functional impairment and low

criminogenic risk or low functional impairment and high criminogenic risk—may require coordination between community corrections and mental health staff but not full-fledged integration. In the top right corner of the matrix, those with high criminogenic risk and high functional impairment may require specialized, targeted, and integrated interventions in order to maximize public safety and public health outcomes.

It is important to note that before a jurisdiction considers actually matching supervision and treatment options to individuals’ varying degrees of criminogenic risk and functional impairment, it must first ensure that it can identify these different subgroups of people. This depends on the screening and assessment procedures of jails and prisons, probation and parole agencies, and mental health treatment providers. Implementing such procedures presents a number of intra- and inter-system challenges that must be addressed before tailoring effective responses to people with mental illnesses.*

This section, framed by the matrix and related issues, highlights research on the strategies developed in community corrections, mental health treatment, and integrative community corrections/mental health treatment settings.

* See Section Three for more on screening and assessment.

Research Findings

1. Which community corrections interventions or strategies improve outcomes (such as reducing recidivism) for people under community corrections supervision?

a. Research strongly supports a number of evidence-based *principles* that have been shown to reduce recidivism for the general population under community corrections supervision:

- Adherence to Risk-Needs-Responsivity (RNR) principles
- Cognitive-behavioral treatment interventions
- Drug treatment in the community

The effectiveness of these interventions and principles has not been examined, however, for people with mental illnesses under community corrections supervision.

- The **RNR model** is a set of principles that maximize the effectiveness of community corrections interventions.

Several meta-analyses of existing evaluations show that offenders are less likely to recidivate when programs target higher-risk cases, matching the intensity of supervision and treatment services to their level of risk for recidivism, (*risk principle*), match modes of service to their abilities and styles (*responsivity principle*), and target a greater number of their changeable risk factors for recidivism or criminogenic need (*need principle*).⁶³ Studies indicate that providing treatment that follows RNR principles reduces an offender's risk of recidivism by 24 to 53 percent when compared with individuals who received no rehabilitative treatment.⁶⁴

- **Cognitive-behavioral treatment (CBT) programs**, a type of therapy that addresses the irrational thoughts and beliefs that can lead to anti-social behavior, has been shown to reduce recidivism for the general correctional population.⁶⁵

In a meta-analysis of 58 studies on the effects of CBT on recidivism, researchers found that CBT significantly reduces recidivism. Further investigation suggested that effective CBT programs were intensive (more hours provided), included individual sessions (not just group treatment), and included a focus on anger control. Researchers concluded that CBT programs reduced an offender's recidivism risk by 25 to 50 percent (average to maximum effect), compared with individuals receiving no rehabilitative services.⁶⁶

- **Drug treatment in the community** has been shown to reduce recidivism for drug-involved individuals under community supervision.⁶⁷

For example, in a 2005 study, researchers analyzed data on 3,328 drug-involved people who were diverted from prosecution to a community drug treatment program. People who entered and completed treatment were less likely to be re-arrested in the five years of follow-up (22 percent) than those who entered and did not complete the program (43 percent). Most notably, more than half (52 percent) of people eligible for treatment who did not enter the program were re-arrested after five years.⁶⁸

b. Research moderately to strongly suggests that a number of community corrections officer *strategies and techniques* can reduce recidivism for people with mental illnesses under community corrections supervision, or increase linkages to services:

- **“Firm but fair” relationships**
- **Compliance strategies that favor problem solving over threats of incarceration and other negative pressures**
- **Boundary spanning**

■ **“Firm but fair” relationships** between community corrections officers and those under their supervision have been shown as an effective general strategy to reduce recidivism for all people under community corrections supervision—both with and without mental illnesses.⁶⁹

In one study, researchers interviewed 82 people with co-occurring mental illnesses and substance use disorders under probation supervision, focusing on their relationships with officers and clinicians. After eight months, results indicate that relationships characterized by caring, fairness, trust, and an authoritative (not authoritarian) style significantly protected against future probation violations.⁷⁰

■ **Officers’ use of compliance strategies that favor problem solving**, as opposed to threats of incarceration and other negative pressures, have proven effective in improving outcomes for people with mental illnesses under community corrections supervision.

For example, in one study, researchers tracked more than 350 people with mental illnesses under probation supervision over 12 months, focusing in part on the impact of an officer’s use of different strategies for monitoring and enforcing compliance on the individual’s outcomes. Results indicate that the use of threats and other negative pressures (e.g., short-term incarceration) significantly increases these individuals’ risk of future arrest and probation revocation.⁷¹

■ **Boundary spanning**, in which officers develop knowledge about mental health and community resources, establish and maintain relationships with clinicians, and advocate for services, has been shown to increase linkages to treatment, but not reduce recidivism, for people with mental illnesses under probation supervision.⁷²

2. Which mental health treatment interventions improve clinical outcomes (for example, improved functioning) for people with mental illnesses?

a. Research strongly supports six evidence-based practices that have been shown to improve the functioning of people with mental illnesses, and for two of these interventions (*), there is some research on criminal justice outcomes:

- Assertive community treatment*
- Illness self-management and recovery
- Integrated mental health and substance use services*
- Supported employment
- Psychopharmacology
- Family psychoeducation

The effectiveness of these practices has not been thoroughly examined, however, for people with mental illnesses under community corrections supervision.

■ **Assertive Community Treatment (ACT)** is an evidence-based mental health treatment program defined as a service delivery model in which individualized treatment is provided by a team of mental health professionals.⁷³ This model is multidisciplinary (including psychiatry, nursing, substance use treatment, and others) and focuses on a broad range of needs with the goal of decreasing hospitalizations.

For example, researchers reviewed 25 randomized control trials that evaluated ACT programs and found that ACT substantially reduces psychiatric hospital use, increases housing stability, and moderately improves symptoms of mental illness.⁷⁴ However, in this review, the effects of ACT on criminal justice outcomes were mixed.

■ **Illness self-management and recovery** focuses on providing individuals with mental illnesses the skills they need to monitor and control their own well-being with regard to mental illness.⁷⁵

For example, researchers identified 40 randomized control trials of illness self-management and found that self-management strategies (psychoeducation, behavioral tailoring, relapse prevention programs, and others) improve clinical outcomes for people with mental illnesses.⁷⁶

■ **Integrated mental health and substance use services** are an effective practice for treating people with co-occurring disorders.⁷⁷ Researchers have identified critical components necessary to produce positive results, including programmatic (e.g., multidisciplinary teams) and treatment (e.g., medications) elements.⁷⁸

For example, researchers identified 10 studies that evaluated comprehensive, integrated outpatient treatment programs for people with co-occurring disorders and found that these programs effectively reduce substance use and improve mental illness symptoms.⁷⁹ In a one-year random assignment of individuals to either integrated treatment for co-occurring disorders or traditional treatment, the integrated group achieved lower rates of arrest.⁸⁰

- **Supported employment** “is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities. Supported employment programs are staffed by employment specialists who have frequent meetings with treatment providers to integrate supported employment with mental health services.”⁸¹ Supported employment is an effective practice for treating people with mental illnesses.⁸²

In a review of six randomized control trials that compared supported employment to traditional vocational services in terms of their effects on people with “severe mental illness,” people with mental illnesses who enrolled in supported employment programs were significantly more likely to obtain and keep employment.⁸³

- **Psychopharmacology**, or medication treatment, has been well established as a critical component to treatment strategies for people with serious mental illnesses.

A recent study by a team of clinical practitioners indicates that medication treatment for people with severe mental illnesses is an important part of usual care, and further identifies and discusses relevant evidence-based guidelines for this type of treatment.⁸⁴

- **Family psychoeducation** involves a partnership between family members and consumers of mental health services. Service providers work with family members and consumers to build relationships and collaborations, and, throughout this process, they learn about mental illnesses, management techniques, and stress reduction.⁸⁵

b. Some empirical evidence supports the widely held belief that two promising practices improve clinical functioning for people with mental illnesses, and there is some research to suggest that they may have a positive impact on criminal justice outcomes:

- **Supported housing**
- **Trauma interventions**

- **Supported housing** program models—both transitional and permanent housing—for people with mental illnesses can improve outcomes for this population.⁸⁶ Researchers have found that providing community-based housing increases use of services and reduces incarceration rates.⁸⁷

- **Trauma interventions** are not yet an “evidence-based practice,” but researchers believe them to be promising and especially relevant given the high rate of trauma among people with mental illnesses, particularly when they are involved in the criminal justice system.⁸⁸ Studies have illustrated that trauma-specific interventions reduce associated symptoms.⁸⁹

3. How have jurisdictions integrated community corrections supervision strategies and mental health treatment strategies? Do these integrated approaches improve criminal justice and clinical outcomes for people with mental illnesses under community corrections supervision?

a. A variety of program models integrate, to varying degrees, community corrections supervision with mental health treatment. Some empirical evidence supports the widely held belief that coordinated, integrated interventions improve outcomes for people with mental illnesses under community corrections supervision, and for one program model (*), the evidence is strong.

- Specialized probation caseloads*
- Forensic Assertive Community Treatment
- Forensic Intensive Case Management
- Parole outpatient clinics for people with mental illnesses
- Partnership for Active Community Engagement

■ **Specialized probation caseloads (see also the Key Features sidebar on page 28)** integrate community corrections supervision strategies with community-based mental health treatment and services through a variety of methods. Research strongly suggests that people with mental illnesses under specialized probation supervision may be *less likely* to have their sentence revoked and *more likely* to receive mental health treatment and other services than they are under traditional community corrections supervision.

- In an ongoing study based on a matched sample of more than 350 people with mental illnesses under specialty and traditional probation supervision, researchers found after one year that compared with people under traditional supervision, people under specialty supervision: 1) received significantly more mental health services, 2) were less likely to be arrested (26 percent vs. 34 percent), and 3) were less likely to have their probation revoked (9 percent vs. 26 percent). The relationship between specialty supervision and positive criminal justice outcomes was partially mediated by “firm but fair” relationships and avoidance of threats and other negative pressures.⁹⁰
- In a study that included 800 participants and was administered by an independent research firm of the IMPACT program in Orange County, California, people with mental illnesses under specialty probation supervision received significantly more mental health services and filled more prescriptions than the individuals in randomized control groups. However, they were no less likely to be booked into jail throughout the follow-up period (see the “Increased Scrutiny” sidebar on page 28).⁹¹

Some research suggests that other types of collaborations between community corrections agencies and mental health treatment providers can reduce probation/parole violations:

- Researchers tracked 16 people with mental illnesses who participated in a collaborative program between a mental health treatment provider and a federal community corrections agency in Baltimore. Participants’ rate of violation before entering the program was higher (56 percent) than their rate of violation after participation in the specialty supervision program (19 percent).⁹²

- **Forensic Assertive Community Treatment (FACT)** is distinguished from ACT (see page 24 for more on ACT) in four ways: participants have criminal justice histories, preventing arrest and incarceration are explicit outcome goals, the majority of referrals come from criminal justice agencies, and supervised residential treatment is incorporated into the program.⁹³ Although FACT is derived from the ACT model, research on the modified program has yielded mixed results to date. Some studies show that program participants have fewer jail and hospital stays, while other studies show higher revocation rates, which may be due in part to enhanced oversight.⁹⁴
- **Forensic Intensive Case Management (FICM)** is the criminal justice adaptation of Intensive Case Management (ICM). ICM mirrors ACT, but is less resource-intensive than ACT because caseloads are managed by single case managers, services are not available 24/7, and access to mental health treatment is brokered (not provided in-house).⁹⁵ The Substance Abuse and Mental Health Services Administration conducted a jail diversion study that evaluated the effectiveness of FICM at nine sites throughout the country. Findings indicate that FICM improved criminal justice outcomes (e.g., fewer jail days) but did not affect, negatively or positively, clinical outcomes (e.g., symptoms).⁹⁶
- **Parole outpatient clinics (POC) for people with mental illnesses** have been studied in California, where they are an extension of the California Department of Corrections and Rehabilitation's Division of Adult Parole Operations. The POC's goal is to reduce the symptoms of mental illnesses among people under parole supervision by providing timely and cost-effective mental health care services. In a 2004 analysis based on a large study of people released from prison, researchers found that the more contacts the individuals had with POC, the less likely they were to return to prison.⁹⁷
- **Partnership for Active Community Engagement (PACE)** is a collaborative project in Colorado involving the chief judge, the sheriff, the probation department, the mental health center, the public health department, and the local community justice services department. PACE is an alternative program to probation, administered by a co-located team from across disciplines. Internal program evaluations indicate a significant reduction in jail time (73–90 percent) for participants following program admission.⁹⁸ Although this model is promising, there is not yet sufficient research to suggest these reported positive outcomes can be replicated.

When Specialized Responses Lead to Increased Scrutiny of Technical Violations

THOUGH RESEARCH ON SPECIALIZED RESPONSES shows positive trends regarding recidivism reduction and increased access to services, some research has begun to show that implementing any type of specialized community supervision program can actually increase the amount of time people with mental illnesses spend in jail—the opposite outcome these types of initiatives are designed to achieve. This seems to happen for at least two reasons.

First, specialized supervisors are typically responsible for fewer individuals than traditional supervisors, and, as a result, they can spend more time with each supervisee in community settings. This may make it more likely for them to observe behaviors that constitute technical violations of the release conditions, such as forgetting to take medications or missing an appointment with a service provider.

Second, community-based mental health treatment providers partnering with a specialized community corrections program may inadvertently become monitors of compliance. A side effect of their otherwise desirable “boundary spanning” may be that they are more likely to report technical violations to the community corrections officer with whom they are collaborating.

What Are the Key Features of Specialized Probation Caseloads?

SPECIALIZED COMMUNITY CORRECTIONS CASELOADS are regarded as a promising practice for improving outcomes for people with mental illnesses under community corrections supervision. As with other innovative practices, specialized caseloads have emerged from the ground up. Agency administrators, staff, and other stakeholders make a logical and pragmatic—but largely anecdotal—case that specialized caseloads meet specific community needs. Typically, the move to specialized caseloads involves adapting program models developed in other jurisdictions.

To determine the defining features of the specialized caseloads that are emerging across the country, Skeem and colleagues conducted a national survey to compare them with traditional caseloads and found the following:⁹⁹

- Specialized caseloads are **smaller** than traditional caseloads, averaging 45 people per probation officer (compared with more than 100 for traditional caseloads), and are **composed exclusively of people with mental illnesses**. As a result, probation officers can spend more time with each individual under their supervision and address his or her risks and impairments.
- Specialized probation officers receive **significant and sustained training** on mental health issues—averaging 20 to 40 hours per year.
- Specialized probation officers **collaborate extensively with community-based service providers**, integrating internal and external resources. They intervene directly with probationers and actively coordinate with external service providers, often working on a team with treatment providers and participating in case staffing.
- Specialty probation officers are likely to **employ problem-solving strategies** when individuals under their supervision do not comply with the conditions of their probation. They identify obstacles to compliance, resolve these problems, and agree on a compliance plan. They are less likely than traditional officers to use threats of incarceration and other negative pressures.

SECTION THREE

Future Research Questions and Implications for Policy and Practice

Though promising strategies to improve the response to people with mental illnesses under community corrections supervision exist, there are still important questions that should be prioritized as part of a national research agenda on this topic. To achieve the outcomes demonstrated by the existing body of research, policymakers must also consider a number of key implementation issues before developing any of these strategies in their communities.

The research reviewed in this document examines the staggering number of people with mental illnesses under community corrections supervision, outlines the reasons why they may be less likely than people without mental illnesses to succeed under traditional supervision, and summarizes the effectiveness of various strategies to improve outcomes for this population. In reviewing the research, a goal of this document is to provide policymakers with sound information that can inform the development of effective interventions based on current science. But many important questions remain unanswered, and implementing some of the proven practices summarized in this document poses a number of challenges for policymakers and practitioners.

This section lists research questions that should be investigated to expand the evidence base on improving outcomes for people with mental illnesses under community corrections supervision. It then outlines some of the issues that policymakers must consider—and some of the tools that they can use—when implementing new approaches.

QUESTIONS FOR FUTURE RESEARCH

A recurrent theme in this document is that research available to answer the questions, “What works, for whom, and under what circumstances?” with regard to people with mental illnesses under community corrections supervision is either non-specific or incomplete. Three broad sets of questions, many of which are partially answered in the research summaries above, require further investigation. (For a more detailed list of research questions, see the appendix.)

1. *For what populations can evidence-based community corrections strategies alone (such as focusing only on criminogenic risk) reduce the risk of revocation for people with mental illnesses under community corrections supervision?*
 - a. *How can these approaches be made responsive to the characteristics of people with mental illnesses?*
 - b. *Are any of these strategies essential for improving criminal justice outcomes for people with mental illnesses?*

2. For what populations can evidence-based mental health treatment practices alone (such as focusing only on functional impairments) reduce the risk of revocation for people with mental illnesses under community corrections supervision?

a. How can these practices be made responsive to the characteristics of people involved with the criminal justice system?

3. For what populations can coordination or integration of correctional supervision and mental health treatment produce better clinical or criminal justice results?

a. What features of coordination or integration are pivotal for achieving these outcomes?

IMPLICATIONS FOR POLICY AND PRACTICE

The proven and promising strategies outlined in this document are relatively straightforward, but policymakers must address a number of related issues if they hope to achieve the kinds of positive outcomes demonstrated by existing research. These issues include, but are not limited to, screening and assessment procedures, the degree of cross-agency collaboration, proper program implementation, performance-based contracting, and agency culture and leadership. Brief summaries of each of these issues are outlined below.

Screening and Assessment

Screening and assessment procedures are critical in matching appropriate interventions to individuals' criminogenic risks and functional impairments. In many jurisdictions, though, screening and assessment instruments and

classification systems are not uniform or coordinated among jails, probation and parole agencies, and community-based treatment agencies. In addition, incongruent guidelines regarding who should be prioritized for supervision or treatment in these different settings can complicate efforts to coordinate screening and assessment strategies. There are large bodies of research on the validity of particular screening and assessment instruments. With appropriate leadership and the willingness to change potentially long-held practices, proven instruments can be collaboratively adopted by criminal justice and mental health systems in a given jurisdiction.*

Cross-Agency Collaboration

Information Sharing: How and when mental health practitioners share information about individuals under community corrections supervision, and how and when probation or parole officers share supervision information about people with mental illnesses on their caseloads, is a critical issue for jurisdictions to explore and resolve. Individuals' confidentiality rights must be protected while ensuring all relevant agencies have the information they need to achieve mutually desired outcomes. Written policies and procedures, memoranda of understanding between agencies, and training on state and federal confidentiality and consent statutes are paramount.

Coordination of Services: Processes by which community corrections and mental health staff provide links to and interface with other clinical and support services such as medical care, housing, employment, and other social services must be explored and standardized, ideally through memoranda of understanding.

* For a recent review of the screening and assessment of mental illnesses, substance use disorders, and co-occurring disorders for individuals involved with the criminal justice system, see Peters, R.H., M.G. Bartoi, and P.B. Sherman, 2008, Delmar NY, The CMHS National

GAINS Center. For a recent review of the screening and assessment of criminogenic risk, see Andrews, B.A., J. Bonta, and J.S. Wormith, 2006, The Recent Past and Near Future of Risk and/or Need Assessment. *Crime Delinquency* (52)7.

Proper Program Implementation

Workforce Quality and Capacity: The existing capacity of community corrections and mental health treatment staff to provide adequate services to specific target populations must be well understood so agency administrators can determine how resources should be allocated and matched to individuals with different levels of criminogenic risk and functional impairment. The ratio of line staff to supervisees with mental illnesses is critical to consider in designing interventions that may require intensive supervision and treatment. The ability of staff within community corrections and mental health agencies to provide evidence-based interventions will have a direct impact on public health and public safety outcomes and has significant implications for training and hiring standards.

Organizational Capacity and Program Fidelity: Community corrections and mental health treatment agencies vary in their capacity to promote best practices and innovation. Tools are available to help organizations determine this capacity. For community corrections agencies, an example is the Correctional Program Assessment Inventory (CPAI), which is framed around principles of effective intervention (such as risk-needs-responsivity, “firm but fair” relationships, and brokerage of treatment and services) and helps agencies determine the extent to which their programs have incorporated these principles.*¹⁰⁰

For mental health agencies, the General Organization Index (GOI) is a tool that measures a set of general operating characteristics that

are related to an organization’s overall capacity to implement and sustain any evidence-based practice. Programs scoring high on the GOI are expected to be more effective in implementing an evidence-based practice and in achieving desired outcomes.¹⁰¹ The GOI is often used with fidelity scales developed for each of the mental health treatment evidence-based practices referenced in this document. Fidelity is the extent to which program models are implemented as designed.†

Outcome Evaluations/Performance Measures: The ability to collect and analyze outcome and performance data is critical to the quality improvement and sustainability of any new initiative. Early in the planning process, policymakers must identify performance measures that are consistent with the shared goals of the initiative and ensure relevant agencies can collect data on these measures. These measures should consider both process and outcome data. Process data should include information on key aspects of program operation (such as the number of individuals who have attended and completed treatment programs) and qualitative data on officers’, supervisees’, and community members’ perceptions of the program. Outcome data should include information on program participants such as rates of technical violations, revocations, and re-arrests; trends in the overall growth of the jail population; as well as information about treatment and service utilization, functional improvements, and symptom reductions.

* For more information on the CPAI, please see Lowenkamp, C. T., E.J. Latessa, and P. Smith. 2006. Does Correctional Program Quality Really Matter? The Impact of Adhering to the Principles of Effective Intervention 2006. *Criminology and Public Policy*. (5)3:575–594 and Gendreau, P., and D.A. Andrews. 2001. *The Correctional Program Assessment Inventory 2000 (CPAI 2000)*. Saint John, Canada: University of New Brunswick.

† For more information on the GOI and fidelity scales, please visit the Substance Abuse and Mental Health Services Administration’s National Mental Health Information Center, Center for Mental Health Services at <http://mentalhealth.samhsa.gov/>

Performance-Based Contracting and Funding

With the right performance measures in place, funding entities (such as state departments of corrections or mental health) can use contract and funding mechanisms to incentivize positive outcomes (and, conversely, disincentivize poor outcomes). In community corrections settings, for example, this might mean measuring performance and providing funding based on reductions in recidivism rates rather than the number of “cases closed.” In mental health treatment settings, this might mean measuring performance and providing funding based on successful treatment completion rates rather than the number of units of treatment provided.

Organizational Culture and Leadership

Designing and implementing one of the specific program models or adopting some of the general, agency-wide principles and techniques identified in this document may depend as much on adjusting longstanding organizational attitudes and beliefs as it does on funding and other resources.

In community corrections settings, for example, some agencies have viewed their role in a manner that some have characterized as “trail ’em, nail ’em, and jail ’em”—in other words, solely as monitors of compliance who do not

consider the complex treatment and service needs of their supervisees as integral to maintaining public safety and reducing recidivism. These agencies face significant challenges adjusting to a new agency culture that emphasizes risk-needs-responsivity principles, establishing “firm but fair” relationships, brokering treatment and services in community settings, and even simply avoiding bad or harmful practices.

In mental health treatment settings, providers may resist working with clients facing criminal charges even though many of their current clients may have significant criminal histories. Some providers may not consider jails, prisons, and community corrections agencies to be part of a continuum of intervention settings, and others may not be familiar with interventions that target criminogenic risks and may therefore feel they have little to offer this population.

In both community corrections and mental health treatment settings, agency leaders who articulate common public safety and public health missions can address these issues. Such leadership is essential in any attempts to change organizational culture, and the presence of individuals or teams with authority and vision to organize and sustain complex change processes is a critical element in these efforts.¹⁰²

Conclusion

Policymakers and practitioners across the country are focusing their attention on improving outcomes for people with mental illnesses under community corrections supervision. Program models and principles are being developed, refined, and evaluated, and although no single program model or set of blanket policy recommendations will work in every jurisdiction, community corrections and mental health agencies are coming together around commonly defined goals and with shared purpose to tackle these challenges. At the federal level, such collaboration is being prioritized through the Mentally Ill Offender Treatment and Crime Reduction Act, and promoted through the Justice and Mental Health Collaboration Program grants authorized by that legislation.* A handful of state governments are mirroring this federal initiative with statewide grant programs that

fund collaborations between criminal justice and mental health systems.

With a growing body of literature on the effectiveness of such collaborations, this document represents an effort to facilitate the development of community corrections/mental health interventions based on sound science. When these interventions are successful, they have the potential to attenuate the cycle of arrest, incarceration, release, and reincarceration experienced by so many people with mental illnesses. In so doing, scarce institutional resources can be reserved for those who pose the greatest risk to public safety, and countless others can be linked to effective treatment and services, enabling them to make forward progress in their recovery from mental illnesses while contributing to, and participating in, the health of their communities.

* For more information on the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) and the Justice and Mental Health

Collaboration Program (JMHCPC), please visit <http://consensusproject.org/resources/government-affairs/fed-leg-MIOTCRA/>.

Appendix: Expanded List of Research Questions

1. Can evidence-based community corrections alone improve outcomes for people with mental illnesses under community corrections supervision?

- a. If providing more treatment services to people with mental illnesses does not always translate into reduced contact with the criminal justice system, what other practices prove more effective?
- b. Which evidence-based community corrections practices can be adapted for people with mental illnesses while maintaining fidelity to the proven practice?
- c. Which evidence-based community corrections practices are essential for improving outcomes for people with mental illnesses?
- d. Which of the “big eight” risk factors for supervision failure are most salient among people with mental illnesses?

2. Can evidence-based mental health treatment practices alone improve outcomes for people under community corrections supervision?

- a. Can evidence-based mental health treatment practices alone—i.e., focusing only on mental health treatment needs—decrease the risk of re-arrest or revocation for people with mental illnesses under community corrections supervision?
- b. If evidence-based mental health treatment practices alone—i.e., focusing only on mental health treatment needs—do not decrease the risk of re-arrest or revocation, which of

the general risk factors must be addressed to achieve successful community corrections outcomes?

- c. Which of the evidence-based mental health treatment practices listed below can be adapted for community corrections populations while maintaining fidelity to the proven practice? At what point do modifications compromise fidelity and require independent research?
 - i. Assertive community treatment
 - ii. Housing
 - iii. Trauma interventions
 - iv. Supported employment
 - v. Illness self-management and recovery
 - vi. Integrated treatment
 - vii. Psychopharmacology
- d. Which evidence-based mental health treatment practices are most important for successful community corrections and mental health outcomes? For whom and under what circumstances?

3. Do combined evidence-based community corrections and mental health treatment practices produce even better outcomes for this population?

- a. What is the respective impact of each of the features that distinguish specialized probation caseloads from traditional caseloads? What are the crucial features necessary to obtain improved outcomes for people with mental illnesses?

- b. How are specialized parole caseloads for people with mental illnesses different than traditional parole caseloads?
- c. What other types of specialized interventions have parole agencies and community-based mental health providers collaboratively developed?
- d. What is the respective impact of each of the features that distinguish specialized parole caseloads from traditional caseloads? What are the crucial features necessary to obtain improved outcomes for people with mental illnesses?
- e. What are the typical clinical and legal outcomes for people with mental illnesses under specialized parole supervision?

4. What other important questions should researchers examine?

- a. How are the debts that individuals face upon release from jail or prison related to supervision outcomes for people with mental illnesses?
- b. What impact do judicial conditions of release have on community corrections outcomes for people with mental illnesses?
- c. What impact do parole conditions of release have on community corrections outcomes for people with mental illnesses?
- d. What is the fiscal impact of specialized community corrections caseloads for people with mental illnesses?
- e. What impact do gender and culture have on outcomes for this population? Do gender- and culturally competent strategies improve outcomes for this population?

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