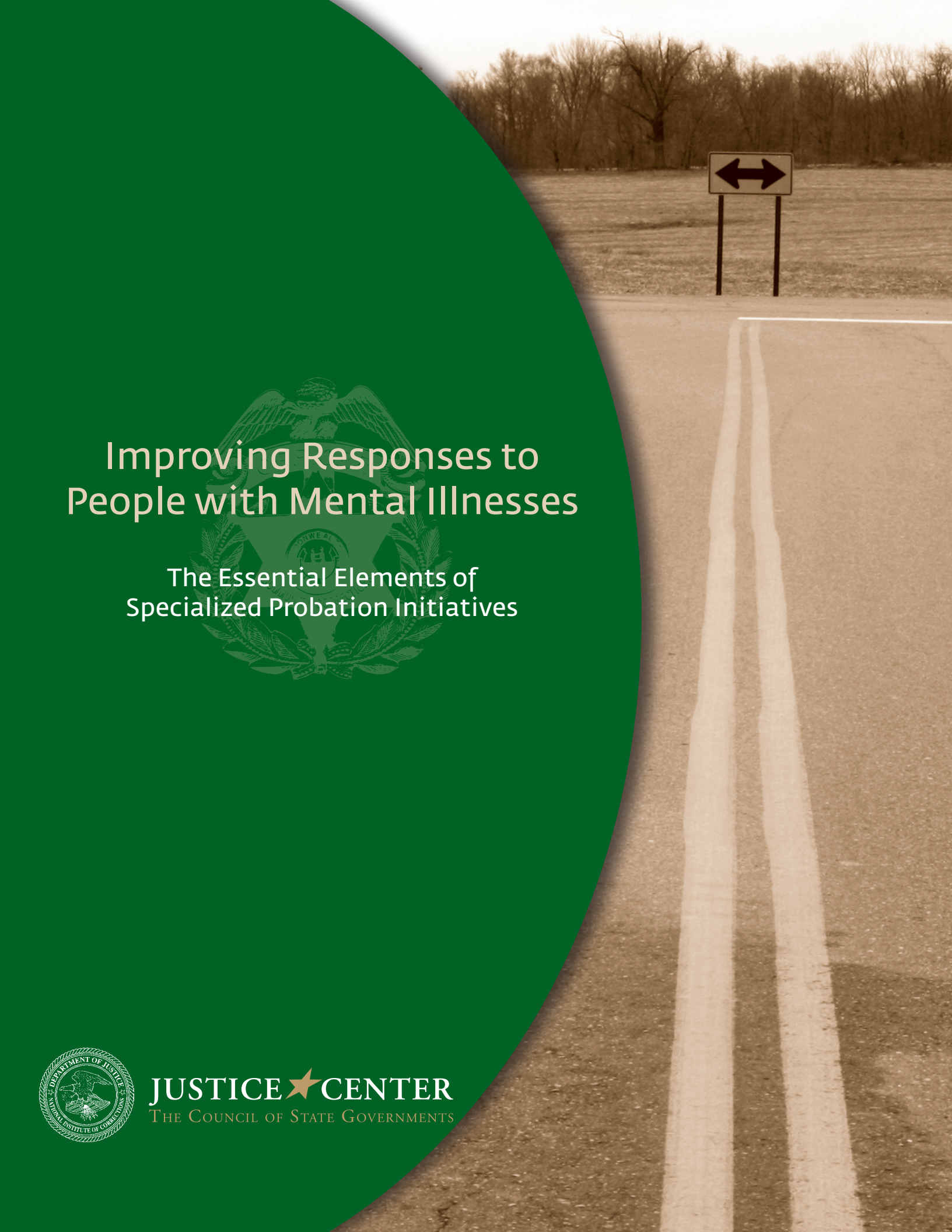

Improving Responses to People with Mental Illnesses

The Essential Elements of Specialized Probation Initiatives

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

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A report prepared by the
Council of State Governments Justice Center

for the

National Institute of Corrections,
U.S. Department of Justice,
Federal Bureau of Prisons

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JUSTICE CENTER
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The Council of State Governments Justice Center is a national nonprofit organization that serves policymakers at the local, state, and federal levels from all branches of government. The Justice Center provides practical, nonpartisan advice and consensus-driven strategies, informed by available evidence, to increase public safety and strengthen communities.

This report is informed by, and builds on, two previous *Essential Elements* publications for court and law enforcement specialized responses to people with mental illnesses (available at *www.consensusproject.org*).

Council of State Governments Justice Center, New York 10005

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Introduction

Probation officers across the country—already facing staggeringly large caseloads and expanding workloads—are supervising unprecedented numbers of people with mental illnesses, most of whom have co-occurring substance use disorders. This population has extensive treatment and service needs and requires supervision strategies that traditional probation agencies were not designed to provide.[1] Probation supervision, however, represents a crucial window of opportunity to link people with mental illnesses to treatments and services that can help them avoid rearrest and reincarceration and ultimately become contributing members of their communities. But all too often this opportunity is missed: people with mental illnesses are nearly twice as likely as others under supervision to have their community sentence revoked, deepening their involvement in the criminal justice system.[2] These revocation rates also confirm what many probation administrators and community treatment providers already know to be true—that inadequate or inappropriate responses to this group can heighten risks to individual and public safety, miss crucial public health opportunities, and make inefficient use of taxpayer dollars.

As a growing number of communities grapple with implementing specialized probation responses, there is a commensurate demand for more information on the key components, or elements, that communities should consider and address to successfully implement such an initiative. This report articulates 10 essential elements for *all* probation interventions that involve people with mental illnesses, regardless of the particular program model. The elements are intended to provide practitioners and policymakers with a common framework for designing and implementing an initiative that will achieve positive outcomes while being sensitive to every jurisdiction's distinct needs and resources.

About the Problem

The reasons why increasingly large numbers of people with mental illnesses become entrenched in the criminal justice system generally, and the probation system specifically, are complex and involve multiple systemic and individual factors.[3] It is clear, however, that once people with mental illnesses are under probation supervision, it can be extremely difficult for them to succeed in the community. This difficulty may be linked to their mental illnesses in a number of ways:

- They might be unable to access treatment, decompensate, and then be arrested for disturbing or dangerous public behavior;
- Functional impairments may make it difficult for them to comply with standard conditions of release, such as maintaining employment and paying fines;

1. Some portions of this document draw heavily from the Justice Center's *Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice* (New York: Council of State Governments Justice Center, 2009), which was developed on a parallel track.
2. Dauphinot, L. "The Efficacy Of Community Correctional Supervision For Offenders With Severe Mental Illness" (PhD. diss., University of Texas at Austin, 1996); Skeem, J., and J. E. Louden, "Toward Evidence-based Practice for Probationers and Parolees Mandated to Mental Health Treatment," *Psychiatric Services* 57 (2006); Porporino, F. J., and L. Motiuk, "The Prison Careers of Mentally Disordered Offenders," *International Journal of Law and Psychiatry* 18 (1995): 29–44; Messina, N., W. Burdon, G. Hagopian, and M. Prendergast. "One Year Return to Custody Rates among Co-disordered Offenders," *Behavioral Sciences and the Law* 22 (2004): 503–18.
3. To learn more about the overrepresentation of people with mental illnesses in the criminal justice system, see Council of State Governments. Criminal Justice/Mental Health Consensus Project (New York: Council of State Governments. June 2002), http://consensusproject.org/the_report.

- Their federal benefits (in particular, Medicaid coverage of pharmacy costs), which were probably terminated rather than suspended upon incarceration, were not reinstated immediately upon release;
- They often have unaddressed risk factors associated with criminal behavior and increased public safety concerns, such as antisocial peers or attitudes;
- Probation officers may monitor them exceptionally closely and report technical violations readily because they mistakenly believe that people with mental illnesses are more likely to be violent.

Compounding these challenges, traditional probation supervision strategies and techniques may make it even more difficult for people with mental illnesses to succeed in the community. Some agencies may view their role solely as monitors of compliance and not consider that addressing their supervisees' complex treatment and service needs can be integral to maintaining public safety and reducing recidivism. In some jurisdictions, challenges to supervising this population (for example, the increased time and energy this group frequently requires) may be perceived as disincentives for probation officers to keep people with mental illnesses on their caseloads. In such jurisdictions, the traditional probation response contributes to poor outcomes for these individuals.

From the perspective of over-burdened probation 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 their workloads (for example, the number of supervision conditions for which they must ensure compliance) have also increased. They typically do not receive the resources or training to collaborate with community-based treatment providers, monitor individuals' compliance with

Pre-Trial Release

There are a variety of pre-trial interventions that avoid court-ordered supervision for people with mental illnesses when appropriate. 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 linkages to appropriate treatments and services. Successful adherence to the terms of these pre-trial interventions (which often include mandated treatment) can then result in reduced or dismissed charges. For example, police-based responses can link people with mental illnesses to treatment without processing charges. Mental health courts can supervise conditions of release without corrections involvement.

In many cases, probation agencies may be involved with pre-trial services. Probation officers may help monitor the conditions of pre-trial release for people with mental illnesses who are charged with minor offenses and who prosecutors, attorneys, and judges agree should not become further involved with the criminal justice system. Pre-trial programs that involve probation agencies are beyond the scope of this document, but the authors encourage policymakers to consider these and other "front-end" interventions that prevent an appropriate subset of individuals from becoming entrenched in the criminal justice system altogether.

For further reading on these and related issues, please see *Improving Responses to People with Mental Illnesses: The Essential Elements of a Specialized Law Enforcement-Based Program* and *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court* available at *http://consensusproject.org*.

treatment, and watch for potentially harmful or dangerous behaviors.[4] From the perspective of equally over-burdened mental health treatment providers, coordinating both the legal and clinical issues of people with mental illnesses under probation supervision presents a challenge—made even more daunting by the large number of clients without justice involvement competing for the same scarce resources.

Specialized Probation Responses

Many community corrections officials and their counterparts in the mental health system understand that their target populations—and their public safety and public health missions—overlap, and that the need for new approaches has never been greater. Across the country, a growing number of probation officials are working with law enforcement officers, 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 probation supervision.

This heterogeneous group often faces a variety of challenges. They face clinical conditions, functional impairments, socioeconomic challenges, and criminal charges or convictions of varying severity, and they pose different degrees of risk to public safety. Probation strategies and interventions designed to improve outcomes for this diverse group are therefore wide-ranging and can be spearheaded by probation systems, community-based mental health systems, or collaboratively by both systems. The essential elements outlined in this document apply to specialized probation responses to people with mental illnesses that are delivered in any of these three ways, but focus primarily on initiatives in which participants have been adjudicated and sentenced to participate, with conditions, in a specialized probation initiative after or in lieu of a jail term.

About the Elements

Each of the 10 essential elements contains a short statement (in italics) describing criteria that specialized probation initiatives should meet in order to be effective, followed by an explanation

Generalizing from Specialized Probation to Parole

This document focuses squarely on locally administered probation responses to people with mental illnesses; however, it may have utility for those interested in specialized parole or other types of community supervision. Individuals with mental illnesses under parole supervision have much in common with those under probation supervision. Both groups share similar challenges to reentry and may even compete for the same limited resources. In some jurisdictions the same community corrections officers provide supervision for both populations. Nevertheless, there are issues unique to parole populations and parole responses that this document does not explicitly address.

For information on strategies to improve outcomes for all individuals on parole (not people with mental illnesses specifically), please see Solomon, A. L., Jenny W. L. Osborne, Laura Winterfield, Brian Elderbroom, Peggy Burke, Richard P. Stroker, Edward E. Rhine, and William D. Burrell. *Putting Public Safety First: 13 Parole Supervision Strategies to Enhance Reentry Outcomes*.

4. See Policy Statement 22, Council of State Governments Justice Center. *Criminal Justice/Mental Health Consensus Project Report* (New York: Council of State Governments Justice Center, 2002).

of the element's importance and how its principles can be achieved. All of the elements rest on two key assumptions. First, each element depends on meaningful collaboration among professionals in the criminal justice and mental health systems. Although achieving the requisite level of collaboration is often difficult—particularly when faced with long-standing systemic or cultural barriers—successful partnerships are needed to carry out each element. Second, probation represents only one "intercept point" for individuals with mental illnesses who have been in contact with law enforcement, courts, jails, and, in some cases, prisons. To address problems raised by the large number of people with mental illnesses in the criminal justice system, a comprehensive community- and system-wide strategy in which specialized probation interventions play only one part is required. Therefore, such an initiative's impact on other components of the criminal justice and community mental health systems must be considered during the planning and implementation process.

This report is meant to guide agents of change in communities that want to develop a specialized probation intervention. As such, it can be used as a practical planning tool at each stage of the process (designing the initiative, developing or enhancing policies and procedures, monitoring practices, and conducting evaluations).[5] It can also be used by personnel from seasoned, long-standing initiatives to improve the organization and functioning of an existing effort. The *Essential Elements* is intended to be a "living document" that will be updated or supplemented as specialized probation responses mature, incorporating new research findings that can provide a stronger base of knowledge about how these initiatives can best operate, their impact on the community, and the relative importance of each of the essential elements.

Methodology

The essential elements are based on information from a variety of sources, including the experiences of probation officials, mental health professionals, advocates, and consumers of mental health services, as well as a review of the scholarly and policy literature. A panel of national experts composed of policymakers and practitioners guided early drafts of this document. They also gathered at an advisory meeting in September 2008 to review, discuss, and debate each element in depth. Comments and suggestions from the advisory meeting and from subsequent reviews by other national experts, are reflected in this publication.

5. Although this document is intended to assist in the design and implementation of programmatic interventions for people with mental illnesses under probation supervision, there may be state legislative or statutory issues that policymakers must address before such programs can be effectively developed. For more information on improving community corrections at the state level, including full provisions and suggested language for legislation, please see The Public Safety Performance Project of the Pew Center on the States. *Policy Framework to Strengthen Community Corrections* (Washington: The Pew Charitable Trusts, 2008).

The Essential Elements

1 COLLABORATIVE PLANNING AND ADMINISTRATION

A multidisciplinary committee of elected and appointed officials, agency administrators and their staffs, treatment providers, consumers of mental health services, and other community stakeholders—representing the criminal justice, mental health, substance use treatment, and social service systems—work together to articulate the goals and objectives of the specialized probation initiative and guide the design, implementation, and oversight of the initiative.

Specialized probation responses to people with mental illnesses occur at the intersection of the criminal justice, mental health/substance use treatment, and social service systems. Their planning and implementation should reflect extensive collaboration among policymakers and practitioners from each of these fields who have the authority to implement significant changes in their agencies' policies, procedures, funding, and staffing. A planning committee should be convened by an official (or officials) with the respect and stature to encourage these changes.[6]

People with mental illnesses under probation supervision have been in contact with law enforcement, courts, and/or jails. Their mental illnesses may be known to these agencies, either from self-reporting or through screening and assessment procedures. A judge, in consultation with prosecutors and defense attorneys, likely determined the conditions of their supervision. Community-based providers may have treated many of these individuals and appropriately shared information about their diagnoses, psychotropic medications, and treatment plans with court, jail, and probation staff. For others, contact with the criminal justice system may be the first time they have been assessed as having a mental illness and linked to community treatment and support services. Because the operation of a specialized probation response is linked so closely with the operations of these and other agencies and systems, the planning committee should include—at minimum—probation agency directors and officers, jail administrators/sheriffs, jail staff, judges, pre-trial services staff, prosecutors, defense attorneys, law enforcement officials, mental health and substance use treatment agency directors and case workers, and individuals with mental illnesses and their family members.

In addition to this core group, the planning committee should include advocates, victims of crime committed by people with mental illnesses, housing agencies, and other community stakeholders to reflect and integrate broader efforts

6. This element can be adapted to well-established, operational initiatives whose planning has long since concluded. If the planning process for such programs did not initially consider aspects of this element, program administrators are encouraged to adapt the element to the ongoing oversight and administration of their initiative.

to improve outcomes for people with mental illnesses involved in the criminal justice system.

The composition of the planning committee raises two critical issues that each community must resolve in its own way. First, there are key local and state agencies in every jurisdiction whose absence from the initial planning process may complicate all subsequent activities. Second, and conversely, in many jurisdictions there may be key stakeholders who present obstacles to collaborative efforts, even when included in the planning process from the beginning. Resolving these issues requires strong leadership and effective tactics that will differ by locale. If obstacles arise from the competing interests of different stakeholders (for example between the public defenders and prosecutors), tackling these issues, identifying shared goals, and devising appropriate compromises can actually strengthen collaborations—and initiative design—in the end.

The planning committee should examine the particular issues facing its community; identify clear, specific, and measurable goals and objectives to address them; and consider how they will measure (and others will evaluate) their progress. This will entail early consideration of key process and outcome data (see Element 10). Committee members, in collaboration with other partners, should also assess gaps in services and identify mechanisms to address them. In so doing, the committee should also determine how it will relate to other criminal justice/mental health boards or task forces that may already exist at the local and state levels.

The next step is to develop processes for determining the initiative's clinical and legal eligibility criteria, supervision conditions, and treatment/service linkages. It should also develop a review process to ensure the policies and procedures of all relevant agencies and organizations are consistent with the goals and objectives of the specialized probation response.[7]

The planning committee should also identify the lead agency or agencies that will administer the initiative's day-to-day activities, train probation officers and community treatment providers, measure the initiative's progress toward achieving stated goals, and resolve ongoing challenges to effectiveness. Administrators should report back regularly to the planning committee, which can advise on adjustments to the initiative's policies, procedures, and operations where appropriate, and assist in keeping key policymakers, the media, and the community-at-large informed of initiative costs, developments, and progress.

To overcome challenges inherent in cross-system collaboration, including staff turnover and leadership changes, policies and procedures should be institutionalized to the greatest extent possible. Interagency memoranda of understanding (MOUs) can be developed to address key issues such as which resources each organization will commit and what information can be shared through identified mechanisms.

7. For example, a jail policy of providing only three days' worth of an individual's medications upon release might be inconsistent with a program goal of ensuring continuity of care from incarceration to community supervision.

2 DEFINING, IDENTIFYING, AND ASSESSING A TARGET POPULATION

Criminal justice and mental health agencies jointly define legal and clinical eligibility criteria to select a subset of individuals whose placement in limited specialized probation supervision slots will have the biggest impact on public safety, spending, and health. Potential participants are identified at intake to a jail facility and/or upon transition to probation supervision by staff qualified to administer standardized and validated screening instruments, followed by standardized and validated clinical and risk assessment procedures.

Specialized probation responses can accommodate only a small percentage of people with mental illnesses involved in the criminal justice system; they are one intervention within a comprehensive set of strategies to provide law enforcement, court, and corrections systems with options other than arrest, detention, and sentenced supervision for this population. Understood in this broader context, careful consideration must be given to determining eligibility to participate in such initiatives.

Individuals with mental illnesses under community corrections supervision are a heterogeneous group. They pose different degrees of criminogenic risk, determined by the nature of their offense; dynamic factors associated with their attitudes, circumstances, and patterns of thinking; and public safety concerns. These individuals also have a wide range of functional impairments determined in part by diagnoses, disabilities, and circumstances. Criminogenic risk and functional impairment are core components in the design of traditional supervision and treatment strategies, respectively. As such, it follows that the range of specialized supervision and treatment options for this population should be derived from an assessment of these two basic dimensions, and the planning committee must carefully choose a subset of individuals who will be eligible for participation in the specialized probation initiative based on these factors.[8]

Figure 1 illustrates this concept.[9] The chart, derived from similar efforts to organize responses to people with co-occurring mental illnesses and substance use disorders,[10] highlights the central considerations that drive criminal justice and mental health system responses. Although it has not been validated, it provides a conceptual approach for matching supervision and treatment options to varying degrees of criminogenic risk and functional impairment, both of which can range from low (nominal) to high (severe). Figure 1 proposes that the level of response intensity and the degree of coordination/integration between probation and mental health agencies should increase as both criminogenic risk and functional impairment increase.[11] The chart suggests reserving the most resource-intensive specialized

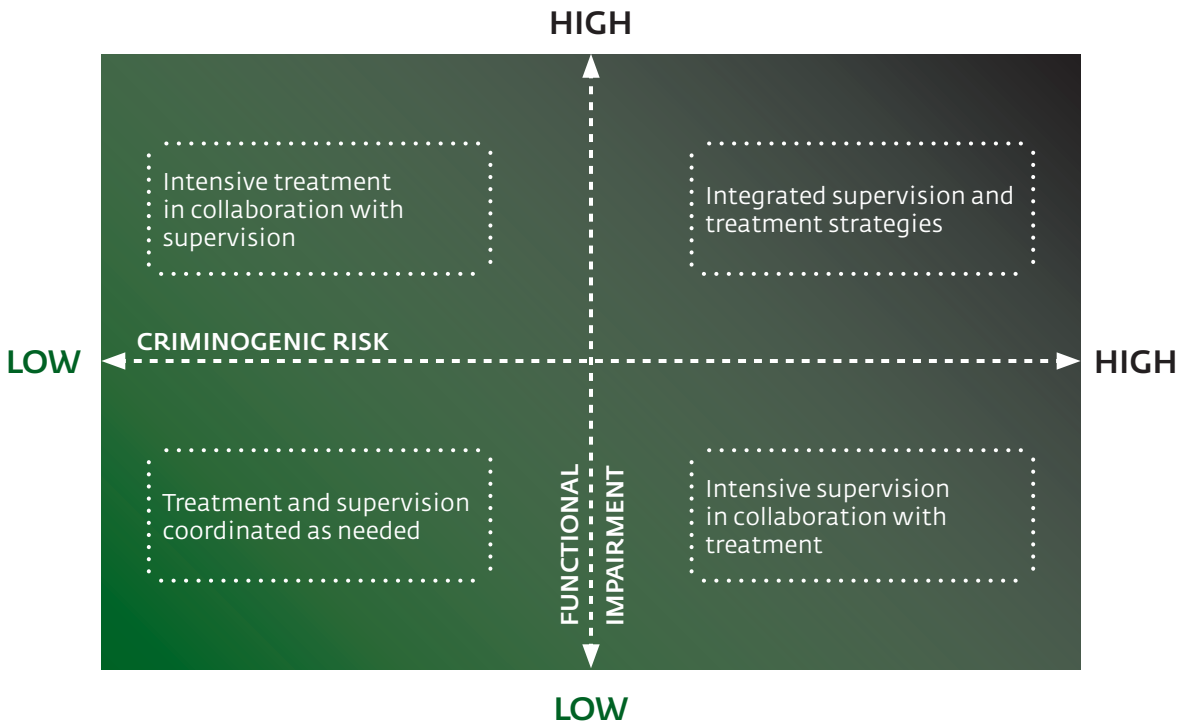
8. This paragraph is adapted from Prins, S. J., and Draper, L. *Improving Outcomes For People With Mental Illnesses Under Community Corrections Supervision: A Guide To Research-Informed Policy And Practice* (New York: Council of State Governments Justice Center, 2009).
9. Ibid.
10. National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors. *National Dialogue on Co-occurring Mental and Substance Abuse Disorders* (Alexandria, VA and Washington, DC: NASMHPD/NASADAD, 1999).
11. *Coordination* exists when each agency is aware of the other's activities and occasionally shares clinical or legal information

probation packages for those individuals with the highest levels of risk and impairment (that is, the highest risk of recidivism). The chart also assumes that relevant criminal justice and mental health agencies can collect and track data on the different subsets of individuals in their systems to determine which group to focus on based on community-relevant factors (see Elements 3 and 10 for discussions on data collection).

When defining a target population, key considerations should be the availability of treatments and support services in the community, the state's definition of its "priority population" for publicly funded mental health services, and the capacities and competencies of relevant agency staff. These factors help narrow the focus of the initiative to a subgroup of individuals who, when provided effective treatment and supervision, can achieve the greatest public safety and public health outcomes.

Determining which subgroups to include will inevitably be informed by addressing questions about which subgroups to *exclude* from the initiative. These questions, the importance of which should not be underestimated, can take a number of forms: "Is there a certain threshold

Fig. 1: Identifying target populations by criminogenic risk and functional impairment



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, share responsibility for this supervision and treatment, share staff and other resources, and participate 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 Services Administration, Center for Mental Health Services, 2006).

of criminogenic risk and functional impairment at which community resources can no longer be effective, or at which political support will evaporate?" "Are there specific charges (for example, sexual offenses) or circumstances (for example, citizenship status) that require different responses?" The planning committee must carefully deliberate about these issues.

Once the planning committee defines the target population based on the key dimensions above, it should ensure that this definition is communicated to the court, jail, probation agency, and community treatment providers—which may have different classification systems, diagnostic categories, and treatment priorities—to encourage collaboration based on a common understanding of the program's goals and who would benefit most from the specialized initiative. Policies and interagency protocols should be in place to ensure all relevant agencies are using similar standardized, validated, and easy-to-administer screening instruments to identify individuals who fit the eligibility criteria.[12] Instruments such as the Brief Jail Mental Health Screen and the Correctional Mental Health Screen are short and accurate and can replace outdated instruments—or be incorporated into existing procedures—with relative ease.[13] Qualified personnel must then use standardized and validated clinical and risk assessment procedures to determine the specific needs of people who "screen positive," and identify the subset of people who meet the initiative's eligibility criteria.

This is not to say that standardized screening and assessment processes create a rigid "scoring rubric" for inclusion or exclusion in the specialized probation initiative. The processes are the objective filters used to identify potential participants. Participation will ultimately be at the discretion of prosecutors, public defenders, judges, probation officials, and community-based treatment providers.

In addition to its obvious impact on the specialized probation initiative's design and implementation, eligibility criteria also play a central role in determining whether the initiative, once operational, is meeting its stated goals and objectives. Focusing on individuals with certain needs and risks can have a differential impact on public safety, public spending, and public health outcomes. For example, using intensive supervision and treatment strategies to target low-risk, low-impairment individuals who have committed minor offenses may actually increase recidivism rates for this population as officers observe minor technical violations that would otherwise go unnoticed.[14] This increased scrutiny may mitigate potential cost savings to the community as supervisees are returned to expensive jail beds; in fact, a focus on a target population with these characteristics may be *more* expensive than the status quo.[15] In contrast, supervising individuals charged with more serious offenses may avert a larger number of jail stays, but may also require more concerted political will to assuage the perceived—but not validated—increase in risk to public safety.

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12. Ideally, jurisdictions would employ electronic jail information systems that can be adapted to code screening categories for mental illnesses and provide monthly reports on the number of people screened into these different groups. This is critical in determining whether adequate resources are available for the specialized probation intervention, and if they are not, determining how to re-focus on a particular group. The probation agency should also ideally have an electronic case tracking system in which key data elements can be captured to identify individuals who have participated in the specialized probation intervention and those who have not. This will allow for process and outcome research to refine the initiative. For many jurisdictions, however, obtaining and implementing advanced electronic information systems is not currently feasible.

13. Goldberg, A. L., and B. R. Higgins. "Brief Mental Health Screening for Corrections Intake," *Corrections Today* August, 2006, http://www.ncjrs.gov/pdffiles1/nij/215592.pdf.

14. Lowenkamp, C., and E. J. Latessa. "The Risk Principle in Action: What Have We Learned from 13,676 Offenders and 97 Correctional Programs?" *Crime and Delinquency* 51 (2006): 1–17, as cited in The Public Safety Performance Project of the Pew Center on the States. *Policy Framework to Strengthen Community Correction*. (Washington: The Pew Charitable Trusts, 2008).

15. Ridgely, M. S., J. Engberg, M. D. Greenberg, S. Turner, C. DeMartini, and J. W. Dembosky. *Justice, treatment, and cost: An evaluation of the fiscal impact of Allegheny County Mental Health Court* (Santa Monica: Rand Corporation, 2007), http://www.rand.org/pubs/technical_reports/TR439/.

3 DESIGNING THE INITIATIVE AND MATCHING INDIVIDUALS TO SUPERVISION AND TREATMENT OPTIONS

The design of the specialized probation initiative is informed by analyses of the target population; the policies and procedures of relevant agencies; and available resources, services, and other supports. The planning committee and initiative administrators identify agency- and systems-level obstacles to effective probation supervision of people with mental illnesses and design the specialized initiative to address these issues.

Participant eligibility criteria should be consistent with the specialized probation initiative's design. There are two broad and related sets of issues that planners and administrators should consider. First, they should determine the most effective combination of treatment and supervision for the criminogenic risks and functional impairments of the initiative's intended target population. Second, they should determine the initiative's participant capacity, that is, its ideal scale, which will largely depend on the fiscal realities and availability of resources in a given community. Decisions regarding these two sets of issues should be well-documented, and limitations should be openly acknowledged.

The first set of issues includes the type and intensity of supervision and treatment that participants will receive, the degree to which probation and mental health agencies coordinate or integrate their responses, and the setting in which supervision and treatment is provided.[16] System-level obstacles such as the availability of case management, integrated substance use and mental health treatment, trauma-specific services, and housing should also be considered as most individuals under probation supervision have multiple issues that require a response including co-occurring disorders,[17] a history of victimization and other trauma,[18] and limited access to stable housing.[19]

16. For example, participants with low criminogenic risk and low functional impairment may require little (or no) supervision and less intensive outpatient mental health treatment. Community corrections and mental health staff may not need to coordinate extensively, dedicate additional resources, or change the setting in which supervision and treatment are provided if both systems are implementing good, routine practices. People with low risk/high impairments or high risk/low impairments may require coordination between probation and mental health staff, but not full-fledged integration. These groups may also require mental health agencies to take the lead and coordinate with probation, or probation agencies to take the lead and coordinate with mental health treatment providers, respectively. Intensive, integrated interventions should be reserved for those with high criminogenic risk and high functional impairment.

17. Lurigio, A. J., I. C. Young, J. A. Swartz, T. P. Johnson, I. Graf, and L. Pickup. "Standardized Assessment of Substance-related, Other Psychiatric, and Comorbid Disorders among Probationers," *International Journal of Offender Therapy and Comparative Criminology* 47 (2003): 630–52; Skeem, J., E. Nicholson, and C. Kregg. March 2008. "Understanding Barriers to Re-entry for Parolees with Mental Disorder. In D. Kroner (Chair), *Mentally disordered offenders: A special population requiring special attention* (Jacksonville: Symposium conducted at the meeting of the American Psychology-Law Society, https://webfiles.uci.edu:443/skeem/Downloads.html.

18. Ditton, P. M. *Mental health and treatment of inmates and probationers* (Washington: Bureau of Justice Statistics, 1999).

19. Ibid.

The planning committee should also review agency-level policy and procedural obstacles to participants' supervision and/or treatment, such as inadequate information-sharing protocols (see Element 9), if they present barriers to appropriate coordination or integration. Furthermore, in some jurisdictions, pre-sentence investigations, level of charge or offense, plea agreements, strict sentencing guidelines, victims' rights statutes, or other laws may dictate specific conditions of supervision, the duration of community supervision, and the impact of successful completion of a community sentence. Planners and administrators should work with relevant officials to adjust these restrictions where appropriate and be clear on issues around which there can be little flexibility for the specialized initiative. If officials cannot be persuaded to remove or modify these sorts of policy and procedural obstacles for the specialized initiative, planners and administrators may need to redefine the initiative's objectives.

The second set of issues, determined in large part by probation and mental health agencies' policies and resources, includes the specialized initiative's capacity—that is, caseload size and composition. The American Probation and Parole Association has explored caseload standards for individuals under probation supervision (but not explicitly for individuals with mental illnesses).[20] In general, the number of individuals an officer supervises should decrease as the overall "case priority" of their roster increases. Furthermore, a national survey found that "specialized caseloads" for people with mental illnesses are smaller than traditional caseloads, averaging fewer than 50 people per probation officer (as compared to more than 100 for traditional caseloads).[21] That said, there is no ideal caseload size. The quality of contacts between probation officers and supervisees has shown to be more important than the quantity of contacts.[22]

Planners need to consider whether caseload composition should be limited only to people with mental illnesses. Officers with smaller caseloads dedicated exclusively to people with mental illnesses can better monitor their supervisees' treatment progress.[23] This is important because recovery from mental illnesses is often a cyclical process; for example, individuals on psychotropic medications who display low criminogenic risk and low functional impairment may become higher risk and more impaired if they stop taking their medications. Officers with small, dedicated caseloads will be better able to detect these sorts of fluctuations and respond in a more targeted, flexible manner than officers with large, mixed caseloads.

If planners do not feel they can design an initiative with appropriate scope and scale due to agency- and systems-level obstacles such as those described above, or general funding and workforce capacity issues, they should reconsider the initiative's eligibility criteria or restrict the number of participants to a pilot project with expansion dependent on outcomes and future resources. All too often a perceived lack of resources can forestall creative planning and problem solving that considers such issues as blending funding sources, sharing staff, identifying in-kind contributions, and public/private/academic partnerships. Planners and administrators are encouraged to be realistic and open about

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20. See Burrell, B. *Caseload Standards for Probation and Parole* (Lexington: American Probation and Parole Association, 2006), http://nicic.gov/Library/021896); DeMichele, M. T. *Probation and Parole's Growing Caseloads and Work Allocation: Strategies for Managerial Decision Making* (Lexington: American Probation and Parole Association, 2007), http://www.appa-net.org/eweb/docs/appa/pubs/SMDM.pdf).

21. Skeem, J. L., Paula Emke-Francis, and Jennifer Eno Louden. "Probation, Mental Health, And Mandated Treatment: A National Survey," *Criminal Justice and Behavior* 33 (2006): 158–84.

22. The Public Safety Performance Project of the Pew Center on the States. *Policy Framework to Strengthen Community Corrections* (Washington: The Pew Charitable Trusts, 2008).

23. In small jurisdictions, however, dedicated caseloads may not be practical or feasible. Under these circumstances, the central objective is providing officers with small enough caseloads to dedicate adequate time to people with mental illnesses under their supervision.

resource limitations, but not allow them to hinder exploration of all possible options. Starting small and building on success can be a useful approach.

Although the basic structure of the initiative should be informed by research on effective probation interventions for people with mental illnesses, administrators (with advice from the planning committee) will likely need to make decisions about the integration of treatment and supervision, caseload size and composition, and the duration and intensity of supervision and treatment without the benefit of jurisdiction-specific research. A "systems mapping" process can complement any available research and help identify how people with mental illnesses move through the criminal justice system (arrest, adjudication, incarceration, and reentry), where "bottlenecks" occur, which types of people receive which types of existing treatment/supervision, and where gaps need to be filled.[24] Planners and administrators should assess the jurisdiction's ability to collect and track new data and revise this systems map once the initiative is operational. This information will be critical to initiative sustainability.

24. For more information on systems mapping, please see Munetz, M. R., and P. Griffin. "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness," *Psychiatric Services* 57 (2006): 544–49 or the National GAINS Center at http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf.

4 SETTING CONDITIONS OF COMMUNITY SUPERVISION

Conditions of community supervision are commensurate with specific criminal charges and offenses, promote public safety, and are clearly enumerated and accurately conveyed to supervisees. Conditions facilitate supervisees' engagement in treatment, are flexible over changing circumstances, and are individualized according to assessments of public safety risk and clinical needs.

Conditions of community supervision are the guideposts for maintaining a law-abiding life and define individuals' responsibilities for successful participation in the specialized probation initiative. During the design process, including the selection of a target population, the planning committee should resolve any of the traditional factors that determine conditions of community supervision (for example, pre-sentence investigations, level of charge or offense, plea agreements, sentencing guidelines, or victims' rights statutes) that conflict with initiative goals. Within the parameters that are ultimately established, the conditions of community supervision should be individualized for each supervisee, and signed by potential participants before they enter the initiative. They should also be made aware of the consequences of noncompliance with these conditions (see Element 7).

Conditions of supervision will likely include adherence to a case plan (that is, a treatment and services plan developed for individuals' transition from jail to the community or upon being sentenced to probation). In many jurisdictions, a judge or prosecutor may make little distinction between supervision conditions and case plans and set both at the same time, without involving probation officers, community-based treatment providers, or other social services personnel. Although conditions of supervision and case plans should inform one another and may ultimately be packaged together for participants, it is vital that any personnel involved in "case staffing" be included in developing each component. Because case plan design must consider the complex and multi-systemic social, economic, and clinical challenges facing people with mental illnesses involved in the criminal justice system, Element 5 is dedicated to a more complete discussion of these issues.

Regardless of whether a jurisdiction makes clear distinctions between supervision conditions and case plans or treats them synonymously, a number of general issues should be considered. First, conditions of supervision should be the least restrictive necessary and reasonably calculated to prevent recidivism or further involvement in the criminal justice system.[25] This is especially true for individuals who pose low risk of future criminal activity; have fewer service or treatment needs; and have been convicted of misdemeanors, ordinance offenses, or other nonviolent crimes. Unlike individuals with higher criminogenic risk, these individuals may require less frequent (or no) contacts with their probation officer. For individuals who have been convicted of more serious offenses, are at greater risk of future criminal activity, and have more

25. Council of State Governments Justice Center. *Criminal Justice/Mental Health Consensus Project Report* (New York: Council of State Governments Justice Center, 2002).

significant clinical needs, their more restrictive conditions might be relaxed after a predetermined period of successful adherence. For all individuals, increases in functionality, decreases in psychiatric symptoms, and reductions in risk behaviors should prompt less intensive supervision regimens, while clinical decompensation or increases in risk behaviors should trigger more intensive regimens.

The ability to adjust the restrictiveness and intensity of supervision conditions depends not only on their flexibility and individualization but also on probation officers or other probation officials having the discretion to modify them based on their best judgment and special training (see Element 8). In some jurisdictions, probation officers are able to make these modifications without involving the courts; in other jurisdictions, consultation with judges may be required.

Second, the development of supervision conditions should be informed by individuals' ability to understand the responsibilities and expectations that these conditions carry. There are important distinctions between the requisite competency to stand trial and the need to ensure competency to comply with conditions of community supervision. Individuals with a high level of clinical disability and functional impairment may need clear, written descriptions and repetitive discussions to fully understand their obligations.

Third, regardless of their charges, public safety risks, or functional impairments, participants should be aware of the sanctions they will incur for violating their supervision conditions and the incentives for ongoing progress (see Element 7). The parameters for these graduated sanctions and incentives should be part of the documentation that individuals sign before they participate in the initiative. Particularly important are any distinctions the specialized probation initiative makes regarding its tolerance for violations of "control conditions" versus "treatment conditions." Control conditions may dictate a very low tolerance for violations, (for example, a supervisee attempts to visit a former spouse despite a condition of supervision that prohibits such an action), whereas treatment conditions may allow for infractions without triggering a violation report to the courts (for example, a supervisee fails to take some of his or her medication or misses an appointment with a treatment provider).

Finally, because many supervisees are adjudicated and granted participation in a specialized probation initiative after, or in lieu of, a jail term, it may not be possible to reduce charges or expunge convictions upon successful completion of a community sentence; however, when appropriate, such options should be considered. In either case, supervisees' length of participation in the initiative should not exceed the maximum sentence they could have received under traditional circumstances.

5 DEVELOPING AN INDIVIDUALIZED CASE PLAN

The specialized probation initiative, working with jail discharge planners and community-based treatment providers, collaboratively develops a treatment and services plan for individuals transitioning to probation supervision. The case plan is developed as soon as possible after individuals' initial contact with the criminal justice system and considers their criminal charges; public safety risk and functional impairments; treatment, service, and housing needs; and the resources of both the community corrections agency and community-based treatment and service providers.

Although case plans will likely be developed in conjunction with conditions of community supervision (as suggested above), they are explored here as a separate element because they represent a traditional function of the mental health system, whose expertise and experience should inform this aspect of collaboration between the probation agency and community-based treatment providers. Furthermore, case plan development involves multiple agencies beyond the criminal justice system and should respond to supervisees' wide-ranging social, economic, and clinical circumstances. Despite the fact that lengths of stay in jail can be relatively short compared to prison terms,[26] the time people with mental illnesses spend in jail after arrest presents a critical public safety and public health opportunity. Nearly all of the 13 million people booked into jails each year will be released,[27] many of them under the supervision of probation agencies.

Within hours of arrest, individuals should be screened and assessed for mental illnesses and co-occurring substance use disorders, perhaps for the first time. Based on the results of screening and assessment, a judge or team of criminal justice/mental health staff should determine whether individuals should be considered for some type of specialized response, such as pre-trial release (with or without conditions), a mental health court or docket, or a specialized probation initiative. In other cases, judges may decide simply to place individuals under probation supervision, and then probation officials may determine who should become part of their specialized initiative. Other individuals may serve sentences of less than a year (although as prisons become more crowded, jails may hold people for increasingly longer periods of time).[28] Rapid, collaborative planning among jail, probation, and community treatment staff is essential to ensure that people who are entering jail at a high risk of crisis do not return to the community for supervision in days, weeks, or months in the same condition—or worse—to the detriment of any specialized probation initiative.[29]

One best-practice model for jail case planning, "Assess, Plan, Identify, and Coordinate" (APIC), is practical and research-based.[30] It can be applied to all individuals with mental illnesses and co-occurring substance use disorders who

26. Even if people who will eventually be supervised by probation agencies were never detained or incarcerated, the period between their initial contact with the criminal justice system and their community supervision is equally important. This element refers to jail transition planning in the interest of brevity, but still applies to these alternative scenarios.

27. Sabol W. J., and T. D. Minton. *Jail Inmates at Midyear 2007* (Washington: Bureau of Justice Statistics, 2008).

28. Osher, F. C., H. J. Steadman, and H. Barr. *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model* (New York: The National GAINS Center, 2002), http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf.

29. Ibid.

30. Ibid.

spend time in jail, and can be used to develop plans for the subset of people who are eligible to participate in the specialized probation initiative. According to the APIC model, screening and assessment conducted at intake should be the first step in developing individualized treatment and community supervision plans for people with mental illnesses. Assessment should include cataloging individuals' criminogenic risks and functional impairments; gathering information from law enforcement, courts, corrections, family members, and community providers to fully inform the case plan; understanding issues of cultural identity, language, gender, and age that should be addressed in the plan; actively engaging individuals in identifying their own needs; and detecting barriers to accessing and paying for treatment and services in the community.[31]

After this assessment, staff should develop a plan that covers the critical period immediately following individuals' supervision assignment and their long-term needs. There are a range of issues that should be considered and addressed in different ways depending on the level of criminogenic risks and functional impairments of the initiative's intended target population. These include housing, food, clothing, transportation, and childcare; optimal medication regimens, including sufficient medication to last until individuals' first appointments and consistent jail and community treatment agency formularies; integrated treatment for individuals with co-occurring substance use disorders; and benefits applications/reinstatements for SSI/SSDI, Medicaid, and other entitlements.[32]

As the case plan is developed, staff should identify the community-based providers who will be responsible for treatment, make referrals, ensure that information-sharing protocols are in place according to confidentiality statutes (see Element 9), ensure that victim notification procedures are followed, and determine treatment and service agencies' level of coordination/integration with the probation officer monitoring the conditions of supervision.[33] The role of probation agencies may differ depending on where these individuals fall in terms of their risks to public safety and clinical needs.

After responsibilities for community-based services and supervision are identified, staff from all relevant agencies should coordinate their efforts. This involves establishing a team of caseworkers, including probation officers, treatment providers, court personnel, and others who meet regularly in "case staffings," to modify treatment plans, monitor adherence to the terms of release, and make changes to these conditions as appropriate.

Supervisees should be involved in developing their case plans to the greatest extent possible; such involvement is thought to increase their engagement in treatment and supervision and ultimately their success in the community. The degree to which supervisees' preferences are incorporated into their case plans, however, should be weighed against the nature of their criminal charges, criminogenic risks, and functional impairments. These preferences also should be balanced against the concerns of prosecutors, defense attorneys, and judges. For example, a district attorney or probation official may not be comfortable allowing an individual charged with a serious violent crime to provide as much input into his or her case plan as an individual charged with a minor misdemeanor. Issues such as these underscore the importance of clearly defined initiative parameters that are the product of collaborative planning and design processes.

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31. Ibid.

32. Program planners and administrators should work with courts, jails, and probation departments to ensure that these benefits are suspended—and not terminated—during individuals' relatively short stays in jail and immediately reinstated upon release.

33. Osher, F. C., H. J. Steadman, and H. Barr. *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-Occurring Disorders: The APIC Model* (Delmar, NY: The National GAINS Center, 2002), http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf.

6 PROVIDING OR LINKING TO TREATMENT AND SERVICES

Probation agencies connect their supervisees to comprehensive, individualized, and evidence-based treatment and services in the community, and work with community-based providers to coordinate and integrate the services that the probation agency and the public health and social service systems can provide.

People with mental illnesses under probation supervision require an array of services and supports, including medication; counseling; behavioral therapy; substance use treatment; halfway, transitional, or supportive housing; public benefits; crisis intervention services; peer supports; vocational training; and family counseling. Specialized probation initiatives should anticipate the needs of their target population and work with community providers to ensure that appropriate services—particularly those required to carry out desired case plans—will be available to participants during community supervision.

Parameters for the type, intensity, setting, and degree of coordination or integration of services should be determined by the initiative's intended target population and refined according to participants' unique criminogenic risks and functional impairments. Individuals with low risk/low impairment can be supervised and treated with little or no coordination. Individuals with high risk/high impairment need integrated strategies. These strategies can include co-location, where services and treatment are delivered in the supervision setting or supervision is provided in a service and treatment setting; staff sharing, where staff is hired by or "loaned" among collaborating agencies; and joint initiative administration in which supervision and case plans are developed and reviewed.

The menu of treatments and services that are provided by the probation agency or community providers will vary across jurisdictions. For example, probation agencies may contract for their own transitional housing programs, monitor drug abstinence requirements by conducting urinalyses, and contract with community providers to deliver treatments and services on premises. In other jurisdictions, community treatment agencies may have probation officers as part of their case management team. In some communities, probation agencies may have in-house staff that provides cognitive-behavioral treatments such as Moral Reconation Therapy to address participants' criminogenic risks.[34] In still other jurisdictions, these treatment modalities may be part of an integrated behavioral health approach provided by a community mental health center that is treating other psychiatric or substance use disorders.

Regardless of whether probation agencies directly provide treatments and services or broker their delivery, the specialized probation initiative should work to ensure that evidence-based practices (EBPs) and promising approaches for mental health treatment are provided to supervisees.[35] If community treatment providers

34. For more information on Moral Reconation Therapy, see the Substance Abuse and Mental Health Services Administration's *National Registry of Evidence-based Programs and Practices* at http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=181.

35. The Substance Abuse and Mental Health Services Administration defines EBPs as "the use of current and best research evidence in making clinical and programmatic decisions about the care of the client." Center for Substance Abuse Treatment. *Understanding Evidence-Based Practices*

do not have the capacity or training to implement these practices—or more broadly, any necessary treatments or supports—the specialized probation initiative should advocate to increase the availability of these services.

A number of EBPs and promising approaches have been shown to improve clinical functioning for people with mental illnesses and may be applicable for people with mental illnesses involved with the criminal justice system. First, given the high prevalence of co-occurring substance use disorders among individuals with mental illnesses, it is particularly important for specialized probation initiatives to access integrated treatment for mental illnesses and substance use disorders. Comprehensive, integrated efforts help people with co-occurring disorders attain remission and reduce substance use, hospital utilization, psychiatric symptoms, and rearrest.[36] Second, access to housing is essential to any case plan or treatment regimen, and supported housing is a promising practice for the successful community reintegration of people with mental illnesses.[37] Third, trauma-informed services, another promising practice, are also critical given the high rates of trauma among people with mental illnesses.[38] Finally, individuals with mental illnesses frequently require some form of case management services. One form, assertive community treatment (ACT), is an EBP associated with reductions in psychiatric hospitalizations and increases in functionality. Without modification, ACT has demonstrated a mixed impact on recidivism. To address this, forensic assertive community treatment (FACT) teams have been developed, often integrating probation officers, and have shown promise in positively impacting clinical outcomes and recidivism.[39]

In addition to linking individuals to evidence-based treatments and services, probation and mental health agency staff should develop protocols for ensuring supervisees' continuity of care (i.e., transitioning from various settings without changing treatment providers) in two critical situations. First, participants may be returned to jail for violating conditions of supervision or for committing a new offense. Probation officers and treatment providers should ensure that information about supervisees' treatment progress, medications, and other key information is transferred to jail staff so they can create a case plan based on this information. Second, participants will eventually complete their term of community supervision; probation officers and treatment providers should ensure they have sustained access to these treatments and other supports when supervision ends. This means that probation agencies and community providers should ensure that participation in their initiative (and more broadly, the criminal justice system) is not the sole mechanism for access to these services.

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for Co-Occurring Disorders: COCE Overview Paper 5. DHHS Publication No. SMA 07-4278 (Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2007).

36. Osher, F. C., H. J. Steadman, and H. Barr. *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-Occurring Disorders: The APIC Model* (Delmar, NY: The National GAINS Center, 2002), http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf.

37. Ibid.

38. Other EBPs for mental health treatment include illness self-management and recovery, supported employment, psychopharmacology, and family psychoeducation. For more information on EBPs and promising practices, see the GAINS Center web site at http://gainscenter.samhsa.gov.

39. Osher, F. C., and H. Steadman. "Adapting Evidence-based Practices for Persons with Mental Illness Involved with the Criminal Justice System," *Psychiatric Services* 58 (2007): 1472–79.

7

SUPPORTING ADHERENCE TO CONDITIONS OF COMMUNITY SUPERVISION AND CASE PLANS

Probation officers—in coordination with community-based treatment providers—support individuals' adherence to the terms of their probation with a "firm but fair" relationship style and employ problem-solving strategies and graduated sanctions and incentives to encourage compliance, promote public safety, and improve treatment outcomes.

Once individualized conditions of supervision, a case plan, and specific treatment regimens are established, probation officers—in collaboration with community providers—are responsible for ensuring that their supervisees comply with the terms of their participation in the specialized probation initiative. The supervision strategies and techniques that officers employ can have a direct impact on whether their supervisees become further entrenched in the criminal justice system or successfully transition to their communities. Probation officials should ensure that their supervision methods are consistent with the objectives of the specialized probation initiative.

Probation agencies should view their role as more than monitors of compliance and consider their supervisees' complex treatment and service needs as integral to maintaining public safety and reducing recidivism. Probation officers should be provided incentives to keep individuals with mental illnesses on their caseloads,[40] with the knowledge that "closing a case" may result in missed opportunities to link individuals to appropriate treatment. Likewise, community-based treatment providers should not avoid working with individuals with criminal charges or convictions. These providers should view jails and community corrections agencies as part of a continuum of intervention settings, and mental health officials should create incentives for providers to implement treatments that target criminogenic risks.

Collaborative planning and cross-training can help ensure that probation agencies and community treatment providers have the workforce capacity to implement these practices and close existing gaps in resources or competencies; however, planning and training should be supported by strong leadership within probation and mental health agencies. In fact, probation administrators across the country have changed the culture of their agencies by articulating a mission—and incentivizing practices—that go beyond law enforcement and consider probation as part of a larger constellation of services that advance public safety and health and strengthen communities. At the same time, many mental health administrators have recognized their role in improving the safety of their communities and embraced this shared mission within their agencies.

40. The Public Safety Performance Project of the Pew Center on the States. *Policy Framework to Strengthen Community Corrections.* (Washington: The Pew Charitable Trusts, 2008).

Although all responses to supervisees' behavior, whether positive or negative, should be individualized, there are general proven supervision strategies and techniques that can reduce probation violations for all people under community supervision.[41] Specialized probation initiatives should ensure that the following strategies are incorporated into their efforts.[42] Officers should apply risk-needs-responsivity principles[43] and establish "firm but fair" relationships with their supervisees that are authoritative (not authoritarian) and characterized by caring, fairness, and trust. Officers should use problem-solving strategies (as opposed to relying on threats of incarceration or other negative pressures) to address compliance issues. For example, if a supervisee has functional impairments that make it difficult to adhere to standard conditions of release, such as transporting him- or herself to appointments, the probation officer should meet with the supervisee to identify and resolve these obstacles to compliance or make necessary adjustments to supervision or case plan conditions. In general, officers should conduct field supervision rather than monitor individuals remotely from a central location.

It is also important that probation officers working on a team with mental health and substance use treatment providers develop a shared understanding of behaviors that constitute a violation of the conditions of supervision. For example, substance use relapse is common early in the recovery process and should not necessarily be grounds for probation revocation. On the other hand, depending on an individual's level of public safety risk, functional impairment, and/or history of dangerous behavior when intoxicated, the response to relapse may include a technical violation. An individual whose past crimes were clearly related to intoxication might warrant less tolerance. The important principle is that responses to an individual's behavior should be consistent with an individual's supervision and case plans and reflect the team's short- and long-term objectives with each supervisee.

When supervisees' behavior does constitute a violation of their supervision conditions, the specialized probation initiative should employ a menu of graduated sanctions (that is, the severity of sanctions increases with the frequency or severity of violations) that are individualized to maximize compliance. The manner in which these sanctions will be applied should be explained to supervisees before they begin participating in the specialized initiative. Sanctions should encourage pro-social choices and adherence to treatment recommendations. They should avoid disengaging individuals from community treatment. Specific protocols should govern the use of jail as a consequence for serious noncompliance. In general, jail should be used only as a last resort, and probation agencies should explore alternatives such as intermediate-sanction facilities or day-reporting centers, staffed by probation officers and community treatment providers, to

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41. These strategies and techniques have been explored in depth in the literature on evidence-based and promising community corrections practices. These community corrections EBPs and promising practices should be distinguished from the mental health treatment EBPs described in element 6. For more on community corrections EBPs and promising practices, see Crime and Justice Institute. *Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention* (National Institute of Corrections, 2004), http://www.nicic.org/pubs/2004/019342.pdf. For information on incorporating general community corrections EBPs into broader statewide policy efforts, see The Public Safety Performance Project of the Pew Center on the States. *Policy Framework to Strengthen Community Corrections* (Washington: The Pew Charitable Trusts, 2008).

42. Skeem, J., and J. E. Louden. "Toward Evidence-based Practice for Probationers and Parolees Mandated to Mental Health Treatment," *Psychiatric Services* 57 (2006): 333–42.

43. Several meta-analyses of existing evaluations show that supervisees are less likely to recidivate when programs focus on 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 criminogenic needs, or changeable risk factors for recidivism (*need* principle). For more information, see Andrews, D. A., et al. "Does Correctional Treatment Work? Clinically Relevant and Psychologically Informed Meta-analysis," *Criminology* 28 (1990): 369–404 and Andrews, D. A., and J. Bonta. *The Psychology of Criminal Conduct*, third ed. (Cincinnati: Anderson, 2003).

ensure continuity of care and prevent further involvement with the criminal justice system.[44]

Probation officers should also have a menu of incentives for sustained adherence to the conditions of community supervision. These might include less frequent contacts with probation officers and treatment providers, certificates of compliance, non-cash rewards, and in some cases, reductions in the length of the probation sentence. Policymakers and practitioners involved with specialized probation initiatives generally agree that incentives are as critical as sanctions to supervisees' success.

It is also important for probation and treatment staff to recognize that, with reduced caseload size and greater coordination and integration between community corrections and mental health agencies, it may be far more likely for a team member to detect behaviors that constitute technical violations of supervision conditions. Treatment providers who have not historically provided services to justice-involved individuals may experience the "treater-turned-monitor dilemma" in which they may be tempted to engage in so-called "benevolent coercion" and use return to jail as a threat to get individuals to comply with treatment.[45] Such strategies undermine the potential benefits of collaboration between probation agencies and community-based treatment providers.[46] The specialized probation initiative should have clear protocols for mitigating these phenomena in a manner that is consistent with the initiative's objectives.

44. For detailed suggestions on developing state statutes that grant officers the authority to implement graduated sanctions for all people under probation supervision (not just those with mental illnesses), see The Public Safety Performance Project of the Pew Center on the States. *Policy Framework to Strengthen Community Corrections* (Washington: The Pew Charitable Trusts, 2008).

45. For example, see Solomon, P. Response to "A Model Program for the Treatment of Mentally Ill Offenders in the Community," *Community Mental Health Journal* 35 (1999) and Solomon, P., and Jeffrey Draine. "One-Year Outcomes of a Randomized Trial of Case Management with Seriously Mentally Ill Clients Leaving Jail," *Evaluation Review* 19 (1995): 256.

46. Ibid.

8 PROVIDING SPECIALIZED TRAINING AND CROSS-TRAINING

Probation officers who supervise individuals with mental illnesses receive substantial and sustained training on mental health issues, co-occurring substance use disorders, and effective supervision strategies for this population. Community-based treatment and service providers receive training on jail and probation policies and procedures, court reporting requirements, and the scope of behavioral health services provided by jail and community corrections staff. When possible, staff from probation and community-based treatment agencies cross-train each other on these issues.

Training should be provided to probation officers and community-based treatment providers to improve both systems' responses to people with mental illnesses under probation supervision. Probation agencies and community providers should work together to plan and implement a training regimen that supports the specialized probation initiative. Multi-disciplinary, multi-system collaboration ensures that training reflects an appropriate range of perspectives. This effort should be coordinated by initiative administrators who choose training content and techniques, select trainers, ensure the training is culturally competent, and evaluate the effectiveness of training.

Initiative administrators should consider a number of other training issues as well. First, they should weigh the costs and benefits of both centralized and local training, as the former can create efficient and uniform training for larger jurisdictions and the latter can create opportunities for building strong, local relationships. Second, initiative administrators should determine how they will select probation officers and mental health treatment providers to receive training. Soliciting volunteers, rather than assigning staff to receive training, may make it less likely that officers who have no desire to work with this population will feel forced to do so. Recruiting new staff who have already received training on mental illnesses or criminal justice issues, or who have a special interest in working with this population, is preferable for the same reasons. Nevertheless, probation agencies can incentivize this type of training as a form of professional development for staff who may not have strong preferences either way. Third, to the greatest extent possible, former supervisees with mental illnesses, their family members, and peers should be involved in training.

All probation officers, regardless of whether they are involved with a specialized initiative, should receive basic training on mental illness and its impact on individuals, families, and communities; signs and symptoms of mental illnesses; stabilization and de-escalation techniques; and legal issues such as confidentiality, victim notification, and other related procedures. Most importantly, probation staff should learn what treatment and services are available in the community and how to access them.

Officers involved with specialized probation initiatives should receive more significant and sustained training. In a survey of officers with specialized probation caseloads dedicated exclusively to people with mental illnesses,

officers received 20 to 40 hours of training per year.[47] These officers should be trained to employ problem-solving strategies, apply risk-needs-responsivity principles, and use graduated sanctions in response to noncompliance. They should also be trained to act as boundary spanners with the mental health and service systems in order to actively coordinate treatments and services with supervision.

Community-based mental health providers working with the specialized probation initiative should be trained in the workings of the criminal justice system and the impact of arrest and incarceration on individuals with mental illnesses. They should understand legal terminology, jail and court processes, correctional classification systems, screening and assessment procedures, and the range of treatments and services provided by jail-based or specialty probation clinicians. Treatment providers should also receive training on when and how to report violations of supervision conditions to probation authorities, their role and responsibilities when warrants are issued, and how to provide information during court hearings. To the greatest extent possible, mental health agencies should also receive training on assessing and treating issues around criminogenic risk and incorporating these practices into their traditional behavioral health treatment packages.

Initiative administrators and collaborating agencies should recognize and acknowledge that the criminal justice and mental health systems have traditionally had different missions, and that cultural differences exist between their agencies. They should understand that cross-training is necessary, but not sufficient, for reconciling these differences, meeting shared goals, and achieving desired outcomes. Structural supports, policies, procedures, agency leadership, and program and performance evaluations discussed in the preceding and subsequent elements are crucial for enabling specialized training to be absorbed and implemented.

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47. Skeem, J. L., Paula Emke-Francis, and Jennifer Eno Louden. "Probation, Mental Health, and Mandated Treatment: A National Survey," *Criminal Justice and Behavior* 33 (2006): 158–84.

9 SHARING INFORMATION AND MAINTAINING CONFIDENTIALITY

Probation agencies and community-based treatment providers standardize a protocol for sharing health and legal information about individuals within their shared target population, and ensure that this procedure is understood and implemented by all relevant staff. The information-sharing protocol is consistent with local, state, and federal privacy regulations and facilitates the exchange of information among all components of the criminal justice system and between the criminal justice and community-based treatment systems.

Information exchange among jails, probation agencies, and community-based treatment providers is a prerequisite for developing case plans, linking individuals to treatment and services, ensuring continuity of care after periods of incarceration, and determining appropriate supervision strategies. In short, the success of specialized probation responses to people with mental illnesses can hinge on whether crucial information about diagnoses, medications, criminogenic risk assessments, substance use, public assistance, and other relevant details of personal history follows people across systems.

All information sharing must, of course, comply with local, state, and federal statutes on the confidentiality of mental health and/or substance use records, such as the federal Health Insurance Portability and Accountability Act (HIPAA); however, HIPAA is often erroneously cited as the reason why information crucial to the success of specialized initiatives cannot be shared. Planners and administrators should recognize the widely held misconceptions about HIPAA restrictions and work with all relevant staff to clarify these issues.[48]

Information should be shared in a way that protects and maintains individuals' confidentiality rights as consumers of mental health services and their constitutional rights as defendants. It is paramount that supervisees are educated about and involved in addressing these issues. Probation officers and treatment providers should establish trusting relationships that can mitigate information-sharing barriers. Informed consent leading to supervisees' signed release of information is the most effective way to honor confidentiality rights and create effective supervision and treatment responses.

Planners and administrators should determine which personnel have the authority to request and provide information about individuals' mental health and criminal histories. Information exchanges should be limited strictly to what is needed to inform appropriate supervision and case plans. To that end, release or consent forms should become standard interagency procedures. They should be developed in consultation with legal counsel; adhere to local, state, and federal laws; and specify what information will be released, to whom, and over what

48. For more information, see Petrila, J. *Dispelling Myths about Information Sharing between the Mental Health and Criminal Justice Systems* (Delmar, NY: National GAINS Center, 2007), http://gainscenter.samhsa.gov/text/integrated/Dispelling_Myths.asp.

period of time. Potential participants in the specialized probation initiative should review these forms with the advice of defense counsel and treatment providers. To the greatest extent possible, and especially when competency may be at issue, staff must ensure that potential participants understand how information will and will not be used. Potential participants should not be asked to sign release forms until all competency issues are resolved.

Planners and administrators must carefully consider the type of information needed and existing barriers to its exchange, and then develop procedures and memoranda of understanding (MOUs) to ensure appropriate sharing. These protocols should be emphasized in cross-training sessions. Planners and administrators may also want to consider ways to share information electronically, by linking different agencies' information management systems on an ongoing or one-time basis.[49] Such arrangements, which can be part of a broader electronic data collection system, are expedient and efficient and can be designed to grant and deny access to appropriate staff.

The exchange of information facilitates communication and collaboration among law enforcement agencies, courts, jails, community corrections agencies, and the community-based treatment system. For example, jail staff can inform the courts when an individual with mental illness is identified at intake so a judge can determine if the person should be considered for participation in a specialized intervention. It is essential that information exchanges flow in both directions—that is, criminal justice agencies further along the continuum and community providers should also be prepared to send information upstream, such as when community treatment information-sharing protocols ensure relevant information follows an individual back into the corrections system if probation is revoked.

Planners and administrators should acknowledge that although the clearly defined policies and procedures described above are essential, they cannot replace trusting inter-system relationships among staff at agencies that have historically had very different goals and cultures. Probation officers should understand that some types of clinical information cannot (and should not) be shared, just as treatment providers should understand that other types of clinical information must be shared with probation officers to ensure successful community supervision. The development of these sorts of relationships is arguably as important as the establishment of any protocols or electronic data collection systems.

In addition to collecting and sharing data about individual participants to improve their clinical and legal outcomes, there is also tremendous value in sharing aggregate data. As discussed in Element 10, aggregate data are required to measure the impact of the specialized initiative and ensure its sustainability. Therefore, procedures and MOUs that explicitly cover the exchange of aggregate data should also be developed.

49. The Bureau of Justice Assistance supports the electronic exchange of information between agencies. To learn more about these and other national policies, practices, and technology capabilities that support effective and efficient information sharing, see www.it.ojp.gov.

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CONDUCTING EVALUATIONS AND ENSURING SUSTAINABILITY

Data are collected and analyzed that demonstrate the impact of the specialized probation initiative on revocation rates, engagement in treatment, and the prevalence of mental illnesses in jails and prisons. These data inform a quality improvement process that results in modifications to the initiative. In addition, the evaluation of initiative effectiveness is used to sustain support for the initiative.

The planning committee and initiative administrators should take steps early in the design process to ensure that they can determine the effectiveness of the initiative and maintain its long-term sustainability. To this end, planners and administrators should identify performance measures based on initiative goals and objectives. These measures can include process data on key aspects of initiative operations; qualitative data on officers', supervisees', and community members' perceptions of the initiative; and outcome data including initiative costs and cost offsets. Where possible, the planning committee should also include program evaluators in the initial planning and design processes outlined in the preceding elements. This can be achieved by establishing early partnerships with local universities or identifying consultants if no in-house researchers or evaluators are available.

The specialized probation initiative should collect data that focus on questions most critical to the initiative's success. Process data include such items as the number of people who screen positive for mental illness, the number of people who have attended and completed treatment programs, or the number of contacts with probation or clinical staff. Qualitative data could include such measures as officers' impressions of how time consuming, easy, or difficult it is to supervise people with mental illnesses, and supervisees' impressions of the quality of supervision and treatment they receive. Outcome data include rates of technical violations, revocations, and rearrest; trends in the overall growth of the jail population; number of hospital days and emergency room costs avoided; as well as information about participants' functional improvements and symptom reductions. Initiative funders frequently request data about cost effectiveness; therefore, this information is of critical concern for continued support. However, cost effectiveness methodology is quite complex, and if the data are not collected correctly or reported clearly, they may not be compelling. Ideally, data on appropriate comparison groups are also collected to demonstrate outcomes that might have occurred in the absence of the specialized initiative. A feedback loop should be established that allows these data to inform initiative refinement.

As discussed in Element 1, formalizing the initiative's policies and procedures is an important component of sustaining the initiative. Compiling information about the initiative's history, goals, screening and assessment protocols, eligibility criteria, information-sharing protocols, supervision strategies, sanctions, and incentives helps ensure consistency and mitigates the impact of staff turnover. It also informs ongoing quality improvement processes and enables initiative administrators to make adjustments when appropriate.

Planners and administrators should also garner both external and internal support. Initiative

leaders should reach out to community leaders and the media to educate them about the public safety goals and other objectives of the specialized probation initiative. They should also involve key elected and appointed officials and other policymakers as early as possible in the initiative's design and implementation, and keep them involved to promote supportive legislation and/or funding opportunities. Probation officers, mental health treatment providers, and other personnel—involved with the effort or not—should also be surveyed so initiative partners can better assess its impact and ideally develop a base of support from within the ranks of collaborating agencies.

Planners and administrators should also develop a crisis communication plan that builds on the positive relationships they forge between the specialized initiative and the community at large, the media, and policymakers. Plan implementers communicate that sometimes there will be incidents involving initiative participants, but that these rare—though often highly publicized—events should not undermine the broader benefits of the initiative.

In addition to calling on policymakers to advance financial support for an initiative, diverse funding options are key to long-term sustainability. Although in-kind contributions from multiple agencies can accomplish a great deal in offsetting initiative costs, planners and administrators should identify and cultivate additional resources. Requests for funding should be tied to clearly articulated initiative goals and incorporate data that demonstrate positive outcomes. Funding should include support for the process and outcome research mentioned above. In general, most local probation departments and other local agencies participating in the initiative do not have the expertise or staff to set up the data collection and analysis suggested in this document. With some outside expert assistance, however, agency personnel may effectively be guided to design and implement the data collection mechanisms that consultants (for example, graduate students supervised by an experienced researcher from a local university) can then analyze and report to initiative stakeholders at appropriate intervals.

Conclusion

Probation agencies across the country are seeing increasing numbers of people with serious mental illnesses on their caseloads. Traditional community supervision strategies are associated with poor outcomes for these individuals; they are twice as likely as people without mental illnesses to have their probation revoked and become further entrenched in the criminal justice system. As a group, they can be challenging to supervise. They have broad treatment and service needs and require supervision strategies that traditional probation agencies were not designed to provide.

Recognizing the need for innovative approaches, probation agencies and community-based treatment providers across the country are working to develop creative interventions that address the unique needs of their overlapping target populations. These agencies are engaged in problem solving with an array of partners from a range of disciplines. Together they are utilizing a growing knowledge base about what works, for whom, and under what circumstances. What the field has lacked is a concise construct of the essential elements of successful specialized probation responses to people with mental illnesses. This publication draws on the broad accumulation of information and the experiences of probation agencies and mental health treatment providers to fill that gap. It is hoped that these elements will help guide policymakers and practitioners who are initiating or enhancing their own initiatives.

The tone of this document may suggest that the changes recommended above are easy to make. They are not. There are many challenges, including complex politics, turf battles, competition for limited funding, and scarce probation and community mental health resources. Despite these obstacles, probation agencies and their community partners have demonstrated a willingness to coalesce around shared goals and purposes to address these difficult issues. These essential elements are written for such innovators and those who will follow in their footsteps, all of whom work tirelessly to make communities safer and healthier, use public resources and tax dollars efficiently and effectively, and improve outcomes for people with mental illnesses who become involved with the criminal justice system.

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