SECTION TWO

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

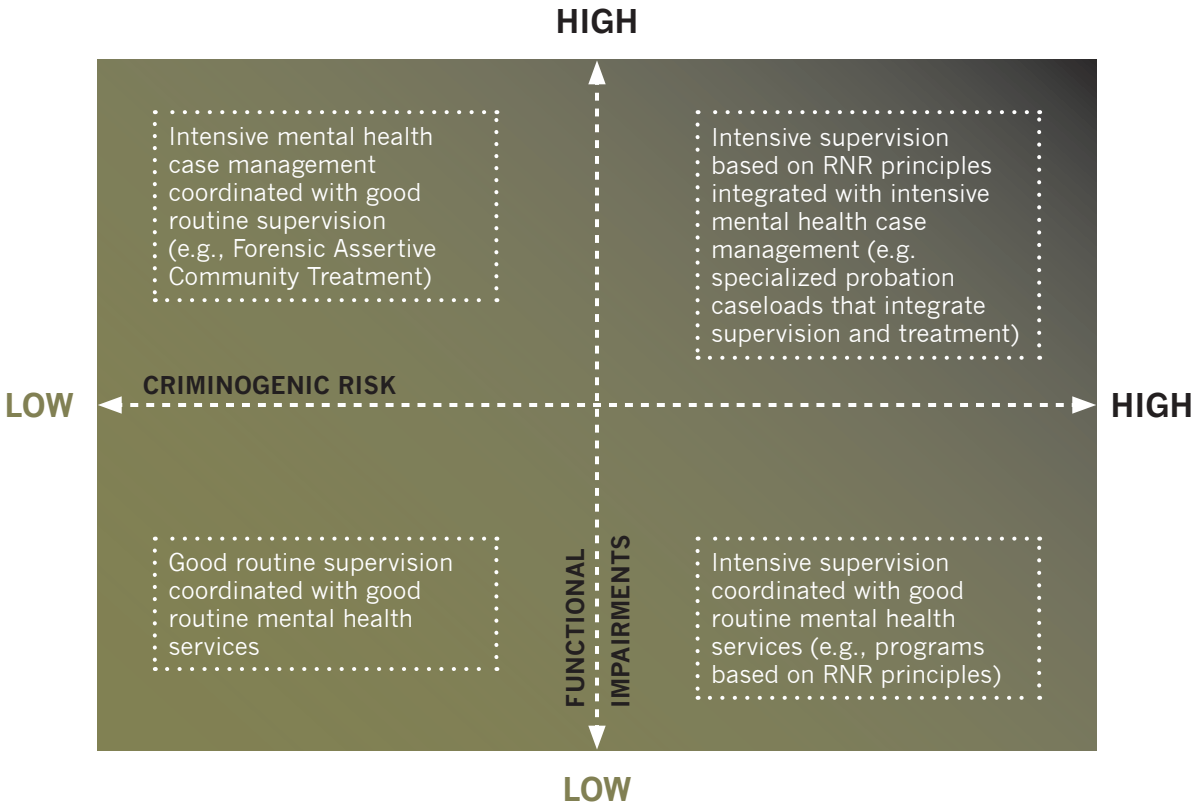
Strategies to reduce recidivism for people under community corrections supervision, and strategies to improve clinical outcomes for people with mental illnesses, have each been well-documented and widely supported by respective bodies of research. Despite their promise, the effectiveness of these community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

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

It is necessary to consider these new approaches within the full spectrum of needs and potential responses discussed at the outset of this guide. People with mental illnesses under community corrections supervision pose different degrees of criminogenic risk, determined by the nature of their criminal offense and dynamic factors associated with their attitudes, circumstances, and patterns of thinking. This degree of criminogenic risk is a core component in the design of supervision strategies. So too, these individuals have a wide range of functional impairments, determined in part by diagnoses, disabilities, and socioeconomic circumstances. This degree of functional impairment is a core component in the design of traditional treatment interventions. As such, it follows that the menu of supervision and treatment options for this population should be derived from an assessment of these two basic dimensions: criminogenic risk and functional impairment.

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

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



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

In addition to the degree of criminogenic risk and functional impairment, both of which can range from low (or minor) to high (or severe), two other critical features of potential interventions for this population are the level of response intensity, which can range from low to high, and the degree to which community corrections and mental health agencies coordinate or integrate their responses (See Research Finding 3.a below).* The matrix proposes that the level of response intensity and the degree of coordination/integration should increase as both

* *Coordination* exists when each agency is aware of the other's activities and occasionally shares clinical or corrections information—within legal parameters—about particular individuals in contact with both agencies. *Integration* exists when community corrections and mental health agencies develop and implement a single supervision and treatment plan in which both have an active role, such as sharing staff and other resources, and participating in each other's case staffing. (Adapted from Center for Substance Abuse Treatment. Definitions and Terms Relating to Co-occurring Disorders. COCE Overview Paper 1. DHHS Publication No. (SMA) 06-4163 Rockville, MD: Substance Abuse and Mental Health Administration, and Center for Mental Health Services, 2006.)

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

For example, people with low criminogenic risk and low functional impairment may require little supervision and less intense outpatient mental health treatment. Community corrections and mental health staff may not need to coordinate extensively or dedicate additional resources if both systems are implementing good, routine practices. Individuals who fall into the upper left and bottom right corners of the matrix—people with high functional impairment and low criminogenic risk or low functional impairment and high criminogenic risk—may require coordination between community corrections and mental health staff but not full-fledged integration. In the top right corner of the matrix, those with high criminogenic risk and high functional impairment may require specialized, targeted, and integrated interventions in order to maximize public safety and public health outcomes.

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

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

* See Section Three for more on screening and assessment.