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Implementing Specialized Caseloads to Reduce Recidivism for People with Co-Occurring Disorders

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Probation departments have used specialized caseloads for years as a way to tailor supervision and better address the specific needs of people at a high risk to reoffend or who belong to certain populations. With these focused caseloads,[1] officers are able to dedicate more time and attention to their cases while also applying targeted supervision and treatment strategies designed to reduce recidivism among their clients.

Many criminal justice leaders are now beginning to look to specialized caseloads as a tool for reducing recidivism among people who have mental illnesses and co-occurring substance use disorders[2]—referred to in this brief as having co-occurring disorders. These individuals, who usually require extensive treatment and services to address their needs,[3] also benefit from a combination of specially trained probation staff working with behavioral health professionals to apply evidence-based practices—a hallmark of specialized caseloads.

Specialized Caseloads Impacts

When specialized caseloads are in place, jurisdictions typically see

- ✓ **Fewer arrests**,[4]
- ✓ **Fewer days in jail for people after probation placement**,[5]
- ✓ **Improved mental health outcomes**,[6] and
- ✓ **Cost savings due to reduced recidivism and reduced use of emergency services and inpatient and residential services**.[7]

This brief presents five key practices for successful implementation of specialized caseloads for people with co-occurring disorders. It relies on a coordinated and collaborative approach[8] and reinforces the need for probation officers to have the appropriate resources to connect people to individualized treatments and supports.

1.
Build a solid program infrastructure by establishing standard operating procedures and providing ongoing training for probation staff and behavioral health partners.

2.
Define the target population and use results from criminogenic risk assessments to match people to their appropriate levels of supervision and behavioral health assessments to determine treatment needs.

3.
Develop specialized supervision case plans that are responsive to the needs of people with co-occurring disorders and maintain accountability and public safety.

4.
Connect people with co-occurring disorders to treatment and community supports through collaborative comprehensive case management.

5.
Sustain the program by tracking outcomes and promoting successes.

The brief serves as an update to the 2009 publication from The Council of State Governments (CSG) Justice Center titled *Improving Responses to People with Mental Illnesses: The Essential Elements of Specialized Probation Initiatives*.[9] Since the release of that publication, the use of collaborative comprehensive case management and the incorporation of a team approach among probation and behavioral health professionals are now key components for reducing recidivism.

Five Key Practices for Successful Implementation

1. Build a solid program infrastructure by establishing standard operating procedures and providing ongoing training for probation staff and behavioral health partners.

Prior to implementing specialized caseloads for people with co-occurring disorders, probation department officials should ensure that the necessary infrastructure is in place. Part of this infrastructure involves establishing clear partnerships with community-based providers and standard procedures for coordinating with partners to provide treatment and ensure that court orders are met. Often, probation departments can leverage existing relationships with community-based behavioral health treatment and social service providers to support caseloads for people with co-occurring disorders. Probation departments should consider establishing a Memorandum of Understanding to formalize roles and responsibilities of each partner and clear staff directives and procedures for handling non-compliance reporting, requesting warrants, and using sanctions and incentives, as well as information-sharing protocols. Probation officials should lead these efforts because their department is ultimately responsible for the administration of the program.

Implementing effective specialized caseloads for people with co-occurring disorders also hinges on identifying appropriate staff to supervise these individuals and supporting them with ongoing training. Officers who manage specialized caseloads should be committed to a collaborative comprehensive case management approach[10] and to working with people who have co-occurring disorders in a manner that is responsive to their needs. Supervision staff should also possess passion for this population coupled with experience and skill to ensure that they handle their cases with a balance of firmness and fairness and that they are invested in seeing positive outcomes.[11] Regular staff trainings help ensure continued success of the specialized caseload program. Potential training topics include using criminogenic risk assessments[12] to determine the factors most associated with someone potentially committing a new crime, best practices in using behavioral health recovery and trauma-informed care principles, and the role of strengths-based approaches that are not typical of traditional supervision strategies for probation staff. Probation staff should also be trained on safety and de-escalation techniques and how to incorporate support from law enforcement as needed. Training should be provided on an ongoing basis to ensure staff are up to date on the latest developments in effective supervision practices. Training also helps offset staff burn-out that can be associated with working with high-risk and high-needs populations who often experience bouts of progress and relapse.

2. Define the target population and use results from criminogenic risk assessments to match people to their appropriate levels of supervision and behavioral health assessments to determine treatment needs.

Since resources for specialized caseloads are generally limited, it's important to have a clear understanding of the number of people on probation with co-occurring disorders. Once this is established, probation departments should define the target population for specialized caseloads and establish a limit for caseload size. Assignment to specialized caseloads should be reserved for people with moderate to high levels of criminogenic risk and high levels of mental

illness and substance use disorders who require extensive treatments and supports.[13] With a clear understanding of the target population size, probation officials can determine how many officers are needed for these specialized caseloads.

To help establish the target population, probation department officials should work with other local leaders to review risk assessment scores and determine the number of people on probation that score as moderate to high risk.[14] From there, leaders can crossmatch this population with the people on probation identified as having a co-occurring disorder as well as other restrictions based on underlying charges, criminal records, residency, and caseload size. Officials should continue to use validated screening tools and follow-up assessments to ensure that people meet the established criteria for specialized caseloads and can be matched to the appropriate risk-reducing interventions.

3. Develop specialized supervision case plans that are responsive to the needs of people with co-occurring disorders and maintain accountability and public safety.

Each person on the specialized caseload should receive a supervision plan that is tailored to their distinct needs to reduce the likelihood that they will reoffend while also ensuring they meet any necessary legal requirements. To reduce risk of recidivism, the goals in each specialized supervision case plan should focus on addressing changeable or dynamic risk factors that are directly related to committing another crime, such as having antisocial thoughts or peers.[15] It is equally important to tailor interventions to match the unique characteristics of people with co-occurring disorders, since substance use disorders[16] and the presence of a mental illness may create barriers to program engagement and participation. These case plans should account for the missteps that people with co-occurring disorders may make and empower officers to employ sanctions in lieu of requesting revocations for minor technical violations. For example, people with co-occurring disorders may not adhere to their medication regimen or may experience relapse, which can potentially lead them to commit new crimes or result in technical violations of their probation. Specialized supervision case plans that consider these factors may include reasonable, less restrictive conditions and build in higher thresholds for non-compliance that are responsive to the person's criminogenic risk factors and behavioral health needs and improve their chances for success.

It is important to balance the needs of the person on supervision with maintaining accountability for any crimes that were committed and protecting public safety. Indeed, some charges may result in legal requirements, including electronic monitoring, urinalysis testing, or restitution requirements. Probation officers should be intentional in reviewing not just the risk assessment results, but also the orders of the court, when developing these case plans. Additionally, they will need to clarify all expectations and consequences of non-compliance and ensure that the client fully understands the legal consequences of non-compliance.

4. Connect people with co-occurring disorders to treatment and community supports through collaborative comprehensive case management.

Collaborative comprehensive case management involves coordinating treatment, supervision goals, and services among the relevant partners in each person's supervision case plan. This kind of collaborative approach can help improve a person's chances of recovery, hold them accountable, and protect public safety because it focuses on connecting people to treatment and cognitive interventions intended to address individual needs and behaviors that might lead to their rearrest.[17]

The structure of collaborative case management may vary. For example, a probation department may embed a mental health professional within the office or choose to use scheduled case conferences with the probation officer and behavioral health partner to monitor the client's progress toward their goals and determine if any adjustments are needed. Another probation department might also engage the client's support network or even peer mentors to keep them actively involved in programming and to help ensure they meet scheduled appointments with treatment providers. No matter the methods used, probation staff should be responsible for reporting progress and non-compliance to court officials as determined by local policies. Necessary release of information forms should also be completed, and the person on probation should be an active participant in the case management process so that they are invested in their own recovery.

5. Sustain the program by tracking outcomes and promoting successes.

Probation officials should identify outcome measures to track to determine if the program is being implemented successfully and understand what, if any, changes are needed. Many of these outcome measures should be related to recidivism, with probation officials collecting data such as new case filings, new convictions, and revocations for technical violations. However, probation officials should also track other outcomes to demonstrate the client's success in maintaining a prosocial lifestyle, such as compliance with treatment and program requirements, drug testing results, education completion, and job placement. If officials find that they are seeing consistent positive outcomes among clients, this outcome data can be used to communicate successes and continued funding needs to state and local leaders. If the data are not indicating program success, probation officials should further analyze the outcomes to determine if they should make changes to policies and practices and if staff need additional support and resources.

Individual successes should also be tracked and shared proactively among the partner organizations and stakeholders. This should only be done with the person's express permission and, if possible, shared in a way that keeps their identity anonymous. Promoting these success stories can help increase trust and respect for specialized caseloads and ultimately make the case for growing and sustaining the program.

Endnotes

1. Specialized caseloads are generally smaller in size than traditional caseloads, "averaging a little under 50 cases while others can be upwards of 100 cases at a time."

2. The research supporting specialized caseloads for people with serious mental illnesses and co-occurring substance use disorders is limited, but positive. See Jennifer L. Skeem, Sarah Manchak, and Lina Montoya, "Comparing Public Safety Outcomes for Traditional Probation vs Specialty Mental Health Probation" *JAMA Psychiatry* 74, no. 9 (2017): 942-948, 10.1001/jamapsychiatry.2017.1384. In this article, they concluded that, "Although it did not specifically reduce violence, well-implemented specialty probation appears to be effective in reducing general recidivism." Thus, the key to effective results and reducing recidivism with the co-occurring disorders population is in the quality of program implementation.

3. Deirdra Assey and Sarah Wurzburg, *Improving Responses to People Who Have Co-occurring Mental Illnesses and Substance Use Disorders in Jails* (New York: The Council of State Governments [CSG] Justice Center, 2020), https://csgjusticecenter.org/publications/improving-responses-to-people-who-have-co-occurring-mental-illnesses-and-substance-use-disorders-in-jails/.

4. Skeem, Manchak, and Montoya, "Comparing Public Safety Outcomes," 942; Nancy Wolff et al., "Mental Health Specialized Probation Caseloads: Are They Effective?," *International Journal of Law and Psychiatry* 37, no. 5 (2014): 464–472.

5. Wolff et al., "Mental Health Specialized Probation Caseloads," 2014.

6. Ibid.

7. Jennifer L. Skeem et al., "Comparing Costs of Traditional and Specialty Probation for People with Serious Mental Illness," *Psychiatric Services* 69, no. 8 (2018): 896-902.

8. For collaborative case plans—sometimes called Collaborative Comprehensive Case Plans—developed with probation department officials as the lead, the partners are typically probation officials, mental health and substance use disorder treatment professionals, corrections agencies, and other agencies and entities involved in the person's reentry and recovery. See "Collaborative Comprehensive Case Plans," the CSG Justice Center, accessed September 25, 2020, https://csgjusticecenter.org/publications/collaborative-comprehensive-case-plans/.

9. This report, released in October 2009, provides specific recommendations to probation and mental health policymakers and practitioners for effectively responding to the complex treatment and service needs of people with mental illnesses while improving public safety and health. See Seth J. Prins and Fred C. Osher, *Improving Responses to People with Mental Illnesses: The Essential Elements of Specialized Probation Initiatives* (New York: the CSG Justice Center, 2009), https://csgjusticecenter.org/wp-content/uploads/2020/02/Improving_Responses_to_People_with_Mental_Illnesses_-_The_Essential_Elements_of_Specialize_Probation_Initiatives.pdf.

10. Collaborative comprehensive case management for people on probation with co-occurring disorders provides a comprehensive approach building on robust partnerships between criminal justice, behavioral health, and other agencies to promote public safety and improve recovery and supervision outcomes.

11. Skeem et al., "Comparing Costs of Traditional and Specialty Probation for People with Serious Mental Illness,"901.

12. R. Karl Hanson et al., *A Five-Level Risk and Needs System: Maximizing Assessment Results in Corrections through the Development of a Common Language* (New York: the CSG Justice Center, 2017), https://csgjusticecenter.org/publications/a-five-level-risk-and-needs-system-maximizing-assessment-results-in-corrections-through-the-development-of-a-common-language/.

13. Diagnoses of serious mental illness and severe substance use disorders are generally preferred versus lower levels of mental illness or substance use disorders to ensure admission is being reserved for people who have the greatest needs. Additionally, similar to mental illnesses, substance use disorders have different levels of severity and symptoms.

14. A helpful reference for determining target populations can be found in *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*, which includes the "Criminogenic Risk and Behavioral Health Needs Framework" as a guide for this process. This framework supports a supervision approach focused on the principles of addressing risk, need, and responsivity, and guides officials through practical ways for establishing target population criteria. See Fred Osher et al., *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery* (New York: the CSG Justice Center, 2012), https://csgjusticecenter.org/publications/behavioral-health-framework/.

15. Ibid. Some criminogenic risk factors are static—such as age at first arrest and arrest history—while others are dynamic. Probation officials should ensure that case plans prioritize setting goals that address dynamic criminogenic risk factors because it is possible to change them through targeted interventions.

16. Substance use disorders are a criminogenic risk, need, and a responsivity issue, both by their direct relationship to crime (for example, use of illicit substances) and because of their potential effect on a person's ability to engage in cognitive interventions.

17. Some examples of these interventions are Thinking for a Change, Moral Reconation Therapy, and Reasoning and Rehabilitation.

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