ADULTS WITH BEHAVIORAL HEALTH NEEDS UNDER CORRECTIONAL SUPERVISION:

A Shared Framework for Reducing Recidivism and Promoting Recovery

NIC National Institute of Corrections

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BJA Bureau of Justice Assistance
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Council of State Governments Justice Center
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The nation's prisons, jails, and pretrial, probation, and parole agencies oversee a disproportionate number of individuals with mental health and substance use disorders—many churning through the criminal justice system over and over again. Mental health and substance use disorder service providers often see these same individuals in the community, some who are at risk of arrest because of behaviors associated with their disorders and others on probation or returning home after incarceration with diverse treatment needs.

The corrections, mental health, and substance use disorder systems share a commitment to help these individuals successfully address their needs and avoid criminal justice involvement, yet each system has its own screening and assessment tools and research-based practices. Although there are many examples of innovative and effective collaborations among corrections, substance use disorder and mental health providers, what has been lacking is a truly integrated framework that can help officials at the systems level direct limited resources to where they can be most effective in achieving both public safety and healthcare goals.

In an important interagency collaboration, the U.S. Department of Justice's National Institute of Corrections (NIC) and Bureau of Justice Assistance (BJA), and the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) convened national experts from the American Probation and Parole Association (APPA), the Association of State Correctional Administrators (ASCA), the National Association of State Mental Health Program Directors (NASHMPD), and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to help develop a planning tool that would ensure resources are used to their best effect and to guide creative responses at the service level. With input from associations, researchers, and stakeholders, the Council of State Governments Justice Center created the **Criminogenic Risk and Behavioral Health Needs Framework**. The framework weaves together the science on risk and needs to provide an approach to achieve better outcomes for adults in contact with the criminal justice system with substance use disorders, mental illness, or both.

The framework and supporting white paper are the result of many lively debates and extensive outreach. These products are intended to advance the national discussion about how to improve public safety and health for individuals with substance use and mental health disorders who are involved in the corrections system. To stimulate creative problem solving across the corrections and behavioral health care systems, the framework provides a common language to describe the populations these systems share. It is not a detailed "how to" guide, largely in recognition of the need to tailor responses to the distinct needs and capacity of particular jurisdictions.

We came together to build on the strong foundational work the substance abuse and mental health organizations forged in addressing co-occurring disorders. Our organizations are pleased to be part of an effort to add the third dimension of corrections as we collectively work to improve the lives of people with mental illness and substance use disorders while improving public safety.

Carl Wicklund, Executive Director
American Probation and Parole Association

Robert Glover, Executive Director
National Association of State Mental Health Program Directors

Camille and George Camp, Co-Executive Directors
Association of State Correctional Administrators

Robert Morrison, Executive Director
National Association of State Alcohol and Drug Abuse Directors

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PREFACE

THE LARGE NUMBERS OF ADULTS with behavioral health disorders (mental illnesses, substance use disorders, or both) who are arrested and convicted of criminal offenses pose a special challenge for correctional and health administrators responsible for their confinement, rehabilitation, treatment, and supervision. As corrections populations have grown, the requirements for correctional facilities to provide health care to these inmates has stretched the limits of their budgets and available program personnel. They often lack the resources to provide the kinds of services many of these individuals need for recovery and to avoid reincarceration.

Addressing the needs of individuals on probation or returning from prisons and jails to the community also raises difficult issues for the behavioral health administrators and service providers who have come to be relied on for treatment. Individuals with behavioral health issues who have criminal histories often have complex problems, some of which are difficult to address in traditional treatment settings. The reality is, however, that public healthcare professionals are already struggling to serve them. A significant number of individuals who receive services through the publicly funded mental health and substance abuse systems are involved in the criminal justice system. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the criminal justice system is the single largest source of referral to the public substance abuse treatment system, with probation and parole treatment admissions representing the highest proportion of these referrals.[1] Overlapping populations similarly exist for corrections administrators and mental healthcare providers.[2]

With state and local agencies enduring dramatic budget cuts, resources are already scarce for serving and supervising individuals with substance abuse and mental health needs who are, or have been, involved in the criminal justice system. The question that many policymakers and practitioners are asking is whether those resources are being put to the best use in advancing public safety and health, as well as personal recovery. They are examining whether allocations of behavioral health resources are increasing diversion from the criminal justice system when appropriate and reducing ongoing criminal justice involvement for individuals under correctional control and supervision.[3] The answer, frankly, is we do not think that the scale of the investments in these efforts has come close to addressing the extent of the problem or that resources are always properly focused.

The dedication of resources made behind the bars and in the community does not appear to stop the individuals with substance abuse and mental health disorders from cycling through the criminal justice system—in many cases, they are simply insufficient to effect a systemwide change or do not focus narrowly enough on the people who would most benefit from the interventions. These investments in treatment and supervision have traditionally not been coordinated and sometimes even work at cross-purposes. Just as the substance abuse and mental health systems used to operate in silos—but now frequently come together to provide integrated co-occurring treatment options—a similar challenge is now before the corrections and behavioral health systems.

The vast majority of inmates eventually return to their home communities from prisons and jails (650,000 or more individuals each year from state prisons alone,[4] and more than 9 million individuals from jail).[5] This influx of returning inmates has sparked an urgent need for corrections and behavioral healthcare administrators to reconsider the best means to facilitate reentry and service delivery to the many individuals with substance abuse and mental health problems. Despite the overlap in the populations they serve, little consensus exists among behavioral healthcare and community corrections administrators and providers on who should be prioritized for treatment, what services they should receive, and how those interventions should be coordinated with supervision. Too often, corrections administrators hear that "those aren't my people" from behavioral healthcare administrators and providers. And just as often, the behavioral health community feels they are asked to assume a public safety role that is not in synch with their primary mission. Misunderstandings about each system's capacity, abilities, and roles, as well as what types of referrals are appropriate, have contributed to the problem.

This white paper presents a shared framework for reducing recidivism and behavioral health problems among individuals under correctional control or supervision—that is, for individuals in correctional facilities or who are on probation or parole. The paper is written for policymakers, administrators, and practitioners committed to making the most effective use of scarce resources to improve outcomes for individuals with behavioral health problems who are involved in the corrections system. It is meant to provide a common structure for corrections and treatment system professionals to begin building truly collaborative responses to their overlapping service population. These responses include both behind-the-bars and community-based interventions. This framework is designed to achieve each system's goals and ultimately to help millions of individuals rebuild their lives while on probation or after leaving prison or jail.

ACKNOWLEDGMENTS

THE COUNCIL OF STATE GOVERNMENTS (CSG) JUSTICE CENTER conducted the project resulting in this white paper under a cooperative agreement with the National Institute of Corrections (NIC). The work has been strengthened by an interagency collaboration with additional support from the U.S. Department of Justice's Bureau of Justice Assistance (BJA), and the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). The project staff thanks the leaders of these agencies for their commitment to addressing the overrepresentation of people with mental illnesses in prisons and jails, and under probation and parole supervision. Special thanks also go to Anita Pollard, NIC; Danica Szarvas-Kidd, BJA; and Ken Robertson, Center for Substance Abuse Treatment, SAMHSA.

Any value this framework has to the field is due in large part to the individuals who drew on their extensive expertise and experience to ensure it addresses the needs of multiple systems. Collaborating agencies include the Association of State Correctional Administrators (ASCA), the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and the American Probation and Parole Association (APPA). The Association of Corrections Mental Health Administrators (ACMHA) also shared their feedback and in an early show of support voted unanimously to support the framework as a vehicle to advance discussions and test integrated approaches. The Association of Paroling Authorities International (APAI) also provided helpful comments and advice.

In addition, the CSG Justice Center staff gratefully acknowledges the contributions of the diverse group of advisors who served on the expert panel and the additional reviewers for this framework (see Appendix A for a full listing). These state corrections, mental health, and substance abuse directors and other experts gave generously of their time and ideas. They provided critical advice and recommendations that developed into the roadmap for this white paper and strengthened its content.

Finally, the authors are grateful to the many CSG Justice Center staff that provided feedback on the framework and its depiction—too many to even list here. Special thanks go to Jessica Tyler for creating a clear visual display of the framework information. Director Michael Thompson provided his enthusiastic support and guidance on this project, enhancing the product's value to the field. Public Affairs Manager Matthew Schwarzfeld edited early drafts of the document, facilitating its development. And Project Assistant Jason Karpman lent his research, fact-checking, and graphics assistance throughout the development of this white paper.

INTRODUCTION

STATE CORRECTIONS AND BEHAVIORAL HEALTH ADMINISTRATORS know that large numbers of adults with mental health and substance use disorders are churning through the nation's criminal justice, behavioral health, and social support systems, often with poor—even tragic—individual, public health, and community safety results.* People with mental illnesses, substance use disorders, or both, often take varied pathways into the criminal justice system. Once involved, however, they tend to get caught up in a whirlpool fueled by relapse and an inability to comply with the requirements of their incarceration, supervision, and release. Their conditions tend to deteriorate, and they often get ensnared in the system again and again because they lack effective integrated treatment and supervision. The costs to states, counties, and communities in excessive expenditures of scarce resources that have a limited effect on public safety, recidivism, and recovery are unacceptable.† The impact on individuals and their families can be devastating.

Research suggests that these outcomes can be improved through the accurate screening and assessment of individuals' risk to public safety and their clinical needs, and then matching these results to appropriate accountability and treatment measures. Criminal justice professionals and behavioral healthcare providers in many jurisdictions are already collaborating in various ways to address the complex needs of individuals that cannot be adequately resolved by one system alone. When appropriate, jail diversion programs and preventive measures can stem the flow of individuals into the system. Once they are involved in the criminal justice system, there also are promising efforts that have appeared across the nation that demonstrate the effectiveness of cooperation and coordination (see Examples of Cross-systems Efforts sidebar).

Although a number of states and jurisdictions have developed a smattering of cross-system pilots and programs, there has been no shared conceptual framework at

*For the purposes of this paper, "behavioral health administrators" refer to individuals responsible for the provision of community-based mental health and substance abuse services. Although there are administrators responsible for mental health and substance abuse services in correctional settings, for the sake of clarity, the term is used in this paper only when referring to community-based services. (Additional definitions can be found in the glossary.)

†Jurisdictions and researchers use differing definitions of "recidivism." In this document, recidivism refers to the repetition of criminal or delinquent behavior, most often measured as a new arrest, conviction, or return to prison and/or jail for the commission of a new crime or as the result of a violation of terms of supervision. (See Marshall Clement, Matthew Schwarzfeld, and Michael Thompson, *The National Summit on Justice Reinvestment and Public Safety,* New York, NY: Council of State Governments Justice Center, 2011.)

the *systems* level to categorize these individuals' risk of involvement in crime and their needs, identify the appropriate supervision and treatment approaches, and prioritize the limited resources of community treatment and corrections programs.

This white paper proposes such a structure as a starting point for state and local agencies to facilitate integrated practices that will produce improved outcomes for people with behavioral health problems in contact with the criminal justice system. It is designed to help corrections and behavioral health agency leaders find more cost-effective investments for their resources that will still advance their agency goals.*

Examples of Cross-systems Efforts

- In 2010, the Ohio Departments of Rehabilitation and Correction, Mental Health, and Alcohol and Drug Addiction Services collaborated with the Alcohol and Drug Addiction Mental Health Board of Franklin County to launch *Succeeding at Home,* a comprehensive program to provide co-occurring substance abuse and mental health disorder treatment to men at medium-to-high risk for reincarceration returning to Franklin County after institutional release. Through this program, the men receive pre-release and post-release substance abuse and mental health treatment with an emphasis on strengthening prosocial and community networks through a cognitive behavioral program to address their disorders and criminal thinking. Ohio Department of Correction works with community-based partners Columbus Area Mental Health, Inc. and the Exit Housing Program to provide post-release behavioral health and housing services. For more information, see Ohio Ex-Offender Reentry Coalition, *2010 Annual Report,* available at http://www.reentrycoalition.ohio.gov/docs/Ohio Ex-Offender Reentry Coalition - Annual Report - 2010.pdf.

- In 2009, Wisconsin policymakers launched the pilot program Opening Avenues to Reentry Success (OARS). Administered by the Department of Corrections in collaboration with the Department of Health Services, OARS is a comprehensive reentry program for people with serious mental illnesses and co-occurring substance use disorders who are assessed to be at medium-to-high risk for reincarceration. The program seeks to promote self-sufficiency among its participants by providing evidence-based community reentry practices such as medication and substance abuse monitoring, motivational interviewing, cognitive behavioral therapy, and intensive case management. For more information, see Wisconsin Department of Health Services, "Opening Avenues to Reentry Success," available at http://www.dhs.wisconsin.gov/publications/P0/p00227.pdf.

(See glossary for definitions of the treatment terms.)

*This white paper focuses on people who have been in correctional facilities or are on probation or parole. This focus in no way diminishes the critical need for prevention and diversion efforts. Much has been written about the causes of the overrepresentation of people with behavioral health disorders in the criminal justice system and much more clearly needs to be done to appropriately stem their flow into corrections systems. This paper, however, addresses the systems as they are now—proposing a framework to complement ongoing diversion efforts by helping to improve outcomes for the many individuals already caught up in the justice system.

Why Now?

The need for this type of unifying framework could not be more pressing. Budgets are shrinking, demands for agency accountability are rising, and states and localities cannot afford to misdirect the resources that remain. Healthcare issues topping the national domestic policy agenda also contribute to the need for the framework. Healthcare reform may significantly help people involved in the criminal justice system access public health insurance and services in the community.* Any increased use of community substance abuse and mental health treatment services, although likely to improve the recovery trajectories for individuals, will require more coordination with corrections agencies charged with supervising case plans and conditions of release.

Even without the impetuses of a weakened economy, data-driven accountability trends, and healthcare reform, the scope of the problem is catalyst enough for creating a more efficient and effective approach to allocating corrections and behavioral health resources. Many adults on probation or parole have behavioral health disorders. A growing body of research also confirms that the majority of individuals in correctional facilities have behavioral health problems—mental health or substance use disorders, or both. The media has captured national attention for this problem, focusing on how jails in particular are becoming the largest institutional setting for people with serious mental illnesses (SMI)† in the country.[6]

- **Individuals with Mental Illnesses in Jails:** In a study of more than 20,000 adults booked into five U.S. jails, 14.5 percent of men and

> "While state substance abuse agencies have a long history of working to address the needs of individuals involved in the criminal justice system, we know that improved cross-agency coordination is critical in order to provide coordinated and effective services across the continuum for people with substance use disorders and mental illness. This conceptual framework is a tool for stakeholders to use as work is done to both ensure public safety and deliver cost-effective care."
>
> —**ROBERT MORRISON,** *Executive Director, National Association of State Alcohol and Drug Abuse Directors*‡

*The Patient Protection and Affordable Care Act (includes the expansion of Medicaid eligibility) and the Health Care and Education Reconciliation Act were signed into law in March 2010 and are known as the "health reform" law. In June 2012, the U.S. Supreme Court upheld the requirement that most Americans obtain insurance or pay a penalty, but rejected provisions penalizing states that choose not to participate in Medicaid expansion. For states that do decide to expand, the majority of individuals cycling through prisons and jails—many of whom have significant behavioral health needs but have not been eligible for Medicaid—will be able to enroll by virtue of their limited incomes. Experts have recognized that broadening Medicaid eligibility and improving access to treatment services will promote better public and individual health outcomes and are likely to reduce state expenditures (Sarah E. Wakeman, Margaret E. McKinney, and Josiah D. Rich, "Filling the Gap: The Importance of Medicaid Continuity for Former Inmates," *Journal of General Internal Medicine* 24, no. 7 [July 2009]: 860–862).

†SMI are mental disorders, other than a substance use disorder, meeting criteria of *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revised (DSM-IV-TR), lasting for at least a year, and related to a significant functional impairment. The American Psychiatric Association DSM-IV-TR is the diagnostic standard in the United States at the time of this writing for determining mental and substance use disorders. (See the glossary for the SAMHSA definition.)

‡Title and agency affiliations for all quotes reflect those at the time of project participation.

31 percent of women (taken together, 17 percent of those entering the facilities) met criteria for SMI*—prevalence rates at least three times higher than those found in the general population.[7]

- **Individuals with Mental Illnesses in Prisons:** In a U.S. Justice Department survey, 16 percent of state inmates were estimated to have a mental illness.[8 †]
- **Individuals with Mental Illness on Probation or Parole:** In U.S. Justice Department and SAMHSA surveys, 9 percent of individuals on probation and 7 percent of individuals on parole were estimated to have a serious mental illness.[9]
- **Adults with Substance Use Disorders in Jails:** Substance use disorders are even more prevalent than mental illnesses; in the year prior to their admission, 68 percent of jail inmates reported symptoms consistent with alcohol and/or drug use disorders.[10]
- **Adults with Substance Use Disorders in Prisons:** In a U.S. Department of Justice study, 53 percent of state prisoners and 46 percent of federal prisoners in the year prior to their arrest met the DSM-IV criteria for substance dependence or abuse. Sixty percent of women in state prison have been estimated to be dependent on or abusing drugs.[11]

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*There are four main reasons why these estimates may be lower than those reported by a particular county jail: 1) jail personnel classify mental illnesses primarily to ensure safety, and these classifications may differ from the diagnostic categories used by researchers or treatment providers; 2) these numbers are of individuals "booked" into jails and do not represent the prevalence in an average daily population; 3) a number of mental disorders that do not meet state and federal definitions of serious mental illness were excluded from this study, including anxiety disorders (e.g., PTSD); and 4) many people experience acute reactive psychiatric conditions, such as suicidal thinking, which pose significant jail management concerns but may not rise to the level of a serious mental illness as defined by the study.

These numbers also may differ from earlier federal government estimates because of varying methodologies. For example, a 1999 Bureau of Justice Statistics (BJS) survey of people in jails asked if they had either a "mental condition" or an overnight stay in a mental hospital during their lifetime—with 16.3 percent self-reporting that they met these criteria. In 2006, BJS again surveyed people in jails and asked if they had a "mental health problem," defined as any *symptom* of any mental illness (such as persistent anger or insomnia)—to which 64 percent reported that they met this criteria. (Additional explanations about the prevalence of mental illness among jail inmates are available in the Frequently Asked Questions about the CSG Justice Center-supported jail mental health study at http://consensusproject.org/jc_publications/frequently-asked-questions-about-new-study-of-serious-mental-illness-in-jails/Psy_S_FAQ.pdf.)

†As with the jail numbers cited above, the number of people with "mental illness" in prisons cited here may appear dramatically smaller than those defined as having "mental health problems" in other studies or reported by states. The 2006 BJS study estimated that 56 percent of state prisoners were found to have a "mental health problem," basing this finding on self-reported data on recent history and broad symptoms of mental health disorders instead of a formal diagnosis. (See Lauren E. Glaze and Doris J. James, *Mental Health Problems of Prison and Jail Inmates,* Washington, D.C.: Bureau of Justice Statistics, September 6, 2006.) The 1999 BJS study, using narrower criteria, estimated 16 percent of state prisoners were found to have a "mental illness." (See Paula Ditton, *Mental Health and Treatment of Inmates and Probationers,* Washington, D.C.: Bureau of Justice Statistics, 1999.)

The Lack of a Link between Behavioral Health Disorders and Violence or Other Crimes

Although this paper highlights the association between behavioral health disorders and criminal justice system involvement, readers should be mindful that the majority of people with mental illnesses are not violent and do not commit crimes.[12] Such misconceptions have led to stigmatization and barriers to supports and services.* These myths must be countered with available research that does not find such a link between mental illness and violence.[13] Research does suggest that some people under the influence of drugs and other substances are more likely to be violent—whether or not they have a mental illness.[14] Moreover, the nation's prisons and jails do hold large numbers of individuals convicted for nonviolent crimes of possession and distribution and for property crimes committed to support their addictions. It is also important to remember that some individuals who are arrested and incarcerated—including those with no mental illnesses—are all more likely to be violent than the general population.[15]

Traditionally, both criminal justice and behavioral health practitioners believed that mental illnesses are the direct cause of criminal justice involvement (e.g., the voices an individual hears tells him or her to commit a crime), and many local programs targeting people with behavioral disorders who have had encounters with police and other criminal justice officials were designed with this in mind.[16] There is also the belief that many individuals are involved in the criminal justice system because their behaviors associated with a mental health disorder bring them into contact with law enforcement for such low-level crimes as trespassing and disturbing the peace. Recent studies, however, have demonstrated that the relationship of mental illness to criminal activity is more nuanced and complex. Researchers looking at the relationship of mental illness and recidivism have found that changes in an individual's psychiatric symptoms do not necessarily relate to whether or not he or she is rearrested or revoked from community supervision.[17] This suggests that interventions to reduce recidivism among people with mental illnesses in the criminal justice system need to not only include traditional mental health treatment, but also incorporate new multifaceted strategies.

*The authors, however, in no way suggest that simply having a mental illness diminishes accountability for individuals' criminal acts.

- **Adults with Substance Use Disorders on Probation or Parole:*** In U.S. Department of Justice and SAMHSA surveys, 35 percent of parolees and 40 percent of probationers had drug or alcohol dependence or abuse "in the past year."[18]
- **Individuals with Both Disorders:** Studies suggest that the co-occurrence of mental health and substance use disorders is also common. In jails, of the approximately 17 percent with *serious* mental illness, an estimated 72 percent had a co-occurring substance use disorder.[19] Approximately 59 percent of state prisoners with mental illnesses had a co-occurring drug or alcohol problem.[20]

People with mental illnesses and co-occurring disorders tend to have greater difficulties under correctional supervision than those without mental illness—both behind bars and in the community. Research shows that they tend to stay incarcerated longer than individuals without behavioral health disorders with the same charges and sentences. For example, a national study of individuals with mental illnesses in state prisons found those individuals, controlled for sentence terms, served an

TABLE 1. Estimated Proportion of Adults with Mental Health, Substance Use, and Co-occurring Disorders in the U.S. Population and under Correctional Control and Supervision†

	General Public	State Prisons	Jails	Probation and Parole
Serious Mental Illness	5.4%[21]	16%[22]	17%[23]	7–9%[24]
Substance Use Disorders (Alcohol and Drugs) — Abuse and/or Dependence	16%[25]	53%[26]	68%[27]	35–40%[28]
Drug Abuse Only[29]	1.4%	17%	18%	N/A
Drug Dependence Only[30]	0.6%	36%	36%	N/A
A Co-occurring Substance Use Disorder When Serious Mental Illness Is Diagnosed‡	25%[31]	59%[32]	72%[33]	49%[34]

*There are estimates that are higher than the statistics cited in the text that refer to studies that measure "involvement" with drug or alcohol abuse rather than substance "abuse" or "dependence." The statistics highlighted in the text focus on the higher-need category of individuals. The attention to abuse and dependence parallels the emphasis of the reported mental health statistics on SMI and not on the broader group of individuals with mental health "problems."

†The numbers used in this table are estimates that come from a variety of sources. The studies cited are from different years, use different methodologies and definitions, and combine different data sets. The table is intended to give the reader a general sense of the prevalence rates of behavioral disorders in corrections populations and is not intended to be the definitive epidemiologic dataset.

‡Note that of those adults with serious mental illnesses, the percentages in this row reflect how many also have co-occurring substance use disorders.

average of 15 months longer than the prisoners without mental illnesses.[35] People with behavioral health needs may be more likely to have difficulty managing the stresses and expectations within corrections settings and incur disciplinary problems at higher rates than those without behavioral health issues.[36] Some may have difficulty understanding directions or controlling impulses while in custody as well. Probationers and parolees with mental illnesses and co-occurring disorders also are significantly more likely to have their probation or parole terms suspended or revoked.[37]

The Problem through Different Lenses

The implications of these findings for corrections facility administrators, individuals involved in the criminal justice system and their families, judges and court staff, probation and parole professionals, and behavioral healthcare providers are cause for serious thought:

Jail and Prison Officials

Access to needed mental health services by inmates is protected under the Eighth Amendment. Corrections facility administrators are required to identify the health needs of inmates, including mental health needs, and provide medication, treatment, and other supports.* Pretrial detainees,† as well as sentenced inmates, may draw on significant health and custodial resources. Corrections administrators are often not equipped with the kinds of in-house expertise, housing assignment options, and funds to provide the range of services that can be accessed in the community. As discussed earlier, because of inmates' comprehensive treatment and supervision needs and extended lengths of stay, the cost to incarcerate individuals with mental illnesses and co-occurring substance use disorders can be significantly greater and provide challenging management problems for administrators.

**Estelle v. Gamble* (429 U. S. 97, 104–105 [1976]) stated that the standard of deliberate indifference to serious medical needs of prisoners violates the Eighth Amendment. This standard is higher than mere negligence. It has since been interpreted by California courts (*Coleman v. Schwarzenegger* NO. CIV S-90-0520 LKK JFM P [ND Cal 2009]) to assert that treatment plans must be consistent with the standard of care in the community. Looking at the lower court ruling (*Ruiz v. Estelle,* 503 F. Supp. 1265, 1339 [S.D. Tex. 1980], p. 25), the court found that the minimum requirements for mental health services in correctional settings must include proper screening, timely access to appropriate levels of care, an adequate medical record system, proper administration of psychotropic medication, competent staff in sufficient numbers, and a basic suicide prevention program (see http://www.ca9.uscourts.gov/datastore/general/2009/08/04/Opinion%20&%20Order%20FINAL.pdf).

†Although many of the issues discussed in this paper can be applied to pretrial populations, the focus is on sentenced individuals. This framework is intended to help state agency administrators and service providers choose strategies within the behavioral health and criminal justice systems that improve post-conviction supervision and treatment of adults with behavioral health disorders. Implementing the framework is meant to primarily reduce recidivism. Its emphasis on screening and assessing all arrestees for behavioral disorders, however, has the added benefit of identifying all individuals who should receive interventions. Many pretrial detainees will ultimately be convicted and sentenced, and reentry planning should include treatment and supports identified through assessments. For those leaving criminal justice settings prior to adjudication, or who are not convicted, linkage to community-based service providers can also be made.

The Incarceration Costs for People with Mental Illnesses

The high prevalence rates of behavioral health disorders in the corrections population have associated costs that administrators need to consider. In addition to routine expenses,* these individuals often draw on resources to more intensely treat, medicate, manage, and prepare them for reentry. Because they stay in custody longer, frequently return, and have higher per diem costs, the cumulative effect on the corrections bottom line is significant. There are no national formulas for determining these costs; individual jails and prisons use different line items to catalog expenses, making comparisons difficult. Several examples can help to illustrate the point, however. In Connecticut, the overall annual per-inmate health cost is estimated at $4,780, while health costs at the corrections facility for inmates with serious mental illness were $12,000.[38] In Florida's Broward County Jail, the daily inmate cost is $78, but the cost rises to $125 per day for inmates with mental illness.[39] In Michigan, psychotropic drugs accounted for 41 percent of all prescriptions for the Department of Corrections.[40] Inmates with behavioral health needs often require additional resources because they are more likely to be involved in incidents that require extra management.[41] In the Iowa Department of Corrections, 76 percent of incident reports of violent acts, suicide attempts, illnesses, and injuries involve inmates with a mental illness.[42]

The Costs Related to Addressing Substance Abuse

The costs of substance abuse to families, communities, and the criminal justice system are well documented. In 2001, according to the most recent estimate available by the White House Office of National Drug Control Policy, the total societal costs of illegal drug use were $143 billion. Nearly two-thirds of these costs (62%) were related to the enforcement of drug laws and the effects of illegal drug use on criminal behavior, including $31 billion in public criminal justice costs, $30.1 billion in lost productivity due to incarceration, $24.6 billion in lost productivity due to crime careers, and $2.9 billion in other costs including property damage and victimization.[43] Research indicates that for most individuals involved in the criminal justice system that lack treatment, recidivism will likely remain high and the courts and correctional systems will likely continue to face increasing costs.[44]

Providing substance abuse treatment in community-based settings is more cost effective than incarcerated settings and has a greater impact on recidivism.[45] State-level research indicates that there is an economic return on investments in treatment services, with a particular reduction in criminal justice costs. For example, in California, a treatment investment of $209 million resulted in a savings to various state systems of $1.4 billion a year with the cost of avoided crime making up 90 percent of the savings.[46] An Oklahoma analysis found that sending 1,666 offenders to drug court rather than prison saved the state $47 million over four years.[47]

*See, for example, Christian Henrichson and Ruth Delaney, *The Price of Prisons: What Incarceration Costs Taxpayers*. New York: Vera Institute of Justice, 2012.

Sentenced Individuals with Behavioral Health Disorders and Their Families

Research has demonstrated that strategies targeting stronger relationships between corrections-involved individuals and their families correlate with better outcomes.[48] Individuals leaving corrections facilities expect that family members, above all others, will provide financial resources, housing, and emotional support on release; and families do, in fact, often provide that tangible and emotional support.[49] Likewise, formerly incarcerated individuals who are married are more likely to find employment after release, and those with children to whom they are closely attached enjoy better employment and substance use outcomes.[50] When sentenced, some individuals and their families are frustrated by the scarcity of alternatives to incarceration that provide appropriate treatment; by barriers to involvement when family members are incarcerated; and by the absence of continuity of care on release. These issues are particularly pronounced for women,* most of whom are mothers to minor children with whom they will reunify once released from incarceration.[51] How to support parental relationships with their children and their caregivers is an important consideration for criminal justice systems.†

Judges and Court Staff

Criminal courts process a high volume of individuals with behavioral health disorders. Judges, prosecutors, and defense attorneys find they need access to accurate information on clinical needs and treatment alternatives to efficiently assess a case, determine disposition options, and make informed decisions. With so many defendants exhibiting mental health and substance abuse symptoms, it is often difficult to ascertain the contribution of these disorders to the current charges and their impact on adhering to conditions of supervision and release. This information is critical to decision making. With insufficient community treatment and supervision options, jails and prisons are sometimes seen as more certain placements to ensure public safety. The revolving-door nature of so many individuals with behavioral health disorders cycling through the criminal justice system frustrates judges and their staffs and underscores the need for more effective diversion, supervision, and treatment strategies.[52]

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*For additional information about gender-specific approaches, please visit the National Resource Center for Justice Involved Women at http://cjinvolvedwomen.org/. The center is operated by the Center for Effective Public Policy and funded by the Bureau of Justice Assistance and National Institute of Corrections.

†See discussion in Jessica Nickel, Crystal Garland, and Leah Kane, *Children of Incarcerated Parents: An Action Plan for Federal Policymakers,* New York, NY: Council of State Governments Justice Center, 2009. Additional resources for working with children of incarcerated parents and families is available through Vera's Family Justice Program at http://www.vera.org/centers/family-justice-program and the Corporation for National and Community Service Resource Center at http://www.nationalserviceresources.org/mentoring-children-prisoners-initiative. For additional research, see Nancy G. La Vigne, Elizabeth Davies, and Diana Brazzell, *Broken Bonds: Understanding and Addressing the Needs of Children with Incarcerated Parents,* Washington, D.C.: Urban Institute Justice Policy Center, February 2008.

Probation and Parole Authorities and Officers

Community supervision professionals have traditionally been most concerned with individuals' compliance with their supervision and release conditions, which people with behavioral health disorders may find difficult to navigate, particularly those with significant impairments. Supervisees with mental health and/or substance use disorders have complex problems and may be unable to locate and pay for health services, make and keep appointments, tolerate the stress of meeting probation or release requirements, or comply with other demands. Failure to comply may result in incarceration. Probation and parole officers often have large workloads and limited resources on which to draw for treatment and services; in fact, a survey found that slightly less than 10 percent of supervisees participate in some type of substance abuse treatment service in community correctional programs.[53] In everyday practice, too few systems effectively focus limited supervision and treatment resources on higher-risk individuals, who tend to be less cooperative and motivated to comply with treatment demands than supervisees who are at a lower risk for committing a crime.[54]

Community Behavioral Health Service Providers

Community-based service providers struggle with how to address the needs of consumers with criminal justice involvement. Many communities have a sharp focus on the prevention of criminal justice involvement and diversion from incarceration for

Mental Health and Substance Abuse Budget Cuts

- According to NASMHPD, it is estimated that funding within control of the state mental health authorities in the 50 states was reduced by at least $3.49 billion between fiscal years 2009 and 2012. In 2011, 81 percent of the states participating in their annual survey reported budget reductions while experiencing increasing demand for community mental health and crisis services.[55]
- Funding for substance abuse services has suffered as well. On the federal level, funding for the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the cornerstone of the states' substance abuse prevention and treatment systems, has experienced declines: from fiscal year 2004 to 2008, the program was cut by more than $20 million.[56] It is estimated that the SAPT Block Grant would have to be increased by a minimum of $403.7 million in 2012 just to maintain services at 2004 levels.
- According to SAMHSA's National Survey on Drug Use and Health (NSDUH), approximately 23.1 million Americans ages 12 or older needed treatment for an alcohol or illicit drug problem in 2010, yet only 2.6 million received treatment that year.[57] For treatment programs with long waiting lists or limited slots, service providers are forced to make difficult decisions regarding who gets priority access.

those individuals with behavioral health problems who are not a public safety threat. Although this front-end work is critical, the approaches advanced in this paper center on adults with behavioral health needs who, despite these efforts, continue to flow into the criminal justice system and fall under correctional control and supervision.

Behavioral health professionals are concerned that criminal justice agencies refer the types of individuals for whom service providers have developed few effective interventions (such as for those who have personality disorders) and the expectations that treatment is sufficient to change their criminal behavior is unrealistic. Deep budget cuts also have sometimes led to staff reductions and a diminished capacity to offer services, including to those under correctional control or supervision.

Criminal Justice and Behavioral Health Systems' Competing Priorities

Criminal justice and behavioral health officials use different methods to prioritize their limited resources—and sometimes at cross-purposes. The foremost concern of criminal justice professionals is public safety, so their primary focus is on individuals who are likely to commit another crime. If an individual does not comply with his or her conditions of supervision or release, being revoked to jail or prison may be warranted. In contrast, behavioral healthcare administrators and providers target individuals whose disorders cause the greatest impairments or increase the risk of harm to themselves or others. Their principal goal is to stabilize a person within the community and advance individual recovery. Improving functioning and reducing hospital and emergency room use are key measures of their success. Although the two systems frequently serve the same population, their fundamentally different ways of allocating personnel and services result in corrections and behavioral health professionals sometimes disagreeing on which individuals should receive program placements. In addition, eligibility criteria for behavioral health services—often based on medical necessity—may not include individuals that corrections staffs believe are in need of treatment.

Even when administrators from both systems agree on which individuals to serve, there are likely to be differences over which interventions to employ. Both the criminal justice and behavioral health systems have their own set of evidence-based policies, practices, and programs (EBPs). Each field's EBPs may be unfamiliar to the other, and therefore their application to individuals with both behavioral health needs and a high risk for future criminal activity is not coordinated, undermining the effectiveness of both approaches.

The Need for a Framework for Coordinating Services across Systems

With these challenges in mind, the National Institute of Corrections (NIC) initiated the "Responding to Adults with Behavioral Health Needs under Correctional Supervision" project in 2010. The goals of the project have been to

1) convene forums for discussion among mental health, substance abuse, and corrections experts who understand the principles, models, policies, and practices related to what works in improving outcomes for corrections-involved people with behavioral health disorders and

2) synthesize the expert guidance from the three fields into a framework that helps system administrators, policymakers, and practitioners focus and prioritize their supervision and treatment resources in ways that produce the greatest public health and safety results.

This paper is the product of the expert forums and other BJA-supported efforts to obtain feedback from the corrections and behavioral health fields.

- Part I summarizes how the behavioral health and criminal justice systems currently respond to people with mental health and substance use disorders after determining their needs and risk for recidivism.
- Part II presents the framework that state and local agency administrators (and practitioners in their system) can use to determine how best to prioritize and allocate resources for adults under correctional supervision with behavioral health disorders. It is also of value to policymakers and practitioners interested in improving responses to this population.
- Part III raises future implementation issues.*

This paper is written in recognition of the current need for a strategic approach to address the overrepresentation of people with mental health and substance use disorders in the justice system, and the impact their treatment has on public safety and health. An underlying principle of this project—and at the heart of this white paper—is that many individuals with behavioral health disorders under correctional control have diverse and complicated needs, but with appropriate supervision and services are capable of recovery and ending their criminal justice involvement. The framework is meant to facilitate agency accountability, promote cross-systems coordination and collaboration, encourage individuals' recovery, and make communities safer for everyone.

*This white paper will be complemented by a summary of the framework and a list of frequently asked questions and their answers. As a follow-up to this project, the team hopes to provide additional information on screening and assessment strategies for criminogenic risk and substance use and mental health needs. A system planning document and research agenda are also being planned.

PART I:
Current Responses to Individuals with Mental Health and Substance Use Disorders and Corrections Involvement

PEOPLE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM have wide-ranging needs, particularly those with behavioral health problems. Individuals under correctional control and supervision also pose various levels of risk to the community (risk of committing a new crime and the dangerousness of that crime). Before introducing the proposed framework for multisystem coordination, it is important to highlight some of the principles that guide the work of mental health, substance abuse, and corrections professionals. This context should help readers appreciate that there is no "one size fits all" approach for advancing the recovery of diverse groups of individuals under correctional supervision with substance abuse or mental health disorders—or both—or reducing their likelihood of reoffending. Treatment, support, and supervision must be tailored to individuals' needs and risk levels.

Mental Health Treatment

Mental illnesses are characterized by the diagnosis of a specific illness or disorder, the duration of symptoms, and the associated disability (the degree to which the person's ability to perform activities of daily living is impaired). While diagnoses and duration are critical dimensions, it is the resultant disability, or functional impairment, that often determines both access to care within publicly funded programs and the types of needed interventions and supports. Some individuals may have disorders not associated with significant functional impairments, but which create challenges for corrections and program management, such as antisocial or borderline personality disorders in which relationships are destabilized by the individuals' hostile, impulsive, or eccentric behavior.*

Community-based treatment settings differ based on need. Individuals with low-level need for intervention and supports or who are otherwise stable are treated

*These disorders are listed on Axis II of the DSM-IV-TR multi-axial typology and are often referred to as "Axis II disorders." Although historically these have been considered enduring disorders, newer cognitive interventions have been shown to be effective in reducing inappropriate behaviors.

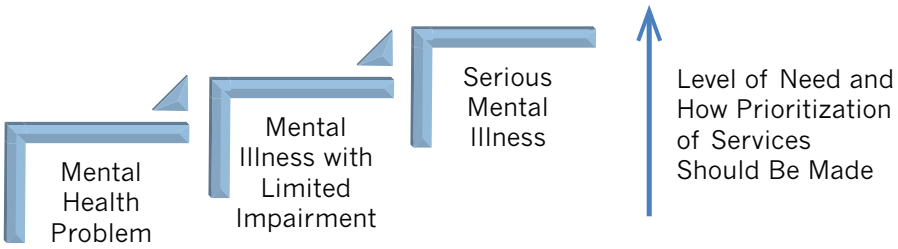
on an outpatient basis by a mental health professional or general practitioner, while people with more serious or acute need for treatment and stabilization may be treated at an in-patient facility. For most cases, the objective of in-patient care is to stabilize patients so they may continue their recovery in the community. Society's increased value on serving individuals in the least restrictive environment has led to greater emphasis on providing the appropriate level of supports for individuals to live in the community. Although individuals going through an acute crisis can receive care at a hospital emergency room (ER), mental health professionals seek to minimize inappropriate use of ERs because they are extremely costly and may reflect a breakdown in continuity of care.

Someone with a mental illness may access the treatment system through any setting. However, inability to pay for services, lack of awareness of symptoms, misinformation about treatment, and fear may delay or prevent an individual from getting diagnosed and treated. Moreover, access to treatment is primarily guided by ability to pay and the payment source. Employer-sponsored health insurance provides a pathway to a wide range of healthcare professionals. A privately insured individual may receive care regardless of level of impairment. In these cases, prioritization is not driven by need but by ability to pay. Individuals whose income or disability qualifies them for Medicaid benefits are limited to accessing providers that accept Medicaid (and new patients). The uninsured often have the most limited options and rely on the resources provided by targeted, special programs in the mental health safety net. Public health officials typically prioritize mental health dollars for people with serious mental illnesses by setting strict eligibility criteria for accessing publicly funded treatment services. However, even with this prioritization, the treatment capacity in any one jurisdiction rarely matches the demand.

The guiding principles for treatment include individualized treatment planning, consumer centeredness, cultural competency, the use of evidence-based practices, and the belief that recovery is possible.[58] SAMHSA has defined recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[59] While acute interventions for individuals with mental illnesses focus on ensuring the safety of the individuals and their community, recovery remains the ultimate intended outcome for service interventions. The assessment process can include the use of tools to help determine the appropriate level of care for individuals.[60] Other than overt threats to self or others, individuals' risk to public safety is not directly assessed in most mental health assessments. Accordingly, the risk for committing a future crime is not a factor used to prioritize treatment.

Figure 1 demonstrates a relationship that is somewhat intuitive: as individuals' level of functional impairment increases, so does their need for treatment and support. At the low-needs end of the spectrum are people with mental health problems whose symptoms do not meet the threshold for a clinical diagnosis of a mental illness. Individuals at the high end experience significant functional impairments as a result of their mental illness.

FIGURE 1. The Continuum of Mental Illness Impairment and Needs



Mental health professionals accept that recovery is not a linear process and people with SMI frequently experience relapses. Through a combination of therapies, medications, and social supports, most of these individuals will experience improved functioning. They may go through periods in which they decompensate and then improve—changing their level of impairment over time.

The mental health system already encounters individuals under correctional supervision because of the large number of U.S. citizens on probation or parole and their high rate of mental health problems and symptoms.[61] Individuals also enter correctional settings with a broad range of mental health needs—from slight to serious impairments. For example, more than one-third of inmates may have problems with sleep,[62] which may be a management issue while in custody but by itself does not constitute a "mental illness" under DSM-IV-TR criteria. The vast majority of individuals under correctional supervision will have significant trauma histories,[63] with a subset meeting the criteria for post-traumatic stress disorder that may require interventions.* When mental illness criteria are met and a diagnosis can be established, the condition still may not be associated with a significant disability. For example, an arrested person assessed with a generalized anxiety disorder might benefit from counseling and/or medication, but his or her symptoms may not interfere with completing routine tasks. Some of these individuals will exhibit behaviors or symptoms not associated with serious mental illness, yet pose significant jail or prison control and operational problems. They may not have been treated in the community because they were not prioritized in the public health system. At the high-needs end of the spectrum, individuals with SMI may have difficulties with activities of daily living, including maintaining their hygiene, complying with rules and adhering to routines, and concentrating and learning.† Treatment and requisite supports for individuals with significant impairments are likely to be initially intense and potentially long term, with recovery a slow process.

*Additional information on the importance of trauma-informed care related to the criminal justice system can be found in the National Institute of Corrections resource library at http://nicic.gov/Library/.

†State-specific definitions for "serious" or "serious and persistent" mental illness will determine eligibility for certain services in the public mental health system.

While it is logical that people with the highest impairment should be prioritized for treatment, in practice, this is not always a population who receives services. Some individuals do not want treatment behind bars or when on probation or parole, and some individuals cannot afford it when released to community supervision.* Some mental health practitioners are reluctant to work with individuals with histories of violence and felonious behavior even though their need for treatment may by high. For many of these individuals, their high level of treatment need is related to personality or co-occurring substance use disorders. Some mental health systems are not easily accessed by people who fall into these latter categories of need and may lack trained clinicians with the skills to effectively change their destructive behaviors. Working with these individuals requires training in cognitive behavioral interventions as well as crisis management and de-escalation techniques. At times, it may not be appropriate to serve some individuals that pose the highest risk to public safety in traditional community mental health settings, although access to in-patient and residential care is limited in most communities.

Substance Abuse Treatment

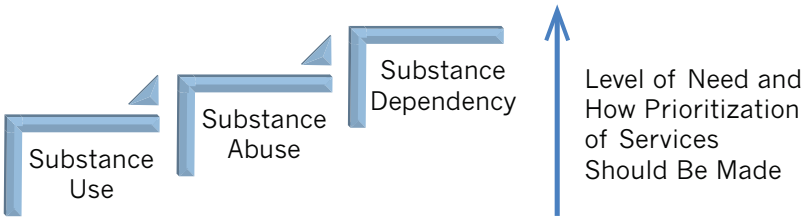
People with substance abuse disorders have varied treatment needs that can be identified along a continuum consistent with the severity of their disorder. Typically, treatment in the community focuses on individuals who are abusing or dependent on alcohol and other drugs. Individuals who use substances, but who are not abusing them or dependent on them, typically do not seek care and may not require formal treatment interventions. A SAMHSA report defines "substance use" as the use of alcohol or other drugs to socialize and feel their effects—use that may not appear abusive and may not lead to dependence.[64]

Determining whether an individual is abusing or dependent on a substance is of critical importance in prioritizing services for those most in need. Several of the criteria for substance abuse and dependence are the same, such as an inability to carry out daily activities, meet responsibilities, maintain education or employment, or avoid recurrent legal problems related to the substance use. Individuals are considered to be "dependent" if they have several of the previous problems and experience tolerance to drug effects, withdrawal, and an inability to reduce or control use.† Individuals have the greatest need for treatment when they are substance dependent and they experience

*Correctional supervision agencies can, however, often be useful in engaging people in treatment and may have resources to show individuals how to access care (e.g., some facilities have staff or partners to help inmates enroll for federal benefits as part of their reentry plan).

†The DSM-IV Criteria for Substance-Related Disorders can be found at http://www.ncbi.nlm.nih.gov/books/NBK26041/. Also see the glossary for other explanations of substance use and disorders. At the time of this white paper's publication, the DSM-IV criteria were being revised, which may result in changes to how substance use disorders are defined along the continuum. The release of the final, approved DSM-V is expected in May 2013.

FIGURE 2. The Continuum of Substance Use



problems with physical health, interpersonal and economic difficulties, and/or criminal behavior (see figure 2).

Individuals with substance use disorders can enter recovery and manage their diseases. A combination of strategies can help individuals achieve sobriety and address their addictions, including well-designed individual and group cognitive-based therapies provided by trained substance abuse treatment professionals, peer support, pharmaceutical interventions for alcohol and opiate addiction (medication-assisted therapies), and residential treatment. For many, relapse is common in the course of recovery; depending on the severity of a relapse, an individual may experience a loss of some or all skills and aptitudes previously gained.

There are a range of evidence-based practices (EBPs) for treating addiction, including behavioral therapy and medications. According to *Principles of Drug Addiction Treatment,*

> The specific type of treatment or combination of treatments will vary depending on the patient's individual needs and, often, on the types of drugs they use. The severity of addiction and previous efforts to stop using drugs can also influence a treatment approach . . . [P]eople who are addicted to drugs [also] often suffer from other health (including other mental health), occupational, legal, familial, and social problems that should be addressed concurrently.[65]

Access to substance abuse treatment is typically driven by whether the individual has a payment source. Lack of health coverage and inability to pay are cited as the main reasons individuals are unable to access treatment.[66] Other barriers include individuals' not being ready to stop using or believing they are able to handle their problems without treatment. Financing of substance abuse treatment services occurs through a patchwork of public and private sources.[67] Private health insurance constitutes an important but declining source of financing for treatment of substance abuse problems.[68] The majority of individuals seeking substance abuse treatment are dependent on publicly financed programs like Medicaid and the Substance Abuse Prevention and Treatment (SAPT)

block grant.* Under the current Medicaid program, states tend to offer limited coverage for substance abuse treatment,† and it is usually not available for childless adults with these disorders.[69]

Research confirms that clients who are assessed as having more severe substance use disorders do better when they receive more intense and protracted treatment.[70] Principles of substance abuse treatment include a recognition that services need to be readily available, that clients' remaining in treatment for an adequate period of time is critical, that treatment does not need to be voluntary to be effective, and that successful treatment attends to multiple needs of the individual, not just his or her drug abuse.[71]

> "Criminal justice and behavioral health practitioners must understand how to target the main drivers of recidivism—including drug dependence, which we know can be effectively addressed through treatment. Dependence (i.e., addiction) to hard drugs is where the research demonstrates a high correlation with recidivism. Practitioners need tools like this [paper's] framework to help them make effective, evidence-based programming and supervision decisions."
>
> —**FAYE TAXMAN,** *University Professor in Criminology, Law and Society and Director of the Center for Advancing Correctional Excellence, George Mason University*

In general, a clinical assessment is performed when an individual enters into a treatment program. According to SAMHSA, a basic assessment consists of gathering key information and engaging in a process with the client that enables the counselor to understand the client's readiness for change and to identify problem areas, diagnoses, disabilities, and strengths.[72] There are tools that can facilitate this process,‡ including those that use set criteria to provide guidance for substance abuse counselors and other treatment staff in determining the best "match" between client characteristics and several levels of treatment services such as residential, intensive outpatient, or outpatient.[73]

For individuals with substance use disorders in the criminal justice system, research has generally found that some interventions alter their behavior such as those that include cognitive behavioral therapy or therapeutic communities that last at least 90 days, employ drug testing, offer a continuum of care, use

*Each year, Congress appropriates funds for states to use in treating substance abuse under this grant. The Center for Substance Abuse Treatment (CSAT) administers the block grant, which totaled $1.7 billion in 2009. According to CSAT, funds from the SAPT block grant went to support nearly 10,000 community-based treatment and prevention service providers in all 50 states, each U.S. territory, the District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota every year. Approximately 40 percent of the public funds spent on treatment and prevention in the states come from this grant. (See National Association of State Alcohol and Drug Abuse Directors, "Fact Sheet: Substance Abuse Prevention and Treatment (SAPT) Block Grant," June 2009.)

†Under federal guidelines, states are required to provide only a limited amount of mental health services and can provide most substance abuse treatment services under Medicaid at their discretion. See Anna Scanlon, *State Spending on Substance Abuse Treatment* (Washington, DC: National Council of State Legislatures, December 2002).

‡ An approach that has been developed to assist in triage and placement decisions for substance abuse treatment services is the revised version of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC-2R) for the Treatment of Substance-Related Disorders, Second Edition, Revised (ASAM 2001).

incentives and sanctions to address compliance issues, and target individuals at higher risk for criminal activity.[74] In many criminal justice settings, referrals to substance abuse treatment are not driven by clinical assessment but instead by plea-bargain decisions, drug-related charges, or positive drug tests. In these instances, prioritizing treatment for those who are dependent rather than abusing drugs and alcohol usually does not occur. A drug-related arrest or positive drug test does not directly correlate to addiction to a substance or the need for higher-intensity services and is not the best criterion for program participation. Having people with less problematic drug abuse disorders in residential treatment beds, for example, is not an effective use of these scarce treatment resources and is not considered good clinical care. Matching the person's need for treatment to the appropriate intervention is particularly important in jurisdictions where there may be low-level diversion programs and higher-intensity probation-based treatment programs and drug courts. With some substance abuse treatment providers receiving the majority of their referrals from the criminal justice system, they are more familiar with the needs of the population than mental health care providers and may have specific training on how to address criminogenic needs.

Mental Health and Substance Use Appearing Together

Among the general public, the co-occurrence of mental health and substance use disorders is not a random event. Individuals with substance use disorders are more likely to have a mental illness than those without a substance use disorder, and individuals with mental illnesses are more likely to have a substance use disorder than those without a mental illness.*

Individuals with co-occurring disorders can enter the behavioral health system for services that address either their mental illness or substance use disorder. In the community, mental health and substance abuse treatment providers have tried to develop a no-wrong-door approach for accessing behavioral health care. Individuals with mental health and substance abuse needs can ideally be screened, assessed, and referred for treatment in either system. However, access to treatment is again driven by medical necessity and payment source, and prioritization for particular services may not be driven by need.

Among the principles of care that govern work with individuals with co-occurring disorders are that, within the treatment context, both co-occurring disorders are considered primary; empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes; and a coordinated system of mental health and

*One such study found that individuals with schizophrenia were more than four times more likely to have had a substance use disorder during their lifetime than individuals without schizophrenia, and those with bipolar disorder were more than five times as likely to have had such a diagnosis. (See Darrel A. Regier, Mary E. Farmer, Donald S. Rae, Ben Z. Locke, Samuel J. Keith, Lewis L. Judd, and Frederick K. Goodwin, "Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse," *Journal of the American Medical Association* 264, no. 19 (1990): 2511–2518.)

addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.[75] Although integrated treatment is a demonstrated EBP for individuals with serious mental illnesses and co-occurring substance use disorders,[76] the availability of integrated services remains limited in most communities.[77] As such, individuals with co-occurring disorders may not get access to interventions associated with positive outcomes—both in terms of their recovery and public safety.

Because having co-occurring disorders is associated with increased criminal justice contact,[78] it is not surprising that the rates of co-occurring disorders in jails and prisons are high. Therefore, at booking and throughout criminal justice processing, personnel can use evidence-based screening and assessment practices to identify the possible contribution of both mental illness and substance use to disorders in mood, thinking, and behavior associated with criminal conduct. The presence of co-occurring disorders has a significant impact on treatment interventions in which effective responses require integration and coordination between mental health and addiction systems.

Corrections: Custody, Control, and Supervision

Corrections officials often conduct assessments both for custodial classifications and for treatment and programming. It is important to distinguish between these uses. Custody and security placement decisions are often determined by an assessment of individuals' level of institutional risk (escape risk, gang affiliations, and other day-to-day management concerns), which directs inmates' facility placement, security level, and work assignments during incarceration. While these concerns are essential to operating safe and secure facilities, it is also critically important that prisons and jails use objective assessments to determine placement in programs that can affect individuals' criminogenic risk—that is, likelihood of reoffending. The same holds true in using assessments for assigning people to community supervision.

Institutional officials have understandably focused on the important functions related to the safe management of inmates. However, as the science of risk assessment has become more widely accepted, officials have recognized the need to broaden their practices. This represents a major cultural and systems change that many institutions are still in the early stages of addressing. Not all correctional facility authorities at present effectively screen for risk or need, in part because of problems associated with choosing, tailoring, and applying instruments. Those that do use screening and assessment tools sometimes lack resources or guidance on how to ensure that personnel use the results consistently to identify and prioritize people for their programs. Inmates also may simply refuse treatment, complicating the prioritization process, or they may sign up for substance abuse or other treatment programs (independent of need) to reduce time served when that option is available. Taken together, these factors may result in individuals participating in programming who are not at the greatest risk for committing future crimes.

Motivation or readiness is important for individuals' success but may not be the best factor for determining program participation in prisons and jails. Unlike the constitutional protections that assure inmates have access to medical care, including mental health treatment and the management of substance withdrawal syndromes, individuals do not have the right to access all types of substance abuse treatment or the types of criminogenic risk-focused cognitive behavioral treatment programs that may be offered in a prison or jail. In facilities and in the community, access to these programs must be triaged. When there is an absence of clear eligibility and priority criteria, sometimes more highly motivated individuals in low-risk/low-need categories take up valuable cognitive behavioral treatment slots and mix with high-risk individuals. Current research clearly shows that not only does this increase the likelihood of low-risk individuals reoffending, it lowers the overall effectiveness of the program for higher-risk individuals.[79] Using motivation as a filter for program participation is particularly problematic because the least motivated may pose a greater threat to public safety (moreover, there are interventions that can improve their motivational state).

Sometimes courts or parole boards assign individuals to supervision and community-based services according to crime categories (e.g., violent, nonviolent, or drug-related) and not objective assessments of a person's risk of reoffending. Without the benefit of assessment information, this can result in lower-risk individuals being assigned to scarce cognitive skills training programs, such as anger management. Not only do they take up valuable treatment slots, but their likelihood of recidivating is also not reduced.

Current research points toward the "Risk-Need-Responsivity" (RNR) model for how corrections authorities should be identifying and prioritizing individuals to receive appropriate interventions.[80] It has been found to be effective across settings (probation, parole, and prisons and jails) and offender populations (including individuals of diverse age, race/ethnicity, and gender).[81] Although focused on the risk of reoffending, its approach also is instructive in connecting behavioral health needs to criminogenic risk. Because the RNR model is a foundation for the proposed framework that follows for coordinating and prioritizing corrections and mental health and substance use resources, it is important to understand its underlying principles.

Risk Principle: Match the intensity of individuals' treatment to their level of risk for reoffending.*

> Research shows that prioritizing supervision resources for individuals at moderate or high criminogenic risk can lead to a significant reduction in recidivism among this group. Conversely, intensive supervision interventions alone for individuals who are at a low risk of recidivism will do little to actually change the person's likelihood of committing future criminal acts, and may even be

*Some risk assessment instruments go beyond determining risks for reoffending and also try to ascertain the risks associated with technical violations of probation or parole that can lead to reincarceration (recidivism measures). There are also specialized risk assessment tools that have been developed to determine specific areas of risk, such as violent behavior and sexual offending behavior. These risk tools may be used in addition to assessing the risk of reoffending, but no risk tool exists that can predict the behavior of a specific individual.

harmful.* High-intensity programming or supervision for low-risk people is an ineffective use of resources to reduce reoffending.[82]

Need Principle: Target criminogenic needs—those dynamic factors that contribute to the likelihood of reoffending.

The need principle states that individuals have criminogenic and noncriminogenic needs, and that treatment and case planning should prioritize the core criminogenic needs that can be changed through treatment, supervision, or other services and supports. Research indicates that the greater the number of criminogenic needs addressed through interventions, the greater impact the interventions will have on the likelihood of recidivism.[83] The available data indicate that if there is a response to just one of the individual's criminogenic needs, recidivism can be lowered. If there is a response to at least three of the individual's criminogenic needs, recidivism can be lowered substantially.[84]

Responsivity Principle: Address individuals' barriers to learning in the design of treatment interventions.[85]

The responsivity principle highlights the importance of reducing barriers to learning by addressing learning styles, reading abilities, cognitive impairments, and motivation when designing supervision and service strategies.[86] It can also apply to appropriate programming depending on the severity of psychosocial functioning.[87] Accordingly, the presence of a mental illness, for example, may need to be addressed to accommodate individuals' level of processing so they can learn from service providers and comply with the conditions of their supervision or release.

There are two types of responsivity—general and specific:

The general responsivity principle refers to the need for interventions that help individuals address dynamic criminogenic risk factors such as antisocial thinking. Research shows that social learning approaches and cognitive behavioral therapies are generally effective in meeting a range of individuals' criminogenic needs, regardless of offender type. The use of prosocial modeling and skills development, teaching problem-solving skills, and using a greater degree of positive reinforcement than negative have all been shown to be effective and reflect this approach.[88]

Specific responsivity refers to the principle that distinct personal needs may need to be addressed to ready an individual for receiving interventions that

*How is this possible? Low-risk individuals that are placed in a close supervision-only program may be more likely to be sanctioned for a violation of the terms of their supervision, especially if placed with high-risk individuals who encourage antisocial behavior. Some close supervision programs' reporting requirements are difficult for individuals to comply with absent adequate treatment and supports. The reporting and compliance requirements may disrupt the very activities in supervisees' lives most likely to reduce recidivism. (See discussion in Clement, Schwarzfeld, and Thompson, *The National Summit*.)

can reduce reoffending behaviors and revocations from probation and parole. It is a "fine-tuning" of the cognitive behavioral intervention. It assesses the strengths, personality, learning style and capacity, motivation, bio-social (gender, culture, ethnicity) characteristics,[89] and behavioral health needs of the individual.

Criminogenic risk factors are categorized as either "static" or "dynamic."[90] Static risk factors are those that are unalterable, such as an individual's demographics and age at first arrest. Dynamic risk factors are those that can change over time and are amenable to interventions. Researchers have identified the "central eight" dynamic risk factors that place a person at risk for future criminal behavior and have found the first "big four" must be effectively addressed before a focus on the remaining factors will show positive outcomes* (see table 2).[91]

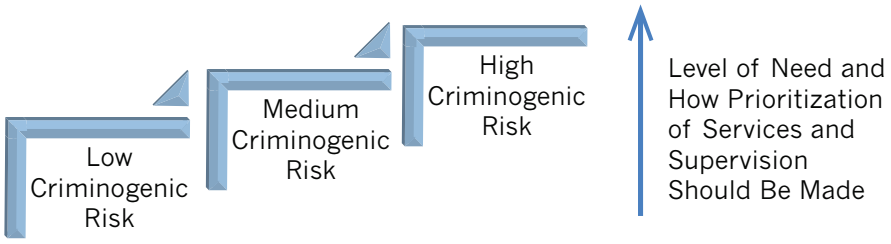
TABLE 2. Major Risk/Need Factors Associated with Committing Future Crimes (Criminogenic Risk)

Risk Factor	Description
1. Presence of Antisocial Behavior	Early and continuing involvement in a number and variety of antisocial acts in a variety of settings
2. Antisocial Personality Pattern	Adventurous, pleasure-seeking, weak self-control, restlessly aggressive
3. Antisocial Cognition	Attitudes, values, beliefs, and rationalizations supportive of crime; displays of anger, resentment, and defiance; and negative attitudes toward the law and justice systems
4. Antisocial Associates	Close association with criminals and relative isolation from law-abiding individuals; positive and immediate reinforcement for criminal behavior
5. Family and/or Marital	Poor relationship quality with little mutual caring or respect; poor nurturance and caring for children; and few expectations that family members will avoid criminal behavior
6. School and/or Work	Poor interpersonal relationships within school or work setting. Low levels of performance and satisfaction in school and/or work
7. Leisure and/or Recreation	Low levels of involvement and satisfactions in anticriminal leisure pursuits
8. Substance Abuse	Abuse of alcohol and/or other drugs (tobacco excluded)

Source: This table was adapted from Andrews, D. A., James Bonta, and Robert D. Hoge, "Classification for Effective Rehabilitation: Rediscovering Psychology," *Criminal Justice and Behavior* 17, no. 1 (1990): 19–52.

*Feedback for this paper revealed that some substance abuse experts believe that there is a degree of overlap in the "big four" and that substance abuse disorders play a larger role among those who are dependent.

FIGURE 3. The Continuum of Criminogenic Risk*



When prioritizing individuals for scarce correctional facility programming and treatment resources, priority should be given to those at higher risk for recidivism, which is determined by a composite score of their static and dynamic risk factors. The same holds true for individuals returning to the community or who are on probation or parole for receiving treatment and supervision resources.[92] As an individual's criminogenic risk increases, his or her need for more intensive supervision and services in the community to address those risk factors also increases (see figure 3). As stated above, research suggests providing low-risk offenders with intensive supervision or mixing them in groups with high-risk offenders can actually increase their level of risk for reoffending.

In the correctional facility, using risk level as a factor in determining program participation helps ensure that those at greatest risk of recidivism receive appropriate intervention prior to their release and limits the mixing of higher- and lower-risk individuals in the treatment programs. Once an individual is released into the community, there should be continuity of services. Adjusting workload size and intensity of supervision by level of risk allows community corrections officers to provide the correct type and concentration of treatment and oversight response in the correct setting.

Treatment and supervision services that address criminogenic risk and need are designed to improve an individual's problem-solving skills, reduce his or her criminal thinking, and help limit his or her interactions with antisocial peers. Coordinating supervision and treatment services is important; current research demonstrates that punishment and deterrence-driven approaches used in isolation have little or no impact. Pairing supervision with cognitive behavioral interventions that address dynamic criminogenic risk and need can significantly reduce recidivism rates.[93]

*There will be some individuals in the highest risk category that will not leave correctional settings (sentenced to life imprisonment or death). Individuals who remain incarcerated will continue to receive constitutionally mandated health care and services that promote safety in the facility, but they will not be prioritized for services that are meant to deter recidivism among individuals returning to the community.

Screening and Assessment

In order to identify individuals' needs that are associated with mental illness, substance abuse, and recidivism, corrections administrators need to ensure that personnel use evidence-based screening and assessment tools. Shortly after individuals' entry into the criminal justice system, and as needed thereafter, they should be screened for substance use, mental health disorders, and the potential presence of both by trained staff. For some individuals, being booked into a jail may provide the first opportunity to detect and diagnose a behavioral health disorder. Screening tools for substance abuse and mental illness are designed to quickly answer a "yes–no" question: Could the individual have a behavioral health disorder? Those who screen "positive" should be referred to a behavioral health professional for further assessment or a comprehensive evaluation. Clinicians use the assessment process to confirm the presence of disorders, identify problems, and recommend the appropriate type and level of services. Proper assessments require careful attention and adequate time to determine if medical conditions or substance use could account for abnormal mood, behavior, or thinking. The choice of screening and assessment instruments is guided by the nature of the population, costs, staff skills, and community resources.*

> "Offenders with behavioral health needs pose a significant challenge for correctional practitioners and it is important to remember that these individuals often have multiple barriers and risk factors that need to be addressed. Assessment is the engine that drives effective interventions and is the first step in designing programs that work."
>
> —**ED LATESSA,** *Professor and Director of the School of Criminal Justice, University of Cincinnati*

Criminogenic risk factors also should be identified at the earliest stage of criminal justice involvement, and individuals should be reassessed over time if dynamic factors may have changed. Pretrial and court services intake forms, with appropriate information-sharing agreements, can complement the screening and assessment processes within jails and prisons. These types of collateral documents provide information that can be essential to determining risk of reoffense and revocation, as well as treatment and social service needs.[94] Information from all sources can then be used to help guide the development of community supervision strategies and case management plans that maximize the use of limited resources.

Determining which screening and assessment tools are the most appropriate to use and how they should be applied will depend largely on the population for which risk and need are being assessed. There are a number of established risk/need assessment instruments that have been validated for specific corrections settings. Staff must be trained on the correct administration and scoring of the instruments, as well as on

*Additional information on available screening and assessment instruments for mental illness and substance use disorders can be found in Roger H. Peters, Marla G. Bartoi, and Pattie B. Sherman, *Screening and Assessment of Co-Occurring Disorders in the Justice System* (Delmar, NY: CMHS National GAINS Center, 2008).

their consistent use in guiding decision making. Administrators should appreciate that modifying existing tools for their population can impact the tools' validity and reliability.* As an alternative, corrections department administrators can develop and validate customized screening and assessment instruments for their own population and available resources, but this can be a labor-intensive process.

The Relationship between Behavioral Health Needs and Criminogenic Risk/Need: Assembling the Parts

To better prioritize scarce treatment and supervision resources, corrections and behavioral health administrators need to understand how identified mental health and/or substance use needs relate to criminogenic risk.

Mental Illness as a Responsivity Factor

Even though mental illness is not a central criminogenic risk factor and by itself is not a strong predictor of criminal behavior, research shows that individuals with SMI in the criminal justice system have more of the central eight dynamic risk factors than individuals without SMI in the criminal justice system.

In contrast, substance use disorders are a major criminogenic need and add significantly to the risk of future criminal justice involvement. The fact that people with SMI have high rates of co-occurring substance use disorders contributes to their relatively higher risk scores.[95]

Mental illnesses often cause functional impairments that may significantly affect an individual's responsivity to interventions targeting criminogenic risk factors. For example, a person with a major depressive disorder may not benefit from participating in treatment to reduce antisocial thinking until the symptoms of depression—hopelessness, lack of energy, and poor concentration—are addressed. Even though depression is considered a noncriminogenic need, case planners must be aware of symptoms or disorders that may impede the individual's ability to adopt new skills. Because the majority of individuals under correctional control have extensive trauma histories, it is also necessary to incorporate trauma-informed principles in developing interventions.[96] A case plan should address the "responsivity issues" that create barriers to successful program participation. However, targeting noncriminogenic needs should never supplant the focus on criminogenic needs.

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*For more information on validating an instrument, refer to Stephen D. Gottfredson and Laura J. Moriarty, "Statistic Risk Assessment: Old Problems and New Applications," *Crime and Delinquency* 52, no.1 (2006): 178–200; Christopher Baird, *A Question of Evidence: A Critique of Risk Assessment Models Used in the Justice System: Special Report (2009)* (Madison, WI: National Council on Crime and Delinquency, 2009); Edward Latessa, Paula Smith, Richard Lemke, Matthew Makarios, and Christopher Lowenkamp, *Creation and Validation of the Ohio Risk Assessment System Final Report* (Cincinnati, OH: University of Cincinnati, School of Criminal Justice, Center for Criminal Justice Research, July 2009).

Substance Use Disorders as Both a Criminogenic Risk and Responsivity Issue

Substance use disorders are a significant risk factor for criminal activity—both by their direct relationship to crime and risk, and indirectly by the negative effect of addiction on responsivity to interventions.[97] Many corrections-involved individuals with a substance use disorder also have antisocial attitudes, behaviors, and peers; lack employment; and have unstable relationships. The combination of these dynamic factors puts them at high risk for committing a criminal act or failing to meet the conditions of their supervision.

Individuals that are substance dependent have difficulty exerting self-control and compulsively seek and use drugs despite harmful consequences. These behavioral disorders often put the addicted individual in contact with antisocial associates, reduce their capacity for successful employment or education, and disrupt family relationships—all of which increase their risk for committing subsequent criminal offenses.

Substance abuse also has a significant impact on responsivity. Regular, ongoing abuse of alcohol, prescribed medications, and illegal drugs will produce enduring changes to brain chemistry and function. Brain imaging studies from drug-addicted individuals show physical changes in areas of the brain that are critical to judgment, decision making, learning, and behavior control.[98] These deficits must be accounted for in the design and delivery of treatment interventions and supervision.

Possession, distribution, and manufacturing of illicit substances are, of course, prosecutable offenses; however, from a criminal justice perspective, it is useful to distinguish people who have substance abuse disorders and were convicted of crimes principally related to their abuse or dependence from people who sell and distribute drugs but do not have substance abuse disorders. With the former group, drug-related offenses—such as committing theft to acquire money to buy drugs—are common.[99] For these individuals, substance abuse treatment that reduces or eliminates their drug dependency may effectively prevent them from committing future offenses. For those in the latter group who present a high criminogenic risk (for example, perhaps they display criminal thinking or have antisocial peers), interventions should focus on these risks. Of course, some individuals have both high treatment needs for substance abuse and are additionally at higher risk to reoffend based on their risk assessment score. It is this subset of individuals that particularly requires a collaborative treatment and supervision approach.

Closing Thoughts on RNR

The effects associated with adherence to RNR principles have been shown to generalize across gender,[100] ethnic, and age groups.[101] This research indicates that these demographic factors should not drive the intervention strategies and should not override RNR principles. Having a trauma-informed system of care, for example, is important in response to high rates of trauma in corrections populations, but trauma services cannot be considered primary interventions in lieu of RNR principles if reducing recidivism

is an objective. However, these characteristics (gender, ethnicity, and age) must be considered as specific responsivity factors to be accommodated in the development and provision of programs and services.[102]

With this section's background about the principles that guide mental health, substance abuse, and corrections professionals in identifying and prioritizing recipients for interventions, it is easy to see that a collaborative approach to focusing on a shared population and determining how resources will be allocated to them can be quite complex. The section that follows introduces a framework that reflects the principles from the various disciplines, applies the research on effective interventions, uses resources to their greatest effect, and encourages creative thinking about coordinated system responses.

PART II:
The Framework

TO REDUCE RECIDIVISM AND ADVANCE PUBLIC HEALTH AND INDIVIDUAL RECOVERY, state correctional and behavioral health administrators must know where their resources will have the greatest impact. They must identify who needs particular treatment and supervision services and when individuals would most benefit from this intervention and oversight. In other words, administrators should understand who to focus on, when to focus on them, and what to provide them that will address their distinct needs related to preventing future criminal activity. Administrators must develop systems to coordinate assessments and responses to this shared service population—including potentially developing new, truly integrated responses. The framework proposed in this white paper presents a different way of thinking about how administrators can help staff and providers from these divergent systems uniformly screen for, discuss, and subsequently prioritize and address the behavioral health and supervision needs of adults under correctional control.

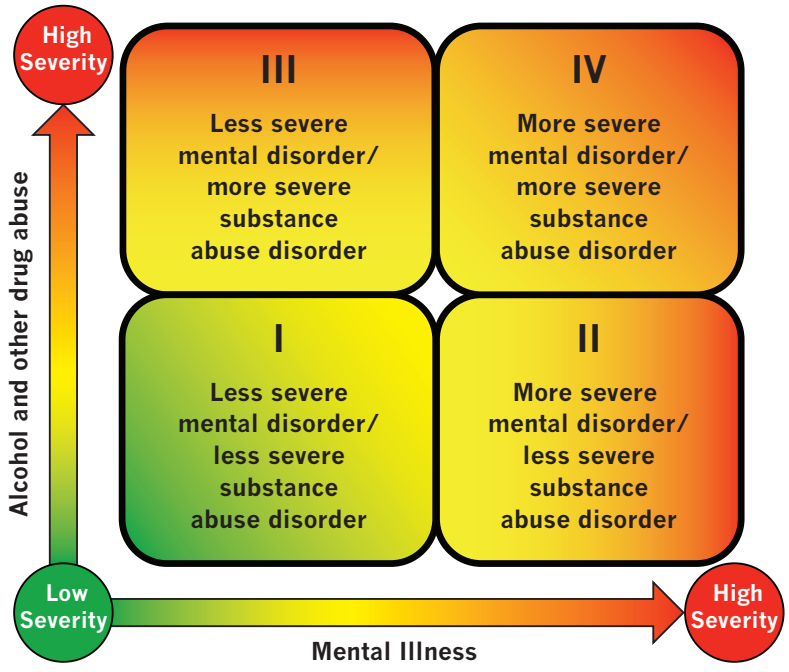
The Strong Foundations for the Framework

The proposed framework builds on several risk/need intervention models that are currently being used by different systems. The RNR model described in the previous section, for example, provides a theoretical approach to achieving positive public safety outcomes by addressing needs that are related to reoffending. It provides a rationale for focusing on those individuals who pose a higher risk for committing a future crime. The model was not designed, however, to provide direction on how to integrate other systems' goals, such as achieving positive public health outcomes. Too often, these goals are viewed as competing—a view reinforced by program approaches that do not address the underlying conditions that impede successful community integration. Individuals with both criminal justice and recovery needs may be forced to choose between attending a group treatment intervention or court appearance scheduled at the same time, or they may be unable to keep required community corrections appointments because of their behavioral health impairments.

The problems with multisystem integration are not unique to criminal justice and behavioral health collaborations. Even within the behavioral health arena, distinct systems have struggled to develop frameworks for collaborative service delivery. Although the treatment interventions for substance abuse and mental health conditions have far more in common than not, these fields historically worked in isolation from one another. There sometimes has been a "punting" of patients between the systems that reflects a failure to build on complementary treatment goals. Research has demonstrated that without concurrent attention to both sets of behavioral health issues, outcomes for individuals with co-occurring disorders are poor.[103] It is also clear that not all individuals with co-occurring disorders are alike in the severity of either their addictive disorder or mental illness. These differences are critical in deciding the appropriate setting and level of care.

In their landmark effort to create a unifying structure to address the needs of individuals with both mental illnesses and substance use disorders, the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors developed a model using mental illness and alcohol and other drug abuse severity dimensions (see figure 4).[104]

FIGURE 4. Co-occurring Disorders by Severity



Reprinted with permission.

The model highlights that the heterogeneity of individuals with co-occurring disorders is a critical factor in the development of appropriate individualized interventions and the identification of the relative roles of mental health and addiction providers. In a review of the model's utility, researchers concluded that the conceptual model has been a helpful planning tool and is in wide use across the country. The model "has informed program and policy discussions at federal, state, and local levels, both within the mental health and substance abuse communities and outside of them, in areas such as the primary healthcare and judicial systems."[105] Development of this framework created a common language to categorize the needs of individuals with co-occurring disorders, and established shared priorities between mental health and substance abuse treatment systems. The appropriate package of services for quadrant II, III, or IV individuals and the most appropriate settings for service delivery is an ongoing subject of discussion and the focus of research. Still, the mental illness and substance abuse (alcohol and drugs) dimensions of this model have been incorporated into the following proposed framework to help state administrators allocate resources and develop policies for individuals with behavioral disorders in contact with the corrections system.

Researchers also have developed tools and practice models in which criminogenic risk and need are used to guide criminal justice professionals in prioritizing and matching treatment services for individuals most likely to commit future crimes. For example, some judges and court officials use the Risk-and-Needs Triage (RANT™) tool to ensure individuals are matched to services and supervision levels based on their criminogenic risk and substance abuse treatment needs.[106] Using a 2-by-2 matrix defined by risks and needs, individuals are grouped into one of four quadrants that have direct implications for court dispositions and the appropriate type of behavioral healthcare treatment. Findings showed that high-risk and dependent individuals in treatment programs experienced more positive results,[107] with high-risk drug court participants twice as successful as low-risk participants.[108] In other models, offenders were also categorized so that the drug-dependent individuals were triaged for more intensive services, and this contributed to reductions in violations and rearrests.[109] These models demonstrate that a shared understanding of the needs of populations that are connected to different systems can improve collaborative opportunities, maximize the impact of expended resources, and promote better individual and programmatic outcomes.*

*Dr. Faye Taxman and colleagues at the Center for Advancing Correctional Excellence at George Mason University are currently piloting an RNR Simulation Tool. This decision-support tool uses the risk/need principles to identify the appropriate levels of control and treatment for individuals involved in the criminal justice system. Additionally, the tool has portals that allow local jurisdictions to assess their capacity to provide responsivity interventions and to rate their current programming. Development of the tool is funded by the U.S. Department of Justice, Bureau of Justice Assistance; the Agency for Health Quality Research; the Substance Abuse and Mental Health Services Administration; and the Public Welfare Foundation.

The Criminogenic Risk and Behavioral Health Needs Framework

To address the overlapping objectives of the corrections and behavioral health fields, a framework for integrated supervision and treatment is provided in figure 5. This figure looks at the three dimensions described throughout this paper: criminogenic risk, need for mental health treatment, and need for substance abuse treatment. The framework builds on the work previously done by the behavioral health field to parse out responsibility for how the mental health and substance abuse systems can collaboratively address the complex treatment needs of diverse groups of individuals with co-occurring disorders. Adding the third dimension of criminogenic risk is meant to help state agency administrators and all stakeholders understand the best service settings and coordinated treatment and supervision approaches to promote individual recovery while improving public safety outcomes. For the sake of simplicity and clarity, treatment needs and criminogenic risk are shown in figure 5 as dichotomous variables: either low or medium/high. In reality, they should be viewed as a continuum. The framework sorts individuals according to their level of risk on each of these three dimensions (i.e., criminogenic risk, mental health needs, and substance abuse needs). This sorting results in eight possible permutations of varying risk and need groupings.

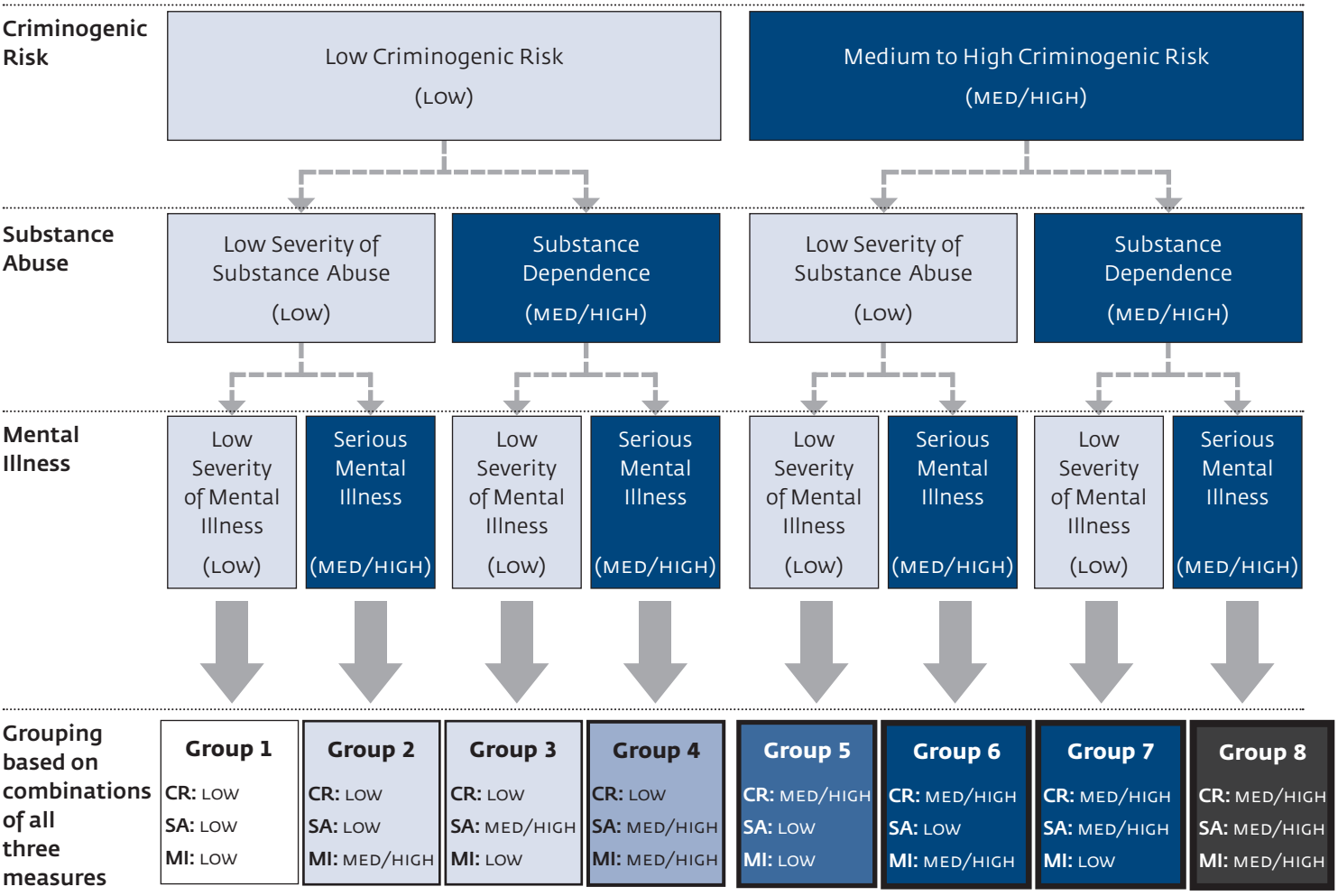
> "This framework is a must-read for state administrators of mental health, substance abuse, and corrections. This collaboration is critical to ensure people with mental health and substance use issues are served within the most appropriate settings."
>
> —**ROBERT GLOVER,** *Executive Director, National Association of State Mental Health Program Directors*

In using figure 5 as a way to think about collaboration and resource allocation among the three systems, note that the missed opportunities for diversion from the criminal justice system are most likely to happen along the left side (lower risk) of the flow chart. Administrators will see that combining groups through a downward action into eight categories presents an opportunity to categorize individuals and assign service resources to each of these groups, both in correctional facilities and in the community, which could include integrating traditional treatments/supervision or might even include treatment and supervision collaborations not currently being conducted.

The first sorting action in figure 5 occurs after assessing individuals for criminogenic risk. They are divided into low- and medium/high-risk groups.* The next sorting is to determine which individuals in those two groups have substance abuse service needs and their severity. The final sorting considers the presence and severity of mental health disorders, resulting in the eight groupings for which service resources can be considered.

*The very highest-risk population that will not be released to the community (such as individuals serving life sentences without possibility of parole and death row prisoners) are not represented in this flow chart. As discussed on page 24, these individuals will still receive the level of treatment that is constitutionally required for health care (including mental health care) and supports sound prison management.

FIGURE 5. Criminogenic Risk and Behavioral Health Needs Framework*



*It is important to remember that all individuals being grouped within the framework have been convicted of at least one crime.

It is important to note that the second sorting could have just as easily been made to determine mental health needs next. The framework places determining substance abuse needs as the second sort based on several factors: (1) substance abuse is one of the eight core criminogenic risk factors, and mental illness is not (because the entire framework is oriented toward reducing reoffending and reincarceration through better behavioral health interventions, it made sense to first sort for criminogenic risk); (2) substance use disorders are more prevalent than nonaddictive behavioral health disorders in corrections populations; and (3) sorting in this order parallels some of the labeling of the quadrants in the model created by NASHMPD and NASADAD (see page 30) and reveals how some of the foundations for this framework are assimilated.*

This criminogenic risk/behavioral health needs framework creates groupings that can facilitate tailored interventions to adults under correctional control and supervision. Consistent with the risk principle, it can serve as a roadmap to effectively

Defining the Groupings

The way in which system managers determine the categories to group individuals depends on what measures are used, the distribution of individuals with low and medium/high risk and need in the population being assessed, and the cut-off scores used for assignment. One challenge will be to operationalize the definitions for low, medium, and high risk and need and then establish benchmarks determined by valid screening and assessment measures. For example, administrators will need to determine what scores from assessment tests qualify someone as "low risk" and what scores place them in another category. If the resulting groupings do not adequately differentiate the population (for example, 95 percent qualify as "high risk"), then changes to cut-off scores may need to be made to further distinguish which individuals have the greatest risk and need factors.

Administrators will then need to be mindful of their supervision and treatment resources when prioritizing subgroups and individuals within subgroups. That is, if assessments determine that more individuals fall within a high-risk category with intensive supervision needs than there are available slots, a narrower slice of the subgroup may be addressed until capacity is increased. Alternatively, if the assessment process identifies fewer individuals with high risk/need than anticipated, the group selected for supervision or services can be extended into moderate risk/need levels. It is important to recognize that individuals at various stages of rehabilitation and recovery may move between these risk/need categories throughout their lives. Periodic reassessments and noted changes in impairment or risk level may require changes in how officials prioritize supervision and treatment services.

*In this framework, when the substance abuse and mental health needs are isolated, subgroups 1–4 correspond to the NASMHPD/NASADAD quadrants (and repeat for subgroups 5–8).

focus on higher-risk and higher-need populations to achieve the greatest impact on recidivism. Although research shows that to increase public safety, community supervision and treatment resources should be concentrated on individuals who pose the greatest likelihood of reoffending, current policies, programs, and practices in many states and localities do not properly identify and prioritize these high-risk individuals. Many jurisdictions also lack multidisciplinary approaches between substance abuse, mental health, and corrections authorities that would create efficiencies and accountability that may offer better outcomes for all.

> "We routinely ask criminal justice professionals to do more with screening, identification, and treatment of behavioral health conditions while individuals are incarcerated. Now we are looking to behavioral health administrators and providers to find new and better ways to help these individuals avoid involvement with the corrections system."
>
> —**LAURA NELSON,** *CSG Justice Center Board Member and Chief Medical Officer and Deputy Director, Arizona Department of Health Services' Division of Behavioral Health*

The framework does not suggest that individuals with low criminogenic risk should be ignored. Individuals with high mental health and/or substance abuse needs must have these needs addressed while in jail and prison as part of correctional health services. On probation or at reentry, these low-risk/high-need individuals should be linked to effective treatments for which they are eligible and that can be paid for by existing behavioral health financing mechanisms, such as Medicaid and other local, state, and federal funding sources. For individuals with low criminogenic risk and low behavioral health needs, interventions should be time-limited and targeted to specific goals.[110]

The proposed framework takes the three systems as they are but provides the opportunity for each to contribute resources that can prompt new ways of doing business and different types of collaborative supervision and care. It is meant to provide a way for administrators and practitioners from the corrections and behavioral health fields to better understand their overlapping populations and to make important decisions about who can be served with existing resources—or how to expand their capacity to better meet public health and safety goals. The framework recognizes the distinct nature of the corrections, substance abuse, and mental health service systems: no single supervision and treatment model works in all settings. How these systems finance their work, conduct planning, regulate providers and staff, license and contract, and evaluate supervision and treatment services varies widely among jurisdictions. Even with this variation in approaches and resources, the framework proposes a paradigm for system administrators and providers to discuss in common terms the complex individual risks and needs within their systems. Once trained professionals have screened and assessed individuals in their respective systems using validated

> "When you focus community supervision resources on low-risk individuals, you can destroy the protective factors that made them low risk in the first place by exposing them to high-risk individuals and by disrupting work and social supports through onerous supervision conditions."
>
> —**CARL WICKLUND,** *Executive Director, American Probation and Parole Association*

> "The framework should not merely perpetuate a more coordinated business-as-usual approach. This is a chance for all three systems—criminal justice, substance abuse, and mental health—to develop creative approaches for supervising and treating individuals in more effective ways."
>
> —**JENNIFER SKEEM,** *Professor, University of California-Irvine*

assessment instruments for their population, they can ascertain the approximate size of their shared service population and collaboratively prioritize individuals for treatment and supervision. Drawing on qualified service providers and corrections professionals, administrators can take a coordinated approach toward reducing recidivism and advancing recovery.

All responses crafted for particular subgroups in the framework should incorporate EBPs and promising approaches from all relevant fields. Interventions should be implemented with high fidelity to research-established program design. Although the framework provides broad outlines for interventions, the exact blend of supervision and treatment for each grouping, and for individuals within those groupings, will need to undergo extensive testing and additional research. Even when the precise combination can be established, some jurisdictions will still be challenged by the lack of resources for a full menu of evidence-based corrections and treatment responses, and clinical judgment will ultimately determine the appropriate mix of treatment and supervision for each individual.* The framework is meant simply as a starting point for administrators and practitioners to discuss the best use of their resources and to identify problems that they can begin to address together.

How the Framework Applies to Resource Allocation and Individual Case Responses

Consistent with RNR principles, individuals classified as high and medium criminogenic risk should be prioritized for more intensive treatment and control services. Doing so will ensure that scarce corrections resources will be used to their greatest effect on public safety outcomes. When high behavioral health needs are part of the risk/need grouping, they should be addressed to enable individuals to be responsive to interventions related to recidivism reduction.† Individuals with co-occurring substance abuse and mental health needs should receive coordinated and integrated interventions that will facilitate other programming to reduce criminal behaviors.

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*In some cases, regional or remote access to services may need to be used to supplement local resources, particularly when rural or low-resourced areas are responding to individuals with extensive needs.

†Research indicates that cognitive behavioral therapy also can reduce criminal attitudes associated with recidivism among individuals with serious mental illnesses. See A. E. Cullen, A. Y. Clarke, E. Kuipers, S. Hodgins, K. Dean, and T. Fahy, "A multi-site randomized controlled trial of a cognitive skills programme for male mentally disordered offenders: social–cognitive outcomes," *Psychological Medicine* 42 (2012), 557–569.

As stated above, when risk for reoffending has been assessed as low but mental health disorders exist, necessary treatment of those illnesses is required when the individual is held in a corrections facility.* However, individuals can go untreated because their needs have not been properly assessed or they refuse the treatment offered. On release, lower-risk individuals with behavioral health needs should be linked to appropriate community providers. With all behavioral health clients, preventing their involvement in the criminal justice system is inherent in the recovery goals of mental health and substance abuse treatment professionals. This outcome measure of behavioral health services (lowering rates of criminal justice contact) is often missing from the metrics used to evaluate service delivery.

Taking into account these goals and limitations, examples of where to potentially put resources and how to tailor responses to the framework's different risk/need categories are outlined below (beginning with groups that pose the greatest risk of future criminal activity). An estimate of the number of individuals within each category will assist system planners in determining supervision and treatment capacity. When gaps in service based on these estimates are identified, resources may be reallocated to address those gaps or new resources and options can be solicited. System-level responses for each category of individuals are provided below. In addition, there are case examples of supervision and treatment that are meant to be illustrative and do not reflect the full range of EBPs that can be applied to individualized case plans. They are simply meant to demonstrate to administrators, in more concrete terms, what types of individuals fall within the various categories and how their staff and service providers might also use the framework groupings to devise collaborative strategies to reduce recidivism and promote recovery.

High Criminogenic Risk with Some High Behavioral Health Treatment Needs†

Group 6	Group 7	Group 8
CR: MED/HIGH	**CR:** MED/HIGH	**CR:** MED/HIGH
SA: LOW	**SA:** MED/HIGH	**SA:** MED/HIGH
MI: MED/HIGH	**MI:** LOW	**MI:** MED/HIGH

System Responses: These subgroups make up a priority population that warrants significant corrections staff time and treatment resources. This focus requires corrections administrators to assess their current capacity and to likely shift existing resources. Within prison or jail they may require special programming. On probation or on their return to the community, scarce treatment (including cognitive behavioral therapy, or CBT) and housing funds controlled by corrections systems (such as transitional housing) should be prioritized for these individuals to reduce their chances for recidivism. They will require intensive community supervision, which can be used in lieu of incarceration or as a condition

*See footnote on page 7 for a discussion of the legal authorities governing correctional facility mental health care.

†The labels on these groupings are "CR" for criminogenic risk, "SA" for substance abuse, and "MI" for mental illness.

of release from jail or prison. This supervision might entail more attentiveness to risk-reduction interventions (such as greater use of motivational interviewing, ensuring greater access to CBT) and closer monitoring. These strategies may be applied when having more frequent check-ins, curfew checks, and monitoring than lower-risk individuals based on RNR principles.* Community supervision agency leaders will need to provide additional training on effective supervision and case management and may need to find incentives, evaluation measures, and other mechanisms to encourage officers to avoid revocations for technical violations related to behavioral health problems and to work with professionals from those systems to increase successful completion of supervision. At the same time, there must be an acknowledgment that officers who are focused intensely on higher-risk individuals may be more susceptible to burn-out and job dissatisfaction—higher-risk individuals, by classification, are typically more difficult to work with and have complex problems that can contribute to their likelihood of committing future crimes.

> "Because of budget cuts, some individuals are staying in jail for up to two years in some states. In other states, jail stays can be a few hours or days. With such variation, it is important to look at length of stay and not simply the setting—jail or prison—to determine how resources might be used. It is also important to consider that jails often have fewer resources to draw on."
>
> —**ROBERT MAY,** *Associate Director, Association of State Correctional Administrators*

Individuals in these groups have significant behavioral health needs that also must be addressed. This can be achieved through the application of evidence-based strategies to reduce substance use, improve functioning, and promote recovery. With the exception of reducing the possession of illegal substances, these interventions alone do not necessarily have a direct effect on recidivism. Nonetheless, they are necessary to improve the responsiveness of these individuals to other recidivism-reduction practices. A large population of group 8 individuals (the highest criminogenic risk and behavioral health need group) suggests the need for significant integrated treatment options—from residential to outpatient programs.

System administrators will need to ensure staff is oriented to and trained on RNR principles to formulate effective case plans. Some probation and parole agencies have developed specialized caseloads to help ensure that individuals with particular needs, such as behavioral health problems, can be given the attention they need by a

*For higher-risk groups, frequent reporting requirements with regular field visits are warranted. Surveillance programs, including electronic monitoring bracelets and global positioning system receivers, may be used. Swift responses to technical violations with graduated sanctions are employed. Incentives to comply with conditions of release are tailored to the probationer/parolee. For an example of how supervision can be linked to such activities as engaging the individual in the prosocial change process and in treatment programs that focus on building skills, see Faye S. Taxman, Christina Yancey, and Jeanne E. Bilanin, *Proactive Community Supervision in Maryland: Changing Offender Outcomes,* February 2006, available at http://www.dpscs.state.md.us/publicinfo/publications/pdfs/PCS_Evaluation_Feb06.pdf.

community supervision officer with experience and expertise in those areas.[111] Drug test results, medication adherence, attendance at treatment, and progress on target behaviors may be reviewed at each contact. Collaboration with community-based service providers is essential for specialized caseloads and may require the development of formal agreements and discussions about increasing particular community service capacity. Whether through specialized caseloads or more traditional staffing, an intensive focus on these higher-risk individuals will require shifting some resources away from supervising probationers and parolees who are at a much lower risk of reoffending. To achieve these goals, community supervision officials may need to significantly transform department policies and procedures.[112]

To better understand how the framework might be implemented by staff and community providers, consider the following examples of specific services for these high-risk/high-need groups:

- Enrollment in interventions targeting criminogenic risk and need: CBTs have been shown to reduce recidivism.[113]
- Special programming while in correctional facilities and intensive community supervision on release.
- For those with either substance dependence or serious mental illness, access to correctional health treatment resources while in jail or prison, and on release to reentry services provided through collaborations between corrections and either mental health or addiction community providers.
- For those with co-occurring mental health and addictive disorders, integrated service models while in jail or prison (e.g., modified therapeutic communities),* and upon reentry coordination of supervision and integrated co-occurring treatment consistent with treatment principles to address the needs of these individuals.[114]

Case Example: John is a 25-year-old male convicted of armed robbery and possession of heroin. He was homeless at the time of his arrest. He has a long criminal record with repeated drug-related arrests. At booking, screening revealed he may be suicidal, and subsequent assessments confirmed a bipolar disorder and opiate dependence. While in the community, he has been prescribed medications for his bipolar disorder in the past but has been inconsistent in using them. During this prison stay, he was detoxed from heroin and started on lithium for his bipolar disorder. He has very little contact with his family and states his only "friends" are those with whom he shares drugs. John's profile is consistent with a group 8 designation.

*See glossary for a definition of modified therapeutic communities.

Some of the interventions that John might receive include the following:

- John might participate in a modified therapeutic community, which is an intensive, long-term residential treatment program that has been modified for use with individuals who have drug abuse problems and mental health disorders. This modified version uses a more flexible, more personalized, and less intense program than traditional therapeutic communities* and targets reductions in substance use and recidivism.[115] This could be a program John starts while incarcerated and continues on an outpatient basis within a community setting upon release.
- Within the modified therapeutic setting, John could complete a program that integrates cognitive restructuring, social skill development, and problem solving to increase his awareness of self and others.
- Upon release, John could be assigned to a specialized parole caseload and directed to an assertive community treatment program, which involves intensive case management.[116] He would continue his medications and be involved in services and/or take additional prescription drugs to address his opiate dependency. A focus of treatment would be to improve his prosocial skills and connection with prosocial peers.
- The parole officer could receive weekly updates from John's case manager and could even be included in team meetings with the treatment staff.
- Incentives and sanctions could be developed to support abstinence, recovery, and compliance with conditions of release.

High Criminogenic Risk without Significant Behavioral Health Disorders

Group 5
CR: MED/HIGH
SA: LOW
MI: LOW

System Responses: This subgroup also requires close correctional supervision. Behind-the-bars programs may include addressing non-behavioral health criminogenic needs. Programming decisions take into account the need to change antisocial thinking and behaviors. On the individuals' return to the community, they may be subject to more frequent and intense monitoring. As with the other high-risk individuals, corrections administrators in both facilities and in the community may need to modify personnel training and supervision policies to align them more closely to RNR principles. To make the discussion more concrete, the following illustration includes several potential interventions for this group:

- High prioritization for enrollment in interventions targeting criminogenic needs, such as those that address antisocial attitudes and thinking.

*See glossary for definition of therapeutic communities.

- Lower prioritization for behavioral health treatment resources within jail and prison.
- Intensive monitoring and supervision.
- Participation in community-based programming providing cognitive restructuring and cognitive skills programming.
- Referrals made to community service providers on reentry as needed to address targeted low-level mental health/substance abuse treatment needs.

Case Example: Michael is a 31-year-old male who served several jail sentences in his early 20s for vandalism and lower-level property crimes. He was more recently convicted of disorderly conduct for his involvement in a fight while he was drunk. He was sent to jail for 30 days and given six months of probation. He uses alcohol occasionally and displays some symptoms of depression (but not those typically associated with enduring functional impairments). He is currently divorced (his third marriage) and has no contact with his two young sons. Michael dropped out of high school at age 16 and has never had steady employment outside of day labor pools. He is required as a condition of release to complete anger management and cognitive skills programming.

Some of the interventions that Michael might receive include the following:

- The small jail to which he is sent has very limited access to treatment resources. While incarcerated for this short time, Michael may receive information on counseling and self-help resources in the community.
- Michael is subject to six months on probation after his release, during which he must comply with all supervision requirements and complete the anger management and other programming that emphasizes self-control, problem-solving skills, and prosocial attitudes. He may also follow up on the information jail personnel gave him about a voluntary reentry program run by a faith-based group that can help with vocational training and job placement, and about a mental health clinic to assess and address his symptoms of depression.

Low Criminogenic Risk with Some High Behavioral Health Treatment Needs

Group 2	Group 3	Group 4
CR: LOW	**CR:** LOW	**CR:** LOW
SA: LOW	**SA:** MED/HIGH	**SA:** MED/HIGH
MI: MED/HIGH	**MI:** LOW	**MI:** MED/HIGH

System Responses: Individuals who can be screened into these subgroups should not require intensive community supervision resources on release if they are engaged in appropriate treatment and given adequate supports. Individuals with substance abuse disorders need to be given tailored interventions and testing with the goal of advancing recovery and reducing reincarceration.

Many of the individuals in groups 2, 3, and 4 are likely to avoid criminal justice involvement without intensive monitoring once in the community. They may have less frequent contact with supervising agencies and different support services. In fact, research suggests that the more closely they are monitored by corrections, the more likely they are to return to prison on a technical violation instead of integrating successfully back into the community—particularly given the propensity for behavioral health relapses or setbacks expected during recovery. And when supervision agencies place them in programming alongside individuals who pose a higher risk of criminal activity, they are more likely to pick up bad behaviors and antisocial thinking.

While in prison and jail, this population must be provided health care for their acute and chronic health conditions. Corrections administrators need to collect data that tracks the prevalence of mental health and/or addiction disorders in order to plan for, or contract for, the provision of health services while individuals with these needs are in custody. On release, however, corrections resources should be limited to linking these individuals to community service providers to ensure continuity of treatment. Outside the corrections facility, the level of care and types of treatment provided will conform to existing eligibility criteria and payment sources. For groups 2, 3, and 4, policies and procedures should reflect these types of resource allocation decisions:

- In accordance with RNR principles, fewer resources spent on intensive monitoring and supervision. This may involve less frequent face-to-face contacts between the community corrections officer and the supervisee.
- Greater investments in training, incentives, and evaluation mechanisms for officers to spend less time with these individuals and to promote behavioral health case management and services over revocations for technical violations and/or mental health- or substance abuse-related issues.
- Separation from high-risk populations for community programming when possible.
- For those with either substance dependence or a serious mental illness, access to correctional health treatment resources while in jail or prison. As part of reentry planning, corrections personnel facilitate connections to community treatment providers. This may entail creating memoranda of understanding or processes such as help with booking first appointments with community providers.
- For those with both mental health and addictive disorders, integrated service models while in jail or prison, and coordination of supervision and integrated treatment upon reentry consistent with co-occurring disorder treatment principles.[117] Co-occurring self-help groups (e.g., Dual Disorders Anonymous) can be held in facilities and the community.

Case Example: Susan is 55 years old and was convicted of simple assault of a spouse who had been abusive. They were both drinking at the time of the incident. She is additionally charged with DUI. She is sentenced to jail for 60 days, followed by a period

of probation conditioned on her completing an alcohol abuse treatment program. Risk assessments reveal that she has a large network of family and friends and has been successfully employed at the same manufacturing plant for the past 18 years. After undergoing a screening and assessment at a county jail, she was diagnosed with post-traumatic stress disorder (PTSD) and major affective disorder (depression). Her alcohol consumption had steadily increased over the past few years with significant tolerance, and she had withdrawal symptoms during custody. Susan's profile is consistent with a group 4 designation.

Some of the interventions that Susan might receive include the following:

- Susan will report to the community corrections agency for her one-year probation term.
- She will be required to use an alcohol ignition lock for her car.
- Medication management can help with Susan's symptoms of depression, and she can participate in group therapies to address her history of trauma.
- Susan's treatment for her alcohol dependence will include individual and group interventions integrated with her mental health care.
- Upon completion of her treatment programs, she can continue with participation in an independent self-help group and ongoing pharmacotherapy as needed.

Low Criminogenic Risk, Low Substance Abuse Treatment Need, Low Mental Health Treatment Need

Group 1
CR: LOW
SA: LOW
MI: LOW

System Responses: These individuals require the fewest supervision and behavioral health interventions. Any treatment should be time-limited and associated with particular goals. Shortening the length of time under supervision for these individuals can free up resources for those posing a higher public safety risk. These individuals may not meet medical necessity or program eligibility criteria for behavioral health care, but they may have health needs that can be addressed in primary care settings.

- Lowest priority for services and treatment programs.
- Low-intensity supervision and monitoring.
- When possible, separated from high-risk populations in correctional facility programming and/or when under community supervision programming.
- Referrals to behavioral health providers as the need arises to meet targeted treatment needs.

Case Example: Jim is a 44-year-old unemployed male who was convicted of forging checks. He is married, has two teenage children, and is active in his church. He tends to drink alcohol in the evenings to calm down but does not use drugs. He is distressed by his arrest and conviction, and he worries about paying his bills. His criminal activity was related to his recent inability to make mortgage payments and meet other financial obligations. He is remorseful for his criminal acts and has recently learned that he can return to work as a machinist with his former employer. Jim was released with time served and assigned to three years of probation with a restitution order.

Some of the interventions that Jim might receive include the following:

- Jim will have periodic visits with his probation officer for the term of his supervision.
- Jim may get assistance from local service groups to which he has been referred that provide supported employment (community-based services that can help Jim hold his job).
- He may use other supportive services, such as financial counseling.

Goals for the Use of the Framework

The scenarios presented above are meant to demonstrate how the framework can help state and local correctional administrators (institutional, probation, and parole) and state and community-based mental health and substance abuse agency leaders to plan and develop service responses that make efficient use of their scarce resources and perhaps build on evidence-based approaches by imagining new cross-agency responses. Although by itself the framework is not suitable for practitioners to use for clinical decision making, it is meant to facilitate clear and consistent communication among those committed to advancing the criminal justice and behavioral health systems.* It can help professionals in each system target the right individuals, promote responsible and effective practices, and better match system responses to service needs.

*It is also not meant to apply to youth in the juvenile justice system.

The framework can help professionals in the criminal justice and behavioral health systems in the following ways:

Advance collaboration and communication by

- developing a shared language around risk of criminal activity and public health needs;
- establishing common priorities between criminal justice and behavioral health systems for individuals who are likely to commit future crimes and have treatment needs;
- underscoring the need for information sharing across systems; and
- creating a common "starting point" and then facilitating cross-systems support for policies, practices, and decision making.

Ensure that scarce resources are used efficiently by

- promoting the use of validated assessment tools to gauge individuals' criminogenic risk and needs (i.e., those associated with the likelihood of committing a future crime) together with substance abuse and mental health needs;
- identifying the right people for the right interventions—those most likely to benefit from coordinated supervision and treatment strategies, and those that can do well with fewer interventions; and
- encouraging collaborative decision making among system leaders to determine how scarce treatment slots and intensive supervision services should be allocated to have the greatest impact, and then aligning and developing capacity to meet those needs.

Promote effective practices by

- matching individuals' risk and needs to programs and practices associated with research-based, positive outcomes;
- ensuring consistency of coordinated approaches while allowing for individualization of treatment and case management strategies; and
- refocusing reentry and other efforts for individuals leaving prisons and jails, or who are on probation or parole, to equip them with the necessary skills and competencies to become law-abiding, healthy members of communities and families.

PART III:
Operationalizing the Framework and Next Steps

THE CONCEPTUAL FRAMEWORK DESCRIBED IN THIS PAPER provides a starting point for ongoing dialogue between professionals in the corrections and behavioral health systems who seek to improve public safety and health outcomes for the populations that they share. The framework offers a rationale and an approach for making better decisions regarding the allocation of scarce resources. The concept assumes that, for the heterogeneous overlapping populations that each system serves, clarity about goals and responsibilities is of paramount importance. The framework was informed by expert advisors and has strong theoretical underpinnings that have been successfully applied in many communities. The field is ready to explore its value: applicants to an FY 2011 grant solicitation from the Bureau of Justice Assistance were "strongly urged to tailor treatment interventions to specific criminogenic risks and functional impairments of people with mental illnesses to improve public safety and public health outcomes."[118] Practical applications and subsequent adaptation will reveal the utility and potential of this approach.

An Example of a Criminogenic Risk-Integrated Program from the Field

The Office of Community Corrections within the Colorado Department of Public Safety's Division of Criminal Justice is the regulatory and oversight agency for a system of 36 residential facilities that supervise adults convicted of felony offenses assigned to community corrections across the state. Community corrections provides services for individuals convicted of less severe offenses who are diverted from prison, individuals in transition between prison and parole, and parolees released by the Colorado Board of Parole. In addition, they provide short-term stabilization services for individuals on probation and specialized treatment for justice-involved individuals with a history of substance abuse and mental illness. All individuals under community corrections supervision are screened and assessed at intake to measure their level of recidivism risk and criminogenic needs. The assessment process also detects and subsequently measures the severity of substance abuse and provides a treatment recommendation based on an individual's level of risk and the severity determination. Through assessment-driven individualized treatment plans, program staff attempts to match individuals' risks and needs with the most appropriate treatment modality.[119]

Individuals in the corrections system that have behavioral health disorders have multifaceted needs and require comprehensive and coordinated treatment and supervision interventions. Even when a correctional institution or community corrections agency has well-designed programs in place—including substance abuse treatment, mental health services, educational and vocational programs, cognitive behavioral skills programs, special needs services, and balanced supervision strategies—administrators still need to target the right individuals to improve the likelihood of success. And even when a behavioral health system has implemented a range of EBPs within their community systems for their clients with behavioral health disorders, they will still need to learn and implement effective strategies to address the criminogenic needs of their clients with criminal histories to promote recovery goals.

To operationalize the framework, a number of key issues and principles need to be addressed. Administrators from each system, their staff, and other stakeholders should meet to discuss how their way of doing business could change by implementing each dimension of the framework and the following considerations:

- Framework-inspired responses should continue to build on multidisciplinary initiatives, including those that involve diversion from further involvement in the criminal justice system, when appropriate. Law enforcement officers increasingly receive training on how to de-escalate crises at the scene and take individuals with behavioral disorders to settings other than jail.[120] Problem-solving courts, including mental health and drug courts, are geared up to identify behavioral health needs of defendants and enforce conditions of supervision that allow these individuals to stay in the community for their treatment and support rather than languish in jail.*,[121] Specialized probation teams can use community sanctions in lieu of incarceration to promote recovery while preserving public safety. System administrators should consider the utility of diversion programs when determining how best to serve their target populations, particularly those grouped with low-risk profiles on the left side of the framework.
- Screening and assessment processes must be carried out by trained individuals to detect behavioral health needs and measure criminogenic risks among individuals who are, or have been, under correctional control. Agency administrators will need to make sure that these processes are applied consistently and that the results are properly used to guide decision making regarding individuals' service programming, treatment, and supervision. Training about the interpretation of assessment results should be given to personnel in a position to make key release decisions, including judges and paroling authorities.

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*For more information on problem-solving courts, see Greg Berman and John Feinblatt, "Problem-Solving Courts: A Brief Primer," *Law and Policy* 23, no. 2 (2001): 125–140. For more information on mental health courts, see Michael Thompson, Fred C. Osher, and Denise Tomasini-Joshi, *Improving Responses to People with Mental Illness: The Essential Elements of a Mental Health Court,* New York, NY: Council of State Governments, 2008. For more information on drug courts, see The National Association of Drug Court Professionals and Drug Court Standards Committee, *Defining Drug Courts: The Key Components,* Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office, January 1997.

- Risk and need instruments must be validated and reliable. The resulting scores not only help identify individuals' service and supervision needs, but also assist administrators in correctional settings to triage resources. There are many commercial and public domain tools, each with their benefits and challenges. Some are validated only for particular settings and populations, so tailoring them can affect their effectiveness. Some agencies are considering developing and testing tools for their own specific use. Understanding which tools to use for which populations and then how to share and use the information to direct resources is a complicated set of tasks that administrators are already facing. The framework's emphasis on the application of these tools for existing resource allocation and new resource procurement makes their proper selection of a validated risk instrument that much more important.
- System administrators must establish mechanisms for sharing screening and assessment information that comply with all legal privacy mandates and promote efficiency.* Regulations must be fully understood by personnel from all systems. Too often, challenges to information sharing are created by misconceptions about what can be shared and under what circumstances. Effective protocols can clarify what information can be exchanged, used, or stored, but they may require formal agreements overseen by legal counsel. Sharing also can be greatly facilitated by

Information-Sharing Project

With BJA funding, the Association of State Correctional Administrators (ASCA) is piloting a project in three jurisdictions to highlight how programs and agencies involved in reentry initiatives can share accurate, timely, complete, and appropriately secured information with one another. ASCA's Reentry Information Sharing Initiative is working with the Rhode Island Department of Corrections, the Maryland Department of Public Safety and Correctional Services, and the Hampden County Sheriff's Department in Massachusetts to implement processes that can be used by the corrections community to exchange information with law enforcement, other public safety personnel, human/social services partners, and other community resource representatives that participate in the reentry process. ASCA is constructing these information-sharing models for corrections in collaboration with the American Probation and Parole Association (APPA), the IJIS Institute (formerly the Integrated Justice Information Systems Institute), and the National Consortium for Justice Information and Statistics (SEARCH). More information is available at http://www.asca.net/projects/13/pages/122.

*These need to be consistent with CFR 42 and HIPAA. See, for example, John Petrila, and Hallie Fader-Towe, *Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws,* New York, NY: Council of State Governments Justice Center, 2010.

having good informed-consent procedures across systems. The bottom line is that assessment information should follow an individual across systems and over time to conserve resources, facilitate treatment, and reduce recidivism.

- Leaders from all systems must maintain an inventory of resources and engage in joint decision making about the best ways to expand capacity for particular services and qualified providers in response to assessed needs in the populations they share. Agencies at all levels of government and community-based organizations constantly struggle with finding adequate resources to meet supervision and treatment demands. The framework is meant to help system administrators closely examine what is at hand, compare that to the risks and needs of groups of individuals, and determine which should be expanded or contracted. In some cases, regional or remote access to services may need to be used to supplement local resources. Greater integration of services across systems may also realize efficiencies and help ensure that there are enough qualified, accountable service providers to deliver evidence-based practices.
- System administrators must work with practitioners to develop clear policies and procedures for accessing and coordinating treatment—with the goal of establishing no-wrong-door approaches that reflect a new level of cohesive responses. Any changes to healthcare policies that affect insurance eligibility, benefit application processes, essential services, and provider networks must be considered to help ensure access to healthcare services for the vulnerable criminal justice population. The behavioral health and criminal justice workforce must be trained to apply effective interventions consistent with the principles associated with positive public health and safety outcomes. This will require a degree of collaboration and creativity that is difficult to achieve across systems. Researchers often talk about a continuum that moves from mere coordination to true integration.* The framework's full potential will likely be realized only when the appropriate degree of collaboration is applied to each of its distinct subgroups.
- Process and outcome data must be collected, analyzed, and used to improve programs. The framework will require that systems rethink how they measure success. For example, the behavioral health service system must count among its metrics whether a consumer, particularly an individual with past arrests, has avoided contact with the criminal justice system over the period of treatment or

*For more on integration principles, see, e.g., Charles G. Curie, Kenneth Minkoff, Gail P. Hutchings, and Christie A. Cline, "Strategic Implementation of Systems Change for Individuals with Mental Health and Substance Use Disorders," *Journal of Dual Diagnosis* 1, no. 4 (2005), 75–96. In reviewing procedures for creating seamless systems, researchers identified a series of service- and system-building components that are effective in ensuring integration: see Faye S. Taxman and Steven Belenko, *Implementing Evidence-Based Practices in Community Corrections and Addiction Treatment,* New York, NY: Springer, 2011. Also, see Bennett W. Fletcher, Wayne E.K. Lehman, Harry K. Wexler, Gerald Melnick, Faye S. Taxman, and Douglas W. Young, "Measuring Collaboration and Integration Activities in Criminal Justice and Substance Abuse Treatment Agencies," *Drug and Alcohol Dependence* 101, no.3 (2009) 191–201.

beyond. A probation or parole system, in contrast, should measure the number of successful referrals to community-based mental health and substance abuse treatment or reduced revocations among its probation or parole officers. Once established, these measures should yield data on processes (such as the numbers served) as well as outcomes (such as reincarceration, revocations, sustained employment, and other metrics) for recovery and public safety. When possible, a university or research team unaffiliated with the state or local agency should conduct the analyses to track progress.

- Further research will be needed to test the ways that criminogenic risk and behavioral health needs intersect and to more clearly articulate what works, for whom, in what dosage for each type of risk and need, and in what setting. Recommendations for specific treatment and supervision combinations for each member of a given subgroup are beyond the scope of the framework. Yet the framework does emphasize the need for effective responses to recognize the heterogeneity of any group of individuals and to tailor treatment and supervision plans to assessed strengths and needs. The framework has set out basic principles to guide plan development, but it cannot be used as a substitute for the care and judgment of the behavioral health and corrections workforce.

Many of these challenges are not new. Rather, the framework sharpens the focus on which practices and policies need to be tested and for what purposes. Achieving the vision of improved outcomes through the effective use of scarce resources will require leadership at the federal, state, and local levels. At the federal level, the National Institute of Corrections, the Bureau of Justice Assistance, and the Substance Abuse and Mental Health Services Administration have taken the first steps by supporting the development of this framework. But a conceptual framework is just that—conceptual. To apply the principles implicit in this framework, leadership at the systems and service level is required. At the state level, ASCA, NASMHPD, NASADAD, and APPA are among the membership organizations that have a central role in moving the field to a common approach to the complex needs of individuals with behavioral disorders in the criminal justice system. At the local level, county administrators, service providers, people with criminal histories who have behavioral health disorders, and citizens must participate in this dialogue. Their voices and commitment to change will ultimately determine if the goals of the criminal justice and behavioral health systems can be advanced by this framework to improve rates of recovery and public safety in all our communities.

APPENDIX A:
Expert Panel Members, Reviewers, and Federal Representatives*

Expert Panel

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GLOSSARY OF TERMS

Assertive Community Treatment (ACT)—An intensive case management model of treatment for individuals with serious mental illnesses that is coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for clients' case management and treatment needs.[122]

Behavioral Health and Behavioral Health System—According to the U.S. Department of Health and Human Services, the term *behavioral health* refers to

> a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illnesses and substance use disorders, which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use, and related problems, treatments and services for mental and substance use disorders, and recovery support.[123]

Although behavioral health services are provided in correctional settings, *behavioral health system* typically refers to the network of community-based services.

Cognitive Behavioral Therapy (CBT)—A therapeutic approach that attempts to solve problems resulting from dysfunctional thoughts, moods, or behavior through brief, direct, and time-limited structured counseling. CBT is often outlined in manuals to promote reliable implementation. It can be used to address specific problem areas such as anger management, criminal thinking, addiction, relapse, and relationships.[124]

Community Corrections—An umbrella term for the supervision of criminal offenders in the community that includes both probation and parole, and excludes institutional corrections. Community corrections is also referred to as community supervision. Community corrections agencies supervise and provide service referrals to parolees and probationers.[125]

Conditions of Supervision—Court-ordered or releasing-authority (e.g., parole board) stipulations that persons diverted from or leaving jail or prison must comply with or face possible sanctions and revocation of their community supervision. General conditions, such as not engaging in criminal activity and reporting to a probation or parole officer, apply to all individuals under supervision. Special conditions, such as participation in drug or mental health treatment, are added on a case-by-case basis.[126]

Co-occurring Disorders—The term refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients are said to have co-occurring disorders when at least one disorder of each type can be established independently of the other and is not simply a cluster of symptoms resulting from a single disorder.[127]

Correctional Control and Supervision—The monitoring and management practices exercised by corrections agencies over individuals for whom they are responsible both in an institution and the community in order to maintain order and safety, and to carry out the mandates of the criminal justice system.

Correctional Rehabilitation—Intervention targeting an individual's attitudes, thinking, behavior, or other factors related to their criminal conduct to reduce the likelihood of reoffending.[128]

Criminal Justice Involvement—Any formal contact with the criminal justice system, such as arrest, pretrial detention, incarceration in jail or prison, or supervision in the community by probation or parole.

Criminogenic Needs—The characteristics or circumstances (such as antisocial attitudes, beliefs, thinking patterns, and friends) that research has shown are associated with criminal behavior, but which a person can change (i.e., they are dynamic). These needs are used to predict risk of criminal behavior. Because criminogenic needs are dynamic, risk of recidivism can be lowered when these needs are effectively addressed. Although a person may have many needs, not all of these needs are directly associated with the likelihood of committing a crime.[129]

Criminogenic Risk—The likelihood that individuals will commit a crime or violate the conditions of their supervision. In this context, risk does not refer to the seriousness of a crime. (People who have committed a violent or assaultive offense may still be considered at low risk of committing a future crime, for example. Standard assessment tools do not predict an individual's likelihood of committing violent crimes; they only provide information on the likelihood that a person will reoffend in the future.)[130]

Criminogenic Risk Factors—Characteristics, experiences, and circumstances that are predictive of future criminal activity (such as criminal history, antisocial attitudes, thinking, patterns, and friends). Through criminogenic risk assessment, the presence of these characteristics can be used to predict the likelihood that the individual will reoffend.[131]

Criminogenic Risk and Needs Assessment—Comprehensive examination and evaluation of both static (historical and/or demographic) and dynamic (changeable) factors that predict individuals' level of risk of reoffending that can provide guidance on services and supervision.[132]

Decompensate—"A temporary return to a lower level of psychological adaptation or functioning, often occurring when an individual is under considerable stress or has discontinued psychiatric medication against medical advice."[133]

Diversion—"A dispositional practice is considered diversion if: (1) it offers persons charged with criminal offenses alternatives to traditional criminal justice or juvenile justice proceedings; and (2) it permits participation by the accused only on a voluntary basis; and (3) it occurs no sooner than the filing of formal charges and no later than a final adjudication of guilt; and (4) it results in a dismissal of charges, or its equivalent, if the divertee successfully completes the diversion process."[134]

Evidence-Based Practices (EBPs)—Clinical interventions or administrative practices for which consistent scientific evidence demonstrates that, when they are implemented correctly, expected and desired outcomes are achieved.[135] EBPs stand in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

Integrated Treatment—Treatment and service provision to support recovery from co-occurring mental illness and substance abuse through a single agency or entity. Counselors, clinicians, or multidisciplinary teams use specific listening and counseling skills to guide individuals' awareness of how mental illness and substance abuse interact and to foster hopefulness and motivation for recovery. Research shows that individuals receiving integrated treatment make great recovery advances from both their illnesses; experience fewer hospitalizations, relapses, and criminal justice involvement; and are more stable in housing.[136]

Mental Health Assessment—A process through which information about an individual's mental health status is gathered. Engagement with the client is conducted in a way that enables the service provider to establish the presence or absence of mental health or co-occurring disorders, determine the client's readiness for change, identify client strengths or problem areas that may affect treatment and recovery, and involve him or her in developing an appropriate treatment relationship. The purpose of an assessment is to establish or rule out the existence of a clinical disorder or service need and to develop a treatment and service plan.[137]

Mental Illness—A term that refers collectively to any diagnosable condition that is characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.[138]

Modified Therapeutic Community—A residential treatment program that adapts a traditional therapeutic community model for populations with co-occurring substance abuse and mental health disorders. A focus of the program is the emphasis of community among participants and staff within a self-help peer environment. It was developed to respond to the psychiatric symptoms and the functional and cognitive impairments of people with co-occurring disorders. As a result, this program is more flexible, more personal, and less intense than traditional therapeutic communities.[139]

Motivational Interviewing—A counseling approach to behavior change that addresses ambivalent attitudes and supports change in a way that is consistent with an individual's own values.[140]

Needs Principle—A principle that states an individual's criminogenic needs should be targeted for intervention in order to reduce recidivism or prevent future criminal conduct.[141]

Personality Disorder—A type of mental health disorder characterized by a pattern of inner experience and behavior that deviates markedly from the expectations of the culture of the individual who exhibits it, and that results often in significant problems with interpersonal relationships.[142]

Recidivism—The repetition of criminal or delinquent behavior, most often measured as a new arrest, conviction, or return to prison and/or jail for the commission of a new crime or for the violation of conditions of supervision.[143]

Recovery—Recovery is a process of change whereby individuals work to improve their own health and well-being, live a self-directed life, and strive to achieve their full potential.[144] Many treatment approaches today are defined as "recovery-oriented," meaning that they provide consumers with tools that will enable them to gain a combination of self-esteem and self-reliance, in turn allowing them to become increasingly or fully independent of the mental health system. When people with co-occurring disorders are in recovery, they are abstinent from the substance causing impairment, are able to function despite symptoms of mental illness, and can participate in life activities that are meaningful and fulfilling to them.[145]

Relapse—The return to active substance use in a person with a diagnosed substance use disorder, or the return of disabling psychiatric symptoms in a person with a diagnosed mental disorder. Relapse is a common event in the course of recovery.[146]

Residential Treatment—A type of substance abuse or mental health care that is provided at a live-in (non-hospital) facility. Residential treatment can include detoxification and is provided on either a short-term (less than 30 days) or long-term (more than 30 days) basis. Typical services include assessments, counseling, and discharge and transitional services.[147]

Responsivity Principle—The principle that stresses the importance of delivering correctional rehabilitative services, both in institutions and the community, using methods and techniques tailored to individual learning styles and motivational levels.[148]

Revocation—A sanctioning mechanism whereby a violation of the conditions of probation or parole is punishable by re-imprisonment.

Risk Principle—A principle that states individuals with higher criminogenic risk (greater likelihood of future criminal activity) should be prioritized for treatment and receive more intense supervision than those with lower criminogenic risk. Targeting interventions to those with higher criminogenic needs reduces recidivism.[149]

Screening—A process to determine the possibility that a client has a mental illness, substance abuse disorder, or both. The purpose of screening is not to diagnose a disorder but to establish the need for an in-depth behavioral health assessment.[150]

Serious Mental Illness (SMI)—Adults with a serious mental illness (SMI) are defined by SAMHSA as persons age 18 and over, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV-TR, resulting in functional impairment that substantially interferes with or limits one or more major life activities.[151]

Substance Use Disorders:

Substance Abuse—The U.S. Department of Health and Human Services define substance abuse as "a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances."[152] Individuals who abuse substances may experience harmful consequences such as repeatedly failing to fulfill roles for which they are responsible, using substances in situations that are physically hazardous, and experiencing legal difficulties as well as social and interpersonal problems.[153]

Substance Dependence—The American Psychiatric Association defines substance dependence as "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems."[154] This maladaptive pattern of substance use includes all the features of abuse, along with some additional features: increased tolerance for the drug, resulting in the need for ever-greater amounts of the substance to achieve the intended effect; an obsession with securing the drug and with its use; and persistence in using the drug in the face of serious physical or psychological problems.[155]

Technical Violation—Procedural infractions of probation or parole conditions, which may include behaviors that would otherwise not be considered crimes, such as consumption of alcohol, failure to attend mandated programs, default on court fee payment plans, failure to report as instructed, or changing of an address without prior permission.[156]

Therapeutic Community (TC)—"Traditionally, this is a long-term (up to 24 months) rehabilitative model that relies mainly on peer staff and on work as education and therapy. Other staff include treatment and mental health professionals and vocational and educational counselors. The aim here is a global change in a person's lifestyle, focused on developing vocational, educational, and social skills. Most residents have been involved with the criminal justice system."[157]

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