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PERSPECTIVES

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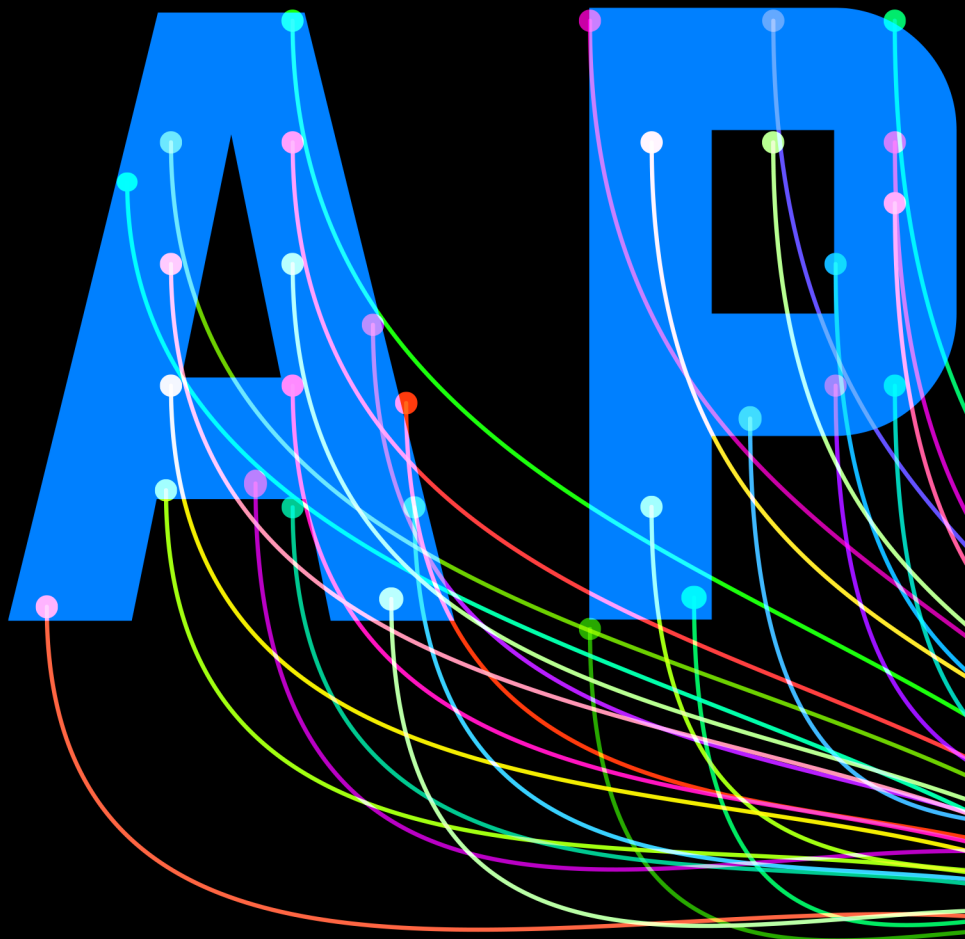
addressing mental health issues

through effective supervision strategies



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president's message

The theme of this edition of Perspectives is addressing mental health issues through effective supervision. When I first thought about this, I immediately thought of all the barriers and obstacles that get in the way of effective supervision. However, the more I considered the topic, the more I thought of ways we have evolved to remain effective. I have witnessed this evolution as I have been employed by the Yuma County Juvenile Court since 1991, and I have served as the Director of the Court for the past 23 years.

As many of you who may work for a small or medium sized agency know, the first thing that comes to mind when addressing mental health issues with youth is the lack of mental health treatment agencies available and/or accessible to the youth we serve. You may also have noticed the prevalence of treatment agency staff turnover as well as treatment agency closures. Regardless of this, probation personnel must remain the foundation of ensuring our youth receive proper mental health services. This begins with making sure the child gets the proper evaluation or assessment to determine if treatment is necessary and, if so, which treatments will be most effective. We also need to remain involved by participating in compassion-focused therapy or other professional staffings.

TIM HARDY
PRESIDENT

We have learned that services may be available but oftentimes, we must be diligent and look beyond our own community. Over the past few years, we have leveraged new technology and employed innovative ways of delivering treatment services, such as utilizing tele-medicine. This can serve as a viable alternative solution, providing the judge believes in the concept. The bottom line is, if we are to have effective supervision, we must remain involved and continue to be that link between the treatment agency, the youth and their family.

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addressing mental health issues through effective supervision strategies

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There is little question that working with individuals diagnosed with mental health (MH) conditions presents unique challenges, and this is particularly true when it comes to those who are justice-involved. Practitioners working in the field can readily attest to the complexity of supervising those who *do not* suffer from mental health issues. The complexity multiplies when those under our charge suffer from mental illness, and it further multiplies if that mental illness results in serious disruption of basic life skills.

The prevalence and unique needs of the justice-involved MH population make it a highly relevant topic. Despite studies showing that mental health, in and of itself, is not significantly correlated with reoffending, it remains critically important for community correction practitioners to identify and interact with mental health concerns more effectively. It takes a caring and highly skilled corrections practitioner to effectively assist those suffering from mental health limitations with their individual journeys toward change. We recognize mental health as a very important consideration in the Risk-Needs-Responsivity equation – one that if appropriately addressed, will improve the effectiveness of risk reduction efforts for individuals suffering from mental illness and thereby help us to accomplish our goal of protecting the public through reduced recidivism. With this context in mind, we are pleased to present this issue of *Perspectives* devoted to research and best practices to manage the justice-involved mental health population.

Jennifer Eno Louden, Rebekah Adair, and Jennifer Skeem contribute an article dispelling the "risk myth," as well as present other myth busters about the justice-involved MH population. They provide a comprehensive overview of the research about justice-involved individuals with mental health disorders and warn against the folly of buying-in to the myths at the expense of applying evidence-based practices while supervising this population. The issue of mental health rightfully expands beyond the corrections element of the criminal justice population. The Sequential Intercept Model (SIM) was created as a means to have an appropriate criminal justice response to an individual with a mental health issue at every single intercept in the justice system. The model actually begins *before police are called* and addresses every intercept through community supervision. Matthew Robbins,

Because of the important responsivity considerations of the justice-involved MH populations, community supervision cannot be business as usual.

of Policy Research Associates, provides us with an overview of SIM with emphasis on the role of community corrections in the process.

Because of the important responsivity considerations of the justice-involved MH populations, community supervision cannot be business as usual. To this end, two collaborative contributions by authors from the University of North Carolina, Boston University, and the North Carolina Department of Public Safety provide our readers with an insightful look at an innovative and research-based model of supervising this population which emphasizes applying clinical case consultation principles. In the first article, the authors present a case study of how one jurisdiction implemented a clinical case conferencing model to attend to the needs of its MH clients. In the second article, the importance of relying on implementation science to advance our use of specialized MH supervision is outlined, reminding us that its not just the "what," but also the "how" when understanding such a complex caseload.

Whether or not one regularly works with clients with mental health concerns, we believe it is important for responsible corrections practitioners to be knowledgeable about best practices for dealing with these issues. As you review this issue of *Perspectives*, we hope that our content accomplishes this objective.

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from the executive director

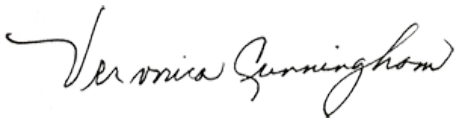
This issue of *Perspectives* focuses on mental health, a topic that could not be more relevant. Although we settled on this theme prior to the emergence of the COVID-19 pandemic, individuals struggling with mental illness may be particularly vulnerable to the negative impacts of this worldwide crisis. The emotional drain and worries brought about by the pandemic can compound normal stressors and considerably increase psychological challenges. Now more than ever, probation and parole officers (POs) must be guided by evidence-based practices that improve the community corrections response to individuals with mental illness. I trust that the articles presented in this issue contribute to the understanding of mental health problems and approaches to addressing them.

Although the focus is on the mental health of individuals on community supervision caseloads, I would be remiss if I did not point to concerns about the emotional health and well-being of POs. APPA is committed to supporting those working in the field, and that includes being mindful of the pandemic's impact on them. Departments across the country have had to respond quickly by pivoting to adopt policies, practices, and remote work technology to help minimize virus transmission, and I applaud this. POs must now cope with the irregular business of working under stressful circumstances in a work environment where stress was already a rising concern. Of course, it is difficult to observe staff's mental health while they are working remotely. Given that, I am elated to learn that many agency heads, even in the midst of their other responsibilities, are not losing sight of the potential mental health challenges facing their staff members.

VERONICA CUNNINGHAM
APPA EXECUTIVE DIRECTOR

For their part, innumerable officers across the country are doing their best to offer support and ensure releasees have access to resources, benefits, and accommodations. POs are compassionate, skillful, and resourceful problem-solvers, and they are keenly aware of the need to maintain frequent contact with this unique population and to link mentally ill releasees with appropriate resources, including working to provide access to technological modalities such as telepsychology or telemental health care services. On behalf of APPA, I appreciate all that is being done to assist justice-involved individuals with mental illness.

Again, mental health is a highly pertinent topic in these trying times. All readers can benefit from the excellent articles presented on this complex and poignant subject of the justice-involved mental health population. The authors have provided useful models, practices, and case studies, and I give them special thanks for their contributions to this timely edition. All advancements in our knowledge surely help us—individually and collectively—to better advance everyone's health and wellness in this new world.



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Unless previously discussed with the editors, submissions should not exceed 12 typed pages, numbered consecutively, and double-spaced. All charts, graphs, tables, and photographs must be of reproduction quality. Optional titles may be submitted and selected after review with the editors.

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Mattson, B. (2015). Technology supports decision making in health and justice. *Perspectives*, *39*(4), 70-79.

Hanser, R. D. (2014). *Community corrections* (2nd ed.). Thousand Oaks, CA: Sage.

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MOVING PAST THE MYTHS: RESEARCH-INFORMED PRACTICES FOR SUPERVISING CLIENTS WITH SERIOUS MENTAL ILLNESS

BYJENNIFER ENO LOUDEN, REBEKAH ADAIR, AND JENNIFER L. SKEEM

Working with clients who have a serious mental illness such as schizophrenia, bipolar disorder, or major depression can cause significant concern for probation and parole practitioners. These clients present challenges to administrators and line staff alike because their needs are complex and often difficult to meet, especially given the resource limitations that are typical within community corrections agencies. Fortunately, research offers guidance for successful correctional rehabilitation for this group. Nonetheless, despite the increase in empirical knowledge on this subject, myths and erroneous beliefs about justice-involved people with mental illness persist and may interfere with evidence-based practices in community corrections. In this article, we confront three key myths regarding people with mental illness and provide guidance to practitioners and administrators regarding best practices for working with this group in a community corrections context.

MYTH: CLIENTS WITH MENTAL ILLNESS HAVE A HIGH RISK OF BEING VIOLENT

The belief that people with serious mental illness are highly likely to be violent is widely held by the public (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). However, research presents a more complex picture of the relationship between mental illness and violence. In reviewing this relationship, we focus on those diagnosed with psychotic disorders, which often features fixed false beliefs (e.g., that one is being persecuted or has special talents or abilities), auditory hallucinations or "hearing voices," and disorganized speech and thoughts. We do so because laypeople often pay most attention to psychotic disorders when thinking about the relationship between mental illness and violence, even though people with mental illness are a heterogeneous group due to the different symptoms that characterize different disorders (see Joyal, Côté, Meloche, & Hodgins, 2011).

Douglas and colleagues (Douglas, Guy, & Hart, 2009) conducted a meta-analysis—a statistical examination of more than 200 prior studies—to comprehensively assess the link between psychosis and violence. They found that although there is a link between psychosis and violence, statistically speaking, this relationship is weak (Douglas et al., 2009). Common conceptions that people with schizophrenia are a highly violent group grossly exaggerate this small relationship. Put simply, most people with psychosis are not violent, and most violence is not committed by people with psychosis (Glied & Frank, 2014).

The odds of violence on the part of offenders with psychosis are only 27% higher than the odds of violence by those without psychosis, an effect size that is "smaller than small."

Importantly, the authors found that the population which is examined matters a lot when examining the link between psychosis and violence. The link is strongest when examined in community samples—samples designed to represent the entire population of community residents. The link is weakest when examined in corrections samples—groups of people involved in the justice system, including clients of probation and parole agencies. The odds of violence on the part of offenders with psychosis are only 27% higher than the odds of violence by those without psychosis, an effect size that is "smaller than small" (see Chen, Cohen & Chen, 2010). Why is the link between psychosis and violence trivial in corrections samples? It is because there are strong, competing risk factors for violence to contend with in these samples. For example, features of antisocial and psychopathic personality disorder are commonly found in corrections populations, and these predict violence much more strongly than mental illness, even within samples of offenders with mental illness (Bonta, Blais, & Wilson, 2014).

MYTH: CLIENTS WITH MENTAL ILLNESS HAVE HIGH RE-ARREST RATES

Recidivism has different definitions that bear directly on clients with mental illness, and re-arrests are not always based on criminality. Recidivism in the sense of committing a new offense differs meaningfully from recidivism based solely on technical violations, as the latter reflects an arguably less serious failure to follow the rules of probation or parole, such as failure to pay fees, complete community service, maintain employment, or meet with the supervising officer. Studies generally indicate similar rates of new offenses for offenders with and without mental illness. For example, an examination of a subset of Washington State's probation population found that probation clients without a mental illness

were almost as likely to re-offend as probation clients with a mental illness, with recidivism rates of 38% and 41%, respectively (Gagliardi, Lovell, Peterson, & Jemelka, 2004). These findings are in line with most of the other research on rates of new offense for disordered and non-disordered offenders on community supervision (Feder, 1991; Lovell, Gagliardi, & Peterson, 2002; McShane, Williams, Pelz, & Quarles, 2005; Porporino & Motiuk, 1995; but see Eno Louden & Skeem, 2011, for an exception).

At the same time, studies also generally show that offenders with mental illness have higher rates of technical violations than those without mental illness (Eno Louden & Skeem, 2011; Porporino & Motiuk, 1995). There are multiple reasons why this is the case. First, people with mental illness on community supervision tend to have more conditions placed on them, in particular participation in mandated mental health treatment (Skeem, Emke-Francis, & Eno Louden, 2006). The more conditions individuals have to meet to successfully complete community supervision, the more chances they have to fail. Complying with probation or parole conditions can be difficult when one of those conditions involves navigating an overburdened mental health care system that is not designed to meet the needs of people involved in the justice system (see Skeem et al., 2006), especially for people whose functioning is compromised by symptoms of mental illness (Skeem, Encandela, & Eno Louden, 2003).

In addition, community corrections officers are quicker to revoke community supervision for clients with mental illness compared to other clients. We examined this in a series of experiments, which is the only type of research design from which conclusions regarding cause and effect can be made (Shadish, Cook, & Campbell, 2002). For example, Eno Louden and colleagues presented 89 probation officers with a description of a hypothetical client with mental illness, and a second "control" client without mental illness. When presented with a scenario in which each of the clients violated the terms of probation by not showing up for work and having a positive urinalysis, officers were more likely to report that they would seek revocation for the client with mental illness than for the client without mental illness (Eno Louden, Manchak, Ricks, & Kennealy, 2018). Further, probation officers reported that the client with mental illness was higher risk than the non-disordered client, even though the two clients had risk ratings based on a structured risk assessment tool and therefore in reality had the same likelihood of reoffending. Officers' desire to revoke the client with mental illness was directly related to their inflated ratings of risk for the client with mental illness (Eno Louden et al., 2018; see also Eno Louden, 2009).

Many officers worry they will be held responsible for a client with mental illness committing a serious offense in the community, so they may err on the side of revocation at the first sign of misbehavior as a form of risk management (Lynch, 1998; Skeem et al., 2003). Other officers may file for revocation in an effort to get the offender into treatment—in jail (Lynch, 1998). As such, some technical violations recorded for offenders with mental illness may be driven by risk aversion or a misguided desire to help on the part of the supervising officer. Given that recidivism among offenders with mental illness is driven largely by technical violations rather than new offenses, it is important to attend to how community corrections officers make decisions regarding revocation for this group.

MYTH: SYMPTOMS OF MENTAL ILLNESS DIRECTLY CAUSE RECIDIVISM FOR THOSE WITH MENTAL ILLNESS

Perhaps the most surprising finding of recent research relates to the effect of mental illness on offending. Historically, policymakers and practitioners held the belief that symptoms of mental illness are the primary driver of offenses for justice-involved people with mental illness (Council of State Governments, 2002). This idea is intuitively appealing, and the logic behind it formed the basis for many types of correctional interventions aimed at reducing recidivism for this group, such as specialty probation caseloads and mental health courts (Skeem, Manchak, & Peterson, 2011). However, as with the other myths already described, research leads to a more complex view.

The study of the effect of mental health symptoms on offending is a relatively new area of research, but a few high-quality studies have revealed consistent results. An exemplar study was conducted by Peterson and colleagues (2014), who conducted interviews and file reviews for 143 offenders with mental illness drawn from probation offices and a mental health court. The interviews elicited a timeline of criminal behavior and the circumstances surrounding each offense. Participants' probation records were reviewed to corroborate the offense data and to confirm diagnoses. The interviews and records were painstakingly coded to determine the extent to which symptoms of psychosis, depression, or bipolar disorder preceded and directly caused each criminal act. Of the 429 offenses that were coded, only about 10% were directly related to symptoms (e.g., a person with paranoia is violent towards someone believed to be plotting against them) and another 28% were moderately related to symptoms (e.g., a person gets into a fight because of being agitated due to hearing voices earlier in the day, but hallucinations were not present at the time of the fight). The remaining offenses

were unrelated to symptoms (e.g., a person with mental illness steals food due to lack of money) (Peterson et al., 2014). These findings align with the other studies on the link between symptoms and offending (Junginger, Claypoole, Laygo, & Crisanti, 2006; Peterson, Skeem, Hart, Vidal, & Keith, 2010). Notably, Peterson and colleagues (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014) found variability within individuals, as those who committed one offense due to symptoms did not consistently commit offenses due to symptoms. This study also found differences in the extent to which symptoms caused offenses based on the offender's diagnosis: Individuals with bipolar disorder (which is rare, even in correctional samples) were much more likely to commit crimes due to symptoms than were people with major depression (a much more common disorder). Because symptoms do not explain most offenses for most offenders with mental illness, symptoms should not be the primary focus in correctional treatment.

BEYOND THE MYTHS TOWARDS EFFECTIVE SUPERVISION

The above discussion tried to shed light on pervasive myths pertaining to people with mental illness who are involved in the criminal justice system. Those in this group are highly stigmatized, and the public has strongly held negative attitudes towards them. Clearly, such stigmatizing attitudes are in part rooted in inaccurate beliefs about people with mental illness, including the mental illness-violence relationship discussed earlier (Link et al., 1999). Since they too are members of the public, those in the probation and parole profession likely have some degree of stigmatizing attitude towards their clients with mental illness, whether they realize it or not. Even among people who consciously report non-stigmatizing attitudes, exposure to negative stereotypes regarding people with mental illness can affect decision-making towards those in this group (Stier & Hinshaw, 2007). As long as stereotypes consciously or unconsciously affect perceptions and are manifested in behavior, such stereotypes and myths have the potential to bias decision-making and negatively affect officers' ability to engage in evidence-based correctional practices, thereby undermining practitioners' efforts to rehabilitate their clients with mental illness.

Taking the above into account, we will provide recommendations on best practices for the supervision of clients with mental illness. Contemporary research suggests that best practices for clients with mental illness should be informed by the Risk-Need-Responsivity model of correctional supervision (Bonta & Andrews, 2017). This model has been extensively studied among diverse types of offenders (e.g., women, youthful offenders) and

Agency policy and associated officer training should clearly articulate the need to implement the risk assessment with fidelity and reinforce the idea that a mental health diagnosis alone does not automatically warrant placement in a high-risk category.

when implemented with fidelity, meaningful reductions in recidivism can be achieved (Bonta & Andrews, 2017). There are some special considerations for applying this model to clients with mental illness (McCormick, Peterson-Badali, & Skilling, 2015; Morgan et al., 2012; Skeem et al., 2011), which we describe below, presented in chronological order based on which point in supervision they are relevant.

The first step towards effective supervision involves using a validated risk and needs assessment to inform the intensity of intervention and how to target those interventions for each client (the Risk principle) (Bonta & Andrews, 2017). Because offenders with mental illness share the same criminogenic needs as those without mental illness, no special risk assessment tool is needed with this group (Bonta et al., 2014). The instrument must be implemented with fidelity, meaning that each officer is trained to administer and score the measure in a uniform manner, as deviation from the tool's protocol undermines the tool's ability to accurately predict risk (Andrews, Bonta, & Wormith, 2006). Implementing a risk assessment tool with fidelity is particularly important with clients with mental illness because officers' intuitive judgments tend to overestimate their risk of recidivism (Eno Louden et al., 2018; Ricks, Eno Louden, & Kennealy, 2016). Officers often override the results of a risk assessment tool when the risk classification offered by the tool does not align with the officer's judgment (Miller & Maloney, 2013), but overrides should be done only in rare cases in which the officer has information relevant to the risk of the client that is not adequately captured by the risk assessment tool (Bonta & Andrews,

2017). Agency policy and associated officer training should clearly articulate the need to implement the risk assessment with fidelity and reinforce the idea that a mental health diagnosis alone does not automatically warrant placement in a high-risk category. If officers are made aware of the research showing decreased utility of risk assessment tools when overrides are inappropriately used, they may show increased buy-in for implementing the tool with fidelity, as officers who believe that their own judgment is superior to a risk assessment tool are more likely to deviate from the tool than are officers who have more faith in risk assessment tools (Schaefer & Williamson, 2018).

Another helpful component of the intake process is assessment of clients' mental health needs, so that interventions can be responsive to the mental health needs of the individual offender (a key component of the Responsivity principle) (Bonta & Andrews, 2017). Relying on offender self-report of mental health diagnosis or treatment need may provide agencies with an underestimate of the scope of mental health needs among their clients, because not all clients who have a mental illness will have received treatment in the past. A brief screening tool can be implemented at intake to identify clients who have symptoms of mental illness so those clients can be referred for further assessment by a mental health professional to determine whether a mental illness is present and, if so, the severity of mental health need (Chandler, Peters, Field, & Juliano-Bult, 2004; Eno Louden, Skeem, & Blevins, 2013).

Case planning should be informed by the assessments of criminogenic and mental health needs, and Skeem et al. (2011) present a useful model for doing so. For clients with high levels of mental health treatment needs (e.g., pronounced symptoms and functioning impairments), intensive community-based mental health treatment, such as integrated dual-diagnosis treatment or forensic assertive community treatment may be warranted. Those with less pronounced mental health needs can be effectively served by high-quality outpatient psychiatric treatment. Psychiatric rehabilitation, which includes a multipronged approach to helping people with mental illness increase functioning (such as medication, family psychoeducation, and supported employment), has shown promise among justice-involved people (see Morgan et al., 2012). Because many offenders with mental illness have co-occurring substance use disorders, and substance misuse is a strong risk factor for recidivism, substance abuse treatment is a key component of rehabilitation for this group (Bonta & Andrews, 2017; Hartwell, 2004).

The intensity of correctional interventions should align with the principles in the Risk-Need-Responsivity model (Bonta & Andrews, 2017), where intensive interventions for criminogenic needs are reserved for high-risk clients. Low-risk clients should receive less intensive supervision and intervention. Matching the intensity of interventions with the level of client need is crucial, because providing too much intervention to low-risk clients can actually increase their likelihood of offense (Bonta & Andrews, 2017). As with judgments of risk, officers' judgments of need should take into account individual differences among clients. Not all clients with mental illness will have a high degree of need for mental health services, and in fact they may have stronger needs in other areas. Officer training should address the myth regarding the link between symptoms and offending as well as research demonstrating that mental health treatment alone does not reduce recidivism for offenders with mental illness (Skeem et al., 2011). Such training should also include a review of the research suggesting that most offenders with mental illness commit crimes for the same reasons as non-disordered offenders: criminogenic needs such as antisocial personality traits, pro-criminal thinking patterns, and substance abuse (Bonta & Andrews, 2017; Bonta et al., 2014; Skeem, Winter, Kennealy, Eno Louden, & Tatar, 2014). In accordance with the Need principle, officers should refer clients with these needs to interventions that target them, particularly interventions based on principles of Cognitive Behavioral Therapy (Bonta & Andrews, 2017).

When routine supervision is underway, officers should strive to develop high quality "firm but fair" relationships with their clients characterized by trust, caring, and an authoritative (not authoritarian) approach (Skeem, Eno Louden, Polaschek, & Camp, 2007). This is a key component of Core Correctional Practice, a part of the Risk-Need-Responsivity model (Bonta & Andrews, 2017; Dowden & Andrews, 2004). Firm yet fair relationships foster rehabilitation among clients with and without mental illness (Kennealy, Skeem, Manchak, & Eno Louden, 2012; Skeem et al., 2007), whereas relationships characterized by surveillance, punishment, and mistrust hinder rehabilitation (see also Paparozzi & Gendreau, 2005). Strategies for building firm but fair relationships are a crucial part of training in evidence-based correctional practices (see Bonta et al., 2011). Because biases towards offenders with mental illness may hamper officers' ability to build high-quality relationships with them, these biases should be addressed in training that targets relationship building. The research on interventions to alleviate mental health stigma provides some ideas on best practices for doing this, such as breaking down the myths surrounding

mental illness and providing examples of individuals who defy common stereotypes about people with mental illness (Corrigan et al., 2001; Sadow & Ryder, 2008).

A key point where officers can make a difference during supervision is when the client struggles to comply with the terms of probation. Problem-solving discussions to identify and eliminate barriers to compliance are a key feature of many effective correctional supervision programs (Bonta et al., 2011; Robinson et al., 2012). As noted earlier, officers often find it frustrating to work with clients with mental illness, and this can be a particular challenge when the client has trouble meeting the conditions of supervision. It should be recognized, however, that clients with mental illness may be particularly sensitive to punishment-based strategies. A recent study found that probationers with mental illness whose supervising officers used threats of sanctions had higher violation rates than similar probationers whose officers avoided these negative strategies (Manchak, Skeem, Kennealy, & Eno Louden, 2014).

Importantly, many agencies lack formal policies regarding how officers should respond to violations for clients with mental illness (Eno Louden, Skeem, Camp, & Christensen, 2008). Without formal policies in place, officers' intuitive judgments regarding risk and negative attitudes towards offenders with mental illness affect their decision-making when it comes to filing (or not filing) a revocation request for a noncompliant client (Eno Louden, 2009; Ricks et al., 2016). Policies regarding when to file for revocation should be informed by risk assessments and can ensure that officers within an agency are responding to clients in a uniform manner and eliminate biased responses that may artificially inflate revocation rates for clients with mental illness. Although research on this practice among clients with mental illness is lacking, sanction matrices specifying the type of response to client misbehavior, taking into account client risk level and past noncompliance, have been used in settings with other challenging clients, such as drug courts (Guastaferro & Daigle, 2012).

An additional tool available for agencies to explore is specialty mental health caseloads, which have been implemented by many agencies across the United States (Skeem et al., 2006). In these agencies, officers with expertise in mental health issues supervise relatively small caseloads, integrate resources available to them within their agency with resources from other agencies, and use problem-solving to address noncompliance rather than threats of incarceration. Rigorous studies of these caseloads suggest they are successful in reducing recidivism for clients with

As noted earlier, symptoms don't drive most offenses for most people with mental illness, so simply treating symptoms will make only minimal reductions in recidivism.

serious mental illness (Manchak et al., 2014; Wolff et al., 2014). However, it should be noted that researchers are still working to disentangle the active ingredients of specialty caseloads, and the evidence thus far suggests that enforcement of mandated mental health treatment is not the primary mechanism by which these programs are effective (Manchak et al., 2014; Skeem et al., 2011). As noted earlier, symptoms don't drive most offenses for most people with mental illness, so simply treating symptoms will make only minimal reductions in recidivism. Importantly, close monitoring of clients without addressing criminogenic needs may only serve to increase the likelihood of discovering bad behavior and do nothing to decrease recidivism (Petersilia & Turner, 1990). In fact, the research thus far suggests that the factors most related to recidivism reduction in specialty caseloads are those that overlap with the Risk-Need-Responsivity model (e.g., firm but fair relationships) (Manchak et al., 2014).

Clients with mental illness can be taxing on agencies' resources and officers' patience. As stated by an officer who participated in a focus group regarding supervision of offenders with mental illness, "No, [we haven't found anything that works] . . . we're stalling. We're baby-sitting until we get them off of our caseload whether we're stalling them out, throwing them in and out of jail to get them through their minimum [sentence] or we're ignoring them or we're handing them off to different officers." (Skeem et al., 2003, p. 442). Since that focus group was conducted more than 15 years ago, the research base has accumulated more knowledge regarding what agencies and officers can do

to successfully rehabilitate this group of clients. Supervision informed by research rather than myths regarding mental illness will likely lead to improved outcomes for clients and less frustration for practitioners.

REFERENCES

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency*, *52*, 7-27.

Bonta, J., & Andrews, D. A. (2017). *The psychology of criminal conduct* (6th ed.). New York, NY: Routledge.

Bonta, J., Blais, J., & Wilson, H. A. (2014). A theoretically informed meta-analysis of the risk for general and violent recidivism for mentally disordered offenders. *Aggression and Violent Behavior*, *19*, 278–287.

Bonta, J., Bourgon, G., Rugge, T., Scott, T., Yessine, A., Gutierrez, L., & Li, J. (2011). An experimental demonstration of training probation officers in evidence-based community supervision. *Criminal Justice and Behavior, 38*, 1127-1148.

Chandler, R. K., Peters, R. H., Field, G., & Juliano-Bult, D. (2004). Challenges in implementing evidence-based treatment practices for co-occurring disorders in the criminal justice system. Behavioral Sciences and the Law, 22, 431-448.

Chen, H., Cohen, P., & Chen, S. (2010). How big is a big odds ratio? Interpreting the magnitudes of odds ratios in epidemiological studies. *Communications in Statistics - Simulation and Computation*, *39*, 860–864.

Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., ... & Kubiak, M. A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, *27*, 187-195.

Council of State Government (2002). *Criminal justice/Mental health consensus project*. Retrieved from http://www.consensusproject.org

Douglas, K. S., Guy, L. S., & Hart, S. D. (2009). Psychosis as a risk factor for violence to others: a meta-analysis. *Psychological Bulletin*, *135*, 679-706.

Dowden, C., & Andrews, D. A. (2004). The importance of staff practice in delivering effective correctional treatment: A meta-analytic review of core correctional practice. *International Journal of Offender Therapy and Comparative Criminology*, *48*, 203-214.

Eno Louden, J. (2009). *Effect of mental disorder and substance abuse stigma on probation officers' case management decisions*. University of California, Irvine.

Eno Louden, J., Manchak, S. M., Ricks, E. P., & Kennealy, P. J. (2018). The Role of Stigma Toward Mental Illness in Probation Officers' Perceptions of Risk and Case Management Decisions. *Criminal Justice and Behavior*, *45*, 573-588.

Eno Louden, J., & Skeem, J. (2011). Parolees with mental disorder: Toward evidence-based practice. *Bulletin of the Center for Evidence-Based Corrections*, *7*, 1-9.

Eno Louden, J., & Skeem, J. L. (2013). How do probation officers assess and manage recidivism and violence risk for probationers with mental disorder? An experimental investigation. *Law and Human Behavior*, *37*, 22-34.

Eno Louden, J., Skeem, J. L., & Blevins, A. (2013). Comparing the predictive utility of two screening tools for mental disorder among probationers. *Psychological Assessment*, *25*, 450-461.

Eno Louden, J., Skeem, J. L., Camp, J., & Christensen, E. (2008). Supervising probationers with mental disorder: How do agencies respond to violations? *Criminal Justice and Behavior*, *35*, 832-847.

Feder, L. (1991). A comparison of the community adjustment of mentally ill offenders with those from the general prison population. *Law and Human Behavior*, *15*, 477-493.

Gagliardi, G. J., Lovell, D., Peterson, P. D., & Jemelka, R. (2004). Forecasting recidivism in mentally ill offenders released from prison. *Law and Human Behavior*, *28*, 133-155.

Glied, S., & Frank, R. G. (2014). Mental illness and violence: Lessons from the evidence. *American Journal of Public Health*, *104*, e5-e6.

Guastaferro, W. P., & Daigle, L. E. (2012). Linking noncompliant behaviors and programmatic responses: The use of graduated sanctions in a felony-level drug court. *Journal of Drug Issues, 42,* 396-419.

Hartwell, S. (2004). Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system. *Criminal Justice Policy Review, 15*, 84-99.

Joyal, C. C., Côté, G., Meloche, J., & Hodgins, S. (2011). Severe mental illness and aggressive behavior: on the importance of considering subgroups. *International Journal of Forensic Mental Health*, *10*, 107-117.

Junginger, J., Claypoole, K., Laygo, R., & Crisanti, A. (2006). Effects of serious mental illness and substance abuse on criminal offenses. *Psychiatric Services*, *57*, 879-882.

Kennealy, P. J., Skeem, J. L., Manchak, S. M., & Eno Louden, J. (2012). Firm, fair, and caring officer-offender relationships protect against supervision failure. *Law and Human Behavior*, *36*, 496-505.

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *American Journal of Public Health*, *89*, 1328-1333.

Lovell, D., Gagliardi, G. J., & Peterson, P. D. (2002). Recidivism and use of services among persons with mental illness after release from prison. *Psychiatric Services*, *53*, 1290-1296.

Lynch, M. (1998). Waste managers? The new penology, crime fighting, and parole agent identity. *Law and Society Review*, 839-870.

Manchak, S. M., Skeem, J. L., Kennealy, P. J., & Eno Louden, J. (2014). High-fidelity specialty mental health probation improves officer practices, treatment access, and rule compliance. *Law and Human Behavior*, *38*, 450-461.

McCormick, S., Peterson-Badali, M., & Skilling, T. A. (2015). Mental health and justice system involvement: A conceptual analysis of the literature. *Psychology, Public Policy, and Law*, *21*, 213-225.

McShane, M. D., Williams III, F. P., Pelz, B., & Quarles, T. (2005). The role of mental disorder in parolee success. *Southwest Journal of Criminal Justice*, *2*, 3-22.

Miller, J., & Maloney, C. (2013). Practitioner compliance with risk/needs assessment tools: A theoretical and empirical assessment. *Criminal Justice and Behavior*, *40*, 716-736.

Morgan, R. D., Flora, D. B., Kroner, D. G., Mills, J. F., Varghese, F., & Steffan, J. S. (2012). Treating offenders with mental illness: A research synthesis. *Law and Human Behavior*, *36*, 37-50.

Peterson, J., Skeem, J. L., Hart, E., Vidal, S., & Keith, F. (2010). Analyzing offense patterns as a function of mental illness to test the criminalization hypothesis. *Psychiatric Services*, *61*, 1217-1222.

Peterson, J. K., Skeem, J., Kennealy, P., Bray, B., & Zvonkovic, A. (2014). How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness? *Law and Human Behavior*, *38*, 439-449.

Paparozzi, M. A., & Gendreau, P. (2005). An intensive supervision program that worked: Service delivery, professional orientation, and organizational supportiveness. *The Prison Journal*, *85*, 445-466.

Petersilia, J., & Turner, S. (1990). Comparing intensive and regular super- vision for high-risk probationers: Early results from an experiment in California. *Crime & Delinquency, 36,* 87–111.

Porporino, F. J., & Motiuk, L. L. (1995). The prison careers of mentally disordered offenders. *International Journal of Law and Psychiatry*. *18*, 29-44

Ricks, E. P., Eno Louden, J., & Kennealy, P. J. (2016). Probation officer role emphases and use of risk assessment information before and after

training. *Behavioral Sciences and the Law*, *34*, 337-351.

Robinson, C. R., Lowenkamp, C. T., Holsinger, A. M., Van Benschoten, S., Alexander, M., & Oleson, J. C. (2012). A random study of Staff Training Aimed at Reducing Re-arrest (STARR): Using core correctional practices in probation interactions. *Journal of Crime and Justice*, *35*, 167–188.

Sadow, D., & Ryder, M. (2008). Reducing stigmatizing attitudes held by future health professionals: The person is the message. *Psychological Services*, *5*, 362-372.

Schaefer, L., & Williamson, H. (2018). Probation and parole officers' compliance with case management tools: Professional discretion and override. *International Journal of Offender Therapy and Comparative Criminology, 62*, 4565-4584.

Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. New York, NY: Houghton Mifflin.

Skeem, J. L., Emke-Francis, P., & Eno Louden, J. (2006). Probation, mental health, and mandated treatment: A national survey. *Criminal Justice and Behavior*, *33*, 158-184.

Skeem, J. L., Encandela, J., & Eno Louden, J. (2003). Perspectives on probation and mandated mental health treatment in specialized and traditional probation departments. *Behavioral Sciences and the Law*, *21*, 429-458.

Skeem, J. L., Eno Louden, J., Polaschek, D., & Camp, J. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment*, *19*, 397.

Skeem, J. L., Manchak, S., & Peterson, J. K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior*, *35*, 110-126.

Skeem, J., Winter, E., Kennealy, P., Eno Louden, J., & Tatar II, J. (2014). Offenders with mental disorder have criminogenic needs, too: Toward recidivism reduction. *Law and Human Behavior, 38*, 212-224.

Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist, 42*, 106-117.

Wolff, N., Epperson, M., Shi, J., Huening, J., Schumann, B. E., & Sullivan, I. R. (2014). Mental health specialized probation caseloads: Are they effective? *International Journal of Law and Psychiatry*, *37*, 464-472.

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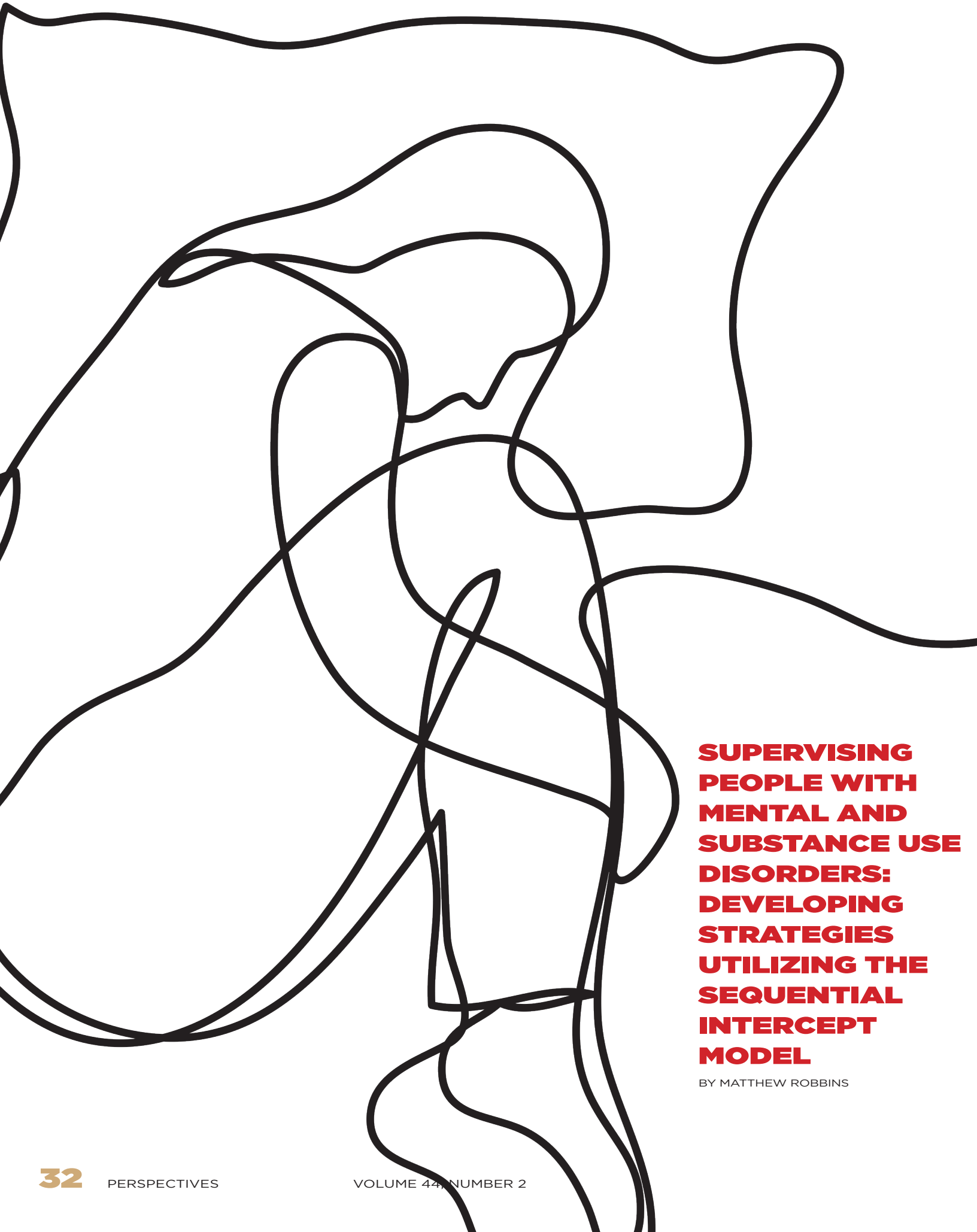
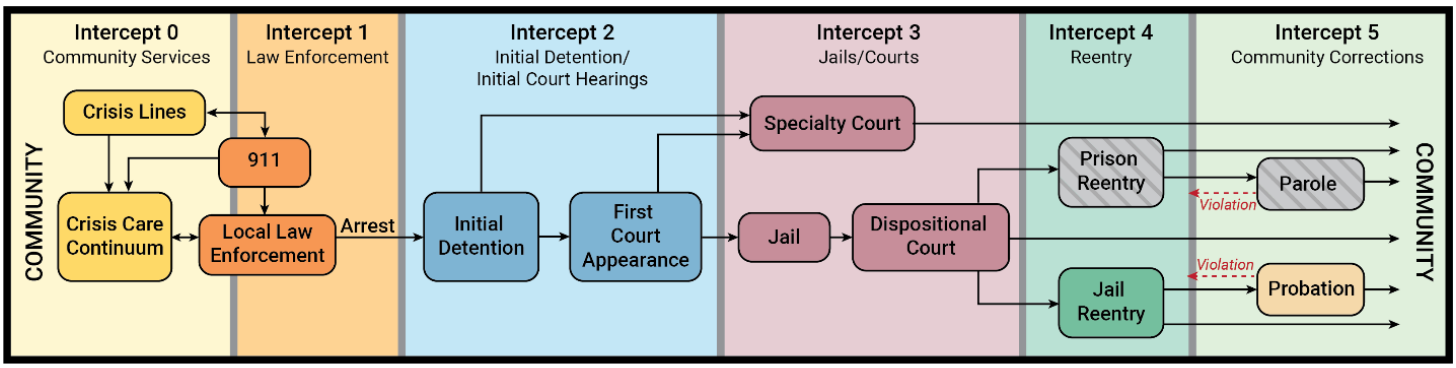


SUPERVISING PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS: DEVELOPING STRATEGIES UTILIZING THE SEQUENTIAL INTERCEPT MODEL

BY MATTHEW ROBBINS

People with mental illness enter the criminal justice system at greater frequency, penetrate deeper into it, and experience worse outcomes compared to people without mental illness. As a result, those with mental illness are overrepresented in the criminal justice system. In fact, 17% of people incarcerated in jails have been diagnosed with a serious mental illness, compared to 4% of the general population (Steadman, Osher, Robbins, Case, & Samuels, 2009); Substance Abuse and Mental Health Services Administration (SAMHSA), 2019). Another important consideration is that 72% of people with mental illness incarcerated in jails have a co-occurring substance use disorder (Abram & Teplin, 1991). Community corrections agencies are in a unique position to change outcomes for this population. Given that 69% of the approximately 6.6 million people involved in the criminal justice system are on community supervision (Kaeble & Cowhig, 2018), probation and parole providers play an important role in supervising people with mental and substance use disorders involved in the criminal justice system.

FIGURE 1: SEQUENTIAL INTERCEPT MODEL



(Policy Research Associates, 2018)

The Sequential Intercept Model provides a conceptual framework for community-based strategic planning and collaboration between criminal justice and behavioral health systems to address concerns about criminalization and improve outcomes for people with mental and substance use disorders involved in the criminal justice system. Developed in the early 2000s by Mark Munetz and Patricia A. Griffin along with Henry J. Steadman, this model established a series of intercept points at which people with mental and substance use disorders can be identified, connected with treatment and other support services, prevented from penetrating deeper into the criminal justice system, and diverted out of the criminal justice system when appropriate (Munetz

& Griffin, 2006). The intercept points are: (Intercept 0) Community Services, (Intercept 1) Law Enforcement, (Intercept 2) Initial Detention and Initial Court Hearings, (Intercept 3) Jails and Courts, (Intercept 4) Reentry, and (Intercept 5) Community Corrections (Abreu, Parker, Noether, Steadman, & Case, 2017).

SEQUENTIAL INTERCEPT MODEL IN ACTION

Communities have been exploring ways to increase collaboration between criminal justice and behavioral health systems—spurred on in part by the need to address concerns about criminalization and to improve outcomes for people with mental and substance use disorders involved in the criminal justice system. It is worthwhile to consider how the Sequential Intercept Model can guide these efforts. The Sequential Intercept Model was first tested in 2002 in Summit County, Ohio, and in five counties in southeastern Pennsylvania (Griffin, Munetz, Bonfine, & Kemp, 2015). Following that, it was the subject of a National Institute of Mental Health Small Business Research study conducted by Policy Research Associates, Inc. (PRA) that formalized a strategic planning approach to the Sequential Intercept Model known as Sequential Intercept Mapping (formerly "cross system mapping"). To date, PRA has conducted Sequential Intercept Mapping (SIM) workshops in over 200 communities throughout the country. These facilitated and interactive workshops involve convening cross-system groups of key stakeholders to assess available resources, identify gaps in services, develop priorities for change, and engage in strategic planning.

Community corrections agencies are essential participants in Sequential Intercept Mapping efforts and can also benefit greatly from the process. Although community corrections agencies operate primarily on the back end of the criminal justice system at Intercept 5, they have a critical role in promoting engagement in treatment, connecting people with services and supports, reducing recidivism, and maintaining public safety, all of which can support positive outcomes for people with mental and substance use disorders who are involved in the criminal justice system. Community Corrections agencies can also be integral partners in efforts at earlier intercepts as well. For example, many community corrections agencies play a role at Intercepts 2 and 3 (Initial Detention/Court Hearing and Jails/Courts), as they provide pretrial supervision as well as supervision for drug court and mental health court participants. Community corrections agencies are also frequently involved in reentry planning and transitioning people from jail or prison into the community at Intercept 4 (Reentry).

In some cases, community corrections agencies have taken the lead in organizing Sequential Intercept Mapping efforts in their communities. The Napa County Probation Department in California organized and hosted a SIM workshop in 2018. The group of key stakeholders who attended used the SIM workshop to guide planning for the establishment of a 72-bed reentry resource center that would be managed by the probation department. The center was designed to assist individuals with mental and substance use disorders being released from jails and prisons with case management and access to housing, medications, treatment, and other support services. Napa County attendees also used the workshop to engage in strategic planning for expanding housing options in the community in response to a lack of housing. In addition, they worked to develop a more coordinated and structured approach to reentry planning, with linkage to community-based treatment providers and other support services. Finally, they successfully worked to address the county's need to improve data and information sharing between agencies within the criminal justice and behavioral health systems.

That same year the Marion County Probation Department in Indiana took the lead in organizing and hosting a SIM workshop. This SIM workshop was used to develop a process for enrolling people in benefits prior to their release from jail or prison in order to improve access to treatment and other supportive services in the community. It also resulted in an increase in the amount of medication provided to individuals at the time of release and the expansion of housing options in the community. Finally, through that workshop the probation department identified validated screening and assessment tools and established specialized caseloads for people with mental and substance use disorders.

Also worth mentioning is a 2019 SIM workshop organized and hosted by the Probation Department in Yuma County, Arizona. Among the areas of focus were guidance in planning for an integrated health clinic within the probation department, Crisis Intervention Team training for probation officers, developing capacity within the probation department to schedule mental health and substance use treatment intake appointments, improving communication between case managers and probation officers, and implementing peer support during reentry.

RESOLVING GAPS AT KEY INTERCEPT POINTS

PRA recently completed an analysis of reports from SIM workshops that took place between 2015 and 2018, and the results revealed that groups of key stakeholders participating in the workshops frequently identified

Priorities established in response included expanding medication availability in jails and prisons, providing medication at the time of discharge (and increasing the amount of such discharge medications provided), and ensuring access to medication sources for continuity of medications in the community.

and developed strategies to address gaps in services at Intercepts 4 and 5 (Reentry and Community Corrections). The most prevalent gaps in services were discharge planning and reentry, access to housing, access to medications, staffing shortages, large caseloads, and transportation (Rogers, 2019).

Discharge planning and reentry was the most frequently identified area with gaps in services. Some of the specific issues identified were limited time for discharge planning and lack of information about release dates, limited knowledge of the availability of reentry services and supports and how to access them, and lack of identification documents needed to access services and supports in the community. To address these gaps, workshop attendees established priorities that commonly included developing discharge planning and reentry guides, improving notification and coordination of discharge timing, implementing programs to assist with obtaining identification and benefits, and improving linkage to treatment and other supports in the community.

Access to housing was the next most frequently identified area with service gaps. Some of the specific issues identified were a lack of immediate emergency and transitional housing, limited permanent housing options—particularly for people with mental and substance use disorders who have criminal justice histories—and the problem of people being unable to pay for housing on their own combined with a lack of funding for housing. The priorities established in response included developing immediate emergency housing and transitional housing, educating the public about homelessness, and developing strategies to expand the availability of safe and affordable housing both generally and for those with both mental and

substance use disorders and criminal justice histories.

Difficulty in getting access to medications was near the top of the problem list as well. Some of the specific issues identified were limited amounts of medications being provided at the time of discharge, need for continuity of medication following discharge, and difficulty obtaining medications in the community. Priorities established in response included expanding medication availability in jails and prisons, providing medication at the time of discharge (and increasing the amount of such discharge medications provided), and ensuring access to medication sources for continuity of medications in the community.

Staffing shortages and large caseloads were reported as a challenge for many community corrections agencies. Some of the specific issues identified in the general category of staffing were high rates of staff turnover, staff shortages and large caseloads, and lack of training. As a result, priorities were often established that included efforts to improve staff retention. In addition, priority was given to designating dedicated officers with specialized caseloads of people with mental and substance use disorders that are typically smaller in size than traditional caseloads, to providing specialized training, and to ensuring access to the latest information about treatment providers and other support services available in the community.

Last but not least were the reported gaps in services involving transportation, with needs particularly acute in rural areas and areas with little or no public transportation. Priorities established in response included expanding transportation options, providing assistance to pay for transportation, and expanding the use of technology to provide tele-behavioral health services.

One combined approach that helps agencies cut down barriers and cross over to address multiple gaps in services has been establishing reentry resource centers. Many community corrections agencies have been involved in the establishment of reentry resource centers with co-located services to connect people with mental and substance use disorders with treatment and other support services in the community. Such centers can also assist clients in accessing identification, benefits, housing, and employment.

SIM workshops assist with the identification of resources and the development of strategic plans to address all the previously mentioned gaps in services, as well as other gaps in services that exist at earlier intercepts, through collaboration between key stakeholders from criminal justice and behavioral health systems.

REFERENCES

Abram, K. M., & Teplin, L. A. (1991). Co-occurring disorders among mentally ill jail detainees. *American Psychologist*, 46, 1036-1045.

Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behav Sci Law*. 2017;1-16. https://doi.org/10.1002/bsl.2300

Griffin, P. A., Munetz, M., Bonfine, N., & Kemp, K. (2015). Development of the sequential intercept model: The search for a conceptual model. In Griffin, P.A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness* (pp.21-39). New York: Oxford University Press. DOI: 10.1093/med:psych/9780199826759.001.0001

Kaeble, D., & Cowhig, M. (2018). *Correctional populations in the United States, 2016*. (NCJ 251211). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57, 544-549. DOI: 10.1176/ps.2006.57.4.544

Policy Research Associates. (2018). *The sequential intercept model: advancing community-based solutions for justice-involved people with mental and substance use disorders*. https://www.prainc.com/wp-content/uploads/2018/06/SIM-Brochure-2018-Web.pdf

Rogers, S. (2019). *Sequential Intercept Mapping Report Analysis*. Unpublished Manuscript.

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60, 761-765. DOI: 10.1176/ps.2009.60.6.761

Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

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ADAPTING A CLINICAL CASE CONSULTATION MODEL TO ENHANCE CAPACITY OF SPECIALTY MENTAL HEALTH PROBATION OFFICERS

BY MARILYN GHEZZI, TONYA B. VAN DEINSE, ERIKA L. CRABLE, KAREN BUCK, MAGGIE BREWER, SONYA BROWN, NICOLE SULLIVAN, AND GARY S. CUDDEBACK

Specialty mental health probation (SMHP) is a form of modified supervision designed to enhance mental health treatment engagement and reduce probation violations and recidivism among adults with mental illnesses (Manchak, Skeem, Kennealy, & Eno Louden, 2014; Skeem, Manchak, & Montoya, 2017; Wolff et al., 2014). Typical SMHP models have five core elements: (1) reduced caseload size; (2) ongoing mental health training; (3) designated and exclusive caseloads of individuals with mental illnesses; (4) coordination with internal and external resources; and (5) use of a problem-solving supervision orientation (Manchak et al., 2014; Skeem, Emke-Francis, & Eno Louden, 2006; Skeem et al., 2017; Wolff et al., 2014). Given the complexity of supervision duties in this setting, strategies are needed to enhance SMHP officers' capacity for acquiring new knowledge and practicing a mental health-focused skill set.

Clinical case consultation has been identified as an effective implementation strategy that utilizes practice feedback, coaching, and active learning to support the uptake of evidence-based practices (EBPs) in mental health services settings (Nadeem, Gleacher, & Beidas, 2013). Research has shown the effectiveness of clinical case consultation in mental health services (Beidas, Edmunds, Marcus, & Kendall, 2012; Fritz et al., 2013; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004; Sholomskas et al., 2005), but studies to date have not specifically examined clinical case consultation in regard to SMHP.

Our research team conducted a study with the North Carolina Department of Public Safety that examined the effectiveness of a clinical case consultation model we designed to provide education and skills training to SMHP officers. The introduction of clinical case consultation in this setting was intended to enhance the SMHP officers' ability to problem solve cases, provide more effective supervision of individuals with mental illnesses, balance criminal justice and mental health considerations in making supervision decisions, and interface with local behavioral health and social service providers. In this article, we describe our study and its outcomes. To aid in further understanding of this subject, we cover the core features of clinical case consultation for SMHP officers, present some lessons learned, and offer suggestions for probation agencies considering using clinical case consultation to build and enhance SMHP programs.

PROCESS FOR PROVIDING CLINICAL CASE CONSULTATION

Clinical case consultation was delivered by a licensed clinical social worker (LCSW) with over 20 years of community mental health experience in working with individuals

who have severe and persistent mental illnesses. This LCSW provided clinical case consultation via monthly meetings with SMHP officers and their specialty mental health chief probation officers (the mid-level managers who directly supervise the state's probation officers). Most consultation meetings occurred in person, with the consultant traveling to meet with the SMHP officers and chiefs in their probation offices, although meetings were occasionally conducted over the phone.

Prior to these in-person and phone consultations, officers were asked to identify cases to present and discuss using a case presentation format (i.e., presentation of diagnosis and/or symptoms, brief psychosocial history, and current behaviors and problems). Since the officers were not familiar with this case presentation format, which is routinely used in mental health settings, an orientation to its use was provided verbally and in writing (see Table 1). The LCSW consultant, SMHP officers, and chiefs discussed each case, and the LCSW offered insights regarding mental health symptoms and behaviors and their implications for treatment and potential impact on an individual's ability to meet probation requirements. This process is described in more detail below.

COMPONENTS OF CLINICAL CASE CONSULTATION ADAPTED FOR SMHP

Typical clinical case consultation models promote knowledge and skills acquisition via the following seven core elements, as defined by Nadeem et al. (2013): (1) continued training; (2) problem-solving to address implementation barriers; (3) provider engagement; (4) direct case application; (5) appropriate treatment adaptation; (6) accountability; (7) mastery skill-building; and (8) planning for sustainability. Although these core elements have been primarily used in mental health services to enhance the uptake of evidence-based practices (Beidas et al., 2012; Edmunds, Beidas, & Kendall, 2013; Nadeem et al., 2013), they have broad applicability for implementing evidence-informed correctional practices, such as SMHP.

CONTINUED TRAINING

Mental health training was provided to SMHP officers via face-to-face biannual training sessions and a six-part web-based training. For the biannual component, all SMHP officers and their respective chiefs (i.e., direct supervisors) participated in 12 hours of training offered over a two-day period. Topics included: (1) as-needed booster sessions on mental health signs and symptoms; (2) introductory and refresher sessions on how SMHP officers and chiefs can best utilize case consultation (e.g., case formulation and

reporting); (3) introductory and booster sessions for dual disorder motivational interviewing adapted specifically for SMHP; and (4) updates regarding any topics pertaining to policy or protocol (e.g., effective notetaking and documentation).

With regard to initial and on-going training, all SMHP officers were required to view the following six mental health training modules delivered through the state's learning management system: (1) how to interpret and discuss individuals' responses to the state's offender mental health screen; (2) severe and persistent mental illnesses and symptoms; (3) psychiatric medications, uses and side effects; (4) personality disorders, traumatic brain injury, and other disorders; (5) mental health services for individuals with severe and persistent mental illnesses; and (6) self-care for probation officers. Content covered in the biannual training and the six learning modules was then reinforced during monthly case consultation sessions with the LCSW consultant, which allowed SMHP officers to ask specific questions about applying different skills and interventions with the individuals on their caseloads.

During case consultation, the LCSW consultant was also able to identify additional training needs and resources. For example, officers identified that working with homeless individuals was particularly challenging. In response, our team arranged for regular contact with a local housing expert from the area's mental health managed care organization. In another instance, SMHP officers indicated that although they had experience supervising perpetrators of intimate partner violence (IPV), they were much less clear about how to talk with survivors of IPV and did not know about local IPV services and resources. This led to the development and delivery of a brief segment about IPV during subsequent biannual training.

PROBLEM SOLVING IMPLEMENTATION BARRIERS

Monthly case consultations allowed officers to discuss challenges that arose in implementing SMHP, particularly during the early phases of implementation. Officers noted challenges related to: (1) working with specific individuals on their caseloads (e.g., those with particularly challenging mental health symptoms); (2) difficulties maintaining the reduced caseload size of 40-50 individuals, often due to officer turnover involving regular probation officers which created vacancies in the department; feeling overwhelmed with their workload; (3) juggling competing demands; (4) managing barriers in communication about the intervention during early implementation; and, (5) difficulties connecting individuals with services due to limited local mental health services.

The SMHP officers raised supervision concerns during clinical case consultations and worked with the LCSW consultant to solve problems involving a variety of issues. Problem-solving approaches often involved the identification of potentially relevant interventions and additional resources available to address officers' specific needs or the needs of individuals on their caseloads.

PROVIDER ENGAGEMENT

Nadeem, Gleacher, and Beidas (2013) describe the importance of engaging providers and other key organizational stakeholders, including leadership and supervisors, to achieve successful implementation of an intervention. During the early phases of implementing case consultation, for example, the LCSW consultant would regularly check in with the SMHP officers' chiefs about the status of the SMHP intervention in order to address questions or challenges raised by the officers and chiefs. The LCSW consultant, chiefs, and SMHP officers all believed that this additional communication with the LCSW consultant was beneficial and decided to formalize the process by inviting the chiefs to each consultation session.

Expanding consultation sessions to include the chief officer rather than just the SMHP officer and LCSW consultant improved the quality of the case consultation meetings because the chief officers were able to share their criminal justice and administrative expertise and provide additional guidance for managing each supervision case. Including the chief officer in these consultations had the added benefit of actively engaging the chiefs in the delivery of SMHP. Furthermore, the LCSW consultant met regularly with state-level Department of Public Safety community corrections' administrators to provide feedback on implementation, troubleshoot barriers (e.g., prohibitively large SMHP officer caseload sizes), and identify additional training needs and resources for the SMHP officers and chiefs.

DIRECT CASE APPLICATION

Monthly consultation sessions were primarily used to discuss cases that SMHP officers found difficult, confusing, or frustrating. Cases were viewed as challenging for various reasons, including: (1) specific characteristics of individuals on the caseload (e.g., lack of motivation, confusing speech patterns, cognitive deficits); (2) problems identifying and accessing resources (e.g., transportation, mental health providers, housing); (3) officers' self-identified limitations for specific skill sets (e.g., lack of experience with motivational interviewing or lack of understanding mental health services); and (4) officers' emotional reactions to individuals on their caseloads. In order to facilitate the consultation process to maximize time spent identifying resources

and practicing skills, the LCSW consultant developed a protocol for case consultation that asked each officer to prepare for the clinical consultation meeting by bringing the case file and developing the case description using a structured format (see Table 1).

TABLE 1: CASE REPORT FORMAT

Case Report Task	Description
Orientation to the case	Provide a brief demographic description that includes age, race, gender, criminal charge, and other pertinent background information (e.g., "Probationer is a 24-year old white female who is on probation for marijuana possession with intent to distribute").
Summary of life domains	Provide a brief description of the individual's status across multiple life domains (e.g., basic needs, medical problems, mental health, substance use, housing, etc.). Examples may include the following: • How long has the individual been on probation? • What is the individual's living situation? Who lives or stays in the home? • Does the individual have a partner or children? • Is the individual working or on disability? • What do you know about the individual's mental health diagnosis or mental health problems? • What do you know about the individual's substance use? • Does the individual have any current or past mental health or substance use treatment?
Topic for consultation	After an overview of the individual is provided, SMHP officers should indicate what question or challenge that they would like to discuss with the consultant.

Through this process, officers become increasingly aware of the importance of an individual's history and social context. The LCSW consultant would then provide more information about the identified issue (such as explaining why an actively psychotic individual might be suspicious about taking medication), reinforce officer skills (e.g., motivational interviewing), problem solve system-level challenges (e.g., securing transportation to provider appointments in a rural area), and/or provide emotional support and validation to the SMHP officers, which often served to boost morale and reduce burnout.

APPROPRIATE TREATMENT ADAPTATION

The goal of delivering clinical case consultation was to promote consistency between real-world implementation of SMHP and the prototypical model of SMHP. However, SMHP model components can and should be adapted to the local contexts to further aid implementation and promote sustainability. For example, the core components of SMHP specify that officers develop relationships and engage regularly with community-based mental health and social service providers. As such, officers delivering SMHP may need to tailor their approach to building and maintaining these relationships based on the capacity of the local service system.

Officers participating in clinical case consultations described how coordination with external resources varied widely from county to county based on the number of mental health providers and the level of involvement and support from the local managed care organization (the entity responsible for managing the array of behavioral health services for a given catchment area). Counties that had well-established partnerships between criminal justice entities and the mental health system required less consultation around service coordination or information about the types of services available; rather, these SMHP officers sought assistance in addressing specific communication challenges between officers and mental health service providers (e.g., responses to requests for treatment confirmation) or ways to advocate for higher levels of services for individuals on their caseloads.

ACCOUNTABILITY

The clinical case consultation process involved a monthly commitment between the LCSW consultant, SMHP officers, and their chiefs. For officers, this commitment required prioritizing consultation time while balancing typical workload responsibilities, reflecting on current caseload challenges to select cases for discussion, preparing materials for the case report, and actively engaging in the consultation session. In addition, state-level administrators endorsed clinical case consultation and asked that SMHP officers and chiefs participate regularly, thereby increasing accountability.

In turn, the primary way in which the LCSW consultant demonstrated her accountability was the consistent application of her skillset to address officers' and chief's challenges. In particular, the LCSW consultant demonstrated clinical knowledge, "fluency" in probation terms and acronyms, knowledge of probation's primary mission of public safety, rapport building with officers and chiefs, and knowledge about the local mental health system's types of services and referral process. In addition, the LCSW consultant

demonstrated accountability and commitment through her regular presence at the probation offices, which were often several hours away from the university, and by making herself available to the SMHP officers and chiefs as challenges arose.

MASTERY SKILL BUILDING

Although most of the consultation sessions were structured around the case report and feedback process, a portion of sessions were used for role plays and modeling behaviors in order to reinforce officers' skills to address specific case-related challenges. For example, an officer may need ideas about how to talk with a person who is hearing voices. The LCSW consultant can use the consultation session to model this behavior for the officer by providing language that will be non-threatening as well as ways to sidestep delusional content in a conversation with the individual. In addition, the LCSW consultant regularly worked with officers to discuss how motivational interviewing could be integrated into SMHP officers' supervision sessions. The LCSW consultant also encouraged SMHP officers to audiotape role plays of motivational interviewing with a fellow officer and submit them to the LCSW consultant for review.

PLANNING FOR SUSTAINABILITY

The final element in the case consultation model (Nadeem et al., 2013) is planning for sustainability. Although the most critical time to implement a clinical case consultation strategy for SMHP may be during initial and early implementation, SMHP officers and their chiefs reported that they benefitted from ongoing consultation. The need for ongoing clinical case consultation is expected because probation officers are using an interdisciplinary approach that requires them to apply knowledge about mental health conditions and anticipate potential supervision challenges for individuals with mental illnesses who are on probation.

Although the benefits of ongoing clinical case consultation may be evident, it is a resource-intensive model that requires a plan for sustainability. Officers and their direct supervisors must dedicate time to preparing for and participating in consultation meetings. Additionally, probation departments will need to consider the cost of funding such as model. For smaller pilot projects, it is possible that one LCSW consultant is sufficient. However, depending on the scale of a state or jurisdiction's approach, multiple consultant positions will be needed. An untested, but potentially cost-efficient model for states, larger county- or regional-level jurisdictions may

include employing a social work assistant to conduct clinical case consultations with officers and chiefs. The clinical case consultation model described here evolved over the last several years and has focused on building the capacity of senior officers and chiefs who may later serve as coaches. Building the capacity and expertise of others within the agency can decrease reliance on an external case consultant and enhance model sustainability. Jurisdictions with multiple levels of management (e.g., direct supervisors, mid-level managers) may have an infrastructure in place that would be conducive to this type of coaching model.

FUTURE RESEARCH

In this article, we describe a model of clinical case consultation adapted for probation settings as an implementation strategy for SMHP. Case consultation has the potential to be an effective strategy for implementing evidence-informed interventions within criminal justice settings, but additional research is needed. Agencies and their research partners interested in this consultation model for SMHP should consider piloting such a strategy in a small number of counties or jurisdictions to examine the feasibility of the model. In addition, agency administrators and researchers should consider examining the outcomes of clinical case consultation regarding SMHP officer knowledge and skills.

REFERENCES

Beidas, R. S., Edmunds, J. M., Marcus, S. C., & Kendall, P. C. (2012). Training and consultation to promote implementation of an empirically supported treatment: A randomized trial. *Psychiatric Services*, *63*(7), 660-665.

Edmunds, J. M., Beidas, R. S., & Kendall, P. C. (2013). Dissemination and implementation of evidence–based practices: Training and consultation as implementation strategies. *Clinical Psychology: Science and Practice*, *20*(2), 152-165.

Fritz, R. M., Tempel, A. B., Sigel, B. A., Conners-Burrow, N. A., Worley, K. B., & Kramer, T. L. (2013). Improving the dissemination of evidence-based treatments: Facilitators and barriers to participating in case consultation. *Professional Psychology: Research and Practice*, *44*(4), 225.

Manchak, S. M., Skeem, J. L., Kennealy, P. J., & Eno Louden, J. (2014). High-fidelity specialty mental health probation improves officer practices, treatment access, and rule compliance. *Law and Human Behavior*, *38*(5), 450. doi:10.1037/lhb0000076

Miller, W. R., Yahne, C. E., Moyers, T. B., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting and Clinical Psychology*, *72*(6), 1050.

Nadeem, E., Gleacher, A., & Beidas, R. S. (2013). Consultation as an implementation strategy for evidence-based practices across multiple contexts: Unpacking the black box. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*(6), 439-450.

Sholomskas, D. E., Syracuse-Siewert, G., Rounsaville, B. J., Ball, S. A., Nuro, K. F., & Carroll,

K. M. (2005). We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology*, *73*(1), 106.

Skeem, J. L., Emke-Francis, P., & Eno Louden, J. (2006). Probation, mental health, and mandated treatment a national survey. *Criminal Justice and Behavior*, *33*(2), 158-184. doi: 10.1177/0093854805284420

Skeem, J. L., Manchak, S., & Montoya, L. (2017). Comparing public safety outcomes for traditional probation vs specialty mental health probation. *JAMA Psychiatry*, *74*(9), 942-948. doi:10.1001/jamapsychiatry.2017.1384

Wolff, N., Epperson, M., Shi, J., Huening, J., Schumann, B. E., & Sullivan, I. R. (2014). Mental health specialized probation caseloads: Are they effective? *International Journal of Law and Psychiatry, 37*, 464–472. doi: 10.1016/j.ijlp.2014.02.019

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USING IMPLEMENTATION SCIENCE TO ADVANCE SPECIALIZED MENTAL HEALTH PROBATION APPROACHES

BY TONYA B. VAN DEINSE, GARY S. CUDDEBACK, MARILYN GHEZZI, ERIKA L. CRABLE, KAREN BUCK, MAGGIE BREWER, SONYA BROWN, NICOLE SULLIVAN

DEVELOPMENT OF THE EVIDENCE SUPPORTING SPECIALTY MENTAL HEALTH PROBATION

The focus on the mental health needs of individuals in the criminal justice system, particularly among adults on probation, has been accelerated by a number of developments over the last two decades. In 2002, in its report on the Criminal Justice/Mental Health Consensus Project, the Council of State Governments (CSG) outlined a number of actionable policy statements and recommendations for addressing the mental health needs of justice-involved individuals. CSG's specific recommendations for community supervision included: (1) impose modified supervision conditions, (2) give more attention to psychosocial needs, (3) ensure greater continuity of federal and state benefits to enable treatment engagement, (4) assign individuals with mental illnesses to designated mental health officers, (5) reduce caseload sizes for specialty mental health caseloads, and (6) develop guidelines for managing supervision compliance (CSG, 2002). In 2003, the American Probation and Parole Association (APPA), advanced CSG's recommendations by adopting a resolution calling for programs, policies, and legislation that would improve the community supervision response to mental illness. APPA also recommended that Congress, the Department of Justice, and the Department of Health and Human Services partner with states and jurisdictions to increase access to funding to meet the goals of the resolution.

Concurrent with CSG and APPA efforts, research focused on individuals with serious mental illnesses in the criminal justice system and interventions at the interface of the mental health and criminal justice systems also accelerated. In 2006, Skeem and colleagues conducted a national survey to assess the variation in specialty mental health probation (SMHP) approaches across the U.S. and codified a prototypical model of SMHP composed of five key elements: (1) caseloads composed exclusively of adults with mental illnesses; (2) small caseloads (i.e., less than 50 individuals); (3) sustained mental health training for officers; (4) a problem-solving supervision orientation;

and (5) collaboration with internal and external resources to link individuals with supports (Skeem, Emke-Francis, & Eno Louden, 2006). In identifying these five elements as prototypical model components, they aimed to reduce the variability in SMHP models and to focus on specific SMHP features that were reproducible in research. Subsequent to publication of that survey, additional studies have examined the effectiveness of the prototypical model to determine the strength of the evidence for this specialty probation approach (Manchak, Skeem, Kennealy, & Eno Louden, 2014; Skeem, Manchak, & Montoya, 2017; Wolff et al., 2014).

Many studies have focused on understanding SMHP's effectiveness, but those in the criminal justice research field have paid less attention to factors affecting the implementation of SMHP.

Many studies have focused on understanding SMHP's effectiveness, but those in the criminal justice research field have paid less attention to factors affecting the implementation of SMHP. In fact, there is a dearth of published, peer-reviewed research and grey literature (e.g., agency reports) examining SMHP model implementation (Manchak et al., 2014; Van Deinse, Bunger, Burgin, Wilson, & Cuddeback, 2019). This gap in the literature is problematic, given the complexity of SMHP models (i.e., multiple interrelated components), their interdisciplinary approach (e.g., behavioral health and criminal justice), and their reliance on the existence of and interactions with an external resource environment, including mental health services (Van Deinse et al., 2019). This lack of focus on implementation leaves probation agencies without a roadmap for implementing complex interventions, such as SMHP, which require probation officers and agencies to expand their role and scope of practice beyond public safety and to establish an infrastructure to sustain SMHP model fidelity beyond initial implementation.

IMPLEMENTATION SCIENCE AND COMMUNITY CORRECTIONS

Twenty years ago, Gendreau, Goggin and Smith (1999) posited 32 principles of program implementation across four distinct categories: (1) organizational factors, (2) program factors, (3) change agents, and (4) staffing activities. Although these implementation principles were based on observations from a single research team's experiences, Gendreau et al.'s approach was one of the first applications of an implementation science approach described within the criminal justice literature. Since then, the nascent field of implementation science has grown across numerous disciplines including medicine, mental health services, and child welfare, and has enhanced our understanding of how evidence-based practices are adopted (Chambers, Feero, & Khoury, 2016; Glasgow et al., 2012; Landsverk, Brown, Reutz, Palinkas, & Horwitz, 2011; Proctor et al., 2009).

For example, in 2002, the national Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) initiative focused on developing implementation strategies to enhance interventions addressing drug abuse in justice-involved individuals (Ducharme, Chandler, & Wiley, 2013; Friedmann et al., 2012; Welsh et al., 2016a; Welsh et al., 2016b). CJ-DATS demonstrated the utility of implementation science frameworks and implementation strategies and the relevance of these methods for enhancing the implementation of interventions in diverse community corrections settings.

SPECIALTY MENTAL HEALTH PROBATION AND IMPLEMENTATION SCIENCE: A CASE EXAMPLE

In 2012, the North Carolina Governor's Crime Commission awarded a research grant to the North Carolina Department of Public Safety (NCDPS) and the University of North Carolina at Chapel Hill (UNC-CH) to pilot test a prototypical model of SMHP in one rural and one urban county. NCDPS and UNC-CH were later awarded a three-year grant from the Bureau of Justice Assistance to expand the pilot into six additional counties. The following section of this article describes four ways NCDPS and UNC-CH used an implementation science approach during the two-county pilot study (2012-2014) and the six-county expansion project (2015-2019) to assess the evidence base for SMHP, examine SMHP implementation, develop reproducible implementation strategies, and use study results to plan for dissemination and sustainability.

DEVELOP AN ACADEMIC PARTNERSHIP

Implementation science research recommends formal relationships between agencies and academic institutions in order to share skills, integrate research perspectives, and conduct evaluations (Powell et al., 2015). The academic

partnership between NCDPS and the UNC-CH began in 2009 when a research team from UNC-CH worked with NCDPS on a project related to the community corrections workforce, caseload size, and specialized caseloads. In 2011, following reports of serious crimes involving probationers with serious mental illnesses, the NCDPS reached out to the UNC-CH team to assist with the development and implementation of special programming for individuals with serious mental illnesses. The UNC-CH team developed a series of mental health training modules for all officers across the state and developed, implemented, and evaluated SMHP in the two-county and subsequent six-county pilot studies mentioned above. This ongoing partnership has created opportunities for rigorous research methods (e.g., randomized controlled trials) and the development and testing of implementation strategies to plan for statewide dissemination of SMHP.

IMPLEMENT HYBRID EFFECTIVENESS-IMPLEMENTATION STUDIES

Hybrid or blended research designs simultaneously focus on the effectiveness of an intervention and its implementation. This dual focus allows for rapid generation of useful knowledge about an intervention and the development of effective implementation strategies, both of which can facilitate quicker uptake of the intervention (Curran et al., 2012). The UNC-CH research team chose this hybrid research design to be able to rigorously assess the evidence of SMHP while examining its implementation under real-world conditions.

The effectiveness arm of the study used a randomized controlled trial in which individuals on probation who agreed to participate in the study were randomly assigned to a standard caseload or a SMHP caseload. The implementation arm was a simultaneous process evaluation (Curran et al., 2012) which examined factors impacting the implementation of SMHP (e.g., barriers and facilitators; see Van Deinse et al., 2019), developed strategies to enhance the uptake of core components of the model, and examined inter-organizational relationships between SMHP officers and resource providers. Due to the lessons learned from the hybrid effectiveness-implementation study during the two-county pilot, NCDPS and the UNC-CH research team were able to rapidly expand the model into the six additional counties.

ASSESS THE LOCAL CONTEXT AND DETERMINE READINESS FOR IMPLEMENTATION

Given the complexity and interdisciplinary nature of SMHP, readiness for implementation depends on multilevel factors (officers, agency, community). The implementation science literature recommends conducting local

assessments to identify factors that will impact successful implementation, including individual and organizational readiness for implementation, leadership support, agency capacity and expertise, stakeholder attitudes, available resources, and other strengths that can be leveraged to support implementation (Powell et al., 2015). To assess the local context and readiness for implementation, NCDPS and UNC-CH have used a number of approaches for assessing officer, agency, and community characteristics to learn more about the needs, resources, and potential challenges impacting SMHP implementation.

On an officer level, NCDPS used a two-part assessment of officer characteristics for individuals interested in becoming SMHP officers. The first part of the process involved administering the Dual Role Relationship Inventory-Revised (Skeem, Eno Louden, Polaschek, & Camp, 2007) to a sample of individuals on prospective SMHP officers' caseloads and to their chief officer. NCDPS used these data to determine the fit of the candidate for the role of SMHP officer. The second part of the officer assessment was an examination of officers' case planning notes and documentation to assess for thoroughness in case planning and the use of supervision tools (such as structured worksheets), as well as their follow-through on action steps related to mental health and substance use services.

At the agency level, NCDPS and the UNC-CH team administered the Organizational Readiness for Implementing Change scale (ORIC; Shea, Jacobs, Esserman, Bruce, & Weiner, 2014) and the Implementation Leadership Scale (ILS; Aarons, Ehrhart, & Farahnak, 2014) to assess key organizational and leadership factors that impact successful implementation of interventions. The ORIC measures an agency's change commitment and change efficacy and the ILS examines key characteristics of leaders and their readiness to support the implementation of interventions, such as being proactive, knowledgeable, supportive, and perseverant. The UNC-CH team administered these surveys to all officers in the six-county expansion project to assess needs across counties prior to initial SMHP implementation and to troubleshoot any problematic trends (e.g., low levels of reported knowledge of SMHP in a particular county).

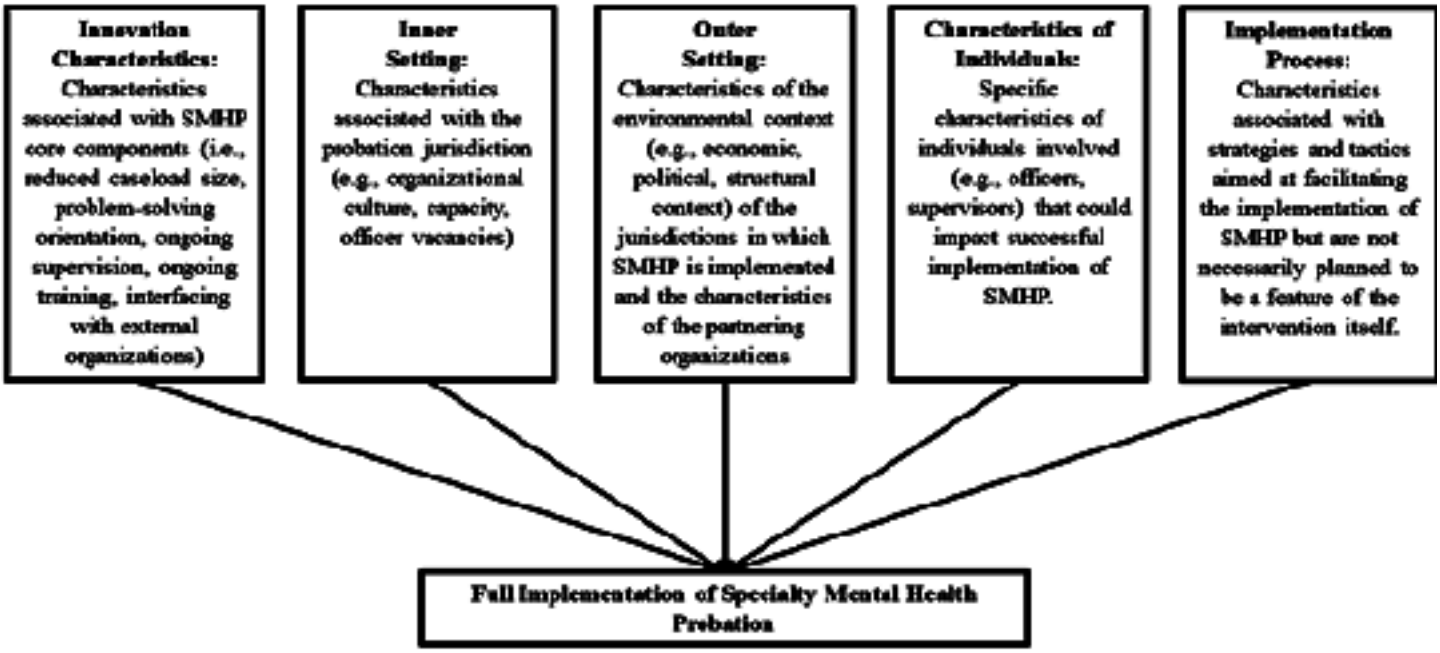
At the community level, the UNC-CH team conducted a number of interviews with key stakeholders involved with initial implementation of the two-county pilot to understand factors that were promoting and/or inhibiting implementation. Results from this analysis were used to identify needs and inform subsequent strategies for implementation (Van Deinse, et al., 2019).

To plan the assessment activities described here, agencies and research partners should consider selecting an implementation framework. Frameworks and theories in implementation science are used to guide how research is translated to practice, to understand what factors impact implementation, and to guide the development of evaluations of implementation (Nilsen, 2015). For instance, for our assessment of implementation challenges and facilitators during the two-county study, the UNC-CH research team selected the consolidated framework for implementation research (CFIR; Damschroder et al., 2009), which consists of five domains that influence successful intervention implementation (see Van Deinse et al., 2019 for a description of how CFIR was applied to SMHP). The CFIR framework (Figure 1) was used to understand the barriers and facilitators associated with implementing SMHP and was selected because it is a widely used framework that provides online resources (cfirguide.org) available to researchers and practitioners. CFIR is just one of the available frameworks, and those interested in using a framework to guide their implementation of SMHP should review articles by Nilsen (2015) and Tabak and colleagues (Tabak, Khoong, Chambers, & Brownson, 2012).

SCALE-UP IMPLEMENTATION WITH A PHASED APPROACH

The implementation literature recommends an iterative approach to

Figure 1: SMHP Application of the Consolidation Framework for Implementation Research



implementing models rather than a full-scale roll out of a new intervention (Powell et al., 2015). As described above, North Carolina's SMHP implementation began with the small, two-county pilot study that tested the model's effectiveness using a randomized controlled trial while also assessing the implementation context and building strategies to enhance the adoption of model components. During the pilot phase, the UNC-CH team developed two implementation strategies: (1) clinical case consultation for SMHP officers, and (2) officer-stakeholder engagement.

Clinical case consultation aimed to enhance SMHP officers' capacity (i.e., knowledge and skills) to work with individuals with mental illnesses through monthly consultation sessions with a licensed clinical social worker. Officer-stakeholder engagement activities focused on building SMHP officers' resource networks (i.e., reliable connections to local behavioral health services providers) and consisted of introductory network events, developing points of contact at different agencies, and creating opportunities for case staffing.

Building on the successes of the two-county pilot study, NCDPS and UNC-CH were granted additional funding to disseminate SMHP into six additional counties. In order to select the new counties, NCDPS assessed the capacity of potential counties, checking for the number of vacancies in leadership and officer positions, and balanced the selection of urban and rural settings. After county selection, NCDPS and UNC-CH then used the implementation strategies (clinical case consultation and officer-stakeholder engagement) developed during the pilot phase to rapidly implement SMHP. Currently, the UNC-CH research team and NCDPS are planning to implement SMHP in seven new counties, with future plans to implement the model statewide.

CONCLUDING REMARKS

This article describes how implementation science methods and frameworks were used to inform and study the implementation of SMHP in one state. The methods described here are not a representative or exhaustive list of the ways in which implementation science can be integrated into community corrections in general or for SMHP specifically. Agencies and research partners interested in integrating implementation science methods into their practices should consider reviewing these two articles available from the journal *Implementation Science* (https://implementationscience.biomedcentral.com/), which is an open source journal that publishes articles on implementation science methods: (1) "An Introduction to Implementation Science for the Non-Specialist" (Bauer, Damschroder,

Hagedorn, Smith, & Kilbourne (2015); and (2) "A Refined Compilation of Implementation Strategies: Results from the Expert Recommendations for Implementation Change (ERIC) Project" (Powell et al., 2015), which includes useful ancillary materials. Although many resources reference health care settings, the methods described therein are broadly applicable to intervention implementation in other sectors such as community corrections.

REFERENCES

Aarons, G. A., Ehrhart, M. G., & Farahnak, L. R. (2014). The implementation leadership scale (ILS): Development of a brief measure of unit level implementation leadership. *Implementation Science*, *9*(1), 45.

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC psychology*, *3*(1), 32.

Chambers, D. A., Feero, W. G., & Khoury, M. J. (2016). Convergence of implementation science, precision medicine, and the learning health care system: A new model for biomedical research. *Journal of the American Medical Association*, *315*(18), 1941-1942.

Council of State Governments. (2002). Criminal Justice/Mental Health Consensus Project. New York: Council of State Governments.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science* 4(1):50. doi: 10.1186/1748-5908-4-50

Ducharme, L. J., Chandler, R. K., & Wiley, T. R. (2013). Implementing drug abuse treatment services in criminal justice settings: Introduction to the CJ-DATS study protocol series. *Health & Justice*, *1*(1), 5.

Friedmann, P. D., Hoskinson Jr, R., Gordon, M., Schwartz, R., Kinlock, T., Knight, K., ... & O'Connell, D. J. (2012). Medication-assisted treatment in criminal justice agencies affiliated with the criminal justice-drug abuse treatment studies (CJ-DATS): Availability, barriers, and intentions. *Substance Abuse*, *33*(1), 9-18.

Gendreau, P., Goggin, C., & Smith, P. (1999). The forgotten issue in effective correctional treatment: Program implementation. *International Journal of Offender Therapy and Comparative Criminology, 43*(2), 180-187. https://doi.org/10.1177/0306624X99432005

Glasgow, R. E., Vinson, C., Chambers, D., Khoury, M. J., Kaplan, R. M., & Hunter, C. (2012). National Institutes of Health approaches to dissemination and implementation science: Current and future directions. *American Journal of Public Health*, *102*(7), 1274-1281.

Landsverk, J., Brown, C. H., Reutz, J. R., Palinkas, L., & Horwitz, S. M. (2011). Design elements in implementation research: A structured review of child welfare and child mental health studies. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(1), 54-63.

Manchak, S. M., Skeem, J. L., Kennealy, P. J., & Eno Louden, J. (2014). High-fidelity specialty mental health probation improves officer practices, treatment access, and rule compliance. *Law and Human Behavior*, *38*(5), 450. doi:10.1037/lhb0000076

Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation science*, *10*(1), 53.

Powell, B. J., Waltz, T. J., Chinman, M. J., Damschroder, L. J., Smith, J. L., Matthieu, M. M., ... & Kirchner, J. E. (2015). A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project. *Implementation Science*, *10*(1), 21

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: an emerging

science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, *36*(1), 24-34.

Shea, C. M., Jacobs, S. R., Esserman, D. A., Bruce, K., & Weiner, B. J. (2014). Organizational readiness for implementing change: A psychometric assessment of a new measure. *Implementation Science*, *9*(1), 7

Skeem, J., Eno Louden, J., Polaschek, D., & Camp, J. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment, 19*(4), 397-410.

Skeem, J. L., Emke-Francis, P., & Eno Louden, J. (2006). Probation, mental health, and mandated treatment: A national survey. *Criminal Justice and Behavior*, *33*(2), 158-184. doi: 10.1177/0093854805284420

Skeem, J. L., Manchak, S., & Montoya, L. (2017). Comparing public safety outcomes for traditional probation vs specialty mental health probation. *JAMA Psychiatry*, *74*(9), 942-948. doi:10.1001/jamapsychiatry.2017.1384

Tabak, R. G., Khoong, E. C., Chambers, D. A., & Brownson, R. C. (2012). Bridging research and practice: models for dissemination and implementation research. *American Journal of Preventive Medicine*, *43*(3), 337-350.

Van Deinse, T. B., Bunger, A., Burgin, S., Wilson, A. B., & Cuddeback, G. S. (2019). Using the consolidated framework for implementation research to examine implementation determinants of specialty mental health probation. *Health Justice, 7*(1), 17. DOI: 10.1186/s40352-019-0098-5

Welsh, W. N., Knudsen, H. K., Knight, K., Ducharme, L., Pankow, J., Urbine, T., ... & Link, N. (2016). Effects of an organizational linkage intervention on inter-organizational service coordination between probation/p%arole agencies and community treatment providers. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(1), 105-121. DOI:0.1007/s10488-014-0623-8

Welsh, W. N., Prendergast, M., Knight, K., Knudsen, H., Monico, L., Gray, J., ... & Shafer, M. S. (2016). Correlates of interorganizational service coordination in community corrections. *Criminal Justice and Behavior*, *43*(4), 483-505. DOI: 10.1177/0093854815607306

Wolff, N., Epperson, M., Shi, J., Huening, J., Schumann, B. E., & Sullivan, I. R. (2014). Mental health specialized probation caseloads: Are they effective? *International Journal of Law and Psychiatry, 37*, 464–472. doi: 10.1016/j.ijlp.2014.02.019

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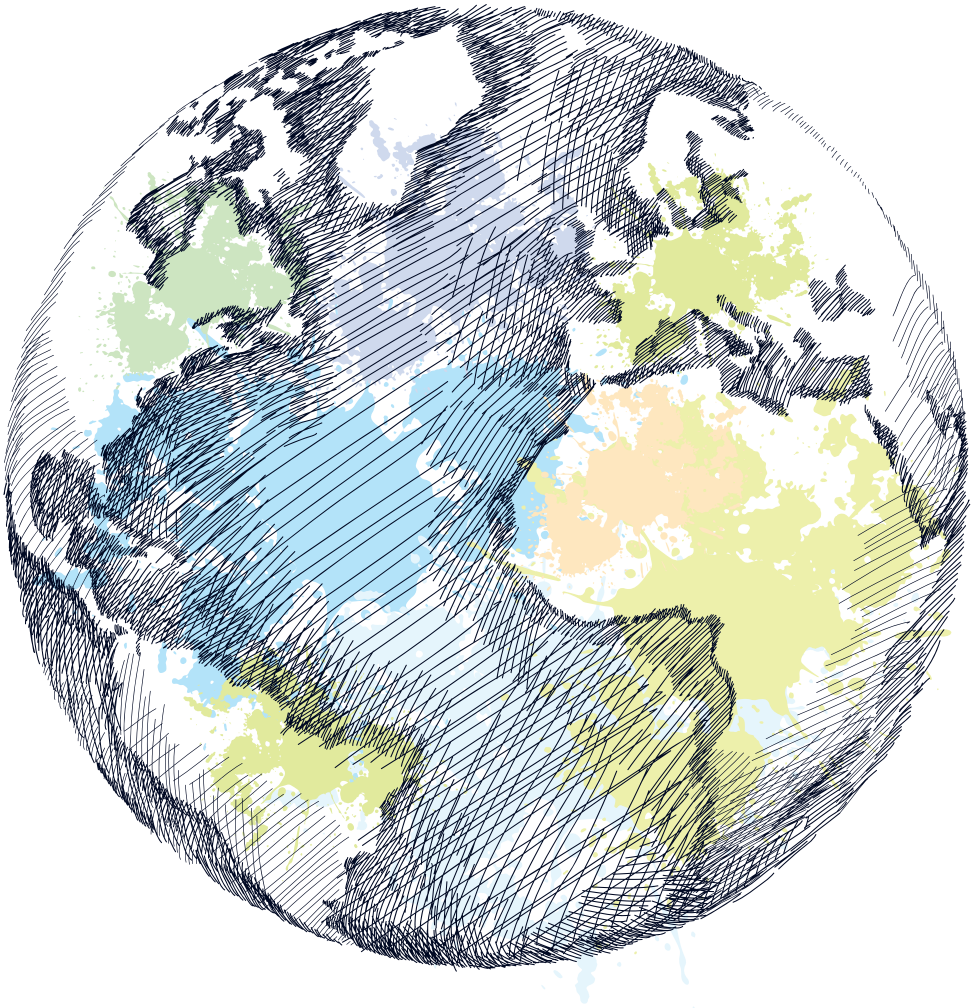
international relations committee update



The International Relations Committee (IRC) is an ad hoc committee whose charteris "to reach out to probation and parole services in other countries in order to exchangeinformation on issues and programs, and to see what application this information mighthave for probation and parole worldwide." Over the years, the IRC has accomplished its charterthrough an evolutionary process of work including:

- International Workshops: Outreach and service as a liaison between APPA and international presenters. Our goal is to attract international workshop presenters at APPA's training institutes and discuss how to reciprocate.
- World Congress (WC): IRC members continue to be actively involved in a number of ways. We have served on the World Congress Advisory (WC)

Committee in which meetings were held in Japan and Australia as well as on-going communication regarding hosting, promoting, and supporting other host countries; co-drafted the WC Terms of Reference (ToR) which was adopted at the 4th WC in Australia in September 2019 (the ToR is designed to be a living document to ascertain a 'fit' for each host that is unique in its country of origin, cultural elements, financial ability, and other surrounding circumstances; and provided input on keynotes, programming, and information related to hosting a WC. Stay tuned for the 5th WC in Ottawa, Canada, in 2021.

- Ambassador Program Concept: International connections will remain as one of the IRC's top priorities. Strengthening international networks and advancing shared learning will be important, albeit challenging given the distance. The IRC is in an early stage of discussion on an ambassador program concept. A number of APPA and IRC members are already doing the work as informal hosts and liaisons. Formalizing some of this work would be helpful to our international attendees and would strengthen relationships.
- Other International Efforts: The Supervision Around the World (SAW) Project was featured in the Winter 2017 issue of *Perspectives*. This initiative is expected to be a good source for information about probation practices around the world. Julie Truschel, SAW Project Director and an IRC member, can be contacted at julie@css360.net if you have questions or wish to support this project.
- Special Thanks: Bob Anderson is thanked for his outreach to young professionals in Europe – he helps APPA gain international membership; and thanks to Ray Wahl and Bill Burrell for their continued guidance in the work of the IRC.

THANH DANG is the current chair of the International Relations Committee and Community Justice Manager with the Multnomah County (OR) Department of Community Justice. She can be reached at thanh.c.dang@multco.us.