Preventing Criminal Recidivism Through Mental Health and Criminal Justice Collaboration

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Criminal justice system involvement is common among persons with serious mental illness in community treatment settings. Various intervention strategies are used to prevent criminal recidivism among justice-involved individuals, including mental health courts, specialty probation, and conditional release programs. Despite differences in these approaches, most involve the use of legal leverage to promote treatment adherence. Evidence supporting the effectiveness of leverage-based interventions at preventing criminal recidivism is mixed, however, with some studies suggesting that involving criminal justice authorities in mental health treatment can increase recidivism rates. The effectiveness of interventions that utilize legal leverage is likely to depend on several factors, including the ability of mental health and criminal justice staff to work together. Collaboration is widely acknowledged as essential in managing justice-involved individuals, yet fundamental differences in goals, values, and methods exist between mental health and criminal justice professionals. This article presents a six-step conceptual framework for optimal mental health–criminal justice collaboration to prevent criminal recidivism among individuals with serious mental illness who are under criminal justice supervision in the community. Combining best practices from each field, the stepwise process includes engagement, assessment, planning and treatment, monitoring, problem solving, and transition. Rationale and opportunities for collaboration at each step are discussed.

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Various intervention strategies are commonly used to prevent criminal recidivism among justice-involved individuals with serious mental illness in community treatment settings. Broadly referred to as "jail diversion" strategies, they include mental health courts, specialty probation and parole, pretrial diversion programs, and conditional release programs. Whereas some diversion strategies simply involve a handoff of patients from the criminal justice system to care providers, most use legal leverage to promote adherence to necessary treatments and services.

Despite the widespread use of leverage-based diversion interventions, evidence supporting their effectiveness at preventing criminal recidivism is mixed at best. In a 2009 review of 21 jail diversion studies, Sirotich (1) stated that the literature "revealed little evidence of the effectiveness of jail diversion in reducing recidivism among persons with serious mental illness." Studies have likewise examined involuntary outpatient commitment, a strategy based on civil law rather than criminal law that also uses legal leverage to promote adherence and prevent recidivism (2,3). Of two randomized controlled trials published to date, only one showed reduced rates of violence and arrest (3). Most recently, a 2014 Cochrane literature review of various forms of legally mandated treatment concluded that "compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard voluntary care" (4).

The effectiveness of leverage-based interventions at preventing criminal recidivism is likely to depend on several factors, including the ability of mental health and criminal justice staff to work together toward common goals. Mental health–criminal justice collaboration is widely recognized as essential in managing justice-involved individuals with serious mental illness in community settings (5–8). In addition, the sequential intercept model has emerged to highlight various points in the criminal justice process that call for such collaboration (9). However, major differences in goals, values, and methods exist between mental health and criminal justice professionals (7,10,11). These differences can directly affect recidivism rates. For example, research by Solomon and Draine (11,12) has shown that involving probation officers in mental health treatment can result in increased threats of jail and increased use of incarceration as a sanction. The authors concluded that this enforcement-oriented approach to collaboration, which uses mental health professionals primarily to report infractions, "significantly enhances the coercive interactions between officers and their clients" (11).

To address this challenge, specialized mental health court, probation, and parole programs have emerged as new models of community supervision designed to "integrate roles, rules and relationships between the two systems" (5). However, studies of these models have continued to show

great variability in how mental health–criminal justice collaboration occurs (13–15). In addition, most justice-involved individuals remain in standard rather than specialty community supervision programs. Also, many mental health professionals remain reluctant to collaborate with criminal justice authorities because of dual-agency concerns (16). These issues have raised the need for a conceptual framework to guide how mental health and criminal justice professionals might collaborate most effectively.

WHAT WORKS

Effective collaboration requires combining best practices in treating mental illness and co-occurring addiction with correctional best practices aimed at preventing criminal recidivism. This strategy is based on strong evidence that the causes of recidivism are essentially the same for people with mental illness and those without mental illness. Therefore, preventing criminal recidivism is likely to require similar intervention approaches for both populations. With over 30 years of research, the field of corrections has examined the effectiveness of various community-based interventions at preventing criminal recidivism (17–19). Interventions have included specialty courts, probation and parole, residential programs, home detention, electronic monitoring, boot camp, and "scared straight"–type programs. These studies have shown that relying primarily on surveillance and punishment is ineffective at preventing criminal recidivism, and the studies underscore the need for rehabilitative approaches to corrections. Research on a variety of rehabilitative strategies—including case management, various forms of counseling, self-help programs, bibliotherapy, pet therapy, acupuncture, and yoga—has consistently shown the superiority of behavioral treatments over nonbehavioral treatments (19,20). Effective correctional programs have been found to share three central characteristics. First, they target risk factors known to drive criminal behavior. Second, they are action oriented, requiring individuals to demonstrate appropriate behaviors. Third, based on social learning theory, they use interventions that reinforce appropriate behaviors while extinguishing inappropriate behaviors. These principles of effective correctional intervention and associated evidence-based practices have become known as the "what works" movement within the field of corrections (17,21,22).

A common misconception about jail diversion programs is that they "divert" justice-involved individuals from one system into another. However, persons with serious mental illness who are under community correctional or judicial supervision in such programs will have ongoing contact with both mental health and criminal justice professionals over a span of months to years. This time frame presents a series of opportunities to combine best practices through mental health–criminal justice collaboration. These opportunities become evident in considering how mental health and criminal justice staff perform similar tasks when managing justice-involved clients in community settings. Both groups of professionals must engage and assess each client, and they must generate and implement individualized service plans. Both groups will also monitor each individual's progress, and both must respond in some manner when problematic behaviors occur. Although the content of these activities differs substantially between mental health and criminal justice professionals, the process by which they are performed has important parallels. These similarities can provide a foundation for effective collaboration in serving justice-involved clients in community settings.

Table 1 provides a basic framework for mental health–criminal justice collaboration in intervention strategies that use legal authority and supervision to promote treatment adherence. The framework conceptualizes the collaborative process as a series of steps with corresponding activities for mental health and criminal justice professionals. It is important to note that Table 1 presents these activities as being separate and distinct in order to provide a clear and logical starting point for discussion between prospective collaborators. However, these activities can and should overlap for effective collaboration, as discussed below.

Step 1: Engagement

Justice-involved individuals should be engaged in each step of the collaborative process (8,23,24). Collaborating mental health and criminal justice staff can begin by engaging their mutual clients around a common goal—to be healthy and free from criminal justice involvement. This approach requires prospective collaborators to embrace public health and public safety as complementary rather than as competing goals. As noted by Matejkowski and colleagues (25), "An approach that pairs evidence-based treatment with accountability under close supervision for offenders with psychiatric or substance use disorders could be more effective at promoting public health and safety than either treatment or supervision alone."

Rapport with justice-involved clients can be strengthened by informing them of the nature and purpose of the mental health–criminal justice collaboration, including what information about them will be shared and how it will be used. As observed by Draine and Solomon, however, such details often are not provided to justice-involved individuals. In a study of clients on probation and parole, those investigators noted that "client comments to researchers reflected a poor understanding—sometimes an overestimation, other times an underestimation—of the nature or extent of collaboration in their case. Such misunderstandings may undermine client trust in both systems" (11). Given that persons with serious mental illness can have significant cognitive deficits, using written materials or pictures and other visual aids to inform them about collaboration can be helpful (26).

Collaborating mental health and criminal justice staff can further engage their shared clients by treating them with respect and empathy, offering them choices, providing encouragement, and being nonjudgmental (27). Although such

TABLE 1. The process of mental health and criminal justice collaboration for justice-involved adults with serious mental illness

Mental health activities	Criminal justice activities
Engagement	
Discuss available treatments and services with client	Discuss legal stipulations and conditions with client
Assessment	
Conduct psychosocial assessment	Conduct criminogenic risk and needs assessment
Planning and treatment	
Plan treatments and services	Plan supervision method and frequency
Provide treatment	Provide supervision
Monitoring	
Monitor adherence to treatments and services	Monitor adherence to legal stipulations and conditions
Submit progress reports to criminal justice partner	Review progress reports with mental health partner
Problem solving	
Consider therapeutic options	Consider rewards and graduated sanctions
Present recommendations to criminal justice partner	Discuss alternatives to punishment with mental health partner
Transition	
Discuss transitional supports with client	Discuss termination of supervision with client

strategies may seem contrary to the correctional ethos, using relationship skills to enhance motivation is recognized as a best practice both in correctional rehabilitation (21) and in health care (28). In addition, evidence suggests that when people feel they have been treated fairly by authorities, they are more likely to accept an authority's decisions (29) and they may have better mental health outcomes (30,31).

Step 2: Assessment

Persons with serious mental illness are overrepresented throughout the criminal justice system (32). Many have attributed this problem to deinstitutionalization and lack of access to psychiatric services (33). However, the lack of association between mental illness and crime (34,35) and the failure of standard mental health treatment to prevent crime (36,37) led mental health researchers to seek a criminologically informed understanding of recidivism among adults with serious mental illness (38,39). These efforts drew attention to the importance of targeting risk factors that drive criminal recidivism in this population, which is a basic principle of effective correctional intervention. It is now widely accepted that criminal recidivism is driven by "criminogenic" risk factors of individuals with or without mental illness (9,40,41). The eight central risk factors are history of antisocial behavior, antisocial personality pattern, antisocial cognition, having criminal companions, family/marital problems, work/school problems, lack of healthy leisure/recreational pursuits, and substance abuse (17). Although mental illness in general is not associated with criminality (42), research has also established that psychosis and mania can sometimes directly lead to criminal justice system involvement (43,44).

The process of identifying criminogenic risk factors and what is needed to prevent criminal recidivism is called risk and needs assessment, or simply "risk assessment" (17). Standardized tools for criminogenic risk assessment such as the Level of Service Inventory–Revised and the Wisconsin Risk and Needs have been shown to reliably predict the likelihood of criminal recidivism among diverse offender groups, including individuals with mental illness (17,45). In general, as outlined in Table 1, criminal justice authorities conduct criminogenic risk and needs assessments, which focus on public safety, whereas mental health professionals conduct psychosocial assessments, which focus on client health. However, there is substantial overlap in these assessments. Although the psychosocial assessment process is not designed to assess risk of criminal recidivism, it involves assessment of risk for other adverse outcomes, including violence, homicide, suicide, and relapse. Also, both types of assessments examine substance use, employment status, financial status, family supports, and residential stability. Sharing respective results can thus improve evaluation accuracy and identification of clients at greatest risk of recidivism while laying the groundwork for collaborative planning and treatment.

Step 3: Planning and Treatment

A recent review examining the applicability of criminogenic risk assessment to persons with mental illness suggests that addressing both mental health problems and criminogenic risk factors together will enhance prevention of criminal recidivism (46). In addressing mental health problems, it is noteworthy that mental health professionals routinely address four of the eight central risk factors (substance abuse, work/school problems, family/marital problems, and lack of healthy leisure/recreation pursuits). This process includes the use of evidence-based practices, such as integrated dual-diagnosis treatment for co-occurring substance use disorders (47), individual placement and support for unemployment (48), and family-based interventions for family and marital problems (49). In addition, mental health professionals routinely apply best practices to address "responsivity factors" that influence how justice-involved individuals respond to correctional intervention. Responsivity factors can include trauma, homelessness, cultural differences, and symptoms of serious mental illness, such as paranoia and impaired cognition (21). However, uncertainty exists concerning who should address the problematic

thinking that leads to antisocial behaviors. Although Table 1 suggests that criminal justice professionals have no role in treatment, they sometimes use cognitive-behavioral treatment to address criminal thinking (50). Cognitive-behavioral best practices have been developed with correctional populations to address antisocial cognitions and attitudes (51,52), and they have shown promise for people with mental illness (46). Yet these interventions are rarely used by mental health professionals to address criminal thinking within outpatient treatment settings. Also, new models, such as effective practices in community supervision (the "EPICS" model), have been developed to teach probation and parole officers evidence-based principles of effective behavioral management (53). Unlike cognitive-behavioral therapies for criminal thinking, however, behavioral management principles are often used by mental health professionals within residential and day programs for persons with co-occurring mental illness and substance use disorders (54,55). These observations provide a clear rationale for mental health–criminal justice collaboration in planning and treatment, including deciding who is responsible for providing which treatments and services for each client.

Step 4: Monitoring

Consistent with principles of effective correctional intervention, collaborating service providers should monitor for both nonadherence and for signs of progress. Because treatment adherence is generally a stipulation of leverage-based intervention strategies, clinicians should submit regular progress reports to their criminal justice partners as part of the monitoring process. Communication is the key to effective monitoring, and it should include face-to-face meetings between representatives of the outpatient mental health team and the supervising criminal justice agency when possible. Such meetings can help build rapport between collaborators while enabling them to better understand and address adherence issues.

Face-to-face meetings also provide a forum for joint meetings with clients. Joint meetings provide collaborators with an opportunity to formally recognize and reinforce clients' progress. In addition, they can foster both engagement and accountability by directly involving clients in the process of identifying and addressing problem behaviors. However, joint meetings are unlikely to reduce recidivism if based on a philosophy of enforcement and control (11,12,56). Evidence suggests that the most effective approach to monitoring clients involves building a therapeutic alliance while incorporating principles of procedural justice to create an environment that is firm, fair, and caring (29,56–58).

Step 5: Problem Solving

Working with justice-involved clients rarely goes smoothly, especially when multiple criminogenic risk factors and responsivity factors are present. Even clients who make good progress can be expected to take backward steps. Responding to these setbacks should reflect a balance between recognizing that such problems are an inevitable part of the recovery process, and the need for accountability and public safety. This balance can be supported by considering the following three principles when addressing nonadherence and other behavioral issues as part of the collaborative process.

Shared problem solving. Shared problem solving is a principle of collaboration whereby decisions about how to manage clients' problem behaviors are informed by input from both their treating clinicians and their supervising criminal justice professionals. This process requires mental health and criminal justice representatives to actively discuss their opinions and ideas in the interest of preventing recidivism. While criminal justice authorities are ultimately responsible for making legal decisions, the decision-making process should involve shared problem solving rather than just enlisting mental health professionals to report client infractions. Simply put, two heads are better than one.

Therapeutic alternatives to punishment. Whenever behavioral problems may be due to inadequately treated mental illness, co-occurring addiction, or associated issues, their management should include careful consideration of treatment and support-based intervention options. Examples of therapeutic alternatives can include offering long-acting injectable medications to clients with nonadherence to oral medications, offering inpatient chemical dependency treatment to outpatients who relapse into substance use, and providing outreach to homeless clients who miss their court hearings.

Rewards and graduated sanctions. A fundamental principle of effective correctional practice is to reinforce appropriate behaviors and extinguish inappropriate behaviors through use of rewards and sanctions. Examples of rewards can include verbal praise or feedback, special activities, or level advancement. Sanctions are generally applied when a client's problematic behavior is attributed to volitional misconduct rather than to a manifestation of illness (25). Making this difficult distinction can benefit from collaborative discussion. When sanctions are deemed necessary, their assignment should occur quickly and predictably, and their level of restrictiveness should be increased gradually (17,59). Graduated sanctions can include negative verbal feedback, writing assignments, community service hours, curfew restrictions, increased frequency of monitoring, and detention time. A hallmark of effective correctional programs is the use of more rewards than sanctions by a ratio of at least 4:1 (60). As noted by Latessa and colleagues, "It is one thing to have a strong conceptual understanding of behavioral management techniques. It is another to implement a behavior management model in a real-world setting" (21). Collaborating partners should work together in identifying appropriate target behaviors, in selecting reinforcements

and sanctions to be used, and in deciding whether reinforcements and sanctions will be tied to treatment progress (21,61).

Step 6: Transition

The transition step involves the conclusion of criminal justice oversight. This event marks a significant change for justice-involved individuals, one that can place them at increased risk of relapse into drug use and other problematic behaviors. Collaborating mental health and criminal justice professionals can help their mutual clients prepare for this event by offering transitional services and supports. Providing extra outpatient appointments can give clients transitional support while enabling clinicians to observe them more closely for warning signs of illness exacerbation. Involving supportive family members, friends, and residential service providers can further give clients the physical and emotional resources necessary for a successful transition. As an added benefit, such individuals are generally well positioned to alert care providers to early warning signs of relapse into psychosis, addiction, or both. Another example of transitional support is offering a representative payee for clients who may be tempted to buy illicit drugs and alcohol in the absence of criminal justice oversight. Among persons with serious mental illness and co-occurring substance use disorders, having a representative payee has been associated with decreased substance use and improved quality of life (62). Also, hosting graduation ceremonies and other recognition events may help clients adjust to this major transition (63).

DISCUSSION AND CONCLUSIONS

Outpatient mental health treatment alone is unlikely to reduce criminal recidivism. In a recent study of 143 justice-involved individuals with serious mental illness, only 18% of their crimes were directly motivated by mental illness (64). Likewise, simply relying on intensive supervision and control may increase justice system involvement among persons with serious mental illness (11,12,56). Effective prevention requires mental health and criminal justice professionals to have a shared appreciation of the issues driving each client's recidivism and of their respective profession's best practices. Collaborators should also appreciate how the availability of community resources can affect outcomes (65). Unfortunately, mental health treatment providers rarely assess criminogenic risk factors in a systematic manner, even within programs that specialize in serving justice-involved clients (66). Similarly, community corrections officials often have little knowledge of their clients' mental health issues (13). These findings highlight the need for training in mental health–criminal justice collaboration in working with justice-involved persons with serious mental illness.

Mental health and criminal justice service providers typically lack training in collaborative care (7,13,67). To help address the issue, this article has presented a framework for understanding the collaborative process as a series of opportunities to combine best practices from each field. Further research is needed to identify the key elements and principles of collaboration, to promote their implementation within leverage-based interventions, and to examine the effectiveness of optimized leverage-based interventions in achieving both criminal justice and therapeutic outcomes.

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