Individuals with Mental Illnesses in the Criminal Legal System: Complex Issues and Best Practices[1]

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INDIVIDUALS ON PROBATION who have severe mental illnesses face complex challenges related to housing instability, substance use, unemployment, trauma, comorbid physical health challenges, and symptoms of mental illnesses that make them more difficult to supervise (Garcia & Abukhadra, 2021; Givens & Cuddeback, 2021; Lurigio et al., 2003). This is significant given that the community supervision population has grown to nearly 4.3 million and conservative estimates suggest approximately 16 percent of people on community supervision have a mental illness (Oudekerk & Kaeble, 2021). Compared to those on probation who do not have mental illnesses, probationers who have mental illnesses place greater demands on probation officers due to their increased levels of criminogenic and non-criminogenic needs, especially functional limitations and substance use, which demand more time, energy, and resources from probation officers (Skeem & Petrila, 2004). Probationers with mental illnesses also exhibit low mental health treatment adherence rates (Kreyenbuhl et al., 2009; MacBeth et al., 2013). Additionally, individuals on probation who have mental illnesses have high rates of probation violations and revocations (Eno Louden & Skeem, 2011) and receive consequences at higher rates than those without mental illnesses (Eno Louden & Skeem, 2011; Prins & Draper, 2009).

In many ways probation supervision strategies for those with mental illnesses look similar to those applied to probationers without mental illnesses (for example, helping to obtain safe and adequate housing, employment opportunities, and prosocial supports are critical); however, obtaining housing, employment, and social support are often more difficult for individuals with mental illnesses, especially those who are justice-involved. Thus, addressing these issues in the context of a problem-solving supervision orientation and with the understanding of the unique challenges for those with mental illnesses is paramount and should be concurrent with referrals to evidence-based mental health services. In this article we will focus on the challenges of supervising individuals with severe mental illnesses who are on probation. Specifically, we will: (a) define severe and persistent mental illnesses; (b) discuss the complex needs of individuals with mental illnesses in the criminal justice system; and (c) outline evidence-based practices and other interventions for individuals with mental illnesses in the criminal justice system.

What Do Probation Staff Need to Know about Severe and Persistent Mental Illnesses?

Severe and persistent mental illness, or severe mental illness, is typically defined as the conjunction of diagnosis, disability, and duration (Goldman et al., 1981). Diagnosis typically refers to those diagnoses that are more profoundly debilitating, such as schizophrenia, bipolar disorder, and/or major depression. Next, disability suggests that someone is so profoundly ill that the person has difficulty

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functioning in the community without significant treatment and support for mental health issues. Finally, duration suggests the disabling diagnosis has lasted several years or longer (Goldman et al., 1981). It is important to note that Goldman et al. (1981) proposed this definition in response to the need at the time to provide guidelines for defining and counting individuals with mental illnesses.

Since then, other groups have proposed similar methods and definitions (Parabiaghi et al., 2006; Ruggeri et al., 2000; Schinnar et al., 1990), although these definitions have not formally been applied to justice-involved populations of people with mental illnesses, and reliable estimates of the number of people on probation with severe and persistent mental illnesses remain elusive. Also, although there are other mental health diagnoses, such as dysthymia, anxiety disorder, or posttraumatic stress disorder, severe and persistent mental illness—often shortened to SPMI or SMI—is used to describe those with debilitating mental illnesses. Given that probation officers routinely encounter offenders with depression, bipolar disorder, and schizophrenia, we'll spend some time describing each of these diagnoses.

Major Depression. Feeling depressed, sad, or disheartened is a very common human experience, and many people who have episodes of feeling down or blue may be responding to a loss or stressful event. Many people will recover from these episodes without professional help; however, when people have depressed mood and other symptoms that interfere with their functioning, this is known as major depression, which can be mild, moderate, or severe depending on the number of symptoms an individual has, the severity of their symptoms, and the degree to which symptoms interfere with functioning (American Psychiatric Association, 2013). Most people can recover fully from major depression.

In order for an individual to be diagnosed as having major depression, they must have at least five of the following symptoms for at least a two-week period: (1) sleep disturbance; (2) appetite disturbance; (3) decreased energy; (4) decreased interest in activities; (5) decreased concentration; (6) increased guilt or feelings of worthlessness; (7) thoughts of suicide; (8) depressed mood; or (9) slowing down of thought processes and physical activity (American Psychiatric Association, 2013). Some people will have major depression that is very disabling and interferes greatly with their ability to function. Often people who suffer from recurrent, disabling depression have not responded to the available treatments for depression, and, in some cases people with severe, recurrent depression can have psychotic symptoms that contribute to the disabling effects of the illness (American Psychiatric Association, 2013).

Bipolar Disorder. Bipolar disorder, which used to be referred to as manic-depression, is characterized as a cycling between the two "poles" of mood disturbance: mania and major depression (American Psychiatric Association, 2013). Here, the disability resulting from this disorder ranges along a continuum—depending on how frequently an individual has cycles, i.e., ups and downs, and the severity of symptoms within those cycles. Individuals with bipolar disorder can also have psychosis—auditory or visual hallucinations and/or delusions—in either the manic or depressive phase.

During a manic episode, an individual's mood can be described as overly happy or ecstatic or extremely irritable, and the individual is extremely active and energetic for at least one week (American Psychiatric Association, 2013). During this week of elevated mood and increased activity and energy, an individual must also exhibit at least three of the following symptoms: (1) an inflated sense of themselves, referred to as grandiosity; (2) a decreased need for sleep; (3) extremely talkative or very rapid speech; (4) racing thoughts that may jump from topic to topic; (5) distractibility; and (6) excessive involvement in risky pleasurable activities that will likely have painful consequences (American Psychiatric Association, 2013). Additionally, in order to be considered a manic episode, the mood disturbance must be severe enough to cause problems in social relationships or work performance or be severe enough so that an individual is hospitalized.

Schizophrenia. Schizophrenia is a psychotic disorder that is generally considered to be the most disabling of all the mental illnesses. Schizophrenia generally has an onset between ages 18-25 and occurs in about one percent of the population (American Psychiatric Association, 2013). The symptoms must be severe enough to cause impairment in an individual's ability to work, have interpersonal relationships, or take care of themselves and must be present for at least six months before the diagnosis can be made by a mental health professional (American Psychiatric Association, 2013).

To be diagnosed with schizophrenia, an individual must have at least one of the following symptoms: (a) delusions—which are beliefs or impressions that are firmly maintained by an individual despite being contradicted by what is generally accepted as realistic or rational; (b) hallucinations—which are perceptual distortions that can be perceived through any of the five senses: vision, hearing, taste, touch and smell or rational argument; (c) disorganized speech; and/or (d) disorganized behavior.

There are additional symptoms that are not required to make the diagnosis but are often present and contribute to the disabling effects of schizophrenia, such as: (a) a lack of emotional expression or flat affect; (b) speech that is very minimal or that communicates very little to another person—this is also known as "poverty of speech" or "poverty of content"; and (c) lack of motivation or enthusiasm (Blanchard & Cohen, 2006). These symptoms strongly interfere with functioning, can look like laziness to others, and are often made worse by many of the medications that are used to treat schizophrenia. Indeed, many of the symptoms associated with schizophrenia or schizoaffective disorders, such as lack of motivation, lack of affect, paranoia, auditory and visual hallucinations, and/or delusions, can make it difficult for a probationer to engage with a probation officer and/or engage with others.

What Do Probation Staff Need to Know about People with Severe and Persistent Mental Illnesses in the Criminal Legal System?

Individuals with severe mental illnesses are at increased risk of having or developing substance use disorders and chronic physical health problems. Also, those who have severe mental illnesses are at an elevated risk of experiencing trauma and developing posttraumatic stress disorder, which can impact probation staff's ability to supervise these individuals.

Substance use. Justice-involved individuals with severe mental illnesses have complex health and behavioral health needs, including high rates of substance use and trauma. It is estimated that somewhere between 40 percent and 60 percent of people with severe and persistent mental illnesses in the general population misuse substances (Hartz et al., 2014), and those rates are even higher among those who are justice-involved (Peters et al., 2015). Unfortunately, co-occurring substance

use should be considered the norm for justice-involved individuals with severe mental illnesses rather than an exception.

It is important to recognize that individuals with severe mental illnesses use substances for many of the same reasons as the general population, such as (a) to get high, (b) to reduce social anxiety, (c) to escape reality, and (d) to decrease tension and boredom. However, there are also unique reasons that individuals with severe mental illnesses use substances, such as an attempt to cope with the troubling symptoms of a mental illness (Pettersen et al., 2013). Moreover, similar to the general offender population, for those with severe mental illnesses, substance use can increase impulsivity and criminal behavior, create conflict with family members, interfere with employment, and decrease motivation (Sheidow et al., 2012).

Trauma. Trauma is defined as an exposure to an extraordinary experience that presents a physical or psychological threat to oneself or others and generates a reaction of helplessness and fear (American Psychiatric Association, 2013). Typically, a traumatic experience is one which overwhelms an individual's coping strategies and psychological defenses, may have occurred in the distant or recent past as a one-time occurrence or over an extended period of time, and causes intrusive thoughts of the event (Ellison & Munro, 2016). Traumatic events vary and can include (a) physical, emotional, and/or sexual abuse in childhood or adulthood; (b) exposure to community violence and or family/domestic violence; (c) involvement in or witnessing horrific events involving violence or death; (d) involvement in accidents or natural disasters; (e) experiences with serious medical illnesses; and/or (f) war, combat, or civil unrest conditions (Gray et al., 2004).

Moreover, individuals with severe mental illnesses, especially those with mood disorders such as depression and bipolar disorder, are at elevated risk of experiencing traumatic events, especially physical and sexual assault, that can lead to diagnosable PTSD (Grattan et al., 2019; Grubaugh et al., 2011; Mueser et al., 2004; Neria et al., 2002). Compared to the general population, rates of PTSD are considerably higher among justice-involved individuals with mental illnesses (Baranyi et al., 2018). Extensive trauma histories can be associated with negative coping behaviors, substance use, dissociation, defiance, anger, aggression, poor memory, limited ability to take care of personal needs, loss of interest in normal activities, self-harm or suicidal ideation, overwhelming guilt and/or shame, hypervigilance to surroundings, negative moods, and avoidance of triggers related to the trauma (Briere et al., 2016; Grattan et al., 2019), many of which can intensify criminal justice involvement (Donley et al., 2012; Fox et al., 2015; Goff et al., 2007). Untreated PTSD has been shown to increase emotional numbing, impulsive behaviors, substance use as a coping mechanism, violence, and cognitive impairments—all of which can increase the presence of criminalized behaviors (Bloom, 1999; Bonta & Andrews, 2007; Howard et al., 2017).

Physical health problems. To exacerbate the complexity of needs of justice-involved individuals with severe mental illnesses, these individuals are at greater risk for having or developing chronic physical health problems as well. For example, compared to those who do not have severe mental illnesses, individuals with severe mental illnesses are less likely to have a primary care doctor and have difficulty accessing health care services, which leads to unmet health care needs (Druss et al., 2002; Kaufman et al., 2012; Parks et al., 2006).

What Are the Evidence-based Treatments for Severe Mental Illnesses?

Clearly, individuals with severe mental illnesses have complex issues and co-morbidities such as substance use, trauma, and physical health problems, all of which should be addressed to improve outcomes generally. It is important to note that having a severe mental illness is associated with a number of other factors, such as low education, unemployment, homelessness, and social isolation, which put individuals at further risk for poor mental health and criminal justice outcomes. Obtaining housing and employment and social support are certainly more difficult for individuals with mental illnesses, especially those who are justice-involved, for a variety of reasons, and it is important for probation staff to recognize this. Thus, addressing these issues in the context of a problem-solving supervision orientation, and with the understanding of the unique challenges for those with mental illnesses, is paramount and should be concurrent with referrals to mental health and other services. Below, we describe a number of services, interventions, and strategies specific to individuals with mental illnesses.

Mental health courts. Mental health courts have spread widely, and there is evidence of their effectiveness at reconnecting individuals to services and reducing recidivism (Hiday & Ray, 2010; Keator et al., 2012; Lowder et al., 2018; Ray, 2014). Observational studies suggest mental health courts improve access to community-based treatment (Boothroyd et al., 2003; Herinckx et al., 2005; Keator et al., 2012; Trupin & Richards, 2003), reduce recidivism (Christy et al., 2003; Cosden et al., 2003; Han & Redlich, 2016; Herinckx et al., 2005; Lowder et al., 2016; Lowder et al., 2018; McNiel & Binder, 2007; Moore & Hiday, 2006; Redlich et al., 2010), and can reduce substance use when combined with evidence-based practices such as assertive community treatment (Cosden et al., 2003).

Integrated dual disorder treatment. Integrated dual disorder treatment (IDDT) combines treatment for substance use disorders and mental illness. Traditional approaches often silo treatment; however, IDDT incorporates evidence-based strategies into a model designed to treat the co-occurring disorders simultaneously (Kikkert et al., 2018; Kola & Kruszynski, 2010). Research suggests that IDDT contributes to a reduction in substance use, although evidence is inconclusive for reductions in psychiatric symptoms (Kikkert et al., 2018). The inconsistency of effectiveness may be attributable to model fidelity and needs further research (Harrison et al., 2017; Kikkert et al., 2018). However, IDDT used in conjunction with other treatments such as assertive community treatment has shown promise for a decrease in criminal acts and convictions (Staring et al., 2012).

Assertive community treatment (ACT) and forensic assertive community treatment (FACT). There are a variety of services for individuals with severe mental illnesses, the most intensive of which include assertive community treatment (McKenna et al., 2018) and forensic assertive community treatment (Cuddeback et al., 2020; Lamberti & Weisman, 2021). ACT is one of the most widely-studied interventions for individuals with severe mental illnesses and entails a community-based team consisting of a psychiatrist, nurse, team leader, social workers, substance use specialist, housing specialist, employment specialist, and peer support workers who provide a variety of services to keep individuals engaged in treatment and stably housed (Bond et al., 2001).

FACT, one of the more recent adaptations of ACT, is designed to reduce recidivism among justice-involved individuals with severe and persistent mental illnesses. Typically, FACT teams adhere closely to the structural and operational characteristics of ACT with some

modifications, including close collaboration with probation staff who may serve as actual team members and taking referrals exclusively from the criminal justice system (Cuddeback et al., 2020). There is some evidence that FACT can reduce recidivism (Cosden et al., 2003; Cusack et al., 2010) and that the addition of cognitive behavioral interventions designed to address criminal thinking can be an effective augmentation to the model (Lamberti & Weisman, 2021).

Housing and homelessness. Homeless individuals with severe mental illnesses are at higher risk of cycling through the criminal justice system than their housed counterparts (Roy et al., 2014). Thus, securing stable housing is essential to an individual's ability to successfully complete supervision requirements. Housing First (Tsemberis, 1999) approaches the complex needs of justice-involved individuals from this perspective. The program first seeks to secure housing for clients before attempting to address the myriad other needs they may have. Additionally, the housing choices are client-centered so that individuals have some autonomy and say in their home (Tsemberis & Eisenberg, 2000). The Housing First approach reduces emergent care contacts for individuals with mental illnesses, lowers criminal justice system contacts, and improves housing retention (Woodhall-Melnik & Dunn, 2016).

Employment support. Given the importance of employment as a protective factor against recidivism (Apel & Horney, 2017; Bahr et al., 2009; Skardhamar & Telle, 2012; Tripodi et al., 2009), an 83 percent unemployment rate among individuals with mental illnesses (NAMI, 2014; Perkins & Rinaldi, 2002), and the frequency of mandating employment as a condition of supervision, as well as the financial insecurity among people with severe mental illnesses (Cuddeback et al., 2017), focusing on employment is a critical treatment intervention. Individual Placement and Support – Supported Employment (IPS-SE) is an evidence-based practice that aims to increase employment among adults with serious mental illnesses through core principles including: competitive support, benefits planning, systematic job development, zero exclusion, rapid job search, time-unlimited support, integrated services, and worker preferences (Frederick & VanderWeele, 2019).

IPS-SE has demonstrated effectiveness within mental health agency settings (Bond & Drake, 2014) and has shown promising results when implemented with individuals with histories of justice involvement (LePage et al., 2021). It is important to note that these IPS-SE models have been implemented within the context of mental health service settings which may have limited reach for individuals with criminal justice involvement, given the empirical evidence indicating low treatment engagement and completion (Sturgess et al., 2016).

Peer support. Peer support interventions, which employ individuals with lived experience of severe mental illnesses, have been widely adopted as important additions to a number of mental health services, such as ACT and IPS-SE (Kern et al., 2013; Storm et al., 2020; Wright-Berryman et al., 2011). Outcomes of peer support interventions include better mental health engagement (Sledge et al., 2011) and improved mental health outcomes (Bellamy et al., 2017), as well as decreased substance use (Reif et al., 2014; Tracy et al., 2012) and homelessness (Barker & Maguire, 2017). The extent to which peer support interventions reduce recidivism among justice-involved individuals with mental illnesses is not clear; however, peer support has the potential to decrease isolation and improve prosocial supports (Puschner et al., 2019).

Motivational interviewing. MI is a widely implemented evidence-based approach designed to strengthen motivation to change among persons who are experiencing substance use, mental illness, or other issues (Miller & Rollnick, 1991; Miller & Rollnick, 2012). MI has been applied to persons with severe mental illnesses with promising results. For example, there is evidence that brief motivational interviewing for individuals with severe mental illnesses reduces substance use (Baker et al., 2002; Graeber et al., 2003; Humfress et al., 2002; Kavanagh et al., 2004; Martino et al., 2000; Moore et al., 2018; Santa Ana et al., 2007) and increases treatment engagement (Dean et al., 2016; Humfress et al., 2002; Romano & Peters, 2015; Santa Ana et al., 2007).

Cognitive behavioral treatments. There are a number of cognitive behavioral treatments designed to address criminal thinking, impulsivity, and other criminogenic risks. There is evidence that these interventions have the potential to reduce recidivism among offenders who do not have serious mental illnesses, although efforts are being made to adapt these interventions to fit the needs of those with mental illnesses.

Although it is not often referred to as a problem-solving intervention, Moral Reconation Therapy (MRT) is aimed at cognitive restructuring among offenders and is based on Kohlberg's theory of moral development (Wilson et al., 2005). MRT is manualized and uses group-based cognitive-behavioral strategies to address criminal thinking. Evidence from an experimental study and several quasi-experimental studies suggests that MRT can be effective at reducing recidivism for some populations; however, the extent to which MRT is effective with individuals with severe mental illnesses is largely unknown (Wilson et al., 2005).

Reasoning and Rehabilitation (R&R) addresses self-control, social problem solving, perspective taking, prosocial attitudes, cognitive style, and critical reasoning (Wilson et al., 2005). R&R specifically targets egocentric thinking, impulsivity, and inflexible thinking patterns during the course of the eight- or twelve-week program comprising 35 sessions. Experimental studies among those without mental illnesses suggest positive but not statistically significant results of R&R on recidivism (Wilson et al., 2005). There has been limited research on R&R among those with serious mental illnesses; however, one small randomized study conducted in a psychiatric facility found that individuals diagnosed with a psychotic disorder who were assigned to receive R&R were less likely to engage in verbal aggression or have leave violations, compared to those who received usual care (Cullen et al., 2012). More research is needed to examine the impact of R&R on community-based samples of justice-involved individuals with mental illnesses. There is an adaptation of R&R for those with mental illnesses—Reasoning & Rehabilitation 2 Mental Health Program (R&R2 MHP)—in which the length of treatment was shortened and peer mentoring was added (Rees-Jones et al., 2012). Limited evidence suggests that R&R2 MHP can improve attitudes towards violence and problem-solving skills; however, more research is needed (Rees-Jones et al., 2012), and the extent to which this program is available in community-based treatment settings or other venues is not clear.

Thinking for a Change (T4C), a model advanced by the National Institute of Corrections (NIC), is a manualized group-based intervention that includes three core components: cognitive self-change, social skills, and problem-solving skills (Bush, 2011). To date, there is limited evidence that T4C among those without mental illnesses can reduce new crimes among those on probation (Golden,

2003; Lowenkamp et al., 2009), but T4C had no effect on outcomes among those in prison (Stem, 2012). More research is needed to examine the efficacy of T4C with justice-involved individuals with mental illnesses.

Mental health probation. Specialty mental health probation is a multi-component supervisory approach in which officers who receive ongoing mental health-related training supervise a designated caseload of adults with mental illnesses and engage in enhanced contact with resource providers. Specialty mental health probation officers also have reduced caseloads and use a problem-solving orientation to supervision (Skeem & Louden, 2006). There is promising evidence of SMHP's effectiveness at increasing mental health and substance use treatment engagement and improving mental health symptoms (Manchak et al., 2014; Van Deinse, Cuddeback, et al., 2021; Wolff et al., 2014). In terms of criminal justice outcomes, results are mixed, with some studies showing a decrease in violations, rearrests, and jail days while others showed a greater number of violations or no measurable effect on criminal justice outcomes (Manchak et al., 2014; Skeem et al., 2017; Van Deinse, Cuddeback, et al., 2021; Wolff et al., 2014).

How Can Probation Staff Support and Enhance Evidence-based Treatment for Severe Mental Illnesses?

Probation staff often find themselves falling into complex roles, such as case manager, advocate, social worker, bill collector, when working with probationers (Ruhland, 2020). Although probation officers who supervise individuals with severe mental illnesses are not treatment providers, there are strategies that staff can implement to have a tailored supervision approach with those who have mental illnesses. Probation officers who are supervising individuals with mental health issues should be able to: (1) identify and recognize severe mental illnesses; (2) refer to appropriate services; and (3) provide ongoing support in the context of a problem-solving orientation. First, probation staff should have the training and knowledge to recognize severe mental illness and its comorbidities and be able to understand that mental illness and symptoms may require ongoing support (Longmate et al., 2021; Manchak et al., 2014; Tomar et al., 2017; Van Deinse, Crable, et al., 2021). Understanding that these symptoms often co-occur with substance misuse, trauma and PTSD and health problems, all of which interfere with probation compliance, is also important (Manchak et al., 2014).

Second, probation staff should know enough about mental health and their local mental health and other services to make appropriate referrals, such as to mental health, substance abuse, and housing providers (Van Deinse, Crable, et al., 2021). Often this extends beyond simple service connection and entails more advanced communication and collaboration with treatment teams (Van Deinse, Crable, et al., 2021). Third, probation staff should support probationers to continue to engage with treatment and other supports; this can be implemented by using the evidence-based practice of Motivational Interviewing (MI), which is a long-standing evidence-based practice associated with improved substance abuse outcomes for a variety of populations (Clarks, 2007).

Conclusion

The large numbers of individuals with mental illnesses in the criminal legal system present complex and unique challenges to probation staff and other agents of the criminal legal system. Understanding mental illness and recognizing how the symptoms of mental illness can make it difficult to meet probation requirements as well as connecting these individuals to evidence-based services designed to address substance misuse, homelessness, unemployment, and social support are important to supervising this population.

Key Terms

Severe and persistent mental illness: Severe and persistent mental illness, or severe mental illness, is typically defined as the conjunction of diagnosis, disability, and duration.

Major Depression: In order for an individual to be diagnosed as having major depression, the person must have at least five of the following symptoms for at least a two-week period: (1) sleep disturbance; (2) appetite disturbance; (3) decreased energy; (4) decreased interest in activities; (5) decreased concentration; (6) increased guilt or feelings of worthlessness; (7) thoughts of suicide; (8) depressed mood; or (9) slowing down of thought processes and physical activity.

Bipolar Disorder: Bipolar disorder is characterized as a cycling between the two "poles" of mood disturbance, mania, and major depression, and is often characterized by: (1) an inflated sense of themselves, referred to as grandiosity; (2) a decreased need for sleep; (3) extremely talkative or very rapid speech; (4) racing thoughts that may jump from topic to topic; (5) distractibility; (6) excessive involvement in risky pleasurable activities that will likely have painful consequences.

Schizophrenia: To be diagnosed with schizophrenia, an individual must have at least one of the following symptoms: (a) delusions—which are beliefs or impressions that are firmly maintained by an individual despite being contradicted by what is generally accepted as realistic or rational; (b) hallucinations—which are perceptual distortions that can be perceived through any of the five senses, vision, hearing, taste, touch, and smell or rational argument; (c) disorganized speech; and/or (d) disorganized behavior.

Motivational interviewing: MI is an evidence-based approach designed to strengthen motivation to change among persons who are experiencing substance use, mental illness, or other issues.

Integrated dual disorder treatment (IDDT): IDDT combines treatment for substance use disorders and mental illness.

Mental health courts: Mental health courts are specialty treatment courts designed to connect individuals with mental illnesses to community-based treatment and other resources.

Assertive community treatment (ACT): ACT is a community-based team consisting of a psychiatrist, nurse, team leader, social workers, substance use specialist, housing specialist, employment specialist, and peer support workers who provide a variety of services to keep individuals with severe and persistent mental illnesses engaged in treatment and stably housed.

Forensic assertive community treatment (FACT): FACT is designed to reduce recidivism among justice-involved individuals with severe and persistent mental illnesses. Typically, FACT teams adhere closely to the structural and operational characteristics of ACT with some modifications, including close collaboration with probation staff who may serve as actual team members and taking referrals exclusively from the criminal justice system.

Individual Placement Support-Supported Employment (IPS-SE): IPS-SE is an evidence-based practice designed to increase employment among adults with serious mental illnesses through core principles including: competitive support, benefits planning, systematic job development, zero exclusion, rapid job search, time-unlimited support, integrated services, and worker

preferences.

Specialty Mental Health Probation (SMHP): SMHP is a multi-component supervisory approach characterized by: (1) a reduced caseload; (2) an exclusively mentally ill caseload; (3) an problem-solving supervision orientation; (4) ongoing officer training; and (5) greater connection to community-based services.

Key Takeaways

1. Individuals with severe mental illnesses in the criminal legal system present complex and unique challenges to probation staff, and often are dealing with housing instability, substance use, unemployment, trauma, comorbid physical health challenges, and symptoms of mental illnesses.
2. It is important for probation staff to recognizing how the symptoms of mental illness can make it difficult to meet probation requirements and refer clients to appropriate services.
3. Probation staff can provide ongoing support to clients with severe mental illnesses by using Motivational Interviewing to encourage clients to continue to engage with treatment and other supports.

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