The importance of evidence-based practice in community-based case management of offenders with mental health problems

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In the 1960s, the traditional institution-based model for treating individuals with mental illness led to the segregation of this population from the community. With the development of more effective psychotropic medications (Broquet, 1999), as well as pressure stemming from mental health advocates, treatment for persons with mental illness shifted from an emphasis on inpatient care to community-based services. It was the hope that offering treatment in the community would give greater autonomy to those suffering from mental health problems and improve their quality of life (Cosden, Ellens, Schnell, & Yamini-Diouf, 2005). Despite these laudable goals, there have been problems with lack of access to, and poor utilization of, community-based services for this population. The resulting situation has been an overrepresentation of mentally ill individuals in the criminal justice system, which has increased over the past few decades (Ogloff, Davis, Rivers, & Ross, 2007; Steadman, Deane, Morrissey, Westcott, Salasin, & Shapiro, 1999). Studies have found that the mental health system is often reluctant to provide services to individuals with legal problems (Skeem, Encandela, & Louden, 2003; Teplin, 1990). This state of affairs is particularly troublesome given that persons with mental illness are more likely to be arrested, often serve longer prison sentences, and are more likely to be subsequently charged with breaches of supervision orders in comparison to individuals who are charged with similar crimes but do not have mental health difficulties (Bureau of Justice Assistance, 2008; Messina, Burdon, Hagopian, & Prendergast, 2004; Skeem, Nicholson, & Kregg, 2008). Although it wouldappear that the presence of mental illness elevates an individual's risk for engaging in crime, contemporary research suggests that mental illness is not necessarily a causal agent forcriminal behaviour for most cases of mentally ill offenders (Bonta, Law, & Hanson, 1998; Hiday & Burns, 2010). Thus, contrary to popular opinion, the link between mental illness and criminal behaviour is mediated by other factors (e.g., poverty, antisocial cognition, antisocial personality traits, substance abuse; Skeem, Manchak, & Peterson, 2011). In fact, research has found that offenders with and without mental health problems have similar criminal thinking styles (Morgan, Fisher,Duan, Mandracchia, & Murray, 2010) and the onset of criminal behaviour often precedes the onset of the mental illness (Hodgins, 1992).

In an effort to better respond to the needs of persons with mental health problems who come into conflict with the law, several types of alternative programs have been developed to manage these offenders in the community (e.g., Mental Health Courts, jail-diversion programs, and specialty probation

services; Bureau of Justice Assistance, 2008; Skeem et al., 2011; Steadman & Naples, 2005). In general, these programs use the criminal justice system to redirect non-serious offender cases to community-based mental health services. Although a bias for punitive-based approaches (i.e., incarceration) exists today for offenders, the research literature strongly suggests that these methods do not reduce recidivism and can increase it (Bales & Piquero, 2012; Cullen, Jonson, & Nagin, 2011). Thus, there is a need for evidence-based strategies that address both the unique mental health factors and criminogenic needs of mentally ill offenders under community-supervision. This is a particularly important concern given that the majority of the offenders in Canada are supervised in the community (Public Safety Canada, 2009).

Despite advances in offender rehabilitation strategies, research on the effectiveness of interventions used with offenders has found problems with program integrity (Bonta, Bourgon, Rugge, Scott, Yessine, Gutierrez, et al., 2011). Many evaluated programs have limited consistency in their content and method focus and fail to target factors related to criminal behaviour and the risk of recidivism (i.e., criminogenic needs; Andrews & Bonta, 2010; Cullen, Smith, Lowenkamp, & Latessa, 2009). Additionally, due to the misconception of a direct link between mental illness and criminal behaviour, programs offered to mentally ill offenders tend to be more concerned with treating the mental health issues than addressing criminogenic needs. Fortunately, programs that adhere to the principles of the Risk- Need-Responsivity (RNR) model have been found to decrease the likelihood of recidivism in general offenders (Andrews & Bonta, 2010; Dowden & Andrews, 2000). The RNR model is one of the most influential models for the assessment and treatment of offenders. It is comprised of three main principles. The *RISK* principle states that recidivism can be reliably predicted using empirically-supported risk assessment tools (Andrews, Bonta, & Hoge, 1990; Andrews & Bonta, 2010) and that the level of intervention services should match the identified risk level (i.e., high risk offenders should receive intensive interventions, whereas low risk offenders should receive minimal services). The *NEED* principle highlights the importance of assessing and targeting criminogenic needs during the design and delivery of a case plan or intervention (for a more in-depth discussion regarding criminogenic needs, see Andrews, Bonta, & Wormith, 2006). Criminogenic risk factors have been empirically linked to the risk of criminal behaviour, are modifiable with treatment, and must be addressed to reduce future criminal involvement. Finally, the *RESPONSIVITY* principle states that treatments based on cognitive-social learning methods are most effective in reducing recidivism, especially when treatments are tailored to match the offender's learning styles and capacities. Despite the critical importance of these responsivity factors, they are often overlooked in treatment planning (Birgden, 2004; Serin & Kennedy, 1997).

Several studies appear to indicate that the RNR model is valid and equally applicable to mentally ill offenders (Bonta et al., 2011; Canales, Campbell, Wei, & Moser, 2011; Girard & Wormith, 2004; Skeem et al., 2011). Consistent with the RNR model, it is essential for community-based programs for mentally ill offenders to focus treatment on criminogenic needs and conceptualize mental health factors as responsivity factors, rather than direct antecedents of crime. Thus, bothaspects of functioning need to be treated: criminogenic needs must be

addressed to reduce the risk of re-offending, whereas mental health needs should be address to enhance the capacity to respond to criminogenic need-focused interventions and improve a person's overall quality of life. By integrating evidence-based methods of correctional and mental health approaches, intervention will be more effective in achieving the goal of reducing the continued criminalization of this population.

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