COMMUNITY CORRECTIONS IN AMERICA

New Directions and Sounder Investments for Persons with Mental Illness and Codisorders

National Coalition for Mental and Substance Abuse
Health Care in the Justice System

This monograph is dedicated to the men and women who serve their communities as community corrections, probation and parole officers. Their service to their communities and the nation often goes unheralded.

This publication is part of the Substance Abuse and Mental Health Services Administration's support of mental health and substance abuse services for offender populations through two of its Centers: the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services (CMHS). The Project Officer was Nicholas L. Demos, J.D., of CSAT. Susan Salasin was the coordinator for the CMHS.

This publication was prepared under CSAT grant No. 5-H87-T100290.

This publication was printed for distribution by the National Institute of Corrections, U.S. Department of Justice. Additional copies are available from the NIC Information Center, 800-877-1461.

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New Directions and Sounder Investments
for Persons with Mental Illness
and Codisorders

March 1996

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This monograph is being produced as part of a larger effort to address and improve the provision of mental health services to persons living in our communities being supervised on Community Corrections.

THE NATIONAL COALITION FOR MENTAL AND SUBSTANCE ABUSE HEALTH CARE IN THE JUSTICE SYSTEM

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- Foreword -

Dear Readers:

The cover of this monograph is an artistic representation of a city scape reflected in a montage of photographs, photographs reflecting the social and cultural complexities of current American society and the people we serve. The cover is an attempt to put a human face on the issues discussed in **"Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and Co-Disorders."**

Since 1989, The National Coalition for Mental and Substance Abuse Health Care in the Justice System (The National Coalition) has led the way in establishing a platform to address the mental health and co-disorders needs of adult and juvenile offenders. We have brought attention to the rising numbers of persons in the justice system having serious mental illness and substance abuse disorders. We have developed monographs covering jails, prisons, and juvenile justice to summarize and integrate available studies and findings.

The National Coalition created a "State Policy Design Academy" that has worked with 11 states and the Navajo Nation. The success of the academy is reflected in the fact that the National Coalition is currently advising many states about the possibility of using the academy model on a state-wide basis to unite their many jurisdictions. A variety of national organizations are also working on duplicating the National Coalition's policy design program as a means of effecting systemic change. Most of the states the National Coalition has worked with have implemented varying approaches to mental health reform in the justice system.

In the current monograph we propose new directions for community corrections in handling persons with mental health and co-disorders at a time when some policy makers are pushing for more punitive sanctions for all offenders.

In the fields of health and human services, the trend is to create a seamless system: a network that does not duplicate services or resources, is client centered, and where health and human service providers communicate with one another. While the justice system has been slow to change in this direction, it is learning that this model can be adapted to bring about better outcomes for both public safety and public health.

We know treatment works for persons with severe mental illness and co-disorders. The greatest challenge in community supervision will be to examine specialized caseloads and systems integration. To alter public opinion toward alternatives to confinement all must see the value of community-based treatment For this to happen, agencies that serve offenders in the community must be proactive and responsive to the ever-changing nature of public safety concerns, and to inspire a sense of confidence in community corrections.

This monograph was introduced at our National Work Session, "Our Neighborhoods' Public Health' which was held at Loyola University on September 7-10, 1995. The session was attended by 24 state delegations. These delegations came to Chicago to seek ways of improving

services for persons with mental illness and co-disorders in community corrections, first by reviewing the chapters in this monograph, and second, to develop policy recommendations for the final chapter.

On behalf of the National Coalition, we extend our greatest appreciation to Arthur J. Lurigio, Ph. D., the editor of this monograph, for his commitment and expertise throughout this project. Special thanks also to all of our chapter authors.

The 28 associations that collaborated in sponsoring the national work session along with the National Coalition's Board of Directors extend their gratitude to Mayor Richard M. Daley of Chicago for proclaiming September 7-10, 1995, to be "National Coalition for Mental and Substance Health Care in the Justice System Days in Chicago," and urging all citizens to be aware of this organization's efforts to reform the justice system to meet the needs of persons who are mentally ill and substance abusers.

Sincerely,

Susan

Susan Rotenberg
Executive Director

Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and Co-disorders

Executive Summary

This monograph is the fourth in a series designed to further the goal of humane and effective mental health and substance abuse treatment for persons with mental illness in the criminal justice system. Since 1989, the National Coalition for Substance Abuse and Mental Health Care in the Justice System (National Coalition) has published monographs on persons with mental health and substance abuse problems in the jail, prison, and juvenile justice systems. These publications have urged a shift in failed and redundant correctional policies that stress more punishment and control, to policies that have more treatment and opportunities for persons with mental illness and substance abuse problems to live crime free and productive lives. This monograph focuses on persons with mental illness and substance abuse disorders who are under the supervision of community corrections. **Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and Co-disorders** focuses specifically on addressing and improving the provision of mental health services to persons living in our communities being supervised by Community Corrections.

In the first chapter, Todd Clear sets the stage for the papers that follow by discussing the context in which corrections operates. He describes the punitive posture that the criminal justice system has traditionally adopted to control its population and emphasizes how the system's policies and practices have been harmful to persons with mental illness. He feels that the neglect of persons with mental illness within today's correctional system is not benign but rather results from the mismanagement of these people. Clear cites six principles in working with offenders with mental illness:

- Offenders with mental illness should be supervised by staff with special training in the area of mental health care.
- Practices in supervising offenders with mental illness should never result in increases in the punitiveness beyond that which is allowable.
- Supervision practices and priorities should be based on a realistic assessment of the actual risk posed by offenders.
- The case management of offenders with mental illness should be carried out in conjunction with mental health agencies working with corrections in the form of a service delivery network.
- An aim in the design of programs to work with the mentally ill should be to save money in the long-term.'
- The purpose of correctional services for offenders with mental illness should always be to maximize their potential for living and functioning effectively in the community.

The next two chapters (Chapters Two and Three) provide original data on persons with mental illness under community corrections supervision. Chapter Two, by Betsy Fulton, presents pragmatic recommendations on how to collect and use data effectively in identifying and supervising persons with mental illness in community corrections. Her paper addresses the dangers of being uninformed; the benefits of data-informed decision making; requirements of good data collection; what is known about persons with mental illness on probation and parole; and future directions for enhancing our knowledge about probationers and parolees with mental illness. Fulton concludes that the benefits of systematically collecting and analyzing data on persons with mental illness are:

- The resulting data can be used to support financial and human resource requests.
- The systematic identification of mental illness increases likelihood of receiving treatment.
- The systematic identification of mental illness contributes to staff and community safety.
- Complete and accurate data guide the development of effective programs and practices.
- Data provide basis for interagency cooperation and communication.
- Performance-based data allow agencies to practice "results-oriented management" by providing structures organizational feedback and a continuous process for monitoring and evaluation.

The second of the empirical chapters is by Ed Latessa. The purpose of his chapter is to examine offenders with mental illness under correctional supervision in the community. Specifically, he presents data that compares offenders with mental illness to other offender groups including sex offenders, drug offenders, high risk offenders, and offenders being supervised on standard probation. Latessa concludes that the supervision of offenders with mental illness in the community poses no greater risk than the supervision of other offender groups. His findings suggest that:

- A specialized unit for offenders with mental illness necessitates more than a differential classification of offenders, but involves a philosophical shift from a generalist approach to a specialized model.
- Regardless of whether existing staff is used or new staff is recruited, ongoing training is essential.
- Probation agencies should develop educational programs and public relations for both the criminal justice community and the larger public.

The next four chapters (Chapters Four through Seven) deal with special groups of persons with mental illness on probation and parole. Chapter Four, by Barbara Bloom, Marilyn Brown, and Meda Chesney-Lind reviews the literature on women in the criminal justice system who have mental health and substance abuse problems. They conclude that women have always been an afterthought in correctional programming and crime research largely because so few women committed serious crimes and were sentenced to prison. As a result, research and programming in this area as well as in the criminal justice system have been built around the needs of men. The literature points to the unique needs of women with mental illness in the criminal justice system and argues for special programming, especially given that they are more likely to be victims of abuse. The authors suggest that programs and services for women should be scrutinized in two ways:

- To insure that they are sensitive to the unique needs of the women they serve.
- To guarantee that they represent the most non-intrusive and non-punitive response possible to women's behaviors and problems, and not over-regulate women's behaviors.

In Chapter Five, Bert Pepper and Ed Hendrickson describe the nature and the extent of the population who have both mental illness and substance abuse problems on parole and probation. This chapter provides information and practical tips on how to assess serious mental illness and substance abusers, promote their treatment and interface effectively with the mental health and substance abuse treatment systems. The authors discuss:

- State of the art knowledge about the prevalence of serious mental illness and substance abusers.
- Assessment and classification guidelines that probation and parole officers can use.
- Training needs for officers working with these individuals.
- Roles and functions that are most effective for officers working with serious mental illness and substance abusers.

Chapter Six, by Cecelia Alfonso, focuses on persons of color, who are over-represented in the criminal justice system and under served in the mental health system. She discusses the prevalence of people of color in the criminal justice system, the propensity of the system to incarcerate mentally ill persons, the history of racism in the system, the general absence of multiculturalism in diagnosing and treating mental illness, and the lack of useful data on mentally ill persons of color in and out of the criminal justice system. She emphasizes the importance of cultural sensitivity and diversity in training and working with this large sub-population on probation and parole. She also encourages the inclusion of people of ***color*** in the legal system and the taking other steps to promote color blind justice, as well as understanding the role of mental illness in criminal behavior, in order to help guarantee better services.

In Chapter Seven, Richard Gable focuses on juveniles. This chapter examines and reintegrates the varying views of the behaviors of youths, and suggests where convergence is likely, desired, and possible. The focus of this chapter is on youth in community corrections settings that maximize the potential for ongoing misbehavior and dictate that planned interventions are rational and feasible. He describes the state of juvenile justice with attention on current legal efforts to "criminalize" juvenile behavior, evidenced by many states expanding provisions for transferring juveniles to criminal court. He advises that the role of justice for children should continue to be ameliorative, and, as such, must consider the individual needs (including mental health and substance abuse problems) of those youths. He cites that as individualization withdraws from criminal justice, so to does individualized decision making withdraw from the treatment process, which has serious implications for youth with mental illness.

The next two chapters (Chapters Eight and Nine) examine organizational and structural impediments to the effective care of persons with mental illness on probation or parole supervision. In Chapter Eight, Ronald Corbett examines how the probation and parole systems are currently organized and structured to deal with persons with mental illness. He offers suggestions for "re-engineering" the delivery of services for mentally ill offenders on probation and parole, drawing on what we have learned to date about systems and structure that ensure quality programs. Corbett highlights the importance of three issues for effective programs:

- Jointly sponsored or operated programs.
- The need for boundary spanners.
- The importance of specialized supervision.

In Chapter Nine, Cheryl Davidson focuses on systems collaboration between the criminal justice agencies and mental health treatment providers dealing with people with mental illness and their muiltisystem needs. She concludes that managing mutli-need persons effectively calls for an interagency response. Davidson offers the model of the "steering organization" as a means to break out of frozen status quo and move toward collaboration between systems, highlighting several successful programs. She identifies six factors that enhance the success of steering organizations:

- Environment
- Membership characteristics
- Process structure
- Communication
- Purpose
- Resources

The purpose of Chapter Ten, by Bonita Veysey, is to discuss the current state of knowledge regarding effective mental health services for persons on probation. Veysey discusses the need for mental health service for persons on probation, the target population to receive such services, the role of the probation department in providing mental health services, and strategies for probation supervision and mental health service delivery. She cites some important concepts in providing these services, including:

- Cross training of probation and mental health staff.
- Jointly developed and operated programs by probation and community mental health agencies.
- ***Services*** integration strategies, such as A.C.T. models and intensive case management.
- Co-location of comprehensive mental health services and probation supervision.
- Mechanisms that encourage system integration, such as community planning boards and memoranda of understanding, to identify and overcome barriers to the provision of services.

The monograph concludes with Arthur Lurigio's discussion of the Coalition's Community Corrections National Work Session. This chapter summarizes the groups' responses to five tasks:

- To describe a vision for improving mental health services for persons on probation and parole.
- To list obstacles that prevent the vision from being realized.
- To enumerate factors that bring the vision to fruitation.
- To identify outcomes that indicate whether the vision is being fulfilled.
- To formulate strategies for translating the vision into practice.

INTRODUCTION

The Mentally Ill on Probation and Parole:

Overlooked, Understudied, and Undeserved

Arthur J. Lurigio, Ph.D.

and

Susan Rotenberg

Nearly every state in this country has turned its attention to crime and violence. The public has expected politicians to address those problems. In response, state governments have increased funding for more prisons, abolished parole, created stricter laws, and lowered the age for processing juveniles through the adult criminal justice system.

The call for more crime control strategies has been accompanied by a growing recognition that a balance must be struck between punishment and crime prevention. As funding is being diverted to corrections and away from social programs, the lives of disadvantaged persons are worsening. The casualties of other social failures (e.g., poor education and employment opportunities, inadequate health care) are contributing to the growing numbers of persons in the criminal justice system. Persons with mental illness are among those casualties.

This monograph is the fourth in a series designed to further the goal of humane and effective mental health and substance abuse treatment for persons with mental illness (PWMIs) in the criminal justice system. Since 1989, the National Coalition for Mental and Substance Abuse Health Care in the Justice System (National Coalition) has published monographs on PWMIs in the jail, prison, and juvenile justice systems. These publications have urged a shift in failed and redundant correctional policies that stress more punishment and control to those that emphasize more treatment and opportunities for PWMIs to live crime-free and productive lives. The current monograph focuses on PWMIs under community corrections supervision. The community corrections population in the United States is vast. According to the Bureau of Justice Statistics (1995), 2.9 million individuals were on probation and 690,000 were on parole supervision at the end of 1994. During the last ten years, the probation and parole populations have increased 58% and 149%, respectively (Maguire, 1995).

Probation

Probation is a court-ordered sanction in lieu of incarceration and is the most common form of criminal sentencing in the United States, with between 60% to 80% of convicted offenders receiving one type or another of probation sentence (Petersilia, Turner, Kahan, & Petersen, 1985). Persons placed on probation are released into the community under conditions that are monitored by probation officers.

There are two types of conditions: mandatory and special. Mandatory conditions are specified by state statute and require all offenders on probation to abide by them. In Illinois, for example, the mandatory conditions of probation include reporting to a probation officer, obeying the law, refraining from the possession of a firearm, allowing probation officers to make home visits, and living in the jurisdiction of the court unless the sentencing judge approves a relocation. Special conditions of probation are imposed in response to the specific circumstances of a case and are designed to meet probationers' needs for services and treatment. For example, probationers with drug or alcohol problems may be ordered to obtain treatment in those areas. Others may be required to keep a curfew, to obtain employment, to earn their high school diplomas, or to pay victim restitution.

Parole

Parole is not a sentence. It is a form of mandatory community supervision for persons who are released early from prison. Generally, parolees are more serious offenders than probationers (i.e., they have been convicted of more serious crimes and have more extensive criminal histories). However, the prison overcrowding crisis has compelled judges to sentence more serious offenders to probation, and parole or prison authorities to release them earlier from incarceration. Hence, probation and parole caseloads have become more similar and more like the prison population.

According to Petersilia (1995), "analysis shows that the probation population has become increasingly dangerous if judged by their prior criminal record, current conviction crime, or substance abuse histories" (p. 18). By the same token, the conditions of parole release and the techniques for monitoring probationers and parolees are very similar.

PWMIs under Community Corrections Supervision

In general, persons on probation and parole with mental illness have been underserved. Nearly fifteen years ago, Lurigio (1981) noted that mental disorders in community corrections populations are likely to be ignored unless an offender's symptoms are an explicit part of the offense or are florid at the time of sentencing. PWMIs with less outwardly disruptive symptoms or signs of mental illness received scant attention from community corrections staff. Lurigio (198 1) also found that probation officers struggling with large caseloads were likely to avoid mentally disordered probationers because of their problematic or bizarre behavior. And most probation officers lacked the experience and background to deal effectively with emotionally troubled clients. Unfortunately, the situation since then has not changed much. PWMIs remain an underidentified and underserved population, and probation and parole officers remain ill-equipped to handle their problems.

Responding to PWMIs

We offer a few observations and recommendations designed to clarify thinking about and to improve responses to PWMIs on probation and parole. Many of our remarks, which set the stage for this monograph, are echoed throughout the volume. When we began developing the monograph, we found rather quickly that there is a dearth of information on this troubled population. Unlike the other content areas that the Coalition has covered in previous volumes (i.e., prisons, jails, and juvenile justice), little data exist on the prevalence or incidence of serious mental illness in the community corrections domain.

Importance of data. The first order of business for practitioners is to launch a series of epidemiological studies on the nature and extent of mental disorders among their caseloads. In short, research is needed to build a knowledge base to guide decisions for treatment and services (Boone, forthcoming). Ideally, mental health screening should take place at the presentence level or at intake, so as to incorporate the needs of PWMIs into routine supervision plans. This assumes that valid and reliable assessment tools are available and that staff are adequately trained to screen and diagnose PWMIs. The field has a long way to go to reach this goal, but it is a necessary initial step toward making progress with PWMIs.

Specialization. Specialization is becoming a common strategy for handling probationers and parolees with particular needs or elevated risk for continued criminality. Community corrections agencies should follow suit in the supervision of PWMIs. Specialization makes sense for several reasons, Officers with educational backgrounds and experience in the mental health arena can be chosen to staff special units for PWMIs. Specialized units can monitor smaller caseloads, which is crucial when servicing PWMIs who need more time and attention than non-PWMIs. PWMIs are typically individuals with a multiplicity of problems: comorbidity with substance abuse disorders and developmental disabilities, poor health, housing and financial difficulties, homelessness, joblessness, and lack of social support mechanisms. These clients need habilitation as much as they need rehabilitation.

Continuing experience with the same types of cases allows specialized officers to gain greater expertise in handling PWMIs and to cultivate closer, and more productive, working relationships with mental health professionals. They also gain more knowledge of referrals and a

better understanding of how to access and use community mental health services. Finally, specialization helps officers avoid the role conflict that is a inherent to being an agent of the court and a supportive care provider.

Training. Training on mental illness should become part of community corrections curricula. It is important to increase the sensitivity and awareness of all probation and parole personnel with respect to PWMIs, not just those involved in the specialized handling of such individuals. This training will help to ensure that mental health issues are at the forefront of caseload supervision and referral decisions.

In most agencies, probation and parole officers will not be frontline caregivers or service providers for PWMIs. And they will become increasingly dependent on mental health professionals as they become more adept at recognizing the mental illnesses afflicting their clients. Therefore, community corrections staff need to become more informed about the activities of the mental health staff who deal with their cases.

Mental health and criminal justice personnel are quite disparate in backgrounds, educations, philosophies, responsibilities, and goals when working with cases. Community corrections staff are driven by their role as agents of the courts or prison authorities. Their goals are to monitor the conditions of probation or parole and to file court petitions to violate individuals who break those rules. Ultimately, enforcing rules and protecting community safety supersede any considerations of the mental health and well being of the individuals under their supervision. In contrast, mental health staff focus on the clinical features of cases and may not understand the actions of community corrections staff, which can appear to mental health professionals as arbitrary or overly harsh.

Cross-training for mental health and correctional staff would go a long way toward increasing their mutual understanding and respect. Cross-training will greatly improve the working relationship between the two groups. They can learn about each other's roles, lexicons, job descriptions, primary responsibilities, practices, and competing interests in their work with PWMIs. Most important, cross-training encourages a team approach to working with the same cases. Community corrections and mental health staff who agree on case management strategies can better serve their own professional interests and the best interests of PWMIs.

Liaisons. Liaisons or boundary spanners (i.e., persons who are neither correctional nor mental health staff) should be hired to facilitate and coordinate the joint efforts of community corrections and mental health professionals dealing with PWMIs. These individuals have "familiarity, skill, and credibility in both systems" (Dvoskin, McCormick, & Cox, 1994, p.14), which allows them to achieve interagency cooperation and commitment, and to overcome turf issues that interfere with coordination between mental health and community corrections agencies, and result in duplication of services (Boone, forthcoming).

Technical violations. Probation and parole officers should find alternative strategies for handling the technical violations of PWMIs (see Rhine, 1993). Technical violations among PWMIs are often a function of symptomology, problems with treatment compliance, or difficulties with following directions (Veysey, 1994). Failure to report to one's probation or parole officer may result from cognitive impairment, delusions, confusion, or side effects of medication. As a rule, incarceration or other harsh penalties should be avoided in responding to such instances. More effective options include relapse prevention techniques and systems of progressive sanctions (Veysey, 1994). Officers can view technical violations as opportunities to forge closer relationships with clients and to assist them in avoiding future, and more serious, problems, including subsequent criminal activity.

Contents of Volume

In the first chapter, Todd Clear describes the punitive posture that the criminal justice system has adopted traditionally to control its population and emphasizes how the system's policies and practices have been harmful to PWMIs. In addition, he elaborates on the fundamental principles of effective interventions and the basic challenges of providing services to PWMIs.

The next two chapters provide original data on PWMIs under community corrections supervision. Chapter Two, by Betzy Fulton, presents pragmatic recommendations on how to collect and use data effectively in identifying and supervising PWMIs on probation and parole. She also presents the findings of a groundbreaking national survey of probation and parole agencies. The survey was commissioned by the National Coalition and gathered new information on mental health programs and services as well as the background characteristics and diagnoses of PWMIs on probation and parole. Her chapter concludes with a list of the benefits of better information in terms of public safety, agency accountability, and more effective care and services for PWMIs.

The second of the two empirical chapters is by Ed Latessa. His study found solid evidence that PWMIs on probation supervision pose no greater risk to public safety than other groups of probationers, such as those convicted of sexual offenses and drug crimes. Latessa also explains the relative merits of adopting a generalist or specialist approach to handling PWMIs under community corrections supervision.

The next four chapters deal with special groups of PWMIs on probation and parole. Chapter Four, by Barbara Bloom and Meda Chesney-Lind, reviews the literature on women in the criminal justice system who have mental illness and substance abuse problems. The authors point to differences between men and women with respect to the prevalence, diagnoses, and treatment of mental illness and drug addiction in the criminal justice system. In addition, their chapter covers a number of other essential issues, including homelessness, domestic violence, access to treatment and community mental health services, relapse prevention, and the need for specialized mental health and substance abuse care for women in the criminal justice system.

In Chapter Five, Bert Pepper and Ed Hendrickson describe the nature and extent of the dually diagnosed population on probation and parole (i.e., those with mental health and substance abuse problems). They present the fundamentals of assessment and treatment with this population and discuss the knowledge, skills and attitudes that probation and parole practitioners need in order to deal effectively with dually diagnosed clients. Their chapter concludes with a description of different community-based models for treating comorbidity.

Chapter Six, by Cecelia Alfonso, reminds us that traditional treatment and assessment models do not necessarily apply to persons of color with mental health problems. Alfonso discusses how racism has prevented persons of color from receiving appropriate treatment and services for their mental health problems. She emphasizes the importance of cultural sensitivity and diversity training in working with this large subpopulation on probation and parole.

In Chapter Seven, Rich Gable focuses on juveniles. He discusses the difficulties of handling juveniles under community corrections supervision who have mental health and substance abuse problems, and he describes the changing nature of the juvenile corrections population: it has become younger, more violent, and more diverse in racial and ethnic composition. He presents the primary issues regarding juveniles with mental illness on probation and parole supervision. These include the movement toward punishing juveniles as adults and the virtual absence of mental health professionals in decision-making on treatment and services for juveniles in the criminal justice system.

The next two chapters examine organizational and structural impediments to effective care for PWMIs on probation and parole supervision. In Chapter Eight, Ronald Corbett examines how the probation and parole systems are currently organized and structured to deal with PWMIs. He offers guidance on redefining and reinventing these systems for the purpose of identifying and servicing PWMIs. Corbett highlights a number of distinctions that must be considered in restructuring efforts, for example, specialist versus generalist approaches and brokering versus incorporating services in an agency. He also applies the concept of boundary spanners to help us understand how to navigate and ultimately transcend the gaps between the criminal justice and mental health systems.

In a closely related chapter, Cheryl Davidson tackles the very tough question of how we can achieve systems' collaboration between criminal justice agencies and mental health treatment providers dealing with PWMIs, who usually have multisystem needs. She discusses the factors that can affect the success of interagency collaboration and provides illuminating object lessons from her own experiences with Community Action for the Mentally Ill Offender and the Washington State Policy Design Academy. She concludes with a description of models for interagency collaboration from Texas, British Columbia, and Milwaukee, Wisconsin.

Chapter Ten, by Bonnie Veysey, discusses why PWMIs present significant management problems for community corrections staff. She enumerates several practical suggestions for monitoring PWMIs, including recommendations about identification and classification, risk management, relapse prevention, specialized programs, and service brokerage. In line with Corbett and Davidson, Veysey recognizes the importance of interagency cooperation between the mental health and criminal justice systems.

The monograph concludes with Arthur Lurigio's discussion of the Coalition's Community Corrections National Work Session. He presents the results of the efforts of state delegations to forge a vision for improving mental health services, to identify the forces working for and against the realization of the vision, to list criteria to evaluate the success of the vision once it is put into practice, and to describe strategies to make the vision a reality.

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CHAPTER 1

The Challenges of Responding to Persons with Mental Illness in the Penal System

Community Corrections

Todd R. Clear
Rutgers University

History tells us that when the correctional system turns its eye toward a social problem, the news is often bad. Although the rhetoric of corrections is nearly always positive, the policy outcomes of correctional reforms frequently do not match the optimism with which they were originally embraced. The quintessential example is the prison itself, which early reformers believed would be an instrument of sublime reformation. Today, the prison stands as an institutional behemoth, incarcerating over one million Americans in often crowded and increasingly dejected conditions. But there are contemporary examples as well: despite widespread popularity, "get tough" boot camps and intensive probation supervision programs have not only failed to achieve their main goals but actually have exacerbated some of the very problems they were designed to ameliorate (see McKenzie & Parent, 1992; Petersilia & Turner et al., 1990; Tonry, forthcoming).

For this reason alone, we would be wise to be cautious about a set of chapters advocating "better ways" for the correctional system to respond to problems of the mentally ill. A cynic would say, "Uh, Oh! The criminal justice professionals have decided to give their 'help' to the mentally ill . . . those poor folks are in trouble, now!"

Any discussion of the need to better manage offenders with mental illness has to begin with a recognition that the track record for good intentions in the correctional system is dismal. The contributors to this volume are sincere in their desire to improve conditions for offenders with mental illness. Who would want to make matters worse for them? Therefore, is incumbent upon us to face squarely the difficulty of reform in the correctional system and the very real problem of reforms that backfire.

In this opening chapter, I set the stage for the papers that follow by confronting the context in which corrections operates. Our nation's correctional system is inhospitable to offenders and, if anything, it is becoming increasingly less friendly to them. Why, then, would a group of experts in corrections propose better ways of dealing with the mentally ill, which might seem to suggest getting better at being harsh with this special subgroup of "clients"?

We certainly do not intend our work to extend the unrelenting harshness of America's correctional system to the mentally ill. We are encouraged by two aspects of our endeavor. First, the neglect of the mentally ill within today's correctional system is not benign; rather, it results in mismanagement of the mentally ill-frequently to their detriment. Second, the setting where we work is community corrections; there the traditional excesses of the correctional system are moderate compared to prison.

In fact, we can be plain about our broad agenda. We hope our efforts will contribute to the following aims:

- To reduce the use of institutions as problem-solving methods for offenders with mental illness;
- To ameliorate the symptoms offenders with mental illness;
- To reduce victimization of offenders with mental illness by citizens and institutions;
- To reduce recidivism among offenders with mental illness; and
- To increase the level of long-term support for persons with mental illness in the correctional system.

These are undeniably laudable goals. The question is, "Can they be achieved in the realities of contemporary correctional practice?" That is, can our goals survive the pressures that afflict so

much of correctional reform? I begin by sorting out the value contexts in which our chapters are offered, paying frank attention to the need for changes in those contexts.

Value Sets

With the recent, unprecedented growth of corrections has come a wholesale rethinking of the correctional agenda. It bears repeating that the rate of imprisonment has quadrupled in the last twenty years, while the number of people incarcerated has quintupled. Counting all forms of correctional programs, more than one in every forty adults is now under some form of correctional control. Only post-communist Russia controls its citizens at a higher rate (Mauer, 1994).

A change of this magnitude could not have occurred without an accompanying change in the values underlying corrections in the United States. Undeniably, this has been true: we have changed from a nation that believed punishment a necessary, but essentially unseemly, practice for a democracy of free citizens, to a nation that values penalty as something of a public resource, to be given funding priority and to be spread as widely and deeply as possible. As a case in point, in the 1994 elections, an incumbent governor of Texas was defeated in part because her policies on crime were not tough enough-even though those policies supported the planned construction of a prison each month for the next eighteen months after the election!

In general, Americans clearly find the prison system valuable, as they repeatedly demonstrate a desire to spend more and more money on it, even while funding for schools, roads, and other services declines. What is it that they find so valuable?

The quick answer is that they want to "fight crime." But this answer dissatisfies: crime in America has remained a major problem despite the enormous growth of the correctional system; obviously, the way to "fight" crime has little to do, practically, with sentencing severity or the growth of prisons.

A more subtle explanation would be that there is a national call for change in the symbolic posture of the correctional system. Old symbols that no longer work include words and phrases such as "rehabilitation," "rights," "least restrictive alternative," "self-determination," and "best interest of the client." New symbols that replace the old include "control," "risk management," "public safety," and other calls to discipline offenders (Feely & Simson, 1993). This new language exemplifies the change in value sets that is now occurring in correctional practice. Whatever is done regarding mentally ill offenders will be carried out in the context of these new semantic symbols. Therefore, it is appropriate that we explore the meaning and importance of these symbols - this new language - for offenders with mental illness.

Some Questions About the Mentally Ill in Today's Correctional Context

If we are correct in saying that the tone of the correctional enterprise has changed in recent years, then we must begin by assessing the importance of those changes for our desire to improve the treatment of offenders with mental illness within that enterprise. In the following sections, I discuss six themes in contemporary corrections and raise questions regarding their importance for offenders with mental illness.

Coercion and virtue. Mental health law is in many ways a story of the ethics of coercion: Who may be made to do what? How and why may they be made to do it? Persons with mental illness have been coerced into a lot of different "programs," and a reasonable review of this

heritage would conclude that not all the coercion was beneficial to them. In the context of bureaucracy, coercion all too often has a way of serving the interests of the organization more than the client. Professionals may know how to define the virtuous life for their clients but that does not mean they know how to coerce them into living that life. Thus, in the mental health field, it has become standard practice to question the wisdom of unreviewable coercive methods.

In corrections, however, coercion takes on a less troublesome mantle because it is precisely the antiautonomous aims of coercion that are sometimes valued. Boot camps are intentionally strenuous and sometimes even insulting. Community corrections places "conditions" upon the freedom of offenders, and these conditions are often designed to be onerous or intrusive in order to be punitive. Probation and parole officers are accustomed to the everyday reality of orders of the court and instructions of legal authority. When their clients fail to follow these orders, it is not merely a breach of good mental fitness, it is a violation of the law. Stem responses often ensue.

When we have learned that coercion in the mental health arena is suspicious, what makes us think that the inherent coercion of the correctional system will be benign? Would it not, in fact, be more reasonable to assume that some of the same unintended consequences of coercion are just as likely in corrections as in psychology? Will a special interest in offenders with mental illness translate into a heightened sense of authority over their lives? If so, will probation officers approach their heightened authority over the mentally ill in the same way they approach their authority over other offenders?

These are neither small nor inconsequential questions. We need to be concerned that we are not merely replacing the somewhat discredited coercions of the mental health system with the more effectively insulated coercions of the correctional system.

There are differences, of course, in the way these two systems practice coercion. The mental health tradition attempts to overpower the will of clients with the aim of improving their functioning. Correctional outcomes are focused on subduing clients. These are generalizations but they are accurate enough to give pause.

Punishment. The central purpose of the correctional system is, after all, to punish, not to correct. When the system fails to correct, we are disappointed; when it fails to punish, we are dismayed. Offenders with mental illness will indeed be punished for their crimes. Most Americans would find this to be only proper. Yet, most Americans would also agree that to punish someone for being mentally ill is decidedly improper.

So we are left with questions: Of what interest is it to the correctional system that a given offender also suffers from mental illness? Of what relevance is this status to the system's role as society's agency of punishment? We can assert that categorizations such as "sex offender" or "recidivist" are arguably relevant to the aims of effective punishment. In what way are categories such as "schizophrenic" or "borderline personality" relevant to punishment?

Obviously, we do not raise the issue of a need to understand mental illness among offenders in order to help us punish them better. Our intentions are to call upon the correctional system to use an improved understanding of persons with mental illness in order to enhance their living capacities. Thus, we must realize that we call upon the correctional system to advance practices that are not ordinarily given priority, and we specifically devalue functions of the system that now receive priority.

Risk management. One of the newest correctional paradigms is "risk management" (O'Leary & Clear, 1995). In this paradigm, attention to clients is differentially distributed based

upon risk. First, the actual level of risk is assessed using standard procedures. Then, assignments to correctional programs are based upon the assessed riskiness of the client-the more intensive programs are reserved for the more risky subpopulations.

One heritage of these new "high-risk" programs has been high rates of program failure (Clear & Byrne, 1992). This is true because these programs provide intensified controls, and offenders whose lives are often undisciplined and even chaotic frequently have difficulty living within those controls. When offenders "fail" to abide by program requirements, they "fail" the program. This can happen in quite large numbers. Recently, as much as 80% of all prison intake in Oregon consisted of probation or parole failures, two-thirds of whom did not have a new criminal conviction (Oregon Department of Corrections, 1994).

Two questions should be raised regarding offenders with mental illness. First, what is the relationship between mental illness and risk? And second, what response will offenders with mental illness have to highly structured programs?

The answer to the first question is complex. Most types of mental illness do not exacerbate risk of serious or injurious crime, rather they exacerbate the chances of otherwise harmless, disruptive behavior (Monahan & Steadman, 1994). For some, less common, types of mental illness, however, the chances of violence are greater than in ordinary offender populations-although violence would still have to be considered "rare" in those instances. Thus, merely to identify a person as suffering from a mental illness is not to identify a person who represents a risk to public safety. The creation of specialized case management systems for offenders with mental illness may, generally, have little to do with the broader aims of risk reduction, except with regard to a subset of the mentally ill.

This leads us to the second question: what are the implications of close program structure for the mentally ill offenders with mental illness? Here, the answer is also a bit complicated. If program structure is "enforced" upon the mentally ill in the same ways it is typically imposed upon the traditional client, we could expect even more of the disruptive behavior typical of that group-and supposedly, even higher rates of program failure. If structure is seen as an aid to adjustment rather than a condition of adjustment, then resistance to structure is responded to not as a breach of custody but as a programmatic event calling for case management intervention.

The preoccupation of traditional correctional practice with the ideal of risk management carries with it the potential for overestimating the risk of offenders with mental illness, even when the risk is small. The advent of "high-risk" programming for offenders with mental illness carries a potential for increases in vulnerability to imprisonment in ways that do not correspond to actual risk.

<u>The politics of "toughness."</u> Nothing captures the contemporary mood of correctional policy better than to characterize it as an unrelenting search for toughness: three strikes you are out, prisons barren of basic amenities such as recreation or television, hard labor, strenuous boot camps, and so on. These regimes of toughness have been replicated in probation and parole programs-when given a choice of release into intensive supervision or continued time in jail, one program found that many prisoners preferred jail as a less intrusive sanction (Petersilia & Turner, 1990).

The politics of toughness operates in two simultaneous modes. It begins with a caricature of the offender in almost animalistic terms: wild, uncontrollable, in need of subjugation. Next, it glorifies programs designed to "break" the person who has been stereotyped.

Offenders with mental illness are especially vulnerable to easy stereotyping. In the public eye-and also perhaps in the eye of the typical correctional system employee-the image of a "mentally ill criminal" can be pretty threatening. The natural response may be to invent tough new versions of self-protective controls to be imposed upon these "dangerous" types. If the rhetoric of toughness appeals to us when confronted with garden variety offenders, how much more will it attract us with regard to those who are mentally or emotionally deficient?

This possibility is made even more troubling by the stark irrelevance of "toughness" to the problems of the mentally ill. Difficulties in thinking or perception are not ameliorated by being treated badly. Nonetheless, it must be admitted that most of the current "reform" talk in the field of corrections has to do with better and cheaper ways of "being tough." In fact, a strong case can be made that the original desire to jettison the medical model from corrections was housed in the rhetoric of "humaneness," but that humaneness never followed because reform was distorted by resonant appeals to toughness in the place of humane measures (Griset, 1994; Hudson, 1987).

Getting "tougher" is a national knee-jerk response to our well-practiced fear of crime, Confronted with the puzzle of h-remedial crime, we have but a single viewpoint it seems: hit back harder. This is probably a self-defeating strategy in general, but it will certainly backfire with the mentally ill.

Public safety. We must frankly admit that offenders who pose a threat to public safety are not, for the most part, the mentally ill. In calling for better strategies for handling the offenders with mental illness, we are, in effect, asking that resources be diverted toward this group. Is this wise?

Resources of the correctional system are under extraordinary strain, and increasingly so. Faced with expanding caseloads, probation and parole agencies find they must triage their clients into layers of risk, with only the highest risk receiving the attention required. Prison administrators search through their populations to find low-risk candidates for early release, so that they may make room for new arrivals at the gate. This obsession with risk seems sensible from the standpoint of community safety.

Will a new emphasis on the mentally ill upend this approach? Because we begin with the recognition that most offenders with mental illness pose less of a criminal problem than a public health problem, will we unwittingly distort the community protection agenda of the correctional system by turning its attention toward low-payoff offenders?

Cost containment. Finally, we recognize that the costs of the correctional system are escalating faster than any other costs of government, including even the now infamous costs of health care. Punishment costs are about one-fourth of Alabama's entire state budget (Alabama Sentencing Institute, 1994), and it has been estimated that if present trends continue, the costs of prisons alone will eat up all the nonmandated expenditures of California's state budget, within the next few years (Zimring, 1994). The premium we must place on containing the costs of corrections has never been higher.

Improved services for offenders with mental illness pose several challenges to cost containment aims. It is well known that there are insufficient mental health services for those in need, nationally; to add services for offenders with mental illness would assuredly require increases in funding for them. Moreover, many of these offenders are multiproblem clients, with needs for basic mental health care, remedial education, substance abuse treatment, and employment training. For many of these individuals, there are no third party payers to cover the costs of care. Thus, at a time when cost of the correctional system are already soaring beyond revenues, any

plans to improve our practices with the mentally ill necessarily invoke questions of funding for additional services.

Challenges in Working with Offenders with Mental Illness

The preceding issues raise serious questions; they call for sober reflection on the possibilities of meaningful improvements in the management of offenders with mental illness. To be effective in addressing the problems of the mentally ill, we have to begin with a clear statement of the challenges that face us when working with this population. Below, I suggest a starting place, in the form of six main challenges.

1. Offenders with mental illness should be supervised by staff with special training in the area of mental health care.

The issues involving mentally ill offenders are complex and often quite subtle. The knowledge needed by staff ranges from a working understanding of the pharmacology of drugs used to treat mental illness to the types of communication strategies effective with such clients. The necessary knowledge base also includes a close working relationship with mental health treatment providers and an appreciation for the professional standards of treatment. It follows that mentally ill offenders should be managed in specialized caseloads carried by specially trained staff.

Currently, the number of trained staff to manage the estimated half-million or more offenders with mental illness under community supervision is grossly insufficient. Moreover, training programs designed to teach staff what they need to know are also lacking. Neither problem should divert our attention from the need, however, to be certain that trained staff are available to manage offenders with mental illness. The alternative is not acceptable; when staff who lack the appropriate knowledge are put in charge of offenders with mental illness, too often the result is inadequate or inappropriate supervision- with sometimes tragic results for offenders and citizens alike.

2. Practices in supervising offenders with mental illness should never result in increases in the punitiveness beyond that which is allowable for the offense.

The temptation is nearly constant within the correctional system to respond to aberrant behavior with increased sanctions. When clients misbehave, the system seems to place its credibility on the line with regard to punitive responses. These responses often lead to an escalation of punishments that go well beyond those deserved for the initial crime that resulted in the original sanction (von Hirsch, Wasik, & Greene, 1988).

Offenders with mental illness can be expected to misbehave, and odd or disruptive behavior may even be more common for this group, perhaps in part because of their mental illness. If trained staff are to increase their involvement in these offenders' lives, it will follow that increased attention to the mentally ill will turn up more instances of misbehavior-r even lead to increases in disruptive behavior, due to the strain of increased attention. The policies with regard to misbehavior by offenders with mental illness need to insure that system responses will not constitute an increase in the penalty for the offense when such misbehavior is not itself a new crime.,

3. Supervision practices and priorities should be based on a realistic assessment of the actual risk nosed by offenders.

The fact that most offenders with mental illness pose little risk to the public's safety is not well known. Labels such as "mentally ill offender" might be commonly taken to indicate a greater risk, but studies show that mental illness often has little to do, directly, with criminal behavior. Policies for supervising offenders with mental illness need to avoid the labeling myth. Where the risk can be assessed using traditional risk assessment practices, supervision policies should for these offenders correspond to the actual risk as assessed. Where the mental illness plays a role in the level of risk, supervision practices need to reflect the risk management priority for control of the mental illness itself.

In setting aside specialized caseloads of offenders with mental illness, administrators need to design the policies in case management so that these persons are not unintentionally disadvantaged by the special attention they receive in those caseloads. More effective supervision should not necessarily translate into a strategy of high-risk supervision practice. Indeed, many offenders with mental illness can be supervised with little direct contact from staff, as long as they are under the care of external mental health professionals.

4. <u>The case management of offenders with mental illness should be carried out in conjunction with mental health agencies working with corrections in the form of a service-delivery network.</u>

Even when staff receive special training and are given specialized caseloads of offenders with mental illness, it is appropriate for mental health and other related agencies to be the primary service providers for these clients. This is true for several reasons. First, cost limitations of correctional budgets militate against duplication of services already available from noncorrectional agencies that specialize in mental health treatment. Second, the legal system and the mental health care system have conflicting goals. Hence, it is wise to allow the latter to be primary caregivers for clients, who need services that are not muddled up with punishments.

Mental health specialists are likely to be more effective with clients than cross-trained correctional staff. However, correctional staff have not always worked effectively with mental health agencies. What is needed is not the traditional arrangement of "referrals" but a much more involved posture that might be referred to as a "partnership." For offenders with mental illness, psychological problems, social deficits, and legal troubles are intertwined. They cannot be effectively resolved without an integrated treatment strategy. Responsibility for the hub for such a strategy belongs with corrections because the legal status of offenders is often the paramount source of leverage for effective treatment.

We must recognize that social service agencies dealing with the mentally ill and those dealing with substance abuse clients have experienced difficulties working with each other. Thus, in addition to partnerships, we also must find new and more effective strategies of service delivery. Finally, we must work better together but we also need to work differently together.

5. <u>An aim in the design of programs to work with the mentally ill should be to save money in the long term.</u>

Our policies with regard to offenders with mental illness have been penny wise and pound foolish. We fail to invest in the training and support of staff. Too often, we see institutional solutions as a first-choice priority for the mentally ill. When we cannot find room for them in jails or prisons, we often bury them in large probation caseloads where close attention is not possible.

There are many instances when a front loading of services can save money in the long run. Offenders with mental illness represent one of these opportunities. If we can change to a focus on

prevention, one that eliminates or manages symptoms, we can avoid the eventual use of prisons, jails and hospitals-solutions that are extremely costly in both financial and personal terms.

6. The purpose of correctional services for offenders with mental illness should always be to maximize their potential for living and functioning effectively in the community.

Our bias is against much of the punitive rhetoric of recent correctional reform but it is a particularly strong bias when it comes to offenders with mental illness. The responsibility of the correctional system should not be misconstrued as isolation and punishment. Success is not achieved when offenders stay criminally active or when misbehaving offenders are given another taste of confinement. Success with any offender, but particularly with the doubly-afflicted offenders with mental illness, can be measured in very simple terms: the capacity to function effectively and legally within society. That is the goal against which all our actions should be measured.

Another way of stating this is that the central reason for adopting a strategy in working with mentally ill clients is that such a strategy enhances their human dignity. Inherent within this idea is the belief that successful and effective living in the community is a foundation upon which dignity is based.

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CHAPTER 2

Persons with Mental Illness on Probation and Parole:

The Importance of Information

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A historical review of the criminal justice system suggests that it should be more appropriately named the "crisis management system." Most of what the system does, from initial arrest to the revocation of probation or parole, is a reaction to circumstances that have reached a crisis state. In community corrections, the focus of the current monograph, program and policy development is driven more by external events and mandates in response to crisis, than by informed decisionmaking and planning. This pattern certainly comes to bear when examining what is known about persons with mental illnesses (PWMIs) on probation and parole.

While states such as Texas, New York, and Arizona are leading the way in identifying and addressing the needs of PWMIs on probation and parole, the overriding conclusion of a 1994 survey conducted by the American Probation and Parole Association (APPA) is that very little is known about PWMIs among probation and parole populations. Critical questions are left unanswered-What is the prevalence of mental illness among probation and parole caseloads? Who are PWMIs? What problems do they present? And, what is the most effective method for supervising this offender population? What is even more disconcerting, however, is that very little is being done to answer these questions.

This chapter provides a rationale and framework for probation and parole agencies to begin searching for answers to these pivotal questions. Specifically, this chapter addresses: the dangers of being uninformed; benefits of data-informed decisionmaking; requirements of good data collection; what & known about PWMIs on probation and parole; and future directions for enhancing our knowledge about probationers and parolees with mental illnesses.

The Dangers of Being Uninformed

Of the forty-one states responding to a state-by-state survey on mental illness in probation and parole populations (Boone & Reeves, 1995), only nine states indicated that records were kept on the prevalence of mental illness and only four states indicated that the information was automated and tracked systematically. Not surprisingly, when asked the policy issues and problems PWMIs that presented, respondents indicated: insufficient treatment resources; the underfunding of public mental health programs; public resistance to supervising PWMIs in the community; no fiscal commitment within the agency for providing services to PWMIs; and inadequate training for staff to deal effectively with PWMIs. These problems and issues are a product of the lack of data regarding the prevalence of mental illness in probation and parole populations. As Davis (as quoted in Jamelka, Rahman, & Trupin, 1993, p. 17) notes:

The lack of data and, even, descriptive information on state programs and systems make it difficult for state administrators to plan and develop programs that are responsive to the fears and concerns of the public at large and, at the same time, meet the needs of the offender population for mental health services.

Ignoring the problems associated with PWMIs opens agencies up to many dangers including, increased failure rates, liability issues associated with the failure to provide appropriate treatment (Cohen, 1993) and the "duty to protect" (Monahan, 1993), and externally-driven policies in response to crisis situations. This reactive posture toward PWMIs leads to detrimental effects on the personal well-being of these offenders and inevitably increases costs for the agency. In contrast, knowing more about the nature and prevalence of mental illness through improved data collection will results in informed decisionmaking, enhancing individual case management and improving broad organizational practices for PWMIs.

Benefits of Data-Informed Decisionmaking

In their best seller, Reinventing Government, Osborne and Gaebler (1993), discuss the need to become an "anticipatory government" in which staff anticipate and plan rather than merely react to crisis. Osborne and Gaebler further suggest that making decisions based on foresight requires strategic planning that includes the following steps:

- analysis of the situation, both internal and external;
- diagnosis or identification of the key issues;
- definition of the organization's fundamental mission;
- articulation of basic goals;
- creation of a vision: what success looks like;
- formulation of a strategy to realize the vision and goals;
- development of a timetable for that strategy; and
- measurement and evaluation of results.

As shown above, the strategic planning process begins and ends with gathering information; that is, with collecting data for future plans and decisions. Agencies must begin with baseline information about the mentally ill population. This information should drive the development of missions, goals, and strategies. Performance-based measures can then provide agencies with a mechanism for ascertaining whether programs are being implemented as designed and whether programs are having desired impacts. And the planning process begins again, basing modifications of programs and services on these performance-based data. Through the comprehensive collection and analysis of data and continuous organizational feedback, probation and parole agencies can learn, improve, and change to meet the needs of PWMIs. Information contributes to effective decisions and positive outcomes. Armed with information, probation and parole agencies can more effectively allocate financial and human resources, serve as better advocates for support and services, and improve the case supervision of PWMIs.

Resource Allocation

Effective resource allocation requires that legislators and agency administrators have access to comprehensive data regarding the prevalence and nature of mental illness among the probation and parole population. A method for systematically collecting, analyzing, and reporting data on PWMIs will assist agencies in answering questions such as:

- Do the risks and needs of this offender population justify the development of specialized programs and services?
- Based upon available workload information, how many PWMIs can an officer effectively manage within a generalized caseload? A specialized caseload?
- What is the most efficient way to supervise PWMIs within a jurisdiction-generalized or specialized caseloads?
- Based upon the treatment outcomes of PWMIs, where should limited treatment funds be allocated?
- Do the impacts of specialized programs and services for PWMIs justify expenditures?

Having answers to these questions will assist agencies in garnering the necessary resources for effectively managing the mentally ill population. It demonstrates their resource needs and the value of their programs and services, both of which are essential to compete successfully for limited funds.

Public Advocacy

Given the shortage in resources for supervising PWMIs and the lack of community support identified through the APPA survey, probation and parole agencies must get involved in public advocacy for the mentally ill population. This can be quite difficult considering the lack of sympathy and support for PWMIs-many people view mental illness as a deliberate attempt to avoid being punished (Jamelka, Rahman, & Trupin, 1993). With the current "get tough" philosophy, this view is perpetuated even further.

Gaining public support will take some convincing. Citizens and government officials alike must be educated about the needs of PWMIs and encouraged to support and develop programs and resources designed to improve the quality of life for PWMIs. "Good advocacy demands that we have our facts straight. There are few things that more quickly compromise effective advocacy than asserting errors as fact" (Dvoskin, Steadman, & Cocozza, 1993, p. 1). Before probation and parole agencies can reach out to external stakeholders for resources and support they must educate themselves on the critical issues associated with managing the mentally ill population. This requires the proper identification of PWMIs and a system for tracking their case activity; it requires accurate and complete information.

Case Supervision

Data are essential in guiding decisions about staff, community safety, effective case planning, supervision, and interagency collaboration. Dennis (1993) states that because inmates with severe mental illnesses may be particularly vulnerable or may disrupt the prison routine, their identification is essential to maintaining a safe prison environment. This same concern exists with community-based supervision, and it looms even larger because of the less- controlled environment of community corrections. Although most types of mental illnesses do not increase the risk of serious or violent crime, offenders who exhibit psychotic symptoms may be at increased risk of violence (Monahan, 1992). It is, therefore, critical to public safety that officers identify, monitor, and report these symptoms.

Proper identification and thorough assessment of PWMIs will allow officers to address proactively the mental health needs of these offenders and to assure continuity in offenders' care upon their release from prison or jail and throughout their periods of community supervision. By systematically tracking and recording the impact of treatment, probation and parole officers and mental health service providers become accountable to the offenders who receive services and to the administrators who fund these services (Dennis, 1993). Systematic and comprehensive data collection on treatment activities and outcomes will contribute to an agency's ability to match offenders with appropriate treatments. Effective offender-treatment matching is essential to treatment success and efficient resource utilization.

An important issue for state and local jurisdictions is the right to treatment. Once offenders are identified as mentally ill, appropriate treatment and services must be provided. A method for obtaining data supporting these resource needs and for tracking offender treatment will assist agencies in resource development and will provide legal protection. Due to the wide range of social and human service needs of PWMI's, interagency collaboration is a core principle of effective

programming for this population (Dvoskin, McCormick, & Cox, 1994). Hence, tracking, recording, and communicating assessment and case supervision information is crucial.

Successful Programs

The following examples demonstrate how the ongoing collection and analysis of data assist agencies with resource allocation, public advocacy, and case supervision.

Texas Council on Offenders with Mental Impairments. Based upon a study that documented a large number of offenders in the criminal justice system with mental health problems and developmental disabilities, the Texas legislature set aside funds and drafted legislation to create the Texas Council on Offenders with Mental Impairments. Since this 1987 decision, the Council has evolved into a centralized, multidisciplinary body responsible for identifying offenders with mental health and developmental disabilities, and for developing a state-wide plan to meet the service needs of these offenders (Kifowit, 1994).

A 1993 Biennial Report outlines the Council's major accomplishments including the implementation of two pilot projects in Travis and Harris Counties designed to link PWMIs with therapeutic and support services and to divert them from the criminal justice system. Combined, these projects served 373 PWMIs in 1992, exceeding the expected performance measure of 250 by 149%. Project evaluations reported a 75-85% success rate (i.e., no new arrests) for program participants. Other Council accomplishments include the provision of specialized training to over 2,300 criminal justice and social service professionals, and collaboration with the Texas Commission on Law Enforcement, the Texas Department of Human Services, and other key agencies in developing state service plan for PWMIs and strategies to maximize federal entitlement programs for PWMIs.

The Council has made significant advances during its four-year existence by demonstrating resource needs and the value of programs and services for PWMIs. Future plans include the continuation of diversionary pilot programs for PWMIs, the implementation of new, special-needs parole programs, and the provision of technical assistance to promote agency collaboration and the development of services for PWMIs.

Maricona County Adult Probation Department. Mickel(l994) describes how the Maricopa County Adult Probation Department (MCAPD) uses agency data to advocate for resources to meet the supervision needs of PWMIs. After identifying a large number of probationers with mental illnesses and recognizing their needs for immediate intervention during periods of distress, the MCAPD established a specialized supervision unit for PWMIs. Data showed that the number of PWMIs exceeded the caseload capacity of this specialized unit. Data also indicated that a lack of appropriate intervention for PWMIs, during times of psychiatric instability, was leading to further contact with police and to the use of jails as "treatment facilities" due to a lack of alternatives.

By demonstrating this need for additional services, MCAPD was successful in securing funding through a legislative appropriation for a Transitional Living Center for PWMIs awaiting appropriate community placement. MCAPD contracts with a local non-profit agency for these services, which are designed to provide offenders with full medical and psychiatric evaluations, to prescribe appropriate medications, to initiate referrals for applicable benefits and entitlements, and to identify follow-up placements and treatment strategies. A review of treatment outcomes indicated that out of 144 offenders served during the fiscal year, 63% were successfully placed in the community. Without the program, Maricopa County would have incurred an additional 5,428 total days of incarceration costs; with the program, they achieved an estimated savings to the county of $81,420. Other benefits of the program include offenders' increased ability to maintain gainful

employment, to abstain from drugs and alcohol, and to avoid further contact with the criminal justice system. In short, based on agency-specific data, MCAPD was able to obtain and allocate resources effectively.

New York State Office of Mental Health. Statistics on New York prison populations in 1987 suggested that approximately 8% had a severe psychiatric disability, and an additional 16% had serious developmental disabilities. In response to these statistics and the increasing prison population, the New York State Office of Mental Health (NYSOMH) established a Forensic Task Force in 1989 to improve mental health services for PWMIs in community-based correctional options and for PWMIs scheduled to be released from prison. The Task Force consisted of state and local officials from both the mental health and criminal justice systems, voluntary service providers, consumers, and family members. To identify barriers to treatment for PWMIs and feasible solutions to those barriers, the Task Force worked on several projects including an analysis of data from a NYSOMH Patient Characteristic Survey. This survey contained information concerning the number of clients with a forensic status who were being served by mental health agencies. When comparing the number of forensic clients being serviced with the estimated prevalence of mental illness in these various populations, it appeared that only a small proportion of forensic clients were actually receiving services. The survey also indicated that forensic clients were less likely than nonforensic clients to receive continuing treatment, residential options, and certified work training. Several panel discussions with representatives from the mental health and criminal justice systems and with NYS Parole Officers supported these data: service access and lack of service coordination were identified as major barriers to providing services to PWMIs.

In 1991, the Task Force delivered a comprehensive report offering nine recommendations for: improving the planning of services for PWMIs; developing and broadening existing funding strategies; developing ongoing interagency processes to ensure appropriate coordination between the mental health and criminal justice systems; expanding its advocacy role to decrease the stigma and discrimination experienced by PWMIs; enhancing cultural sensitivity; providing ongoing training and technical assistance to criminal justice and clinical staff; developing prevention strategies for children; clarifying mandates and regulations regarding agency responsibility for PWMIs; and increasing family/consumer input into the planning of mental health services for PWMIs.

A 1994 memorandum of understanding between the Office of Mental Health and the Division of Parole reflects several enhancements that have been made since the release of the Task Force report including: the establishment of a statewide interagency discharge planning process for PWMIs; the introduction of intensive case management services for parolees with mental impairments in New York City; the formulation of a streamlined and accountable referral process to access New York City providers; a pilot study of mechanisms to access entitlement eligibility upon release from prison; and mental health training for parole officers in New York City and basic recruit officers in the Division's academy. Through a comprehensive analysis of data on PWMIs and barriers to services, the NYSOMH Forensic Task Force was able to develop a comprehensive plan and to secure the support, funding, and services required for the effective treatment of PWMIs.

As shown through these program examples, collecting, analyzing, and reporting information highlights positive outcomes, uncovers ineffective practices, and guides agencies to explore alternative methods for achieving organizational goals. It contributes to data-informed decisionmaking that leads to improved agency operations and organizational credibility. Most important, it assures that PWMIs will receive the treatment and resources needed to increase their quality of life and to protect the community.

Requirements of Good Data Collection

Good data collection is purposeful, systematic, and relatively simple. It requires the commitment of staff at all organizational levels as well as several critical components. Key questions guide agencies in formulating a comprehensive and accurate data collection strategy to increase their understanding of mental illness among probation and parole populations.

Critical Components

A review of literature suggests that four components are integral to collecting and using data on PWMIs.

A standard definition of mental illness. There is little agreement on the definition of a "mentally ill offender" (Jamelka, Rahman, & Trupin, 1993). This lack of consensus makes it difficult to identify mental illness and to determine its prevalence among probation and parole populations. For the purposes of this and other monographs developed by the National Coalition for Mental and Substance Abuse Health Care in the Justice System, mental illness is defined as "adults having a disabling mental illness, which includes schizophrenia and/or an affective disorder." These individuals can also have a secondary diagnosis such as, substance abuse disorders, personality disorders, or mental retardation. To collect accurate data on the prevalence and nature of mental illness, probation and parole must work with the mental health system, prisons, and jails to develop a standard definition of mental illness.

Comprehensive and centralized assessment protocol. Assessment procedures and responsibilities should be clearly defined for the proper identification of PWMIs. The following aspects should be included in an assessment protocol:

- Initial screening upon intake to probation and parole-Offenders enter probation and parole through various entry points (i.e., jail, prison, direct placement from court) and they typically are not accompanied by readily available assessment information. Therefore, to ensure the identification of PWMIs, routine screening is encouraged upon intake.
- Multiple levels of mental health screening-Based on the finding that current methods used for gathering data on PWMIs in the juvenile justice system are not always appropriate for identifying particular problems, Otto, Greenstein, Johnson and Friedman (1992) recommend a multimethod/multisource approach to assessment. A brief and standardized screening tool should be used at probation and parole intake, and when mental health concerns are identified, referrals should be made for a comprehensive follow-up evaluation by professional mental health staff (Dennis, 1993; Hartstone, 1990).
- The use of a standardized screening instrument-Standardized measures can be effectively used by trained laypersons. One such instrument is the Referral Decision Scale (RDS) as developed by Teplin and Swartz (1989). It requires little time to administer and has a 79% detection rate. The RDS includes 18 questions, most of which focus on whether the respondents have experienced specific symptoms (e.g., loss of appetite, flight of ideas, persecutory thoughts) at some point in their lives (Ogloff, Roesch, & Hart, 1993). Officers in the New York State Division of Parole use a structured interview format covering symptoms of mental illness, psychiatric treatment history, presence of mental retardation or developmental disabilities, current treatment and medications, history of suicide attempts and current suicidal ideation, and history of violence.

- Trained staff-A PWMI's chances of being identified should not depend on who conducts the assessment. This can be avoided by carefully training staff on screening procedures (Dvoskin, 1990).
- Clear documentation and communication of assessment results-The results of the screening must be documented and communicated to supervising officers, mental health providers, and other agencies or professionals involved in the treatment of offenders.

Systems integration. Helping PWMIs who generally have multiple social and human service needs requires systems-level integration (Veysey, 1994). A collaborative approach among mental health service providers, substance abuse treatment agencies, educational programs and other social services widens the network of support available to PWMIs. Interagency cooperation is also important with law enforcement agencies, jails, and prisons to share information properly and to insure the continuity of care. Interagency agreements outlining each agency's responsibilities and commitments facilitates relationships and enhances the provision of services to PWMIs (Dvoskin, McCormick, & Cox, 1994). The formation of a multidisciplinary planning committee or advisory board, such as the Texas Council on Offenders with Mental Impairments, is also an effective strategy for facilitating systems integration.

A fully integrated management information system. An automated management information system is essential to efficient data collection and analysis. A state-of-the-art management information system can reduce paperwork, maintain data in an organized fashion, and provide quick access to information. The ideal system will allow agencies to share and exchange information. A multiuser information system requires decisions about ownership of records and responsibilities for updating and maintaining records. Procedures must also be developed to ensure the confidentiality of offenders' records.

Key Questions

Several key questions require consideration when developing data collection processes and procedures for PWMIs.

For what purposes are data on PWMIs being collected? In Chapter 1 of this monograph, Todd Clear states that most types of mental illness do not exacerbate risk of serious or injurious crime; therefore, identifying persons with mental illnesses is not done for the purpose of protecting public safety. Because it is decidedly improper to punish someone for being mentally ill, "of what interest is it to the correctional system that a given offender is mentally ill? The intentions of the authors of this monograph are to develop an improved understanding of the mentally ill in order to 'enhance their living capacities" (Clear, this monograph). Hence, "what is our purpose and intention" is the first question that agencies should consider when devising a data collection strategy.

What data fields need to be collected? To determine the extent to which probation and parole "enhances their [PWMIs] living capacities," data will be needed in five key areas: identifying information (e.g., age, case number, sociodemographic information); assessment information (e.g., criminal history, mental health background and needs, substance abuse background and needs, diagnoses); case objectives (e.g., specific supervision objectives and time frames); case activities (e.g., program placement, services provided, treatment participation, medication prescribed, sanctions imposed); and case outcomes (e.g., changes in education/employment, level of independence, drug/alcohol use, stabilization, violations, new arrests, successful completion of supervision).

This list serves only as an example. Each agency must determine carefully what information is needed to plan and improve services for PWMIs. An important guideline is: collect only data that will be analyzed, reported, and used to modify and improve agency operations.

Who is responsible for data collection, coding, management, and analysis? The type of data to be collected, the availability of a management information system, staffing configurations, and the current treatment model for PWMIs will influence the division of these responsibilities. In clearly defining these responsibilities, it is important to involve representatives from all levels of the organization to help develop data collection procedures and to determine what data are needed to assist them in better identifying and serving PWMIs. Agencies can avoid duplication of efforts by using simplified data collection instruments and coding systems. Furthermore, it is important to develop concise policies and procedures for data collection and analysis, and to update them as needs and responsibilities change. Broad-based involvement and streamlined procedures will increase buy-in and commitment to the data collection process.

What procedures will be followed for reporting the information? It is one thing to obtain data; it is quite another to explain data in a way that is both technically correct and useful. Key stakeholders within the criminal justice and mental health systems should be informed of agency and program outcomes on a regular basis. An honest, straightforward approach to reporting outcomes is essential. It is always best to control information from the inside, rather than to leave its interpretation to someone who knows little about the issues associated with the supervision and treatment of PWMIs.

How data are reported should be determined by the audience for whom the data are intended. Sharing both positive and negative outcomes will earn greater respect and credibility with all audiences. The amount of information and its presentational format should be carefully considered. The usefulness of long, comprehensive reports is most likely limited to agency personnel who are directly impacted by their contents. Legislators, judges and parole boards may prefer to receive only information that affects their decisionmaking. The information should be concise and, wherever possible, in the form of graphs, tables, or charts. Information presented in a usable, reader-friendly format is more likely to gain the desired attention and support of audiences.

How will the information be used? Collecting data and measuring results is a critical first step toward understanding the issues associated with the mentally ill offender population. But unless this information is acted upon, probation and parole agencies will remain stagnant. Improving programs and practices is a continuous, long-term process of testing, modifying, and retesting. Feedback from data collection facilitates this process. Data can be used to drive program modifications, to identify staff training needs, to justify new programs and services, and to reallocate financial and human resources. In short, comprehensive and accurate data provide a credible source of information and knowledge about the effectiveness of programs and practices, and open the door to new challenges and organizational growth.

What We Know
Estimating Prevalence from Prison and Jail Studies

Although mental illness can be a significant contributing factor in many crimes, there is a lack of available information about mental illness in the probation and parole populations (Clear, Byrne, & Dvoskin, 1993). One common practice has been to use information from prison and jail populations to estimate the prevalence and types of mental illness in probation and parole populations (Veysey, 1994). Key studies have reported the following statistics regarding the prevalence of PWMIs in jails and prisons.

- A national survey of state and federal mental health and corrections facilities found that 6.6% of detained offenders were designated as mentally ill (Monahan & Steadman, 1983).
- The results of a survey of a random sample of New York State inmates using a standardized survey instrument showed that 8% of the state's prison inmates have severe psychiatric or functional disabilities, and another 16% have significant developmental disabilities (Steadman, Fabisiak, Dvoskin, & Holohean, 1987).
- A survey of 1,391 jails conducted by the National Alliance for the Mentally Ill and Public Citizen's Health Research Group (1992) indicated that 7.2% of inmates were seriously mentally ill.
- Based on a survey of 542 randomly selected, prearraignment inmates in the Cook County jail, 7% of the inmates were severely mentally ill (Teplin, 1990).
- The best methodological studies suggest that, at any given time, 10% to 15% of state prison populations are suffering from a major mental disorder (i.e., schizophrenia, depression and mania) (Jamelka, Rahman, & Trupin, 1993).

The methods of diagnosing mental disorders in jail and prison studies often consist of unstandardized, clinical interviews (Monahan, 1992). Furthermore, "wide differences in the methodology and results of existing studies have yielded conclusions of marginal utility for mental health planning or research" (Jamelka, Rahman, & Trupin, 1993, p. 11). These methodological problems combined with the explosive growth of the probation and parole populations, and recent changes in sentence type and length and conditions of release raise some concerns about the accuracy of using information from prison and jail populations to estimate the prevalence and types of mental illness among probationers and parolees (Boone, 1995). As an initial effort to fill this information void, APPA, in cooperation with the National Coalition for Mental and Substance Abuse Health Care in the Justice System, conducted a state-by-state survey on the prevalence of mental illness among the probation and parole populations.

APPA Survey Finding

The primary objective of the survey was to gather preliminary information on the prevalence of mental illnesses among probation and parole populations and the procedures being implemented within agencies to identify, treat, and track PWMIs. For the purposes of this survey, the definition of mental illness was consistent with the National Coalition's definition described earlier. Individuals identified as being the most knowledgeable about mental illness among the probation and parole populations within their state were the participants in the survey. The survey was distributed to at least one contact person in each of the fifty states. Usable data were received from forty-one states. The following is a summary of the survey results reported by Boone and Reeves (1995). These data represent the current state of knowledge on mental illness among probationers and parolees at the state level.

Accessibility of data on PWMIs. Based on the lack of existing data on mental illness in probation and parole, APPA first wanted to determine the extent to which this information was gathered and maintained. Of the forty-one responding states, nine (22%) indicated that records were maintained on the incidence of mental illness in probation and parole caseloads. Four of the nine states reported that this information was automated and tracked systematically (see Table 1).

Prevalence of mental illness. In addition to the states listed in Table 1, survey respondents in several states reviewed case files to compile the requested data. The prevalence of mental illness among the respondents' probation and parole populations is reported in Table 2. The percentage of

PWMIs among the probation population ranges from 3% to 23% with a mean response of 6% and among the parole population it ranges from 1% to 11% with a mean response of 5%.

Four states were able to provide information on the number of mentally ill probationers and parolees exhibiting specific DSM-III-R Disorders (see Table 3). Personality disorders and depression appear to be the most prevalent.

Demographic factors. Data were requested on race, sex, and age in an initial attempt to describe the mentally ill offender population. Data reported in Tables 4 and 5 suggest that PWMIs are primarily white, male and between the ages of 30 and 40. It is not clear how closely these data reflect the characteristics of the overall probation and parole caseloads in the participating states.

Assessment and treatment of PWMIs. To determine the types of services available for PWMIs, the survey included several questions regarding current procedures and options for assessment and treatment. The major findings include:

- 61% of the respondents indicated that the initial assessments of PWMIs are conducted by local mental health agencies.
- 22% of the respondents indicated that the initial assessment is conducted in-house.
- 61% of the respondents indicated that the court system has the authority to order mental health treatment as a condition of probation supervision; 56% reported that the parole board has this authority.
- Most states had more than one treatment option available for probationers and parolees with mental illness including: local mental health agencies n = 34), private mental health practitioners (n = 30), state mental health agencies (n = 31), and private mental health agencies (n = 29).
- Thirteen states (32%) reported active contracts for mental health services.
- Ten states (24%) operated specialized supervision programs for PWMIs (CA, CO, IL, MD, MI, MO, NY, TX, UT, WA).
- Two states (5%) have a line item in their state budget for supervising mentally offenders (MO, TX).
- Four states (10%) have specific legislation addressing the mentally ill offender population (MO, NB, TX, NY); Missouri's and Nebraska's legislation is limited to sex offenders with mental illness.

Conclusions. APPA's survey is the first attempt to obtain nationwide data on PWMIs at the state level. Agencies operating at the county level were not represented in the study. Based on these survey results, approximately 6% of the probation and parole population suffers from some form of mental illness. The data, while not generalizable, are consistent with the reported prevalence of mental illness among the prison population. If these data are a true indicator of mental illness in probation and parole populations across the United States, over 210,000 offenders (i.e., 6% of the 3,514,915 probationers and parolees in the United States as reported by Gillard and Beck, 1994) under community supervision require some form of mental health services.

Perhaps the most important finding from this survey is that there is little valid, verifiable, state-level information on this population. Certainly, without a systematic means for identifying PWMIs on probation and parole, it is quite unlikely that the needs of these offenders will be met.

The low priority given to the treatment of these offenders is reflected in the limited extent of contracts for mental health services and the neglect of treatment in legislation and agency budgets, In the next section of this article, I recommend local and national initiatives for overcoming some of the deficiencies suggested by the survey findings.

Future Directions

Local Initiatives

States and local jurisdictions must begin collecting and maintaining data that support their resource needs for effectively supervising PWMIs. The following recommendations will assist in securing these data.

1. Appropriate assessment techniques and strategies must be employed to identify PWMIs on probation and parole supervision. This requires a standard definition of mental illness and a comprehensive and centralized assessment protocol.

2. An automated management information system should be developed for recording and tracking information on PWMIs. This system should allow jails, prisons, mental health agencies and probation and parole departments to share and exchange information.

3. Performance-based measures should be developed to document how procedures for supervising PWMIs are being implemented and to evaluate the impact of supervision and services. Performance-based measures provide agencies with feedback for program improvements. They also provide agencies with information that can be used to justify resource requests. Examples of performance-based measures for the assessment and treatment of PWMIs include:

    - 100% of all offenders placed on probation and parole will be screened for mental illness;
    - 100% of those offenders identified as having a mental disorder through the initial screening will be referred to a local mental health professional for further assessment and evaluation;
    - 75% of offenders identified as mentally ill will take their prescribed medication as ordered for a period of 90 days;
    - 60% of offenders identified as mentally ill will maintain gainful employment; and
    - 80% of offenders identified as mentally ill will successfully complete their term of supervision.

National Initiatives

National initiatives should be undertaken to determine the prevalence of mental illness among the probation and parole population and to assist state and local jurisdictions in collecting and maintaining data on PWMIs. The following strategies may enhance our knowledge about mental illness among probation and parole populations:

1. National standards should be developed for collecting, maintaining, and reporting data on PWMIs. These standards could include a recommended assessment protocol, a list of

important variables, model management information systems, and formats for reporting information to policymakers and other stakeholders.

2. Demonstration sites should be established for the purpose of collecting and maintaining state-level data to determine the true prevalence and nature of mental illness among their offender population. Funds could be awarded to several selected states that agree to participate in a comprehensive data collection process. Each selected site would agree to apply a standard assessment protocol to all offenders placed under probation or parole supervision for a specified period of time and to document the data fully and accurately.

3. Professional organizations could provide training and technical assistance to state and local jurisdictions on data management techniques including, developing standardized assessment protocols, establishing interagency linkages, implementing data collection procedures, and designing a comprehensive management information systems.

4. The dissemination of information pertaining to the assessment and treatment of PWMIs on probation and parole is crucial. Agencies can find guidance for developing effective data collection and maintenance techniques by reviewing research materials and information from other agencies.

Conclusion

The benefits of systematically collecting and analyzing data on PWMIs are clear.

- The resulting data can be used as support for human and financial resource requests, allowing probation and parole agencies to compete successfully for limited public funds.
- The data will contribute to effective public advocacy through the education of probation and parole practitioners.
- The systematic identification of mental illness increases the likelihood of offenders receiving appropriate treatment and services.
- The systematic identification of mental illness contributes to staff and community safety by allowing proactive intervention.
- Complete and accurate data guide the development of effective programs and practices.
- The proper identification of mental illness can lead to short-term cost savings by increasing treatment effectiveness and the efficient use of resources, and to long-term cost savings by minimizing recidivism and the use of incarceration for this offender population.
- Data provide a basis for interagency cooperation and communication.
- Performance-based data allow agencies to practice “results-oriented management” by providing structured organizational feedback and a continuous process for monitoring and evaluation.
- Data empower community corrections agencies by arming them with information and the capacity to demonstrate their value.

Probation and parole agencies must aggressively confront the challenges presented by PWMIs through early identification and appropriate intervention. An increased understanding of the prevalence and nature of mental illness among probation and parole populations will assist in the preservation of human dignity among these offenders. The systematic collection, maintenance, and analysis of data are essential for data-informed decisionmaking, and data-informed decision-making, rather than crisis management, will then become a hallmark of the probation and parole profession.

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Table 1

Accessibility of Data

	Probation	Parole	Automated MIS
Colorado		**Yes**	
Connecticut	**Yes**		
Georgia		**Yes**	
Illinois	**Yes**		**Yes**
Iowa	**Yes**	**Yes**	
Maryland	**Yes**	**Yes**	**Yes**
Michigan		**Yes**	**Yes**
Oklahoma	**Yes**	**Yes**	**Yes**
Texas	**Yes**	**Yes**	

Table 2

Number and Percentage of PWMIs by State

	Probation		Parole	
	Number	**%**	**Number**	**%**
California			6,784	1
Colorado			68	
Connecticut	11,919	23		
Florida	6,600	5	145	5
Georgia			276	1
Hawaii	133	3		
Illinois	2.081	4		
Kansas			52	1
Maryland	2,414	6	246	3
Massachusetts			200	5
Michigan	1,500	5	600	5
South Carolina	5,042	13		
Texas	557	3		
Utah	398	5	281	11
Wyoming	110	3	3	1

Table 3

Percentage of DSM-III-R Disorders

	Percentage			
	DE	**MA**	**MI**	**WY**
Schizophrenia	10	20	25	22
Schizophreniform Disorder	5	5	10	3
Depression	20	70	26	48
Dysthymia	20	10	-	2
Mania	-	20	-	25
Personality Disorder	15	75	64	-

Table 4

Demographic Factors for the Probation Population

	Percentage			
	DE	**MA**	**MI**	**WY**
RACE				
White	40	-	69	92
Black	55	-	30	2
Hispanic	5	-	-	2
Native American	-	-	-	3
Other	-	-	1	-
SEX				
Male	65	80	80	75
Female	35	20	20	25
AGE				
Below 18	9	-	-	-
18-25	5	-	18	19
25-30	20	-	17	19
30-35	30	-	20	12
35-40	30	-	18	12
40-50	10	-	19	32
50-60	5	-	7	2
Over 60	-	-	3	3

Table 5

Demographic Factors for the Parole Population

	GA	MA	MD	MI	WY
RACE					
White	-	-	61	52	100
Black	-	-	39	46	-
Hispanic	-	-	-	1	-
Native American	-	-	-	-	-
Other	-	-	-	-	-
SEX					
Male	83	-	88	92	100
Female	17	-	12	8	-
AGE					
Below 18	-	-	-	-	-
18-25	-	10	7	17	25
25-30	-	15	14	18	-
30-35	-	20	18	18	-
35-40	-	25	21	18	25
40-50	-	15	29	18	25
50-60	-	10	9	6	25
Over 60	-	5	2	5	-

CHAPTER 3

The Supervision of Persons with Mental Illness on Probation Supervision

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It is with disease of the mind, as with
those of the body; we are half dead
before we understand our disorder,
and half cured when we do.

-Charles Caleb Colton

A number of important issues concerning the mentally ill and criminal behavior have occupied researchers for a number of years. Predicting violent behavior among the mentally ill and identifying risk factors associated with violence have been the focus of a great deal of research. This literature is much too extensive to review here. The range of variables relating to violence is broad, including, but not limited to, childhood, family, and parenting factors; biological, psychological, neurochemical, and congenital differences; and the abuse of drugs and alcohol.[1]

In general, prior research suggests that the mentally disordered who are at risk for crime are likely to abuse alcohol or drugs and to have a history of childhood behavioral problems (Maughan, 1993; Robins, 1993). Furthermore, studies suggest that minor brain damage, often caused by pregnancy and delivery problems, appears to be strongly associated with violent behavior in adults but only in the presence of a genetic predisposition for a major mental disorder (Brennan, Mednick, & Mednick, 1993; Moffitt, 1984).

Studies on the determinants of violent behavior among the mentally ill have identified several factors correlated with violence for the purpose of creating prediction tools. The benefits of more accurate prediction are earlier intervention, better classification, and more effective treatment programs. However, the interaction of factors, the wide range of mental disorders, and the difficulties associated with measuring many of these factors, have made it nearly impossible to develop accurate and reliable models of prediction.

Another critical issue that has dominated this literature concerns the criminality of the mentally ill. Despite claims by mental health advocates that "people with mental illness pose no more of a crime threat than do other members of the general public" (National Mental Health Association, 1987), strong evidence suggests that this is not the case. In one of the best-designed studies to date, Link, Andrews, and Cullen (1992) found that mental patients had higher rates of violent and illegal behavior when compared to members of the general population. These differences could not be explained by sociodemographic or community context variables (e.g., differential police treatment). Other researchers, such as Taylor (1993), have reported similar findings. Even Monahan (1993), who argued previously that there was little relationship between crime and mental disorders, has begun to question his earlier conclusions.

Although studying the link between mental illness and criminal behavior is important, it can, as Hodgins (1993) points out, contribute to the stigma, rejection and fear of the mentally ill. Nonetheless, she also notes that "describing a problem is the necessary first step to solving it" (p. ix).

For the correctional system, the issue of whether the mentally ill are more "dangerous" than members of the general public is not a particularly relevant question. I would argue that for mentally ill individuals who have been convicted of an offense, a more appropriate question is whether they pose more of a risk than other offender groups being supervised in the community.

Dangerous Compared to Whom?

The purpose of this chapter is to examine offenders with mental illness under correctional supervision in the community. Specifically, I present data that compares offenders with mental illness to other offender groups including, sex offenders, drug offenders, high risk offenders, and offenders being supervised on standard probation. Published research on mental illness among probation populations is limited, and comparative studies are virtually nonexistent. The data presented in this chapter are unique because they provide a picture of offenders with mental illness under probation supervision and compare them to other offender groups that are commonly supervised in the community. The primary question that I will address is whether offenders with mental illness on probation pose any more of a risk to the community than do other offender groups.

Correctional Crisis

Across the country, states are experiencing significant increases in their prison populations. Recent figures released by the Department of Justice (1994) indicate that there are over 1.1 million individuals incarcerated in prison and nearly 500,000 in jail. Despite an unprecedented growth in new prison construction, most states still have shortages of prison space.

The ever-increasing prison population still lags behind the probation population. Probation is the most widely used correctional sanction in the United States, with over 2.8 million adults under probation supervision and an additional 700,000 on parole (Department of Justice, 1994).

Many states have turned to probation in attempts to alleviate the prison crowding crisis. For example, in 1978, Ohio introduced a probation subsidy program that offered local counties funding to reduce state incarcerations through pilot community corrections programs. The first county to take advantage of this program was Lucas County, which includes the City of Toledo. The original grant funded one intensive probation supervision unit designed to monitor prison-bound offenders. Over the years, Lucas County formed a variety of specialized probation units that target particular offender types, such as offenders with mental illness.

In addition to Lucas County, there are now over thirty counties taking part in Ohio's Community Corrections Program. Among them is the largest county in Ohio, Cuyahoga, which includes the City of Cleveland. In 1985, Cuyahoga County started an intensive supervision program, which operates a Mentally Disordered Offender Unit.

The aim of the Lucas County and Cuyahoga County programs is reducing the county incarceration rate without seriously increasing risk to the community. These two programs are the source of the data for this chapter.

Probation

Probation agencies have always served a wide range of offender groups. In recent years, however, classification instruments have permitted them to use offender characteristics in order to focus on specific groups of offenders. In many of the larger probation departments, the result has been the development of specialized units, which have allowed probation departments to manage caseloads better and to increase services.

The two most common criteria employed by probation departments to distinguish among offenders are risk and needs. Risk classification is commonly based on criminal history and

conviction offense. Offenders are usually classified for supervision into high-, medium-, or low-risk groups. Low- to high-risk offenders receive increasingly higher levels of supervision, The second type of classification system usually involves examining offender background characteristics such as, substance abuse history, psychiatric history, prior treatment, and social adjustment. This type of screening usually results in placing offenders into special units or treatment programs. These groups are often supervised by specially-trained staff. The most common probation units consist of programs for sex, substance abusing, and high risk offenders.

Research Methods

To address the question of whether mentally ill probationers with mental illness pose a greater risk to public safety than do other offender groups, data were drawn from the two probation departments described earlier: Lucas County and Cuyahoga County. These two probation departments each operate specialized units for various offender groups including offenders with mental illness.

The Lucas County Mentally Disordered Unit includes one probation officer who monitors about forty active cases. Cases are screened by the department and, when appropriate, an external psychiatric assessment is conducted. Offenders in this unit receive both outpatient treatment in the community as well as group counseling provided by the probation officer.

The Cuyahoga County Mentally Disordered Program is considerably larger, with three probation officers, a unit supervisor, and about 120 active cases at any given time. Offenders are screened and referred to the program from the court's psychiatric clinic; the majority are diagnosed psychotic. According to the unit supervisor, many cases are also classified as bipolar affective and dual diagnoses. Clients are referred for treatment to a local outpatient counseling program.

Data from five probation groups are presented in this chapter; sex offenders, drug offenders, mentally disordered offenders, high risk offenders, and offenders on routine probation supervision. All offenders were felons. Data with regard to the drug, sex, and high risk offenders were drawn from Lucas County only. Data with regard to the mentally disordered units and the regular probation groups were combined from both sites. The sample size of each group was as follows: drug offenders, 121; sex offenders, 64; mentally disordered, 238; high risk offenders, 646; and regularly supervised probationers, 877.

Data from Lucas County included all of the offenders sentenced to these units from 1989 to 1993. A total of 76 mentally disordered and 424 regular probationers were form this site. The Cuyahoga County data included all of the offenders with mental illness supervised between April 1990 and April 1993. The regular probationers from both sites were randomly selected over a similar time frame as the cases in the special units. The average time under supervision was approximately 13.5 months for the mentally disordered group, 18 months for the sex offenders, 14.7 months for the drug offenders, 13.9 months for the high risk group, and 16 months for the regular probation group.

Information was gathered from the case files of the departments. The outcome indicators included arrests, convictions, technical violations, and offender status at the time of data collection. Offender status was used to create the variable "outcome," which was defined as success or failure. The success group included offenders released from supervision or still under supervision at the time data were collected.[2] Failures included absconders and offenders whose probations were revoked because of new offenses or technical violations.

Results

Background Characteristics

Table 1 summarizes the background characteristics of the five groups, which were recorded at the time of admission to probation. These data indicate that the drug and mentally disordered groups had the highest percentages of females, 29% and 20%, respectively, whereas the sex offender group reported the lowest, 3%. A majority of probationers in the sex offender and high risk groups were white, and a majority of the mentally disordered, drug, and regular probationers were nonwhite. The sex offender group was the oldest whereas the high risk probation group was the youngest. The educational levels of the groups were similar, with the mentally disordered and the sex offender groups the most educated, and the high risk and regular probation groups the least educated.

A majority of probationers in all five groups were single; however, the mentally disordered group reported the highest percentage of single persons, 89%. A majority of probationers in all five groups, except the mentally disordered, also lived with their families. In terms of length of residence, the drug group had the least stable residence whereas the regular probation group had the most stable.

The sex offender sample was the only group to report a majority employed at the time of arrest (59%). Not surprising, the mentally disordered group reported the lowest percentage employed (18%). With regard to presentence investigation recommendations, a majority of offender in all five groups, except the drug and high risk groups, were recommended for probation. The mentally disordered group had the highest percentage recommended for probation (74%). Risk assessment data indicated that the high risk sample was the highest risk group, followed by the mentally disordered group. This finding is particularly interesting given the fact that the majority of the mentally disordered sample were recommended for probation.

Criminal History

The criminal histories of the five groups are presented in Table 2. The drug, high risk, and regular probation groups had a more extensive criminal history than the other two groups, especially the sex offender group. The high risk group had the highest percentage of persons with prior state commitments (33%), followed by the sex offender group (23%).

Special Problems

I examined the special problems of the five groups at program entry. This is an important consideration because these areas are likely to be used to select offenders into one of the units. These data are presented in Figure 1. As expected, the vast majority (89%) of the mentally disordered group had a psychiatric history. In contrast, the sex offender group was second with only 25%. Similarly, 47% of the mentally disordered group reported a prior suicide attempt versus 24%, 12%, and 11% of the high risk, drug, and sex offender groups, respectively.

A majority of offenders in all five groups had a history of drug use, ranging from a high of 100% in the drug group to a low of 59% in the sex offender group. A history of alcohol abuse was present in a majority of the drug, sex offender, and high risk groups (88% for drug and sex offender groups, and 84% for the high risk group), with the mentally disordered group reporting only 36%.

Services and Contacts Received

Four major service areas are presented in Figure 2: employment, mental health, substance abuse, and living arrangements. These data indicate that a majority of the drug offenders received employment services (70%), followed by the high risk (35%) and the mentally disordered (34%) groups. A majority of the sex offender and mentally disordered groups received mental health services, 82 and 80%, respectively. As expected, nearly all of the drug offenders received substance abuse treatment (96%). The percentage of those receiving living arrangement assistance ranged from a high of 36% for the drug group to a low of 1% for the regularly supervised probationers. Approximately one-fourth of the mentally disordered offenders received assistance in this area.

The average number of monthly contacts by the probation staff are shown in Figure 3. The average number of contacts per month for each group was: 5.1, drug; 4.6, sex; 4.1, mentally disordered; 3.3, high risk; and 1.3, regular.[3]

Arrests and Technical Violations

The data on arrests, convictions, and technical violations are presented in Figures 4 through 7. Figure 4 shows the percentage of offenders arrested and convicted for misdemeanors since being placed under supervision. The high risk group had the highest percentage arrested (33%), followed closely by the drug group (31%). The drug group had the highest conviction rate (27%). The sex offender group was third, with 23% arrested and 13% convicted for a new misdemeanor. The mentally disordered and regular probation groups were similar, each averaging 13% arrested and 7% and 8% convicted, respectively.

The data with regard to felony arrests and convictions are shown in Figure 4. Again, the high risk and drug groups reported the highest percentage of offenders who were arrested and convicted. The mentally disordered group reported the third highest percentage arrested (19%). The conviction rates for the sex, mentally disordered, and regular probation groups were almost identical at approximately 10%.

To examine the overall arrest and conviction rates for the five groups, the misdemeanor and felony data were combined and are presented in Figure 6. As expected, the drug and high risk groups led in both categories and the sex offender group was third. The rates of arrests and convictions for the mentally disordered group were almost identical to the regular probation group.

Finally, the data on technical violations are presented in Figure 7. Technical violations are typically filed when probationers violate special conditions of their probation. Although the filing of technical violations does not necessarily result in the revocation or termination of probation, it can be an important indicator of an offender's ability to succeed under community supervision.[4] Nearly half (45%) of the drug group had a technical violation filed against them, compared to only 23% of the sex offender group. The mentally disordered group had 44% with a technical violation compared to 41% for the regular probation group.

Probation Status

The data in Figures 8 and 9 indicate the probation status of the five groups: released or under supervision, revoked, absconded, and other.[5] The sex offender and mentally disordered groups were more likely to be released or under supervision, 73 and 63%, respectively, and the

drug group was the least likely (38%). The drug group was more likely to be revoked (32%) and to abscond (24%). The mentally disordered group reported 21% revoked and 16% absconded.

Probation status data were collapsed into two categories (success and failure) and are presented in Figure 9. A majority of three groups were classified as successful: sex offender (78%), mentally disordered (63%), and regular probationers (61%). The drug and high risk groups reported more failures than successes.

Probationers with Mental Illness

Although predominately male, the mentally disordered group had a relatively higher percentage of females, who typically are in their mid-30s with a high school education or better. They are single and, compared to the other groups, less likely to live with their families and to be employed at admission. They are likely to be recommended for probation and are generally classified as high to medium risk. This group is likely to have been on probation previously, and 43% had prior felony convictions. They were selected for specialized supervision on the basis of their psychiatric histories (e.g., 47% had attempted suicide). A majority had a history of drug use. If arrested, this group was likely to commit a felony; however, overall, they were no more likely to be arrested or convicted than the regular probation group and were less likely to be arrested or convicted than the drug or sex offender groups. A high percentage had a technical violation, but this was also true for every group except the sex offenders. Despite the technical violations for this group, the majority were considered successes (i.e., they were not likely to abscond or be revoked).

Caveats

A number of caveats should be noted concerning these data. First, they were drawn from two probation departments in one state and are not necessarily representative of probation departments elsewhere. Thus, the generalizability of these results is limited. Second, the combination of cases from two probation departments also poses several problems. The selection criteria used by these two departments varies and so do their policies and supervision practices. These differences can affect technical violations, absconder rates, and probation outcomes. Size is another factor that has to be considered. One department services a very large urban area whereas the other operates in a midsize county. In addition, the treatment and service programs offered in the counties also differ greatly, which can affect outcomes.

Another important limitation is the length of time under supervision for each group. The mentally disordered group was under supervision for just over one year compared to sixteen months for the regular probationer group. Time at risk can be an important factor in follow-up studies. There are some groups, such as sex offenders (Furby, Weinrott, & Blackshaw, 1989) and habitual drunk drivers (Langworthy & Latessa, 1993), that require a considerably longer follow-up period to adequately gauge recidivism.[6] Whether this is the case for offenders with mental illness is not known at this time. Finally, the data related to arrests and convictions were limited to official crime statistics. Self-report data were not available.[7]

Conclusions

Despite these limitations, the data presented here can help to address a crucial question: Does the supervision of offenders with mental illness in the community pose a greater risk than the supervision of other offender groups? The answer appears to be, no. These data indicate that offenders with mental illness are being supervised in the community without increasing risk to

public safety. Offenders with mental illness perform as well and often better than drug offenders, sex offenders, high risk offenders, and regular probationers. Given these findings, what are the implications for supervising offenders with mental illness in the community?

As mentioned previously, these two probation departments are not necessarily representative of other departments. On the other hand, there is no reason to believe that they are any different from the majority of midsize to large probation agencies across the country. Hence, the following implications for probation practices need to be considered.

Developing a specialized unit for offenders with mental illness on probation necessitates more than just the differential classification of offenders. It involves a philosophical shift from a generalist approach, which requires officers to handle a cross-section of cases irrespective of their special characteristics, to a specialized model, which requires officers to handle one type of offender in a specialized caseload.

Many probation administrators committed to the generalist philosophy claim that it is simply too expensive to start and operate specialized units, given the wide availability of community services. They also claim that, because of widespread staff shortages, it is more efficient to use generalized supervision strategies and to rely on available community resources to provide for offenders' special needs. They argue that to have community resources available, and not to use them, would be inefficient and ill-advised.

Advocates of specialized units maintain that community resources are not always available and community treatment agencies are not always willing to handle offenders. They also point to large caseloads and overwhelming paperwork and argue that specialized units can siphon off more difficult cases from the general caseloads. In turn, those involved in specialized units cannot only become experts in their particular area of supervision but can also become more familiar with community resources (Latessa, et al., 1979).

Another issue confronting probation agencies that want to develop specialized units for offenders with mental illness involves staffing, which includes recruiting and training personnel. The question is whether to recruit and train probation officers from within the department or to recruit specialized staff from outside the agency. Experienced probation officers are more familiar with probation in general and the problems associated with offender supervision. Yet, to train them to handle offenders with mental illness may be more costly and time consuming than recruiting staff who are already familiar working with these clients. Regardless of whether existing staff are used or new staff are recruited, on-going training is essential.

A final issue for probation agencies involves developing educational programs for both the criminal justice community and the larger public. An effective public relations strategy should include several features: (a) Articulating clearly the goals and objectives of the specialized unit for offenders with mental illness; (b) Keeping the law enforcement community informed about any problems or unique situations involving offenders in the unit: (c) Informing attorneys and mental health officials about unit goals, objectives, and operations; and (d) Making the community aware of the unit through public service announcements and other public relations activities.

For judges deciding on an appropriate sentence for offenders with mental illness, these data recommend community supervision. For probation departments deciding on the best way to manage this type of offender, it appears that specialized treatment and supervision is an effective strategy for caseload management. For mental health advocates and others who lobby on behalf of the mentally ill, these data provide support for community alternatives to incarceration. Finally, for policy makers and legislators, these findings indicate that the community supervision of offenders

with mental illness can be undertaken without increasing the risk to public safety, at least when compared to other offender groups who are being routinely released into the community.

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[1]For an excellent review of the risk factors the mentally ill, particularly as they relate to violent behavior, see part two of Hodgins, S. (Ed.). (1993). Mental disorder and crime. Newbury Park, CA: Sage.

[2]Those offenders still under supervision were classified as successes since they were meeting all the conditions of their probation at the time the data were collected.

[3]The contact data does not include group sessions or contacts by external treatment staff.

[4]It should be noted that each probation agency follows different guidelines for the filing of technical violations. Since data from two probation departments are being utilized it can explain some of the variation in these rates.

[5]Absconders are those offenders whose whereabouts are unknown. The "Other" category includes those offenders who transferred to another jurisdiction, dies while under supervision, and incarcerated on a previous charge.

[6]A11 of these groups are still under study and will be followed indefinitely.

[7]For some offender groups, such as sex offenders, official arrest and conviction data are generally considered inadequate measures of criminal behavior.

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Table 1

Background Characteristics of the Drug, Sex,
Mentally Disordered, High Risk, and Regular Probation Groups

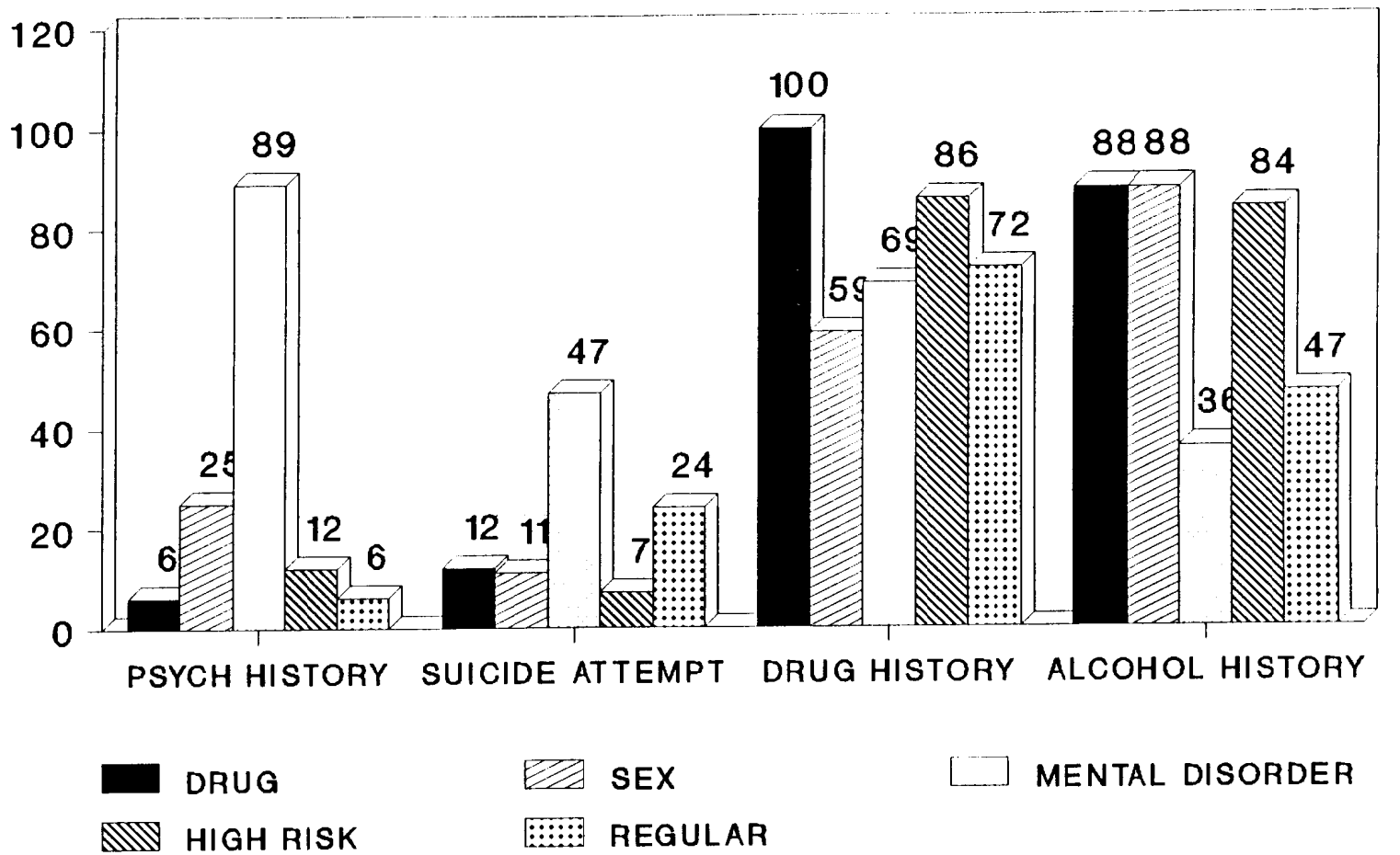
FACTOR	DRUG		SEX		MENTAL		REGULAR		HIGH RISK	
	N	%	N	%	N	%	N	%	N	%
SEX										
Male	86	71	62	97	191	80	719	82	575	89
Female	35	29	2	3	47	20	158	18	71	11
RACE										
White	45	37	46	72	83	34	220	28	350	54
Non-white	76	63	18	28	158	66	578	72	296	46
AGE										
18-21	6	5	2	3	21	9	105	12	119	18
22-28	41	34	18	28	58	24	318	37	245	38
29-35	50	41	19	30	83	35	240	28	145	23
36+	24	20	25	39	75	32	206	24	133	21
EDUCATION										
< than H.S.	55	46	27	43	119	48	490	56	392	61
H.S. Grad	53	44	27	43	92	37	315	36	214	33
Post H.S.	13	10	8	14	37	15	69	8	39	6
MARITAL STATUS										
Single	97	80	42	66	210	89	686	80	517	81
Married	23	19	22	34	26	11	175	20	125	19
LIVE WITH FAMILY										
Yes	88	73	47	75	118	49	637	74	484	75
No	33	27	16	25	120	51	220	26	161	25
LENGTH OF RESIDENCE										
< than 1 yr	80	66	35	56	126	58	291	36	362	56
1 to 2 yr	13	11	7	11	41	18	142	18	100	16
> than 2 yr	28	23	21	33	59	24	367	46	183	28
EMPLOYED AT TIME OF ARREST										
Yes	31	26	37	59	42	18	331	40	188	29
No	90	74	26	41	196	82	497	60	457	71
PSI RECOMMENDATION										
Probation	26	22	32	52	162	74	491	61	178	29
Incarceration	94	78	30	48	58	26	311	39	439	71
RISK CLASSIFICATION										
High	46	39	20	32	117	50	254	30	619	96
Medium	61	51	30	48	71	30	469	55	21	3
Low	12	10	13	21	47	20	134	15	4	>1

Table 2

Criminal History of the Drug, Sex,
Mentally Disordered, High Risk and Regular Probation Groups

FACTOR	DRUG		SEX		MENTAL		REGULAR		HIGH RISK	
	N	%	N	%	N	%	N	%	N	%
JUVENILE RECORD										
Yes	57	58	20	31	58	35	304	44	468	76
No	61	51	44	69	106	65	387	56	147	24
TIMES ON PROBATION										
0	3	3	0	0	17	7	91	10	15	2
1	48	40	43	67	130	55	397	45	149	23
2 or more	70	58	21	33	91	38	389	45	482	70
PRIOR FELONY CONVICTIONS										
Yes	55	46	19	30	102	43	412	47	501	78
No	66	56	45	70	136	57	465	53	145	22
PRIOR STATE COMMITMENT										
Yes	25	21	15	23	47	20	146	17	214	33
No	96	79	49	77	191	80	731	83	432	67

FIGURE 1
PSYCHIATRIC & SUBSTANCE ABUSE HISTORY



Percentage of each group

FIGURE 2
Services Received

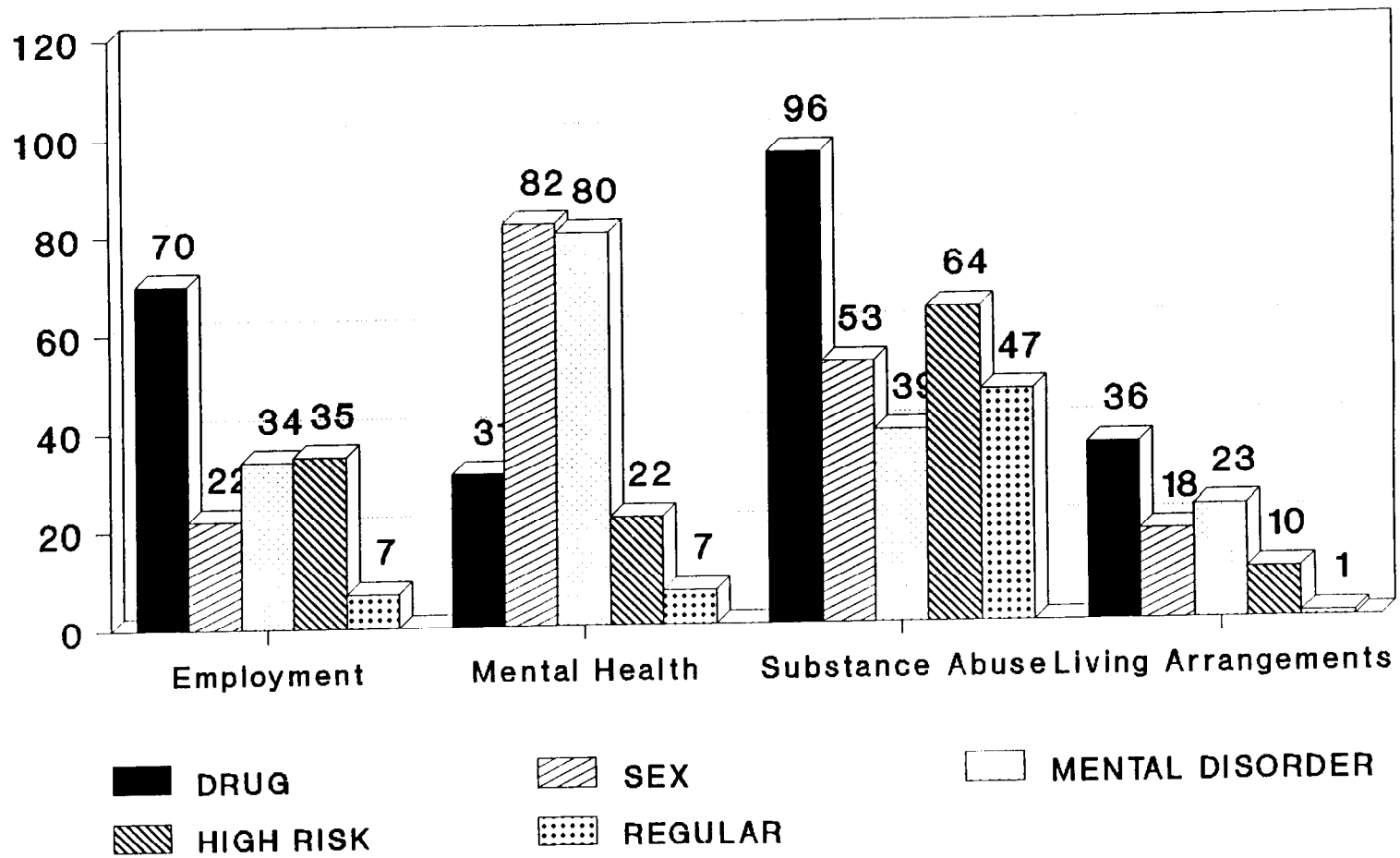


FIGURE 3
Number of Monthly Contacts by Probation Officer

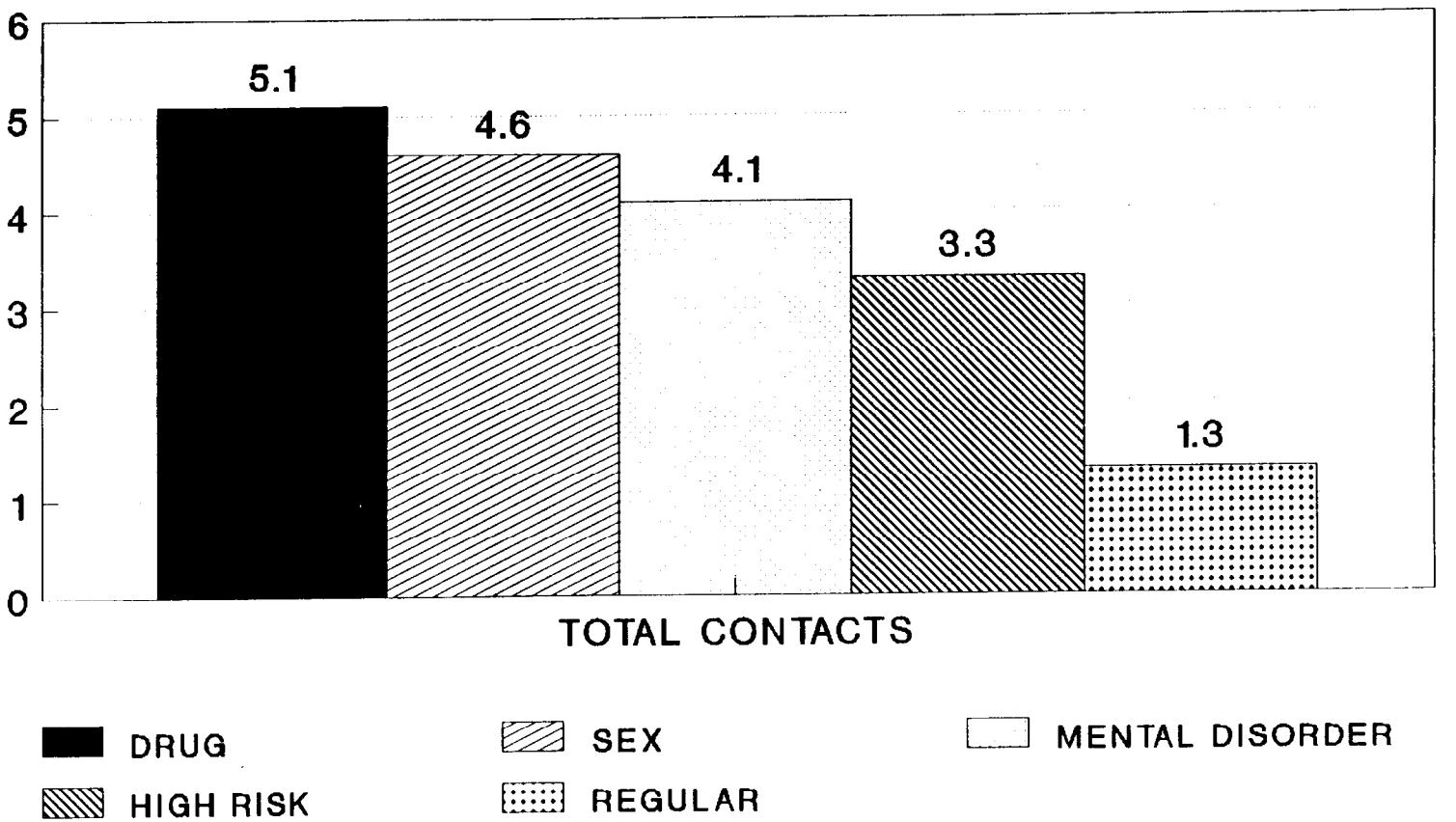


FIGURE 4
% Arrested/Convicted of a Misdemeanor

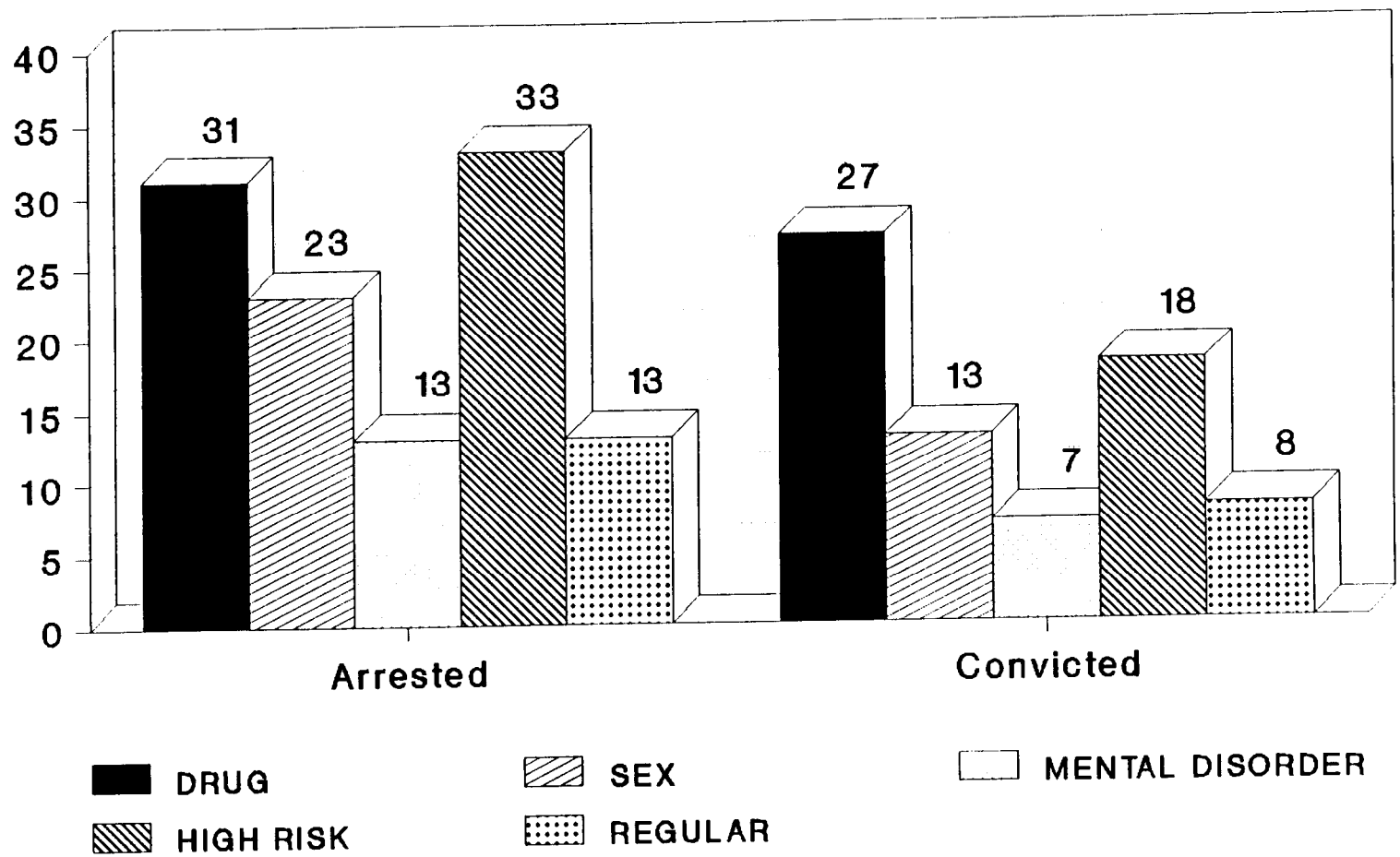


FIGURE 5
% Arrested/Convicted of a Felony

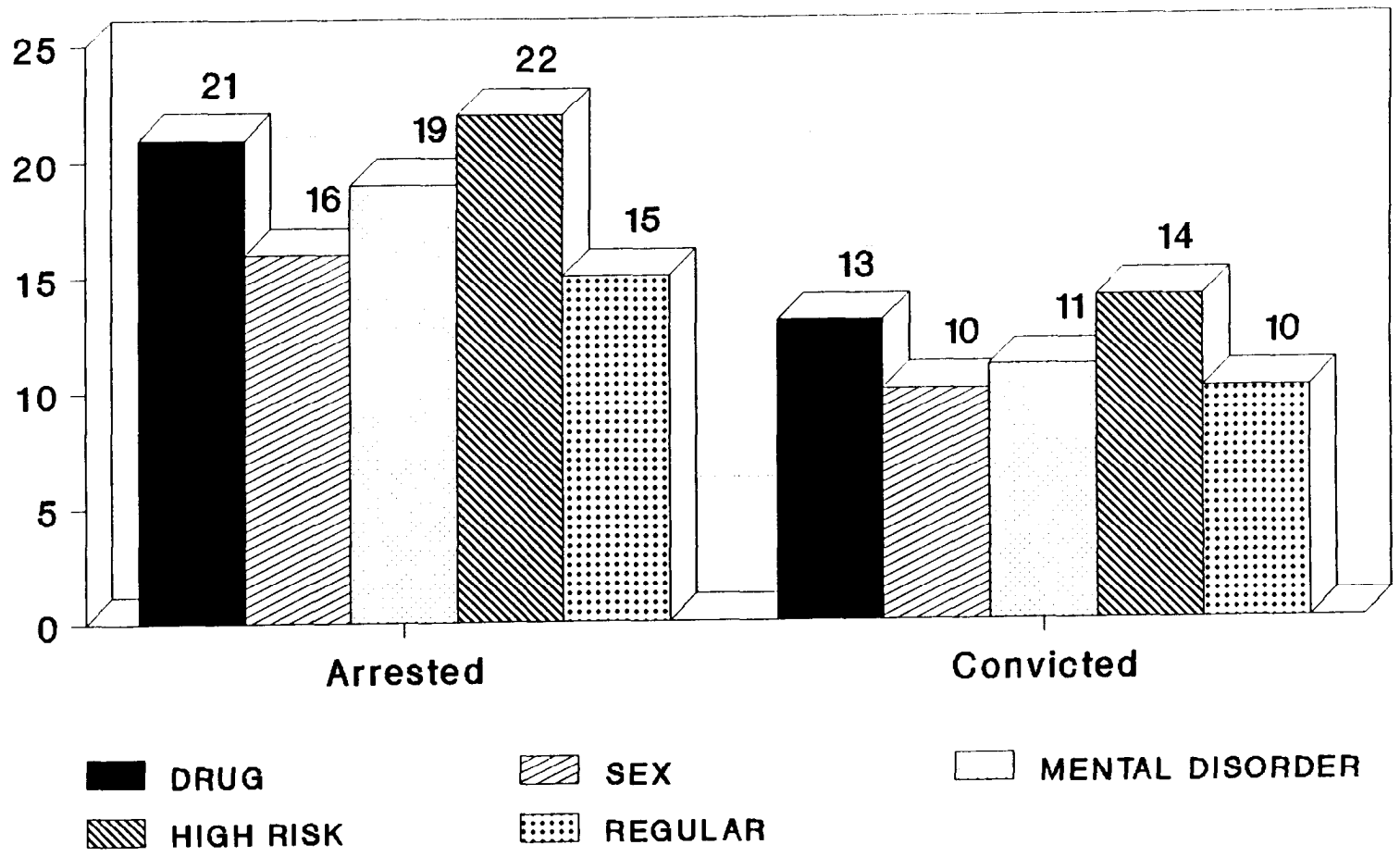


FIGURE 6
Total % Arrested/Convicted

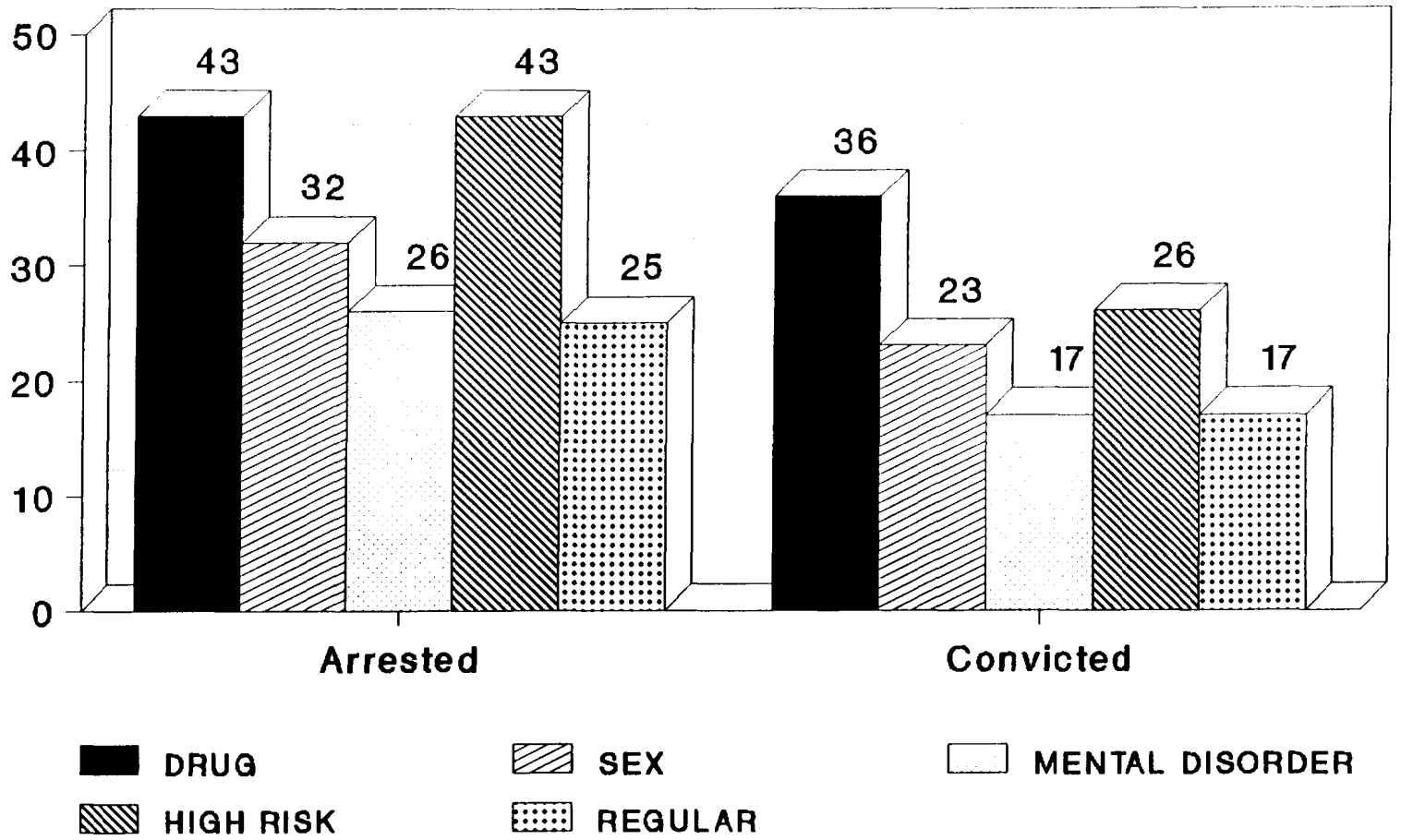


FIGURE 7
% Charged with a Technical Violation

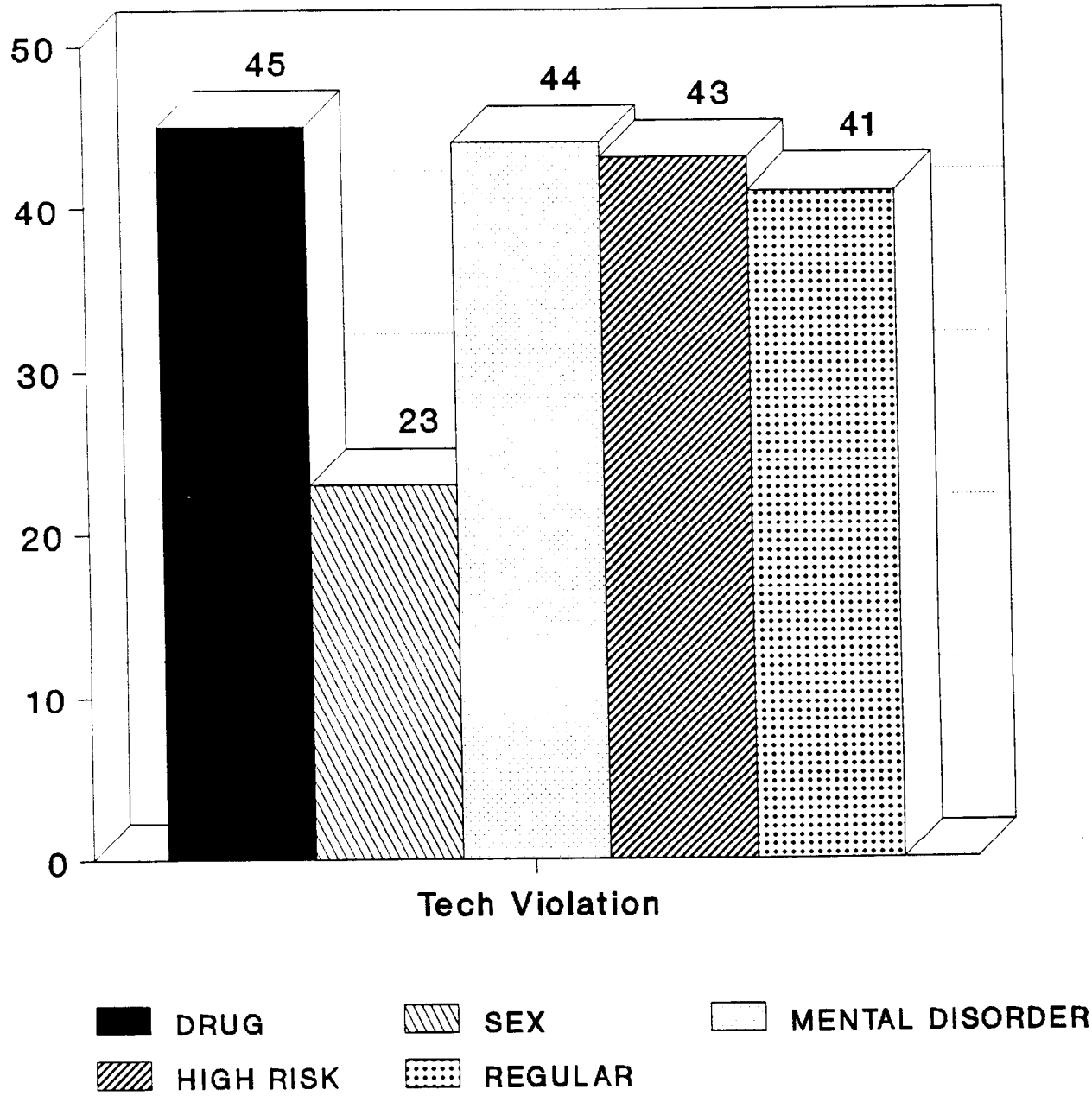
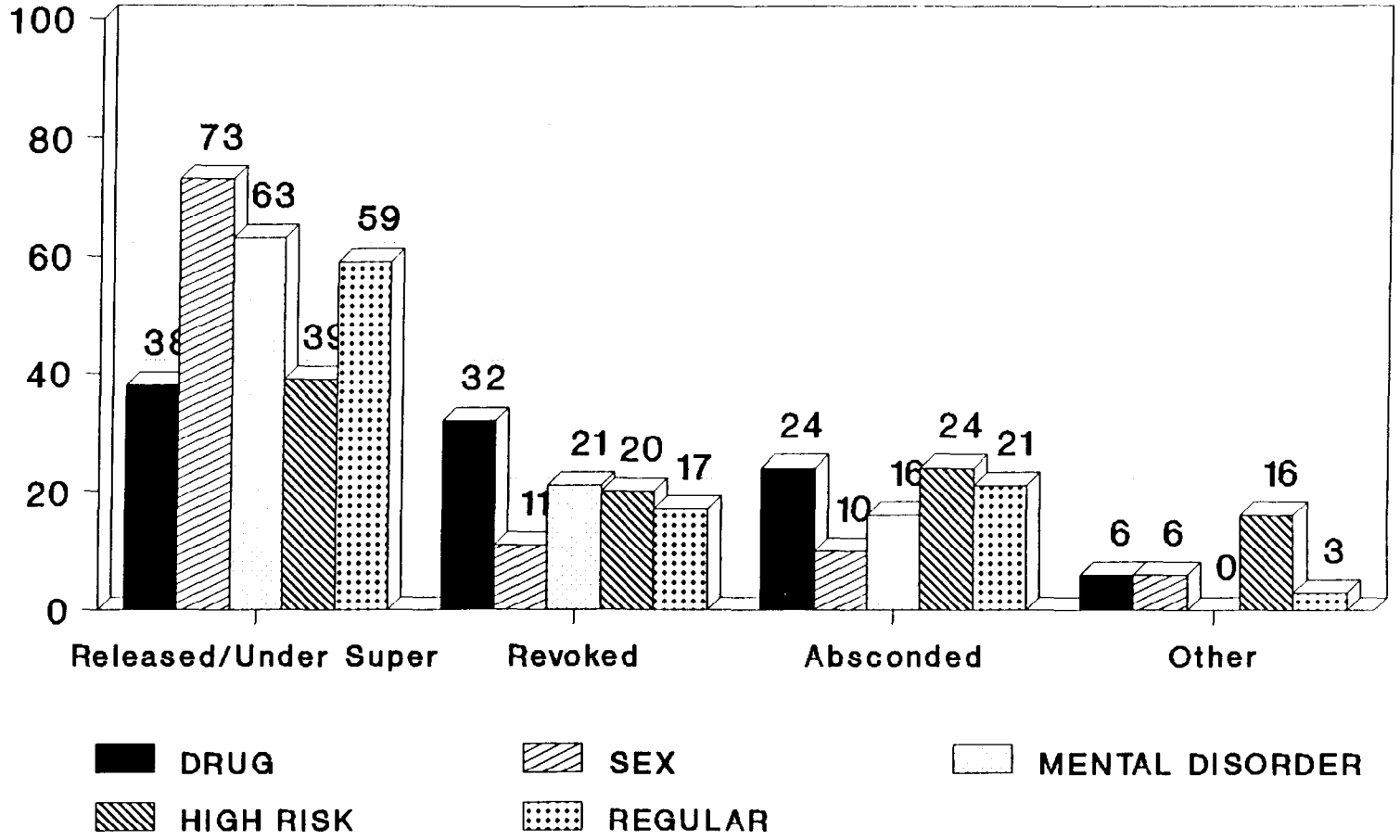
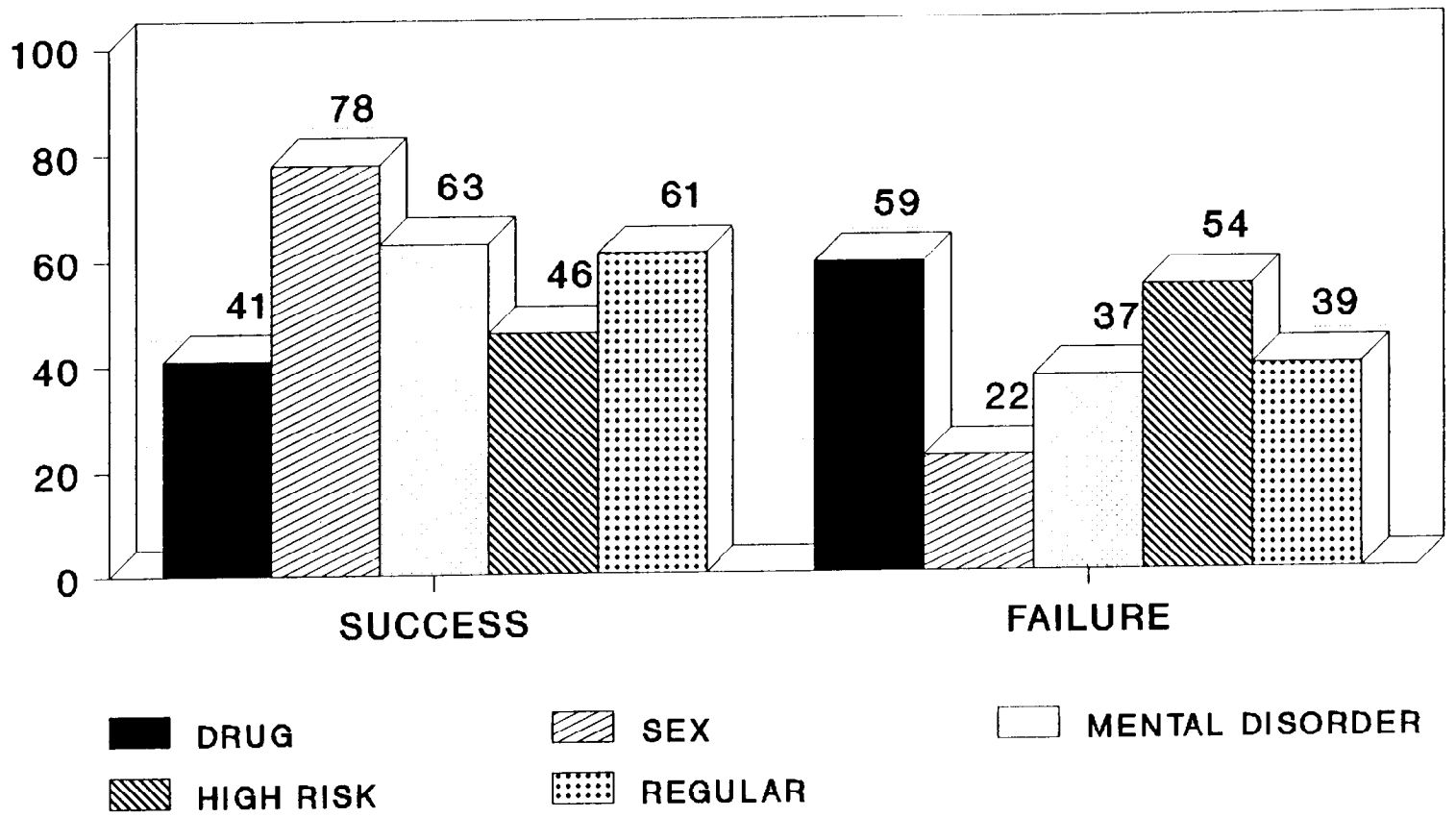


FIGURE 8
Probation Status



Percentage of each group

FIGURE 9
Probation Outcome



Success = Released from Probation or Under Supervision. Failure = Revoked or Absconded. "Other" was not included.

CHAPTER 4

Women on Probation and Parole

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For more than a decade, the rate of growth in women's imprisonment has far outstripped that of men's. During the 1980's, the number of women imprisoned in the United States tripled. On any given day, over 95,000 women are now incarcerated in United States jails and prisons. Over 55,000 women are incarcerated in state and federal prisons (Bureau of Justice Statistics, 1994). The dramatic increase in the imprisonment of women has been driven primarily by mandatory sentencing for drug offenses. Today, women in jail and prison are far more likely than men to be committed for drug offenses (Bureau of Justice Statistics, 1991). Under current punishment philosophies and practices, women are also increasingly subjected to the criminalization of noncriminal behaviors. For example, large numbers of poor and homeless women are being processed through the criminal justice system as cities across the nation pass ordinances prohibiting begging and sleeping in public places.

Similar to jail and prison populations, the number of persons placed on probation and parole has increased dramatically over the last decade. On January 1, 1994, 2,216,880 adults were on probation supervision and 569,121 were on parole supervision. From 1989 to 1994, the size of these populations grew approximately 25% (Camp & Camp, 1994). The vast majority (78%) of women under community correctional supervision in the United States are on probation. Although there are over 550,000 women on probation and parole, limited data are available on their characteristics and needs. The literature on women probationers and parolees suffering from mental illness, including substance abuse disorders, is even leaner; very little is known about their treatment needs and information on programs for these populations is scarce. Such gaps in knowledge are significant. What holds true in the traditional male-oriented criminal justice setting often collapses when it is generalized to female offenders. Even within the population of women under correctional supervision, ethnic and racial differences limit the usefulness of programs built around the problems of white women.

Because relatively little is known about women in the criminal justice system who have mental health and substance abuse problems, we begin by reviewing studies of these disorders in the general population. Next, we discuss what is known about these disorders among incarcerated women. For women especially, probation, prison, and parole are often revolving doors (Bloom, Chesney-Lind, & Owen, 1994). Hence, we examine the mental health and substance abuse issues that render women so vulnerable to reincarceration, and we discuss populations of women in prisons and jails, which probably do not differ substantially from those of women on community correctional supervision. We also broaden the range of concerns here to include homelessness, domestic violence, and other issues of abuse that effect the complex needs of this population.

Prevalence Studies

Prevalence studies of mental illness among the general population suggest that women are at greater risk than men for certain kinds of psychiatric diagnoses. However, men are more likely to have had a psychiatric disorder in their lifetime (Robins et al., 1991). Women tend to have slightly higher rates of schizophrenia with lifetime prevalence rates of 1.7% compared to 1.2% for men. This difference may be due to the fact that women occupy lower levels of SES and experience more serious consequences from divorce and separation, factors that are highly correlated with increased rates of schizophrenia (Keith et al., 1991). The same studies confirm that women suffer more frequently from depression and anxiety whereas men experience higher rates of antisocial personality and substance abuse disorders (Robins et al., 1991). Similar studies have found that women have higher lifetime and 12-month prevalence rates for three or more comorbid psychiatric disorders (Kessler et al., 1994).

Women's Imprisonment and Mental Illness

The prevalence of psychiatric disorders among incarcerated persons is stunning, especially in light of our legal system's provision of reduced culpability for crimes committed by mentally ill or mentally retarded persons. Pallone (1991) provided some strong support for what is known as the "Penrose effect"; that is, the inverse relationship that has been found between the number of prison beds and mental hospital beds. Although the "Penrose Effect" has been challenged (see Edwards et al., 1994; Maden et al., 1994), data suggest strongly that the sizes of institutionalized criminal justice and the mental health populations have closely covaried. Specifically, while beds in mental hospitals declined from 451,000 in 1965 to 177,000 in 1985, the number of incarcerated persons in state and federal prisons increased from 210,000 to 420,000 during roughly the same period (Pallone, 1991).

In their report on the Epidemiological Catchment Area study of psychiatric and substance abuse disorders, Regier et al. (1990) noted the "strikingly high" prevalence of serious mental and substance abuse disorders in the prison population. Rates of bipolar disorder and major depression are significantly higher in prisons and other institutions. Such disorders may, in fact, grow worse in institutionalized settings in the absence of appropriate treatment (Weissman et al., 1991).

Other evidence for the Penrose effect can be found in the institutionization of girls. As a consequence of a major effort to deinstitutionalize status offenders from juvenile justice detention centers, admissions of girls to psychiatric units of private hospitals have increased dramatically. For example, Weithom (1988) found a fourfold increase in adolescent psychiatric admissions during a four-year period in the early 1980s. Furthermore, she reported that whereas the bulk of adult admissions were for "severe" or "acute" mental disorders, adolescent commitments were more likely to involve "acting out" behaviors. Adolescent admissions constitute well over half of all admissions to private hospitals, up from 37% in 1971 (Weithom, 1988).

Although adult women represent a small proportion of the United States prison population, some scholars suggest that incarcerated women experience a higher rate of psychological disorders than incarcerated men (Maden et al., 1994). Because women are more frequently diagnosed with certain psychiatric disorders compared to men, we need to investigate whether this pattern of transinstitutionalization may disproportionately affect women. The dearth of literature on the mental health needs of incarcerated women signifies the lack of services to this population. Although substance abuse treatment seems to be available for incarcerated women, few services are available for women with psychiatric disorders, which has implications for their adjustment to postincarceration life including parole. Indeed, many psychiatric programs in prisons are "add women and stir" or they exist in smaller numbers as women-only programs.

Because little data exist on incarcerated women with mental disorders, patterns of under or over diagnosis are difficult to assess (for an outline of this debate, see Kaplan 1983a, 1983b; Williams & Spitzer 1983). Although the rates of incarceration and mental illness among nations differ, a study on women incarcerated in Britain raises important issues. Maden et al. (1994) studied a cross-section of nearly 25% of the women imprisoned in England and Wales. They were interested in whether the British criminal justice system was acting in ways that "psychiatrise" women offenders.

Based on the common assumption that women offenders are mentally ill, Holloway Women's Prison in England was essentially transformed into a mental hospital. This policy was changed when it was recognized that separation of the clinically ill inmates from the general population was necessary. Women offenders in the sample suffered more frequently than men from neurotic disorders, personality disorders, and drug abuse problems, but their rates of

psychosis were not significantly different from men. Women (45%) were more likely than men (36%) to have had previous psychiatric contacts. Nearly 60% of the women were given at least one psychiatric diagnosis compared to 38% of the men. Women with serious mental illnesses were nearly twice as often diverted to psychiatric treatment by the courts compared to men with similar disorders. More studies of incarcerated women are required to know whether these data apply to women incarcerees in the United States.

Chandler and Kassebaum (1992) studied incarcerated women in Hawaii. They recommended that more attention be paid to women's mental health needs and substance abuse problems to assist in their successful transition from the prison to the community (Chandler & Kassebaum, 1992). Complex patterns of polydrug use, estrangement from family and other social networks, histories of sexual and physical abuse, and educational disadvantages, all make this transition difficult. In addition, these women are at risk for poor pregnancy outcomes due to drug and alcohol use and have difficulty providing for the health and welfare of their children. The focus of the Chandler and Kassebaum's (1992) study, treatment alternatives for formerly incarcerated women, identified only three residential/outpatient programs specifically contracted with the Hawaii Department of Public Safety to deal with these women and their many problems. One permitted mothers and children to live together. The second focused on substance abuse treatment, while the third was a pre-release residential facility. The transition from women's prison to community-based substance abuse treatment was difficult for these women who were left to their own devices in finding and gaming access to treatment. A number of incarcerated women in Hawaii suffered from the comorbidity triad of drug, alcohol abuse, and mental illness. Hence, Chandler and Kassebaum (1992) recommend that the corrections system should follow these women into treatment services in the community and should institute more treatment services inside the women's prison.

Characteristics of Women in the Criminal Justice System

Selected jurisdictions have only recently begun to collect data on women on probation and parole. However, there is currently no comprehensive national data base on this population. Consequently, the following description presents a profile of incarcerated women based on a Bureau of Justice Statistics (1994) survey. As we noted earlier, this profile is likely to apply to women on probation and parole supervision because at various stages in their lives, the same women may cycle through the criminal justice system, from probation to jail or prison, onto parole, and back to jail or prison.

Descriptive characteristics. Women in the criminal justice system are disproportionately women of color. African American women comprise 46% of women prisoners and 43% of women in jail, white women 36% of women in prison and 38% of women in jail, and Hispanic women 14% of women in prison and 16% of women in jail. The average age of women in prison is approximately 32 years; jailed women are younger with an average age of 29 years.

The majority of jailed and imprisoned women were unemployed prior to arrest and approximately 23% had completed high school. The majority of incarcerated women are also unmarried and approximately 80% have children, two-thirds of whom are under age 18. The majority of the children of imprisoned mothers live with relatives, primarily grandparents. Approximately 10% of the children are in foster care, a group home, or other agency. About eight to 10% of women are pregnant when they are incarcerated.

Abuse. Women under criminal justice supervision frequently have histories of childhood or adult abuse. More than 40% of women in prisons and jails reported being physically or sexually

abused at some time in their lives prior to incarceration. More than four in every 10 women reported that they had been abused at least once before their current admission to prison. Compared to men, imprisoned women were at least three times more likely to have been physically abused and at least six times more likely to have been sexually abused since age 18. For most women under correctional supervision, their problems begin as girls; another national study of women in United States prisons and jails indicated that nearly half (46.7%) had run away as girls, and two-thirds of these women ran away more than once (American Correctional Association, 1990).

Drug use. Incarcerated women use more drugs and use them more frequently than do incarcerated men. About 54% of the women used drugs in the month before their current offense, compared to 50% of the men. Women prisoners are also more likely than their male counterparts to use drugs regularly (65% vs. 62%), to have used drugs daily in the month preceding their offense (41% vs. 36%), and to have been under the influence of drugs at the time of their offense (36% vs. 31%). In addition, women are more likely than men to report having used a needle to inject drugs prior to incarceration.

The rate of HIV infection is higher for women prisoners than for men prisoners. According to the Bureau of Justice Statistics (1994), among state prisoners tested for HIV, women were more likely to test positive. An estimated 3.3% of the women reported being HIV positive, compared to 2.1% of the men. Among prisoners who had shared needles to inject drugs, more women than men were likely to be HIV positive (10% vs. 6.7%).

From 1986 to 1991, the percentage of women in prison for drug offenses increased significantly. Nearly one in three women prisoners were serving a sentence for drug offenses in 1991, compared to one in eight in 1986. The percentage of women in prison for property offenses declined from 41% in 1986 to 29% in 1991. Women incarcerated for violent offenses included about three in ten women prisoners in 1991, down from four in ten in 1986.

Mental health issues. Women's mental health issues are sometimes tied to stages of their life-cycle and development including onset of puberty, adolescence, and pre- and postreproductive experiences (Seiden, 1989). However, because a disturbing number of women are sexually and physically abused as girls and as adult women, attention has been focused on the anxiety, depression and other psychological illnesses resulting from these events (Seiden, 1989; Frank et al., 1979). The trauma of early sexual and physical abuse may be manifested in borderline and multiple personality disorders as well as the more common post-traumatic stress disorders and alcoholism (Seiden 1989; Miller et al., 1987). These illnesses may be aspects of stress response syndromes (Seiden, 1989; Bryer et al., 1987; Rieker & Carmen, 1984). Therefore, abuse, trauma and victimization are all highly significant components in the etiology of mental illness and addiction in women (Hamilton, 1989). However, the relationships among these factors should be considered as interactive, not determinate (Abbott, 1994).

Depression seems especially crucial in this discussion of mental health because it is a common (and debilitating) illness among women and because it is associated with substance use. In addition, women and men may differ in their learned responses to depressive states (Nolen-Hoeksema, 1990). Men's depression may be expressed as alcoholism, which is highly correlated with depression, whereas women are more often diagnosed as simply depressed. In fact, alcoholism is diagnosed roughly twice as often in men than in women, pointing to potential diagnostic biases in prevalence rates (Williams & Spitzer in Nolen-Hoeksema, 1990). Abuse plays a role in the etiology of both addiction and in depressive disorders. Furthermore, violence and trauma are implicated in the depressive disorders, appearing in 53% of battered women (Rounsaville, 1978). Women may try to medicate their symptoms with legal pharmaceuticals and illicit substances (Abbott, 1994).

Hamilton (1989) explains how racism, inferior social and economic status, and cultural values all contribute to women's risk of and responses to the "trauma of gender-based abuse" (p. 39). Women who are members of marginalized subgroups may be at higher risk of some types of abuse, such as gang rape, while cultural values, such as family propriety, may cause women to be silent about the abuse. This is particularly true for women in subpopulations already at risk for the psychological effects of racism and other forms of chronic discrimination (Hamilton, 1989). Women's membership in marginalized racial, ethnic, class, and sexual preference groups are all essential in assessing the risk of psychological illnesses and in making accurate decisions about diagnoses and treatment.

Substance abuse. Although women are more frequently incarcerated for drug-related offenses than are men, studies of licit and illicit drug use in the general population show some interesting and contrasting patterns of use in both groups. Chen and Kandel(l995) found that lifetime prevalence rates for illicit drug use (and alcohol use) for men are significantly higher than for women. However, women are more likely than men in the same age groups to have taken (and to be currently taking) prescribed psychotropic drugs including, minor tranquilizers, sedatives, and stimulants. Other studies also suggest that women's path into addiction may be mediated in part by access to legal pharmaceuticals-a phenomenon that may give rise to chemical dependency (Reed, 1987; Abbott, 1994).

Ryan's (198 1) study of addicted males and females in drug treatment suggests that men more often report the recreational use of drugs whereas drug use for women frequently becomes a means of self-medication for psychological and physical distress. Indeed, women may become addicted to drugs through their contacts with medical providers who dispense pharmaceuticals for anxiety, depression, and gynecological problems (Ryan, 1981). In one study of jail inmates, researchers found that polydrug use was associated with a variety of psychiatric illnesses including depressive disorders and chronic cocaine use (Peters & Kearns, 1992).

Studies of criminality and addiction focus variously on the criminogenic aspects of narcotics, the role of crime in initiating and perpetuating drug use, and the interactions between drug use and criminality (Hser et al., 1990). A "third variable," such as drug availability or psychiatric disorder, may interact with drug addiction and crime. Powers et al. (1990) point to a "long-term interlocking chain reaction pattern" involving drug use and property crime, which further suggests that these behaviors constitute a life style. Likewise, Chandler and Kassebaum (1994) argue that polydrug use among the offender population they studied is an aspect of lifestyle. In fact, addiction in women offenders frequently occurs in the context of relationships with abusive spouses or significant others. Hser et al. (1990) found that women involved in drug-related crime have a range of income-producing strategies that may involve support by a male (especially a dealer), dealing, property crimes, and prostitution. Furthermore, income from property crimes seems to lead to further drug use over a longer term in women but not in men (Hser et al., 1990). This lifestyle commitment presumably makes women extremely vulnerable to contacts with the criminal justice system.

In summary, women's and girl's mental health issues are often tied to stages of development, such as onset of puberty and adolescence. A disturbing number of women are sexually and physically abused as girls and as adults. Abuse, trauma, and victimization tend to be highly significant components in the etiology of mental illness and addiction. Furthermore, addiction in women frequently occurs in the context of relationships with abusive partners. Women frequently use drugs as a means of self-medication for psychological and physical distress. Women substance abusers often become involved in drug-related offenses, for example, drug dealing, prostitution, and property crimes to support their addiction. Hence, appropriate interventions for women on community corrections should pay attention to social network and economic support in addition to treatment for psychological and substance abuse problems.

Probation and parole programs should consider the woman's past history including, familial and other relationships, physical and sexual abuse, mental health and substance abuse treatment, and employment.

Women's Issues in Treatment

Women on probation and parole who are mandated to drug abuse treatment are usually referred to community treatment programs. Perhaps because men outnumber women in drug treatment about 5 to 1 (Abbott, 1994), programs have historically been built on a male model of alcoholism and addiction. Ryan (198 1) argued that treatment modalities for men and women must be different because the factors that shape drinking and drug use for the sexes also shape their needs in recovery. She noted that whereas men in recovery frequently emphasize the problems caused by consequences of drug use, women more often report difficulty with the "stressors" leading to drug use. Women addicts are more likely than men addicts to report histories of family pathology (Ryan, 1981; Inciardi, Lockwood, & Pottieger, 1993) including physical and **sexual** abuse. After entry in treatment programs, women find recovery complicated by childcare issues, inadequate social support and lack of financial resources (Ryan, 1981). They may also be suffering from higher rates of eating disorders, anxiety, and psychosexual disorders (Lex, 1993). Thus, treatment for women probationers and parolees must take these complex issues into account.

For men, unemployment and legal problems are significant aspects of drug addiction recovery. In contrast, women are apt to seek help for emotional problems, economic support, and medical complaints (Ryan, 1981). Men seek help for addiction frequently because of legal difficulties and other adverse consequences of substance abuse, including legal coercion, whereas women commonly seek help in response to the emotional and psychological sequelae related to life problems (Ryan, 1981). Reed (1987) reports that men more frequently engage in obvious rule-breaking behaviors in connection with substance use. In contrast, women's behaviors in relation to drug or alcohol addiction have fewer economic and social consequences, which results in less attention being paid to women's substance abuse problems (Reed, 1987).

Homelessness. Homelessness is linked to contacts with the mental health and criminal justice systems. Michaels et al. (1992) indicated that mentally ill detainees who are homeless are more likely to remain incarcerated and that, in fact, homelessness is strongly correlated with mental illness. Although little data are available for women in this predicament, a case study by Detrick and Stiepock (1992) illustrates how homelessness, drug addiction, and psychiatric disorder may place women at risk for incarceration:

> After one of Mary's arrests for prostitution, police called NRI [Northern Rhode Island Community Mental Health Center] to report that she was out of control and psychotic. There were new track marks on her arm. Emergency services staff first arranged for Mary to go to an involuntary medical detoxification unit, from which she was transferred on a ten-day commitment to a local general hospital psychiatric unit. MTT [Mobile Treatment Team: an outreach intervention program] staff were introduced to Mary on the psychiatric unit and then attempted numerous outreach contacts when she left the hospital and returned to her boarding house. (p. 74)

The MTT intervention services assisted Mary and others in finding housing as well as in avoiding contacts with the criminal justice system. This excerpt provides an example of the type of intensive outreach that is necessary to keep these persons from being inappropriately diverted to the criminal justice system. Interestingly, the NRI staff also reported that the woman's arrests for prostitution were linked to her manic episodes. This case study and the report on NRI's intervention for the homeless mentally ill suggest a model of community mental health services and care for women at risk for reincarceration.

The criminal justice system is becoming the primary care provider for the mentally ill homeless population (Solomon et al., 1992). Neither homelessness nor mental illness are criminogenic per se and some of the crimes committed by homeless persons may be viewed as survival strategies (Solomon et al., 1992). This is especially true for girls on the run (often from abusive home situations) who are not legally permitted to be without adult supervision. Blocked from school or legal employment, runaway girls and boys often resort to prostitution and petty theft to survive (Chesney-Lind & Shelden, 1992).

Upon release from jail or prison, there may be few options for women with mental illness because both their families and the psychiatric community are reluctant to provide shelter and care for them (Solomon et al., 1992). Similarly, Draine et al. (1994) found that incarceration was strongly related to mental illness and substance abuse; these three factors plus young age increased the likelihood of reincarceration. Draine et al. suggested that individuals with a psychiatric history should be followed up to insure that they receive community mental health treatment. These studies do not address women incarcerees, noting that the numbers of women in their data sets were too small to be considered.

A result of severed social relations, economic vulnerability, addiction, and abuse, homelessness is a frequent complication in the lives of women suffering from mental illness. Few studies have compared homeless women and men but North and Smith (1993) reported that homeless women are far more likely to have young children in their care, to be young themselves, to be members of minority groups and to be more dependent on welfare. They also were less likely than men to have had previous substance abuse problems, and histories of incarceration and felony convictions. Nearly one-quarter of the men but only 5% of the women in the study group of 600 men and 300 women had been previously incarcerated. Although psychiatric disorders were less common among homeless women compared to homeless men, nearly half (48%) of the women qualified for a lifetime diagnosis of some psychiatric disorder. Finally, in North and Smith's (1993) sample, many more homeless women (23%) than men (4%) reported being sexually abused as children.

Although one theory (reviewed in Benda, 1990) suggests that male homelessness is the ultimate outcome in a spiral of troubles related to crime, drug abuse, and mental illness, this "drifting down" process differs in women. The cascade of losses generally takes place over a period of years and is mediated by socio-economic status and individual vulnerability. Criminal history is more likely to be a part of men's drifting down to homelessness. But women's homelessness also involved substance abuse, mental illness, disaffiliation, and other variables including past incarceration. Although the author does not provide a breakdown by gender for deinstitutionalized persons, it is significant that 50% of the former mental patients and prisoners in the sample were released during the preceding 12 months. Of these persons, half were receiving no regular social services despite continued social and psychological problems (Benda, 1990). Presumably, women as well as men are being released to the streets as a result of state prison and psychiatric policies.

Domestic violence. More and more, epidemiological research demonstrates the prevalence of domestic violence and its impact on significant numbers of women in the United States. One study indicated that as many as 30% of women who visit emergency rooms have injuries or conditions linked to domestic violence (McLeer & Anwar, 1989). Women who are involved in the criminal justice system appear to be at greater risk for physical abuse than those in the general population.

A survey of female offenders shows that incarcerated women are very likely to have histories of physical abuse (American Correctional Association, 1990). This study indicated that

53% of adult women and nearly 62% of juvenile girls had been victims of physical abuse. Nearly half of both these groups (49% of adults and 47% of juveniles) reported experiencing 11 or more episodes of physical abuse. Furthermore, the violence is most likely to have been perpetrated by a boyfriend or husband in the case of adult women offenders (50%) or by a parent in the case of juvenile girls (43%).

Juvenile girls report that most violence in their lives occurs between the ages of 10 and 14 years. Adult incarcerated women report being subjected to the most violence at ages 15 to 24, suggesting that abuse follows these women into adulthood. Although the extent to which women on probation and parole experience domestic violence is unknown, this population is at high risk for experiencing abuse for several reasons including higher rates of substance abuse and social isolation.

Studies of alcohol and drug-abusing women strongly suggest a relationship between substance abuse and domestic violence. For example, Miller et al. (1990) argue that female alcoholics are at significantly higher risk for becoming victims of domestic abuse. According to the same study, male parolees are at high risk for involvement as perpetrators of spousal abuse. Although Miller et al. do not address whether spouses or partners of male parolees are themselves former offenders, these findings have ominous implications for women on probation or parole who may be involved in these relationships.

Supervision on probation or parole can make it more difficult for women in abusive relationships to get help. Economic marginalization, drug or alcohol addictions, the severance of social and family networks, and the alienation women may feel upon release from incarceration may make them vulnerable to abusive relationships. Revocation of parole and return to incarceration may be used as an intervention to get women out of extremely abusive relationships. This may occur when a parole officer feels that a woman parolee is at extreme risk for domestic violence. These situations speak as much to the lack of alternatives for victims of domestic violence in the community as to the policies of parole authorities. More research is needed on the interpersonal relationships of women on probation and parole and what might be done to decrease their risk of becoming victims of domestic violence.

Child custody. Many women under criminal justice supervision face losing custody of their children. Some women have relatives or friends who will care for their children while they are supervised in jail, prison, or in the community. Placement with relatives generally reduces the likelihood that children will be permanently separated from their mother and other family members. Maternal grandmothers most often care for the children of women prisoners (Bloom & Steinhart, 1993).

If a mother is unable to place her children with relatives or friends, the local child welfare agency will place them in foster care. Estimates show that between 7% and 13% of the children of incarcerated mothers are in foster care with nonrelatives (Bloom & Steinhart, 1993). When children of imprisoned mothers are placed in foster care, caseworkers are expected to make concerted efforts to sustain family ties and to encourage family reunification. This calls for the development of a case plan shortly after the child is placed in foster care and parental involvement in the development and implementation of that plan.

Continuing contact between parents and children is a significant predictor of family reunification following parental incarceration. Child welfare laws provide for termination of parental rights, usually after 12 to 18 months, if the incarcerated mother has failed to sustain an adequate relationship with her child who is in foster care. Most incarcerated mothers, particularly those who are mentally ill, do not have access to the resources they need to meet other reunification

requirements imposed by the court such as, parent education, counseling, drug treatment, and job training.

Upon release form custody to community corrections, mothers face numerous obstacles in reunifying with their children. They must navigate through a number of complex governmental and social service agencies in order to regain custody of their children. although differences may exist across jurisdictions, in many cases, it is considered to be beyond the purview of probation and parole agencies to intervene in child custody cases.

Access to Treatment. If mental health treatment is not a condition of a woman's probation or parole, her participation in mental health services is voluntary. Although persons under community supervision should have the same access to mental health resources as any other community member, their access is often restricted because of their status as probationers or parolees. Many community mental health providers are reluctant to admit persons under criminal justice supervision because probation and parolees are believed to pose potential risks to public safety. In addition, there are few affordable women-specific treatment slots in the community. For juvenile girls, the lack of gender specific treatment is even more serious.

Effective Intervention Stratepies and Services

Special programs designed to address the needs of women probationers and parolees with mental illness include: (a) mental health programs provided by community mental health agencies or by probation and parole agencies, or both; (b) cross-training of probation officers in mental health issues and mental health staff in corrections issues; (c) special supervision practices; and (d) systems integration strategies, such as community planning boards and interagency memoranda of understanding. Below are a series of recommendations made by Veysey (1994) in an assessment each of these programming aspects, followed by our caveats relating to women and girls.

Community Mental Health Services

Veysey (1994) notes that individuals on probation who have mental illness require access to a full range of community mental health services. Gender-specific and culturally-appropriate services are particularly relevant. Programs should also be available to juveniles without their having to obtain parental permission.

Specialized Probation Caseloads and Programs

A growing number of probation departments assign persons with mental illness to specialized caseworkers. Specially-trained probation officers should facilitate the reintegration of offenders with mental illnesses. Wherever possible, these caseloads should be segregated by gender; the problems encountered by mentally ill girls and women are fundamentally different from those of their male counterparts.

Jointly - Sponsored Programs

Collaboration is the key to program success for mentally ill women and girls on community correctional supervision. Developed and sponsored jointly by community mental health and probation agencies, these programs encourage active communication between the provider agencies and probation, which is important to achieving the overall goals of the program: to reduce recidivism and to increase the probationer's ability to live in the community. Important services,

such as counseling for survivors of family related sexual assault and domestic violence, are essential to effective programs for girls and women on probation and parole supervision.

Crosstraining in Mental Health and Corrections

Crosstraining is an important component in the community supervision of women and girls with mental illness. Crosstraining is especially important for probation officers supervising specialized caseloads. Also, community mental health providers need to be informed about the demands and nature of the criminal justice system-particularly the need to work with offenders who have mental illnesses to help them meet the conditions of their probation. Specialized training on the different etiology of male and female offending as well as the unique problems of women with mental illness is also important.

Special Supervision Practices

Persons with mental illnesses tend to have high rates of technical violations of their probation sentences. Currently, a substantial number of "new" admissions to women's prisons are women in violation of the conditions of their probation and parole (Chesney-Lind & Pollack, 1995; Oregon Intermediate Sanctions for Female Offenders Policy Group, 1995). To accommodate their unique needs, many community supervision agencies have developed strategies to help them become successfully integrated into the community and to meet their conditions of release. Supervision practices should also be reviewed to insure that women are not receiving more monitoring (and more conditions) than their male counterparts.

Relapse Prevention

An integrated approach utilizing probation officers as case managers is critical in helping former offenders to avoid repeated contacts with the criminal justice system. Treatment practitioners and other service providers as well as family members and other social supports are critical in assisting women with substance abuse and mental health issues make a successful transition from incarceration to community living.

Progressive Sanctions

Given that women on probation with mental illness are particularly prone to technical violations of probation, scheduling sanctions appropriate to these cases is essential. With the cooperation of mental health and other providers, realistic strategies for complying with mandated treatment protocols can be worked out for these individuals.

Systems Integration

As we have already discussed here, persons with comorbid substance abuse problems and psychiatric disorders require intensive support to cope with their many social, psychological and economic problems. The integration of responses to these persons provides for a wider spectrum of assistance. But better integration between and within systems is necessary in order to provide service at this level.

A study by Austin, Bloom and Donahue (1992) identified 100 community-based programs serving women offenders exclusively but not necessarily specific to women with mental illness. In terms of service needs, program staff indicated that most of their clients were in need of a wide array of social, medical and residential services including drug treatment, domestic violence and

sexual abuse counseling, and employment, education, housing, and legal aid. The primary form of service provided to the clients was residential care, involving services for women and children.

The day treatment programs discussed in Austin et al. (1992) primarily served women on probation or parole, along with other offenders directly sentenced to the program. The programs generally emphasized substance abuse treatment, life skills training, and employment services. The most promising programs identified in their study did not employ the medical or clinical model of correctional treatment. Rather than attempting to "cure" clients of emotional disorders, programs worked with clients to broaden their range of responses to various type of situations and needs, and to enhance their coping and decision-making skills. Effective therapeutic approaches were multidimensional and dealt specifically with women's issues relating to addiction, parenting, interpersonal relationships, gender bias, domestic violence, and sexual abuse.

A subsequent study by Wellisch et al. (1994) assessed the availability of treatment services for drug-abusing women offenders. As their report suggests, addiction cannot be separated from a host of other psychosocial and health problems that hinder recovery. Drug addiction, as these authors point out, is a chronic condition often characterized by relapse. Therefore, addicted individuals in recovery may require on-going support. Little research, they argue, has been done on this group of women and their specific treatment needs despite the growing numbers of women incarcerated for drug or drug-related offenses. Moreover, little data exist on the efficacy of women-only programs. Wellisch et al. (1994) found that few of these programs address the many problems of these women, who are likely to be indigent, undereducated, and cut off from social networks such as family and community institutions. Furthermore, they suffer disproportionately from histories of family violence, incest, rape, and mental illness (see also American Correctional Association, 1990).

With respect to psychological services for these women, almost all of the programs in the Wellisch et al. study conducted some type of assessment. However, fewer than one-third of the 165 community-based programs surveyed used a standardized instrument. Most programs reported that they depended upon clinical interviews and staff observations. Methadone maintenance programs were the exception; they used standardized psychological instruments in all cases. Of the various types of community-based programs, half-way houses were least likely to make any assessment of women's mental health status (Wellisch et al., 1994).

Thorbum (1995) reports that the health care system in the Hawaii women's prison and elsewhere are based on the military sick-call model in which the patients are mostly young and male and sicknesses are mostly injuries or self-limiting conditions. Women tend to have ongoing health issues that are not appropriately addressed by this type of service delivery. The sick-call model is also not an appropriate way to address women's mental health care needs. Hence, women's physical and mental health concerns are not being identified, much less addressed, during incarceration. Systematic changes must be instituted and fiscal resources shifted to a more appropriate, albeit, more costly, model of care.

Compared to men, women have more restricted access to fewer re-entry programs to prepare and support them for transition from prison to their families and communities. With some exceptions, most transitional programs continue to be based on models designed for men and fail to address the gender-specific needs of women. Local jails provide the lowest level of transitional support.

Research on the ability of correctional treatment to improve the quality of life for persons (including women) with serious mental illness indicates that effective services are clear about their purposes and directed toward the criminogenic needs of high-risk individuals. Services that are

highly structured, behavioral, or cognitive-behavioral intensive and located in the offender's community work best. Appropriate treatment targets include changing antisocial attitudes and peer associations, reducing chemical dependencies, enhancing social skills training, and increasing self-reliance. Services should emphasize teaching and learning in small, incremental steps. Clients should have opportunities to share responsibility. Programs should have a stable, consistent staff for whom roles and purpose are clear. Services should also be available for clients' families.

Persons with mental illness (including women) who come into the criminal justice system often have needs beyond conventional supervision. In Milwaukee, a day reporting program established by the Wisconsin Correctional Service, a private, nonprofit organization, takes an innovative approach to meeting these needs. This program combines daily reporting for surveillance and medication, and provides these offenders with two innovative services to stabilize them in the community: assistance in money management and housing assistance and placement. The aim of the program is to keep people with chronic mental illnesses out of local jails and hospitals and to help them live independently. A study of the Milwaukee program, sponsored by the National Institute of Justice (NIJ), concluded that such a program can be readily adapted to the needs of other jurisdictions and illustrates the utility of day reporting for a specific offender population. Milwaukee's effort appears to be reducing the number of mentally ill persons in jail (NIJ Journal, November 1994).

Conclusions

Women have always been an afterthought in correctional programming and crime research-largely because so few women committed serious crimes and were sentenced to prison. This has led to a paucity of information about the causes of women's offending and about ways to encourage women to avoid future criminal behavior. Ironically, the same cannot be said about the mental health field; women have always been present in the mental health system in large numbers (Chesley, 1972). Yet, even here, research and programming has been built around the needs and problems of men.

This chapter has reviewed the unique needs of women and girls with mental illness who are under community correctional supervision. The literature points to a number of ways in which the needs of girls and women are unique and therefore argues for special programming for such offenders. Girls and women under correctional supervision share many of the problems of their economically and politically marginalized male counterparts but they also face special problems as a result of having been born female. They are more likely to have been the victims of sexual abuse, they face an adolescence and adulthood of violence and revictimization at the hands of intimates and strangers, and they are more economically vulnerable. They also face, especially as girls, the prospect of their survival strategies being criminalized, and their lives being over controlled by well-intentioned middle class social workers and probation and parole officers.

The history of women and madness, as well as the history of defiant girls and women, is a litany of efforts to reform and save women. In our efforts to help women with mental illness in the community corrections, we should be particularly conscious of this legacy. Of particular importance is the impulse to over-regulate women's behaviors, virtually guaranteeing their reincarceration. Programs and services for women should be scrutinized in two ways: first, to insure that they are sensitive to the unique needs of the women they serve, and second, to guarantee that they represent the most nonintrusive and nonpunitive response possible to women's behaviors and problems.

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CHAPTER 5

Working with Seriously Mentally Ill Substance Abusers

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Individuals with serious mental illnesses (SMIs) began, in the mid-1960s to be returned to the community from large state mental hospitals as part of the deinstitutionalization process. Since then, they appeared in increasing numbers in the criminal justice system (Abram & Teplin, 1991; Pepper & Massaro, 1992). A serious mental illness greatly impairs the daily functioning of individuals by altering their thinking or feeling processes, which can result in behaviors that are disruptive to the community. Two major classes of mental disorders, psychotic and mood disorders, fall in the SMI category. Included in the psychotic disorders are schizophrenia, schizoaffective, and schizophreniform disorders; included in the mood disorders are bipolar disorder and major depressive disorder. Although only about 9% of the general population experience these disorders in their lifetimes (Robins & Regier, 1991), they appear in much greater numbers among persons who come in contact with the criminal justice system (Pepper & Ryglewicz, 1984; Regier et al., 1990; Test, Knoedler, Allness, & Burke, 1985).

A major contributing factor to criminal justice involvement by this population is alcohol and drug use. The vast majority of individuals with these SMIs use alcohol and other drugs. The interaction between serious mental illness and alcohol and other drug use greatly increases psychiatric symptoms and disinhibits behavioral controls (Barbee, Clark, Crapanzano, Heintz, & Kehoe, 1989; Richard, Liskow, & Perry, 1985). This explosive mixture often results in behavior that is disruptive and dangerous to the community, such as, increases in disorderly conduct, shoplifting, trespassing, and assaultiveness (Test et al., 1985; Yesavage & Zarcone, 1983).

The following seven facts about SMIs, substance use, and crime (Pepper, 1993) are important for developing an understanding of how these three issues interact with one another. First, psychiatric patients who do not abuse alcohol or street drugs are no more likely to commit crimes than the public-at-large. Second, alcohol is responsible for more criminal behavior than any other drug and perhaps as much as for all other drugs combined. Its disinhibitory effects can lead to a variety of impulsive and illegal acts. Third, psychiatric disorders and their symptoms frequently lead to alcohol or other drug abuse, which may, in turn, lead to crime. This is, in part, explained by the self-medication hypothesis, which is supported by data from the National Institute of Mental Health (NIMH) (Robins et al., 1991). These data indicate that, in a dually-disordered individual, the odds are nearly 3 to 1 that psychiatric symptoms will occur before the person begins abuse of alcohol or other drugs. Fourth, psychiatric patients who abuse alcohol and other drugs have an increased incidence of severe, and sometimes violent, psychotic episodes and out-of-control behavior. Fifth, abuse of cocaine, alcohol, marijuana, PCP, LSD, and other drugs is highly correlated with violent psychosis. Sixth, the abuse of alcohol or other drugs often causes psychiatric symptoms, leading to an error in diagnosis. In susceptible individuals, these drugs can cause: symptoms of psychotic illness, such as schizophrenia; panic and other symptoms of anxiety disorders; and depressive symptoms of varying degrees of intensity. Seventh, psychiatric disorders per se tend to lead to inhibition of action whereas alcohol or other drug abuse more often lead to disinhibition.

The purpose of this chapter is to increase the ability of probation and parole officers to work effectively with SMISAs. To this end, the chapter will provide information and practical tips concerning how to assess SMISAs, promote their treatment, and interface effectively with the mental health and substance abuse treatment systems. Included in this chapter is state-of-the-art knowledge about prevalence of SMISAs, assessment and classification guidelines that probation and parole officers can use with SMISAs, training needs for officers working with these individuals, and those roles and functions that are most effective for officers working with SMISAs.

Prevalence of Dual Disorders

Epidemiological research conducted by the National Institute of Mental Health (NIMH) (Regier et al., 1990) found high rates of comorbidity between mental and substance abuse disorders (dual disorders) in the general population. This research showed that 29% of individuals with a mental disorder had a coexisting substance abuse disorder, 37% of individuals with an alcohol disorder had a coexisting mental disorder, and 53% of individuals with a drug disorder (other than alcohol) had a coexisting mental disorder. This research also indicated that dually-disordered individuals are twice as likely to be in treatment for one or more of their disorders than individuals with only a single disorder.

In the general population, 47% of persons with schizophrenia have a coexisting alcohol or other drug disorder (Regier et al., 1990). They appear in substance abuse treatment programs at rates 2 to 4 times higher than those found in the general population (Hesselbrock, Meyer, & Keener, 1985; Powell, Penick, Othmer, Bingham, & Rice, 1982; Ross, Glaser, & Germanson, 1988). Mental health professionals working with this population report that 30% to 54% of their schizophrenic population experience problems from substance abuse (Damron & Simpson, 1985; Drake & Wallach, 1989; Safer, 1987).

Drake et al. (1989) found that 50% of persons with schizoaffective disorder used alcohol and other drugs. Chabderdon (1991) also found that individuals with schizoaffective disorder were much more likely to be using three or more different types of drugs and had much higher hospitalization rates than individuals with schizophrenia. Schizophreniform disorder is diagnosed when schizophrenic-like symptoms occur but do not last at least six months. Substance use may be a significant contributing factor in the development of this disorder. Schuckit (1994) reports that approximately 3% to 10% of alcohol abusers experience psychotic-like reactions, but these symptoms abate completely when alcohol use is discontinued.

The rate of comorbidity in the general population between substance-related and bipolar disorders is 56% (Regier et al., 1990), and the rate of comorbidity between substance-related and depressive disorders is 32% (Regier et al., 1990). Significant numbers of individuals with mood disorders participate in substance abuse treatment (Drake et al., 1989; Hesselbrock et al., 1985; Khantzian & Treece, 1985; Powell et al., 1982; Ross et al., 1988; Schuckitt, 1983; Weissman, Myers, & Harding, 1980). Research has also found that mood disorders are present in 25% to 53% of individuals being treated for substance abuse.

Although this chapter focuses specifically in SMISAs, it must be noted that correctional populations now contain even larger numbers of individuals who are not seriously mentally ill but who do suffer from various psychiatric symptoms and disorders that can lead to recurrent substance abuse and other violations of community corrections requirements. That is, there are many who do not suffer from schizophrenia, bipolar disorder, major depressive disorder, or any closely related problem, but who do experience panic attacks, social phobia, agoraphobia, or other specific phobias; persistent, low grade depression (dysthymia), which lasts for years; and a variety of personality immaturities and disorders that produce acting out and violent behavior, depressive and anxiety symptoms, and, more important, relapse to alcohol and other substance abuse in an attempt at self-medication.

Classification Guidelines

Probation and parole officers will encounter many individuals with a history of mental illness and substance abuse symptoms, but not all of them will need either substance abuse or mental health treatment. The following classification scheme concerning criminality, substance use,

and mental illness can be used to identify who needs treatment and what type of treatment is needed.

Purely Criminal Acts

When offenders use alcohol and other drugs to assist them in committing criminal acts (e.g., to overcome fear or anxiety) or when their substance use is part of their involvement in drug trade, such acts are not the product of substance abuse or mental illness. However, after being apprehended for a crime that the person fully intended to commit, these individuals may fall back on a substance abuse or mental illness defense in order to be treated more leniently by the judicial system. They do not need substance abuse or mental health treatment.

Criminal Acts Caused Primarily by Substance Abuse

A nonmentally ill substance abuser behaves in an emotionally unstable manner as the result of drug-induced disinhibition or may experience an organic, drug-induced psychotic episode, both of which can lead to a violent criminal act. However, the role of substance abuse in such cases is often missed, and a mental illness is incorrectly determined to be the cause of their acting out. The important distinction is whether symptoms occur only during or immediately after intoxication. In such cases, the substance abuse should be seen as primary and substance abuse treatment should be required.

Criminal Acts Caused by Mental Illness

Mentally ill persons, usually in the grip of psychotic paranoid delusions or hallucinations, may commit acts of violence. Although there may be a history of substance use by these individuals, no recent substance use can be documented. In such cases, mental illness should be seen as primary and mental health treatment should be required.

Criminal Acts Caused by Mental Illness and Substance Abuse

Mentally ill persons may use alcohol and other drugs for a variety of reasons ranging from self-medication to peer acceptance. This use can lead to a reduction in behavioral control and an increase in persecutory, paranoid, and psychotic thinking. The final consequence may be violent or criminal acts. In such cases, both substance abuse and mental illness should be seen as primary disorders and concurrent treatment of both disorders should be required.

Assessing Substance Use in the SMI Population

Assessing for substance abuse in individuals with SMIs is a complex process that requires an examination of the interactive nature of substance abuse and symptoms of mental illness. What follows is both an overview of the current state-of-the-art for assessing substance abuse in this population and guidelines for conducting a substance abuse assessment of SMI clients.

Four basic interviewing techniques should be followed when collecting substance use information. These techniques include: construction questions in a manner that assumes drug use (i.e., “When did you first begin using drugs? not “Do you use drugs?“)), clarifying responses until you get a clear answer (i.e., if an individual continues to give evasive answers, assume drug use and attempt to obtain third party validation); maintaining low reactivity to the information being

presented (i.e., not reacting negatively to what an individual tells you allows the person to tell you more); and using third party validation whenever possible (i.e., family, other professionals, court records, etc.). In addition, SMISAs tend to deny or under report their alcohol and other drug use to the same extent as other individuals (Kofoed & Key, 1986; Helzer & Pryzbeck, 1988; test, Wallisch, Allness, & Ripp, 1989); urine tests, therefore, should be an integral part of the assessment process in order to obtain important baseline information about current alcohol and drug use.

Many published instruments exist for diagnosing mental illness or chemical dependency (Peters & Hills, 1993), but few have been tested for their accuracy when used with SMISAs. Drake et al. (1990) examined several commonly used tests for alcoholism to determine their effectiveness in identifying alcoholism in SMISAs. He found that the four question CAGE Test (Mayfield, McLeod, & Hall, 1974) was as effective in identifying current alcoholism (73.2% accuracy) as the criteria used in DSM-III-R (73.7% accuracy) and that both were more effective than the commonly used 25 question Michigan Alcoholism Screening Test (MAST) (Seizer, 1971) (57.1%). He also found that the MAST occasionally produced false positive diagnoses of alcoholism because individuals with SMI incorrectly answered yes to questions as a result of their experiencing symptoms of mental illness. Kofoed (1991) reported that another commonly used alcohol and drug abuse assessment instrument, the Addiction Severity Index (McLellan, Luborsky, O'Brien, & Woody, 1980), which measures the impact of use on five spheres of a person's life, has not been tested for accuracy with SMISAs.

To date, no published instrument has been specifically designed to examine the complex relationship between SMI and substance use. However, any assessment of SMISAs must include information about this dynamic relationship for the purpose of developing realistic treatment strategies. An unpublished substance abuse assessment instrument for the SMI population, developed by Hendrickson, Schmal, Kline, and Ingate (1994), is designed to evaluate the relationship between mental illness and substance use. It identifies the extent of substance use by the individual, how the individual's mental disorder symptoms are affected by the use, reasons why the individual uses these substances, and what stage of abstinence the individual has reached. The instrument can be used as a comprehensive guide for substance abuse assessment of persons with SMIs.

Extent of Substance Use

The first component of a comprehensive drug use history for SMISAs involved determining the types of drugs they are currently or have previously used, frequency of their use, existence of physical or psychological dependency on drugs and physical risks from drug use. In general, the types of drugs used by SMISAs are very similar to those used by the general population. The five most commonly used drugs in the SMISA population are alcohol, marijuana, cocaine, caffeine, and nicotine (Ridgely, Goldman, & Talbott, 1987). Each of these drugs can be very destabilizing to an individual with SMI, and nicotine is used at much greater rate by the SMI population than by the general population (Davis, 1984). In addition to assessing for the use of these and other psychoactive drugs, it is important to evaluate the abuse of certain side-effect medications (e.g., cogentin and artane) (Bergman & Harris, 1985), or over-the-counter drugs (e.g., benadryl, diet pills, inhalants, etc.) because of the high incidence of abuse of these substances by this population.

The assessment instrument developed by Hendrickson et al (1994) recommends obtaining the age at which the individual first used each drug and the overall lifetime pattern of each drug's use. Collecting such information presents a clear picture of the person's overall involvement with drugs and if drug use is increasing or declining. The instrument proposes four different types of

drug use patterns: Binge use occurs in no set pattern, but ingestion of alcohol or other drugs always results in significant intoxication and an ensuing period of heavy use with an unpredictable duration; Infrequent use also has no set pattern, may or may not result in significant intoxication, and the usage is usually three or fewer times per month; Regular use is a set pattern of use that is at least once or twice per week; and Frequent use is a set pattern of use that occurs three or more times per week.

The criteria in DSM-IV for substance use dependence provides guidance concerning the presence of psychological or physical dependence on any substance. Because SMISAs under-report the impact of their drug use, third party corroboration will be very important in confirming dependency. Also, because they have high rates of suicidal and other self-destructive behaviors (Pepper et al., 1984), it is important to obtain information on whether drugs were ever used for these purposes. If an individual reports overdosing on a drug, it is also important to inquire how that happened and if the overdose was intentional. This information alerts the probation or parole officer that certain drugs may be particularly high risk for that individual.

Impact on Mental Disorder Symptoms

The second component of the assessment focuses on how substance use may impact the symptoms of mental illnesses. Because almost all symptoms of alcohol and other drug intoxication and withdrawal mimic symptoms of mental illnesses, any use of these substances will exacerbate mental illness symptoms to some degree. However, the level of intensification varies greatly among individuals. There does not appear to be a direct link between amount, frequency or type of drug use and level of symptom exacerbation. One SMISA may decompensate and have to be hospitalized on a very small amount of marijuana whereas another may be able to remain in the community while consuming substantial amounts of several different drugs. Hendrickson et al. (1994) propose three different levels of impairment when individuals with SMIS use alcohol and other drugs (see Table 1).

Table 1

Levels of Impairment

Moderate Impairment: Mild to moderate increase in thinking, emotional and behavior symptoms or a mild to moderate decrease in the ability to manage these symptoms. Changes not readily noticeable to the individual or those around them. Awareness is normally the result of education or counseling from treatment professionals.

Major Impairment: Significant increase in thinking, emotional, and behavioral symptoms and/or a significant decrease in the ability to manage these symptoms. Impairment is eventually readily noticeable to individuals and those around them.

Destabilization: A rapid and significant increase in thinking, emotional, and behavioral symptoms, which requires either hospitalization or else an increase in the intensity of needed treatment services.

Reasons for Use

The third component of the assessment identifies what motivates individuals to continue their alcohol or other drug use. Identifying reasons for use is critical because if these issues are not addressed and resolved, a stable abstinence will never be achieved. Although individuals with SMIs use alcohol and other drugs for many of the same reasons that other individuals do, they also use these substances for adaptive purposes related specifically to the symptoms of their mental illness. Hendrickson et al. (1994) proposed seven reasons why persons with SMIs use substances, and they report that most of them use for more than one reason:

A number of persons with SMIs use drugs to experience a different sense of being or altered state. For them, drugs are a way to explore new sensations and perceptions and are short cuts to these new states of being. The purpose of drug use is not to escape an uncomfortable feeling or situation but to experience something new. Although many SMISAs used drugs for this reason initially, few are using for this reason by the time they come in contact with probation or parole officers.

Other persons with SMIs use drugs to manage or reduce psychiatric symptoms. Self-medication can manifest itself in three different ways; to feel normal, to help manage intolerable emotional states, or to avoid these states by achieving numbness. The use of alcohol or other drugs to inflict injury or to create potential danger for oneself is also a motivation for drug use. This is a common phenomenon for persons who have a history of sexual abuse or who for moral reasons cannot commit suicide.

Individuals with SMIs usually have limited social networks, social skills or interests, and have a great deal of time on their hands. Hence drug use can act as a time management tool, because finding drugs, using drugs, being intoxicated and then withdrawing from drugs can use up a great deal of time. The symptoms that individuals with SMIs experience often make them isolated, or appear odd or inappropriate to others. The use of alcohol and other drugs may reduce symptoms, such as paranoia or abusive voices, that interfere with social interactions. With tension reduced, the individual finds it easier to spend time with other people. Drug-using individuals can

be more accepting of odd or inappropriate behaviors, so individuals with SMIs often use the commonalty of drug use as a bridge for acceptance into a peer group.

Another reason that individuals with SMIs use alcohol and other drugs is to deny or minimize their status as a "psychiatric patient." They attempt to avoid the stigma of mental illness by explaining their symptoms as the result of excessive drug or alcohol use.

Finally, the use of alcohol or other drugs may be to avoid symptoms of withdrawal. In these instances, individuals are physically dependent on drugs and will experience withdrawal unless a specific level of the drug is maintained in their bodies.

Stages in Obtaining Stable Abstinence

The process of achieving abstinence consists of many steps; stable abstinence is the last. Hendrickson et al. (1994) propose seven stages that SMISAs may go through before achieving long-term abstinence. Using these stages as guide posts can help probation or parole officers to recognize the subtle changes that an individual is experiencing in their relationship with chemical substances and can assist officers in measuring clients' progress toward abstinence.

1. Denial: Individuals in this stage do not believe or admit that their alcohol or other drug use is causing them problems.

2. Recognition: Individuals in this stage recognize that alcohol and other drug use may cause them negative consequences but do not acknowledge to others that they have a problem with their drug use. It is common in this stage for individuals to notice and discuss substance abuse problems in friends or family members but not in themselves.

3. Acknowledgment: Individuals in this stage recognize the negative effects of their drug use and acknowledge this to others. However, during this stage, individuals are not yet willing to reduce use or attempt abstinence.

4. Desire to reduce use: Individuals in this stage acknowledge that their drug use is a problem and desire to reduce their intake of drugs. They are not yet willing to discontinue all drug use and still believe that they can control how much they use.

5. Commitment to abstinence: Individuals in this stage acknowledge that they cannot always control their drug use and desire to discontinue all use. However, in this stage, they are not yet willing to make significant life style changes to insure continued abstinence.

6. Commitment to recovery: Individuals in this stage are committed to abstinence and have found that in order to maintain abstinence they must change their life style. They believe that they must change the way they think, with whom they spend time, where they go, and how they behave.

7. Relapse prevention: Individuals in this stage are committed to abstinence and to maintaining and expanding the changes they have made in their life.

Treatment Recommendations

The fourth component of assessment determines if an individual is in need of substance abuse treatment, and, if so, what type of treatment would be most effective. A treatment recommendation is always the product of what is the best form of treatment for an individual, what treatment services are available to an individual, and what an individual is willing or can be coerced to do. There are three different types of substance abuse treatment settings. An outpatient setting consists of substance abuse services being provided to an individual all day, part of the day, or by appointment in a nonresidential treatment facility. An inpatient setting provides detoxification and other substance abuse treatment services in a hospital based or nonmedical detoxification treatment center. The length of inpatient treatment is usually from one week to one month. Residential settings are live-in, and may adapt elements of the therapeutic community, providing intense substance abuse treatment for individuals over an extended period of time (usually three or more months).

All SMISAs, except those who are actively psychotic, in physical withdrawal, or refusing to attend treatment, can be treated in an outpatient setting. Although outpatient treatment may not be the ideal form of treatment for certain people (those with poor impulse control, those who are living in drug-using environments, those who fail to see their drug use as a problem and are unmotivated to achieve abstinence, etc.), sometimes, it is the only treatment setting available to a probation or parole officer. Currently, there are few inpatient and residential treatment settings designed for SMISAs. However, the following guidelines can assist officers in deciding which type of treatment setting would be most appropriate for a particular individual. First, SMISAs who are willing to participate in an outpatient substance abuse treatment program, who either acknowledge that chemical substances are having a negative impact on them, or who can be forced into abstinence without experiencing major withdrawal symptoms are suitable for outpatient treatment. Second, SMISAs who need a short-term interruption of the drug use in order to achieve longer-term abstinence or who will experience major withdrawal symptoms that interfere with their ability to participate in either outpatient or residential treatment need inpatient care and detoxification. Individuals who do not acknowledge use as a problem should be referred to a residential setting upon completion of this treatment program. Third, SMISAs who have little motivation or lack the skills necessary to obtain long-term abstinence (i.e., ability to delay desires or control impulses or follow-through on required activities) and who have been detoxed (if necessary) are appropriate for residential treatment. These persons usually have failed in outpatient settings and thus need a more structured and longer term treatment experience than either outpatient or inpatient care can offer.

Research concerning substance abuse treatment outcomes for SMISAs is very limited (Hendrickson, Stith, & Schmal, 1995). Studies have found that clients participating in specialized outpatient services for SMISAs have very similar success rates compared to clients participating in regular outpatient substance abuse treatment (Hanson, Kramer, & Gross, 1990; Hendrickson et al., 1995; Washington, 1991) which is approximately 40%. In addition, more positive attitudes toward treatment, longer treatment stays, greater involvement in other treatment services, and participation in self-help groups have been strongly associated with positive treatment outcomes in outpatient settings (Hanson et al., 1990; Hendrickson et al., 1995; Washington, 1991). Ries and Elingson (1989) found that 12 of 17 (70%) dually disordered clients who participated in a specialized dual diagnosis inpatient program reported they were abstinent one month after discharge. However, Bartels and Thomas (1991) found that 37% of the clients in a specialized residential program for the dually diagnosed completed treatment, but all eventually relapsed.

A Training Agenda

To manage SMISAs effectively on probation and parole, officers must add certain mental health and substance abuse knowledge and skills to their professional repertoire. A Dual Diagnosis Policy Report published by the Metropolitan Washington Council of Governments (1995) recommends specific, cross-training topics for mental health and substance abuse professionals. Several of the topics discuss knowledge and skills that are essential for probation and parole officers dealing with SMISAs and the mental health and substance abuse professionals treating them.

Philosophical base

The biopsychosocial theoretical models is currently the philosophical base best suited for understanding the many complex issues related to dual diagnosis. This model is based on the assumption that all behaviors are the result of the interaction of biological, psychological, and social processes. These processes are constantly interacting, influencing, and altering one another and all need to be addressed simultaneously. The model encompasses knowledge and skills from many professional disciplines; thus, community corrections professionals working with SMISAs must expand their knowledge base and add to their repertoire of skills but also must not forget anything they already know.

Psychoactive Drum and Their Effects

Probation and parole officers should develop a good working knowledge of the commonly abused drugs and how they affect the way a person feels, thinks, and behaves. This knowledge base includes the primary action of the major drugs of abuse, their long- and short-term effects, their withdrawal symptoms, and the effects that substance use has on the symptoms of mental disorders.

The Psychopathology-Based Model

Probation and parole officers should know the different diagnoses contained in the Diagnostic and Statistical Manual (DSM-IV). They should know how diagnoses are made and how valid they are if alcohol and other drugs are involved. They should know how psychiatric symptoms are similar to and different from the symptoms of alcohol and other drug use, and how substance use can impact on the symptoms of mental illness.

Nature of Addiction

Probation and parole officers should develop a clear understanding about the nature of addiction. They should understand the concepts of obsessive thinking, craving for drugs, and compulsive drug use behavior. They also should understand how biopsychosocial factors affect the development and continuation of alcohol and other drug addiction.

Abstinence

Probation and parole officers should understand that any psychoactive drug use by individuals with SMIs increases their mental illness symptoms to some degree. Therefore, the treatment goal for all members of this population is abstinence in order to promote maximum functioning levels in the community.

Importance of Medication

Most SMISAs cannot obtain or maintain abstinence or psychiatric stability without psychotropic medication. Prescribed medication is part of a treatment regimen, not another dependency. Probation and parole officers need a knowledge base regarding medication that includes the types of medication, purposes of the medication, potential risks and side effects, effects of discontinuing medication, consumer rights, and interactions of prescribed medications with alcohol and other drugs.

Importance of Self-Help Groups

Few SMISAs can maintain long-term abstinence without the support of a self-help group such as Alcoholics Anonymous, Narcotics Anonymous, Double Trouble, or Dual Recovery Anonymous. Probation and parole officers should learn about the culture of self-help groups and how self-help groups work, so they can effectively promote participation of their clients in these programs.

Importance of Functioning Level

SMISAs have a wide range of functioning levels. Some dually-diagnosed clients are fragile and have few strengths to draw on, whereas others are mostly self-sufficient. The functioning level (especially tolerance for confrontation, limit setting and stress-not the diagnosis- indicates how much SMISAs can be expected to do within a certain period of time. It is important to match treatment requirements with what individuals can either tolerate or do. For example, delusions, paranoia or other symptoms of a mental disorder, may make it difficult for individuals to participate in group treatment initially; therefore, officers may only require individual treatment until that person develops the skills needed to participate in group therapy. Because more can be expected and demanded of higher functioning individuals, officers must learn how to develop flexible requirements concerning substance abuse treatment, which are based on what clients can realistically do.

In addition to the training topics recommended by the Council of Government's Policy Report, two additional areas are essential for probation and parole officers working with SMISAs: mandatory treatment and cultural differences among the mental health, substance abuse, and community corrections systems.

Mandatory Treatment

Community corrections personnel will have on their caseloads clients who are willing to accept a simple referral, to participate actively in treatment, and to keep their officers informed about their progress and medication compliance. Unfortunately 90% or more of the dually-disordered individuals on community correction supervision will not fit this description. Mandated treatment is essential because the vast majority of the dually disordered on probation and parole will not voluntarily participate in community mental health or substance abuse programs. This is particularly true when their symptoms are at their worst. The reasons may include paranoid fear of the helper, fear of discontinuing a drug because it provides some relief of the psychiatric symptoms, or the fact that treatment is not part of the person's view of how to cope with life. The authority of the court, coupled with the wish to remain out of jail and prison, may tip the balance in favor of accepting coerced treatment.

Mandatory treatment is known to work for community corrections clients who require mental health, medical, or substance abuse treatment. Treatment professionals often observe a relationship between coercion to enter treatment and voluntary continuance when, after treatment has begun to be effective in improving mood, social relations and general conditions of living, the client continues to participate and shows voluntarily improvement.

In addition to tipping the cognitive and emotional balance from treatment avoidance and toward treatment acceptance, coercion has another benefit. It can be used by the client to justify treatment participation to family and friends without the need to wear the burden of shame of being known as "crazy or an addict." We have seen clients participate fully and actively in treatment while maintaining a cover outside: "My P.O. thinks I'm nuts and I go along with him and show up at the clinic, that way he will get off my back." IN the early stages of accepting the need for treatment, when coercion is most helpful, such stories may be necessary to protect clients' low self-esteem.

Cross-Cultures

The primary function of mental health and substance abuse professionals is to address the individual needs of their clients whereas the primary function of probation or parole officers is community protection. These two different perspectives can create a variety of conflicts and misunderstandings when community corrections, mental health, and substance abuse professionals work together.

For example, mental health treatment programs in the community have a tradition of working with voluntary clients. They are therefore unlikely to call officers to report that a client did not show up, is not taking medicine, or is using drugs again. Such failure to inform are often viewed by the community corrections officer as unprofessional acts that endanger the community. Likewise, it is common for substance abuse professionals to see a relapse as an opportunity for their clients to experience more pain for their addiction, which can then lead to long-term sobriety. They may fail to understand why the community corrections officer responds to the same relapse in a heavy-handed manner because of the potential danger to the community. These misunderstandings are based on an ignorance of the professional cultures in which each of these groups operate. Cross training involving professional ethics and practices is essential to the development of effective working relationships among these three groups of professionals.

Current Work Environment

Community corrections personnel find themselves embroiled in the evolutionary struggle within and among the mental health, substance abuse, and criminal justice systems. The Twentieth Century has seen a see-saw struggle between two competing models for the provision of publicly-funded services. The institutional model (mental hospital, prison) competes with the community care systems model (community mental health, community corrections). Although the two systems are linked, the linkages have often been weak. For the past thirty years, a smooth transition for the patient from the mental hospital to the community mental health center has been interfered with by competition between hospital and community agencies for funding and other resources. Similarly, there are problems of resource allocation and competition between correctional institutions and community corrections agencies.

Substance abuse treatment has not experienced the same internal conflict as corrections and mental health. Aside from voluntary efforts such as Alcoholics Anonymous, which began in the 1930s, most funded substance abuse treatment programs began in the 1970s. **By** that time, the nation had moved away from institutional solutions and toward community treatment systems for

alcohol and drug abuse. However, funding based on a single disability has greatly hindered both the substance abuse and mental health systems in combining or developing services for individuals with multiple disorders. In addition, relationships among community corrections, mental health, and substance abuse services often range from distant to adversarial.

The situation in the mid-1990s calls for integration of these three models into one overarching super-system, as we plan for protection of the community and treatment of the individual. Both correctional institutions and community corrections find themselves responsible, both by default and by the principle of "where found," for psychiatrically-troubled substance abusers, many of whom are SMISAs.

Getting the Job Done

Within the context of the current corrections/treatment environment, what duties should community corrections officers perform when dealing with SMISAs? Their first duty is to insure that clients are in active treatment for both mental illness and substance abuse problems. Ideally, one community treatment agency has accepted responsibility for this dual-track treatment, preferably in an integrated, dual-disorders program whose staff has been trained to deal with both problems. However, the state-of-the art of dual diagnosis treatment in most communities has not yet advanced to that point, and so it is more likely that offenders will need to be treated by a mental health team for one disorder and by a substance abuse counselor for the other. In such cases, the second duty of officers is to insure that the two teams are communicating. If they are not already working together closely, the officer's third duty is to promote this cooperation to achieve effective case management. Without such communication, a well-meaning psychiatrist may prescribe a benzodiazepine such as Valium for a sleep or anxiety disorder, which could be contraindicated because of the individual's propensity to abuse sedative drugs.

The fourth duty of officers is to insure that the offender is actively participating in mental health and substance treatment programs. When offenders are convinced that officers are in frequent contact with the other team(s), compliance with medication and clinic visits, are likely to increase. And finally, the fifth duty of officers is to link the judge and court system with community mental health and substance abuse treatment providers. When offenders are convinced that all parties are talking to one another and sharing information, mandated treatment is more likely to be complied with, and to succeed.

Fulfilling these duties can best be accomplished by developing a face-to-face relationship with one or more members of the treatment team. Both mental health and substance abuse teams are accustomed to sharing information with other team members. Therefore, the ideal way for officers to accomplish this is for the treatment team(s) to view officers as team members, working with them to insure that their clients stay in treatment and on track. Such arrangements will become routine in the future. But for now it may be up to officers to actively seek to become and be seen as a team member.

Conclusions

Increasing numbers of SMISAs are being placed into community corrections settings, and this requires probation and parole officers to become more skilled in assessing and dealing with mental health and substance abuse issues. This chapter has provided officers with basic knowledge about the issues they will face when dealing with dually diagnosed persons and has presented a training agenda for officers working with these individuals. Although SMISAs present many challenges to community corrections personnel, they also present many opportunities to expand professional skills and to be part of an emerging paradigm that examines concurrently the needs of

both the community and the individual. Community corrections professionals much assume active roles in developing creative solutions to eliminate the barriers that currently exist to effective treatment and management of this population. When professionals from all three systems learn to work together, solutions will be found.

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Author's Note

For a complete description of the Substance Abuse Assessment instrument for SMISAs or the Community-Client Protection System, which provides a complete description of the historic rationale, justification and possible methodology of a combined and integrated treatment team, which includes corrections, mental health and substance abuse, the reader is invited to contact the authors of this chapter.

CHAPTER 6

People of Color

Cecelia Alfonso

This chapter focuses on persons of color, who are overrepresented in the criminal justice system and underserved in the mental health system. It discusses the prevalence of people of color in the criminal justice system, the propensity of the system to incarcerate mentally ill persons, the history of racism in the system, the general absence of multiculturalism in diagnosing and treating mental illness, and the lack of useful data on mentally ill persons of color in and out of the criminal justice system. Finally, the chapter offers recommendations for professionals working with persons of color under correctional supervision.

Overrepresentation of People of Color in the Criminal Justice System

During the last half-century, government officials and social researchers in the United States have been far more attentive to racial than to social class differences when describing statistics on crime and punishment in the United States. Racial categories are prominent in official arrest statistics as well as in sentencing and correctional data (Bureau of Justice Statistics, 1994).

Although African Americans make up only 12.4% of the general population, they accounted for 50.6% of all inmates in state and federal prisons at the end of 1993 (Hallinan, 1995). In that year, African Americans accounted for 21% of all new inmates admitted to prison (Hallinan, 1995). Currently, African Americans are 7 times more likely than whites to be incarcerated (Beck & Gilliard, 1995). Furthermore, from 1980 to 1993, the incarceration rate for Hispanics more than tripled (Beck & Gilliard, 1995). The national portrait of prisoners is a spectrum of color: Nearly two-thirds of all sentenced prison inmates are African American, Hispanic, Asian or Native American (Hallinan, 1995).

Mauer (1990) reported that one-in-four African American men between the ages of 20 and 29 was under some form of criminal justice control. These men were either in jail, in prison, or on probation or parole supervision. Statistics such as these, while reinforcing racial stereotypes, highlight a grim reality that the African American community faces: a significant percentage of their young men are not available to care for and support families. And when they are released from prison, they are stigmatized.

In the State of New York alone, for example, more than 80% of the prison population consists of African American and Hispanic males. These defendants are under the age of 30, unemployed, and without high school diplomas. According to Kramer (1988), their imprisonment is largely due to a growing nationwide incidence of random violence perpetrated by and against young persons. In his words,

> In the course of observing the proceedings in Family Court, cases of delinquency, neglect and abuse, custody and PINS, (youngsters alleged by their parents to be Persons in Need of Supervision), I have found they form a continuum from the abused infant to the abusing adolescent. (p. 17)

Myth of Black Violence

Are African Americans genetically prone to commit more violent acts? This question springs from a powerful mythology that is inextricably linked to their overrepresentation in the criminal justice system. In light of media stories and official statistics, this question seems perfectly appropriate. However, such data can be misused to perpetuate racial stereotypes that contribute to interracial conflict and misunderstandings. To acknowledge the possibility is not to minimize the "reality" of high rates of crime among African Americans. Many Americans' perceptions of crime

are based less on personal experience and observations and more on sources that draw on official crime data or research reports (Bureau of Justice Statistics, 1994). Stark (1993) notes that

> The problem with the portrait of an underclass of violent, drug-abusing black males is that its primary source-the figures on the numbers of black males arrested and imprisoned for violent crimes-may itself be a product of racial discrimination. If police are more likely to arrest black people for violent crimes than white people, and if racial bias is a factor in the assignment of counsel, the denial of bail, and who is likely to be convicted and imprisoned, then our picture of black violence . . . may reflect official attitudes and behaviors rather than racial differences. This alternate view is supported by self-report studies and surveys of crime victims-far less biased sources of information on violent crime that arrest reports (p. 486).

There are a host of reasons to discount the notion that African Americans are inherently prone to violence, the most compelling of which is that blacks in Africa have a homicide rate about equal to that of Europeans and therefore lower than that of both African Americans and whites in the United States (Harrington, 1984). Hence, the high incidence of crime among African Americans may be directly related to their cumulative history in a society where they experience discrimination, poverty, racism and hate crimes. Many authors have suggested that the overrepresentation of African Americans in correctional institutions is caused by racism, which affects their processing through the criminal justice system from arrest to conviction (Abram & Teplin, 1991; Chunn et al., 1983; Lawson et al., 1994; Stark, 1990, 1993).

The vast majority of defendants tried for crimes are impoverished people of color. Lack of economic opportunity and financial resources, while a contributing factor, does not preclude lawfulness. Poverty does not automatically turn people to crime. Poor people all react differently to their situations.

Mentally Ill Persons of Color and Minorities in the Criminal Justice System

Offenders with mental illness constitute a disproportionately high percentage of the incarcerated nonwhite population. The mentally ill are arrested, jailed and imprisoned at higher rates than the general population (Sue, 1992; Torrey et al., 1992). A recent study on the mentally ill in jails, by the National Alliance for the Mentally Ill and the Public Citizen's Health research group, found that "each day, over 30,700 seriously mentally ill serve time in our nation's jails," and that "twenty-nine percent of jails surveyed hold the seriously mentally ill without any criminal charge against them." On any given day, our nation's jails and prisons hold an estimated 1.2 million men and women. Studies consistently demonstrate that about 20% of America's inmates are seriously mentally ill and in need of psychiatric care; and up to 5% are actively psychotic (Editorial, American Journal of Psychiatry, 1989, p. 1094). Persons with mental illness who have committed illegal acts-dangerous or nondangerous-have most often done so as a result of neglect or inappropriate treatment of their illnesses (Davis, 1991; Lawson & Cuffel, 1993).

People with severe mental illnesses (e.g., schizophrenia, schizoaffective disorder or bipolar disorder) are highly likely to abuse or be dependent on alcohol or other drugs. Well-known risk factors-anxiety, deficient interpersonal skills, social isolation, poverty, lack of structured activities-combine to render people with mental illness more vulnerable to alcohol, drug abuse, and criminal-related activities (Conklin & Stockman, 1993; Vesey, 1994). Substance abuse exacerbates health and social problems by contributing to poor nutrition, unstable relationships,

inability to manage finances, disruptive behavior, and housing problems. Perhaps due to their poor treatment compliance and psychosocial instability, people with both mental illness and substance abuse problems are highly vulnerable to incarceration (Abram & Teplin, 1991). There is a need for active intervention on behalf of those who are mentally ill and in prisons and jails. Also needed are proactive measures in preventing persons with major mental illnesses from being "dumped" into the criminal justice system (Davis, 1991; Torrey et al., 1992).

Intake screening is one of the most important services that a jail or probation department can offer. For example, probationers should be questioned about their mental health history, including suicide attempts, admissions to psychiatric hospitals, or acts of sexual deviance. This screening should also ascertain whether there is a pattern of violence or substance abuse and whether the probationer is currently taking any medication. Finally, at intake, visual observations of the probationer's behavior, particularly signs of delusions, hallucinations, memory deficits, and self-mutilation should be recorded.

Although the implementation of a screening procedure is widely encouraged, it is designed only to identify disturbed probationers who respond affirmatively to questions about mental health problems or who manifest overt signs of mental illness while being booked (Steadman, 1986). It is therefore possible that probationers with serious psychiatric problems will still go undetected (Boone, 1995). It is also possible that the stress of being convicted may cause some probationers to break down after they have been sentenced (Boone, 1995; Veysey, 1994).

History of Racism in the Mental Health System

The history of racism in the mental health system must be addressed in any discussion of persons of color with mental illness. Myths and stereotypes concerning mental illness in persons of color have existed in America since the seventeenth century. Psychiatry, along with other professional disciplines, has consistently perpetrated myths and stereotypes that were necessary to justify slavery. During the 1800s, with the establishment of mental hospitals in the United States, separate accommodations were maintained for African Americans by the few facilities that accepted them in the North. Otherwise, they were placed in jails (Chunn et al., 1983).

A growing literature has pointed to problems in accurately assessing psychiatric disorders among people of color (Ivey, 1991; Stark, 1993). It is clear that steps must be taken to educate mental health professionals about the pitfalls in diagnosing people of color. In addition, discussions about people of color in the mental health system should look at the roots of psychotherapy, which was created by Western Caucasian men in their own image. Since its earliest beginnings in Europe, psychotherapy has emphasized white male society's definition of what is healthy and normal, and for the most part, has ignored the diversity of the population it serves (Prochaska & Norcross, 1994). It was envisioned as a universal, transcultural process: one type would fit all potential patients. However, psychotherapy was created by humans to solve human problems and any product of human ingenuity is by definition cultural (Prochaska & Norcross, 1994). In a study of state mental health institutions and outpatient care at community mental health centers, Lawson and his colleagues found that

> Racial differences in diagnosis have been attributed to misdiagnosis, failure to appreciate cultural differences in presentation of symptoms, and actual differences in prevalence of mental disorders. Our findings suggest that although such factors are important, bias in the admission process may skew any epidemiological investigations. (p. 71)

Despite the disproportionate impact of various types of mental disorders in communities of color, only general references are made in the literature regarding preventive efforts in these particular communities. The assessment of health or illness in minority populations is as controversial as it is difficult. It has been generally acknowledged that mental health disorders are not distributed randomly in the population but tend to concentrate within definable subgroups. The problem is further compounded when the minority persons are recent immigrants with a different language and culture. The assessment of mental illness in terms of both degree and type is affected by the clients' use of their dominant or second language in reporting symptoms or difficulties to the clinician. Hence, linguistic differences between therapists and clients and cultural evaluations of symptoms influence diagnoses among persons of color.

The standards of normality and mental health developed in Euro-American societies typically result in non-European societies being perceived as deviant or mentally ill. (Ruiz, 1990). African Americans, Hispanic Americans, Asian Americans and Native Americans who think, feel and act like Europeans are defined as "normal and healthy" and are subsequently rewarded with more educational and professional opportunities. The more a person of color thinks, feels, and acts different from a European, the more likely it is that he or she will be considered a troublemaker, a deviant, a sociopath or a schizophrenic; such persons are often punished for their "different" behaviors. In terms of mental health, people of color will never be able to develop optimal psychological functioning and affirm their cultural heritage and identity as long as they are relating to the world through a European cultural perspective (Ruiz, 1990).

The impact of racial oppression manifests itself in various ways with regard to the mental health functioning of people of color, including internalized racial oppression, and an inability to identify and use internal or external resources and support systems.

Hispanic Americans. The primary role of major life changes in provoking stress disorders among Hispanics, especially among immigrants, has been described in both the popular and academic literature (Gottesman, 1994; Kanellos & Perez, 1995; Morcate, 1995; Schink & Schink, 1991; Vega et al., 1985, p. 3). For example, poverty and immigration may precipitate psychopathology among Mexican Americans but little research has examined these factors (Jenkins, 1988). In addition, studies suggest that Hispanics develop a range of dysfunctional behaviors and symptoms in response to racism, such as denial of ethnicity, acute anxiety, dissociation, and stress reactions associated with coexistence in two cultures (Baron, 1981; Chau, 1991; Levine & Padilla, 1980; Vega & Miranda, 1985). Hispanics account for 5% of those receiving psychiatric services nationwide (Schick & Schick, 1991). Hispanics are admitted to psychiatric hospitals at a rate of 451.4 per 100,000, compared with a rate of 550.0 for whites, a rate of 931 for African Americans, a rate of 818.7 for Native Americans, and a rate of 268.1 for Asians or Pacific Islanders (Schick & Schick, 1991; pp. 118ff). In the criminal justice system, however, Hispanics are among the fastest growing "minority" group-increasing from 7.7% of all State and Federal inmates in 1980 to 14.3% in 1993.

These numbers are particularly compelling against the backdrop of the Hispanic population in this country. Estimates of the current total of Hispanics range from 22 million to 24 million (Valdes & Seoane, 1995). Given population projections for persons of Hispanic origin, the Bureau of the Census and other sources expect an additional 6 to 8 million Hispanics by the year 2000, making them the fastest segment of the population. With this exceptional growth, we can expect increasing rates of poverty, crime, unemployment, and other stressors. Hispanics were the only major group among persons of color to experience a decline in income since 1980; they remain the most undereducated group. And, despite high levels of work effort, in 1991, 27.5% of all Hispanic families below the poverty level had at least one year-round, full-time worker (compared to 21.8% of whites and 11.9% of African Americans). Recent literature suggests that "pervasive

discrimination" against Hispanics is a key factor contributing to their economic and employment problems.

The pivotal role of poverty and discrimination as pervasive stressors in the lives of Hispanics (and other people of color) needs much more attention among community corrections and mental health professionals. They need to be also aware of barriers to Hispanics' use of correctional and medical services.

One major barrier is the stigma associated with use of mental health services (Jenkins, 1988; Lopez, 1981). For example, beliefs centering on ma1 ojo, susto, empacho, and nervios should be addressed. Nervios is used by Mexican-Americans, for example, to label outbreaks of extremely irrational behavior. Jenkins sees this usage as "euphemistic, to reduce stigma and reinforce family solidarity," akin to Anglos' usage of "nervous breakdown" (Vigil & Long, 1993, p. 221).

A fuller understanding of language, traditional beliefs, and cultural mores are just as critical as acknowledging the impact of poverty and racism on the mental health of Hispanic-Americans (Cross et al., 1989; Sue, 1992). There is strong evidence to suggest that the cultural meaning of a disorder, the idioms that are used to describe it, and the social evaluation of the disorder by members of the sufferer's primary social network have an important influence on the course of a disorder and its effect on the social functioning of the sufferer (Miranda & Kitano, 1986).

It is important that community corrections professionals recognize the diversity within the Hispanic community. The major groups include Mexicans, Puerto Ricans, and Cubans; others include Latin Americans and South Americans. Distinctions between native born and foreign born Hispanics must also be made when developing mental health programs (Valdes & Seonane, 1995).

Pacific Islanders and Asian Americans. No data exist prior to 1985 on mental health status of Pacific Islanders (Robillard, 1987). Within that culture, race is less critical than the particular social station one enters by birth or the physical location of their residence. The majority of Pacific Islanders are members of the low and lower-middle classes. Regardless of socioeconomic position, most experience a sense of marginality (i.e., a feeling that they do not belong in the mainstream of contemporary life). They are subjected to western values and economic demands that overwhelm modem Hawaii. Yet many of the traditions of ancient Hawaii remain as active determinants of their life style. The contrasts between the traditional and the western ways of life are stressful for native Pacific Islanders. This stress manifests itself in anger, depression, resignation, passivity, and helplessness. For many, the anger and resentment build beyond their capacities to cope, which leads to violence or aggressive behavior. Alcohol and drug use become escapes, resulting in mental and physical deterioration, antisocial and illegal behavior, and finally, participation in the criminal justice system (Robillard, 1987).

It is probably safe to say that most Asian and Pacific-Americans families share several cultural characteristics, such as close family ties, conformity within the family, role structures, and filial piety. Nonetheless, many Americans believe that Asian Americans experience few mental health problems, have little need for mental health-related social services, and have sufficient resources to cope with such needs. The widely-held belief is that Asian Americans are reluctant to seek mental health services because of cultural values. Such behavior would be an admission of personal weaknesses and "bad blood," and would be a disgrace for both the seeker of help and their families (Sue & Morishima, 1992).

However, studies show that recently migrated Asian Americans experienced higher rates of mental disorders than mainland Asians, with older females and those of lower economic status

suffering most. Those who had more contact with modem lifestyles and strong traditional values had lower rates than those with less contact and weak traditional values. In addition, young females, mostly because of their lowly status in Asian society, were particularly subject to psychosocial stresses relative to family affairs in Asian society (Wen-Shing, 1985).

Several researchers have emphasized the importance of recognizing that Asian Americans are a diverse group and that they are not the "model minority" immune from racism or emotional difficulties (Dhooper, 1991; Nba, 1994; Sue & Sue, 1973). Indeed, the stereotypic view that Asians under use services because they have few mental health care needs fails to address what is more likely the case: These services cater to European-Americans and are not culturally sensitive to Asian Americans (Lorenzo & Adler, 1984).

Recent data on inpatient psychiatric services indicated that Asians or Pacific Islanders were admitted at a rate of 268.1 per 100,000 whereas whites, African Americans, Hispanics, and Native Americans were each admitted at rates of 555.0, 931.8, 451.4, and 818.7, respectively (Schick & Schick, 1991). In Hawaii, Japanese, Chinese and Filipinos accounted for 24.5% of those receiving mental health services, compared to 28.5% of whites (Gall & Gall, 1993).

Perhaps, most Americans continue to cling to the myth of Asians as the "model minority" because it functions as a denial of racial discrimination and other social inequities (Dhooper, 1991; Uba, 1994). Researchers are still battling "the myth: . . . this belief in Asian Americans' immunity to the ill effects of racism serves to obfuscate problems of educational-vocational deficiencies, culture conflicts, unemployment, poverty and mental health" (Dhooper, 1991, p. 47).

Native Americans. Researchers have found that Native Americans, compared to other ethnic groups, experience a higher rate of mental illness (Davis, 1994; Nelson et al., 1992). The prevalence of mental illness can be attributed to severe life stressors in their communities. These include a rate of poverty reported to range from 30% to 90%; an unemployment rate of 13% to 40%; a rate of accidental death three times the national rate; an alcoholism rate of 30% to 80%; and levels of domestic violence, teen pregnancy, child neglect, and suicide that are two times the national level (Swinomish Tribal Mental Health Project, 1991). Alcoholism is the single most destructive health problem confronting Native Americans (Swinomish Tribal Mental Health Project, 1991). According to Dr. Scott Nelson, Chief of Mental Health Programs for Indian Health Services, depression is the most prevalent mental disorder found in Native American communities, and alcoholism frequently follows or complicates depression.

The serious problems of Native Americans stem from a variety of causes, which include the disintegration of Native American culture, the outlawing of Native American religions, the removal of Native American children from their families, the loss of many Native American languages, and the forced introduction of non-Native American languages and non-Native American values. For example, in the late 1800s, it was illegal for Native Americans to practice any form of their traditional religions, dances, or healing practices (Swinomish Mental Health Project, 1991). Taken together, such oppressive measures adversely affected the psychological health of Native Americans. The toll is great: The high suicide rate of Native Americans is also an indicator of widespread despair and hopelessness. Native Americans were admitted to inpatient psychiatric services at a rate of 818.7 per 100,000 general population compared with 555.0 for whites and 931.8 for African Americans (Schick & Schick, 1991).

Nearly half of Native Americans now reside in larger cities. In the move from reservations, they lost education, health care, housing, and other benefits. Although the Urban Health Care Center operated 34 centers in 1992 to serve the needs of relocated Native Americans, its budget was a mere 1% of the total Indian Health Services' budget (Davis, 1994; Nelson et al., 1992).

Increased funding is crucial to Native Americans on reservations and in the urban regions of the nation. Persons trained in mental health care-serving families, children, substance abusers, and a wide range of other groups-are sorely needed. Funds for training, planning, and community development must also be allocated. Prevention, while rarely emphasized, is, in fact, another key to reducing the incidence of depression, violence, alcoholism substance abuse, and other forms of mental illness in Native American communities (Davis, 1994; Nelson et al., 1992).

African Americans. Numerous studies have found racial disparities in the treatment of persons with mental illness in the general population, in prison, and on probation and parole (Adebimpe, 1994; Boone, 1995; Chau, 1991; Chung et al., 1995; Dressler, 1991; Pallone, 1991; Stark, 1990, 1993). In one investigation, a team of researchers found differences between African Americans and whites in the diagnosis and treatment of psychotic disorders, alcoholism, drug addiction, and personality disorders (Chung et al., 1995). Although the presence of racism has been clearly documented in studies of our nation's mental health system, efforts to reduce its prevalence have lagged. The need to attack racism becomes more imperative as African Americans experience a greater range of stressors in their communities. The problems African Americans face have been examined extensively in the literature; they include: crime, poverty, unemployment, limited educational and vocational opportunities, racism, and violence, (Dressler, 1991; Neal & Gray, 1991; Stark, 1990). The ever-present specter of racism has led African Americans (and other people of color) to cope by developing a variety of psychological defenses and behaviors. I have created a term-"the Click Syndrome"-to demonstrate that perceptions have powerful behavioral components. African American males often comment that as they walk along the streets, they notice that whites parked in their cars automatically "click down" the lock on their car doors (Alfonso, 1995). Clearly, perceptions of racism are based, at least in this instance, on verifiable behavior.

African Americans were admitted for inpatient mental health services at state and county mental hospitals at a rate of 364.2 per 100,000; at private psychiatric hospitals at a rate of 62.9; at non-Federal general hospitals at a rate of 386.6; and at veterans' administration medical centers at a rate of 118.2 (Horton & Smith, 1993). With the high rate of criminal sentences among African Americans and their wide range of mental health problems, the specialized training of corrections professionals is a priority. Culturally-informed programs in prisons, community mental health centers, and community corrections agencies must be staffed by culturally- skilled and knowledgeable staff.

Role of Mental Health and Corrections Staff

African Americans, Asians, Native Americans and Hispanics in prisons and on community corrections supervision, like those in the general population, are ill-served by the mental health system. For some persons of color, correctional facilities and probation agencies can be frightening and oppressive places. Their trepidation, in part, is a consequence of their unwillingness to seek help from predominantly white providers, but it also results from the racism of the providers-intentional and otherwise (Dvoskin, 1990). Those who provide services to offenders must be trained to be culturally competent. They must help persons of color deal effectively with the feelings of anger, fear, distrust and rejection, which they experience in mainstream America. The irony is that all these feelings are absolutely valid in a society that was built upon racism and in which racism continues to dictate social policy both overtly and covertly. If persons of color act on these feelings, they are considered "mentally unhealthy" and unable to function well in society. If they rationalize away these feelings, then they are considered "healthy" and "adjusted". Traditional therapy has mostly ignored how the pathology of discrimination impacts persons of color.

A factor contributing to the continued criminal behavior of probationers and parolees is that they do not feel connected to the community. Not only should mental health therapists and corrections staff help their clients of color deal with family and developmental issues, but they should also teach them to understand white society. They must help offenders bridge the gap between their cultures and mainstream culture. White corrections and mental health staff should anticipate a certain degree of distrust from minority clients. Grier and Cobbs (1968) refer to what is known as "healthy paranoia" (i.e., fear, distrust, suspicion) that minorities have used to protect themselves against prejudice and racism. Persons of color can never be assured that they will be well-received or understood by white practitioners, and so they develop resentful anxiety. This distrust results in an unwillingness to reveal weaknesses, hindering the effectiveness of treatment programs. White practitioners must understand the dynamics involved when racial experiences become intertwined with adjustment difficulties.

Another issue of great concern for people of color is how they are perceived by mental health and corrections staff (i.e., if these workers harbor ill feelings towards "minorities"). The process of engaging these clients becomes a challenge for racially/ethnically dissimilar workers. It requires the helper to communicate, not so much through words or actions, but rather through what is commonly known as "vibes." African Americans have had to learn the subtle ways in which racism manifests itself (i.e., the "perception of racism"). They are very attuned to nonverbal cues in all interactions. They have been socialized to pay attention to the nuances of behavior, making their assessments of others on more than just verbal messages (Dressler, 1991; Franklin-Boyd, 1989; Stark, 1993). The helper must also be able to comprehend the sometimes subtle, sometimes explicit, differences in linguistic style. Clients of color have diverse backgrounds, and practitioners must be flexible enough in their approaches to determine which method is best for which client. They must also recognize that poor patients of color may need immediate relief from the oppressing problems of daily living-only after that will they be interested in treatment issues (Chunn et al., 1983). Within the predominately white context of professional training, persons of color who are professionals themselves may lose the ability to communicate with other people of color (for example, African American psychiatrists, see Chunn, 1983). This ignorance may result in lost opportunities within the helper/client relationship. Furthermore, its consequences are insensitivity, miscommunication and, more important, a limited ability to engage clients in their own recovery. A lack of communication can also breed disrespect, separation, and alienation. For alienated clients, this confirms their beliefs that the criminal justice system does not work for them.

In the social service arena, professionals never learn to manage problems that result from institutional racism or poverty. Poverty affects the way people view the world. Most advocates for the poor, who have middle class backgrounds, have difficulty representing poor people and people of color because they have had little or no social interaction with these populations and know little about their cultures. Workers who are unable to empathize with, or appreciate their clients, or who fail to appreciate their clients' view of the world cannot fully engage them in the recovery process. The greater the gap in life experiences and class, the greater the need for practitioners to develop special communication skills (Ivey, 1991; Sue et al., 1992).

Failure of the Mental Health and Criminal Justice Systems

The number of mentally ill persons of color in the criminal justice system is high. These individuals, whose criminal acts may stem from mental illness, continue to be assessed according to criminal justice criteria rather than mental health criteria. Individuals who are both "criminal" and "mentally ill" have to be supervised more closely, with greater restrictions placed on their activities. Any misbehavior must be perceived as a manifestation of their mental illness.

Opinions differ as to how far we have come in terms of merging the criminal justice and mental health systems, but there is no argument that the two systems have increased their points of contact. In many respects, this increased contact between the two systems is a natural development. The types of people managed by the criminal justice and mental health systems overlap considerably; they come from the bottom of the socioeconomic scale, they have limited social skills, and they are likely to be persons of color. In many instances, assignment to one category or the other is highly arbitrary, having more to do with personal characteristics (such as income levels) and administrative convenience. Individuals are frequently shifted back and forth from one institution to another-prison, mental hospital, institution for the retarded, and so on. Research suggests that there is an inverse relationship between prison and mental hospital populations; that is, states with a higher prison population tend to have a relatively low mental hospital population and vice-versa (Grob, 1991).

Race plays a role in how forensic clients are treated in the criminal justice system. Issues concerning the rights of persons confined under state authority have been the subject of increasing litigation during the past two decades. Prisoners and mental health patients have sought relief from the courts for perceived constitutional infringements in the way they were confined and treated in correctional institutions. Usually, correctional and mental health cases are handled separately, each with its own developing body of law, except for at least one area of concern that crosses the boundaries: the transfer of inmates from correctional facilities to mental health facilities (Monahan et al., 1983).

The health care system in America reflects the general conditions of its population. It reflects the matrix of social, economic, and political factors that segment American society. Race and ethnicity influence the use of the health care system and the personal habits that allow people to maintain a healthy lifestyle. Cultural diversity can only exaggerate these differences when patients interact with medical practitioners whose orientation toward the health care system is totally different from theirs (Monahan et al., 1983). As Americans, we are not taught to recognize institutional racism or its effects. Until the late 1960's, race was largely ignored in professional literature. "Color-blind practice" was encouraged in attempts to avoid racial bias and to foster feelings of genuine regard for minority clients. However, this practice is not realistic, as one cannot deny the obvious. In fact, it has now been firmly established that race continues to have a significant effect on health care practices (Proctor & Davis, 1994).

Inadequacy of Data for Persons with Mental Illness in the Criminal Justice System

Although the mentally ill are arrested, jailed and imprisoned at disproportionately higher rates than the general population, there are very little data on persons with psychiatric problems in the criminal justice system. The National Alliance for the Mentally Ill (NAMI) and Public Citizen's Health Research Group (PCHRG) obtained survey data from 1,391 jails across the nation and nearly 400 families of the seriously mentally ill. They found that one out of every 14 inmates suffered from serious mental illness (National Alliance for the Mentally Ill, 1993). Their research also showed that over the past 10 years, services for seriously mentally ill individuals have declined so much that one of the most common "treatments" is now jail.

No data are available on people of color with mental illness who are imprisoned or on parole or probation. For example, an excellent and comprehensive survey, "An Overview of Mental Health Services for American Indians and Alaska Natives in the 1990s" (Nelson et al., 1992) includes no statistics on the correction population within the Native American community.

Most disciplines have yet to examine mentally ill persons of color in the criminal justice system due to the long-time tradition of not addressing mental illness among offenders, except as popularly portrayed in the mass media, that is, "the criminally insane." Popular stereotypes must now be confronted. The failure to investigate persons of color in the criminal justice system who have mental illness may be a consequence of their perceived low social status. In his national survey of mental illness among probation and parole populations, Boone (1995) reported that only 3 states provided data on the racial/ethnic composition of probationers and parolees with mental illness. Based on such inadequate information, we are unable to draw generalizable conclusions about this population. Clearly, mental illness among the community corrections population is one of the most understudied topics in the criminal justice system (Boone, 1995). The current inadequacy of data must be redressed if mentally ill persons of color on community corrections supervision are to receive the services they require and deserve. Therefore, the need for research concerning this population is a priority of the same order as the need for training.

Community Corrections and Alternative Sentencing Programs

With prison populations at record levels, a variety of community-based alternative sentences have appeared. While the Bureau of Justice Statistics provides data regarding the incarceration of African Americans, Hispanics, Asians and Native Americans, data on people of color who are on probation and parole are not available (Bureau of Justice Statistics, 1994). At the same time, studies of alternative sanctions have focused on programs with a majority of white participants (Pallone, 1991; Whitehead, et al., 1995).

Although intermediate sanctions such as Intensive Supervision Programs (ISP), Boot Camps, Electronic Monitoring, and Residential Treatment Programs include people of color with mental illness, they rarely, if ever, specifically address how these individuals can effectively deal with racial discrimination and its relationship to psychopathology. Nor are these factors addressed in assessing participants' success in completing these programs. For example, ISP programs often involve drug and alcohol treatment, job skills training, and mental health counseling (Brown & Roy, 1995). More studies are needed on the nature and extent of these interventions and how relevant they are to people of color.

People of color are less likely to be sentenced to ISP or other community alternatives, including electronic monitoring. Thus, race may preclude individuals from being referred to community corrections programs that have services and treatments for mental health problems.

Residential programs or halfway houses have become an integral part of intermediate sanctions. They are one of the few places where persons with mental illness have the same opportunities as other offenders to qualify for community corrections supervision. The general rationale for residential programs in community corrections is that some offenders, because of their particular risk and needs, require highly structured and supportive living conditions while they attempt to reintegrate into the community. Residential programs usually provide employment, educational opportunities, substance abuse prevention, and job skills training. The goal of these facilities is to integrate offenders into the community on the basis of the assumption that structured interventions will discourage future criminal behavior.

Minor and Hartmen (cited in Smylka, 1995) found that racial factors contribute to successful termination in residential treatment. People of color who need structured living arrangements may not be getting any psychotherapy to help them cope with the consequences of racism. Therefore, it is not surprising that persons of color who are in these transitional programs (half-way houses) end up incarcerated more often in the long-run than whites do.

Community Mental Health Service Programs Targeted to People of Color

The following programs are not designed expressly for offenders with mental illness on parole or probation, but they provide useful examples for developing such programs. A key theme-and major source of their success-is their focus on traditional Native American beliefs in the treatment process. These programs are culture-specific, with strong components of "mainstream" treatment approaches. They offer great opportunity for community corrections because of their emphasis on family involvement, and community values and leaders.

Swinomish Tribal Mental Health Project

Founded in 1985, the Swinomish Tribal Mental Health Project, in the State of Washington, is administered through a cooperative agreement between the Swinomish and Upper Skagit tribes. Client services and staff training generally take place at tribal sites, where staff officers are also assigned. The project's success in serving Native Americans was recognized by a special grant award, in 1988, from the Office of Human Development Services and the Administration for Native Americans.

The project is successful primarily because of its focus on tribal mental health services that are delivered from a Native-American perspective, which requires that such services meet the immediate needs of Native Americans for practical help in emergencies; recognize the extended family as the appropriate "unit of treatment"; are flexible about the time and place of treatment sessions; and fit into everyday tribal community life.

The services of the project are provided by Native American staff and emphasize holistic approaches to assessment and treatment. Specific services include home visits, supportive counseling, play therapy, problem solving and advocacy, referrals, and immediate support in crisis situations. The project involves clients' extended families because in Native American culture important decisions require the approval of spouses, senior relatives, and grandparents. In addition, the project's tribal support counselors cooperate with traditional healers and employ a 78 year-old tribal elder as a cultural consultant. The elder has been a key player in galvanizing family involvement in the treatment of clients. The project has developed an extensive training program that involves a local community college. Basic training includes specialized workshops on Native American mental health issues, formal coursework in mental health and human services, seminars on tribal mental health issues, and supervised fieldwork. The project's training program was designed following a survey of training priorities (Swinomish Tribal Mental Health Project, 1991).

Flathead and Winnebago Communities

Several tribal communities have developed programs to break the cycle of desperation, hopelessness, alcoholism, family dissolution, and violence among Native Americans. In Montana, the Flathead community organized programs to confront alcoholism and violence. The community decided to integrate the intervention strategies of elders and younger professionals, and to seek guidance from ancient spiritual customs and beliefs. The mental health services delivery system was reorganized with elders taking on a greater role in guiding youth. Traditional methods of maintaining the balance between mind and body were combined with modem treatment techniques (Davis, 1994).

In Nebraska, the Winnebago community responded to widespread substance abuse and related problems by coordinating its local resources in these areas. Community agencies in the fields of social services and psychology were linked to the local hospital. Hospital staff were

trained in counseling alcoholics, and in understanding alcohol-based physiological and psychological problems. Family members of alcoholics in treatment were invited to participate directly in the treatment process. In 1992, the program was chosen from more than 300 federally-funded programs to receive an award for excellence (Davis, 1994). The program's focus on forging linkages, involving families, and incorporating the leadership of elders has been successful.

Community Corrections Programs for Mentally Ill Offenders
Utah's Specialized Supervision Program

Opened in 1984, the Orange Street Community Correctional Center in Salt Lake City, Utah designates 14 of its 60 beds for male offenders with mental illness. They receive individual psychotherapy, psychiatric and nursing services, instructions in living, and training in personal hygiene for a period of five months. The Utah program has received national recognition for its success in fostering a closer relationship between the state's mental health and corrections systems (Boone, 1995).

Maine's Cumberland County Dual Diagnosis Collaborative

The Greater Portland Area is Maine's urban center. With a population of more than 250,000, it is the locus of the state's economic base, arts, health care system, and mass transit services. As with other urban centers in America, Portland's response to inner-city residents includes measures to battle increasing crime, violence, health problems, poverty and poor housing. Recognizing the interrelationship among these problems, the Cumberland County Dual Diagnosis Collaborative (CCDDC) was established. It began by training mental health and substance abuse workers to diagnose and treat people with dual disorders.

The next step in CCDDC's development was to formulate holistic treatment approaches based on clients' needs rather than reimbursement streams. To accomplish this objective, the staff conducted cross-training sessions, required family input in treatment protocols, and created an interdisciplinary team of treatment providers. More than 20 professionals-substance abuse, mental health, public health and criminal justice-make up CCDDC's staff. The collaboration has eased previously strained relationships and introduced new relationships where none existed. The collaboration has enhanced client services. For example, the range of sanction options for nonviolent parole violators has been expanded. Parole Services now has great discretion in responding to such violations-a crucial new development. The collaboration among mental health and criminal justice professionals has reversed the usual cycle of rearrest and incarceration. Prison is the last resort, not the first response.

This program, along with the others I have highlighted, share common components for successful operations. Structurally, they are client-centered and multisystemed or "cross-systemed." They are inclusive-forging ties with families, communities, and other institutions. They are flexible in their operations. They are also self-evaluating and dynamic, which allows them to self-correct and change easily. Finally, they include training as a key aspect of their functioning.

Conclusions

The mental health and criminal justice systems are quite separate. Involvement in the criminal justice system typically precludes or limits access to the mental health system. Mental health and criminal justice professionals often have different types of training and espouse conflicting philosophies. Mental health professionals often view substance abuse as a symptom or response to mental illness and therefore minimize the need for substance abuse treatment. Criminal

justice professionals who deal with persons with mental illness often emphasize the role of substance abuse in producing the symptoms of mental illness and therefore discourage active psychiatric treatment. The two systems, therefore, are unlikely collaborators. However, the training of professionals in the two systems can focus on linkages and interrelationships. I believe that training should closely examine the crucial role that judges can play in both systems. To deal properly with the problem of what to do with offenders with mental illness, it is imperative to insure that the issue is considered in its proper context. All too often, primary responsibility for developing a response to disturbed criminals has been delegated to local corrections officials when a much broader group of actors is actually involved (Steadman, 1986). The judiciary plays an important role. Judges are frequently asked to rule on applications to transfer prisoners with mental illness to state hospitals or to approve the involuntary commitment of persons who can no longer be cared for by their families. Judges must also select an appropriate disposition for disturbed persons who have just been convicted of or who have plead guilty to a criminal offense. The range of options includes diversion to a community treatment program, a suspended sentence, probation, or confinement to a jail or prison. Finally, judges may have to render a verdict in class actions suits alleging that the quality or availability of mental health care in the criminal justice system is unconstitutional.

Of the nearly 12,000 full-time state court judges across the country in 1991, only 465 were African American and 150 were Hispanic. Some states, such as Texas, brazenly continue to elect their judges under schemes that have been found by federal courts to discriminate against people of color. In the Federal System, the White House has seemingly adopted the same criteria for selecting judges for the court of appeals that many private country clubs use to select their members. No African American, for example, sits on six federal appeals courts that have jurisdiction over 24 states.

With the ever-increasing debate over crime and punishment, this ominous trend is likely to continue. The "Taking Back our Streets Act," proposed by the Republican Controlled Congress, calls for the authorization of $10.5 billion over six years for the Attorney General to award grants to states so they can build, expand, and operate more prisons (Gingrich & Armey, 1994). Current data suggest that most of the cells will be filled by African American, Hispanic, Asian, and Native American persons.

It is little wonder that people of color have minimal confidence in the capacity of our courts to dispense color-blind justice. As the poet Langston Hughes wrote over 30 years ago: "That Justice is a blind goddess/Is a thing to which we blacks are wise/Her bandages hide two festering sores that once perhaps were eyes."

States must elect judges who will abolish electoral schemes that prevent people of color from electing representatives of their choice. Equally important are affirmative action efforts by the federal government and the states to put more people of color on the bench. While the NAACP's list of reforms that must take place in the criminal justice system are specific to African Americans, they are applicable to all people of color:

1. We must deal forthrightly with the problem of excluding people of color from decision making positions in our systems of justice-on both state and federal levels.
2. African Americans must be given an equal opportunity to serve as jurors. In too many cases, people of color continue to be peremptorily struck from juries by prosecutors. Prosecutors routinely remove large numbers of minority jurors because present law requires only that they provide a "race neutral" reason for the removal. For example, jurors who "look like the defendant" or are the "same age as the defendant" have been successfully removed.

3. In racially-charged cases, changes of venue should not exclude people of color. Cases that arise in jurisdictions populated by substantial numbers of people of color should be moved only when it is clearly shown that the removal is necessary to ensure a fair trial. And they should be moved only to communities with comparable ethnic or racial characteristics.

4. Eliminating police brutality against people of color must become a national priority. All communities must insist on civilian review of complaints of police misconduct and the active, independent prosecution of legitimate claims of police abuse. Police departments must take responsibility for implementing policies on the proper and nonracist use of force, and officers must be regularly retrained to ensure that those policies are not merely empty promises to people of color. Finally, all police departments in the United States need to provide racial sensitivity training.

5. Racial disparities in sentencing must end.

A 1990 report from the General Accounting Office found that racial disparities in sentencing exist throughout the country. For much of our history, our judicial system has valued white lives more than minority lives and has punished more harshly people of color who commit crimes against whites. Bias in sentencing is most clearly seen in capital sentencing. People of color who kill whites are far more likely to receive the death penalty than are those who kill other people of color. Congress has failed to pass the Fairness in Sentencing Act, a bill that would require state officials to show that the death penalty was not administered in a discriminatory manner. Its passage is long overdue.

Many of these problems can and must be solved by legislation. Encouraging the inclusion of people of color in the legal system and taking other steps to promote color-blind justice and to understand the role of mental illness in criminal behavior will help to guarantee equal justice for all Americans.

In conclusion, the notion of "color-blind justice" directly confronts a primary stressor common to persons of color, namely the "perception of racism" (Dressler, 1991). In the counseling profession, monoculturalism is the norm, which makes professionals "blind" to the needs of people of color. As Sue et al., (1992) have noted:

> It seems that a major obstacle in getting our profession to understand the negative implications of monoculturalism is that white culture is such a dominant norm that it acts as an invisible veil that prevents people from seeing counseling a potentially biased system. Counselors who are unaware of the bias for differences that occur between them and their culturally different clients are likely to impute negative characteristics. What is needed is for counselors to become culturally aware, to act on the basis of a critical analysis and understanding on their own conditioning, the conditioning of their clients, and the sociopolitical system of which they are a part. Without such awareness, the counselor who works with a culturally different client may be engaging in cultural oppression using unethical and harmful practices. (p. 480)

An often forgotten element in multicultural counseling is the importance of white professionals developing self-awareness. Such awareness is crucial to an understanding of racism (Alfonso, 1995; Cross et al., 1989; Ivey, 1991; Sue et al., 1992).

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CHAPTER 7

Juveniles: The First Frontier

Richard J. Gable

"So . . . What seems to be the matter with Alex?"
They replied in unison . . . a stereophonic eruption.
"He's bad," said Father. "He's crazy," said Mother.
And so it begins. . . .
-A Clinical Interview, 1978

The co-occurrence of mental health and substance abuse problems in youth involved in the juvenile justice system has long been discussed and studied. In fact, the two problems have become intertwined as the juvenile court moves forward to rehabilitate youngsters and intervene positively in the lives of their families while the mental health system has begun to proactively treat children in their home environments. Interestingly, however, dichotomous approaches have been applied to further our understanding of the "inner workings" of delinquent youth.

The social science literature is replete with references to "antisocial" youth, and juvenile justice is debating the culpability of young people and the extent to which they should be held accountable for their criminal behaviors. "Delinquency," a legal term, has often been far removed from "conduct disorder," a clinical term, although both describe, with different perspectives, a child who does not stay within the bounds of accepted behavior in our society. These two visions of the same child have hampered our ability to address the mental health needs of the delinquent population. They have also sent researchers and practitioners in vastly different directions in planning policy and practice to respond to the rising fear of youthful lawlessness, violent crime, and the perceived anomie of a growing number of today's adolescents.

This chapter examines and reintegrates these varying views of the behavior of youth and suggests areas where convergence is likely, desired, and possible. It discusses the positive interfaces between professions, emphasizing the sometimes thorny issues that separate professional people's attempts to intervene in a significant way with out-of-control youth. The focus of the chapter is on youth in community corrections settings, which maximize the potential for ongoing misbehavior and dictate that planned interventions be rational, feasible, and effective. In this environment, the best hope for intervention lies and the most potential for mishaps occurs. As was once said, "There's no place like home." The chapter also describes the state of juvenile justice, with attention on current legal efforts to "criminalize" juvenile behavior.

Caseflow of the Juvenile Court

In 1992, courts in the United States with juvenile jurisdiction handled an estimated 1.5 million cases in which a juvenile was charged with a delinquent offense (i.e., an offense for which an adult could be prosecuted in criminal court). Because an individual juvenile may be charged in more than one case, the annual ratio of cases to juveniles is 3 to 2. Therefore, the juvenile courts handled about 1 million individual juveniles charged with one or more delinquency offenses in 1992 (Butts et al., 1992).

Changes in the nature of offenders brought to the juvenile court in recent years have placed different demands on the court's resources and programs. The 26% increase between 1988 and 1992 in the volume of cases that passed through the juvenile courts naturally placed a strain on the system. In addition, the courts were asked to respond not only to more cases but to a different set of problems. Specifically, over the five year period from 1988 through 1992, the juvenile courts saw a disproportionate increase in violent offenses and weapons law violations while alcohol and other drug offense cases declined. These changes have required the courts to expand their programs in some areas and to decrease their capacities in others (Butts et al., 1992).

Soon after a referral to juvenile court, a decision is made to handle the case formally or informally. Informal processing is considered when the decision makers believe that accountability and rehabilitation can be achieved without the use of formal court intervention. Informal sanctions are voluntary; the court cannot force a juvenile to comply with an informal disposition. If the decision is made to handle the matter informally, an offender may agree to perform community service, pay victim restitution, submit to voluntary probation supervision, or comply with a range of other sanctions. In many jurisdictions, before juveniles are offered informal sanctions, they must admit that they committed the alleged acts. Cases are generally held open pending successful completion of informal dispositions. Upon successful completion of these arrangements, the charges against offenders are dropped. However, if offenders do not fulfill the court's conditions for informal handling, their cases are likely to be reopened and formally prosecuted.

Informal handling is common in the juvenile courts. In 1992, half (51%) of delinquency cases were handled informally. These cases present a tremendous opportunity for courts to become involved as referral sources for mental health and substance abuse problems identified at the intake stage. In 1992, informal court handling was most common for delinquency cases in which a property offense was the most serious charge. Drug cases were the least likely to be handled informally. Whereas the use of informal processing remained fairly constant between 1988 and 1992 for most offenses, informal handling declined somewhat for cases involving drug law violations (Hurst & Torbet, 1993; Synder & Sickmund, 1995).

Cases are more likely to be handled informally in rural areas than in large cities. In 1992, in jurisdictions with a population of less than 10,000, courts informally processed 55% of their delinquency cases. In jurisdictions with a population of greater than 100,000, only 43% of their delinquency cases were processed informally (see also Table 1).

More than half (53%) of the informally handled delinquency cases processed in 1992 involved some type of services or sanctions beyond the warning and counseling of the youth. These cases consist of a significant number of youngsters who might have benefited from referrals or clinical interventions. In nearly a third (30%) of informally processed cases, the youth agreed to a term of voluntary probation supervision, and 23% agreed to other sanctions such as voluntary restitution, community service, or referral to another agency. In a very small number of cases, the youths and their families agreed to a period of out-of-home placement as a result of the court's action (Butts et al., 1995).

Programs such as pretrial diversion or deferred prosecution are informal dispositions that have attracted increasing interest in recent years. Courts at all levels have found that diverting certain cases from the formal justice system can be cost-effective both in terms of public accountability and offender rehabilitation. Diversion programs reduce the administrative burdens and the costs of prosecution and trial, and allow the justice system to intervene in relatively minor violations of the law. Offenders benefit by avoiding trial and the stigma of formal conviction. Diverted or deferred cases also move efficiently because they do not involve protracted courtroom procedures. Unfortunately, this practice often misses the opportunity to respond to mental health and substance abuse issues that are presented in a perfunctory fashion as part of the rapid intake process.

Juvenile Probation: The Bedrock of the Juvenile Court

Probation is the oldest and most widely used community-based disposition. Probation may be used at either the "front-end" or the "back end" of the justice system: for first-time, low-risk offenders, or as an alternative to institutional confinement for more serious offenders. During a period of probation, juvenile offenders remain in the community and can continue normal activities

such as school and work. In exchange for this freedom, juveniles must submit to a number of activity-limiting conditions. Their submission may be voluntary, where youths agree to comply with the conditions of informal probation in lieu of formal adjudication. Or, once adjudicated and formally ordered to a term of probation, the juveniles must submit to the conditions set by the court. More than one half (54%) of juvenile probation dispositions in 1992 were informal (i.e., enacted without formal adjudication or court order) (National Center for Juvenile Justice, 1991).

Probation conditions typically involve mandates designed to control as well as to rehabilitate juvenile offenders. For example, a juvenile may be required to meet regularly with a probation officer, adhere to a strict curfew, and complete a specified period of community service. The conditions of probation may also include provisions for the revocation of probation should the juvenile violate the conditions. If probation is revoked, the court may reconsider its disposition and impose a stricter sanction.

The total number of delinquency cases resulting in probation climbed by 23% between 1988 and 1992, from 434,000 to 533,000, annually. The number of adjudicated delinquency cases placed on formal probation increased by 24% over this period, from 197,000 to 244,000, annually. Between 1988 and 1992, probation was the most severe disposition used by juvenile courts in nearly two of every five delinquency cases and in nearly three of every five adjudicated cases, with the annual proportions remaining constant over this period. Therefore, the growth in probation caseloads was directly related to the general growth in referrals to juvenile court (see Table 2).

The juvenile probation function, within the juvenile court, is the front-line for identifying, assessing, planning, and delivering services to youth with substance abuse and/or mental health problems. In one fashion or another, juvenile probation, in most states, "lays hands" on every young person referred to the juvenile court. With a steady flow of incoming cases, the probation department sees more at-risk youth than any other social service entity, with the possible exception of school. It is clear that the working relationship between probation and the mental health system must be reliable, trusting, and rational if early interventions are to take hold in this adolescent population (National Center for Juvenile Justice, 1991).

The Criminalization of Juvenile Justice

Facts from the field. In recent years, the single most rapidly moving juvenile justice activity in state legislatures has been to identify youth who, for reasons of instant offense or criminal history, should be regarded as adult criminals. These changes in the law have shifted classes of people, under the age of 18, to adult courts and correctional systems.

Historically, most states have relied on judicial waiver for transferring juveniles to criminal court. For many years, all states except New York and Nebraska have had statutory provisions that allow juvenile court judges to waive the juvenile court's jurisdiction over certain cases and to transfer them to the adult court for prosecution. Statutory exclusion and concurrent jurisdiction (between the court and the prosecutor) have been relatively less common, but the number of states in which these options exist are growing. At the end of 1992, legislatures in 20 states statutorily excluded from juvenile court jurisdiction cases involving certain offenses and certain aged youth. In 13 states, prosecutors were given the discretion to file particular juvenile cases in criminal court.

State legislation specifies the conditions under which youth charged with a law violation, whose age alone would place them under the original jurisdiction of the juvenile court, may or must be processed as adults. During the 1993 and 1994 legislative sessions, at least 20 states expanded their statutory provisions for transferring juveniles to criminal court. Generally, this was

done by lowering minimum ages, adding eligible offenses, decreasing the weight of criminal history, or making judicial waiver presumptive (therefore placing the burden on the child to say why he should not be transferred). Three states expanded their concurrent jurisdiction provisions, two expanded judicial waiver and statutory exclusion, seven expanded judicial waiver exclusively, and eight expanded the list of offenses for which a youth is initially within the jurisdiction of the adult criminal court. By the end of 1994, more states had a combination of judicial waiver and statutory exclusion. Relying on judicial waiver alone has become the second most common transfer mechanism. Legislatures have taken it on themselves to decide who should go to the criminal court, irrespective of the needs and individual characteristics of the youth appearing before the court (Szymanski, 1994).

Implications for youth with mental illness. As the legislature assumes more of the discretion of the juvenile court, it limits judges from exercising creative decision making in individual cases. A mentally ill 16 year-old, charged with the third burglary of a private household, may, by statute, be within the jurisdiction of the adult criminal court. There will be no intake interview and the focus of the system will turn away from rehabilitation and toward punishment. This child will be subject to the primary mission of the adult criminal justice system: finding guilt and imposing an appropriate sanction. At best, this new "adult" criminal will be seen as a first-timer and will be summarily dismissed from further consequences, with neither a diagnostic interview nor a plan for treatment. At worst, this youth will be given an adult sentence, the purpose of which is to insure that justice is served and that the punishment fits the crime. In either case, the "moment of intervention" is lost. Rather than viewed as an individual, the subject in question has become one of a class, with no individual needs or characteristics. As individualization withdraws from criminal justice, so too does individualized decision-making withdraw from the treatment process.

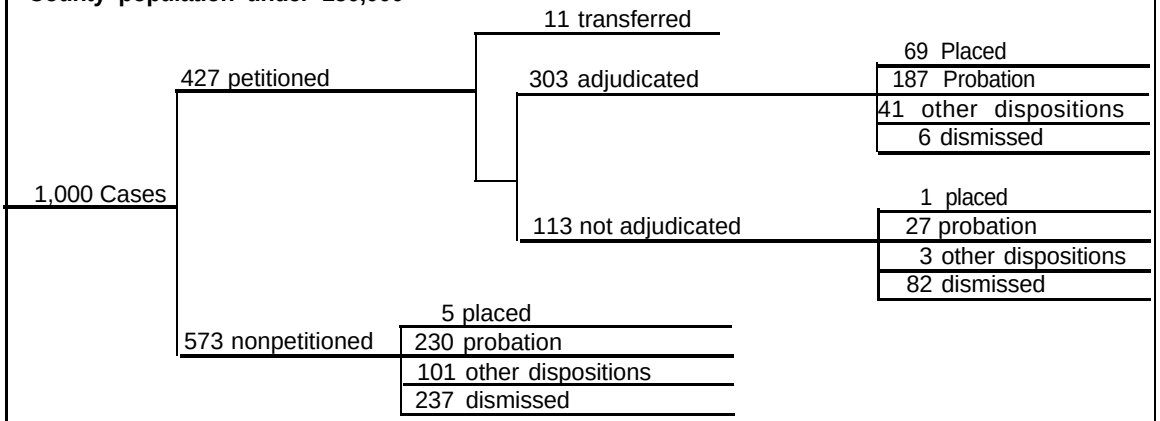
Policy implications. The trend towards classifying youthful offenders as adults should be reversed unless there is compelling evidence that those identified for adult processing will respond to those interventions in a meaningful and positive direction. Otherwise, decisions to remove youth from the juvenile justice system with its tradition, mission, and practice of individual assessment and treatment should be maintained. The role of justice for children should continue to be ameliorative, and, as such, must consider the individual needs (including the mental health and substance abuse problems) of those individuals.

Where Shall We Go From Here?

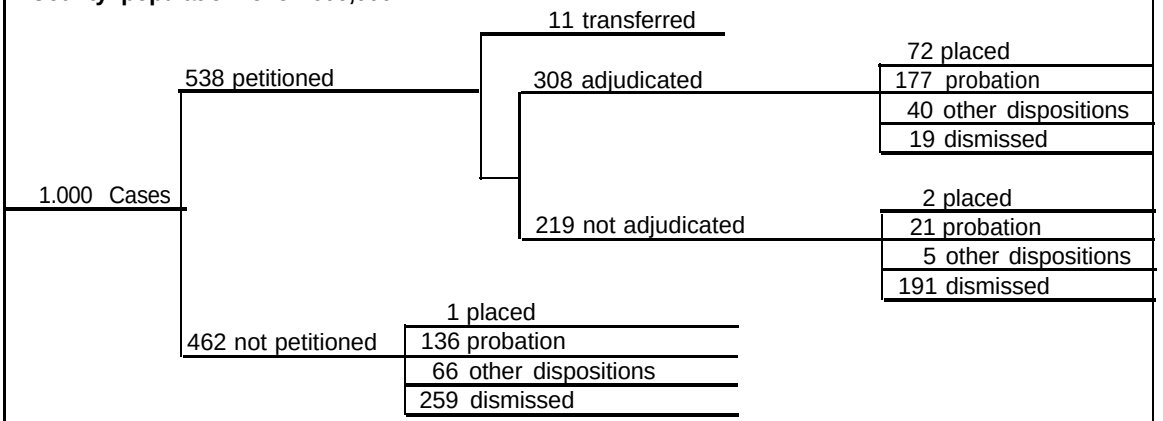
If the juvenile justice system is to survive, the joint needs of children and the general public must be simultaneously addressed. The need for public protection is paramount. Without the perception or reality that people are safe in their homes and communities, no plan of intervention for youth is feasible. The role of mental health in joining the juvenile court must be to clearly articulate its promises. There are many programs that have a demonstrated record of success with juvenile offenders. These should be brought to the fore. On the other hand, mental health interventions that can only promise individual gains, without reducing criminal activity, are not within the public interest. Laws to exclude juveniles from the jurisdiction of the juvenile court will continue as long as there are no effective and accessible alternatives. In the end, the question remains: "Is he bad . . . or is he crazy?"

How does juvenile court case processing differ in small and large jurisdictions?

County population under 150,000



County population over 600,000



- For every 1,000 delinquency cases handled in small jurisdictions, 427 are petitioned and 573 are processed informally, compared with large jurisdictions that handle 538 cases formally and 462 informally for every 1,000 delinquency referrals.

- When cases are processed formally with the fifing of a delinquency petition. adjudication IS more likely in small jurisdictions. Of every 1.000 delinquency referrals in large jurisdictions, 219 cases are formally petitioned but not subsequently adjudicated. Most of these cases (191) are subsequently dismissed for lack of evidence or other reasons.

Source: NCJJ. *(1994). National Juvenile Court Data Archive: Juvenile court case records 1992* [machine-readable data file].

Reprinted from:
Snyder, Howard N. and Sickmund. Melissa **(1995).**
Juvenile **offenders and victims: A national report. Washington, DC**
Office of Juvenile Justice and Delinquency Prevention

Between 1983 and 1992 the percentage growth in juvenile arrests for murder, weapons law violations, and motor vehicle theft far surpassed the growth in adult arrests

	Percent change in arrests					
	1991-1992		1988-1992		1983-1992	
	Juvenile	Adult	Juvenile	Adult	Juvenile	Adult
Total	3%	-1%	11%	6%	17%	21%
rime Index Total	1	-2	12	5	16	25
Violent Crime Index	5	2	47	19	57	50
Murder	0	-6	51	9	128	9
Forcible rape	2	-2	17	3	25	14
Robbery	1	-2	50	13	22	21
Aggravated assault		4	49	23	95	69
Property Crime Index	0	-4	8	1	11	16
Burglary	-1	-3	1	-3	-20	-3
Larceny-theft	0	-4	8	2	13	21
Motor vehicle theft	-4	-4	12	-5	120	45
Arson	8	-3	25	-7	26	-18
Nonindex offenses	4	0	11	6	18	20
Other assaults	9	5	49	26	106	113
Forgery	-3	4	5	8	9	25
Fraud	10	0	-2	17	-41	31
Embezzlement	3	1	-38	-13	35	53
Stolen property	-4	-2	6	-2	39	21
Vandalism	5	-3	28	7	34	32
Weapons	16	5	66	13	117	21
Prostitution	-8	-4	-27	-1	-54	-17
Sex offense	10	4	28	6	41	22
Drug abuse	14	7	-10	0	7	64
Gambling	15	3	52	-17	25	-58
Against the family	27	7	53	56	212	79
Driving under influence	-19	-8	-37	-6	-52	-18
Liquor law violations	-12	-13	-24	-14	-12	12
Drunkenness	-14	-6	-26	-4	-47	-31
Disorderly conduct	6	-1	24	1	35	6
Vagrancy	57	-14	38	-8	36	-11
All other offenses (except traffic)	6	4	11	16	3	55
Curfew	1	*	5	*	9	*
Runaways	4	*	13	*	31	*

- Because the absolute number of juvenile arrests is far below the adult level, a larger percentage increase in juvenile arrests does not necessarily imply a larger increase in the actual number of arrests. For example, while the percentage increase in juvenile arrests for a weapons law violation was much greater than the adult increase between 1983 and 1992, the increase in the number of arrests was 9% greater for adults.

* Not applicable to adults.

Source: FBI. (1993). Crime in the United States 1992.

Reprinted from:
Snyder, Howard N. and Sickmund, Melissa (1995).
Juvenile offenders and victims: A national report Washington, DC
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CHAPTER 8

Reengineering the Delivery of Services to Mentally Ill Probationers and Parolees

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> Social scientists would perhaps accomplish a good deal more by directing their attention to examining and understanding the complex system-level context in which interventions take place.
>
> -Roesch and Lorrado, 1983, p. 405

"It's the Structure, Stupid."

During the 1992 presidential campaign, a sign reading "It's the economy, stupid," was prominently displayed in Bill Clinton's campaign headquarters as a reminder to the candidate and his key staff that economic issues would be paramount in the election but also dangerously easy to ignore. In the world of social policy and in the on-going efforts to improve social responses to our most vexing problems, we are beginning to learn that perhaps the most important issues-the underlying systems, structures, and processes for the delivery of services-have traditionally been overlooked or de-emphasized.

Although breakthroughs in management/administrative theory and practice almost always first appear in the private sector and are only later exported to the public sector (if at all), in the past few years, there have been some strong indications that government agencies are putting aside the traditional assumption that practices that work for the private sector do not transfer to the public sector. Osborne and Gaebler's (1992) Reinventing Government was crucial in demonstrating the effectiveness of hard-nosed business practices within government agencies. Their bestseller was a call to all government executives to examine closely cutting-edge practices in the business world for applications that could be pertinent to them and their agencies.

One movement that has had a long and distinguished history in the private sector and has lately been embraced as a theme by the public sector is that of "Total Quality Management"(TQM) (also known as "Continuous Quality Improvement," or more recently, "Reengineering"). Based on the work of Edward Den-ring and other management consultants, a cardinal precept of this movement is that the greatest opportunities for progress are found not in the people or the product itself but in the systems and processes by which employees produce a product (Basile, 1994). In other words, what Den-ring and his cohorts are telling the typical manager is: "It's the System, Stupid."

What evidence do we have that a focus on such issues is relevant to the delivery of services to offenders with mental illness? Interestingly, while not explicitly referring to management theory, a number of researchers working on the topic of mentally ill offenders (MIOs) have independently identified the need to emphasize the "administration of services" (Jemela et al., 1993, p. 17) and "organizational and management change" (Casey, 1992, p. 107) and to examine issues "in systems terms" (Steadman, 1992, p. 75). These same writers observe that past reform efforts with MIOs have focused nearly exclusively on either legal issues such as protection against institutionalization or the right to treatment, or on clinical issues such as new diagnostic protocols or treatment modalities (Steadman, 1992). Nonetheless, the notion that we may be failing to meet the needs of MIOs because of defects in the way we are organized to deliver services has been given scanty attention in most studies.

Armed with some new paradigms for improving organizational effectiveness and with the exhortations of key researchers who are calling attention to system's issues, I first look at what is known about the scope of the problems facing MIOs on probation and parole. Next, I examine

current practices to handle MIOs and discuss some exemplary programs for this population. Finally, I offer several suggestions for "reengineering" the delivery of services to MIOs on probation and parole, drawing on what we have learned to date about systems and structures that insure quality programs.

The Scope of the Problem

If the beginning of wisdom is knowing what we do not know, then we are truly wise in the area of probationers and parolees with mental illness. What emerges most clearly from diverse writing and commentary in this area is a consensus that much too little is known about the prevalence of the problem, the nature of the discrete illnesses involved, the profile of MIOs, and the services available to treat them. Hence, it must first be said that our understanding of the dimensions of the problem and the appropriate responses to it are pitifully incomplete.

But we do know something. There are few studies of prevalence but the convergence in their findings is remarkable. In a 1994 report on services for New York parolees with serious mental illness, it was estimated that 5% had a "compelling need for mental health services" (Dvoskin et al., p. 17). In a study conducted in Bexar County (Texas), approximately 6% of offenders screened for mental health services were identified as needing treatment of some kind (Andersen, 1994).

By comparison, studies of arrestees in Cook County Jail (Chicago) found that 6% needed treatment services (Teplin, 1990), and a national survey of prisons and mental health facilities in 1978 found that 6.6% of offenders were identified as mentally disordered (Monahan & Steadman, 1983). Although far from conclusive, the similarity of findings regarding the base rates of serious mental health problems among offenders in these studies is indeed striking.

The American Probation and Parole Association (APPA) undertook a national survey regarding prevalence and practice issues for MIOs on probation and parole. Of the ten states that reported data, remarkably again, 6% of probationers and 5% of parolees were identified as mentally ill (Boone, 1995). Despite convergence in these findings, it should be emphasized that the aforementioned studies were very limited in their scope and methodology and are therefore only suggestive.

Other Dimensions of the Problem

Information relating to how MIOs are identified and treated is also scarce. Such data are generally descriptive and not evaluative and are primarily anecdotal and not empirical. Nonetheless, certain themes do emerge. For example, a number of reports indicate that services for MIOs are quite limited (Clear, 1995; Veysey, 1994). This shortfall appears to be a product of tight budgets for human services and a resistance to prioritizing services for this population. For example, a 1991 report on the delivery of forensic services in New York State found that community programs block successful referrals because practitioners are reluctant to serve MIOs, which they perceive as both dangerous and resistant to treatment. In explaining this phenomenon, Dvoskin (1993) and his colleagues offer the following analysis:

> Consider that many mental health providers have extensive waiting lists. Upon release from prison, parolees must compete with other persons who have already requested services. The results it that the parolee is placed at the end of a long waiting list. Further, offenders, especially those who have endured long periods of incarceration are unknown quantities -"criminals'‘-to mental health providers.

> Compounding this is the reality that many mental health community residences are specifically "sold" to communities with promises that they will house no "criminals." This leads to permanent discrimination against parolees, who will always be convicted felons (p. 14).

Related to this problem is the practice of "case dumping." The unreliable nature of mental health diagnoses allow individual problems to be redefined by either the mental health or criminal justice system as falling into the other's domain. For example, nuisance criminal cases such as disorderly behavior can be redefined as a mental health problem to jettison the case from criminal processing; alternatively, a case of bizarre behavior by a threatening individual referred to a mental health clinic can be redefined as a criminal act requiring the restraints available through the courts, Keilitz (1992) reports mounting evidence of just such a shuttle-like system with criminal justice and mental health actors looking to divert troublesome cases to their wary (and weary) counterparts.

Mad or Bad?

One issue underlying systems' conflicts involves implicit beliefs about the dangerousness of MIOs and whether they present a heightened degree of risk compared to other offenders. In this area, the data are improving and prompting a change in perspectives. In the early 1980's, Monahan and Steadman (1983), two highly respected forensic researchers, concluded after a massive review of over 200 studies that there was no correlation between mental illness and violence. This finding remained the conventional wisdom for nearly ten years. In the meantime, a number of more recent studies that Monahan (1993) describes as "vastly superior" (p. 288) found that there was indeed a significant, though modest, relationship between the two factors. Although it is true that the great majority of individuals with mental illness are not violent, Monahan concluded that "mental disorder may be a robust and significant factor for the occurrence of violence, when the disorder in question involves psychotic symptoms" (p. 288, emphasis added).

Multiple-Need Offenders

Another common finding with respect to MIOs is that they experience problems in many areas of their lives simultaneously, suggesting that mental health treatment will be only one component of an adequate response for these clients (Veysey, 1994). The co-occurrence of mental health and substance abuse problems has been long recognized. To that problem, we can add others relating to housing, education, and medical services. This general finding will obviously drive the design of appropriate and effective intervention programs, as I discuss in a later section of this chapter.

Profile of Current Delivery Systems

As with every other significant area touching MIOs, there is a paucity of information regarding the ways in which systems are organized to deliver services. One of the most in-depth analysis of this issue, performed by Keilitz and Roesch (1992), is purely conceptual and is based only slightly on information regarding actual programming. Despite these limitations, Keilitz and Roesch (1992) propose a framework that is useful in understanding service delivery systems and in designing service delivery models.

In the Keilitz-Roesch scheme, the provision of services to MIOs can be organized in one of four different ways:

The integrated model, in which forensic services are a sub- component of the criminal justice system and mental health professionals are employees of the court or corrections;

The coordinated model, in which a mental health unit is housed within a court or correctional entity and provides dedicated services; yet, its employees work for the mental health system to which they are ultimately answerable;

The independent model, in which an agreement or contract is executed between a mental health entity and the court or correctional system specifying the scope of services to be provided; and

The ad hoc model, in which the criminal justice system essentially "scrambles" for services by calling on the help of individual mental health practitioners in particular cases.

Although the Keilitz-Roesch study does not provide information on the prevalence of these various models, data presented elsewhere in this volume (see Fulton) are suggestive of their distribution. The most common providers of assessment services for MIOs were mental health agencies, of which only one-third had formal agreements. In only a small minority of cases were services provided by practitioners working for the court or correctional system. For assessment purposes, private practitioners were used in about one-quarter of the systems surveyed, although they played a greater role in the provision of treatment services after assessment.

The following are existing programs that exemplify the types described by Keilitz and Roesch, although these examples are drawn from other studies.

1. An integrated model. The Maricopa County, Arizona Probation Department operates a "Transitional Living Center (TLC)," which is a residential program for probationers with mental illness. TLC provides residential services for a sixty-day period, during which the offenders are stabilized and a community placement is sought. The program is a bridge to independent living and provides clients with medical and psychiatric evaluations, treatment, and casework services, which help them to acquire financial benefits and to locate permanent residences (Mickel, 1994).

2. A coordinated model. The Massachusetts Department of Mental Health houses the Division of Forensics Mental Health Services, which provides court clinic services to 87 court locations throughout the state. Employing a group of psychiatrists, psychologists, and social workers who have passed a forensic qualifying exam, these staff occupy office space within court buildings, respond to the court's need for forensic evaluations (e.g., competency or criminal responsibility exams), and play a limited role in treatment and crisis intervention. Massachusetts has had such a court clinic system since the mid-1950s and its employees have always been under the control and supervision of the state Department of Mental Health (Fersch, 1995).

   Keilitz and Roesch reported that "court clinics represent the most prevalent mechanism by which courts avail themselves of the services of mental health professionals" (p. 13); they added that little is known about how they are organized or about the mix of public vs. private practitioners involved in these clinics.

3. An independent model. Wisconsin Correctional Services, a private, nonprofit agency located in Milwaukee, operates the Community Support Program (CSP), under contract with the local court and correctional system to provide a host of services to MIOs in the community. Standard services include medical and therapeutic interventions, financial assistance, housing referrals, and daily monitoring (Weber, 1994).

CSP services about 250 clients at any one time and receives its referrals from the court as well as the probation systems at both the pretrial and post-disposition stages. Participation in CSP can be a condition of release awaiting trial or a condition of probation supervision. Evaluative data are not yet available on CSP but preliminary findings suggest that only a small number of referrals to CSP are discharged due to subsequent offenses or violations of release terms (Weber, 1994).

Characteristics of Effective Models

As I mentioned earlier, solid evaluations on the impact or quality of services provided to MIOs are scarce. If we held the available information to the highest tests of empirical soundness, we would have precious little to go on. We are left mainly with "reports from the field" and it is from these sources that we must mainly draw our clues regarding what is working. In doing so, the importance of three issues comes to the fore: jointly sponsored or operated programs, the need for boundary spanners, and the importance of specialized supervision.

Joint Programs

In her review of services available to MIOs, Veysey (1994) concludes that "some of the most comprehensive and promising programs for probationers with mental illnesses are those sponsored and developed jointly by community mental health and probation agencies" (p. 6). In the absence of collaboration, barriers between the mental health and criminal justice systems guarantee higher rates of refusal to accept MIOs into treatment or higher rates of failure in treatment. When both sides to the bargain have not negotiated and do not agree on the terms of client acceptance, the desired course of treatment, the appropriate response to client recalcitrance, or their own respective roles and responsibilities, then frustration will ensue, clients will not be properly served, and client failure on probation is increased (Wilson, 1978).

Clear, Byrne, and Dvoskin (1993) reached similar conclusions in their study of discharge planning for MIOs. Where parole officers relied on an ad hoc model in brokering services for clients one at a time, the undeveloped arrangement between parole officers and treatment providers seemed to confound their working relationship (each side having blind spots regarding the other's role and responsibilities) and to compromise offenders' abilities to participate successfully in treatment as they got caught in a quagmire of ambiguous, conflicting, or unarticulated expectations. Where brokerage is the main model for the provision of services, Clear and O'Leary (1983) have found a high rate of technical violations.

On the other hand, Clear et al. (1993) point out that services based on agreements between both parties are not only more appropriate for clients but also ensure that the "management" of cases goes more smoothly. The mutual education that is a prerequisite to forging an agreement results in a clearer understanding of the goals and limitations of both parties.

Boundary Spanners

As a result of his research and consulting experience, Steadman (1992) concluded that a key factor associated with effective forensic programming is the concept of "boundary spanners," which is adopted from the organizational development literature. Wherever he was impressed with the level of services being provided to MIOs, Steadman discovered a "core position that directly managed the interactions between correctional, mental health, and judicial staff" (p. 26). This position called for its occupant to "massage" relationships among the correctional, mental health, and court systems, to have the respect of these three groups, and to possess sufficient expertise to "crosswalk' and resolve conflicts among the systems.

Steadman concluded that the concept of "boundary spanners" best described these key positions. Boundary spanners occupy positions that "link two or more systems whose goals and expectations are likely to be at least partially conflicting" (Miles, 1980, p. 62). As an illustration of how such a position can work effectively, Steadman (1992) highlights the jail diversion program of Multnomah County in Portland, Oregon. The jail and local prosecutor staffs had been frustrated at their inability to divert MIOs effectively through early identification and placement for services. Although both sides had worked on it, turf issues and organizational prerogatives seemed to impede agreements. Officials from the jail and prosecutor's office agreed to hire and pay for a diversion coordinator who is a social worker trained in the treatment and diagnosis of mental illness and responsible for identifying MIOs in jail who are appropriate for diversion. This person also develops community supervision and treatment plans for the prosecutor and the court. The program succeeded, it was thought, because the coordinator was not a jail, mental health, or court employee, yet understood the constraints on all parts of the system without being "so intimated as to be unable to overcome them" (p. 81).

In their article on services for parolees with serious mental illness, Dvoskin, McCormick, and Cox (1994) also emphasized the importance of boundary spanners. They enumerated nine core principles of effective programming, one of which involves the establishment of a boundary spanner position consistent with Steadman's notion. Furthermore, Dvoskin et al. asserted that all agency representatives who must cooperate with other agencies should take on the qualities of a spanner by developing "familiarity, skill, and credibility" in both systems (p. 17) and by promoting regular communication among participating agencies through the convening of periodic meetings and other coordinating activities.

Specialized Supervision

In his contribution to this volume, Clear recommends specialized caseloads as one of five main principles for dealing with MIOs. Clear rests his case on two major considerations: first, such cases are complex, involving detailed knowledge of diagnostic categories and treatment modalities and, second, understanding the systems that serve such cases and the professional standards governing those who work within them is crucial to effective casework.

Clear, Byrne, and Dvoskin (1993) cite studies suggesting that, for demanding clients of any type, case specialization has generally been found to be more effective than a generalist approach. They caution systems considering specialization to be on the alert for burnout among specialists, wherein the stresses of dealing with a heavy concentration of difficult cases can overwhelm an office dedicated to dealing with such clients.

The Need for Reengineering

> Reengineering is the fundamental rethinking and radical redesign of business processes to bring about dramatic improvements in performance
> -M. Hammer in The Reengineering Revolution, 1995, p. 3.

Einstein is reputed to have said that the definition of insanity was doing things the same old way but expecting different results. If better delivery of services to MIOs is to be achieved, the principal parties involved in this effort must be willing to rethink current arrangements and to be open to a significant restructuring of the systems now in place. Instead of defining the problems in terms of "who" (the offenders eligible for services) or "what" (the assessment techniques and treatment modalities to be provided) the emphasis should be placed on the "how" question, which

invites attention to the existing structures, processes, and systems for service delivery. This is what the Total Quality Management revolution would have us do and it would, as Einstein suggested, be the sanest approach.

But what would such a reengineering agenda focus on? Keeping in mind the previous discussion, three major areas should be considered. The first involves the issue of the locus of services. Should programs for MIOs be the principal responsibility of corrections, mental health, or a hybrid? The second involves what could be called "boundary management," which is essential irrespective of the service site. The third involves specialized supervision within corrections and the role it plays in improving services.

Who's Responsible for Services?

Information on existing delivery systems indicates that a variety of models exist, although they can be classified into a few basic types. It appears that no comparative evaluation research has been done on these models, which significantly hampers the task of recommending a preferred approach. Without denying the urgent need for data, some general observations and recommendations can be made.

Neither a corrections-based or mental health-based program for servicing MIOs has an inherent advantage over the other as an ideal system. As Nelson and Berger (1988) have suggested, placing the locus of responsibility with corrections may have the advantage of more stability in resources, given the expansion in prison budgets over the last decade. It may also mean that utilization rates are higher and communication pathways are more open due to a sense of "ownership" of the program. Countering these advantages, in my view, would be the considerable professional isolation for staff that would come from running what would inevitably be a small unit in a "foreign" organization as well as the tendency to accent security and prison-system needs in decision making at the expense of good clinical and therapeutic judgment.

Situating the services at a mental health agency offers professional advantages to the staff involved, as they could easily network and consult with a range of colleagues. It would also insure the integrity of the clinical process, as the milieu in which judgments would be reached is dominated by mental health and not by corrections. As Nelson and Berger (1988) also suggested, a mental health agency is likely to be more successful in recruiting qualified staff, who would view such an agency as a more hospitable place to work, professionally speaking, than a probation or parole agency.

A further advantage of situating services at a mental health agency relates to economies of scale. All of the collateral responsibilities such as record keeping, fiscal management, and staff training, are much more efficiently and economically managed when staff are part of a larger agency with an administrative support system that can handle these responsibilities. In addition, when services for MIOs are housed in a community health agency, fewer cases will require expensive and difficult to arrange outside consultations because of the greater variety of staff and the wider expertise available in the typical multiservice mental health center. Finally, in an era when all government entities are looking to deliver services in the most flexible and least expensive manner, an interagency agreement or contract that focuses on billing for specific services allows for quicker expansion when demand is up and cost savings when demand is low, as opposed to a system that involves the hiring of government employees with all the attendant rigidities in downsizing or adding temporary staff.

On balance, the advantage seems to rest with a mental health-based system for servicing MIOs. However, there are both exemplary corrections-based programs (see TLC in Maricopa,

above) and serious problems with mental health-based programs, as indicated by widespread complaints about the difficulty in accessing services. What seems even more important than where services are located is how the relationship between corrections and mental health professionals is managed.

The Importance of Boundary Management

The term "boundary management" is imported from clinical psychology and given a new twist. I am not talking about the manner in which therapists must maintain an appropriate and professional relationship with their patients but rather about the critical need for the systems and units involved with servicing MIOs to keep as much of an eye on their working relationships and interactions as they do on their clients. It calls for all parities to become reflective practitioners (Schon, 1983) with the capacity to go "meta" in their day-to-day interactions with their counterparts in the allied domain. This task, it must be said, is equally as urgent whether the model employed is based in corrections or mental health. In one instance, we are concerned with inter-agency and, in the other, with inn-a-agency coordination.

For reasons I enumerated earlier, all systems of any significant size must consider the creation of a "boundary spanner" position. In this area, putting aside traditional thinking in government is urgently needed but probably very difficult to achieve. Government agencies are not accustomed to creating or funding positions that are charged with facilitating the working relationships between them and those entities with whom they commonly interact. Yet, as we have seen, such positions do exist and, by many accounts, are an essential ingredient for quantum improvements in services. It is the government's fixation with issues of direct service that may make prioritizing the "process" issues difficult, but it is a necessary first step.

In addition to creating boundary spanner positions, or in lieu of it if such a step is not possible, are the multiple initiatives that could solidify and improve the working relationships between correctional and mental health professionals. Casey (1993) and her colleagues at the National Center for State Courts hosted a seminar in the early 1990's involving justice system and mental health practitioners who were called "to discuss strategies for improving interactions between these two systems" (1993, p. 108). The seminar participants agreed on the importance of some key issues: the need to formalize cooperative agreements between the two systems and the necessity for periodically updating that agreement so that ineffective procedures do not become entrenched over time due to a failure to review them. The participants also accented the need for interdisciplinary training and "cross-system participation" to lessen the mutual ignorance that develops over time and corrodes or impedes collaboration.

In this last connection, an interesting observation was offered. Under the principle of "you can't fix what you don't understand," it was believed that few of the practitioners charged with responsibility for MIOs understood much beyond their own specific roles. This unnecessary myopia worked against trouble-shooting difficult cases or appreciating the difficulties and constraints that often impinge on the other side (Casey et al., 1992).

In fostering good boundary management, some of the best ideas may also be the simplest. Dvoskin and Steadman (1993) discuss the importance of periodic meetings between criminal justice and mental health practitioners involved with MIOs. Since its inception, the court clinic system in Massachusetts has sponsored such meetings regularly, and they serve two vital purposes. The meetings are usually built around a particular problematic case and, at one level, they serve the purpose of working through specific cases difficulties. At a second, and perhaps more important level, the meetings educate all parties on the workings of each other's systems, the pressures the participants feel on each side, the algorithms for decision-making that each has

adopted, and the professional limits each side must face. These meetings have resulted in greater mutual understanding and smoother coordination in future cases (Fersch, 1995). Regular and informal communication truly appears to be the life blood of effective boundary management.

Need For Specialized Supervision

The trend toward specialization that has become endemic to most professions has largely eluded corrections. In medicine, for example, the last twenty to thirty years has witnessed a near total conversion from a generalist to a specialist model (Thomas, 1983). While the parallel with corrections is far from total, it is nonetheless striking that the generalist model still prevails in corrections. For example, the APPA national survey of services for MIOs reports that only 25% of responding systems have adopted a specialist approach (Boone, 1995).

Organizational needs for smooth case assignment procedures and equitable workloads may militate against specialization (Clear, Byrne, & Dvoskin, 1993), Nonetheless, the failure to specialize, particularly in midsize and larger agencies where specialization is feasible, can only work against improving services for MIOs. Probation and parole officers simply cannot be expected to attain the necessary working knowledge of mental health theory and practice if they are preoccupied with a variety of other problem cases. These common deficits make good casework much more difficult and strain the working relationship with mental health providers.

One practical benefit of case specialization is financial- no small benefit in an era of diminishing resources. Probation and parole officers with specialized caseloads would be capable of the kind of threshold assessments that could identify offenders requiring further evaluations by mental health practitioners, which are more elaborate and hence more expensive. In the absence of the kind of cross-training that would equip officers with the ability to do prescreenings, the cost of a more broad-based evaluation procedure would almost certainly cut into the monies available to treat MIOs. Research indicates that correctional personnel are capable, once trained, of performing screening functions in this manner (Ogloff, Roesch, & Hart, 1993).

Specialization makes sense. Here again, however, the "reengineering" of case assignments and workloads, which are required to make specialization work, may go against the grain of traditional arrangements and managerial ease. But breakthroughs in practice may require nothing less.

Making a Habit of Evaluation

One symptom of the public agency tendency to focus on micro issues (clients and services) as opposed to macro issues (structures and processes)-the habit of seeing all trees and no forest-is the nearly complete neglect of provisions for evaluation. As has been often said, too much focus gets put on doing the right things instead of doing things right. All commentators on the subject of responding to MIOs would seem to agree with the conclusion of Wheller and Whitcomb (1977) that we have "woefully inadequate empirical information" (p. 19).

In an era of increasingly sophisticated, computer-driven management information systems, we do not lack the wherewithal to establish workable evaluation protocols. The right questions are easy enough to develop and, in a recent and related publication, Clear et al. (1993) propose an ambitious research agenda that could be adapted to the present topic.

Because most agency administrators do not conceive of their organizations as entities that require built-in feedback loops to succeed and because demonstrated effectiveness and future

support in the public sector are not always directly related, the will to take evaluation seriously does not always exist. We are instead in thrall to what Finckenauer (1982) has referred to as "doism," a philosophy of practice that puts a premium on ambitious, innovative, and fashionable programs without regard to existing knowledge about their likely impact or the need to establish formative evaluations so that progress toward desired goals can be tracked. For these reasons, of all of the suggestions for reengineering, building a credible system for the evaluation of practice may be the most difficult to achieve.

Staving the Course

Administrators and other concerned professionals who undertake the reform of existing systems toward the goal of improving services to MIOs may well be daunted by the task in front of them. Bureaucracies resist change-the bigger the change, the bigger the expected resistance.

Broad backs and strong hearts are called for. All would-be reformers might also consider the advice of Weick (1984), who recommends a philosophy of "small wins" as a prudent strategy in addressing social problems. Instead of looking for major structural change all at once, which Weick says would drive away potential supporters and prove self-defeating for being too ambitious, he recommends embarking on a course of steady but modest incremental change that could build momentum, garner support, and make reformers more willing to keep investing the necessary time and energy:

> Once a small win has been accomplished, forces are set in motion that favor another small win. When a solution is put in place, the next solvable problem often becomes more visible. This occurs because new allies bring new solutions with them and old opponents change their habits. Additional resources also flow toward winners, which means that slightly larger wins can be attempted (p. 43).

For those committed to improving the lot of MIOs and possessing the courage and persistence to address the comparatively mundane issues of structures and processes, real reform and reengineering can meaningfully take place one step at a time.

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CHAPTER 9

From Territoriality to Collaboration:

A Multisystems Response to Offenders

with Mental Illness

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> Prior to the twentieth century, persons suffering from mental illness were thought to be "alienated," not only from the rest of society but from their own true natures. Those experts who studied mental pathologies were therefore known as alienists.
> -Caleb Cat-r, The Alienist (1994)

As we move into the 21st century, the practitioners, family members, and administrators who play a role in the lives of offenders with mental illness remain "alienists" to the community. "Why spend time and resources with these violent, bizarre individuals? Lock them up! If not in prison, then in state hospitals. Get them off the streets and out of my sight." It is not difficult to understand this attitude. The study of mental illness is an inexact science. Although we are learning more and more about brain chemistry, this research is still in its infancy. Moreover, the community is not interested in science but in crime on-the-streets, especially if the individuals free to commit the crimes are regarded as different or unpredictable.

Despite America's reactionary posture toward crime and punishment, people are slowly beginning to work together to change the multisystems that have contact with the mentally ill. Much of the impetus to bring the mental health and criminal justice systems together came from local jail and corrections staff. As the mentally ill leave jail, prison, or work release, they have to go somewhere: they need a home, medication, and supportive services to help them to "make it on the streets" and to avoid a return to the criminal justice system. Regrettably, resources for the mentally ill are limited particularly for persons with mental illness who have been convicted of a felony. Yet the societal cost of ignoring the needs of the mentally ill in the community will continue to increase. In this age of shrinking service dollars, we cannot afford to have the systems that touch the lives of offenders with mental illness working in isolation from one another or being territorial. Territoriality, is surely an inefficient use of resources.

Professionals in mental health, corrections, and related fields are just beginning to form coalitions to identify barriers to providing care for the mentally ill in the community. Relying on the experience and wisdom of those who are making these valiant attempts, this chapter explores how the many needs of offenders with mental illness require a multisystem response; why interagency efforts are now beginning to occur; how to plan a collaborative process; how the model of a policy design academy can be used to bring systems together; and lastly, accomplishments in Texas, Wisconsin, and British Columbia that serve as "models for success."

The Multisystem Needs of Offenders with Mental Illness

Research on the supervision of offenders with mental illness in the community is scarce. The little that has been written on the topic points to the need for a case management system that brings together the various agencies that serve the mentally ill in order to assure continuity of care and to reduce recidivism. Clear, Bryne, and Dvoskin (1993, p. 145) argue that to provide useful services to mentally ill correctional clients, " . . . there must be a point at which systems come together to benefit clients." It is rare, however, to find a merging of case management or planning for offenders with mental illness across service provider lines. Reasons for fragmentation among various agencies are outlined in Hightower and Eaves (1992, pp. 223-224). Although they focus on British Columbia, their description is apt for most jurisdictions in the United States:

> There are regional disparities, gaps in the systems, and often poor coordination between agencies. Yet these mentally disordered individuals move in and out of mental health and correctional

> facilities . . . [they] have multiple problems that cross the jurisdictions of many social service agencies, so no one agency is willing or even able to assume primary responsibility for their management.

Few clear guidelines exist on how agencies or systems can combine services. Community mental health agencies do not have staff trained in providing services for offenders with mental illness. Many of these individuals are chronically mentally ill and are substance abusers. Typically, they have severed ties to family and friends and they have serious legal problems. If we are able to access services at all for this problematic group, the services are generic (i.e., they work for the typical person with mental illness). But the needs of offenders with mental illness are beyond the response of the traditional case manager or probation officer. "As a result, multiproblem offenders released into the community are nearly always rehospitalized or reincarcerated" (Wilson & Buckley, 1992, pp. 225-226).

> They require continuous rather than episodic care . . . [They] need regular monitoring, especially when symptoms are absent or at a low ebb, to contain the individual and situational factors that may result in violence, rather than just treat symptoms. (Dvoskin & Steadman, 1994, p. 680)

The intensive case management model proposed by Dvoskin and Steadman (1994) focuses on a multisystem approach for managing offenders with mental illness on community correctional supervision. Monitoring must be frequent and ongoing, not only when illegal behaviors or symptoms are present. Case managers must have small caseloads and access to a comprehensive array of community services (i.e., mental health, medical, social services). The role of case managers is integrating these services through creative brokering; facilitating communication and cooperation among agencies; convening meetings with representatives of agencies to coordinate roles and services; and acting as an advocate for mentally ill clients. Support from community agencies in such a venture is formalized through interagency agreements or memoranda of understanding.

Probation/parole officers (PPOs) are a critical link in the intensive case management model. PPOs provide the structures, limits, and sanctions that increase compliance to treatment plans. PPOs are also important allies for clients with illness; they support offenders in their efforts to change the behavior that leads to future crime.

Why Interagency Collaboration Now?

In Reinventing: Government, Osborne and Gaebler (1992) maintain that the people who work in government do not create its inefficiency and waste; the systems in which they work are the problem. However, government has important functions: it is the mechanism to make policy decisions, to provide services that benefit people, and to solve collective problems. However, governments generally get bogged down in HOW THEY ACCOMPLISH THEIR GOALS, rather than WHAT THE GOALS ARE. Reinventing Government (Osborne & Gaebler, 1992, pp. xix-xxi) proposes that we look for new ways to interweave scarce public and private resources "to maximize productivity and effectiveness." Public, private, and voluntary (nonprofit) sectors must together seek opportunities that do not appear to exist when each looks only from within the confines of their own bureaucratic box. We must look outside the box.

Force Field Systems Change

The dilemma, then, is getting the systems to move from a territorial (i.e., "business as usual") approach to a collaborative, interagency course-of-action. Changing course is not an easy undertaking; not for an individual and certainly not for organizations. It may be helpful to look at multisystem interplay as a force field. In his force field analysis, Lewin (195 1) describes how driving and restraining forces determine whether a condition's status will remain stagnant or change. When the condition is a problem, there are forces that facilitate or inhibit a solution. As long as the facilitating and restraining forces are of equal strength and direction, the problem will remain a problem. Solutions will be impossible. The status quo prevails and the force field is frozen. Change only occurs when the competing forces are unequal. The strength of the inequity determines the direction and degree of change.

Various methods may be used to overcome a frozen force field. For example, the strength of intensifying forces can be increased. A restraining force can change direction or be diverted so its energy is placed elsewhere. Additional driving forces can be marshaled to attack the problem. The problem can be restated to extinguish or weaken restraining forces.

When entrenched problems or lack of communication exist among service providers for the mentally ill, agents of change are needed to unfreeze or unbalance the relationship between the driving (e.g., advocates for mentally ill offenders) and restraining forces (e.g., agency territoriality). Senge (1990, p. 15) describes how organizations and systems "learn" or explore new opportunities for growth and change. He also describes how "small, well-focused actions can produce significant, enduring improvements if they are in the right place," that is, a place of high leverage. In the force field analogy, whether that action is small, but well placed, or on a grand scale, it can impact the interplay among mental health, corrections, and the other systems that touch the lives of the mentally ill. The 21st century alienists are involved in a movement nationally and internationally to attack systems' territoriality and thaw the frozen force fields. I describe examples of well-focused actions that have produced significant, enduring results in system's integration for offenders with mental illness.

CAMIO (Community Action for the Mentally Ill Offender)

In July 1986, I was program director for Lincoln Park Work Release, a 30-bed Department of Corrections facility for offenders with mental illness in the state of Washington (WA). Both myself and my colleague, Susan Rotenberg, who was a psychiatric social worker for the Special Offender Center, a WA prison housing the seriously mentally ill, were having difficulty in helping these individuals make a successful transition to the community when they completed their incarceration. Although Lincoln Park provided treatment, skills training, medication monitoring, and day treatment for the mentally ill in residence there, our hands were tied when it came to discharging offenders. Congregate care facilities, group homes, and local apartment complexes would not accept releasees because of their dual label of "mentally ill" and "offender." Local community mental health centers were deluged with referrals and convicted felons were low on their priority lists. Susan was experiencing the same difficulties with prison discharge planning.

As a consequence, offenders with mental illness were spending more and more time in prison and work release, not because of their criminal behavior but because they were mentally ill. Susan and I agreed this was an unfair and intolerable situation. Through a series of forums and brown bag lunches, we brought together professionals working in the fields of corrections and mental health in WA to identify barriers in providing continuity of care for persons with mental illness who were in the criminal justice system. We enlisted family members, consumers, and

other concerned citizens. By mid-1987, CAMIO was formed and incorporated as a nonprofit organization.

CAMIO's membership grew and we began communicating with the directors of the Department of Corrections and the Department of Social and Health Services in WA. Jail corrections administrators and staff began meeting with state corrections personnel; cross-training workshops were held around the state to inform case managers, jail staff, and community corrections officers about one another's systems and issues surrounding the mentally ill. CAMIO also sponsored legislation in 1992 to allow judges to sentence to community supervision prison-bound, nonviolent individuals with mental illness who were convicted of a felony. The legislation proposed that these individuals would be monitored by a multidisciplinary case management supervision team. Although this bill failed to pass, legislative hearings enlightened lawmakers to the plight of the mentally ill caught in the revolving door of the criminal justice system.

Systems change is a slow process, but progress has been made since 1986. Agency collaboration is still growing in WA, and advocacy groups, such as CAMIO and Washington Alliance for the Mentally Ill (WAMI), continue to work to unfreeze the force field that maintains closed systems.

How do We Get to Systems Collaboration?

One model of interagency collaboration, proposed by Osborne and Gaebler (1992), is the steering organization, which sets policy, cuts across agency/system boundaries, and monitors program performance and cost. Generally, it does not deliver services or "do the rowing." Rather, the steering body focuses on the destination and ensures that the right course is being maintained to arrive at the goal. The steering organization identifies problems, provides comprehensive solutions, and attacks the root of the problem, using a multisystem approach. The various stakeholders are brought together in a policy development process, which guarantees that a broad rather than a parochial perspective is brought to bear on a problem. The players are hooked into the process, and are motivated to action and success. They decide who will implement a program or deliver a service by assessing ability rather than by referring to an agency's stated role definition. By assigning tasks beyond agency boundaries, the steering organization can be more effective, not only in setting goals, but in accomplishing them.

Systems Collaboration: Factors Influencing Success

Mattessich and Monsey (1992) identify six factors that enhance the success of any steering organization involved in a collaborative process. The first is environment: Does a history of collaboration or cooperation exist in the community? Is the collaborative group seen as a leader in the community? Is the political/social climate favorable?

The second is membershin characteristics: Is there mutual respect, understanding and trust among members? Is there an appropriate cross section of members? Do members see collaboration as being in their own self-interest? Is there an ability to compromise and reach consensus?

The third is process structure: Do members share ownership in both process and outcome? Are there multiple levels of decision making that allow line, middle, and upper level staff participation? Is the group open to different ways of organizing itself and accomplishing its work? Do members clearly understand their roles, rights, and how to carry out their responsibilities? Can the group sustain itself and adapt to changing conditions?

The fourth is communication: Is there open and frequent communication? Have informal and formal communication links been established?

The fifth is purpose: Are goals, and objectives clear, concrete, and attainable? Is there a shared vision that has been collaboratively developed? Is the purpose of the group unique from those of the member organizations?

The final factor is resources: Does the group have an adequate, consistent financial base? Does the convener of the group have the legitimization and respect from its members?

Membership for Corrections-Mental Health Collaboration

Who should be included in a steering organization with the goal of establishing continuity of care for individuals with mental illness caught up in the criminal justice system (Davidson, 1991)? It should consist of corrections professionals from law enforcement, jails, prisons, and community correction agencies who have direct contact with the mentally ill, deliver services to them, and have to deal with safety and liability issues relating to their care. It should also involve mental health professionals and service providers from mental health centers, hospitals, and residential programs. These professionals also have direct contact with and provide direct treatment to the mentally ill, and they are knowledgeable about interventions that work. In addition, substance abuse treatment providers must be an integral part of such a collaborative group because many mentally ill are also drug or alcohol abusers. Families have to be involved. They provide firsthand examples of living with the mentally ill and trying to access services in the bureaucratic morass of the mental health system. In addition, they can exert a tremendous influence on legislators and share a common experience that these professionals often fail to recognize.

Administrators of agencies represented in the steering organization must be brought into the entire collaborative process; without their commitment and leadership, change is unlikely. Legislators and public officials at the local and state levels should also be included. They are change agents who affect funding, appropriations, and legislation. Advocacy groups offer passion, energy, and commitment, and often a fearlessness that agency professionals do not exhibit. Universities, especially representatives from schools of social work, psychiatry, and criminal justice, should be brought into this effort. Their ability to access and conduct research can be critical. Likewise, they can play a role as facilitators or consultants to the group. Professional organizations, such as the National Council on Crime and Delinquency, the American Corrections Association, the American Probation and Parole Association, the American Psychiatric Association, and other similar associations are important to include. They can provide grants and forums and can muster support from their membership.

Often forgotten are the consumers of services from the mental health and corrections systems. Who else knows so intimately what it is like to be a multiservice user in a fragmented service delivery system? We must include victims and victim groups. Their viewpoint gives us a critical perspective. They are also a political influence that evokes public emotions and shapes public policy. The wisdom of the adage, “it takes a community to raise a child” must not be ignored when selecting members of a collaborative group. Churches, schools, and neighborhoods should be represented. Sharing the problem shares the resources.

Getting the Steering Organization Players “Hooked”

In some instances, the first meeting of the steering organization may also be the first time the players have sat around a common table. They arrive bearing the standard of their agency. How, then, can a group identity emerge with a sharp focus on a common, boundary-free vision?

It is desirable to have a neutral, highly-regarded facilitator in the first set of meetings to move the group through a process of discussion and understanding. We must begin by removing barriers and rules that have impeded collaboration in the past. In dealing with offenders with mental illness, confidentiality of information is often one such "rule." How can different entities share necessary information and yet protect the confidentiality rights of individuals? One solution is to start with the premise that the treatment of the individual is primary and then establish protocols for how to disseminate information among the entities of the multisystem collaboration group.

Another important step is to provide seed money or to mix agency pots of money. In addition, the individuals involved in the steering or collaboration group as well as the practitioners from the different disciplines must be crosstrained. Our systems are so bureaucratic, complex, and jargon-ridden that joint training sessions are the only way to simplify and integrate various systems. As the members of the steering organization gain an understanding of one another's systems, communication becomes clearer. They may begin sharing information about techniques or programs that are successful with offenders with mental illness (e.g., defusing techniques that PPOs use with their caseloads can similarly be used by mental health case managers). The members may begin to realize that there are problems common to the various systems. Problem solving becomes more creative and comprehensive when the members of the steering organization bring their unique perspectives into the process.

Ultimately, the individuals in the organization create a new identity and a shared vision by working together with a common purpose. The image of the desired reality becomes "more intense, more lifelike. When more people come to share a vision, the vision becomes more real in the sense of a mental reality that people can truly imagine achieving" (Senge, 1990, p. 13). Being cocreators of a vision not only forges a group identity but shares the responsibility of change. Old turf diminishes as the group moves toward coherency. Boundaries become fuzzy or they shift and expand. The mission of the group becomes the focal point rather than the mission of each agency (Osborne & Gaebler, 1992). Even differing philosophies (corrections versus mental health) move toward compatibility (Bryne, Clear, & Dvoskin, 1993).

Systems Collaboration at Work: Policy Design Academy

The National Coalition for Mental and Substance Abuse Health Care in the Justice System has, in the past five years, been instrumental in bringing together national and state decision makers, academia, and family members to focus on continuity of care for offenders with mental illness. With its coordination, two state policy design academies have been held. Here, governor-designated administrators or influential delegates from different disciplines (mental health, substance abuse, corrections, jails, families, consumers, elected officials, law enforcement) meet as state teams. Each team works through a process to develop a statewide policy plan to address system integration in the delivery of services to adult and juveniles with mental disorders who are caught up in the criminal justice system.

The policy design process is a modified version of a process developed by the Council of Governor's Policy Design Advisors (National Coalition for Mental and Substance Abuse Health Care in the Justice System, 1995). The purpose of the policy design academy is to develop and implement specific, strategic plans for change in the statewide systems that serve the mentally ill, including those with substance abuse problems, in the justice system. The design process is intended to build commitment across public and private sectors to implement the systemic changes necessary to improve mental health outcomes.

The policy design academy is conducted in several steps: First, each state team meets locally to outline the problems identified in their state. Second, the state teams are brought together

in an intensive, three-day academy to produce a draft of their vision, a statement of outcomes, and policy goals. Third, back in their home state, the team meets to expand membership and to refine the policy document. Technical assistance is provided in the refining process. Fourth, at a second, three-day academy, the state teams reconvene to develop a legislative agenda, a financing strategy, a plan to build public support for the policy and an evaluation plan to measure the impact of the policy. Fifth, the states finalize the policy document and begin implementing the strategic actions.

The primary goal of the academy is to create a cohesive interagency team with a shared vision of change and the authority and ability to make those changes. Each team acts as a steering organization to bring about systems' integration. So far, a total of eleven states and the Navajo Nation have participated in this effort. Not only have the academies affected the states involved, but they have raised the concept of interagency collaboration to a higher level than it has reached in the past, especially within the disciplines of mental health and corrections.

Washington State Policy Desk Team

In the 1992 WA legislative session, a bill was passed obliging the Department of Corrections and the University of Washington to enter into a collaborative relationship in planning, designing, and implementing a new prison wing that would house offenders with serious mental disorders. In introducing such a bill, there was concern from CAMIO and others that this wing would be a magnet for the mentally ill. With such well-planned treatment and research, and with trained staff, it would become a highly attractive sentencing option. Lacking similar community-based treatment options, judges would sentence individuals with mental illness to prison rather than to community supervision. Responding to this concern, the legislation also required the formation of an advisory group to identify and address the issues affecting offenders with mental illness in the community.

Under the leadership of the Department of Corrections and the University of Washington (DOC-UW), the DOC-UW Collaboration Advisory Committee was formed in 1993. Membership consisted of representatives from law enforcement, jails, prisons, and community corrections; state/local elected officials; mental health; substance abuse; courts and prosecutors; families and advocacy groups; and the WA Council on Crime and Delinquency. This committee identified three focal points (FRONT DOOR, PRISON, AND BACK DOOR) for adults and juveniles who are mentally ill and in contact with the criminal justice system. The FRONT DOOR focused on the mentally ill in the community who move in and out of jail but have not been sentenced to prison. PRISON focused primarily on the design of the new mental health prison wing at McNeil Island Correctional Center. BACK DOOR focused on helping the mentally ill in prison make a successful transition to a community setting.

In 1994, WA was selected as one of the states to participate in the State Policy Design Academy conducted by the National Coalition for Mental and Substance Abuse Health Care in the Justice System. A Governor-appointed team met to participate with the other selected states in the academies in August 1994 and February 1995; their purpose was to develop a strategic plan. A vision statement was articulated, proposed outcomes and barriers were identified, and strategies were developed.

In the spring of 1995, three cross-training symposia entitled, "Creating a Seamless System," were held in different areas in WA. The concept of the forums grew out of the strategies developed by the State Policy Design Team. They focused on improving cross-agency collaboration, especially relating to diversion and transition programs for offenders with mental illness. As part of the symposia, county teams of service providers met to identify local problems, to create action plans to make the best use of resources, to increase public safety, and to improve

the treatment of people who are mentally ill, chemically dependent, and involved in the justice system. These interdisciplinary county teams continue meeting across the state to refine and implement the planning that began at the symposia.

The collaborative process in WA is an example of top-down leadership, in which the top administrators in the state developed the strategic plan. They then handed it to middle management and line staff for further development and the sharpening of details from a local perspective. The WA Policy Design Team continues to act as a steering organization providing leadership and follow-up consulting to counties with action plans that cut across the agencies' "seams" or boundaries.

Benefits. Barriers and Buy-In

In the spring of 1995, I surveyed the members of the Washington Policy Design Team to capture the unique perspectives of the individuals who were in the formative stage of the collaborative process. I focused on the benefits of intersystem collaboration, the barriers that impede the process, ways to overcome those barriers, and the reasons agencies and individuals are motivated to work together. What follows is an enumeration of their responses.

1. WHAT DO YOU SEE AS THE BENEFITS OF INTERSYSTEM COLLABORATION?

- Increased intersystem understanding and the development of mutual goals.
- Active exchange of ideas and viewpoints of people who normally never talk to one another. The decision-makers are talking and meeting, which promotes an "US" rather than a "WE VERSUS THEM" mentality.
- Integrated system to improve continuity of care, which reduces the level of misunderstanding about offenders with mental illness, provides better outcomes for them, decreases costs to the government, and increases public safety.
- Clearly articulated issues that get on policy makers' agenda.

2. WHAT BARRIERS IMPEDE THE COLLABORATIVE PROCESS AND PREVENT SUCCESSFUL OUTCOMES?

- Bureaucratic inertia and agency provincialism prevent a system-wide vision.
- Anxiety associated with change; an aversion to taking risks.
- Fragmentation of responsibilities for care and treatment across systems coupled with a lack of systemic coordination. The belief that someone else is doing the job.
- No history of working together.
- Philosophical differences between corrections and mental health.
- Categorical funding streams; when funding gets threatened, collaboration decreases.
- Shifting to a public policy that emphasizes incarceration.
- Confidentiality constraints.
- Inconsistent definitions of priority populations across service agencies.
- Staff resistance fed my misperceptions instead of facts about the other agencies.

3. WHAT COULD ASSIST IN OVERCOMING THOSE BARRIERS?

- Strong, consistent, risk-taking leadership.
- Flexible funding.
- A design team with a cross-systems membership.
- Opportunities that provide a system-wide perspective; cross training, forums, meetings to encourage communication.
- Co-located work areas for interagency gatekeepers.
- Cosponsored legislation in support of sentencing alternatives.
- Expanded, formalized multiagency agreements and memoranda of understanding.

4. WHAT IS YOUR AGENCY'S INTEREST OR MOTIVATION TO MAKE THE COLLABORATION SUCCEED?

- The local treatment system has identified decreased jail/ prison bed utilization for this population as a priority outcome.
- The department head of corrections has a strong belief in the goals of the collaboration but the goals are not valued at all levels; hence, a commitment to problem solving must continually be checked and clarified before action steps can be implemented.
- To participate in the provision of a seamless approach of service delivery to insure that needed services are provided in a coordinated, cost-efficient manner while addressing concerns about public safety.
- Once educated on how working together can better meet the needs of clients, motivation is high.

5. IF DIFFERENT FROM ABOVE, WHAT IS YOUR PERSONAL INTEREST IN ITS SUCCESS?

- I want to work to free the mentally ill from the confines of the ever-widening criminal justice net.
- This population must be treated with the same respect and dignity as the nonoffender population.
- I want to facilitate the process that maximizes successful post-prison community transition.
- I would like to see us take more chances, both within and outside the agency, and experiment to see what might get us over some of the historical hurdles in managing the mentally ill. Where costs are involved, it seems to take others of a like mind in order to get much accomplished.

Models of Success

In addition to the efforts I discussed earlier, there are other innovative linkages being formed nationally and internationally. A well-focused action is occurring in New Mexico, where the Alliance for the Mentally Ill of New Mexico (AMI-NM) has accepted an invitation from the

New Mexico Corrections Department to train approximately 200 state PPOs about probationers and parolees with mental illness. It is expected that the PPOs will be able to write better reports, conduct more effective interviews, and make more accurate referrals. Cross training will also improve communication among PPOs, mental health providers, clergy, and community members.

Other models of collaboration are noteworthy. Similar to WA, legislation mandated cooperation between departments of mental health and criminal justice in Texas. Other efforts, such as those in Wisconsin, have been initiated by private agencies responding to an existing need in the community. In British Columbia, Canada, government departments or ministries developed a proactive plan to increase services to offenders with mental illness. These model programs serve only a small proportion of such individuals in the community, and it may not be possible or desirable to duplicate these efforts in other areas. But they deserve attention, both for what they have achieved and for what they offer to others as ways to integrate corrections and the mental health system.

Texas Council on Offenders with Mental Impairments

The Texas Council on Offenders with Mental Impairments was created by the Texas Legislature in 1987 to spearhead a collaborative effort addressing the growing population of juvenile and adults in the criminal justice system with mental health problems, mental retardation, and developmental disabilities. A subsequent legislative session expanded that population to include the elderly, terminally ill, and physically handicapped.

The Council consists of agencies and organizations with an interest in offenders with special needs, including state agencies, private sector client advocacy groups, and governor-appointed members. Its membership has expertise in the care and treatment of multineed offenders. Subsequent legislation directed the Texas Department of Criminal Justice and a number of state and local health and human service agencies to enter into memoranda of understanding for the purpose of establishing agencies' responsibilities in developing a continuity of care system. The Council was the coordinating or steering body that monitored the intersystem activities and agreements. Among the directives to the Council were: to cooperate in coordinating the procedures of represented agencies for the smooth and orderly provision of services for offenders with special needs, and to monitor and coordinate the establishment of a continuity of care system for these offenders.

One of the Council's guiding principles, which shaped the development of continuity of care services is, "Interagency or interdisciplinary treatment is critical toward improving multiagency collaboration, communication and accountability of service systems and their response to the offender with special needs" (Texas Council on Offenders with Mental Impairments, 1995, p. 18). With that, several council-funded programs have been implemented across the state, exemplifing systems' collaboration. For example, Project ACTION provides client advocacy, referral, follow up, and continuity of services to offenders with mental illness in Harris County. Project CHANCE provides intensive case management services, including linkages with needed services and advocacy for offenders with mental retardation in Travis County. Both projects use flexible and targeted funding to ensure immediate service access; specialized probation and parole officers as active participants in treatment and decision making; and community coordination and collaboration.

Project RAPP (Rehabilitative Alternative for Persons on Probation/Parole) serves parolees and probationers with mental illness in Tarrant County. Here, interdisciplinary teams consist of a forensic specialist, a rehabilitation trainer, and a specialized parole officer, A nurse, a psychiatrist and a financial liaison also provide services to the team. Rather than being assigned to only one

case manager or parole officer, parolees with mental illness are assigned to a team and work with many staff members. The teams focus on assisting offenders to live independently in the community, to comply with the requirements of their parole, to gain independent living skills, and to work on specific problems such as substance abuse. A financial liaison assists clients in applying for social security and managing money. Project RAPP's approach uses the team members' collective skills and experience in addressing offenders' needs; reduces staff bum out and lowers staff turnover rates; ensures continuity of care during staff vacancies or vacations; shares the frustrations and successes of working with this challenging population; and decreases the risk that signs of potential problems affecting offenders' mental health or parole status will go unnoticed.

Milwaukees' Community Support Program

An innovative approach to managing offenders with mental illness in the community has been in operation in Milwaukee, Wisconsin since 1978. The Community Support Program (CSP) is a free-standing outpatient mental health program run by the Wisconsin Correctional Service (WCS), a not-for-profit organization. In the mid-1970s Milwaukee was experiencing the all-too-familiar downsizing of psychiatric hospital beds and inadequate community-based services for persons with mental illness who were arrested. Little, if any, discharge planning was occurring for these individuals. WCS had been screening individuals in the Milwaukee County Jail for possible substance abuse problems. But it found that an increasing number of persons, who also required monitoring of psychotropic medications, were in the jail. In response to this need, WCS began monitoring medication and providing case management services for the mentally ill, and it subsequently received funding from Milwaukee County to begin a forensic community support program (McDonald & Teitelbaum, 1994; Weber, 1994).

CSP operates out of a small clinic in a predominately residential neighborhood in Milwaukee. Serving a potential population of 250 clients, its staff is composed of nurses, a part-time psychiatrist, case managers, and financial, housing, and pharmacy staff. Program elements include medical therapeutic services, money management, housing and other support services, day reporting, and close monitoring. While enrolled in CSP, clients do not generally participate in other outpatient mental health programs or programs that provide similar support services. In CSP, multiservices for multineed clients are under one roof.

Referrals to CSP come from several sources. WCS's Court Intervention Program identifies individuals who could benefit from these services as a condition of pretrial release or as a structured option to incarceration for offenders convicted of municipal ordinance violations. Probation and parole officers can also refer offenders with mental illness to CSP, especially those in need of intensive supervision and mental health services. This option is useful in discharge planning for offenders being conditionally released from state institutions. The CSP and the probation and parole mental health unit have created a consistent set of rules and expectations for these clients and have provided a range of supportive services backed by firm legal authority.

Linkages to CSP have been closely developed with probation and parole staff who receive an orientation to CSP as part of their training in the specialized mental health unit. Monthly progress reports are submitted to PPOs and violations are reported immediately. A process for exchanging information is established as part of intake procedures for clients. Similar relationship building has occurred with funding sources and other local service agencies.

The program is widely accepted. CSP has reduced the number of county jail bed days used by this population. The cost per service slot is low, about $4,000 per year, which is one-quarter to one-third the cost of intensive outpatient treatment in the state and county mental health systems.

Perhaps as important, but less fiscally tangible, is the fact that CSP is providing a resource that would not likely exist otherwise. The time investment of PPOs has been reduced with the supportive services of CSP. Program staff also attend regular community meetings to respond to any neighborhood concerns or complaints. Likewise, there can be a prompt, personal response if clients are causing concerns in the community. WCS personnel feel that similar programs can be duplicated in other communities and administered by either private or governmental agencies.

The British Columbia Experience

In the middle decades of this century in the United States, the deinstitutionalization movement created a tragedy for the mentally ill. As Isaac and Armat (1992) point out vividly in Madness in the Streets, with the decline of hospital beds there was a dramatic increase in the number of homeless mentally ill and in the criminalization of the mentally ill. Lacking the structure of a hospital setting and with inadequate community mental health resources, mentally fill persons often decompensate; their disruptive behavior can result in arrest. Regrettably, in many communities, county jails have become mental health treatment facilities. Not by choice, but by necessity.

In an effort to avoid the pitfalls of the United States' experience with deinstitutionalization, British Columbia, Canada, embarked on a strategic plan after it began downsizing its psychiatric hospitals in the late 1970s (Tien & Goresky, 1992). The Mental Health Initiative, a multiagency/ ministerial effort, was completed in 1987. It reexamined the province's strategy for providing mental health services. An interministerial committee, the Committee on the Effects of Multi-Problem Persons on the Criminal Justice System, was established to monitor the implementation of the Mental Health Initiative.

The committee first surveyed persons with mental illness who had prior contacts with the criminal justice system. Each client's contact with corrections and with mental health and forensic hospitals was recorded. Results showed that of the 457 individuals identified, more than half had a severe mental disorder (e.g., schizophrenia). A significant number had more than one intake at a mental health center or psychiatric hospital and more than one contact with corrections. Many had been involved in serious offenses, such as assaults or break-ins; and many had alcohol or drug problems. The conclusion of the survey was that these individuals move across systems boundaries. Many who were in the community reoffend; and a number of them are incarcerated. Lack of community support seemed to accelerate their entry into the criminal justice system. The results pointed to the need for a cooperative solution. However, no clear protocols existed to guide interagency or interministerial transactions. Consequently, there was lack of coordination in providing services to these offenders. Two projects have been initiated to address these needs: the development of Mentally Disordered Offender (MDO) Protocols and the Interministerial Project (IMP).

Mentally Disordered Offender (MDO) Protocols. In 1992, a group designated by the ministries of the Attorney General, Solicitor General, Health, Social Service and Housing, and Labour developed guidelines and identified areas where protocols were needed to improve the coordination of treatment services for persons with mental disorders who are in conflict with the law (Hightower & Eaves, 1992). These guidelines clarified the roles and responsibilities of ministries and agencies, helped to identify mentally disordered persons and their needs, and assisted in formulating a consistent, efficient, coordinated, and humane province-wide response.

Points of contact or "key junctures," where mentally disordered persons pass and where critical decisions are made affecting their management, were identified. The MDO protocols address the policy considerations that influence each agency's decisions in order to make those

decisions more rational, fair, and considerate. Those key junctures are Investigation of Offense in the Community/Arrest; Coordination of Roles for a Public Interest Assessment; Being Held in Custody; First Court Appearance; Coordination of Community Case Management; Trial (Adjudication and Sentencing); Incarceration and Release Planning; and Community Supervision. A subsequent protocol on Consultation with Community Services is pending.

The protocols are based on certain assumptions (Report to Deputy Ministers, 1992). Local working groups in all areas of British Columbia would be established to develop specific regional and local interministry protocols. These protocols would detail the administrative and organizational arrangements that are required to provide services for accused persons with mental disorders or mental handicaps. Tasks necessary to operationalize the protocols would be identified and assigned. The tasks assumed by the interministry staff would be consistent with the expertise and strength of that ministry. The working group would also identify available community resources and consult with community agencies when they are involved with persons with mental disorders or handicaps.

The Interministerial Project. The Interministerial Project (IMP) was jointly developed in 1987 by the Forensic Psychiatric Services Commission, the British Columbia Corrections Branch, and the Greater Vancouver Mental Health Service. The IMP assists multiproblem individuals in the criminal justice system who have psychiatric, behavioral, or psychosocial problems. The project helps these individuals successfully reintegrate into the community (Wilson & Buckley, 1992). The goals of the IMP are to extend their length of time in the community and to improve their quality of life by preventing or reducing the number of rehospitalizations and reincarcerations. A byproduct is cost savings to the health and legal systems.

The IMP is located in downtown Vancouver, British Columbia, and operates out of a storefront office. Referrals come either from the probation officers at the Vancouver Probation Office or from a provincial correctional center. Staff consists of a project coordinator, social workers, and a probation officer. An assertive case management model is followed wherein case workers adopt a “hands-on” approach. They assist offenders whenever and wherever the need arises. This involves frequent contacts with clients, a long-term commitment to clients, a team approach and shared caseloads, a focus on preventing rehospitalizations and incarcerations, anticipation and prevention of life crises, home visits, and on-site interventions. The collaboration of corrections and mental health professionals in a supervision plan not only facilitates communication and cooperation among agencies but also draws upon the unique qualities and expertise of each system. When their efforts are combined, offenders with mental disorders receive the treatment and services they need to succeed.

Summary and Conclusions

Supervision and management of offenders with mental illness in a community setting creates dilemmas for PPOs and mental health case managers. As offenders, they present mental health issues beyond PPOs’ experience and training. As mental health clients, they present crime-related dynamics that case managers do not routinely handle. These offenders are frequently drug or alcohol abusers, which increases the complexity of their management and brings them into contact with substance abuse agencies. They are multineed persons who interact with various agencies and systems. Managing them effectively, calls for an interagency response.

An example of such an interagency response is intensive case management (Dvoskin & Steadman, 1994). This model not only brings together PPOs and mental health case managers but also integrates services and communication among other agencies. A primary advantage of involving PPOs in an interdisciplinary supervision and treatment plan lies in their authority role.

One of the problems in treating the chronically mentally ill is persuading them to accept medication and other treatment services. The PPOs' role as enforcer of court and parole board conditions of release motivates offenders with mental illness to comply with medication and treatment regimens. This is especially effective when PPOs and case managers are in a supportive relationship and have agreed on strategies to manage their clients.

However, even when practitioners in service agencies agree that system's integration is a desirable goal, it is not an easy task to accomplish. Years of working in isolation and within the policy framework of one's own agency has created system territoriality. Shrinking state's budgets have made agencies compete for funding and often placed them in adversarial roles. No longer can we afford territoriality, which generally leads to an inefficient and redundant use of resources. It is neither cost effective nor responsible state policy to have case managers from probation and parole, mental health, substance abuse, and institution corrections (i.e., jails and prisons), each working independently with an individual who is mentally ill. To combat agency isolationism, it is important that the administrators of mental health and corrections focus on common goals rather than just their own respective systems.

The steering organization is offered as a means to break out of the frozen status quo and move towards collaboration among systems. The state policy design process is one model that states or other interdisciplinary groups can use to arrive at mutual goals and strategies. Examples of what is working effectively in a number of communities are available. As Isaac and Armat (1992, pp. 309,331) conclude, merely adding more community programs for the mentally ill will not address their needs:

> Seriously mentally ill people cannot be expected to negotiate a bureaucratic maze to obtain unconnected, scattered services from disparate authorities, none of which takes any overall responsibility for their welfare. . . . Community services, including supported residential programs and rehabilitation programs must be provided in one, integrated system.

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CHAPTER 10

Effective Strategies for Providing Mental Health Services to Probationers with Mental Illnesses

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The purpose of this chapter is to discuss the current state of knowledge regarding effective mental health services for persons on probation. Empirical research on the effectiveness of various models of mental health services to persons under community supervision is virtually nonexistent, Hence, potentially useful supervision strategies and mental health services for probationers with mental illness must be inferred from observations and informal program evaluations, what we know about community mental health services to other vulnerable populations, such as homeless persons with mental illness, and, to some extent, mental health services to incarcerated populations.

This chapter discusses the need for mental health services for persons on probation, the target population to receive such services, the role of the probation department in providing mental health services, and strategies for probation supervision and mental health service delivery.

Background

Similar to jails and prisons, probation and parole departments have experienced explosive growth over the past decade. On January 1, 1994, 2,216,880 adults were under active probation supervision and 569,121 were under active parole supervision. This represents a 25 percent increase in the population size just since 1989 (Camp & Camp, 1994). The growing community corrections population includes increasing numbers of persons with special treatment needs. Yet, while probation caseloads continue to grow, departmental expenditures have not kept pace (Byrne et al., 1989; Jacobs, 1987). With ever-greater reliance on community corrections to manage persons at risk, departments will be required to provide quality services with fewer resources. This ultimately means that community corrections departments will need information regarding best practices, including the effectiveness of programs or procedures for persons with mental illness.

The management of persons with mental illness is problematic at all levels of the criminal justice system, be it police, jails, prisons, probation, or parole. Management problems arise because corrections staff often are not trained in issues relating to recognizing mental illnesses or to managing people with serious psychiatric disorders; individuals with acute psychiatric symptoms often have difficulties following directions and conforming their behavior to supervisory conditions; and resources are frequently insufficient or inaccessible to meet the many needs of persons under community supervision.

Models of probation supervision for persons with mental illness vary widely from strictly supervision and monitoring strategies to comprehensive mental health programs. There are many ways to provide quality services. Individual community corrections departments must decide how they can best implement services within the historical, social, political and economic contexts of their communities. The kinds of mental health services and probation supervision strategies developed are dependent on the level of client need and the availability of community resources.

Estimates Of Mental Health Needs

The percent of persons on probation who have mental illness is unknown. To date, there has been no rigorous prevalence study of mental illness within this population. However, jail and prison estimates may be applicable, considering probationers generally come from one or the other of these facilities.

A recent survey of a random sample of male jail admissions in Cook County (Chicago) found that 6.1 percent had a current psychotic illness and were in need of treatment services (Teplin, 1994). Among female Cook County detainees, the estimates of mental illness were even

higher: 15.0 percent had a current diagnosable mental illness of schizophrenia or affective disorder (Teplin, unpublished).

Prison statistics are similar. Estimates of mental illnesses generally range from 6 to 15 percent of the prison population. A national survey of prisons and mental health facilities in 1978 found that 6.6 percent of offenders were designated as mentally disordered (Monahan & Steadman, 1983). In fact, a recent review of the literature noted that

> surveys of facility administrators suggest that 6 to 8 percent of adjudicated felons are currently being designated as seriously mentally ill. A study of New York State prison inmates revealed that 8 percent had 'severe psychiatric and functional disabilities' that required mental health services and an additional 16 percent had 'significant' disabilities that required periodic mental health services. Clinical studies, however, suggest that 10 to 15 percent of prison populations have a major DSM-III-R thought disorder or mood disorder and need the services usually associated with severe or chronic mental illness (Steadman & Cocozza, 1993, p. 6).

Based on jail and prison estimates, a large number of probationers are mentally ill and need ongoing mental health treatment services in the community and have rates of disorder that are typically two to three times those in the general population (Teplin, 1990). Even in the absence of empirical data documenting the level of need, given the prevalence of mental illnesses in jails and prisons and the fact that many serious disorders are undertreated, a significant proportion of probationers require mental health services in the community.

Persons with mental illness who come into contact with the criminal justice system are a particularly vulnerable group. They are doubly stigmatized. In addition to the burden and stigma of their psychiatric disabilities, they also carry the burden associated with their arrest and sentencing. These individuals do not represent a small class of people. They also include a large proportion of persons in state psychiatric facilities, of homeless persons, and of persons in the public mental health and health care systems. This double stigma of being labeled both an offender and mentally ill (and often a substance abuser) creates real barriers to services in the community. In addition, decreasing community resources, particularly the lack of available or accessible emergency mental health services, have increased the likelihood that persons with mental illness will come into contact with the criminal justice system (CMHS, 1994).

In this time of fiscal constraints and competition for scarce resources, offender services and services for persons with mental illness have a low priority. Without strong advocacy on the behalf of these individuals, there is no pressing need for systems to change the way they typically do business. Without an affirmative decision to make these groups a priority, they will continue to cycle through the criminal justice and public mental health systems.

Classes Of Probationers With Mental Illnesses

From among the 6 to 8 percent of the probation population estimated to have a serious mental illness, only a portion are required to receive mental health services. There are, therefore, two classes of probationers with mental illness: persons who have a mental illness and are court mandated to receive services as a condition of probation and persons who have a mental illness and do not have a court mandate to receive treatment. Probation departments must individually decide whether they will support mental health services for persons who do not have special conditions of probation that mandate treatment.

Jails and prisons have a substantial Constitutional mandate to provide health care, including mental health and substance abuse services to incarcerated individuals under the 8th and 14th Amendments (Cohen & Dvoskin, 1992). The 14th Amendment of the U.S. Constitution, the 'due process' clause, states "nor shall any State deprive any person of life, liberty or property, without due process of law, nor deny to any person within its jurisdiction the equal protection of the laws." This is the clause that is typically used in case law decisions regarding conditions of pretrial detention. Case law decisions, such as ***Estelle*** v. ***Gamble,*** established the right to minimal medical care and subsequently to other essential treatment. Similar arguments have been made for sentenced jail and prison inmates under the 8th Amendment's 'cruel and unusual punishment' clause. The case law in this area arrives at two conclusions. First, persons with mental illness in custodial care should not be punished for having a psychiatric disorder (i.e., persons should not receive longer sentences, be denied access to pretrial release or in-jail programs, or in any other way be limited based solely on a psychiatric diagnosis). Second, persons with mental illness in custodial care should not leave custody in worse condition than when they entered.

Community correction agencies have no such Constitutional duty to provide mental health care because community correction agencies, including probation departments, do not have 24-hour physical custody of offenders, and corrections agencies are not required to maintain clients' well-being. They are not required to provide universal medical, mental health, or substance abuse services, or even access to these services. For persons with mental health treatment conditions, probation assumes only the duty to assure access to appropriate treatment and to supervise participation in that treatment. Without a Constitutional mandate for treatment and their doubly-stigmatized status, it is difficult for probationers and the probation departments that supervise them to access mental health and other needed services.

Where mental health treatment is not a condition of probation, individuals' participation in mental health services is voluntary. Because persons under community supervision are living in the community, they should have the same mental health resources available to them as any other community member. However, access may be restricted because of their status as probationers. The role of probation officers as advocates to insure that those who want to participate in community programs can do so when participation is not a condition of release must be determined by individual jurisdictions.

Probation, Risk Management. And Multiple Need Offenders

In addition to supervising persons who have been sentenced to probation, probation departments may also have responsibility for administering pretrial release services and alternatives to incarceration programs (ATI). Throughout the remaining discussion, conditions of probation can be considered to apply also to conditions of pretrial release. The required collaboration between probation departments and community mental health agencies and the services needed to fulfill court mandates are the same regardless of whether individuals are awaiting trial or have been sentenced.

According to the Community Corrections Division of the National Institute of Corrections, the primary intent of probation supervision in most U.S. jurisdictions has changed from rehabilitation to risk reduction through community-based sanctions (USDJ, 1993). The main goal is the protection of the community. With growing corrections populations and ever-increasing costs of incarceration, community corrections alternatives are gaining popularity. The increasing emphasis on such programs reflects "probation's growing role as a community sentencing option that offers control, treatment, and services outside an institutional placement" (USDJ, 1993, p .l).

Risk management can be understood as a two-pronged approach. Probation services can reduce risk by motivating offenders to refrain from criminal activities or, for those who cannot or will not refrain, to remove them the community. It is becoming clear that an emphasis on surveillance alone only increases the probability of early detection of violations but does not reduce criminal behavior or assist in offender rehabilitation (Stroker, 1993). If the goal of probation is risk management, programs that are designed to reduce criminal activity or increase community participation may offer long-term solutions by intervening before recidivism occurs.

Risk reduction for persons with mental illness is the same as risk management for any other group. The primary question is how to reintegrate the person into the local community. Most probationers have specific problems that must be addressed for them to become fully productive community members. Some individuals require assistance with housing and employment, some with substance abuse services, some with mental health or physical health care. Many probationers with mental illnesses require assistance across some or all of these areas. Attention to only one area will not effectively assist probationers to reintegrate into the community.

Because probation departments are primarily concerned with minimizing the risk of reoffending, conditions of mental health treatment typically refer to clinic services, especially to medication compliance. Verbal and behavioral therapies are not usually considered within a probation context, except for specialized sex offender and substance abuse programs. Furthermore, participation in psychiatric rehabilitation programs, day or continuing treatment programs, or other mental health outpatient programs are not usually required.

Persons with mental illness typically need three types of services. First, they have behavioral excesses (i.e., symptoms) that are often helped by biomedical treatment, especially psychotropic medications. Second, they frequently lack basic life skills, such as the ability to socialize and communicate with others. Acquiring these skills is essential in fostering recovery from mental disorders. Third, they are commonly disconnected from family, the community, and other forces that motivate prosocial behavior and provide support when people's resources are inadequate. To meet this need, public human service systems must offer "artificial" social supports (e.g., case managers) either permanently or until the person's recovery allows him or her to maintain a social network.

The reliance on psychiatric medications as the primary mental health intervention reflects a fundamental misunderstanding of current community-based mental health practices and, to some degree, the nature of mental illnesses. Required adherence to a medication regimen presumes that, if a person with a serious mental illness (i.e., schizophrenia or a major affective disorder) can be maintained on medication, this will reduce the probability of an acute psychiatric episode and, therefore, reduce recidivism. This further assumes that psychotic or other acute psychiatric episodes are related to criminal behavior. Although recent research has demonstrated a moderate relationship between certain types of psychiatric disorders and violence (i.e., acute psychotic disorders with specific threat-control override characteristics) (Swanson et al., 1990; Link et al., 1992), this relationship is not constant across all mental illnesses or at all times within a particular diagnosis. Compared to other factors, such as age, gender, and substance abuse, even acute mental illnesses represent only a mild risk of future violence and criminal activity.

Current research in community-based mental health services underscores the need for a wide array of mental health and other support services delivered in an integrated and continuous manner. Within the public mental health sector, continuity of care models, specifically Intensive Case Management (ICM) and Assertive Community Treatment (ACT) have continued to gain support. These treatment services approaches stress 24-hour, seven days-a-week accessibility, a strong case management component to establish linkages to both mental health and other support

services, and *in vivo* learning of daily living skills. The hallmark of these programs is that they are not office-based. They take the needed services to where clients live, work and play.

Persons with serious mental illness in the criminal justice system are not single-issue people; that is, they are often require multiple social services and interventions. They are among the most disenfranchised populations in American society. In addition to their mental illness and high level of co-occurring substance abuse disorders, they are also more likely than other groups to have serious health problems, such as AIDS/HIV and tuberculosis, to be homeless, and to have few social supports, a poor education, and few job skills. For probation or mental health treatment to be successful, persons with mental illness on probation must have their basic human needs met, in conjunction with, or prior to, their mental health treatment.

For probation services to be successful in the supervision of persons with mental illness, they must address the broad range of offender needs. This does not mean that probation departments must provide all of these services. They must, however, collaborate closely with the community services agencies that provide mental health, substance abuse, health care, and other human services.

Strategies To Provide Needed Services

Typically, probation departments broker services for persons with treatment conditions. However, some probation departments have developed programs or approaches specifically for persons with special treatment requirements. Special procedures and programs designed to meet the needs of probationers with mental illness include officer training in mental health issues; specialized caseloads, intensive supervision and revocation practices; mental health treatment, rehabilitation, and support programs; and systems integration strategies, such as community planning boards and interagency memoranda of understanding. Comprehensive programs may incorporate all or several of these elements (Veysey, 1994).

Training and Education

There are two important education targets to improve supervision practices for probationers with mental illness: probation field officers and mental health and probation staff in general.

Preservice and Inservice Training. Field officers who may supervise persons with mental illness on standard caseloads and probation officers who supervise specialized mental health caseloads both need training. The intensity and detail of the training may differ depending on the role of the officer in relation to persons with mental illness. It is widely accepted that probation and parole officers need a minimum understanding of topics such as substance abuse and emergency medical treatment. They also require a basic understanding of mental health issues and appropriate crisis management techniques, which should be included in preservice training and supplemented as needed by inservice training. Probation officers who supervise specialized caseloads of probationers with mental illness should have a broad knowledge base including, the symptoms of mental illnesses, uses and effects of common psychotropic medications, the purposes and goals of mental health services, and, most important, the availability of emergency and community-based mental health services and how to access those services.

Cross-training. Cross-training is an important component in all settings where criminal justice and mental health professionals work together. For effective community supervision of persons with mental illness, probation staff and mental health providers must understand each other's roles.

In particular, community supervision staff need to understand the characteristics of mental illnesses and their effects on daily functioning, what services are available in the local area and how to access them, as well as an understand of confidentiality statutes and mental health law, and the goals and outcomes of treatment.

By the same token, community mental health providers must be informed about the demands and nature of the criminal justice system and the need to work with offenders who have mental illness to help them meet the conditions of their probation. It is particularly important for clinicians and mental health staff to understand how the criminal justice system works and the specific demands and procedures of corrections operate, including conditions of release and violations, goals of community supervision, and the hierarchical organizational structure of most correctional agencies.

Probation Supervision Procedures and Practices

Persons with mental illness tend to have high rates of technical violations (Wilson, 1978). To accommodate their unique needs, many probation departments have developed specialized services to help persons with mental illness become successfully integrated into the community and to meet their conditions of release. Alternative strategies developed for persons with mental illness that include continuous monitoring, increased communication between probation and other service providers, greater client responsibility, and more flexible sanctions will allow for some mistakes without resulting in an immediate return to jail or prison.

Identification and classification. Although we estimate that probation populations have similar percentages of persons with mental illness as do jail and prison populations (i.e., about 7 percent), only a portion of these are required to receive mental health services as a condition of probation. The role and mandate of the probation department does not demand the identification of persons with mental health needs beyond those required by the court to receive services. Thus, screening instruments and universal policies that provide for minimal services to all identified individuals are unnecessary.

Similar to any other class of individuals on probation, persons required to receive mental health services represent a range of threat to the community from high-risk individuals who are either likely to reoffend or whose conviction crimes are particularly serious, to low risk offenders who are not likely reoffend and whose conviction crimes are not serious. Persons on probation may be assigned to differing levels of supervision or to specialized caseloads depending on their assessed risk. Many departments do not consider the presence of a mental illness or the requirement to receive mental health services as an indicator of greater risk. However, persons with mental illness who are high risk should be classified as such.

Specialized caseloads. In large probation departments, specialized caseloads may be developed for persons required to receive services. Nonetheless, many smaller departments reserve specialized caseloads for other priority groups such as, sex offenders, juveniles, and persons with histories of substance abuse. Persons with mental illness on probation may be assigned to specialized community supervision caseload. Such specialized caseloads tend to be smaller, and the probation officer in charge of these clients has special skills and knowledge that facilitate the integration of individuals with mental illness into the community.

Sometimes these services are transitional. Persons with mental illness who are newly released from jail or prison may be assigned to a specialized caseload. Early, intensive assistance tailored to the specific needs of each person is important because these individuals may have more difficulty adjusting to community living after incarceration, have fewer community resources (e.g.,

employment, social supports, housing), and require special conditions for treatment. After individuals are stabilized in the community, they may be transferred to a standard probation caseload.

Intensive supervision. Intensive supervision is generally used to monitor high-risk offenders. Persons with mental health conditions may be placed on intensive supervision, if they are high risk or if they are experiencing acute symptoms. It is essential to consider that persons with mental illness may require differing levels of supervision over the course of their probation term. Probation departments should be able to frequently monitor and reassign individuals based on individual need.

Relapse prevention. Relapse prevention has recently gained widespread support in the substance abuse field (Palmer, 1992). This approach focuses on the development of social and emotional supports that may reinforce an individual's resistance to further criminal behavior. The key to relapse prevention is the probation officer who acts as an intensive case manager, maintaining up-to-date information on an individual's progress in treatment programs and in employment, family, and social environments. Close monitoring allows the officer to anticipate periods of increased stress and exacerbated symptoms as well as possible criminal activity. During these periods, the officer intervenes to avoid recidivism. Relapse prevention emphasizes the shared responsibilities of clients, community supervision staff, and service providers in producing successful outcomes. Ideally, relapse prevention strategies should teach clients to recognize risky situations based on past episodes of failures, especially with respect to their own violent behavior. They also seek to assist clients in acquiring and using the skills they need to avoid or safely negotiate such situations in the future.

Progressive sanctions. The use of progressive sanctions for technical violations is another strategy that may be used alone or in conjunction with other approaches to reduce recidivism for persons with mental illness. Many probation departments have progressive sanctions policies in place for all probationers. However, specific policies directed at the unique issues encountered by persons with mental illness would be of further benefit.

These policies should recognize the fact that many persons with mental illness on probation are in a "Catch-22" situation, where terms of probation often mandate mental health treatment, but an individual's refusal to cooperate with the treatment plan may result in a technical violation (Clear & O'Leary, 1983). The purpose, however, of mental health treatment in this context is to increase the probability of successfully completing probation. Thus, if community supervision staff adhere to rigid sanctions for technical violations with regard to treatment compliance, special- needs clients - particularly those with mental illness - are likely to fail.

To avoid this problem, the use of progressive sanctions is suggested. The essential component of this effort is to avoid an "all or nothing" approach to success or failure in treatment. For example, probationers may be required to report on a weekly basis and, as a condition of release, be required to receive psychiatric services. If a probationer fails to keep a clinic appointment, the probation officer might increase the frequency of contact to several times per week. Given the cyclical nature of many serious mental illnesses and the fact that probationers may be required to participate in services against their will, progressive sanctions allow the system to be responsive to an individual's changing needs and circumstances without necessarily returning the person to jail or prison (Clear et al., 1993). For this strategy to be effective, open lines of communication and cooperation must be maintained between probation departments and community mental health and other service providers.

Mental Health Treatment. Rehabilitation and Support Programs

Probation is foremost a corrections agency. In general, probation departments should be able to continue performing their traditional duties without expanding their responsibilities to include treatment. Mental health and substance abuse treatment providers are expert in their fields and should be fully utilized by probation departments. The probation supervision strategies that I have discussed so far represent alternatives to traditional supervision that may assist probationers with mental illness to successfully complete their terms. Nonetheless, these strategies alone will not accomplish the overall goal of community integration and long-term success. This requires probation department involvement in partnerships with community mental health, substance abuse, and other human services agencies. Creative collaboration can help to accomplish the goals of all systems.

Brokering and single service contracts. Most probation departments provide access to mental health treatment on an "as needed" basis. Probation departments or individual officers broker services as the need arises. In this case, the department will identify all necessary services and negotiate access for specific individuals. Given the small percentage of persons with mental health needs on probation, many departments believe that arranging services for individual probationers as needed accomplishes the probation department's short-term goals of meeting the court's supervision requirements in the most flexible, cost-effective manner. This ad hoc brokering approach may, in fact, be the best of all strategies in small communities, where familiarity with the offender and informal interagency relationships are common. However, in larger communities, this approach to accessing services is time consuming, labor intensive, and may create service redundancies.

In other cases, probation agencies have developed standing contracts with community providers. These working agreements support the activities of both the systems and the clients they jointly serve. Community agencies that work with probationers tend to be familiar with corrections practices and are more receptive to nonvoluntary clients (Cole et al., 1994). Such arrangements may also allow probation officers to intervene at the mental health service provider site when emergencies involve persons under their supervision.

'Although such arrangements insure access to treatment for many persons with mental illness, problems may arise when the mental health agency is not equipped to serve individuals with varying levels of disability or with differing needs and interests. In addition, many community mental health agencies are reluctant to provide treatment to persons with a criminal record or to individuals who are participating in services involuntarily.

Probation department-delivered services. In addition to brokering or using services provided by another agency, probation departments can implement their own treatment programs. It is not realistic to expect probation departments to provide psychiatric services. Yet, some mental health services may be offered on-site, such as individual or group counseling. Other generic programs may also be adapted by departments to provide services to probationers with mental illness, such as vocational or educational programs.

Due to their reluctance to participate in treatment programs against their will, probationers who receive services from generic community agencies tend to have higher rates of technical violations of probation (Wilson, 1978). However, persons involved in programs operated by probation agencies have demonstrated reduced recidivism for certain types of offenders (Gottfredson et al., 1977).

Jointly sponsored programs. Some of the most comprehensive and promising programs for probationers with mental illness are jointly sponsored and developed by community mental health agencies and probation departments. Any program or procedure that focuses attention on a specific population stands the possibility that the increased interaction or attention will cause an increase in technical violations. But departments that develop surveillance/revocation practices in conjunction with appropriate, integrated mental health services that **probationers are willing to use, can** have excellent results.

Similar to other community members with disabilities, probationers with mental illness require a full range of mental health and other support services that are accessible, appropriate, and relevant to their needs. The probation department is not always the best agency to determine the clinical and support needs of persons with mental illness. Community-based mental health programs working in conjunction with probation departments can fill this gap in expertise. Typically, collaborative efforts between probation and community mental health agencies use one of two strategies: single point access to services or holistic programs with co-location of services.

Single point access to community-based services involves the joint development of probation-mental health case management programs, particularly ICM or ACT programs. The core ideas within both of these service approaches are client-oriented focus, continuity of care, comprehensive services, 24-hour, seven-day availability, small caseloads, and service delivered in natural environments. ICM models may use single case managers or a team of case managers. These programs typically provide support for many domains of living, including mental health, substance abuse, housing, money management, and other support services. Intensive case managers may also provide counseling and training in daily living skills. The funding and intensity of the services of ICMs are flexible. Such programs appear to be effective in reducing the inappropriate use of psychiatric services and the number of days spent in hospitals and jails by some of the most difficult-to-serve individuals.

As I mentioned previously, ACT models share many of their core components with ICM models. However, the distinguishing feature of ACT models is the use of interdisciplinary teams of clinical and support staff. Teams typically include psychiatrists, RNs, psychiatric social workers, and other paraprofessional case workers. The primary goals of this approach are stabilizing symptoms, preventing relapse, meeting basic needs, enhancing the client's quality of life, and optimizing instrumental and social functioning (Test et al., 1992). To achieve these goals, each team is able to provide "generic mental health services, psychiatric evaluations, crisis intervention, individual therapy, group therapy, medication administration/monitoring, assistance with activities of daily living, budgeting, and full case management services" (Plum & Lawther, 1992, p. 38).

These models have had a great deal of success in reducing both hospital admissions and the average number of inpatient days among persons with mental illness in the community (Plum & Lawther, 1992). Applied to criminal justice populations, several studies have found that ICM programs reduce the risk of violence in the community including, fewer days in jail, fewer arrests, and reduced incidence of harmful behavior (see Dvoskin & Steadman, 1994 for review of the New York, Texas, and British Columbia studies).

Collaborative co-locution ofservices. It is often difficult for persons with mental illness to negotiate one, much less multiple, services systems. In response, some innovative programs for persons with mental illness use day-reporting/day-treatment centers that combine probation monitoring with comprehensive mental health services. For example, in Milwaukee, WI, the Wisconsin Correctional Service developed a Community Support Program to serve persons with serious mental illness on probation (45%), on pretrial release (40%), and others, including persons

who have gone to trial but before sentencing and persons at risk of becoming involved with the criminal justice system (15%). This program provides traditional mental health services, money management, housing and assistance with gaining other needed supports, such as entitlements, as well as close monitoring through daily reporting. The goal of the program was to keep individuals out of jail and out of the hospital. Although not formally evaluated, program managers, court and jail staff, defense and prosecuting attorneys all believe the program is accomplishing its goals.

Another program, Lehigh County's (Allentown, PA) Special Program for Offenders in Rehabilitation and Education (SPORE) was the recipient of the American Probation and Parole Association's President's Award for outstanding programs. The program is a collaborative effort between the Lehigh County Probation Department and the Lehigh County Mental Health/Mental Retardation Office. The program provides screening and evaluation, supervision and case management, education and job training skills, and public education of issues relating to offenders with mental disorders. Program goals are to increase the employability and reduce the recidivism of the people it serves. The program has successfully reduced the recidivism of its clients.

The Cleveland, OH Mentally Disordered Offender Program (MDOP) is a specialized unit of the Cuyahoga County Probation Department that supervises felony offenders with serious mental illness and is a collaborative effort between the probation department and the Cuyahoga County Community Mental Health Board. In addition to small caseloads (not to exceed 50), persons in the MDOP are provided with case management, vocational, substance abuse (dual diagnosis-SA/MI), inpatient and outpatient mental health, and crisis intervention services. According to two independent reports, MDOP has been successful in reducing recidivism overall. Moreover, program participants are returned to custody most often for violations of special conditions of probation, the majority for substance use (Jones, Zureick & Friedman, 1992; Porter, 1991).

Both single point access and comprehensive co-location of services strategies appear to be effective in managing persons with mental illness on probation. These programs reduce the duplication of services, particularly case management services, increase information flow, have superior client outcomes, such as probationers' reintegration into the community.

Systems Integration Strategies

Developing partnerships between probation and community mental health authorities requires organizational support, which may be formal or informal. Formal mechanisms of mutual support, including memoranda of understanding, planning boards, and contracts that specify roles and responsibilities, increase the probability of program success because they provide a written framework for establishing permanent relationships between agencies.

Community planning boards. People who come into contact with the criminal justice system, particularly those with mental illness, have a high incidence of co-occurring substance abuse and physical health problems. In addition, they are likely to be impoverished and in need of housing or other social services. Helping individuals with multiple problems often requires systems-level integration, which ultimately supports and enhances the efforts of frontline probation staff and mental health personnel.

At a minimum, communities may want to consider the development of a standing mental health/criminal justice planning committee whose primary responsibility is to clarify the responsibilities of each of the agencies involved. Such a group should represent law enforcement, jail, and community corrections administrators; mental health services administrators; judges, public defenders and district attorneys offices; local government officials; consumers and family advocates; and other relevant community service providers.

The group should have the authority to plan and implement the full spectrum of integrated services to meet the needs of this population. Individual members of the planning board should be of a sufficiently high level of authority to be able to implement planning board initiatives within their own agencies.

In particular, a joint planning group could develop streamlined procedures for criminal justice processing and facilitate access to appropriate mental health treatment. Furthermore, access to services, such as housing, health care, alcohol and drug treatment, entitlement assistance, and education and vocational training programs, can also be enhanced through planning boards.

Memoranda of understanding, letters of agreement, and contracts. To assist the integration of probation and other community-based services, both formal and informal mechanisms may be used. In small communities, letters of agreement or memoranda of understanding establishing priorities and cooperation among parties may be sufficient to access necessary services. In larger communities or jails, formal contracts can be developed with local mental health agencies to provide services to probationers with mental illness.

Within these various documents, it is critical to state the intended purpose and the desired goals, to clarify the roles and responsibilities of each of the parties, and to establish mechanisms to identify and overcome problems as they arise.

Confidentiality and information exchange. Information exchange and mutual support between participating agencies is critical. In particular, issues of client confidentiality must be explored. Although community supervision officers must be informed of an individual's non-participation in services when treatment is a condition of release, many mental health consumers object to the idea of complete information exchange between the mental health and criminal justice systems. Discussions with consumer advocacy groups result in a clearer understanding of the kinds of circumstances under which information may be exchanged.

The goal of all systems integration strategies is to improve coordination of services. By reducing redundancies in the systems and improving communication, these approaches can improve service delivery with little or no additional funding. Making maximum use of existing resources, in some cases by jointly funding cooperative efforts, can overcome many barriers between systems.

Conclusions

To prevent probation failures among persons with mental illness, including rearrest or technical violations, several concepts have proved important:

- Crosstraining of probation and mental health staff is crucial to developing an understanding of the complex needs of individual probationers and of the systems involved in providing services.
- Probation supervision strategies that are currently in use may be tailored and applied to the specific issues of probations with mental illness, including specialized caseloads, classification and intensive supervision, progressive sanctions, and relapse prevention.
- Programs that are jointly developed and operated by probation and community mental health agencies in conjunction with special revocation or supervision practices show great promise.

- Flexible, appropriate, and integrated mental health services that **probationers are willing to use** must be available. Core mental health services that must be available to probationers in the community include psychotropic medications with periodic reviews of compliance, case management, and 24-hour crisis intervention services.
- Services integration is critical to meet the many needs of probationers with mental illness.
- Intensive case management programs and assertive community treatment programs that emphasize low caseloads, 24-hour availability, and continuity of care linking mental health, substance abuse and other social support services with housing and entitlements appear to be highly effective.
- Co-location of comprehensive mental health services and probation supervision seems to be an effective alternative strategy.
- Mechanisms that encourage systems integration, such as community planning boards and memoranda of understanding, can be used to identify and overcome barriers to the provision of services, particularly fiscal and turf issues.

Fragmented services and poorly conceived treatment interventions can result in persons with mental illness receiving no services at all or receiving inappropriate treatment, including unnecessary hospitalization or rearrest and incarceration. Coordinated planning among probation, law enforcement and correctional personnel, mental health agencies, and social service providers, such as housing, income support, and substance abuse programs, can help meet the needs of all parties involved.

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CHAPTER 11

Responding to the Mentally Ill on Probation and Parole

Recommendations and Action Plans

Arthur J. Lurigio

From September 7 through September 10, 1995, the National Coalition sponsored a Community Corrections National Work Session at Loyola University in Chicago. The session was cosponsored by Loyola's Office of Government and Community Relations and was attended by delegations of mental health, substance abuse, and corrections practitioners from twenty-four states. Mayor Richard M. Daley proclaimed September 7- 10 to be "National Coalition for Mental Health and Substance Abuse Reform Days" and "urged all citizens to be aware of this organization's efforts to reform the justice system to meet the needs of persons who are mentally ill and substance abusers".

National Work Session participants engaged in several activities. To inaugurate the work session, they attended a community rally involving local politicians, community activists, and mental heath professionals. The rally was sponsored by the Adas McKinney Social Service Agency, the largest in Illinois with 26 locations throughout the state. Those involved in the rally brought attention to the plight of the mentally ill in the criminal justice system through speeches and display tables with information about community mental health services. The theme of the rally was: "community is the cornerstone of our success for crime-free living". During the rally, participants talked about the work session, socialized, ate dinner, and enjoyed music and street performers. They also learned about innovative ways to educate and involve citizens in the struggle for better health care for persons with mental illness in the criminal justice system.

The state delegations at the work session were encouraged to meet in caucuses to share knowledge, information, and experiences regarding persons with mental illness on probation and parole supervision. More important, the delegations were expected to create a long-term strategic plan for addressing the problems of the mentally ill in the community corrections systems of their own states. From the Coalition's perspective, the delegations would form the core of an alliance that would eventually lead to productive changes in the lives of probationers and parolees with mental illness.

The first day of the work session featured introductory remarks by the Coalition's executive director, a keynote address by Nelba Chavez of the Substance Abuse and Mental Health Services Administration in Washington, D.C., and a presentation on community policing by Deputy Superintendent Charles Ramsey of the Chicago Police Department. Following the featured speakers, the editor of the monograph and the facilitator of the plenary sessions (Donna Gamett) each gave an overview of the conference and introduced the major tasks of the conference participants. The authors of the monograph chapters then summarized their contributions.

Participants were separated into six groups; each was assigned one of the following chapters: Working with Seriously Mentally Ill Substance Abusers; Effective Strategies for Providing Mental Health Services to Probationers with Mental Illness, From Territoriality to Collaboration: A Multisystem Response to Offenders with Mental Illness; Juvenile Offenders with Mental Illness; Women on Probation and Parole; People of Color; and Reengineering the Delivery of Services to Probationers and Parolees with Mental Illness. The group members collaborated with the chapters' authors to complete five tasks: to describe a vision for improving mental health services for persons on probation and parole, to list obstacles that prevent the vision from being realized, to enumerate factors that can help bring the vision to fruition, to identify outcomes that indicate whether the vision is being fulfilled, and to formulate strategies for translating the vision into practice. The monograph chapters provided the background and impetus for discussion. At the end of each day, participants returned to a plenary session at which the groups summarized their activities and accomplishments.

Products of the National Work Session

The following summarizes the six groups' responses to the five tasks. Because their observations overlapped considerably, I combined them across groups to avoid redundancy. I also focused on those points that were most common across groups.

Vision Statement

Groups' vision statements for persons with mental illness on probation and parole supervision contained several basic elements. Groups agreed that communities must assume responsibility for the care of persons with mental illness in the criminal justice system. To them, taking responsibility meant that each community would implement a neighborhood-based, integrated, and accountable system of treatment, services, and support for this population. It also meant forming local councils that would unite the various stakeholders involved in the care of the population: mental health practitioners, criminal justice staff, substance abuse workers, and medical professionals. Participants believed that a comprehensive vision of care for persons with mental illness on probation and parole must:

* build lasting bridges between the mental health and criminal justice systems, leading to coordinated and continual health care for clients of both systems;
* involve clients in treatment decisions;
* ensure public safety as well as the safety of offenders;
* facilitate the successful integration of offenders into the community;
* promote offender responsibility and self-sufficiency;
* permit equal access to health care services, including medical, psychiatric, substance abuse, and psychological interventions;
* avoid discriminating against or stigmatizing persons with mental illness and criminal histories;
* accommodate clients with multiple needs and problems (e.g., mental illness, substance abuse, developmental disabilities, financial difficulties, housing problems, etc.);
* be sensitive and responsive to the special needs of women, juveniles, and people of color through diverse and culturally-competent programs;
* require families to be involved in treatment and supervision plans for juvenile offenders;
* match services and treatments to clients' specific problems and needs; and
* raise public awareness about persons with mental illness in the criminal justice system.

Obstacles to Achieving the Vision

Participants identified several impediments that prevent the vision from becoming a reality. The most frequently discussed obstacles were:

* current political climate that favors punishment over rehabilitation, incarceration over community alternatives, and stringent supervision over treatment:

* public's fear of crime and their "lock 'em up mentality";
* "turfism" and battles among and between criminal justice and mental health agencies over limited resources;
* lack of communication between the mental health and criminal justice systems due, in part, to the different "languages" the systems speak;
* divergent philosophies and priorities of the mental health and criminal justice systems;
* no transitional programs for persons released from jail or prison and into the community corrections system;
* no awareness of the significant costs of failing to treat offenders' mental health and substance abuse problems;
* assessment and treatment techniques that are insensitive to the needs and concerns of women and people of color; and
* federal and state policies that discourage systems' collaboration, even though they insist on such collaboration at the local level.

Opportunities to Improve Care

Participants enumerated factors that help the vision to be realized. The most frequently mentioned were:

* the health care reform movement;
* block grants that allow flexibility in expenditures for programs and services;
* advocates who work on keeping persons with mental illness out of jail;
* increased roles for consumers in developing and implementing services for persons with mental illness and substance abuse problems;
* lessons learned from successful pilot programs that have achieved systems integration;
* willingness of employers to hire persons with mental illness (i.e., mainstreaming);
* corrections' efforts to reduce prison overcrowding through community-based programs;
* returning to a spirit of volunteerism and community involvement to combat social problems; and
* recognizing the need to "reinvent" government.

Outcomes

Participants described outcomes to indicate whether the vision is being achieved. Outcomes that were common across the groups were:

* reduced recidivism (rearrests, reconvictions, probation and parole violations, reincarcerations);

* money savings attributable to reductions in incarcerations and psychiatric hospitalizations;
* fewer self-reported criminal behaviors;
* successful reintegration into the community;
* improved quality of life for clients;
* fewer clients falling through the cracks between the criminal justice and mental health systems;
* fewer clients dropping out of treatment;
* a reversal in the trend of imprisoning more persons of color;
* more reliable and accurate data on persons with mental illness on community corrections supervision;
* more sharing of resources among and between agencies in the criminal justice and mental health systems;
* diminishing the stigma associated with mental illness and drug abuse;
* greater client (i.e., consumer) satisfaction with services; and
* higher levels of community involvement in the criminal justice and mental health systems.

Action Strategies

Participants formulated strategies to bring their visions to fruition. The following actions were discussed:

* work on common definitions of mental illness, treatment success, and recidivism across and within the mental health and criminal justice systems;
* create categorical (i.e., protected) funding for persons with mental illness on probation and parole supervision;
* use federal funding mechanisms and other devices to require states to assist counties in dealing with mentally ill probationers and parolees;
* put money into safe, affordable, and effective treatments for clients;
* expand mental health care reform to include mentally ill probationers and parolees;
* revise mental health and criminal codes to encourage intersystem coordination;
* modify notification laws;
* form community-based assessment and treatment teams;
* offer financial incentives for pooled funding;
* institute a continuum of treatment and services;
* align the criminal justice and mental health codes on the issue of clients' rights;
* open a single entry point for accessing services and care;

* cross-train mental health and criminal justice professionals;
* educate criminal justice and mental health professionals on how to work with culturally, racially, and ethnically diverse clients;
* unify MIS systems and develop common standards for releasing client information and for protecting client confidentiality;
* implement more pretrial programs for defendants with mental illness;
* construct more sophisticated assessment tools that are sensitive to gender and race issues;
* use one case manager to coordinate all client services;
* help create education and employment opportunities for clients;
* deploy mobile crisis intervention and treatment teams;
* develop standard criteria to evaluate programs;
* pool resources among and between the criminal justice and mental health systems to avoid duplicating services; and
* influence legislators to increase resources for probationers and parolees with mental illness.

Conclusions

In its fourth National Work Session, the Coalition convened professionals from across the country; their purpose was to forge new directions in polices and practices for mentally ill probationers and parolees. Even though attendees came from different backgrounds and states, they arrived at highly similar conclusions about the problems of this population and about ways to address those problems. Participants also held similar opinions about the opposing and facilitating forces affecting humane and effective mental health care for persons with mental illness on community corrections supervision.

The publication of this monograph and the participation of delegations in a work session are important steps in fulfilling our vision. In community corrections, research and practical knowledge about mentally ill clients are sparse. Hence, the Coalition has again contributed to our understanding of mental health issues in the criminal justice system-this time, in an area with little data and merely a handful of exemplary programs to lead the way. However, real progress can only be achieved through actions along many fronts: in legislatures, courtrooms, neighborhoods, and probation and parole agencies.

*U.S. GOVERNMENT PRINTING OFFICE: 1997-417-737/84257