Challenges for the Future

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Persons with mental illnesses who come into contact with the criminal justice system are a particularly vulnerable group. Combined with the stress and stigma associated with their mental disabilities, the burden resulting from their arrest and charges can exacerbate the isolation and distrust that often accompany their mental illnesses. Moreover, decreasing community resources, particularly the lack of available or accessible emergency mental health services, have increased the likelihood that persons with mental illnesses will come into contact with police and be arrested (CMHS, 1994).

The management of persons with mental illnesses is problematic at all levels of the criminal justice system, whether for police, jails, prisons, probation, or parole. Management problems arise because:

- Most corrections staff have not been trained in issues relating to mental illnesses or in managing people with serious psychiatric disorders;
- Individuals with acute psychiatric symptoms often have difficulty following directions and conforming their behavior to that required by corrections agencies; and
- Mental health resources are frequently insufficient to meet the many needs of persons with mental illnesses in jails and prisons and are often inaccessible to those under community supervision.

Persons with mental illnesses may come under probation supervision through standard criminal justice processing or through special mental health diversion programs. Torrey and colleagues (1992), in their report, "Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals," decried the state of U.S. jails, stating that jails are inappropriate places of detention for persons with mental illnesses whose crimes are more symptomatic of their illnesses than of criminal intent. Diversion from jail into mental health treatment has been presented as a key mechanism to reduce the unnecessary detention of persons with mental illnesses. Probation is an important component of many jail mental health diversion programs.

Estimates of Mental Health Needs

Like 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 and Camp, 1994). Although the percentage of persons on probation who have mental illnesses is unknown, jail and prison estimates are useful in understanding the magnitude of the population.

A recent study of a random sample of males admitted to the Cook County (Chicago) Jail 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 are even higher; 11.2 percent had a current diagnosable mental illness of schizophrenia or affective disorder (Teplin, unpublished).

Estimates of mental illnesses among prison populations are similar, generally ranging from 6 to 15 percent. A national survey of prisons and mental health facilities in 1978 found that 6.6 percent of offenders were designated as mentally disordered (Monahan and 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 and Cocozza, 1993:6).

Based on the estimates of the prevalence of mental illnesses in jail and prison populations, which are typically two to three times those of the general population (Teplin, 1990), it is clear that a significant number of probationers are suffering from serious mental illnesses and are in need of mental health treatment in the community.

Probation and Mental Health Services

According to the NIC Community Corrections Division, the primary intent of probation supervision in most U.S. jurisdictions has changed from rehabilitation to risk reduction (USDJ, 1993). The main goal is the protection of the community. With growing corrections populations and the ever-increasing costs of incarceration, community corrections alternatives are gaining popularity. The increasing emphasis on innovative probation programs reflects "probation's growing role as a community sentencing option that offers control, treatment, and services outside an institutional placement" (USDJ, 1993: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-by removing the offenders from the community. It is becoming clear that an emphasis on surveillance alone increases the probability of early detection of violations but does not reduce criminal behavior or aid 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 should offer long-term solutions by intervening before recidivism occurs.

The reason that treatment conditions are imposed as part of probation sentences for some individuals is to guarantee that the individual will receive needed services and will remain in treatment. This increases the probability that the probationer will be stabilized and will receive emergency interventions, if they become necessary. The goal of mental health treatment is not to "cure" criminal behavior. However, treatment may reduce recidivism when an individual's criminal behavior is the direct result of his or her mental illness, if the array of services maximizes periods of stability and provides for timely intervention when symptoms are acute. Mental health treatment may also reduce criminal activity if the services provided include meaningful assistance to help individuals integrate into their communities.

The presence of a mental illness does not necessarily require probation to enforce mental health treatment. For individuals who have mental health treatment listed as one of the conditions of their probation, community supervision incurs the duty to ensure access to appropriate treatment and to supervise participation. In the case of refusal, the person may be returned to custodial care based on a technical violation of the conditions of release.

If mental health treatment is not a condition of probation, an individual's participation in mental health services is voluntary. Although persons under community supervision living in the community 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. Currently the subject of debate is whether probation officers should be advocates to assure that those who want to participate in generic community programs can do so when participation is not a condition of release.

Strategies for Meeting Special Needs

Special procedures and programs designed to address the needs of probationers with mental illnesses include: 1) mental health programs, either provided by a community mental health agency, the probation department, or jointly; 2) cross-training of probation officers in mental health issues, and of mental health staff in corrections issues; 3) special supervision practices; and 4) systems integration strategies, such as community planning boards and interagency memoranda of understanding. Comprehensive programs incorporate a combination of these elements.

Mental health programs

- ***Community mental health services.*** Individuals on probation who have mental illnesses, like other community members with similar disabilities, require the availability of a full range of mental health services that are accessible, appropriate, and relevant to their needs. Some probation agencies have developed standing contracts with community providers. These working agreements support the activities of both the probation and the mental health systems and the clients they jointly serve. Community agencies that work with individuals on probation tend to be familiar with corrections practices and to be receptive to non-voluntary clients (Cole et al., in press). Such arrangements may also allow probation officers to intervene at the mental health service provider site when emergencies involve persons under their supervision.

In other jurisdictions, probation departments or individual officers broker services as the need arises. In this case, probation identifies all necessary services and negotiates access for specific individuals. This process can be greatly enhanced if probation officers take advantage of mental health case management programs, particularly intensive case management programs. These programs typically provide support for many domains of living, including mental health, substance abuse treatment, housing, money management, and other support services. The funding and intensity of the services 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 clients (Dvoskin and Steadman, 1994).

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

- ***Specialized probation programs.*** Some probation departments provide their own treatment programs. Probationer resistance to participating in treatment programs against their will has been linked with higher rates of technical violation among those who receive services from generic community agencies (Wilson, 1978). In contrast, certain types of offenders involved in programs operated by probation agencies have demonstrated reduced recidivism rates (Gottfredson et al., 1977).

- ***Jointly sponsoredprograms.*** 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. In such a program, a community mental health agency might provide traditional clinical services, housing, and case management for access to other needed supports, such as entitlements, while also providing close monitoring of participants through daily reporting. The probation department, in turn, might provide probation officers to oversee a small specialized caseload of probationers in the mental health program. Active collaboration and communication between the provider agency and probation are important to achieving the overall goals of the program: to reduce recidivism and to increase the individual's ability to live in the community.

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

Cross-training is especially important for probation officers who will supervise specialized caseloads. In particular, community supervision staff need to understand:

- The characteristics of mental illnesses and the effects that these illnesses have on daily functioning;
- The mental health and other services available in the local area and how to access them;
- Confidentiality statutes and mental health law; and
- The goals and desired outcomes of treatment.

By the same token, community mental health providers need to be informed about the demands and nature of the criminal justice system and the need to work with offenders who have mental illnesses to help them meet the conditions of their probation. Clinicians and mental health staff should be trained in the specific procedures of corrections work, including conditions of release, violations, goals of supervision, and corrections' typically hierarchical organizational structure.

Special supervision practices. Persons with mental illnesses tend to have high rates of technical violation of their probation sentences. To accommodate their unique needs, many community supervision agencies have developed strategies to help them become successfully integrated into the community and meet their conditions of release.

Usually, technical violations of an individual's conditions of release result in immediate and prescribed sanctions. Alternative strategies developed for persons with mental illnesses allow for continuous monitoring, increased communication between community supervision and other provider agencies, greater client responsibility, and more flexible sanctions that allow for some mistakes without an immediate return to jail or prison. Alternative strategies include specialized caseloads, relapse prevention efforts, and systems of progressive sanctions.

- ***Specialized caseloads.*** Persons with mental illnesses on probation may be assigned to a specialized community supervision caseload. Such specialized caseloads tend to be smaller than regular caseloads. The probation officer in charge of these clients has special skills and knowledge that may facilitate the integration of the individual with mental illness into the community.

  Sometimes placement in a specialized caseload is transitional. For instance, persons with mental illnesses who are newly released from jail or prison may be assigned initially to a specialized caseload. Early, intensive supervision tailored to the specific needs of each person is important. Compared to other releasees, these individuals may have more difficulty adjusting to community living after incarceration, have fewer natural resources (e.g., employment, social supports, and housing), and require supervision of special conditions for treatment. Once the individual is stabilized in the community, he or she may be transferred to a generic probation caseload.

It is important to recognize that persons with mental illnesses may also require more intensive supervision at a later date. Probation departments should be able to monitor probationers frequently and reassign individuals based on their needs.

- ***Relapse prevention efforts.*** Relapse prevention has recently gained widespread support (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 this effort is the probation officer, who acts as an intensive case manager, maintaining up-to-date information on the individual's progress in treatment programs and in employment, family, and social environments. Close monitoring allows the officer to anticipate periods of increased stress, exacerbation of symptoms, and possible criminal activity and to intervene to avoid recidivism. This approach incorporates and articulates the shared responsibilities of the client, community supervision staff, and service providers in achieving successful outcomes.

- ***Progressive sanctions.*** Imposing 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 illnesses. This approach recognizes the fact that many persons with mental illnesses on probation are in a "catch-22" situation: probation conditions often mandate mental health treatment intended to increase the probability of success on probation, but an individual's refusal to cooperate with the treatment plan may result in a technical violation (Clear and O'Leary, 1983). Thus, if community supervision staff adhere to strict sanctions for technical violations based on treatment non-compliance, special needs clients-particularly those with mental illnesses-are likely to fail.

  Progressive sanctions can help avoid this problem. The essential component of this effort is to avoid an "all or nothing" approach to success or failure in treatment. For example, a probationer may be required both to report on a weekly basis and to receive psychiatric clinical services. If the individual fails to go to the clinic appointments, 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 individuals' changing needs and circumstances without necessarily returning the person to jail or prison (Clear et al., in press). For this strategy to be effective, open lines of communication and cooperation must be maintained between probation agencies and mental health and other service providers.

Systems integration. People who come into contact with the criminal justice system, particularly those with mental illnesses, 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 front-line probation staff and mental health personnel.

At a minimum, communities may want to consider developing a standing mental health/criminal justice planning committee or board, whose primary responsibility is

to clarify the responsibilities of each agency involved. Such a group should represent law enforcement, jail, and community corrections administrators; mental health services administrators; judges, public defenders, and district attorneys; local government officials; consumers and family advocates; and other relevant community service providers. The group may be supported by a formal memorandum of understanding and should have the authority to plan and implement a full array of integrated services to meet the needs of this population.

In particular, a joint planning group could develop streamlined procedures to facilitate appropriate inpatient and outpatient mental health treatment. In addition, such services as housing, health care, alcohol and drug treatment, entitlement assistance, and education and vocational training programs must be available and accessible. These approaches to developing effective criminal justice/mental health collaboration usually can be accomplished with little or no additional funding. Making maximum use of existing resources, in some cases by jointly funding cooperative efforts, can overcome many barriers among systems.

Information exchange and mutual support between participating agencies is critical. It is especially important to explore issues of client confidentiality. 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 may achieve a clearer understanding of the kinds of circumstances under which information may be exchanged.

Factors Important to Success

To date, there has been no systematic study of the need for specialized services for probationers with mental illnesses, nor has any study been conducted on the effectiveness of strategies probation departments have used to supervise persons with serious mental illnesses. The information presented here simply describes some approaches that have proven helpful to some probation departments.

Based on what is known, however, several important concepts are generalizable to all community corrections agencies:

- Cross-training of probation and mental health staff is crucial to develop understanding of the complex needs of individual probationers and of the systems involved in providing services.

- Probation programs that contract for or provide mental health services in conjunction with special revocation or supervision practices show great promise.

- Services integration is critical to meet the many needs of probationers with mental illnesses. Intensive case management programs that link mental health, substance abuse treatment, and other social support services with housing and entitlements are effective mechanisms to promote services integration.

- 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 illnesses receiving no services at all or receiving inappropriate treatment, including being hospitalized unnecessarily or rearrested and returned to jail. Coordinated planning among probation, law enforcement and correctional personnel, mental health agencies, and social service providers can help meet the needs of all parties involved.

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What the Research Says About Effective Service

by Grant T. Harris and Marnie E. Rice, Research Department, Oak Ridge Division, Mental Health Centre, Ontario, Canada

Mentally disordered offenders (MDOs) are a heterogeneous group defined both by changing policies of the criminal justice systems over time and across jurisdictions and by the fluctuating practices of mental health professions over time and across disciplines. No services for MDOs have been implemented with sufficient rigor to permit one simply to copy a fully developed program with any guarantee of effectiveness. There are few data that inform us about how age, sex, ethnicity, offense severity, or language of origin influence the effectiveness of treatment for MDOs.

In evaluating the effectiveness of services for this group of offenders, the question of the appropriate outcome arises immediately. Appropriate indices of effectiveness arc measures of criminal and violent behavior, symptom severity, social and vocational adjustment, and personal happiness. Two distinct empirical literatures inform us about what ought to be done for MDOs: research on the principles of effective intervention to reduce criminal recidivism among offenders, and research on psychosocial rehabilitation for persons with mental illness. The research base also suggests recommendations for appropriate services for mentally disordered offenders.

Reduction of Criminal Recidivism

Research on the criminal and violent recidivism of MDOs indicates, first, that the personal characteristics that predict further antisocial behavior among MDOs are the same as those that predict recidivism among criminal offenders in general. Mental illness (other than antisocial personality disorder or psychopathy) appears to be unrelated, or even negatively related, to recidivism among persons who have already committed a serious offense.

Second, the risk of criminal and violent recidivism among mentally disordered offenders can be appraised with reasonable accuracy using actuarial or statistical methods. This permits interventions to be targeted to persons of higher risk. Almost all MDOs, except those high in psychopathy and with lengthy criminal histories, would be determined on this basis as no worse than moderate risk.

Third, because the personal characteristics associated with recidivism among MDOs are the same as those for offenders in general, interventions known to reduce recidivism among offenders will, in all likelihood, be effective for MDOs.

Meta-analytic studies on reducing the recidivism of criminal offenders through treatment show that interventions are effective as long as they adhere to the following principles:

- ***Interventions shouldfocus on individual risk.*** More intensive interventions should be targeted to individuals who present a higher risk. Targeting intensive service to low-risk offenders can increase recidivism.

- ***Interventions should address criminogenic needs.*** Interventions should target criminogenic needs-that is, changeable personal characteristics empirically related to antisocial conduct. Appropriate targets include social skills and interpersonal problem-solving ability; procriminal values and attitudes; antisocial peer groups; family cohesion and supervision; and substance abuse. Inappropriate targets for intervention include self-esteem and other vague intra-psychic forces or conflicts.

- ***Interventions should be responsive.*** The style or modality of service must match the learning style of offender clients. Appropriate therapeutic styles for most offenders include behavioral, cognitive-behavioral, and psycho-educational techniques. Harsher penalties, getting tough, manipulation of criminal sanctions, shock incarceration, the "scared straight" approach, boot camps, psychodynamic therapy, emotionally evocative treatment, and non-specific counseling are all among the styles of service that are not effective for most offenders.

Psychosocial Rehabilitation for Mental Patients

Research on the ability of mental health treatment to improve the quality of life of persons with serious mental disorders indicates that effective services are those that are clear about their purposes. Effective services are also described in the following ways:

- ***They employ conservative medication practices combined with skills training to improve drug effectiveness and increase compliance.***

- ***They emphasize teaching and learning.*** Improved rehabilitative outcomes result from explicit step-by-step training with coaching practice and feedback in social skills, vocational skills, and symptom management, coupled with training for clients' families.

- ***They ensure that clients share responsibility.*** The negative effects of being a patient are minimized by having clients live in their communities and, when possible, participate in decisions that affect them.

- ***They ensure program integrity.*** Objective data on outcomes, clinical progress, and staff performance are essential for ensuring that services are delivered as specified.

- ***They emphasize the importance of client contact with clinicians, especially in the context of community services.*** Contacts are enhanced by staff training and assertive service delivery and by keeping client and clinician turnover low.

Implementation

Certain barriers can impede the implementation of psychosocial programs for MDOs, whether those programs are behavioral, cognitive-behavioral, or psychoeducational in approach. These barriers may be political, organizational, professional, or technical.

Ways to improve the adoption of psychosocial interventions have been identified, however. They include:

- Obtaining authoritative, personal consultation from outside experts.
- Developing detailed, step-by-step training packages for both clients and clinicians.
- Creating and using a system to monitor, report, and reward staff and managers in their performance of program duties.
- Ensuring that the implementation process has a committed, enthusiastic leader.
- Allowing for consequences, both positive and negative, both financial and nonmonetary, to accrue directly to the organization for successful or unsuccessful implementation.

The research bases for both offender treatment and rehabilitation of persons with serious mental disorders are completely compatible. Although the ideal program for MDOs may not have been identified empirically, it is possible to describe its essential features. They include conservative use of psychiatric medications with means to maximize compliance; behavioral or psychoeducational training in relevant skills targeted at criminogenic needs; assertively delivered service whose intensity is in proportion to clients' actuarially-determined risk; a staff selected, trained, monitored, and rewarded in a manner that reflects clarity of clinical purpose; and the objective measurement of outcomes, clinical progress, and clients' and clinicians' performance.

All of the key, essential features have already been implemented in one place or another. The knowledge to provide effective service for MDOs without greatly increasing costs already exists. All that is required is the will to use it.

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Services for Parolees with Serious Mental Illness

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During the decade of the 1980s, parole populations in the United States more than doubled, to nearly half a million offenders. A significant proportion of individuals released on parole have serious mental illnesses. Even if persons with substance abuse disorders are not counted, a number of studies across the country have shown that state prison populations have significantly higher rates of mental illness than the general population. Our own studies here in New York indicate that at least 5 percent of state prison inmates suffer from severe psychiatric disabilities, and another 10 percent suffer from significant psychiatric disabilities.'

Barriers to Obtaining Community-Based Services

There arc few empirical studies on the use of community mental health services by persons with mental illness on parole. Evidence suggests that community mental health providers-largely because of fears and assumptions of potential violence among "criminals''-create barriers that prevent many parolees from gaining access to services.[2] Parole officers report that they have often given up trying to obtain mental health services for their clients.

Though this phenomenon of rejecting parolees from mental health services has not been empirically documented, it is so consistently reported by parole officials that it must be taken quite seriously. It is also intuitively sensible. 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 result is 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.

Ineligibility of inmates in correctional facilities for Medicaid has been identified as a barrier both to diverting persons with mental illness from incarceration and to providing pre-release planning for inmates leaving correctional facilities.[3] Prior to 1985, inmates were eligible for Medicaid during the first and last months of their incarceration. These funding windows gave mental health providers an opportunity to divert offenders when appropriate and to develop service linkages before inmates were released. Federal regulations that became effective in 1985[4] eliminated Medicaid coverage for any services provided to correctional inmates and created an

enormous additional barrier for local providers who attempted to assist clients in returning to the community.

As a result of these forces, many parole officers have felt forced to "go it alone" and provide only basic counseling to people who may need far more sophisticated clinical services, especially psychotropic medication. In addition, parole officers must attempt to broker a variety of other needed services for their clients.

Pepper[5] has referred to offenders with mental disorders as "multi-need, multi-agency clients." In addition to their mental illnesses, these clients are likely to have had problems with substance abuse, homelessness, poor health, and the myriad of social ills that often accompany poverty in America. They have dealt, often unsuccessfully, with a staggering array of human service and criminal justice agencies in their lifetimes, and many have come to view the government as their enemy. Strategies aimed at providing effective services to parolees with mental illness must therefore be creative and aggressive.

Core Principles for Effective Programming

There arc at least nine core principles, many of which have been articulated elsewhere,[6] which should guide efforts to bring mental health services to parolees. Briefly summarized, the following characteristics are those that appear most important in developing effective programs:

- ***Interagency effort.*** Parole and mental health agencies are obviously at the core of this effort, but the multiplicity of social and human service needs of these clients may require the participation of a wide variety of agencies, including state and/or local departments responsible for parole, mental health, police, social services, health, child protective services, mental retardation and/or developmental disabilities, substance abuse, adult education, and vocational rehabilitation, as well as local clergy. Wherever possible, these relationships should be formalized in a memorandum of understanding.

- ***Interagency cooperation and commitment.*** Service agreements among the primary agencies, especially between parole and mental health, need to be developed as a first step in creating a responsive program for parolees. The role of other critical providers, such as social services agencies, also needs to be clear to ensure interagency commitment on even the most difficult-to-serve parolees. Cross-agency training is necessary to encourage communication and mutual understanding. In New York State, a three-day mental health training program has been developed to strengthen parole officers' skis in working with persons with mental illness and in accessing services. Equally important, mental health providers have been familiarized with the role of parole and ways to integrate their services effectively with those provided by parole officers.

- ***Clear targeting of services and the population to be served.*** Programs that attempt to serve every difficult parolee and do not identify the special service needs of this population are likely to fail. Later in this article we discuss two approaches being used in New York-for most mentally ill offenders, we pursue

early engagement in community-based services before offenders are paroled, while using intensive case management with the highest-risk individuals.

- ***Cultural appropriateness.*** Young men and women of color who grow up poor, witnessing or experiencing violence, with no hope, may need a very different type of human service provider than white, middle-class, young people who grow up believing that the system works for them. In addition, many people are reluctant to reveal personal issues to a person they perceive as quite different from themselves. Ideally, many of the case managers should come from the same cultures as the parolees. If this is not possible, then, at the very least case, managers must receive extensive training in the culturally competent provision of services.

- ***Use of progressive sanctions.*** Serious mental illness, especially among criminal justice populations, is seldom marked by an unbroken string of treatment successes. Clients of these programs are quite likely to refuse to participate in treatment or rebel against psychotropic medication. The goal of these programs is not to increase recidivism, so treatment resistance or relapses should not automatically result in revocation. Less dire consequences can include more frequent reporting, urine testing for drug use, and so forth. These choices should be developed ahead of time, in conjunction with treatment providers, as part of contingency planning.

- ***A focus on residential stability.*** Homelessness can disrupt every aspect of a person's life, increasing the likelihood of arrest[7] and making successful treatment of mental illness infinitely more difficult. Thus, advocacy efforts need to be targeted at obtaining and maintaining stable housing for the parolee. Parolees with mental illness who are too disabled to work after release require government supports such as Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). Housing choice should be assessed individually. It is often assumed that people with mental illness leaving prison require congregate living. While this is true for some people, for others individual housing may in fact be safer and more appropriate. Programs such as supported apartments can provide support and structure without forcing a person into a congregate living arrangement he or she might find irritating, confusing, or frightening. For some people, the stress of congregate living could actually increase their risk of violence.

- ***A focus on prevention of relapse of substance abuse.*** Prevention of substance abuse relapse may be the single most important feature of the treatment plan of a person with these two disabilities. Although the primary problem may vary, both mental illness and substance abuse need to be addressed in an ongoing fashion by someone who understands the interaction between the two disabilities and their treatments. Fortunately, many of the social supports and treatments for mental illness are also very helpful to someone who is battling an addiction. Stable housing, good nutrition, sober friends, and a job are as valuable in treating one disability as the other. Unfortunately, people with mental illness and substance abuse diagnoses often report being given the choice of stopping their psychotropic medication or being thrown out of a substance abuse program, even one that has been mandated.

- ***"Boundary spanners."*** Interagency collaboration relies heavily on staff who have familiarity, skill, and credibility in both systems. Although such staff often have little authority and receive little acknowledgement, their contributions are essential. Case managers can and should be boundary spanners. Case managers must also have the organizational authority to convene periodic meetings around individual clients or groups of clients served by a team of providers from various agencies. Further, these boundary spanners require organizational authority to refer their clients to publicly funded providers.

- ***Effective parole officers.*** The role of parole officers is crucial. Not surprisingly, parole officers are the major source of parolee referrals to mental health programs. They can also provide external structure for parolees, which may increase the chance that an individual will participate in treatment. This structure need not be coercive, but can come in the form of positive reinforcement, encouragement, or simple reminders about appointments. Parole officers also serve as an important safety net for mental health clinicians, who often ask, "What happens if this person becomes a problem in our clinic?" By providing external structure, information, clinician support, and even emergency response in the rare cases where it is required, parole officers can make mental health staff more at ease until the parolee is accepted as a person in need of treatment.

New York's Broad-Based Approach

In New York, there are currently more than 25,000 individuals on parole, at least 1,250 of whom have a compelling need for mental health services in the community. Collaborative efforts between the state's offices of mental health and parole to link these persons with mental health care were formalized in a 1994 interagency memorandum of understanding. Efforts have been initiated in several areas, emphasizing early engagement practices on-site in state correctional facilities.

- ***Funding for parole transition services. The*** New York State Office of Mental Health (OMH) in 1989 made its first comprehensive effort to integrate parolees into the generic community mental health system. This effort focused on the western New York region. OMH used money as in incentive, creating a fund that enabled a contractor to serve the mental health needs of parolees directly. To avoid an expectation that agencies would treat parolees only if they were paid extra, the state limited use of these funds to a period beginning shortly before offenders' release and extending only through their first few months in the community. During that time, it was reasoned, the contractor could help parolees to access entitlements such as SSI, SSDI, and food stamps and to establish Medicaid eligibility. Clients would then be able to "pay their own way."

  A second expectation was that during this period, the provider would come to know each individual as a person, instead of fearing him or her as a "parolee." Fortunately, the provider selected was a multi-faceted provider of substance abuse, retardation, and mental health services and was already committed to serving criminal justice clients. The program has been successful in helping clients make the transition from the forensic component into "regular" mental health care. Within the agency, access to service has improved for parolees served by the program.

- ***Access to services in New York City.*** Prior to 1991, OMH provided services to parolees in New York City solely through a small parole clinic. Because of its small size and the large number of parolees, the clinic limited these services to short-term assistance to parolees in crisis and evaluations for the Division of Parole (DOP) and/or the Parole Board. Though the clinic was able to provide mental health treatment for only a small percentage of parolees with mental illness, it was important to DOP as a resource for emergency evaluation and treatment, and also as a symbol of the mental health system's commitment to DOP clients. However, no special procedures were in place to help parolees with mental illness gain access to the community mental health system. Further, our prison mental health staff, already overloaded with prisoners in need of crisis help, had little time left over for extensive discharge planning.

  When the clinic was forced to close as a result of budget problems, the State of New York took the opportunity to revisit broad issues of parolees' access to mental health care. Fortunately, the New York City Department of Mental Health became strongly committed to improving parolees' access to services. A series of informational meetings familiarized prison mental health staff and parole supervisors with the referral system and how to access services. Parole officials in turn educated mental health providers about the support and structure they could provide and what would happen in the event of an episode of violence. At the same time, the DOP was working very hard to begin the process of making offenders eligible for Medicaid prior to release. Most importantly, each borough developed a contact point from which services could be accessed more efficiently. Parole officers have the option of calling programs directly or going through the offices of the five borough commissioners.

- ***Comprehensive Outpatient Psychiatric System.*** Access to the generic mental health system for parolees was greatly improved in New York State when OMH implemented a "Comprehensive Outpatient Psychiatric System" (COPS), which enhanced funding to mental health agencies for specific groups of persons with severe and persistent mental illness (SPMI). Persons with SPMI involved with the criminal justice system generally, and parolees in particular, were among the targeted groups. This mechanism improved the access to generic providers within the clients' communities.

- ***Dischargeplanning initiative.*** Concurrently, the Division of Parole embarked on a discharge planning initiative that included pre-release planning conducted jointly with mental health and medical services in the prison and improved referrals to substance abuse, medical, and mental health treatment in the community. Determining offenders' eligibility for SSI and SSDI benefits prior to their release made these clients more fiscally desirable customers to human service agencies.

This broad-based approach has clearly helped to reduce the service barriers experienced by parolees and their parole officers. It has also reduced mutual misunderstanding and cynicism. However, it has been a limited success. Medicaid eligibility is not achieved prior to release, Medicaid reimbursement is limited, and much stigma, fear, and discrimination remain. But the improvements noted have persisted over time for parolees with mental illness.

Intensive Case Management for High-Risk Parolees

A small number of individuals released on parole are at very high risk of bad outcomes, such as interpersonal violence, suicide, homelessness, psychiatric emergencies likely to result in expensive emergency room visits or hospitalizations, or criminal recidivism. The specific needs of these highest-risk individuals are addressed in New York through intensive case management. Dvoskin and Steadman[9] have described the ways in which intensive case management can reduce the risks of living with mental illness in the community, including the risks of violence, arrest, and days spent in jail. Although their article dealt with case management as a component of the overall community mental health system, the fit to the special needs of parolees is clear.

Though still rare, the concept of intensive case management for parolees with serious mental illness is not unique to New York. We are aware of at least one other program that is reporting similar success with this approach. The Texas Council on Offenders with Mental Impairments funds and coordinates a statewide program of case management for parolees with mental illness, mental retardation, head injury, and physical disabilities. ***(See related article beginning on page 26.)***

OMH and the Division of Parole began serving parolees with concurrent mental illness and substance abuse disorders in 1993 through an intensive case management program. Parole officers are assigned special caseloads of approximately thirty-eight parolees, each with a serious mental illness. Further, through a direct contract with a local provider, OMH provides four intensive case managers who work in teams with each of two parole offices. Each case manager carries a caseload of ten parolees. Clients are rostered individually by name and assigned to specific case managers. Ongoing negotiations with other local human service providers are aimed at making staff available to the teams on at least a consultative and facilitative basis. However, whenever specific outside individuals play an important role in the services brought to each parolee, they are invited to team meetings to coordinate efforts, reduce waste, and enhance communication.

Whenever possible, case management staff meet the client prior to release and follow up by telephone contact to initiate the rapport that will be relied upon in the streets. To enhance this bond and also "hook" the client immediately into service, case management staff generally meet clients as they arrive in the community and assist them in their initial community transition problems, including treatment service appointments. Clinic appointments are scheduled well in advance of the offender's release, so that they occur as soon as possible, sometimes even the same day as the release.

Critical to the implementation of this type of program is educating the prison mental health staff in the identification, referral, and preparation of inmates with SPMI who are about to return to their communities. Frequent meetings are needed to screen each client for social, medical, clinical, and criminal justice factors that would place the client at risk of failing in his/her reintegration into the community. These meetings should occur both in prison and the community, should involve both parole and mental health, and should result in a transition plan that includes appointments for timely treatment services with specific providers.

Plans are in place to evaluate this program, but these efforts will be hampered by methodological problems, especially the absence of a randomly assigned control group. Because assignment to this program is specifically related to need, it will be necessary to use inferred control groups, such as similar parolees from boroughs that do not yet have this program. Despite the difficulties inherent in such evaluative efforts, however, the novelty of these approaches make such investigations essential.

Opportunities for Action

Providing mental health services to parolees requires an interagency commitment. The planning principles suggested in this paper have evolved from trial and error over time, and they have as yet not been tested empirically. Clearly, they must be tested.

The urgency of such research is clear. Even if the percentage of inmates with mental illness has remained constant, the explosion of prison populations in this country has created pressure in almost every area of state budgets. The absence of mental health treatment and planning keeps people with mental illness in prison longer, despite the lack of evidence that they present greater risk than other offenders. Creating programs that make mental health treatment systematically available to parolees is likely to increase their rate of release and may well keep them in the community longer and more safely.

For more information, contact Dr. Joel Dvoskin, Associate Commissioner, New York State Office of Mental Health, 44 Holland Ave, Albany, New York, 12229; (5 18) 474-3290.

Notes

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5. B. Pepper, N. Albert, and H. Rygiewicz, "The Multi-Need/Multi-System Client," in *Tie Lines (New* York: The Information Exchange, 1993), p. 1-6.

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7. L. Gelberg, L. Linn, and B. Leake, "Mental Health, Alcohol and Drug Use and Criminal History among Homeless Adults, "American *Journal of Psychiatry* 145(2) (February 1988): p. 191-196.

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9. J. A. Dvoskin and H. J. Steadman, "Using Intensive Case Management to Reduce Violence by Mentally Ill Persons *in the Community," Hospital and Community Psychiatry* 45(7) (July 1994): p. 679-684. ■

Helping Mentally Ill Offenders Develop Greater Self-Reliance

by Douglas W. Weber, Wisconsin Correctional Service, Milwaukee, Wisconsin

The goal of the Community Support Program (CSP), operated by Wisconsin Correctional Service (WCS), a private, not-for-profit agency based in Milwaukee, is to deliver intensive and extensive services to mentally ill offenders in the community while at the same time closely monitoring their behavior. Started in 1978, the CSP was created in response to the increasing number of chronically mentally ill people entering the courts and jails in Milwaukee.

WCS based its program on a community-based model rather than the more traditional-and costly-approach of incarcerating or institutionalizing mentally ill offenders. The CSP model includes five defining elements:

- ***Medical and therapeutic*** services-Medication is prescribed and administered five days a week. A pharmacy on the premises closely monitors the prescriptions. Psychotherapy and group sessions are also available. Case management services are provided to help clients obtain primary health care.

- ***Money management-The*** program arranges to be the legal recipient of each client's Social Security and other disability benefits. The client's fixed expenses, such as rent, are paid directly by the program. The remainder is given to the client in a daily allowance after the client has taken his/her medication.

- ***Housing and other support*** services-Intensive case work provides for clients' basic needs, either after arrest or upon release from jail or a hospital. The program provides referrals to other social service agencies, arranges housing, and monitors clients through periodic home visits.

- ***Day reporting and close monitoring-Most*** clients are required to report to the clinic daily, Monday through Friday. They can stay either for a brief period to take their medication and get their money or for longer periods. This daily observation and interaction with clients enables the staff to monitor behavior and to determine when changes in medications are needed. Failure to report is noted, and staff attempt to locate missing clients.

- ***Participation in treatment-Although*** clients must agree to enter the treatment program, their choice is constrained by other less desirable and more restrictive alternatives, including jail. Many mentally ill people are difficult to manage and often resist treatment instructions. However, the program's combination of supportive services backed by firm legal authority is effective in bringing them into and keeping them in treatment.

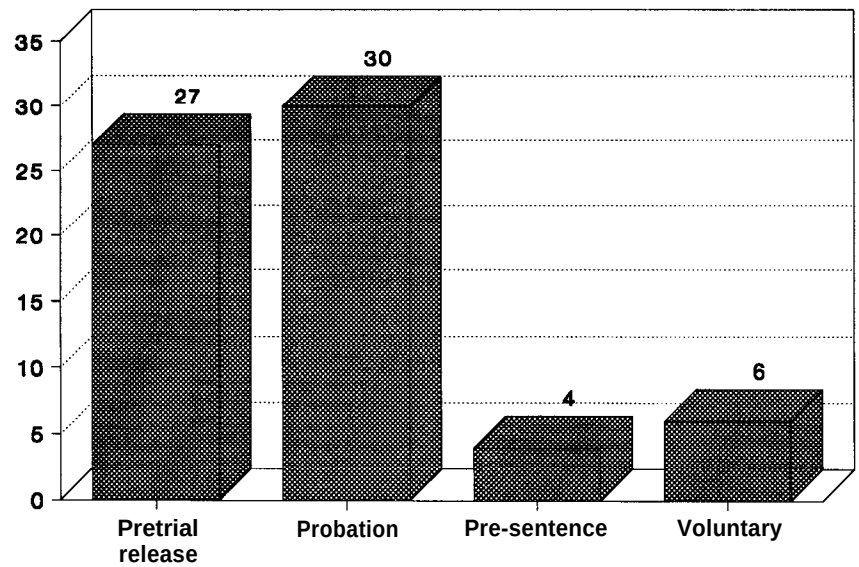
Referrals and Admission

The program can serve about 250 clients on an ongoing basis. Most clients enter the program through referral from WCS's Court Intervention Programs in Milwaukee, which operate out of the Milwaukee Municipal Court and the central intake unit of the Milwaukee Criminal Justice Facility and Jail. However, mentally ill people may enter the CSP at many points in their involvement in the justice system and through several different referral sources.

- The primary goal of the Milwaukee Municipal Court Intervention Program is to keep in the community people convicted of municipal ordinance violations and in need of mental health, alcohol, or drug treatment. The program provides a structured option to incarceration for these offenders.

- Central Intake Unit staff, located inside the Milwaukee Criminal Justice Facility and Jail, interview all people scheduled for arraignment in Milwaukee Circuit Courts. Staff conduct hundreds of interviews each day to obtain information for bail and custody decisions. Through this process, staff identify people who exhibit behaviors that indicate a need for treatment. These people are then interviewed in depth and referred to WCS programs or other community providers. Treatment needs and pending referral become part of the Central Intake Unit's release recommendation presented to the court. The court may then refer the defendant to CSP as a condition of pretrial release. An important advantage of this design is that defendants can move quickly from arrest and arraignment into treatment in the community. In many jurisdictions, the mentally ill offender must wait a long time for transfer from one facility to another. The defendant's mental and physical condition often worsens during the wait. WCS's Central Intake Unit works closely with the courts to minimize the time between arrest and treatment for mentally ill defendants.

Admissions to CSP, 1992



- WCS's Pretrial Services, another referral source, continues to monitor local jail and House of Correction populations to identify inmates with treatment needs. WCS develops release plans that are presented to the court, followed by a referral to the CSP, if appropriate.

- Probation and parole officers provide yet another route to the CSP. The program's extensive services provide close monitoring for mentally ill offenders in the community, resulting in frequent contact between CSP staff and probation or parole staff. The relationship between probation and parole staff and the program have led to the formation of a consistent set of rules and expectations.

- Though nearly all CSP clients enter the program through a referral, a small percentage enter voluntarily. Although most clients are referred after contact or entry into the justice system, CSP can also accept mentally ill people whose behavior is deemed at risk for law enforcement intervention.

Clients entering the program are often homeless and have no means of support. As soon as someone is admitted to the program, staff move quickly to meet his/her basic needs, including housing, in addition to arranging for treatment and medication. Immediately meeting these basic needs motivates the client to continue in the program. Clients stay with the program and succeed through a combination of coercive elements, incentives, and encouragement. CSP enforces release conditions and rules, closely monitors behavior and medication, and regularly reports to the courts or other authorities. This model meets the concerns of law enforcement and the courts and instills confidence in the program.

Client Characteristics

Of the approximately 1,000 arrestees in Milwaukee County identified each year as being mentally ill, 700 to 800 had their charges dropped, re-entered programs where they had been previously enrolled, or were hospitalized. The remaining 200 to 300 are eligible for release and appropriate to enter CSP. However, due to demand, CSP treatment slots are not always available. In 1992, for example, CSP admitted sixty-seven new clients. Those who could not be admitted because no slots were available were referred to other county programs.

In recent years the number of clients admitted has remained steady. However, with the rise in cocaine use in the area, CSP has seen an increase in the number of dually diagnosed (mentally ill and drug-using) clients. The increase in cocaine use has also caused the rearrest rate of CSP clients to climb from 10 to 25 percent.

The typical CSP client is male, never married, in his mid-thirties, has some secondary education, and is schizophrenic. More than half the clients have at least two prior arrests. Clients admitted in 1992 averaged seventy-five days in psychiatric hospitals during the previous two years. Data on 1992 admissions arc presented on the following page.

Characteristics of Clients Admitted to the Community Support Program, 1992

Sex	Male	87 percent
	Female	13
Education	Did not finish high school	43
	High school graduate	28
	Post-secondary education	28
Race/Ethnicity	Black	46
	White	45
	Hispanic	8
	Native American	1
Illness	Schizophrenia	90
	Manic depression	9
	Other	1

The program often works with clients who have not complied with treatment elsewhere. In 1992, 39 percent of CSP's clients returned to the program, voluntarily or through referral, after having been discharged. The average length of stay is one and a half years, but this varies greatly from client to client. A few clients have been enrolled for fifteen years-as long as the program has existed.

Clients leave the program for many reasons. A total of eighty-four clients were discharged in 1992:

- Twenty-eight fulfilled their legal obligations and dropped out;
- Twenty completed their legal obligation and were referred to other, less structured outpatient programs;
- Six were found to need closer supervision and treatment and were placed in inpatient mental health facilities;
- Three were referred to hospitals for long-term treatment for physical illnesses;
- Three were sent to long-term residential drug treatment programs;
- Five moved to another state;
- Three died;
- One disappeared; and
- Fifteen were discharged after being jailed for having committed new offenses or violating their release terms.

Benefits of the CSP Program

Milwaukee's approach to working with mentally ill offenders is quite different from the methods of other jurisdictions. In cities where mentally ill offenders are commonly incarcerated, mentally ill individuals can comprise 15 to 20 percent of the jail's population. In Milwaukee, the CSP and other programs have helped to reduce jail populations; fewer than 3 percent of the jail population are diagnosed as mentally ill. As Milwaukee County District Attorney E. Michael McCann stated in

Federal Probation, "Jails are ill-suited for such prisoners as treatment is rarely provided and such prisoners can be disruptive and aggravating to other prisoners."'

At the core of CSP's success is its ability to provide service at a low cost. Cost per service slot is about $3,500 a year. That figure is one-quarter to one-third the cost of intensive outpatient treatment in the state and county mental health systems. To control costs, the program employs paraprofessionals-most of whom have a bachelor's degree-to provide services.

Nevertheless, the program did not gain immediate acceptance. Today, CSP is located in a mixed residential and business area. Business people were initially concerned about the effect the program's clients might have on local business. Program administrators took a proactive approach to this resistance and, through timely response to resident and business complaints, diffused tensions and resolved situations before they got out of hand. Judges, prosecutors, and defense attorneys have voiced their acceptance of the program. Many other court officials recognize the necessity of the program.

Providing treatment in the community "under one roof' has made possible more effective and efficient means of monitoring and responding to client needs. In turn, this supportive environment has helped clients learn to become more self-reliant. An incarcerated mentally ill offender may have had his/her needs met in the institution-but only until he or she is released. Back in the community, the person will find little support from the institution. The Community Support Program attends to the clients' basic needs, helping them to find housing and a means of financial support. The program continues to manage the client's money. With time and progress, the client will require less reliance on the program and, if possible, on public means of support.

CSP is funded through the Milwaukee County Department of Human Services, the United Way of Greater Milwaukee, the State of Wisconsin Community Options Program, and Medicare, Medicaid, and private insurance. Milwaukee County budget officials say that it is unlikely that the county would provide these services if it required creating additional government positions.

The Community Support Program is not based on conditions found only in Milwaukee. This model can be replicated, in whole or in part, elsewhere in the nation, although some aspects of our situation-including WCS's pretrial services and screening program and its status as a private organization-facilitated the development process.

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Notes

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A State-Level Approach to Special Needs Offenders

by Dee Kifowit, Director, Texas Council on Offenders with Mental Impairments, and Judy Briscoe, Council Member

One approach to improving the management of special needs offenders is to establish a central agency responsible for initiating change throughout the various levels and components of a state's correctional system. The Texas legislature responded to the unique challenges presented by special needs offenders -especially those with mental health disabilities-by creating a Council on Offenders with Mental Impairments, whose work affects all levels of the state's correctional system. This article describes how the council was formed and how it is attempting to carry out its leadership role in programming for special needs offenders.

How the Council Was Created

Recognizing the growing number of offenders with mental health and developmental disabilities, the Texas legislature nearly ten years ago called for a study on offenders with the following problems:

- Developmental disability
- Emotional disturbance
- Mental health disability
- Terminal illness
- Physical disability
- Advanced age.

The study identified a large number of these offenders within the criminal justice system and recommended increased cooperation and collaboration among mental health, law enforcement, and correctional agencies to deal with them. The legislature responded to this recommendation in 1987 by setting aside funds and drafting legislation to create the Texas Council on Offenders with Mental Impairments. The Council has since evolved into a centralized body that responds to an increasing variety of offenders' special needs, primarily by supporting innovative programming.

The Council is made up of nine appointed members with expertise in managing special needs offenders, plus representatives from various state agencies-including the Commission on Alcohol and Drug Abuse, the Department of Mental Health and Mental Retardation, and the Department on Aging. Advocacy groups involved with offenders with mental health disabilities are also represented. Every state agency and

advocacy group that has responsibility for, or interest in, offenders with mental health disabilities is a legislatively mandated member. This mandatory representation has encouraged broad-based cooperation and collaboration.

The Council's Leadership Role

The legislation also defined the Council's responsibility to identify offenders with mental health and developmental disabilities and the services these offenders need. The Council funds community-based alternatives to incarceration to deliver these services and also develops a state-wide plan for meeting the treatment, rehabilitative, and educational needs of offenders with mental health disabilities.

Intensive case management pilot programs. The Council established its first pilot project, Project CHANCE, in 1988. Operated by the Association for Retarded Citizens, Project CHANCE is a diversion program that provides community-based, cost-effective alternatives to incarceration for offenders who have some level of mental retardation or developmental disability and have not committed aggravated offenses. Offenders remain in the program until they meet certain goals or are discharged from the criminal justice system. Case management services are provided for 100 offenders at a time, and approximately 175 offenders go through the program in a typical year.

Project CHANCE provides a vital and consistent link between the criminal justice and social service systems. In a nutshell, the project offers the offender the opportunity to obtain needed life skills while remaining in the community. Intensive case management helps participants identify their needs and establish goals. Staff help each offender to develop an individual justice plan that emphasizes community support services designed to help offenders master appropriate social behavior and improve their independent living skills.

In the 1993 fiscal year, 180 offenders participated in Project CHANCE. Most of these participants either successfully completed the program, are still involved in it, or were discharged from the criminal justice system. Project CHANCE's success is evaluated primarily in terms of recidivism, but participation in Project CHANCE improved the lives of virtually all participants, primarily because the program adapts all correctional programs and services to meet each offender's needs.

Project ACTION, also an intensive case-management program, was the Council's second pilot project. Like Project CHANCE, Project ACTION is designed to divert non-aggravated offenders with general mental health disabilities away from the criminal justice system and reduce their rate of recidivism. However, Project ACTION places a greater emphasis on programming than does Project CHANCE.

Organizations represented on the Council-

- Texas Commission on Alcohol and Drug Abuse
- Texas Council of Community Mental Health and Mental Retardation Centers, Inc.
- Texas Department of Mental Health and Mental Retardation
- Texas Department of Criminal Justice (Institutional Division, Pardons and Paroles, and Community Justice Assistance Division)
- Texas Education Agency
- Texas Commission on Jail Standards
- Texas Criminal Justice Policy Council
- Texas Rehabilitation Commission
- Association for Retarded Citizens
- Texas Department of Human Services
- Parents Association for the Retarded
- Mental Health Association
- Texas Youth Commission
- Texas Juvenile Probation Commission
- Texas Alliance for the Mentally Ill
- Texas Commission on Law Enforcement Officer Standards and Education
- Planning Council on Developmental Disabilities
- Texas Department on Aging.

Nine members-at-large arc appointed by the governor.

Project ACTION can serve no more than 120 offenders at a time, but it also provides ongoing technical assistance to other offenders or agencies. Thus far, almost 400 offenders have been involved in Project ACTION. The maximum length of stay in the program is two years. If an offender is stable for a significant period, case managers are encouraged to discharge them before the end of the two years.

Project ACTION reports quarterly to the Council on the recidivism rates of offenders in the program. Recidivism rates are measured by arrests, new convictions and/or incarcerations, and noncompliance with probation and parole conditions. Program success is measured by offenders' subsequent ability to obtain a job, secure income, re-establish social skills, maintain a stable home, and comply with medication requirements. A 1993 study by the Texas Criminal Justice Policy Council reviewed the pre- and post-program arrest rates of Project CHANCE and Project ACTION participants. The study revealed a 63 percent reduction in arrest rates for participants.

Projects similar to ACTION and CHANCE have now also been developed in the eight most populated counties in Texas. Unlike the initial projects, these programs serve both mentally retarded and mentally ill offenders. All programs are also responsible for providing screening and pre-release planning for offenders with mental impairments in county jails or prisons who are in need of aftercare treatment. ***(See related article, page*** 33.) This pre-release planning activity has recently been expanded to include juveniles with mental impairments who are committed to facilities operated by the Texas Youth Commission.

"Special needs" parole release. In addition to keeping offenders with special needs in the community, the two pilot projects attracted federal funding for eligible offenders. Partly in response to this funding success, the Texas legislature recently broadened the Council's responsibilities. Legislative changes were made to allow for the early release of special needs offenders in three new categories eligible to receive federal funds: the elderly, the terminally ill, and persons with physical disabilities. The Council established intensive case management and placement services for eligible inmates.

Target populations for this "special needs parole program" are inmates who have not been convicted of an aggravated offense and who are elderly, significantly or terminally ill, or physically disabled, and whose medical condition qualifies them for a nursing home, hospice, or other similar care. After being released from incarceration, the special needs parolee remains in the program for life or until he or she is m-incarcerated for a new offense. To date, 140 inmates have been approved for special needs parole.

The program is intended to reduce the state's correctional health care costs. Federal medical care funding reimburses nursing homes and other providers of health care services, and 80 percent of special needs parolees have been placed in their family homes. Since offenders incur no residential fees, state costs are reduced to case management and the state's share of Medicaid-reimbursed medications or treatments.

Outcomes of the Council's Efforts

A centralized approach to dealing with special needs offenders allows correctional systems to make programs that are already in place and known to be effective accessible and relevant to this previously excluded group. Independence and access to additional funding allow the central body to move beyond conventional treatment categories and to develop programs and policies that are more relevant to special needs offenders.

Cooperation among agencies has been significant in Council-funded programs. For example, the Pardons and Paroles Division of the Texas Department of Criminal Justice, the Texas Department of Human Services, and the Social Security Administration collaborated with private nursing homes and others in the special needs parole program. Further, although the pilot projects have been the main focal point for collaboration, there has been a subtle but significant increase in overall cooperation among the agencies and advocacy groups. In cooperation with the Texas Commission on Law Enforcement Officers Standards and Education, the Council recently helped develop a training curriculum for the Specialized Mental Health Deputies Program. The training increases participants' awareness of mental health disability and teaches them how to respond appropriately. Some sheriff's departments have created specialized mental health deputy positions.

The Texas legislature recently passed legislation requiring the criminal justice and mental health systems to plan and develop joint funding requests for special needs offenders. At the same time, the Pardons and Paroles and the Community Justice Assistance Divisions of the Texas Department of Criminal Justice have each created specialized caseloads of offenders with special needs.

Although these are some of the positive results of the work of the Council, the following statement, made 176 years ago, still rings true today:

> But the insane criminal has nowhere any home, no age or nation has provided a place for them. They are everywhere unwelcome and objectionable. The prisons thrust them out, the hospitals are unwilling to receive them, the law will not let them stay at home and the public will not permit them to go abroad. And yet, humanity and justice, the sense of common danger, and a tender regard for deeply degraded individuals all agree that something should be done-that some plan must be devised, different form and better than any that has yet been tried, by which they may be properly cared for, by which their malady may be healed, and their criminal propensity overcome.
>
> -E. Jarvis, ***American Journal of Insanity*** 13,3 (1817).

We are still searching for answers. Jarvis' statement, meant to describe offenders with mental health disabilities, could apply today to any offender with special needs.

For additional information, contact Dee Kifowit, Director, Texas Council on Offenders with Mental Impairments, 8610 Shoal Creek Blvd, Austin, Texas, 78757; telephone (512) 406-5406; or Judy Briscoe, Council Member, P.O. Box 5260, 4900 North Lamar Blvd., Austin, Texas, 78765; (512) 483-5269. ■

A Little "TLC": Maricopa County's Transitional Living Center

by Kyle Mickel, Coordinator, Transitional Living Center, Maricopa County Adult Probation Department, Phoenix, Arizona

Alan is a twenty-nine-year-old construction worker recently released from jail after violating probation on burglary charges. He is typical of the 566 mentally ill offenders being supervised by the Maricopa County Adult Probation Department (MCAPD) in Phoenix, Arizona. Locating effective treatment options for Alan and other members of this challenging population is no easy task. Seriously mentally ill (SMI) defendants arc often rejected for services by behavioral health agencies. Reasons for their rejection include offenders' active drug or alcohol abuse, changes in their diagnosis, loss of contact with case workers, or offenders' refusal of services.

When serious mentally ill offenders are in distress and need immediate intervention, probation officers need to find ways to tap a limited pool of resources. Maricopa County Probation currently employs six specialized mental health probation officers who work solely with SMI offenders, but whose caseloads are usually capped at forty clients. Offenders on the waiting list for specialized supervision may therefore lack appropriate intervention during times of psychiatric instability. The result may be that these offenders again come in contact with police, jails, and the criminal justice system.

All too often, our jails become the "treatment facilities" for the mentally ill only because there apparently is nowhere else to turn. To avoid the seemingly endless cycle of SMI recidivism, the standard probation officer needs additional skills and resources when the doors to successful supervision are closed. That's where the Transitional Living Center comes in.

Referrals Key to Transition Process

Funded through legislative appropriation since 1989, the Transitional Living Center (TLC) is a probation-operated residential program for psychiatric intervention. TLC is home to twenty-five SMI probationers who are awaiting appropriate community placement and is housed in the renovated Elsinore Baptist Church. The average length of stay at TLC is about sixty days, but this varies, depending on the time it takes to achieve linkages with community support services and facilities.

TLC's role is limited and well-defined. Falling far short of addressing all of its clients' psychiatric, personal, and legal needs, the program serves as a bridge toward independent living:

- Clients receive full medical and psychiatric evaluations. In most cases, appropriate dosages of psychotropic medications are prescribed.
- Staff initiate referrals for applicable benefits and entitlements.
- Initial and monthly case staffings identify follow-up placements and treatment strategies based on each probationer's needs.

Court-ordered terms of probation often dictate offenders' placement following their stay at TLC. However, input from interested parties helps locate ideal options. These options are discussed during regularly-scheduled staffings held the initial week of admission and every thirty days thereafter. TLC staff counselors report the results of an Addiction Severity Index, which identifies the client's medical, psychiatric, employment, family/social, legal and drug/alcohol treatment needs. Staffing participants include the probation officer, counselor, project coordinator, clinical director, psychiatric nurse, and case managers.

After the treatment plan is outlined, TLC's in-house case manager establishes community contacts to achieve placement at the desired treatment setting. The follow-up setting varies greatly from client to client. Relatively stable probationers may be placed at their homes and referred to outpatient services, while those in need of longer-term residential treatment may enter the most intensive therapeutic environments available.

Program Operations

Maricopa County contracts with a local non-profit agency, New Arizona Family, Inc. (AFI), for TLC's daily operations. The facility is staffed by a clinical director, project coordinator, three full-time counselors, six part-time counselor aides, a case manager, an independent living skills coordinator, an on-call psychiatrist, an on-call psychologist, and a psychiatric nurse.

TLC is one of three residential treatment programs administered in Phoenix by AFI. AFI also operates a drug treatment facility with a twelve- to eighteen-month program and a six-month program for dually diagnosed SMI clients who are also battling chemical dependency. These two facilities often serve as placement options for TLC graduates.

A TLC Coordinator is provided by MCAPD to screen cases and serve as department liaison. The program coordinator must be selective in approving clients for admission and rejecting those who might jeopardize the facility's safety and integrity.

Certain types of offenders are usually ineligible for TLC:

- Offenders with a significant history of violent criminal behavior;
- Offenders with non-SMI mental health problems, such as mental retardation or developmental disability; and
- Offenders needing extreme medical intervention, court competency evaluations, or treatment for mental problems resulting from long-term substance abuse.

TLC Successes

In statistical terms, TLC is a resounding success. Last year, 144 clients benefitted from TLC's unique services, with 63 percent achieving successful community placement.

More than 70 percent of those admitted to the program were released early from jail sentences into TLC under a specific court order to enter treatment. Had these offenders remained in jail to complete their sentences (and thus received no treatment), Maricopa County would have incurred an additional 5,428 total days of incarceration costs. The average daily cost of TLC treatment is about $60 per client, significantly less than the average daily cost of $75 to incarcerate an inmate in the Maricopa County jail's psychiatric unit. From July 1, 1993, through June 30, 1994, eighty-eight clients were released early through the TLC, for an estimated savings to the county of $81,420.

The true test of TLC's worth, however, is not as easily calculated. Perhaps the probationer's definition of success is the degree of insight he or she has gained about the specific complexities of his/her mental illness, its symptoms, and how these can be treated and controlled. This knowledge leads to self-understanding and confidence, which can enable SMI probationers to address the psychiatric obstacles that interfere with their transition to productive, independent living.

We witness success in the TLC beneficiary who maintains gainful employment; who remains clean and sober; who avoids further contact with the criminal justice system; who improves his/her own quality of life; and who contributes to the community by helping fellow Phoenix residents. This is the true test of success, for which there is no real measurement.

For additional information, contact Kyle Mickel, Coordinator, Transitional Living Center, Maricopa County Adult Probation Department, 6655 W. Glendale Avenue, Glendale, Arizona, 85301; (602) 435-6738. ■

Community-Based Forensic Case Management

by Linda Andresen, Forensic Unit Coordinator, Center for Health Care Services, San Antonio, Texas

The Center for Health Care Services in San Antonio, Texas, provides a unique approach to continuity of care for mentally impaired offenders in Bexar County. While also serving the mental health needs of the community at large, the Center operates a Forensic Unit that offers intensive treatment and support to offenders with serious mental disorders. The Forensic Unit works with the courts, jail, probation, and parole to assess the needs of mentally impaired offenders and link them with services in the community so that offenders can remain in non-institutional placements when appropriate.

Recommendations for individual clients may include services provided by the Center. For mentally impaired offenders receiving forensic clinical treatment from the Center, the program provides a combination of outpatient services and intensive case management, as well as crisis intervention services.

The Center's philosophy is to ensure that services delivered to persons with severe mental disabilities are tailored to individual needs so that these people can achieve the highest possible level of independent functioning in the community. Services for each client are constantly re-evaluated to be sure they meet the client's changing needs.

The Center's Service Matrix

The Center's Forensic Unit provides comprehensive services to improve the chances that mentally impaired offenders will adjust successfully in the community.

- ***Assessment and evaluation.*** Center staff provide screening, evaluation, and. consultation for the courts, the Bexar County Detention Center, Bexar County Probation, and the Texas Department of Corrections. Staff may recommend that offenders be referred to programs provided by corrections agencies such as probation, by other community organizations, or by the Center itself. The Bexar County Adult Detention Center provides security badges for forensic case managers and the forensic psychiatrist so they can easily meet with offenders for this purpose.

- ***Intensive case management.*** Each offender receiving services from the Center is assigned a forensic case manager to provide overall coordination of mental health care, including care provided by the Center. The case manager also locates low-cost housing as needed and provides linkages to appropriate community resources. Other responsibilities include working closely with probation or

parole officers, the courts, and other criminal justice agencies on issues related to community supervision. The client ratio is one case manager to twenty clients. Clients are seen face-to-face five times a week and are in contact by phone the other two days a week during the first thirty days of case management. After that period, the treatment team determines an appropriate treatment level.

- ***Forensic clinical services.*** At the Center, Forensic Intensive Treatment Services staff have special skills needed to work with offenders with mental impairments. The staff includes a unit coordinator, a forensic psychiatrist, a registered nurse, forensic case managers, and a contracted psychologist who assists with research and outcome analysis. Psychiatry residents from the University of Texas Health Science Center at San Antonio also see clients regularly. A forensic psychiatrist and nurse based at the Center's outpatient clinic provide comprehensive clinical evaluations of offenders with complex presenting problems, specialized treatment for severe mental impairments and dual diagnosis with substance abuse, and medication management. Substance abuse treatment may be provided by the Center's substance abuse outpatient clinic.

- ***Community referrals and living assistance.*** Clients are referred to a range of community services and receive help with their basic needs. Case managers assist with transportation, leases, disability subsidies, and the acquisition of household items. Because supportive and drug-free housing is important to client success, a main goal is to establish more housing choices for severely mentally impaired offenders. The Center can have difficulty finding placements for clients who are offenders, despite providing twenty-four-hour crisis response, and sometimes pays providers an extra amount for the first month to help get these clients accepted as residents.

- ***Crisis intervention.*** In situations requiring clinical crisis intervention, the Center can admit offenders into its own crisis resolution residential unit or detox unit. Beds in these units are immediately accessible to offenders twenty-four hours a day, seven days a week.

Providing Services to Offender Populations

The Center's main target populations include detainees in the pretrial investigation and pre-sentencing stages who are being held at the Bexar County Detention Center, inmates sentenced to the Texas Department of Corrections but being held at the detention center, probationers, parolees, and persons found not guilty by reason of insanity under Texas law.

Jail/prison detainees. A close partnership exists between the Bexar County Detention Center's medical/psychiatric department and the Center's case management program. A specially trained Center caseworker works as part of the jail's mental health team and provides liaison between the detention center and the Center for Health Care Services. The caseworker screens and evaluates detainees for mental impairments including mental illness and the dual diagnosis of mental illness and substance abuse. The Center may provide diagnosis, medications, and treatment while the offender is at the detention center.

The case manager also works with detention center staff to develop a discharge plan for continuity of care after release, providing initial linkages to mental health service providers in the community. Approximately eighty jail detainees per year who-are severely mentally impaired are referred to the Center for treatment on release from jail/prison. Those with mental disorders who do not meet the criteria for severe mental illness or who have special needs, such as sex offender treatment, are referred to other community resources.

Center staff also work with state inmates being held at the jail. Through its regular screening and service recommendation process, the Center is able to pull some of these offenders out of their intended institutional placements to receive community-based services coordinated by the Center.

Probationers. Staff conduct screenings for an estimated 1,000 mentally impaired potential probationers annually and submit recommendations to the sentencing court. Community management recommendations for offenders who are not severely mentally ill may include the use of probation department resources, such as electronic monitoring and Antabuse maintenance, rather than care provided by the Center. The Center's crisis intervention services are available to these probationers if needed.

Of the individuals who are screened for service needs on probation, approximately sixty per year will go on to receive clinical treatment and/or intensive case management services from the Center. Center caseworkers also provide consultation to probation officers on how to manage individuals and assist the probation department with offenders who are particularly difficult to manage.

Offenders found not guilty by reason of insanity. Center staff provide screening and evaluation for Bexar County's criminal law magistrate, who hears all cases involving competency and insanity. Eligible offenders judged not guilty by reason of insanity are placed on court-ordered outpatient commitments and released to the custody of the Center, which provides them with all regular services while they are in the community. Approximately twenty such cases are managed per year. Any failure to comply with treatment is immediately reported to the court, which may require the client to be incarcerated or hospitalized.

Parolees. A law passed by the Texas legislature in September 1994 requires the state prison system to notify local service providers before releasing mentally impaired individuals on parole. In Bexar County, the Center for Health Care Services is the designated site to receive this notification. This enables the Center to perform evaluations and recommend service plans for offenders before they are released. Previously, parolees were referred to the Center, but their contact was much less reliable. Offenders often did not receive needed services and were more likely to re-offend and be returned to prison.

Offenders at risk for probation or parole revocation. Center staff play a role in the revocation process by conducting assessments and making recommendations to the court or hearing officer. In most cases, the Center is successful in recommending continued community placement along with treatment services. However, limited availability of some services in the San Antonio area can lead to a recommendation

that offenders be incarcerated in order to receive needed treatment. For example, since only thirty- to ninety-day substance abuse treatment placements are available locally, mentally impaired offenders who need long-term substance abuse treatment in order to become stabilized must be sent to the state corrections system. Sex offenders are another population for whom adequate treatment is not presently available in the community.

Interagency Collaboration

Liaison between the Center and criminal justice agencies is integral to the Center's role. Center staff work out of the Bexar County Detention Center and Adult Probation offices, and staff of these agencies have offices on-site at the Center. For their work with parolees, staff maintain connections with the Texas Department of Corrections Institutional Division. The Center works with the maximum security unit at the Vernon State Hospital in matters relating to offenders not guilty by reason of insanity, and it maintains ties with the Texas Council on Offenders with Mental Impairments. This collaborative approach ensures that mentally impaired offenders receive the supervision and care they need to function independently.

In addition, cross-training contributes significantly to the effectiveness of the program and further exemplifies its interagency approach. Forensic Unit staff attend training provided by the state's parole academy, and the Center trains probation, parole, and jail staff on issues in mental illness and disability.

Since its inception in 1986 with one staff member, the program has grown to a staff of twelve. Funding is provided by the Texas Council on Offenders with Mental Impairments, the Texas Department of Mental Health and Mental Retardation, the Texas Criminal Justice Assistance Division, and through Medicaid and other third-party reimbursements.

For additional information, contact Linda Andresen, Forensic Unit Coordinator, Center for Health Care Services, 1407 N. Main St., San Antonio, Texas, 78212; phone (210) 299-1071. ■

Hints on Developing a Continuity of Service System for Offenders with Mental Illness and Mental Retardation

- Involve the highest level officials from each participating agency.
- Involve all agencies and consumers in the service area in the strategic planning process.
- Establish a liaison system between the mental health system and all facilities/agencies involved.
- Cross-train staff of all organizations.
- Establish an information exchange among all agencies.
- Establish collaborative, on-going communication on a daily basis among agency staff.
- Establish a mechanism whereby the highest level officials and key staff of all organizations meet at intervals to work through implementation strategies. ■

Accessing Federal Disability Resources

by Kyle A. Matting, MS., Mental Health Therapist/Case Manager, Adams Community Mental Health Center, Commerce City, Colorado

People who are unable to work or engage in gainful activity because they are mentally ill may be eligible for disability benefits provided through the Social Security Administration (SSA). Two types of disability benefits are available: a monthly cash benefit for obtaining food and housing, and disability insurance that covers psychiatric evaluation, medications, and mental health therapy. These supports help a disabled individual start a course of recovery, and they are key to accessing mental health and other rehabilitation resources in the community.

The application process is initiated with a phone call to a local or national SSA office. Information will be requested, including the person's name, Social Security number, date of birth, diagnosis, and an address to which the follow-up formal application should be sent. Because the time between application and final review can be lengthy, it is important to start the process early and to provide complete and accurate information. It may be advisable to assign a responsible person as the disabled applicant's representative payee-a probation department, community corrections facility, mental health center, or a family member. The payee agrees to manage the disability income and ensure that the funds are used as intended.

Publication no. SSA 64-039, "Disability Evaluation Under Social Security," defines the criteria for disabling mental disorders. The law defines a disability as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than twelve months." Based on this definition, the Social Security Administration evaluates an application based on the following specific criteria:

- ***Clinical signs and symptoms of mental disorder.*** Clinical signs are "medically demonstrable phenomena which reflect specific abnormalities of behavior, affect, thought, memory, orientation, or contact with reality." They may include auditory hallucinations or other perception disturbances, delusions or other thought disturbances, and depression or other significant mood disturbances.

- ***A description of the individual's functional impairment that is a direct result of the mental disorder.*** A functional impairment may be a neglect of personal care or an inability to perform activities of daily living.

- ***Evidence of the person's inability to function outside of a structured setting or evidence of repeated deterioration or exacerbation of symptoms under stress.*** Examples could include the inability to find housing, employment or food.

The national toll-free number for the Social Security Administration is (800) 772-4213.

The application must document the ways in which the disabled person meets each criterion. His or her status in the correctional system is also important in determining eligibility: an offender currently in prison serving a sentence for a felony is ineligible until he/she is on parole. In most cases, a person engaged in a work release program is also ineligible for disability benefits. ■