

Doing Justice for Mental Illness and Society: Federal Probation and Pretrial Services Officers as Mental Health Specialists

Risdon N. Slate, Ph.D.

Florida Southern College

Erik Roskes, M.D., Director, Forensic Treatment

Springfield Hospital Center

Richard Feldman, LCSW

Senior United States Probation Officer

Migdalia Baerga, LCSW, Mental Health Administrator

Administrative Office of the U.S. Courts

AT THE BEGINNING of this century, approximately 6.6 million people were on probation, in jail or prison, or on parole in the United States. Of this population, over 2 million were incarcerated in the nation's jails and prisons (Bureau of Justice Statistics, 2003A). In fact, the number of those incarcerated in the United States has quadrupled since 1980 (Bureau of Justice Statistics, 2003B).

It is estimated that roughly 5 percent of Americans in society have a serious mental illness, and Americans with mental illnesses are significantly overrepresented in the criminal justice system (Council of State Governments et al., 2002). Mental health problems are notably common among correctional populations, including community corrections populations. However, it is difficult to obtain meaningful data on the prevalence of mental illness among correctional populations (Pinta, 2000; Clear et al., 1993). A variety of efforts have been made to attempt to understand the rates of mental illness among different correctional populations, the role of mental illness in propelling individuals into the correctional system, and the importance of collaboration between mental health and correctional professionals in managing persons with mental illness.

An estimated 16 percent of inmates in jails and prisons, or 284,000 individuals, reported

suffering from mental health problems or having been admitted to a hospital for mental health reasons (Ditton, 1999). This finding, while subject to criticism because it relied primarily on the self-report of the correctional populations surveyed, fairly closely reflected previous research findings (for instance, see Steadman et al., 1987; Teplin, 1990; Teplin et al., 1996; Pinta, 1999). Statistics such as these fuel the concern, noted by Petersilia (1999), that the majority of these persons with mental illness who are currently incarcerated will return to the community under some type of supervised release.

The prevalence of mental illness among the community corrections population is less well studied. However, about 16 percent of probationers, or approximately 548,000 individuals, are estimated to have mental health needs (Ditton, 1999). According to Lurigio (2001), no studies have measured the number of parolees with serious mental illnesses in the United States, but he estimates that 5 to 10 percent of those on parole have serious mental illnesses. This discrepancy between the percentage of persons with mental illness who are incarcerated or on probation (about 16 percent) versus those on parole (5-10 percent) may stem in part directly from those individuals' mental illness. Many mentally ill people in correctional environments may not receive adequate or optimal treatment and

may therefore be unable to comply with institutional rules and regulations. The symptoms they display may thus prolong their incarceration and reduce the likelihood of their receiving parole.

Despite these large numbers, the criminal justice system appears ill equipped to meet the special needs of persons with mental illness who are incarcerated or on custodial release in the community. For example, only 15 percent of probation departments nationally acknowledged operating a special program for mentally ill probationers (Lurigio, 2000). Likewise, Lurigio (2001) indicates that most parole agents lack the exposure and foundation to handle those who are mentally ill under their supervision. A national survey reflects that fewer than 25 percent of parole administrators report operating specialized programs for mentally ill clients; Camp and Camp (1997) found no parole agencies that reported providing any specialized mental health services for offenders with mental illness.

Criminalizing Mental Illness

A number of rationales have been offered to explain the criminalization of the mentally ill. Deinstitutionalization—the release of persons with mental illness from state hospitals under the erroneous assumption that adequate treatment programs would be put in place in the community to serve this popula-

tion—is one common explanation for the criminalization of the mentally ill (Kalinich, Embert, & Senese, 1991; Winfree & Wool-dredge, 1991). Primarily because of a lack of funding, community treatment programs generally never emerged (Jerrell & Komisaruk, 1991; Sargeant, 1992; Torrey, 1995). The deinstitutionalization movement has shifted more than 400,000 people, from 500,000 persons in 1960 being housed in state hospitals to fewer than 60,000 patients being housed in such public hospitals today (Sharfstein, 2000). Note, however, that a recent study of inmates with mental illness found that only about half of them had ever been in a psychiatric hospital at all (Fisher, et al, 2002). The authors compared this to findings from the National Comorbidity Survey (which can be accessed at <http://www.icpsr.umich.edu:8080/SAMH-DA-STUDY/06693.xml>) that about 18 percent of a similar control group had been hospitalized. Thus, those in jail were three times as likely to have been hospitalized. The implication of this study is that access to inpatient care may not be the issue at all. However, it is possible that **at the time of the incident leading to arrest**, lack of access to inpatient care may result in an individual being detained in the correctional setting. Hogan (2000), the Director of Mental Health for Ohio and the chair of President Bush's New Freedom Commission on Mental Health, cautions that to suggest that deinstitutionalization alone is responsible for the criminalization of the mentally ill is an oversimplification and may mistakenly imply that somehow reinstitutionalization is the proper solution.

Some suggest that managed-care companies sometimes invoke penalties against primary care providers and front-line mental health service providers who make too many referrals to psychiatrists (Miller, 1997), and Stone (1997) maintains that fewer persons with mental illness would wind up in jail if they had adequate insurance coverage. Similarly, "medication reimbursement caps, capitation, restricted formularies, preferred pharmacy networks, copayment plans, 'economic credentialing,' and the use of nonmedical professionals to screen mentally disordered patients" (Miller, 1997: 1207-1208) have been identified as impediments to adequate treatment for persons with mental illness. In an era of managed care, some psychiatrists face conflicting responsibilities to the patient and to the payer, and patient care may suffer as a result (Miller, 1997).

Three strikes laws have also likely contributed to institutionalizing the mentally ill

within the criminal justice system as well, in part because those with mental illness may, when the illness is not effectively treated, be less able to follow the rule of law. They may thus be more vulnerable to long-term incarceration for minor crimes than are those without mental illness. Other explanations for the criminalization of the mentally ill are offered by Goldkamp and Irons-Guynn (2000) and include the growing homeless population, co-occurring disorders (whereby mental illness often co-exists with a substance abuse problem), law enforcement crackdowns as part of the war on drugs, and police focus on quality of life and ordinance violations.

Some law enforcement officers refer to locking up persons with mental illness as mercy bookings, believing that at least shelter, food, and safety will be provided for those in need while detained (Sargeant, 1992). Unfortunately, the treatment for their illness encountered in jails is often nonexistent or woefully inadequate (Butterfield, 1998; Kerle, 1998). According to Walsh and Bricourt (1997) over 20 percent of jails offer no formal access to treatment for the mentally ill, and Kerle (1998), in a study of more than 3,000 jails nationwide, found only 35 with mental health treatment models worth replicating. As for treatment of the mentally ill, Ditton (1999) in a self-report survey found approximately 60 percent of state and federal prison inmates and 41 percent of jail inmates/detainees indicating that they had received some sort of mental health service.

Whatever the reasons, the criminal justice system has become the social service system of last resort. "With 3,500 and 2,800 mentally ill inmates respectively, the Los Angeles County Jail and New York Rikers Island Jail are currently the two largest psychiatric inpatient treatment facilities in the country" (Sharfstein, 2001:3).

Probation Officers as Resource Brokers

Even an inmate fortunate enough to receive some semblance of mental health treatment while incarcerated will find that discharge planning, particularly from jails, is often non-existent (Steadman and Veysey, 1997). This deficiency can result in persons with mental illness being released into the community with no medication, follow-up appointments or any assurance of contact with the mental health treatment community (Osher, Steadman and Barr, 2003). Mental health courts have been one mechanism for enlisting pro-

bation officers to assist in establishing this vital link of mental health treatment upon release from custody into the community (Slate, 2003). Griffin et al. (2002) have found that such courts rely upon probation officers, community treatment providers or mental health court staff, or on teams made up of both probation and mental health treatment personnel, for monitoring and assisting in linkage to community services. Probation officers have played integral roles in status hearings before the court (Lurigio and Swartz, 2000; Petrila, Poythress, McGaha and Boothroyd, 2001) and can serve as resource brokers or boundary spanners in navigating and linking clients to mental health treatment, housing, benefits, and vocational/employment opportunities (McCormick, 2001; Steadman et al., 2001). Probation officers also play a pivotal role in providing the court with a comprehensive history of the client's background when a presentence or pre-release investigation is ordered.

Unfortunately, unless symptoms of mental illness are overtly obvious at the time of offense or manifest themselves at sentencing, such specialized attention from the criminal justice system rarely is available to the person with mental illness who encounters the criminal justice system. As noted by Veysey (1994), probation officers typically do not have the background and experience to deal with persons with mental illness effectively. However, specialized programs are emerging, with an influx of more resources and better training for probation officers. With these fiscal, training and personnel resources, mental health treatment can be mandated as a condition of release (Lurigio and Swartz, 2000; Roskes and Feldman, 1999; Roskes and Feldman, 2000). For example, specialized programs have emerged for probationers with mental illness in the Cook County Adult Probation Office in Chicago (see Lurigio and Swartz, 2000), for parolees under the supervision of five outpatient clinics and a conditional release project within the California Department of Corrections (Lurigio, 2001) and for those under probation, parole, supervised release or conditional release supervision with the U.S. Probation Office in Baltimore (Lurigio, 2001; Roskes and Feldman, 1999, 2000). Broward County, Florida, which established the nation's first mental health court for misdemeanants (Slate, 2000), has now implemented 32 hours of specialized training for probation officers who supervise in the community felons who are mentally ill (E. Miller, personal communication, May 12, 2003).

Assertive community treatment (ACT) is also a team approach to care that can provide coordinated treatment and supervision options to individuals with mental illness who encounter the criminal justice system. ACT models include psychiatrists, substance abuse specialists, housing procurement specialists, rehabilitation and vocational counselors, clinicians, nurses, and peer counselors who offer necessary services and assist in monitoring the client in jail if necessary (Lurigio and Swartz, 2000; Allness and Knoedler, 1999; Kondo, 2000; Edgar, 2001). These practitioners follow the client into the community to assist in psychosocial rehabilitation and facilitate community living, with the goal of eliminating or reducing institutionalizations (Allness and Knoedler, 1999). Although recipients of ACT services typically receive such services voluntarily, probation officers have at times ended up as members of ACT teams because of court-ordered conditional releases (Sheppard, Freitas and Hurley, 2002; Herbert, Conklin and Keaton, 2002).

Recidivism

Probation officers sometimes feel torn between the conflicting roles of law enforcement agent and social worker, and this can be particularly true when called upon to supervise persons with mental illness in the community. There is some research focusing on the criminal recidivism of the mentally ill offender. Participation in mental health treatment for those under conditional release in the community has been found to be correlated with a lower risk of incarceration for technical violations; however, those who were revoked for a technical violation have been found to be six times more likely to have been the recipients of intensive supervision (Solomon et al., 2002). While these researchers noted that the jail system being studied had a comprehensive mental health treatment system in place that made it easier to re-incarcerate violators, they indicated that results appear mixed on whether intensive case management services lessen the risk of imprisonment. The researchers concluded that: "providing services that emphasize monitoring tends to increase the risk of incarceration for technical violations of criminal justice sanctions. However, any participation in treatment and motivation to participate in treatment appears to reduce the risk of incarceration" (2002:50).

A recent study (Harris and Koepsell, 1998) found that a group of mentally ill offenders

had an equivalent recidivism rate when compared to a matched control group of non-mentally ill offenders. However, the same group has reported that the introduction of pre- and post-release interagency coordination significantly reduced the recidivism risk in a pilot group (Harris et al., 1998). Another study recently reported that the introduction of case management services led to a significant decrease in the recidivism rate of mentally ill offenders (Ventura et al., 1998), and previous research has demonstrated that judicially monitored treatment resulted in good outcomes during a one-year follow-up phase (Lamb et al., 1996). Taken together, this work indicates that the mentally ill offender has a high likelihood of having ongoing contact with the criminal justice and correctional systems, and there are clinical interventions that may be able to positively affect the recidivism rate.

Probation Officers as Part of the Discharge Planning Process

Of all services provided to inmates, discharge planning for persons with mental illness being released from jails has been found to be least likely to be offered (Steadman and Veysey, 1997). Recently, *Brad H. v. City of New York* (1999), which was the first class action suit ever initiated for mentally ill jail or prison inmates, resulted in the New York City jail system being ordered to arrange discharge planning services for mentally ill inmates being released into the community (Barr, 2003, complaint is available at www.urbanjustice.org/litigation/PDFs/BradHComplaint.pdf; settlement document is available at www.urbanjustice.org/litigation/PDFs/BradSettlementMHP.pdf). Osher, Steadman and Barr (2003) maintain that probation officers can be cross-trained with mental health professionals and work hand-in-hand with clinicians in supervising those with mental illness released into the community, relying on graduated sanctions that rise to include hospitalization instead of incarceration.

Therapeutic Jurisprudence

Therapeutic Jurisprudence has been described as an assessment of how "substantive rules, legal procedures and the roles of lawyers and judges produce therapeutic or antitherapeutic consequences" (Wexler and Winick, 1991:981). It is argued that lawyers engaged in the adversarial process of law have a tendency to ignore the long-range consequences of their decisions for both their

clients and society (Finkleman and Grisso, 1994; Miller, 1997).

The traditional criminal justice system tends to look backward finding fault and assessing blame, carrying out a punishment upon someone for perpetrating a criminal act, without much, if any, consideration of the consequences of the imposition of the penalty on the perpetrator or society. ...Decisions within the therapeutic jurisprudence framework are made with consideration of future ramifications for individuals, relationships and society long after a person's contact with the criminal justice system has ceased (Slate, 2003:15).

Probation officers are strategically located within the criminal justice system to assist with dispensing therapeutic jurisprudence, and their actions can benefit not only those under their supervision but society as well. Armed with carefully crafted conditional and supervised release plans, appropriate monitoring, adequate resources and proper training, probation officers can function as therapeutic jurisprudence change agents, helping people change their lives for the better. The remainder of this article will focus on how the Federal Probation and Pretrial Services System is grappling with effectively supervising persons with mental illness on their caseloads.

Federal Probation & Pretrial Services Data

As of September 30, 2002, a total of 34,880 cases were receiving pretrial supervision from United States Pretrial Services, and a total of 108,792 cases were under the supervision of the United States Probation Office (Administrative Office of the U.S. Courts [data on file], 2003, February 25). These latter cases include individuals on probation, on parole, and on supervised or conditional release.

Of the cases on supervision, 14 percent (n=4,720) of those on pretrial release and 18 percent (n=19,731) of those on probation (this category refers to those on parole and supervised or conditional release as well) had a special condition for mental health treatment (Administrative Office of the U.S. Courts, 2003, February 25). Of these cases, 31 percent (n=1,454) of those on pretrial release and 47 percent (n=9,340) of those on probation supervision received contracted services. Congress appropriates funds for the federal judiciary annually. The funding pays for employee salaries as well as a myriad of pro-

grams for defendants and offenders [including mental health treatment] (Administrative Office of the U.S. Courts, *Court and Community, January 2003*). Certainly, those not receiving contracted services may be rendered assistance from Medicaid, Medicare, the Veterans Administration, private insurance carriers, and/or via free or sliding fee community-based programs. The total mental health expenditures for contracted services for fiscal year 2002, according to the Administrative Office of the U.S. Courts (2003, February 25), was \$10,731,324, or an average of \$994 per contracted case.

Data is not available for the clinical or legal breakdown of individuals under the jurisdiction of U.S. Probation or Pretrial Services on a national basis. Roskes and Feldman (1999) published a pilot study examining some of this information. They found that their shared cases primarily had psychotic illnesses: 44 percent (7 of 16) were diagnosed with schizophrenia and 50 percent (8 of 16) with severe mood disorders, including major depression and bipolar disorder. In addition, 94 percent (15/16) of the cases had co-occurring substance abuse or dependence. Finally, 44 percent (7/16) were also diagnosed with a personality disorder, six (38 percent) of whom met criteria for antisocial personality disorder. Each of these co-morbidities is relevant for both treatment and supervision agencies, as they make both treatment and supervision much more complicated and make collaboration all the more relevant.

Roskes and Feldman (1999) also examined the crimes that had been committed by their cases. Bank robbery was the most common index offense, occurring in 44 percent (7/16) of the cases. One (6 percent) of the index offenses was a serious personal crime (kidnapping, rape, assault with intent to murder). One of the individuals convicted of bank robbery subsequently killed a correctional officer while incarcerated. Another 44 percent of the index offenses were a variety of property crimes.

Mental Health Specialists

Some officers within the federal probation and pretrial services system have been classified as mental health specialists (Administrative Office of the U.S. Courts, 2003, January). As with probation officers who serve as substance abuse specialists (Torres and Latta, 2000), agency philosophy can have a significant impact on the style of supervision rendered by mental health specialists and whether or not someone is designated as a

mental health specialist in a particular district.

Typically these mental health specialists have a solid foundation in mental health education, and in a number of instances they are licensed/certified clinical social workers, counselors or psychologists (Administrative Office of the U.S. Courts, 2003, January). While there is no standardized national mental health training program currently in effect, officers are routinely exposed to and participate in local, regional or national specialized mental health and/or substance abuse treatment conferences (such as regional or circuit trainings, annual district trainings, and specialized training sponsored by the Federal Judicial Center (FJC) and/or the Administrative Office of the U.S. Courts via the Federal Judicial Television Network [FJTN]). Included among the topics covered during such training sessions are discussions of mental health, substance abuse, domestic violence, dual disorders and assessment, and treatment and supervision of sex offenders. For instance, in May of 1999, the Administrative Office of the U.S. Courts hosted a national mental health and substance abuse conference, at which the former U.S. Surgeon General David Satcher served as the keynote speaker. Because of specialized training opportunities such as this one, mental health specialists or line officers working with mental health cases are adept at recognizing the signs and symptoms of mental illness and can coordinate required services in the community, often using contractual agreements (Administrative Office of the U.S. Courts, 2003, January). Often, the U.S. District Court or the U.S. Parole Commission orders a defendant and/or offender to participate in a mental health evaluation and/or treatment. In these cases, mental health specialists often serve as contractual brokers to ensure such services as counseling (individual, group or family), psychological/psychiatric testing and assessment, medication, transit to and from mental health treatment, and even money for food and clothing in emergencies (Administrative Office of the U.S. Courts, 2003, January). These officers also play an integral role by being keenly aware of issues related to non-compliance with court-ordered conditions of release and are equipped to monitor problems that require a proactive response.

Discussion

The finding that 14 percent of individuals on pretrial release and 18 percent of offenders on probation, parole, supervised or conditional

release in the federal system have mental health conditions is remarkably consistent with existing research indicating prevalence rates of mental illness in correctional populations. This provides some reassurance that the evaluators recommending such conditions and the judges imposing these conditions are (in a statistical sense, at least) imposing the most appropriate special conditions to foster strategies not only aimed at stabilizing mental health symptoms that may present a danger to a defendant/offender, the officer, and/or other third parties, but also to maximize the individual's potential for living and functioning effectively in the community. At the most basic level, therefore, the needs of the population are being met. Clearly, more research is needed in this important area. Nonetheless, the state of our science suggests that these interventions can be helpful, and are common sense as well.

In our experience, it is clear that several attitudes and skills are required for the most effective community-based treatment of the offender with mental illness. First and foremost, all should recognize that this collaboration can increase the likelihood of a successful community reintegration for an offender with mental illness. Many clinicians and supervising personnel are unaware of the body of research demonstrating that clinical interventions can help mentally ill offenders successfully re-enter the community.

Next, all involved must be willing to view each other as important team members in the management of these individuals. This willingness does not necessarily come easily, and in many instances we have experienced that one party is for some reason unable to develop a working relationship with another party in the management team. It is all too easy to find mental health providers who are unwilling to work with individuals who have legal entanglements; conversely, many probation agents and officers, particularly those with large caseloads, find themselves unable to deal with the complexities of the person with mental illness and prefer not to maintain them on their caseloads. Thus, to effectively manage mental health cases, particularly chronic and/or severely mentally ill individuals, a strong case can be established to ensure that officers with specialized mental health duties be allowed to carry significantly smaller caseloads than the average officer. Officers working with mental health cases (particularly severe or chronic mentally ill individuals) more often than not make intensive field (community) contacts, and maintain active collateral contacts with

treatment providers, local law enforcement officials, and family/community support systems. Additionally, they are responsible for ongoing assessment of third-party risk issues, treatment referrals and/or proactively fostering strategies to address uncooperative behaviors (such as non-compliance with court-ordered conditions).

These relationships work best if a team approach is developed that makes use of each team member's strengths and skills. Ideally, these should complement one another, to minimize the likelihood of someone falling through cracks in the safety net. Thus, in establishing a collaborative partnership, we envision the roles of the probation officer (primarily public safety in orientation) and of the clinical providers (primarily concerned with the psychiatric well-being of the individual client) as part of a "whole picture" rather than as competing with each other.

A final crucial factor is the ability to speak and understand each other's language (Roskes and Feldman, 1999). The jargons of the criminal justice and mental health systems are sophisticated codes that allow practitioners to easily communicate but often keep non-practitioners in the dark. Our experience together has convinced us that the ability to communicate and respect each other's roles is a key to the successful treatment of the defendant and/or offender with mental illness.

Examples of collaborative models offering comprehensive services to mentally ill offenders in the community can be found in Milwaukee, Wisconsin and Multnomah County, Oregon (see Roskes et al., 1999). However, there are numerous barriers to the development of such collaborative models. Managers of probation offices and other supervising agencies do not always understand the prevalence of behavioral disorders and the added layers of complexity presented by these cases; therefore, the need for specialized services for such individuals is not always clear to the managers of these agencies. Given the minimal understanding that many agencies have about the role of mental illness in the genesis of criminal behaviors, supervising agents are unable to effectively manage these cases. For instance, the ability of an individual with mental illness to adhere to even standard conditions of supervision may be far inferior to that of the average case. Given such lack of understanding, it is not surprising that managers of probation offices seldom encourage (or pay for) the development of specialized expertise in the area of mental illness. Instead, they may conclude that people

with mental illness are doomed to a high level of recidivism and therefore fail to invest the required time and energy in maintaining such cases in the community.

Mental health providers also have a reluctance to work with patients who are under the jurisdiction of the criminal justice system. Most providers of care have a very limited understanding of the role of the supervising agency in the management of a case in the community. The supervisory agent's preference for maintaining cases safely in the community is poorly understood by the average mental health professional. In addition, mental health providers are (rightly or wrongly) afraid of clients who are involved in the legal system. At times, the referred client may not meet the so-called "target population requirements" or "medical necessity criteria" of the Medicaid or other payment system. Thus, providers have concerns about who is responsible for payment for services. While the federal probation system can pay for at least some services, this is not generally the case for state supervising agencies. Finally, providers may be concerned with liability issues surrounding the care of this population. Thus, rather than learning how fruitful it can be to work in a collaborative fashion with supervising agencies, many mental health providers simply refuse to accept these cases.

Conclusion

It has been the experience of the authors that collaborations such as these can work and can greatly benefit the clients involved in the collaboration, enhancing their community adjustment in a way that less integrated service cannot. Several such cases are described in the literature (see Roskes et al., 1999), and we have seen a number of other such cases. Such collaborations take work to maintain, as with all relationships. It is not clear that we are able to justify such work in a "bottom-line" oriented fashion. Rather, we focus on the mission of the probation office to help offenders transition back into their communities as participating citizens. For the offender with mental illness, competent and collaborative mental health care is a part of that mission. What better way for probation and pretrial services officers to aid in this process than by assisting persons with mental illness to become responsible for their actions to the ultimate benefit of all?

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