

# COMMUNITY MENTAL HEALTH REPORT

CRIMINAL JUSTICE  
SYSTEM INTERVENTIONS  
VICTIM SERVICES  
PROGRAMS FOR HIGH-  
RISK POPULATIONS

Vol 3, No. 2

Pages 17-32

ISSN 1531-1848

January/February 2003

*From the Editor*

## Stigma: Its Impact on the Criminalization of Mental Illness

### Negative Media Images Abound

Words and images have power. Wahl (1995) writes, "They have the power to hurt or soothe, to honor or misinform. Words [and images] reflect and shape prevailing attitudes, attitudes that in turn shape social behavior. And words [images]—disparaging and disrespectful labels in particular—inflict emotional pain on those to whom they are applied" (p.14). The words and images applied to mental illness in the United States have historically and today continue to increase stigma associated with persons with mental illness. The National Mental Health Association notes:

As a society, we are bombarded with negative images of people with mental illnesses. The media and entertainment industries overwhelmingly present people with mental illnesses as dangerous, violent, and unpredictable individuals. These inaccurate and unfair portrayals shape the public's perception of those who suffer from mental disorders as people to be feared and avoided. (National Mental Health Association-Stigma Watch Web, 2002)

Researchers and mental health advocates have continued to document the degree to which the media portrays

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## Addressing Gaps in Post-Release Services for Offenders With Mental Illness: One Community's Response

by Sonja Shield

### Introduction

**The Nature of the Problem.** Offenders with mental illness fall through the cracks of both the criminal justice and mental health systems. An estimated sixteen percent of people in jail are mentally ill (Ditton, 1999), compared to only 5% of the general population (Kessler et al., 1999). This imposes a huge cost both in financial and human terms. For example, California spends between \$1.2 and \$1.8 billion per year in total criminal justice and corrections costs for offenders with mental illness, while this same population could be treated in the community for \$4,000-\$7,000 per person (Izumi, Schiller & Hayward, 1996). Upon release, the criminal justice system does not provide effective post-custody care. Offenders with mental illness have difficulty independently complying with supervision terms, accessing treatment, and addressing areas of their lives that were disrupted by incarceration.

When released from jail, an individual may have lost housing and possessions, and may have had public benefits or Supplemental Security Income (SSI) suspended or terminated. The individual may have trouble following up on referrals to community-based mental health treatment, or may be denied services. In addition, many offend-

ers with mental illness have substance-use disorders (Abram & Teplin, 1991), and returning to the old environment may trigger a substance abuse relapse. The individual may also be re-arrested for reasons relating more to symptoms than to criminal actions.

Probation and parole officers' excessive caseloads hinder their ability to provide the close supervision and linkage to treatment that many offenders with mental illness require. Many of these individuals are willing but unable to follow the terms of their probation, even such seemingly simple requirements as attending probation appointments or court dates. Punitive re-incarceration may be an unnecessarily harsh and ineffective sanction for substance-using individuals who are trying to abstain from drug use. Effective community treatment is the key to breaking this cycle and helping offenders with mental illness achieve stability in the community without re-incarceration.

### National and State Responses

**Consensus Project.** In June 2002, the Criminal Justice/Mental Health Consensus Project was published for the United States Senate. This report (Council on State Governments, 2002) identifies policies and recommendations for how the criminal justice

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system should respond to those with mental illness. Recommendations include assisting defendants with mental illness in complying with conditions of pretrial or supervised release, responding appropriately to release violations, and implementing training about offenders with mental illness. Spearheaded by the Council for State Government (CSG) and written with input from top criminal justice and mental health officials, the Consensus Project provides an authoritative framework to judge how local programs measure up.

**California's Response.** In 1998, California responded to the grave problems posed by offenders with mental illness by establishing and funding the Mentally Ill Offender Crime Reduction Grant (MIOCRG) Program, enacted in Penal Law § 6045 (Mentally Ill Offender Crime Reduction Grants Act). According to the Board of Corrections (n.d.), this joint project of the California State Sheriffs' Association and the Mental Health Association is intended to address gaps in services for offenders with mental illness and to thus reduce crime, jail time and criminal justice costs. Criminal justice and other relevant stakeholders were involved in the planning of local MIOCRG programs, as required by statute. Due to this early acceptance by key criminal justice players, there is a high degree of investment in the success of these programs by all stakeholders.

While other states have also responded to this problem—e.g., Texas and Connecticut—this article focuses on one California city's programs.

***Because approximately 75% of mentally ill offenders are estimated to be dually diagnosed, engaging offenders with mental illness in substance abuse treatment is crucial to success.***

### San Francisco's MIOCRG Programs

**Citywide Forensic Program.** San Francisco responded to MIOCRG I, beginning July 1999, with the Citywide Forensic program (CFP), to address the problem that 94% of paroled offenders with mental illness have their parole revoked and are returned to prison (San Francisco Sheriff's Department, 1999). CFP serves a high-risk population of offenders with mental illness who are likely to be committed to state prison. CFP uses a multidisciplinary team of case managers, occupational therapists, psychiatrists, psychiatric technicians, on-site probation officers and a money manager to help clients remain successfully in the community.

**Connections Program.** The second phase of MIOCRG grants, started in July 2001, did not mandate a prison-bound population. San Francisco determined that

many low-level offenders were being denied pretrial release because their disabilities and myriad needs made them too difficult to supervise in the community. The Connections program was created to provide enhanced services to existing supervision and pre-trial release case management programs. Connections provides case management; manages clients through court dates; outreaches to clients in the community; arranges for temporary housing; and assists with benefits, treatment, and vocational training. Specialized psychiatric case management is provided by Progress Foundation, which links clients to providers in the community mental health system.

San Francisco's programs use intensive case management techniques, which help the offender with mental illness achieve stability in the community and avoid re-incarceration. This article examines these programs' use of graduated sanctions within a harm reduction philosophy. Because approximately 75% of mentally ill offenders are estimated to be dually diagnosed (Abram & Teplin, 1991), engaging offenders with mental illness in substance abuse treatment is crucial to success. This article also explores the challenges faced by the case manager: as a boundary spanner between criminal justice and treatment who must negotiate the dual mandate of individual treatment and community safety; as an advocate for clients; and as an educator to other mental health providers and to criminal justice about the particular needs of offenders with mental illnesses.

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*Community Mental Health Report* (ISSN 1531-1848) is published bimonthly by Civic Research Institute, Inc., 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528. Periodicals postage paid at Kingston, NJ and at additional mailing office (USPS # 0015-086). Subscriptions: \$159 per year in the United States and Canada. \$30 additional per year elsewhere. Vol. 3, No. 2, January/February 2003. Copyright 2003 by Civic Research Institute, Inc. All rights reserved. POSTMASTER: Send address changes to Civic Research Institute, Inc., P.O. Box 585, Kingston, NJ 08528. *Community Mental Health Report* is a registered trademark owned by Civic Research Institute, Inc., and may not be used without express permission.

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## Holistic and Intensive Community Case Management

The foundation of San Francisco's MIOCRG programs is intensive case management, which helps stem some of the typical problems associated with the release of offenders with mental illness to the community. This holistic approach provides a full range of services by an interdisciplinary team, including coordinated medical and psychiatric care; case management; around the clock coverage and low caseloads. Upon their release, staff helps clients link to community treatment, secure new housing, and address other areas of their lives that were disrupted by incarceration. Clients are assisted in complying with requirements of pretrial release, probation, or parole.

Community case management has been found to be effective with the mentally ill offender population. As it helps individuals comply with pretrial and supervised release terms, it is also a key element toward meeting the Consensus Project's recommendations #12 and #16 (CSG, 2002). Case management has been shown to lead to a reduced probability of arrest and a longer period of time without being arrested (Ventura et al., 1998).

## Problem of High Recidivism Rates

With increased supervision, however, comes increased oversight of the individual by treatment and criminal justice staff. Research tracking offenders in highly intensive case management programs has found that they violate probation more often than offenders in less intensive treatment programs, typically for technical violations rather than new offenses (Solomon et al., 2002). In another study, Solomon and Draine (1995) found that more clients in an assertive community treatment program were returned to jail (60%) than clients of less intensively supervised case management programs (40%). They found that forensic case managers who asked the court to stipulate treatment and who actively sought criminal justice interventions were more likely to have clients return to jail.

This higher rate of recidivism can be attributed to the higher degree of interaction with clients in an intensive case management program, as well as to the unrealistic abstinence model used by criminal justice. The intensive case manager sees the client more often than a probation officer with a high caseload, and is more likely to know if the client has relapsed,

## Selected Policy Statements From the Consensus Project

**Consensus Project Policy Statement 12:** Assist offenders with mental illness who are released pretrial in complying with conditions of pretrial release.

**Consensus Project Policy Statement 12b:** Develop guidelines on compliance and termination policies regarding defendants with pretrial release conditions.

**Consensus Project Policy Statement 16:** Assist offenders with mental illness in complying with conditions of probation.

**Consensus Project Policy Statement 22(f):** Develop a range of graduated sanctions to compel (and incentives to encourage) compliance with conditions of release.

**Consensus Project Policy Statement 31(b):** Develop in-service curricula for mental health staff that address obstacles to working with criminal justice clients.

**Consensus Project Policy Statement 22(b):** Encourage community corrections staff to conduct field supervision . . . within the communities, homes, and community-based service programs where the releasee spends most of his or her time.

**Consensus Project Policy Statement 16(c), 22(a):** Assign offenders with mental health conditions on probation/parole to probation/parole officers with specialized training and small caseloads.

dropped out of treatment, or is otherwise not fulfilling the terms of his or her release. A probation officer who insists on abstinence may send a relapsing individual back to jail, when a more intensive level of treatment might instead be more appropriate.

## The Impact of Harm Reduction Principles on Reincarceration

The San Francisco MIOCRG programs suggest ways to integrate harm reduction into community treatment and release conditions, and identify issues arising from the close collaboration between community treatment and criminal justice. Harm reduction is an increasingly accepted philosophy, based on public health principles, that is intended to reduce the harm of drug use both to the user and to society. Harm reduction uses a range of interventions and strategies, and many low-threshold programs that meet the individual where he or she is (Denning, 2000). This pragmatic approach accepts that not everyone is ready or able to cease all drug use immediately. Although abstinence is the ultimate goal, it is also one end of the spectrum of possible drug treatment practices. Harm reduction views a reduction in drug use or a change to a safer kind or method of drug use as a success. This need not conflict with criminal justice goals, as harm reduction focuses on both preserving public safety and reducing the personal toll of drug use on the user.

Harm reduction views substance abuse as a disease. Like diabetics, addicts are responsible for taking care of their addiction disease, but the addiction is properly

addressed through treatment, not punishment. The disease model is commonly used in the medical field, but less so in criminal justice. However, the criminal justice system has become more willing to acknowledge and incorporate the disease model, as evidenced by its incorporation in drug court programs and the passing of Proposition 36 in California, which mandated that non-violent drug offenders be allowed to enter drug treatment instead of being incarcerated.

**Harm Reduction and the Dually Diagnosed Offender.** Harm reduction has been found to be more realistic and effective with the severely mentally ill population than a strict abstinence model. Ho et al. (1999) found that "[m]any patients with chronic psychotic illness were unable to tolerate the confrontational and abstract spiritual approach [of 12-Step programs]. In addition, the applicability of the strict self-help requirement for these severely mentally ill patients has been questioned" (p. 1765). Harm reduction is especially important to explore with this population, given the high percentage that is dually diagnosed with substance-use disorders (Abram & Teplin, 1991). According to MIOCRG program reports, 95% of CFP clients and 92% of Connection clients are dually diagnosed. It does not make sense to continue to insist on using treatment strategies that do not work with this population. As Jo Robinson, director of San Francisco's Jail Psychiatric Services, points out, "Everyone agrees abstinence is the ideal. But that is not going to happen, so let's not make them flee from treatment" (personal communication, July 19, 2002).

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CFP case managers use harm reduction techniques as they work with individuals as well as with groups. Clients are taught about symptom management and helped to understand their drug use and motivation. Meeting clients where they are helps them talk openly and critically about their drug use, opening the door to potentially stopping drug use. This is part of the process of engaging and motivating the client to change harmful behavior. Through harm reduction groups, some clients have become abstinent; others have increased the length of time between

The decision whether to treat or incarcerate for technical violations has grave consequences for the client. The Consensus Project recommends in Policies #12(b) and #22(f) that graduated sanctions be implemented so that violations, including both decompensation and relapses, are first met with adjustments in treatment rather than revocation of release, as incarceration should be reserved for the most severe situations. This is consistent with California's model plan for Proposition 36 clients (Center on Juvenile and Criminal Justice, & Drug Policy Alliance, 2002). For example, Connections serves a population that cycles in and out of

educates the wider world about mentally ill offenders (Steadman, 1992). This may range from educating the criminal justice system about treatment methods to advocating for a client to be admitted into a community treatment program.

When case managers interact with the criminal justice system, criminal justice learns that case managers can help offenders with mental illness comply with release requirements such as making appointments and entering treatment. Probation and parole officers witness how case management helps to reduce drug use and violations due to absconding. This collaboration also educates the criminal justice system about mental illness, dual diagnosis and the disease model of addiction, which increases the likelihood that judges will release clients to treatment programs, or probation officers will defer to or incorporate the case manager's treatment recommendations.

Advocacy by case managers can help get a client admitted to a treatment program, and can help address any treatment problems which may arise. Traditional mental health services are often resistant to treating offenders with mental illness (Roskes & Feldman, 1999). The Connections program was created because existing programs were denying clients services due to their mental health disabilities, substance abuse history, or criminal justice involvement. However, because clients may require outside services, institutionalized partnerships are not always sufficient. CFP and Connections staff have observed that it is difficult to get clients admitted to mental health programs, and extra advocacy on the part of the case manager is required. "Reggie," a Connections client, e.g., was court-mandated to a specific mental health provider for treatment. At intake, he was denied services because they believed he would miss appointments due to his substance use. After repeated phone calls, the case manager was able to advocate for Reggie to be admitted to treatment on the condition that he be accompanied by staff to all of his appointments. Without the case manager's intervention, Reggie would have been incarcerated for violating his release conditions (personal communication, Riker, August 2, 2002).

On a systemic level, education of mental health providers about forensic issues can increase understanding of the specific needs of this population, thus reducing the need for individual, case-by-case advocacy. San Francisco's County Mental Health Services staff provides trainings for mental health workers on the criminal justice system and

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***This commitment to engaging clients in treatment and exploring all treatment options before resorting to incarceration gives individuals the best chance to get the treatment they need.***

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drug use, switched to less dangerous drugs or to less dangerous environments. In treatment, clients are also taught basic living skills, such as how to keep housing, get ID, and build relationships. This is all a part of the early recovery process that helps provide the skills necessary to build a life that is not dependant on drugs.

**Case Examples.** Through psycho-education, some clients realize that they have been self-medicating their psychiatric symptoms with drugs, and become motivated to instead start taking psychiatric drugs. One CFP client, "Jim," a long-time user, was stabbed while on crack and speed. In jail, he received psychiatric medication. He realized that he felt better on medication and didn't hear voices anymore. This motivated him to stay on medication, since he knows that if he goes off them, he will relapse and end up back in jail (personal communication with Lee Hewitt, Project Director, and Kathleen Connelly, Clinical Supervisor, CFP, July 17, 2002).

Treatment of mental health needs often lessens clients' dependence on illicit drugs. A Connections client, "Lionel," used heroin for 35 years and had a long history of brief stays in treatment followed by relapses. After being connected to a therapist, as well as to housing and money management services, Lionel has been able to stay clean (personal communication with Alissa Riker, Director of Jail Services, Center on Juvenile and Criminal Justice, August 2, 2002).

the county jails, often for low-level offenses. If the client is sent back to jail, he or she may later be released without treatment. "Don," e.g., a Connections client diagnosed with schizophrenia and charged with trespassing and vandalism, was extremely resistant to addressing his crack use or following his treatment plan. In response, staff escorted him to all appointments and dedicated a great deal of time to his case, knowing that if he was returned to custody for failure to appear or failure to follow his treatment plan, he would do a brief stint in jail and then would be returned to the streets with no support (personal communication with Richard Rendon, Case Manager, SF Pretrial Diversion, August 2, 2002). This commitment to engaging clients in treatment and exploring all treatment options before resorting to incarceration gives individuals the best chance to get the treatment they need.

**Creating Systemic Change for Offenders With Mental Illness**

An objective of MIOCRG is to create systemic change for offenders with mental illness. San Francisco's CFP and Connections programs educate mental health professionals and the criminal justice system about specific issues faced by these offenders, and the most effective treatment methods.

**Education About Offenders With Mental Illness.** The case manager acts as a boundary spanner who interacts with other systems, coordinates treatment, and

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mentally ill offenders. This training is in line with the Consensus Project's recommendation #31(b). As the mental health system becomes more familiar with forensic issues and particular clients, the stigma about forensic clients diminishes, enabling offenders with mental illness to receive better care.

**Education About Harm Reduction.**

The mental health and criminal justice systems have different philosophies about mental illness and substance abuse, which leads to varying responses to client behavior, such as when a client tests positive for drug use. Despite this, exposure to the successes of harm reduction and graduated sanctions can lead to incorporation of these philosophies in criminal justice.

As judges learn about treatment options and see clients succeeding in treatment, they become willing to divert or sentence offenders with mental illness to treatment instead of incarceration. Other criminal justice arenas, such as parole, have seen the success of CFP, Connections and similar programs and would like to incorporate harm reduction methods themselves. Parole has less flexibility to follow a harm reduction philosophy than can probation, as it is limited by the Parole Board violation policies. On a case-by-case basis, however, parole officers are sometimes willing to negotiate about treatment planning. CFP is currently advocating for parole to implement graduated sanctions and be more treatment oriented. One CFP client, "Bob," followed his case manager's recommendation to tell his parole officer that he had used recently. Instead of deciding that Bob had violated parole, his parole officer agreed to send him to residential treatment (personal communication, Hewitt & Connelly, July 17, 2002).

Bringing criminal justice personnel into the treatment milieu increases their understanding of the treatment process and harm reduction techniques. CFP has two on-site probation officers, in line with the Consensus Project's Policy #22(b). Being on-site allows them to communicate frequently with treatment staff, witness treatment and participate in treatment planning. Being in this clinical setting also helps the probation officer incorporate harm reduction principles and graduated sanctions. For clients, the presence of an on-site officer is more convenient and less threatening than going to the probation office, increasing the chance that they will appear for appointments and comply with release terms.

**How to Harness Case Management Benefits Without Producing Increased Recidivism**

Solomon and Draine (1995) have shown that clients in intensive supervision case management programs tend to have increased recidivism rates. Case management alone, however, helps clients remain stable in the community and lowers their arrest rates. The question, then, is how to harness the benefits of case management without producing increased recidivism.

Besides technical violations due to the higher degree of monitoring in an intensive supervision program, this increased recidivism may also be due to an eagerness on the part of mental health to use criminal justice interventions. As mental health and criminal justice work together, each gains additional tools to help the offender with mental illness. The case manager may see probation as another tool that can be used to motivate the client, and may advocate for criminal justice strategies to be used. The probation officer, in contrast, may see case management and mental health treatment as an additional intervention option to the usual criminal justice tools, and be eager to try treatment as an alternative to incarceration.

Case managers are called on to play multiple and often conflicting roles with the criminal justice system and their clients. Dubbed "court accountable case management" by San Francisco's Pretrial Diversion, case managers must balance their dedication to helping clients remain stable in the community without re-incarceration, with their accountability to the court if clients violate the terms of their release. Case managers must ensure that they do not duplicate a law enforcement role, losing sight of their appropriate therapeutic, advocacy and reporting function. At the same time, they must maintain credibility with the court. If a client fails to comply with his or her supervision terms, the case manager will accurately report this to the court. It is important to balance the client's clinical treatment needs with issues of community safety, and the case manager must consider how best to achieve this balancing act without losing sight of the need for both public safety and individual treatment.

On their websites, the Consensus Project (CSG, 2002) and the National Association of the Mentally Ill (NAMI, 2001) call for specialized training for all criminal justice personnel that work with this population, in order to improve treatment and decrease the needless re-incarceration of

the mentally ill. To this end, CFP brings the on-site probation officer into treatment meetings, and Connections provides the experience of their specialized psychiatric case managers to criminal justice personnel.

Case conferences, where the client meets together with his or her mental health and criminal justice workers, can also lead to productive collaboration and planning. Open dialogue allows all participants to share information, learn about possible treatment methods, problem solve together, and decide collectively on a treatment plan. Any information sharing should of course respect the client's confidentiality rights. The more the judge and parole/probation officer understand treatment methods and the client's clinical issues, the more likely they are to refer clients to treatment instead of re-incarcerating them.

Roskes and Feldman (1999) demonstrated that the close working relationship between probation and mental health and sharing of treatment methods led to a decrease in probation violations for mentally ill offender clients. When criminal justice and mental health are familiar with the full range of treatment options, and the relative successes of each method, they can participate as equal partners in treatment planning. This collaborative, open process, with the client as an active participant, furthers the goals of harm reduction and treatment.

**Conclusion**

San Francisco's District Attorney has been a vocal supporter of incorporating harm reduction into a criminal justice setting, but San Francisco is not unique in its ability to implement these programs. Harm reduction is increasingly being accepted and implemented around the country, and has been shown to be one of the few successful drug treatments for this difficult-to-reach population. The intensive case management model, providing holistic, continuous case management, is a tried-and-true success story in the mental health field. However, within criminal justice, research has shown that intensive supervision can increase recidivism. The keys to addressing this challenge are thoughtful dialogue and education about treatment methods and collaboration around treatment planning between mental health and criminal justice. The harm reduction and case management models are effective at their stated purpose: decreasing the continued re-incarceration of people with mental illnesses, protecting public safety, and reducing jail overcrowding and criminal justice costs.

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