

The Effects of Serious Mental Illness on Offender Reentry

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FUNDAMENTAL CHANGES in mental health policies and laws have brought criminal justice professionals into contact with the seriously mentally ill at every stage of the justice process: police arrest people with serious mental illness (SMI) because few other options are readily available to handle their disruptive public behaviors; jail and prison administrators strain to attend to the care and safety of the mentally ill; judges grapple with limited sentencing alternatives for persons with SMI who fall outside of specific forensic categories (e.g., guilty but mentally ill); and probation and parole officers scramble to obtain scarce community services and treatments for people with SMI and to fit them into standard correctional programs or monitor them with traditional case management strategies. When mentally ill inmates are released from prison, their disorders complicate and disrupt their reentry into the community (Council of State Governments, 2002). This paper focuses on released inmates who are afflicted with SMIs such as schizophrenia, bipolar disorder, or major depression—chronic brain diseases that cause extreme distress and interfere with social and emotional adjustment (U.S. Department of Health and Human Services, 1999).

In this paper, we examine the factors that have led to increasing numbers of the mentally ill being processed through the criminal justice system. We review findings to estimate the prevalence of major psychiatric problems in the parolee population. We discuss the importance of implementing specialized case management strategies to respond more effectively to the needs of parolees with SMI. We describe a program, administered by Thresholds, that

uses Assertive Community Treatment (ACT) to facilitate the reentry of mentally ill parolees in Illinois. Finally, we explore the common challenges of managing mentally ill offenders (MIOs) in the community.

Pathways into the Criminal Justice System

More than 30 years ago, Abramson (1972) noted that more and more people with SMI were being routed through the criminal justice system instead of through the mental health system. Since then, data have suggested that the mentally ill are arrested and incarcerated in numbers that surpass their representation in the general population and their tendencies to commit serious crimes or be arrested (Council of State Governments, 2002). In light of these data, mental health advocates and researchers have asserted that people who have been treated in mental health agencies and psychiatric hospitals are more frequently shunted into jails and prisons (Teplin, 1983).

People with SMI enter the criminal justice system and people involved in the criminal justice system enter the mental health system through a variety of pathways, including "crisis services, departments of social services, human services agencies, educational programs, families, and self-referrals" (Massaro, 2003, p. 2). For most MIOs, SMI complicates rather than causes their involvement in the criminal justice system (Draine, 2003). The disproportionately high numbers of people with SMI in correctional facilities are associated with the rising number of discharges from state hospitals, the passage of restrictive commitment laws, the splintering of treat-

ment systems, the war on drugs, and the deployment of order-maintenance policing tactics (Lurigio & Swartz, 2000).

Deinstitutionalization. A fundamental change in mental health policy, known as deinstitutionalization, shifted the locus of care for patients with SMI from psychiatric hospitals to community mental health centers. This policy is the first major contributor to the processing of the mentally ill through the criminal justice system (Grob, 1991). After World War II, state mental hospitals nationwide began to release thousands of psychiatric patients to community-based facilities that were charged with providing follow-up treatment and services. This policy of deinstitutionalization substantially reduced the number of patients in state mental hospitals nationwide, from 559,000 in 1955 to 72,000 in 1994 (Center for Mental Health Services, 1994). The length of the average stay in psychiatric hospitals and the number of beds available also declined sharply (Kiesler, 1982).

The deinstitutionalization movement was fueled by media accounts of patient abuse, the development of effective medications to treat SMI, federal entitlement programs that paid for community-based mental health services and insurance coverage for inpatient psychiatric care in general hospitals (Sharfstein, 2000). Deinstitutionalization, however, was never properly implemented. Although the policy provided for appropriate outpatient treatment for a large percentage of the mentally ill, it often failed to care adequately for those who had limited financial resources or social support, especially those with the most severe and chronic mental disorders (Shadish, 1989).

The failed transition to community mental health care had the most tragic effects on patients who were least able to handle the basic tasks of daily life. Public psychiatric hospitals became treatment settings for the indigent. Their patients became younger because new medications obviated the need for extended periods of hospitalization. Before these medications were discovered, psychiatric patients could remain in the state hospital for decades and be released when they were elderly. New cost-saving measures in hospital policies shifted the costs of care from state budgets, which paid for hospitalization, to federal budgets, which paid for community mental health services. Unlike earlier generations of state mental patients, those who were hospitalized during and after the 1970s were more likely to have criminal histories, to be addicted to drugs and alcohol, and to tax the patience and resources of families and friends (Lurigio & Swartz, 2000).

Lack of affordable housing compounds the problems of people with SMI and interferes with the provision of mental health treatment. An estimated 20 to 25 percent of the adult homeless population is afflicted with an SMI (Council of State Governments, 1999). The mentally ill, therefore, began to resemble many criminals: poor, young, and estranged from the community (Steadman, Cocozza, & Melick, 1978). As the Council of State Governments (1999) noted, "without housing that is integrated with mental health, substance abuse, employment, and other services, many people with mental illness end up homeless, disconnected from community supports, and thus more likely to decompensate and become involved with the criminal justice system" (p. 8).

Many persons with SMI also fall into the lap of the criminal justice system because of the dearth of mental health treatment and other community services (Grob, 1991). Moreover, links between the criminal justice and mental health systems have always been tenuous, and the mentally ill who move from one system to the other often fail to receive adequate treatment or services from either. As a result, their mental health deteriorates and they become both chronic arrestees and psychiatric patients (Lurigio & Lewis, 1987).

Legal restrictions. Reforms in mental health law have made it difficult to admit the mentally ill to psychiatric hospitals and constitutes the second major contributor to the influx of mentally ill persons into the criminal justice system (Torrey, 1997). Seri-

ous restrictions on the procedures and criteria for involuntary commitment sorely limit the use of psychiatric hospitalizations. Most state mental health codes require psychiatric hospital staff to adduce clear and convincing evidence that patients who are being involuntarily committed are either a danger to themselves or others, or are so severely debilitated by their illnesses that they are unable to care for themselves. In addition, mental health codes strengthened patients' rights to due process, according patients many of the constitutional protections granted to defendants in criminal court proceedings. Thus, only the most dangerous or profoundly mentally ill are ever hospitalized, resulting "in greatly increased numbers of mentally ill persons in the community who may commit criminal acts and enter the criminal justice system" (Lamb & Weinberger, 1998, p. 487).

Fragmented services. The third major factor in the increased presence of mentally ill persons in the criminal justice system is the compartmentalized nature of the mental health and other treatment systems (Laberge & Morin, 1995). The mental health system consists of fragmented services for predetermined subsets of patients. Most psychiatric programs, for example, are designed to treat "pure types" of clients, mentally ill or developmentally disabled, alcoholic or chemically dependent. By the same token, vast majorities of drug treatment staff are unwilling or unable to serve persons with mental disorders and frequently refuse to accept such clients. Furthermore, research has shown that offenders with co-occurring disorders are difficult to engage in treatment and are often resistant to efforts to treat their addiction to alcohol and illicit drugs (Drake, Rosenberg, & Mueser, 1996).

Abstinence from substance abuse is often a prerequisite for acceptance into mental health and drug treatment programs. Therefore, persons with co-occurring disorders, who constitute a large percentage of the mentally ill in the criminal justice system, might be deprived of services because they fail to meet stringent admission criteria (Abram & Teplin, 1991). In short, when persons with co-occurring disorders—most of them with SMI and substance abuse and dependence disorders—come to the attention of the police, officers have no choice but to arrest them, given the lack of available referrals within narrowly defined treatment systems (Brown, Ridgely, Pepper, Levine, & Ryglewicz, 1989).

Drug enforcement. The fourth major factor associated with the pervasiveness of MIOs

is the arrest and conviction of millions of persons for drug violations. The highly significant growth in the volume of drug arrests and convictions stems largely from the war on drugs. Offenders convicted of the use, sale, and possession of drugs constitute one of the fastest-growing subpopulations in the nation's prison and parole systems (Beck, 2000). A fairly large proportion of these incarcerated and parolees have co-occurring mental illnesses, adding to the number of MIOs in the nation's criminal justice system (Swartz & Lurigio, 1999).

Police tactics. The fifth major factor contributing to the processing of people with SMIs through the criminal justice system is the recent adoption of law enforcement strategies that emphasize quality-of-life issues and zero tolerance policies in response to public-order offenses: loitering, aggressive panhandling, trespassing, disturbing the peace, and urinating in public. These strategies have netted large numbers of the mentally ill for publicly displaying the symptoms of untreated SMIs. The implementation of public-order policing tactics has outpaced the development of diversionary programs for persons with SMI (Ditton, 1999).

Mental Illness Among Parolees

To date, no studies have assessed the nature and extent of SMIs among parolees (Massaro, 2003). Research that has examined the incidence of mental illness among prisoners, however, can render reasonable estimates of the numbers of paroled MIOs. The vast majority (95 percent) of inmates are eventually released from prisons and 80 percent are placed on parole supervision (Hughes & Wilson, 2004). Hence, studies of these former inmates can be used to approximate the upper and lower limits of the parolee population with mental health problems.

According to Pinta (2000), data on the prevalence of SMIs among inmates are unreliable and have limited utility for prison mental health services planning, research, and policy. Studies of mental illness in the prison population have produced inconclusive results because of inconsistencies in how mental illness was defined and evaluated (Clear, Byrne, & Dvoskin, 1993). For example, prevalence estimates in prisons for schizophrenia range from 1.5 percent to 4.4 percent; for major depression, from 3.5 percent to 11.4 percent; and for bipolar disorder, from 0.7 percent to 3.9 percent. These estimates are significantly higher than those found in the general popu-

lation (Robins & Reiger, 1991). Specifically, rates of SMI among prisoners are estimated to be 3 to 4 times higher than rates among the general population (Ditton, 1999).

The most-reliable studies of mental illness among state prisoners have found that 15 percent suffer from an SMI (Jemelka, Rahman, & Trupin, 1993). Pinta (1999) reviewed studies of current mental illness among state prisoners and also reported an average prevalence rate of 15 percent. Based on the 15 percent estimate, at midyear 2003, 183,225 inmates were suffering from an SMI (Harrison & Karberg, 2004). Similarly, if this estimate is accurate, at the end of 2002, a total of 37,657 parolees were suffering from an SMI (Glaze, 2003). In a national survey, parole agency administrators estimated that only 5 percent of parolees have a diagnosed mental illness and less than one-fourth of the administrators indicated that their agencies had special programs for mentally ill parolees (Boone, 1995).

Ditton (1999) conducted a nationwide survey of the prevalence of SMI among inmates of state prisons. She found that 16 percent of prisoners reported that they had an emotional or mental condition or had spent a night in a mental hospital. Based on Ditton's (1999) findings, 195,440 state prison inmates at midyear 2003 would have identified themselves as having a mental illness (Harrison & Karberg, 2004). Compared with the rest of the prison population, Ditton (1999) found that a higher percentage of mentally ill inmates were in prison for a violent crime and a lower percentage of mentally ill inmates were in prison for a drug offense. Ditton (1999) also found that mentally ill inmates were twice as likely as other inmates to report lifetime histories of physical and sexual abuse. They were also more likely to report homelessness in the twelve months before they were arrested for the crime that led to imprisonment. In addition, mentally ill inmates reported lengthier criminal histories than did inmates who were not mentally ill. Finally, Ditton (1999) reported that more than 60 percent of mentally ill inmates indicated that they received mental health services while incarcerated.

Despite inconsistencies in methodologies and measures, the above studies suggest that SMI is common among parolees. Research also suggests that the SMI is associated with other problems that increase the risk of parolee recidivism. Specialized reentry strategies are therefore needed to help released MIOs successfully re-enter the community.

More and better-designed studies should be conducted to determine the mental health services needs of inmates before they enter and leave the prison system (Lurigio, 2001).

Reentry Strategies for MIOs on Parole

Discharge services. Effective reentry strategies for mentally ill parolees must begin with a comprehensive discharge plan that contains specific information on an inmate's needs for community-based treatment, employment, housing, and financial and social support. Prisoners with mental illness can serve longer prison terms because of the absence of an approved parole-discharge plan that includes housing, psychiatric care, and substance abuse treatment services. The lack of services for mentally ill parolees is especially acute in rural areas where parole board members or releasing authorities have little confidence that local community resources are available for this troubled population (Council of State Governments, 2002).

Despite the well-documented importance of transitional services in achieving re-entry success (Faenza, 2003), more than one-third of correctional agencies provide no such supports for mentally ill inmates (Beck, 2001). Little is known about the provision or quality of aftercare services for parolees with mental illness (Human Rights Watch, 2003). In *Wakefield vs. Thompson*, the federal appeals court considered whether a plaintiff's Eighth Amendment rights were violated when his doctor released him from prison without a prescription for psychotropic medication. The court ruled that the state

must provide an outgoing prisoner who is receiving and continues to require medication with a supply sufficient to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply. A state's failure to provide medication sufficient to cover this transition period amounts to an abdication of its responsibility to provide medical care to those, who by reason of incarceration, are unable to provide for their own medical needs (*Wakefield vs. Thompson*).

The characteristics of mentally ill inmates often place them at higher risk of rearrest and reincarceration. For example, more than 80 percent of mentally ill inmates have criminal histories, including previous incarcerations and probation sentences (Beck, 2001). Parolees are at greatest risk for recidivism in the

first few months following discharge. A study of prisoners with mental illness in Tennessee found that nearly 40 percent of those released from prison returned within 12 months (Human Rights Watch, 2003). Feder (1992) found that 64 percent of mentally ill inmates released from state prison were rearrested within 18 months of discharge and nearly half were rehospitalized during that period. Without discharge planning for transitional services, mentally ill parolees are likely to decompensate, commit new offenses, violate the conditions of release, and return to prison (Council of State Governments, 2002).

To be most effective, post-release services should be intensive and ongoing. Lovell, Gagliardi, and Peterson (2002) reported that 73 percent of mentally ill inmates released from Washington State prisons received social or mental health services. Nonetheless, few received clinically meaningful levels of care during the first year of release and the majority (70 percent) was rearrested for new charges or parole violations. Those who committed more serious crimes received fewer services and received services later than those who committed less serious crimes. Overall, mentally ill releasees tended to commit public-order crimes that were "more a reflection of a marginal urban existence than a violation of the basic rights of other citizens" (Lovell et al., 2002, p. 1296). State parole directors reported that the inadequacy of services for mentally ill releasees was the most formidable obstacle in their agencies' attempts to meet the special needs of this population. The absence of services for housing and substance abuse treatment was particularly problematic (Council of State Governments, 2002).

Parole conditions. Parole officers attempt to balance the monitoring and control of offenders, which is in the interest of public safety and the administration of justice, with the brokerage of social services, which is in the interest of offender rehabilitation and reintegration into the community. Parole supervision can be an excellent vehicle for delivering services to MIOs and can exercise the authority of the prison system to improve compliance with medication and other conditions of release, which should be enforceable, reasonable, and tailored to the risk and needs of parolees (Council of State Governments, 2002).

Numerous studies indicate that court-mandated drug treatment, using the leverage of the court and criminal justice systems, increases enrollment and participation in

interventions and programs and reduces criminal activity (Lurigio, 2002). These findings might also apply to the effects of involuntary or coerced mental health treatment (Colvin, Cullen, & Vander Ven, 2002). Research has demonstrated that involuntary treatment for MIOs can dramatically increase their compliance with medication and significantly reduce the likelihood of psychiatric and criminal recidivism (Heilbrun & Griffin, 1998; Lamb, Weinberger, & Gross, 1999). Correctional supervision "creates and maintains the boundaries and structures that [will allow MIOs] to focus on their recovery" (Massaro, 2003, p. 41). Draine (2003) suggests that coercion is most effective in reducing recidivism among MIOs when it is balanced with supportive services.

Case management. Reentry programs should take advantage of case management strategies that have proven successful in criminal justice, substance abuse, and mental health systems. Case management techniques can help parolees access multiple services in an overall treatment plan that integrates and coordinates care across different service domains. Case management techniques include enumerating goals and objectives that can be employed to evaluate program effectiveness, establishing and maintaining clients' eligibility for income-support payments through Supplemental Security Income or Social Security Disability Insurance, protecting clients' rights as citizens and members of the community, triaging clients' service needs, and advocating on clients' behalf for more and better services in all areas. In addition, case management techniques address the needs of MIOs for mental health treatment as well as the mandates of parole supervision and the availability of community-based services for substance abuse, housing, job training, employment, and medical conditions (Bemus, 1993). In short, case management builds a formal support network for mentally ill persons who lack an informal support network (Culter, Tatum, & Shore, 1987). Network support alleviates stress and offers "resources to cope with adversity through non-criminal means" (Colvin, Cullen, & Vander Ven, 2002, p. 24) and therefore, can serve as a crime-prevention tool (Draine, 2003).

In their study of interventions for offenders with co-occurring disorders, Peters and Hills (1997) found that criminal justice and treatment staffs rarely interact with each other. When these interactions occur, however, they increase both groups' awareness

of potential service options and improve client outcomes in all areas of service provision. Hence, another key component of case management techniques is the ability to foster regular communication between parole officers and treatment providers. Such communications ensure that they will better understand and respect one another's goals and perspectives and that they will coordinate their activities when working with the same clients (Lamb, Weinberger, & Gross, 1999). Wolf and Diamond (1997) reported that clients involved in case management programs, which emphasized the cooperation of members of both the criminal justice and mental health systems, had significantly fewer arrests than clients who were involved in non-case management programs (Wolf, Diamond, & Helminiak, 1997).

Solomon (2003) observed that the results of studies of case management strategies for MIOs are mixed. For example, Solomon, Draine, and Marcus (2002) studied 250 adults with SMI who were on probation or parole supervision in a specialized psychiatric unit. Most of the sample was comprised of African American males, and half were on psychiatric medications. All had been diagnosed with an SMI. Solomon, et al. counted parole officers' contacts with clients. Solomon et al. (2002) found that participants who received psychiatric treatment were overall less likely to be reincarcerated for technical violations. However, they also found that those who received intensive case management services were six times more likely to be reincarcerated for such a violation. Solomon (2002) concluded that services that emphasize monitoring increase the risk of technical violations and incarcerations, whereas motivation to participate and actual participation in treatment diminish the likelihood of violations and incarcerations.

According to Lurigio (2001), technical violations of parole supervision can often be the result of clients' symptoms or the side effects of their medications—both of which can cause cognitive and memory impairments that reduce their ability to follow directions or keep appointments. He recommends the use of relapse prevention strategies or graduated sanctions to handle technical rule breaking and incarceration to prevent the commission of new crimes. In addition, Lurigio (2001) views technical violations as opportunities for preventive intervention. Technical violations can be the harbingers of more serious crimes and present occa-

sions for redoubling therapeutic interventions. Imprisonment should be a last-ditch response to technical parole violations.

Team approach. A specialized team approach should be adopted to manage MIOs on parole. Teams of parole officers, case managers, and treatment providers should collaborate in decisions regarding the selection, supervision, treatment, and continuity of care for MIOs after discharge from prison. The various strengths and expertise of the team members should be considered in defining the function of each team member. For example, parole officers would be responsible for monitoring and enforcing the conditions of release. Case managers would coordinate and broker the various services needed by mentally ill parolees. Treatment providers would deliver medications, counseling, and other medical interventions. To ensure continuity and consistency in implementing re-entry programs, the same criminal justice, case management, and treatment professionals should be assigned long-term to the same teams.

A team approach underscores the importance of coordinating decision-making and core case management activities. Each member of the team is familiar with the functions and responsibilities of the others. Case conferences provide a forum for selecting and tracking the progress of program participants. Similarly, any major decisions about the status of parolees are made with the input of all team members. Case conferences also involve continued discussions about the quality of the services that are being delivered by the participating treatment agencies. In addition, based on the results of drug treatment court studies, members of the team should be instrumental in monitoring MIOs' participation in treatment through an offender-specific schedule of meaningful contacts with parole officers.

In summary, a team approach is a vehicle for sharing information about MIOs' participation in treatment and compliance with parole conditions, identifying crises in MIOs' lives and episodes of relapse and decompensation, developing positive and negative sanctions to shape MIOs' behaviors and to keep them on track for successful parole outcomes, updating case supervision plans, and maintaining open lines of communication among all team members (Peters & Hills, 1997). MIOs are typically afflicted with more than one disorder and have a broad range of services needs. Therefore, mental health services should be at the core of an array

of social support services and other treatments. In particular, MIOs are highly likely to have comorbid psychiatric and substance use disorders. The combination of these illnesses places parolees at higher risk for failure in treatment, continued criminality, violent behaviors, and violations of parole conditions. The most effective strategies for managing parolees combine individualized case management strategies with long-term psychiatric treatment and habilitation services. Other services needs of parolees are housing, education, childcare, employment referrals, vocational training, and medical interventions for acute and chronic illnesses.

MOUs and cross training. Parole administrators should enter into formal agreements or memoranda of understanding (MOU) with mental health agencies and create opportunities for cross training among correctional staff and service providers (Council of State Governments, 2002). Community mental health providers are critical members of the team that is responsible for monitoring and serving MIOs. MOUs can enumerate provisions for procedures and processes such as obtaining releases of information, defining referral processes, and meeting federal and state requirements for client confidentiality (Massaro, 2003). The ultimate goal of MOUs is to construct lasting bridges between the mental health and correctional systems, leading to coordinated and continual care for MIOs.

Cross training involving parole officers and mental health care providers should be an important early component in relationship building. Parole officers are knowledgeable about legal issues and enforcement techniques. However, few of them have much background in the routine clinical evaluation and treatment of MIOs. Hence, to best institute a team approach for handling MIOs in the community, members of correctional agencies should be educated about the causes, diagnosis and treatment of mental illnesses. They should also be conversant in current diagnostic nomenclature and the latest advances in medications and other treatments for psychiatric disorders. For example, Council of State Governments (2001) recommended that:

Parole board members should have some familiarity with the nature and types of mental illness, and how these disorders can be diagnosed and treated. Training curricula should be developed and, depending on the jurisdiction, tailored for individuals appointed to serve as

parole board members, both for new appointees as well as on an annual or ongoing basis for all members. (p. 160)

Few mental health and other social services providers have expertise in prison and parole operations. They should learn about criminal statutes and sentencing decisions; court operations and exigencies; and parole mandates, policies, and procedures. Parole staff can help mental health providers develop their skills for addressing the criminal behaviors of their clients. Finally, parole officers, case managers, and service providers should participate in trainings that will clarify their roles and responsibilities with MIOs and ensure that they understand the basic operations and guiding principles of parole supervision.

Thresholds Program

The PAP program. Thresholds' Prison Aftercare Program (PAP) serves people with SMI—referred to as program clients or members—exiting Dwight and Dixon Correctional Facilities in the Illinois Department of Corrections. (Although parole was abolished in Illinois in 1978, people under mandatory supervised release from prison are still called “parolees” and the agents who monitor them are still called “parole officers.”) Adapted from Thresholds' Jail Linkage Project, which serves people with SMI discharged from Cook County Jail (Chicago), the PAP is based on the Assertive Community Treatment (ACT) model. ACT has many advantages as a service model for criminal justice populations and is one of the most well-defined and well-researched treatment models for people with SMI (Bond, Drake, Mueser, & Latiner, 2001). ACT is best conceptualized as a strategy for organizing and delivering intensive services. ACT uses multidisciplinary teams with small, shared caseloads and daily staff meetings to discuss individual clients and coordinate a comprehensive range of services. For people leaving jails and prisons, treatment noncompliance is a chronic problem that often results in relapses and rearrest, particularly during the critical 12- to 18-month post-release period. ACT is very effective in promoting compliance with treatment.

Using outreach techniques, ACT teams spend a lot of time visiting members in their homes or other community settings, rather than waiting for clients to “show up” for clinic-based services. To take a proactive role in crisis situations, the team is available 24-hours-a-day, 7-days-a-week. Typically, ACT services offer practical assistance with everyday needs,

such as medication management, housing assistance, and money management (Phillips, et al. 2001). For parolees with SMI, these types of supportive services are essential for rebuilding a productive life in the community.

The PAP currently serves 12 clients. The program's director meets weekly with prison administrators in order to develop detailed discharge plans. After a referral is received from the prison, a PAP team member visits the prison to conduct the screening and intake process. The team focuses on inmates with the most serious histories of psychiatric hospitalizations, incarcerations, and arrests to ensure that this costly service is reaching parolees in direst need. Enrollment criteria include:

- History of repeated arrests and/or incarcerations
- History of repeated state psychiatric hospitalizations
- Low risk of violence in the community
- Diagnosis of severe mental illness (e.g., usually schizophrenia-spectrum illness or major affective disorder)
- An agreement to work with a Thresholds psychiatrist in finding an acceptable psychiatric medication regimen
- Willingness to live on the North Side of Chicago, where the team is based
- Eligibility for Supplemental Security Income
- Willingness to have Thresholds as Representative Payee
- Willingness to cooperate with Thresholds in the treatment planning process

Adaptations from ACT. The stated mission of Thresholds' PAP is to help parolees avoid rehospitalizations, reincarceration, and homelessness by providing a comprehensive array of supportive services. The program operates at a high level of intensity—exceeding the typical ACT contact standards—to meet the multiple needs of this population. The average program staff member has 6 clients, lower than the ACT ratio of 1:10. All services that are available during the week are also offered on weekends. All parolees served by the team have access to the team's on-call pager all day, every day, in case of crises or emergencies. During the week, staff meetings are held every morning and afternoon to keep team members apprised of each client's status and the events of that client's day.

Discharge planning and coordination before release from prison is an essential element of Thresholds' approach to prison aftercare. Prisoners with SMI are often released without proper supports in the com-

munity, triggering the downward cycle of relapse, rehospitalizations, reincarceration, and homelessness. Client engagement in community mental health treatment begins several weeks before release, with weekly contacts between the team and the client. These contacts help the team assess the needs of the client and help the client feel comfortable with the team and form the therapeutic relationship that is so important in mental health care. When properly notified, the team can join prison administrators in stipulating the conditions of release that will facilitate reentry, such as the requiring of representative payeeships, outpatient commitments, or other conditions reflecting the parolee's particular needs. This joint decision-making task is usually the beginning of an effective alliance between the prison and mental health systems for the benefit of the client.

Thresholds' PAP considers itself a conscientious resource for the parole authority, balancing client advocacy with public safety concerns. Parole officers have 24-hour access to the team's on-call pager for immediate problem solving. After the client's release from prison, a team member meets the person "at the gate" and brings him or her back to Chicago. As quickly as possible, the team members find appropriate, safe housing for the client and reapply for disability benefits. The team helps clients transport their belongings to their new homes, keep psychiatric, social services, and parole appointments, and negotiate the social services and the criminal justice bureaucracies.

The program takes advantage of representative payeeships and outpatient commitments to keep clients engaged in treatment. Representative payeeships in the PAP are a routine aspect of practice whereas other ACT programs are beginning to use them more sparingly. For the mentally ill parole population, representative payeeships can help former inmates maintain their housing, buy groceries, pay utility bills on time, and receive adequate healthcare. The team routinely uses evidence of representative payeeships to persuade reluctant landlords to rent apartments to clients with criminal and substance abuse histories.

Other key elements of Thresholds' program are medication management and education. Thresholds psychiatrists simplify medication regimens so that clients are more likely to master the schedule, comply with it, and benefit from it. Although vocational services are not provided directly by the PAP team, Thresholds offers a comprehensive psychiatric rehabilita-

tion program including job preparation, job placement, and job support services. The PAP also creates opportunities for individuals to work in local businesses and group placements with rehabilitation supervision provided by Thresholds. For clients with criminal records, these placements can strengthen their employment credentials as they apply for competitive jobs in the community.

One of the most distinctive elements of the Thresholds model of aftercare is the continuation of services after a parolee is rearrested, reincarcerated, or rehospitalized. Once the parolee has become a service recipient, the team will follow that person indefinitely. The model's effectiveness is most apparent when a client is in crisis. Rather than closing the case when another service system assumes responsibility for the client or dismissing the client as a "failure," the team continues to visit the client in the jail, prison, or hospital in order to preserve their relationship. The overarching philosophy of the model is to remain committed to the client—a philosophy that the most problematic clients challenge on a regular basis.

ACT effectiveness. Because ACT services are both intensive and expensive, they should be reserved for the most severely ill parolees with SMI, that is, those experiencing frequent hospitalizations or emergency room visits, incarcerations, homelessness, co-occurring substance use disorders, or poor compliance with traditional mental health treatment. When applied to this special population, ACT is an effective treatment, particularly in reducing hospitalizations and maintaining the clients in stable housing (Bond, Drake, Mueser, & Latimer, 2001; Mueser, Bond, Drake, & Resnick, 1998). Roughly half of controlled studies on ACT have shown favorable effects on employment when the team includes a vocational specialist (Mueser et al., 1998). Similarly, fidelity to the ACT model has also led to the remission of co-occurring substance use disorders in people with SMI (McHugo, Drake, Teague, & Xie, 1999). In addition to improving a number of key client outcomes, ACT is a cost-effective program for people with extensive and recurring hospitalizations, reducing hospitalization costs 58 percent more than less intensive case management services (Latimer, 1999).

An evaluation of Thresholds' Jail Linkage Program, which is similar to the PAP, found positive client outcomes and cost savings. Using simple pre-post measures on the first 30 clients to receive these ACT services, researchers reported an 85 percent reduction

in state hospital days from the year prior to admission (2726 days), compared with the first year of ACT treatment (417 days). Assuming a daily hospital cost of \$500, this reduction produced a savings of approximately \$1,154,500 (less the cost of community-based services). Using the same evaluation methods, the Thresholds ACT program also demonstrated an 83 percent reduction in jail days (3619 pre-treatment vs. 632 days post-treatment). Assuming a daily jail cost of \$70, this reduction saved the county jail approximately \$209,000 (Lurigio, Fallon, & Dincin, 2000). The Thresholds PAP expects to produce similar positive outcomes for people with SMI exiting Illinois prisons.

Challenge of Monitoring MIOs

The criminal justice system must be prepared to handle MIOs at every step, from broadening the range of alternatives to incarceration, to allowing greater access to mental health services for recently released inmates. The criminal justice system must likewise be prepared to balance MIOs' needs for treatment with mandates to protect public safety. In addition, community-based treatment providers must be prepared to serve MIOs in local mental health systems—many of which have few or no resources to serve additional clients (Council of State Governments, 2002). Despite the high incidence of SMIs among offender populations, current services in most communities are earmarked for people who are judged not guilty by reason of insanity (NGRI) or for MIOs who are charged with misdemeanors and processed through specialized mental health courts. Sweeping system changes are needed to respond effectively to the vast numbers of other MIOs who are appearing in criminal justice and mental health systems across the country (Council of State Governments, 2002).

The cost of not caring properly for MIOs is high. Untreated MIOs are more likely to return to the criminal justice system through repeated arrests and incarcerations. They are also more likely to be admitted and readmitted to psychiatric hospitals. Moreover, without effective treatment, MIOs pose considerable threats to public safety, especially when they have histories of comorbid substance abuse or dependence disorders (Lurigio & Lewis, 1987; Lurigio & Swartz, 2000).

The transition of MIOs from prisons and into communities challenges the staff in the correctional and mental health fields because of numerous obstacles, including cultural

and language barriers and the lack of coordination between mental health and criminal justice agencies. Services for MIOs are largely inadequate, especially in terms of providing coordinated or continuing care. Moreover, gaps in psychiatric services are common within and among criminal justice agencies (Massaro, 2003). Although they share many clients, criminal justice and mental health system staffs rarely exchange information about the MIOs that they monitor or treat (Lurigio & Swartz, 2000).

Laberge and Morin (1995) observed that many MIOs have problems taking responsibility for their illnesses or their criminal activities or are reluctant to admit their need for treatment. They can be resistant to engaging in therapeutic relationships, have trouble remembering to take their medications or keeping their medical appointments, and are difficult to place in stable or affordable housing. As a result, mental health professionals are likely to regard MIOs as unwelcome or undesirable clients.

Described as "resistant to treatment, dangerous, seriously substance abusing, and sociopathic," MIOs can intimidate community treatment providers (Lamb & Weinberger, 1998). Mental health and criminal justice staffs frequently have divergent views regarding MIOs' treatment needs and have different levels of tolerance for MIOs' behaviors that might pose risks to the community (Peters & Hills, 1997). Therefore, an approach that considers the different perspectives and concerns of criminal justice and mental health professionals will result in more effective and coordinated programs and services for MIOs. This is the approach that will facilitate the re-entry of MIOs into their communities (Clear, Byrne, & Dvoskin, 1993).

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