MENTALLY ILL OFFENDERS' EXPERIENCES IN A COMMUNITY-BASED SUPERVISED TREATMENT PROGRAM

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

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BY

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Date

To the Dean of the Graduate School

I am submitting herewith a dissertation written by Lucindra Campbell entitled "Mentally Ill Offenders' Experiences in a Community-Based Supervised Treatment Program." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in nursing.

Anne Young, Ed.D., Major Professor

We have read this dissertation and
recommend its acceptance:

Accepted

Dean of the Graduate School

DEDICATION

This work is dedicated to my children, grandchildren, other family members, and friends who supported me through this challenging but rewarding process.

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ABSTRACT

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This study's purpose was to explore the experiences of mentally ill offenders (MIOs), as residents currently participating in an innovative and highly successful community-based program. Data were collected from MIOs who were currently in the program and program staff (key informants) who were employed with the program. The program was located in the southwestern region of the United States. These experiences were explored through qualitative research methods. A purposeful sample of 12 MIOs and 3 program staff was drawn for the study. Participants were interviewed by use of semi-structured mentally ill offender and key informant interview protocol guides. Interviews were audiotaped and transcribed verbatim. Participant observation also was used to gather data. Field notes were completed and used as a method for registering data collected during participant observation. A pilot study was conducted to assess the proposed study methodology. Analysis of the data used a modified process analysis and grounded theory methodologies. Findings suggest that although similar programs are

provided for this population, services are not provided to the same extent. The low rate of recidivism in this program, less than 2%, can be explained by the intensity of support and extensive resources that are available. Findings also indicated that MIOs' experiences evolved through a process of moving through and surviving the program. The stages of this process include: "Learning the rules," "Understanding the consequences (not following the program)," "Trying to fit in," "Keeping their noses clean," "Maintaining focus," and the final challenge of "Getting off paper." and moving on.

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CHAPTER 1

INTRODUCTION

Rapidly increasing numbers of severely mentally ill offenders are resulting in the nation's jails replacing public mental hospitals as primary mental health service providers. Many jails are faced with a role for which they were neither designed nor staffed to assume (Steadman, Barbera, & Dennis, 1994; Steadman et al., 2001). Prison systems are ill equipped to handle crises that arise among the mentally ill. Unfortunately, the prison system is the entry point into care for many in this population (Steadman et al., 2001). For the mentally ill, involvement in the criminal justice system is generally the result of minor violations (Belcher, 1998; Torrey et al., 1992; Treplin, 1983). Although it is true that persons with untreated chronic mental illness are more likely to be violent, the rate of violence is only slightly higher. Most persons with mental illness do not represent a significant danger to others (Lamb & Weinberger, 1998).

Several supporters of community-based treatment approaches have recommended ways to prevent or alleviate the urgent problem of mentally ill persons in the criminal justice system (Lamb & Weinberger, 1998; Roskes, Feldman, Arrington, & Leisher, 1999; Treplin, 1983). One such recommendation made by Roskes et al. (1999) included the diversion of mentally ill persons who have committed minor offenses to the mental health system instead of the prison. The proponents proposed a model of working with mentally ill offenders that called for a collaborative relationship between community

mental health centers and probation offices. On release from incarceration, offenders would be assigned to a parole officer and a psychiatrist for supervision, education, and therapy to obtain needed mental health services and to prevent re-arrest for parole violation. While reports about the program were anecdotal in nature, the authors reported success in diverting many long-term offenders from the criminal justice system and into the mental health service system (Roskes et al., 1999).

Another model community-based treatment program (Texas Council on Offenders with Mental Impairment [TCOMI], 2001) is a prison diversion program similar to the one proposed by Roskes et al. (1999). Prior to release, the Texas Department of Criminal Justice (TDCJ) system assigns mentally ill offenders to the program from prison or during the pretrial phase. Mentally ill participants receive intensive case management and supervision services. Overall goals of the program are to reduce recidivism among probationers as well as parolees. Components of the program include medical services, job education/training, and visitation of participants in the community. Success requires intensive supervision and services after institutional release as well as a focus on reintegration during incarceration and a highly structured, gradual transition process that bridges institutionalization and aftercare (TCOMI, 2001).

In the Texas program, mentally ill offender care is managed through a collaborative effort of the courts, probation/parole officers, and the jails. Presently, the program serves 325 mentally impaired offenders including 150 parolees and 175 probationers. Some participants are required to attend the program daily, whereas others,

depending on the conditions of their probation or parole, might be required to attend the program 2 to 3 days a week (TCOMI, 2001).

There is a significant need to better understand and manage the risk of violent behavior in persons with severe mental illness (SMI) through supportive community care. Development of effective jail diversion programs is essential to break the revolving door pattern of institutional recidivism that is prevalent in severely mentally ill populations (Walsh & Bricout, 1997). To date, little empirical research has been done to examine the specific dimensions of violent incidents or describe the implications of these findings for future research funding and care priorities (Swartz et al., 1999).

Problem of Study

Unfortunately, individuals most in need of mental health services often become involved in the criminal justice system. Many are arrested because of behaviors related to their psychiatric disorder. Appropriate community-based treatment could positively influence the lives of mentally ill offenders (Roth & Ross, 2002). Limited research has been completed on community based treatment programs, particularly regarding the perspectives of chronically mentally ill offenders, particularly their experiences in the mandated community-based treatment programs. The purpose of this study was to explore the experiences of mentally ill offenders, as residents, participating in an innovative and highly successful community-based program.

Rationale for the Study

According to the landmark Global Burden study, mental health disorders affect nearly one in five Americans in any given year (United States Department of Health & Human Services [DHHS], 1999). The Global Burden study reported that the 10 leading causes of disability for people ages 5 years and older include the following mental disorders: anxiety disorder, schizophrenia, major depression, and bipolar disorder (DHHS, 1999).

The care of individuals with chronic mental illnesses has shifted since the 1950s. According to the Bureau of Justice, in 1959 nearly 559,000 mentally ill patients were housed in state mental hospitals (TDCJ, 2002). A shift to deinstitutionalize mentally ill persons by the late 1990s reduced the number of persons housed in public psychiatric hospitals to approximately 70,000. Unfortunately, many mentally ill persons did not adjust well in the community and began to experience increasing contact with the criminal justice system. The Bureau of Justice Statistics (1999) reported for midyear 1998 that an estimated 283,000 mentally ill adults were incarcerated in prisons and jails and another 547,800 adults with histories of mental illness or treatment were being supervised on probation. These growing numbers of mentally ill offenders have strained correctional systems that are not designed or staffed to manage them (Roskes et al., 1999).

Texas is one of only ten states to enact legislation that directs both Criminal Justice and Health and Human Service agencies to establish a continuity of care system for offenders (TCOMI, 2001). To assess the effectiveness of the program, the Legislative

Budget Board (LBB) used an outcome measure of reduction in arrests as one indicator of performance (TCOMI, 2001). Based upon analysis of arrest rates for the 1999 fiscal year, the reduction in arrests was 34% (TCOMI, 2001). In addition to measuring arrest data, the TCOMI also compiled data on the number of offenders with special needs sentenced or returned to prison during the fiscal year. Of the 1,882 offenders served by TCOMI programs, only 37 mentally ill offenders (2%) were admitted or returned to prison during the 2000 fiscal year (TCOMI, 2001).

One of the most critical aspects of this continuity of care program is the coordination of services between the justice system, mental health providers, and other support systems. Establishing effective options can reduce unnecessary use of jail and prison resources. Local diversion programs can help defuse crises and ensure that a disturbed mentally ill person will receive evaluation, treatment, and referrals as needed ("Position Statement," 2002).

Knowledge gained from this study may help nurses as well as other health care providers gain a better understanding of the fundamental mechanisms underlying the thoughts, emotions, and behaviors of the mentally ill offenders as they move through the program. Findings may potentially improve the ability to provide better treatment options and improved services for mentally ill offenders. Understanding these experiences from the perspective of the clients can help identify potential interventions and facilitate clients' communication of perceived clinical needs.

Theoretical Underpinnings

Symbolic interactionism provided the underpinnings for this study. Interactionism seeks to explain human behaviors in terms of meanings. These meanings are derived from the social interaction between individuals and groups and are adapted through an interpretive process used by the person dealing with the things that are being encountered (Blumer, 1969). This process can be seen in terms of the interpretive paradigm and attempts to understand and explain the social world primarily from the point of view of the individual directly involved in the social process (Burrell & Morgan, 1979). The methods of investigation based on the interpretive paradigm are designed primarily to understand human beings, their innermost thoughts and feelings, and the ways in which behaviors are cognitively expressed (Burrell & Morgan, 1979). The subjective realities of individuals thus become the focus of the investigator's attention.

Denzin's (1970, 1989b, 1989c) seven principals of interpretive interactionism offer a naturalistic framework for understanding problems or life-altering experiences occurring within the daily lives of people. According to Denzin (1970, 1989c), there are seven principles to consider when selecting methods to pursue the goals of the symbolic interactionist methodology. Denzin's principals draw on the approaches of hermeneutics, symbolic interactionism, ethnography, and naturalistic inquiry. The person in symbolic interactionism is said to be active and creative rather than passive. Researchers, therefore, attempt to explain how people fit in relation to the fit of others (Denzin, 1970; 1989b, 1989c).

Symbolic interactionism is the theoretical perspective that looks at how individuals construct meaning, language, and thought (Blumer, 1969). Meaning is central in human behavior; in other words, individuals act toward people and things based upon the meanings they have given to those people or things (Blumer, 1969). First, any method examining symbolic interactionism must look both at symbols and at interactions (behaviors). Second, researchers must assume the perspectives of the subjects and view their world through their eyes. Third, researchers must relate the subjects' symbols and definitions with the social relationships that provide those conceptions. Fourth, researchers must record the dynamics of the particular observational situations. Fifth, research methods must reflect the process of change as well as static behavioral forms. Sixth, researchers must realize that their own definitions, values, and ideologies shape their investigations. And seventh, concepts are sensitizing, not operational; theory is formal, not grand; and causation is seen as interactional directions in which to look in place of operational definitions (Denzin, 1970; 1989b, 1989c).

The argument in Denzin's principles is that each person is able to act because that person has agreed on the meaning that will be attached to relevant objects in the environment. Based on such agreement, individuals plan and align their actions with others (Denzin, 1970; 1989b, 1989c). For example, a mandated treatment program may be viewed by the participant as the only means of managing symptoms or as the only means for staying out of prison. The participant might be inclined to follow the rules of the program and make sure that behavior is consistent in manner to other successful participants in that program.

Nursing is an area in which symbolic interactionism has been applied to the delivery of care. Morse (1992a) wrote on empathy and caring and examined patients' past experiences and responses to suffering. This viewpoint enables the researcher to develop a degree of theoretical sensitivity, foster an ability to recognize social processes inherent in the interaction, and thus attempt to understand behavior as the participants understood it. According to Morse (1992b), interviews and observations are strategies used to understand the experience and lives of others, with the following assumptions. First, participants must be familiar with their every day worlds. Second, participants must be able to reflect on and describe their worlds and experiences. Some of the experiences of interest to the researchers are implicit, embedded in the culture, and not immediately apparent even to the participants themselves. Participants can only report about what they themselves know. Third, by listening, observing, reflecting, and asking questions, researchers can share participants' worlds and comprehend, interpret, and communicate their experience to others. This third assumption is the fundamental purpose of qualitative research (Morse, 2000).

Denzin's (1970, 1989c) principles offer a way of looking at mentally ill offenders and their experiences in the community-based treatment program. Because the participants interviewed came from all sorts of different backgrounds and educational levels, it was important to consider this diversity and allow the participants' uniqueness to form the interview structure (Denzin, 1989a). Denzin emphasized that there is no single interpretive truth. Therefore, the use of triangulation allows the use of multiple perspectives to interpret the data. Triangulation involves the use of observation of

behaviors and program process, information gathering from participant's records, and interviewing of key informants and mentally ill informants (Denzin, 1970; 1989a, 1989b, 1989c).

Denzin's (1970; 1989b, 1989c) seven principles were appropriate for this study and served as a theoretical foundation for understanding the experiences of the mentally ill offenders who participated in the program. The principles can be applied to nursing because the philosophical underpinnings of interpretive interactionism are consistent with the study of nursing phenomena (Denzin, 1989b). The practice of nursing is contextual in nature as well as a relational, caring activity that recognizes and values the uniqueness of each person and multiple modes of inquiry. Nurses also are concerned with the everyday experience of people and seek to understand meaning within a shared context. In interpretive interactionism, the individual experience is considered unique; discovery and associated meanings are the research focus.

Research Questions

The research questions for this study were:

1. What are the experiences of mentally ill offenders who participate in a community-based supervised program?
2. Does knowledge about mental illness affect mentally ill offenders' experience in the program?
3. How do mentally ill offenders manage their illness in the community-based supervised treatment program?

Orientational Definitions

The following terms were defined for the purpose of this study:

1. *Community-based supervised diversion program* is defined as a program that is an effective alternative to sending nonviolent offenders to prison and offers literacy training, substance abuse treatment, and other rehabilitative services to offenders on community supervision.
2. *Mentally ill offender* is a participant in the selected community-based program with a documented major mental illness, who has committed a criminal offense and is on either parole or probation under the supervision of the Texas Department of Criminal Justice or a Community Supervision and Corrections Department.

Summary

Community-based diversion programs are alternative-to-incarceration programs for seriously mentally ill offenders. By bridging the gap between the criminal justice and mental health systems, these programs help participants manage symptoms related to their psychiatric illness and avoid re-arrest. An ethnography study was conducted to describe experiences of mentally ill offenders and their understanding of mental illness. Findings might potentially improve the ability to provide better treatment options and improved community services for mentally ill offenders. These experiences might eventually suggest interventions that help to facilitate MIOs communication of perceived clinical needs.

CHAPTER 2

REVIEW OF LITERATURE

In this chapter, literature relevant to the exploration of experiences of mentally ill offenders participating in the community-based program is reviewed. An exhaustive search of peer-reviewed journals and books was conducted in an attempt to find prevalence studies, particularly those designed to investigate incarcerated populations. Multiple bibliographic databases, such as the Social Work Research and Abstract, ERIC, PsychINFO, Proquest, Sociological Abstracts, CINAHL, and Medline from 1980 through 2002, were searched. Recent publications and journals related to criminal justice and mental illness, such as United States Department of Justice, National Institute of Justice, *Community Mental Health Journal, International Journal of Offender Therapy and Comparative Criminology, Social Service Review, Social Work, Journal of Criminal Justice Education, Archives of Sexual Behavior International Journal,* and *The British Journal of Psychiatry,* also were reviewed. This chapter provides a review of the literature related to the overall prevalence of mental illness, mentally ill offenders' patient profile, types of mental health treatment for offenders, evaluation of treatment programs, and the therapeutic milieu.

Prevalence of Mental Illness

Regardless of age, economic status, or race, anyone can develop mental illness. During any one-year period, up to 50 million Americans--more than 22%--suffer from a diagnosable mental disorder involving a degree of incapacity that interferes with employment and/or daily activities (Wahl, 1999, 2002). One important reality is that as many as 8 in 10 people suffering from mental illnesses can effectively return to normal, productive lives if they receive appropriate treatment. People suffering from mental illnesses often do not recognize they may be suffering from a mental illness, and, according to Wahl (2002), about 27% of those who seek medical care for physical problems actually suffer from some psychiatric illness. Stigma is one of the most important problems encountered by individuals with severe psychiatric disorders. It lowers their self-esteem, contributes to disrupted family relationships, and adversely affects their ability to socialize, obtain housing, and become employed (Wahl, 1999, 2002). The Surgeon General's report on mental health (U.S Department of Health and Human Services [DHHS], 1999) indicated that the stigma associated with mental illness is powerful as well as pervasive.

Mental disorders can be treated and controlled, but only one in five people who have these disorders seek psychiatric help. The burdens of caring for individuals with mental illnesses are considerable, and financial problems frequently arise. Moreover, the social costs that result from untreated mental disorders are substantial--similar to those for heart disease and cancer. According to estimates by the Substance Abuse and Mental Health Services Administration (SAMHSA), the direct costs for support and medical

treatment of mental illnesses total $55.4 billion a year (DHHS, 1999). The direct costs of substance abuse disorders come to $11.4 billion a year; additionally indirect costs such as lost employment, reduced productivity, criminal activity, and social welfare programs increase the total cost of mental and substance abuse disorders to more than $273 billion a year (World Health Organization [WHO], 2001). According to the National Comorbidity Survey (NCS) carried out in 1990-1992, 54% of individuals with serious mental illness (no numbers stated) received no treatment in the previous 12 months (WHO, 2001).

A study was conducted to determine the number of people in the United States with untreated serious mental illness (SMI) and investigate the reasons why these individuals did not seek treatment. Kessler et al. (2001) used the face-to-face National Comorbidity Survey, a cross-sectional, nationally representative household survey, to collect the data. The SMI definition from the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act was used to identify individuals with SMI in the 12 months prior to the interviews. The study was carried out in two parts (Part I & Part II) between 1990 and 1992. The results were reported for part II of the study. The combined number of respondents for parts I and II of the study included 5,877 SMI respondents 18 years or older. The authors reported only percentages in regard to the findings. The majority, 55 %, denied they had any problem. Of those not receiving treatment, 55% voiced no awareness of their illness and thus did not seek treatment. The study findings contradicted claims that many individuals with serious mental illnesses do not seek treatment because of fear of stigma or dissatisfaction with available services. Few

individuals in the study cited dissatisfaction with available services or inability to get an appointment and so forth as a reason why they were not in treatment. The most frequent reason for not seeking treatment was the individuals' lack of awareness of their illness. Such individuals will not voluntarily utilize psychiatric services, no matter how attractive those services are, because they do not believe that they have an illness (Kessler et al., 2001).

Of those individuals suffering from a mental illness, 45% acknowledged that they needed treatment but still were not receiving treatment. Some reasons given for not seeking treatment included: dealing with the problem on their own (32%), believed that the problem would get better by itself (27%), indicated that cost was too expensive (20%), thought that seeking help probably would not do any good (17%), indicated that health insurance would not cover treatment (16%), and did not know where to go for help (8%) (Kessler et al., 2001).

People with mental illness, especially those with psychosis, are perceived to be more violent than in the past (US DHHS, 1999, p. 7). An Epidemiological Catchment Area (ECA) survey conducted between 1980 and 1983 reported much higher rates of violent behavior among individuals with severe mental illness living in the community compared to other community residents. For example, individuals with schizophrenia were 21 times more likely to have used a weapon in a fight (Swanson, Hozer, & Ganju, 1990). This 1990 study investigated violent behavior among severely mentally ill individuals in 1,401 randomly selected families who were members of the National

Alliance for the Mentally Ill (NAMI). In the preceding year, 11% of these individuals were reported to have physically harmed another person (Swanson et al., 1990).

Walsh, Buchanan, and Fahy (2001) conducted a study of 1,015 forensic patients with severe mental illness and reported that individuals with a diagnosis of schizophrenia were strongly associated with personal violence and that more than 75% of those with psychosis indicated being driven to offend by their delusions. Although the investigators did emphasize that the proportion of total violence in society attributable to schizophrenia was small (below 10%) they indicated that treatment appears as important for the safety of the public as for personal health. The investigators also noted that comorbid substance abuse considerably increases the risk (Walsh et al., 2001).

Mentally Ill Offenders' Patient Profile

Tough laws introduced in the late 1980s overwhelmingly increased the number of offenders sent to prison and the length of time they serve. The United States' rate of incarceration has grown at a decade-long rate of about 7% a year (Anno, 2001). Most people who commit crimes are not mentally ill, and most with mental disorders do not commit crimes. However, inadequate care and treatment for persons with severe mental disorders can place them at higher risk of arrest and incarceration (Swanson et al., 1999). In addition, since most mentally ill offenders are not treated in prison, they leave prison still symptomatic and are likely to commit crimes repeatedly until they are caught and returned to prison. According to the Office of Justice Programs, Department of Justice,

less than half of all released offenders do stay out of trouble for at least 3 years after their release from prison (Anno, 2001).

Besides lack of treatment, the prison environment is an inappropriate place for individuals suffering from mental disorders (Lamb & Weinberger, 1998). When treatment programs do exist, effectiveness is often undermined by weak links to the professional mental health community. In addition, mentally ill offenders represent a challenge to community-based treatment because of resistance to psychiatric treatment even prior to involvement in the criminal justice system (Lamb & Weinberger, 1998; Lamb, Weinberger, & Gross, 1999).

For programs to be successful in supervising persons with mental illness, it is important that services address the broad range of the offender needs. Collaboration and coordination of parole and mental health staff are essential to the success of any special programming for clients on parole or probation. Violations are often a function of clients' symptoms or their difficulties in following directions or a failure to report. Mentally ill parolees who violate the terms of their parole or who fail to maintain a required treatment regime and aftercare program are committed to either a locked psychiatric facility for treatment or a less restrictive mental health treatment program that meets the parolee's or the probationer's treatment needs. When all other interventions fail, the mentally ill offender is referred back to court (Anno, 2001).

The United States Justice Department (Ditton, 1999) estimated that 16% of individuals currently incarcerated in prisons and jails suffered from a severe mental disorder such as schizophrenia, bipolar disorder, or major depression. Large proportions

of this population also suffer from alcoholism or other drug abuse. Of that total, an estimated 60% of mentally ill offenders were using illicit drugs or alcohol at the time they were arrested. The United States Justice Department further indicated that 60% of persons with severe mental illness in jails and 40% of those in state prisons received no treatment (Ditton, 1999; Substance Abuse and Mental Health Services Administration, 2000).

Solomon and Draine (1999) conducted a study to examine the extent to which sociodemographic characteristics, clinical characteristics, substance abuse problems, and lifetime criminal behavior may explain lifetime arrests among offenders supervised by the psychiatric probation and parole services. In this study, 325 clients newly referred to the psychiatric probation and parole services at a large urban center were screened for major psychiatric disorders. The subjects were also interviewed to determine sociodemographic characteristics, mental health treatment histories, criminal behavior, and arrest histories. Researchers used a hierarchical block multiple regression analysis to test a model explaining lifetime arrests. Allowing for age and other demographic variables, the number of lifetime psychiatric hospitalizations ($t = 2.566$, $p < .05$) and lifetime occurrences of mania diagnosis showed a significant relationship to lifetime arrests ($t = 2.359$, $p < .05$), which accounted for 10% of the variance in lifetime arrests. Opportunity variables of age and age at first arrest accounted for a total variance of 45%. The findings of this study supported the belief that symptoms, rather than diagnosis, may be the most important in terms of clinical factors explaining criminal arrest among persons with mental illness (Solomon & Draine, 1999).

The goal of reducing the number of parolees with mental illnesses who commit new crimes or violate their parole depends in part on the availability of community-based services. One frequently proposed approach for responding to offenders with mental illnesses in jail is to remove them from jail to appropriate community-based treatment programs (Bonta, Hanson, & Law, 1998). Goals of community-based care are to help people with mental illness to succeed at home and to prevent crises that may require hospitalization or imprisonment (Bonta et al., 1998).

Types of Mental Health Treatment Centers for Offenders

Access to community-based services is critical to ensure that mentally ill offenders who need service can get it. Moreover, medication is a key treatment intervention to manage symtomatology. Stable housing and employment--both integrated into the community-based approach--also are very important. Persistent outreach consisting of caregivers reaching out to those who are reluctant or unable to regularly participate in services reduces recidivism by providing proactive interventions that deal with potential crises before they occur. Learning about the illness and its symptoms also gives mentally ill offenders and their families valuable skills to successfully self-manage the disease (Ditton, 1999).

Treatment for offenders in the community has been extensively studied and evaluated over the past several years. Results have been consistent in demonstrating that treatment works; it reduces crime and recidivism. Recent researchers have reached the same conclusion from their studies. Community-based intervention for individuals with

severe psychiatric disorders both improves compliance and reduces episodes of violence. Thus far, 41 states use a form of community-based treatment commonly referred to as outpatient commitment, also called assisted outpatient treatment. Assisted outpatient treatment for individuals who have a history of medication non-compliance involves court ordered treatment (including medication) as a condition of remaining in the community (Torrey, 1997). Typically, violation of the court-ordered conditions could result in the individual being hospitalized for further treatment or returned to jail (Torrey, 1997).

Wexler, Melnick, Lowe, and Peters (1999) studied recidivism outcomes for 478 randomly assigned offenders, of whom 289 were included in the intent-to-treat group and 189 were included in the control group. The intent-to-treat group received treatment in a therapeutic community in Amity Prison in California and then received additional treatment and aftercare in the community. Researchers found, at 3 years after release, a statistically significant difference ($X^2 = 63.41 \pm 2, p = .001$) in recidivism between the groups. About one-fourth (27%) of the offenders who received in-prison treatment and treatment after prison recidivated, while 75% of offenders who did not access in-prison and after-care treatment had gone back to prison (numbers of subjects were not reported). Substantial reductions in drug and alcohol use also were documented (Wexler et al., 1999).

The Nathaniel Project, a program developed in 1999, is another innovative program that uses an alternative-to-incarceration program for individuals with serious mental illness who are charged with felony offenses. The program, the first of its kind in

New York City, provides an alternative-to-incarceration program for felony offenders with serious and persistent mental illness and Parole Community Supervision (*Nathaniel Project Policy Statement,* 1999). The program incorporates support and case management to assist mentally ill offenders in their reintegration into society to prevent further crime. The Project provides intensive case management and regular reporting to the court and has three primary objectives: to help mentally ill felony offenders live productive, law-abiding lives; to promote public safety; and to reduce public expenditures. Project staff members facilitate access to comprehensive mental health and medical care, housing, drug treatment, and supportive services in the community (*Nathaniel Project,* 1999); however, no evaluative research studies or statistical data were reported for this project.

Thresholds, a psychiatric rehabilitation program located in Chicago, used the assertive community treatment model (ACT) to provide services to individuals with mental illnesses who have been arrested (Lurigio, Fallon, & Dincin, 2000). The Thresholds program was described as providing a range of intensive case management services, medication monitoring, housing assistance, transportation, and money management services. Thresholds implemented a 2-year Assertive Community Team demonstration project with the goal of significantly reducing recidivism among participants. Enrollees during the project's initial phase were 20 participants with chronic mental illness and lengthy histories of hospitalizations. Criteria for participation included a low risk for violence in the community when compliant with medication and a willingness to take psychotropic medications as prescribed. Caseworkers accompanied

members to court dates and worked with the court to secure release into the program's custody. Caseworkers visited each program member at least once a day, and staff members were available around the clock. One of the unique aspects of the program was that it delivers long-term services across cases, staying with clients through subsequent hospitalizations and arrests. Services were available for as long as a member wished to stay in the program. There were up to 40 members at any one time in the long-term program. Thresholds also provided short-term services for a period of 90 days. The short-term program had a capacity of 25 members (Lurigio et al., 2000). Lurigio et al. (2000) followed the progress of eight of the Thresholds participants over an unspecified period of time, and the data were reported in the form of case studies. According to the researchers, preliminary results of the project suggested that those mental ill offenders with severe and persistent mental illness could profit from an assertive community treatment approach such as the Thresholds project (Lurigio et al., 2000).

Over a 2-year period, Montgomery County, Pennsylvania implemented an array of programming such as pre- and post-booking diversion for offenders with mental illnesses. Mental health services are furnished through a comprehensive service agency, Montgomery County Emergency Services (MCES) (Bazelon Center for Mental Health Law, 2000). Post-booking diversion is the result of regular and direct communication between MCES and the county jail. Inmates with mental health and substance abuse problems are identified by regular screening or by trained correctional officers, or are offenders already known to MCES. Following evaluation inmates are conditionally released, as negotiated on their behalf by MCES, with the promise of mental health

services. Alternatively, charges may be dropped once someone is identified as an MCES client who may benefit more from mental health treatment than from prosecution. MCES also furnishes mental health services on-site in the county correctional facility and provides mental health training of correctional officers. MCES include a mobile crisis intervention team, case managers (short-term and long-term), a forensic social worker, a criminal justice intern, and a transition specialist. Cooperation between MCES and the correctional facility, with efforts by intensive case managers and social workers, opens up a variety of treatment options (Bazelon Center, 2000).

Project Link is another university-led consortium of five community agencies featuring a mobile treatment team with a forensic psychiatrist, a dual diagnosis treatment residence, and culturally competent staff (Ortiz, 2000). The results of the 1993 Monroe County Office of Mental Health study documented a group of mentally ill individuals who, over 3 years, had undergone repeated stays in a local jail and an inpatient hospital. These findings led to the development of Project Link, an ACT program. The project led, in turn, to improved traditional outcome measures, such as decreases in numbers of hospital days, jail days, and costs of the adaptation of assertive treatment within the community. Four factors contributed to the project's success: mobile treatment with cultural sensitivity, 24-hour community services availability, criminal justice system incorporation, and community mental health groups' cooperation and acceptance.

Project Link services are available 24 hours a day, 7 days a week. Clients are referred from multiple sources, including jails, state prisons, and police departments. Staff collaborates with probation and parole officers and provides training on mental

illness and on Project Link to those working in the criminal justice system. Case advocates, who are employees of Project Link's partner agencies, are assigned a caseload of about 20 clients. Case advocates link many individuals to existing services, and housing is provided in single-unit supervised apartments. Individuals with the highest need (generally with co-occurring substance abuse disorders) for more intensive services receive services from the mobile treatment team based on the ACT model. Participants also have access to a supervised residential program, which furnishes integrated treatment for co-occurring disorders, self-help groups, and a psycho-education group. Individuals generally stay in this program for 2 years. Consumers have played an important role in Project Link's development by identifying personal needs, such as housing, and in monitoring the program. Consumer satisfaction was reported as being high, although the author did not report the basis for this classification or how satisfaction was assessed. For consumers, service empowerment is related to the following outcomes: lower levels of depression, anxiety, and psychotic symptoms as well as increased functioning, quality of life, and self-esteem. Project Link leaders attributed their success to coordination and linkage with an array of service agencies and to the fact that diverse cultural issues are addressed (the population is heavily minority, primarily African-American) (Ortiz, 2000).

The Maryland Community Criminal Justice Treatment Program (MCCJTP) is a program for individuals 18 and older who have a serious mental illness with or without a co-occurring substance abuse disorder. The program targets offenders who are confined as well as probationers and parolees, particularly those who are homeless (Conley, 1999). Maryland Community Criminal Justice is a multi-agency collaboration that provides

shelter and treatment to offenders with mental illnesses in their communities. It operates in 21 of the state's 24 jurisdictions. All locations provide post-booking diversion and community follow-up after release including services for probationers and parolees, and some locations provide pre-booking diversion. Individuals enter the program in various ways. Some participants are identified following arrest; others self-refer or are referred by the arresting officer, the classification officer, or medical or other jail staff. Probation and parole officers have support from case managers, who monitor and report clients' progress. Essential features of the program include strong collaboration between state and local providers as well as local advisory boards to provide ongoing case management, crisis intervention, screening, counseling, release planning, and community follow-up services with an emphasis on housing and services for homeless individuals, and appropriate services for individuals with co-occurring mental illnesses and substance abuse (Conley, 1999). The program was reported to be collecting evaluation data on intake, aftercare planning, and community follow-up information on each MCCJTP client. It will provide data on the characteristics of clients who receive MCCJTP services; the types and amounts of services MCCJTP clients actually use, both in jail and in the community; the costs of services; and changes in client circumstances within the jail and in the community (e.g., regarding housing, employment, psychiatric hospitalization, arrest, or substance abuse treatment) (Conley, 1999). However, no data were given (Conley, 1999).

The California Department of Corrections provides specialized services, staffed with psychiatrists and psychologists, for mentally ill parolees through five Parolee

Outpatient Clinics (POCs) and a Conditional Release Program known as CONREP (Nieto, 1999). CONREP is a small but successful community-based program for the persistently mentally ill who are transferred from prisons to state hospitals and to outpatient psychiatric programs as a condition of parole. Eligible participants must have been in mental health treatment in prison for 90 days or more during the past year and must be assessed as a substantial risk to public safety. After completing treatment in a secured hospital facility, CONREP parolees are held to stringent conditions of release and receive mental health care in the community. According to Nieto, studies have shown that CONREP participants are four times less likely to re-offend than are unconditional release offenders, a success rate that is comparable to the performance of parolees in similar programs in New York and Oregon (Nieto, 1999).

Another program that has made noteworthy achievement of service coordination and collaboration in providing services for the persistently mentally ill in the criminal justice system is the Wisconsin Correctional Service's Community Support Program (CSP) (McDonald & Teitelbaum, 1994). Established in 1978, the Wisconsin Correctional Service's Community Support Program effectively combines the advantage of court-ordered program participation and close monitoring with basic social and health care services, including psychiatric treatment, money management, and housing. The program's goal is to keep clients out of jail and out of the hospital (McDonald & Teitelbaum, 1994). The researchers reported that although the program has not been formally evaluated, it appears to be achieving its goal of enabling mentally ill offenders

with chronic mental illness to live independently in the community and to keep them out of jails and hospitals (McDonald & Teitelbaum 1994).

Located in Kentucky, the Community Treatment Alternatives Program (CTAP) is yet another community-based program that was developed as an alternative to incarceration for offenders with chronic mental illness. The State Department of Mental Health developed the guidelines for this program. The criteria for admission in the program are severe, chronic mental illnesses and a misdemeanor crime; however, individuals with personality disorders and primary substance abuse were excluded from the program. Referrals come from judges, other mental health professionals, attorneys, court liaison, and/or jail mental health workers. Potential CTAP clients were assessed by caseworkers who visited the jail every morning and, based on their assessments, decided if the program was appropriate for the detainee. If so, a coordinated plan for the detainee's release from jail was developed by correctional services, community mental health services, and the courts working together to meet the assessed mental health needs. Mentally ill offenders meeting the above criteria were then released back to the community. Almost half of the offenders live in their own homes, while others live in housing provided through other programs or live in boarding homes (Steadman & Bonita, 1997).

Upon release into the program, CTAP participants are monitored very closely. The participant's contact in the first month after release is primarily with the CTAP caseworker. After the first month, the "Seven Counties" staff takes over the case. The staff's duties include home visits to check life management skills and close monitoring of

medications. Some of the participants must come to the center each day to get their medications, while others receive injections (Steadman & Bonita, 1997).

Community Treatment Alternative Program participants must sign a contract, which is their commitment to the program for a 2-year period. In this contract, jail terms are specified in case their status is revoked, for example, if they fail to participate in the treatment plan. If the contract is violated, the CTAP detainee appears before a judge. The judge then can alter the sentence from treatment to the jail term specified in the contract or impose a new 2-year contract with added additional prospective jail time (Steadman & Bonita, 1997).

One form of community-based treatment is conditional release, whereby a patient's discharge from a psychiatric hospital is conditional on compliance with treatment, including taking medication when prescribed. In New Hampshire, findings from a conditional release study indicated increased treatment compliance by more than threefold and reduced episodes of violence to less than one-third the rate before using conditional release (O'Keefe, Potenza, & Mueser, 1997). Using a retrospective file review, O'Keefe et al. (1997) examined hospital days, hospital compliance, substance abuse, violence, employment, and stable housing in the year prior to the patients' conditional release and compared them to the 2-year period after their conditional release. The researchers reviewed the files of 26 patients discharged from the hospital under the conditional release that they receive community-based treatment. Patients on conditional discharge showed improvement during the first year in number of days in the hospital, number of moves per year, and months of employment as well as improvement for the

first and second year in medication compliance, substance abuse, and violence (O'Keefe et al., 1997).

Evaluation of Treatment Programs

Treatment programs should be evaluated to determine their effectiveness. One type of program that has been evaluated is conditional release. Researchers (Bloom, Bradford, & Kofoed, 1988; Bloom, Williams, & Bigelow, 1991) in their studies of conditional release programs have found this action to be similarly effective to the findings of O'Keefe et al. (1997). Bloom et al. (1991) conducted a literature review documenting changes that had taken place from the 1960s to 1990 in the treatment and management of offenders with the development of conditional release programs. Programs such as these provide care for the offenders in the least restrictive environment and appear to be more cost effective than other types of programs. The researchers cited the Oregon Psychiatric Security Review Board as an example of a comprehensive program for the management and treatment of offenders found not guilty by reasons of insanity. The board was created in 1977 as a means to address the concerns regarding release of offenders back into the community. When offenders were assigned to the board's jurisdiction, the board assumed responsibility for placement of the offender to an appropriate treatment program (Bloom et al., 1991).

Another form of community-based treatment is outpatient commitment, in which patients are court-ordered to comply with their treatment plans. Outpatient commitment has been shown in some studies to increase treatment compliance. Hiday and Scheid-Cook (1987) conducted a comparison study of outpatient commitment patients with those

released from the hospital and those involuntarily hospitalized. The purpose of the study was to review the changes in the civil commitment statutes for involuntary commitment of the mentally ill in North Carolina and to observe how outpatient commitment compared as an alternative to release and involuntary hospitalization. Demographic data were collected on history of mental illness, and dangerousness was collected from court records at the time of sampling. Data were collected on a larger study of 1,226 adults who were identified as potentially having a mental illness. The sample consisted of 740 mentally ill adults who had civil commitment hearings in the months of July 1984 and June 1985; 161 of these adults were ordered to outpatient commitment. Results of the study indicated that more outpatient commitment patients lived in their homes after release than either the released or involuntary patients. Patients were more likely to comply with the treatment program, were more likely to take their medication, and were less likely to use community mental health centers (Hiday & Scheid-Cook, 1987).

Munetz et al. (1996) explored changes in patients' patterns of service use in the year prior to and following assignment to outpatient commitment. A retrospective study design was used to study 20 patients with serious mental illnesses and a history of noncompliance and recurrent hospitalizations, but they had good treatment response. After outpatient commitment, significant reductions were found in visits to the psychiatric emergency service ($t = 2.56 \pm 19$, $p < .02$), hospital admissions ($t = 6.54 \pm 19$, $p < .001$), and lengths of stay ($t = 2.77 \pm 19$, $p < .01$) (Munetz et al., 1996).

Van Putten, Santiago, and Berren (1988) conducted a comparison study of patients for whom outpatient commitment was sought and those who were admitted to

involuntary inpatient settings. Data were collected through a retrospective review of medical, clinical, and court records of 384 patients. Results indicated that when outpatient commitment orders were applied, the median numbers of hospital days were lower when the order applied outpatient commitment than when it applied inpatient treatment (10 days compared to 19 days). The data suggested that when outpatient commitment is utilized using clearly defined statuary guidelines and appropriate clinical judgments, benefits are likely (Van Putten et al., 1988). Outpatient commitment has also been shown to reduce the potential violence in the community. In several follow-up studies conducted by Swartz et al. (1999), the researchers found that of patients who remained engaged in outpatient treatment beyond the commitment order period, 57% experienced decreased admissions and 20 fewer hospital days over the study period compared to the total study group. The purpose of the study was to evaluate the effectiveness of involuntary outpatient commitment in reducing rehospitalizations in individuals with persistent mental illness. A total of 264 subjects were randomly assigned to two groups--135 subjects involuntarily committed about to be released and 129 subjects who were to continue under outpatient commitment (Swartz et al., 1999).

Ventura, Cassel, Jacoby, and Huang (1998) examined the effect of community mental health treatment services on post-incarceration recidivism in mentally ill offenders. This study was designed to investigate the effect of intensive case management, with and without a special treatment team, and the usual system of community mental health care on the 6-month recidivism of homeless mentally ill people leaving jail. The researchers examined the relationship between the intensity of case

management and criminal recidivism of 261 mentally ill persons who were released from jail and followed for 3 years (September 1987 through August 1990). The researchers hypothesized that after controlling for demographic, criminal history, and diagnostic variables, recidivism would be inversely related to the amount of case management received both inside and outside jail.

Ventura et al.'s (1998) sample included all jail detainees who were evaluated by clinicians at the jail and diagnosed with a *DSM-III-R* axis I or axis II mental disorder. Subjects were included in the sample if they were released directly from detention in jail or if they spent a subsequent term of no more than 12 months in another correctional facility. Subjects were grouped depending on the type of care they received: intensive case management with a special treatment team, the same care without a special treatment team, and the usual system of community health care. Almost three-fourths, 71% (n = 185), were male, while ethnicity varied from 51% (n = 134) African Americans, to 44% (n = 116) whites, to 4% (n = 10) Hispanics. Subjects' mean age was 30 ± 8.9 years, and the mean education level was 11 ± 1.8 years. Subjects had a mean of 14.9 ± 18.6 previous criminal charges, including 9.3 ± 15.3 nonviolent misdemeanors, 2.3 ± 3.3 violent misdemeanors, 2.3 ± 3.6 nonviolent felonies, and 1 ± 1.5 violent felony (Ventura et al., 1998, pg.1330). A total of 48% (n = 125) of the subjects had previous psychiatric hospitalizations, and 24% (n = 63) were actively psychotic at jail admission.

According to Ventura et al. (1998), no significant differences were found in recidivism between recipients in each of the three treatments groups. However,

significant relationships were found when comparing management time invested with re-arrest or violence. The more community-based case management time that was invested (18 months to 2 years) the longer mentally ill offenders were sustained in the community without re-arrest ($X^2 = 7.561 \pm 1, p < .01$) or violence ($X^2 = 8.12 \pm 1, p < .05$), even after controlling for age and history of previous arrest (Ventura et al., 1998).

Roskes, Feldman, Arrington, and Leisher (1999) investigated a specialized mental health program developed in 1996 by the United States Parole Office in Baltimore for mentally ill offenders on federal probation, parole, supervised release, or conditional release in the community. The program involved the close coordination of a probation officer with community-based treatment providers, including a psychiatrist and two master's-prepared therapists. Services consisted of psychiatric and medical interventions, drug treatment, assertive case management, urine drug screening, and integrated programs for offenders with substance abuse and dependence disorders. Preliminary study findings indicated that clients' violation rates fell from 56% before they were in the program to 19% following participation (Roskes et al., 1999). (Only the percentages with no numbers were reported for this study.) The investigators suggested that program success depends on factors such as individualized treatment plans and services, collaboration between the program and pharmacy to ensure the continual availability of medications, and staff commitment.

Data have been collected to measure Project Link's treatment program effectiveness (Lamberti, 2000). The experiences of 46 non-randomized people who had been admitted to the mobile treatment team were reviewed from October 1997 to

December 1998. Comparisons were made between the data during the subjects' involvement with Project Link and the data from the year prior to their involvement. The data indicated a notable drop in mean number of days spent in jail per month (9.1 to 2.1) and mean number of hospital days (8.3 to 3) after involvement in Project Link.

Lamberti (2000) reported that in 2000 Project Link had treated 71 clients. Of these clients, 39 (55%) were diagnosed with schizophrenia; 15 (21%) had psychosis; 9 (13%) were diagnosed with schizoaffective disorder; 6 (8%) had bipolar disorder; and 2 (3%) had other disorders. Of the 71 clients, 63 (89%) had a comorbid diagnosis of substance abuse and 66 (93%) were not employed at the time of intake. Outcome evaluation indicated substance abuse was significantly improved at the time of discharge, as measured by the MCAS (before 2.2, after 3.3; $p > .001$; $n = 44$) and the Substance Abuse Treatment Scale (SATS) (before 2.3, after 4.8; $p > .001$; $n = 44$). A decrease in the total number of hospital days during the 1-year period after treatment was found when compared with the 1-year period before treatment (16 and 100 days, respectively; $n = 41$). A decrease in jail days also was found (100 and 45 days, respectively; $n = 45$). Consumer satisfaction ratings also were obtained for Project Link, with 4.6 out of 5 (highest satisfaction level). Of the 46 consumers (clients), 35 reported that the project helped them reduce their substance abuse (Lamberti, 2000).

The Therapeutic Milieu

The therapeutic milieu treatment approach is used in many community-based programs. *Milieu therapy* is defined as a form of therapy involving specific activities and

social interactions according to the individual patient's emotional and interpersonal needs (Klonoff, 1997). Milieu work has its primary roots in the therapeutic community movement, which emphasized the social and societal role in ameliorating mental illness and its symptoms (Adler, 1988). Milieu therapy consists of a planned treatment environment in which the participants' everyday activities and interactions are designed for the purpose of enhancing social skills and building self-confidence. This treatment model applies interdisciplinary treatment approaches in which the total environment is thought to have therapeutic potential (Adler, 1988). The milieu environment, although not static, incorporates the use of common structures such as daily routines, predictable rules, and activities (Adler, 1988).

Psychotherapeutic milieu therapy as a treatment method was first used in1929 (Simmel, 1929). This psychotherapeutic model consists of nonverbal group therapy followed by interpretation of the individual's interaction. Ammon (1994) developed a similar model of milieu treatment. However, his milieu contained components that combine a holistic approach of treatment and rehabilitation. In this type of environment, the clinic setting is perceived as home, with the essential difference being that the atmosphere in the clinic is considerably more therapeutic for the patient's personal growth than the emotional climate within the individual's own family (Ammon, 1994).

The milieu allows for understanding how a client's relationships have become disrupted. It is also the environment where the client is offered many opportunities to develop better ways of relating. The most striking characteristic of therapeutic milieu is the community itself--and the individuals are considered the most powerful influence on

treatment (Adler, 1988). Unlike other settings, many of the values that formed the underpinnings for every milieu are clearly articulated, such as honesty, openness, and trust.

These values are essential to the development of the therapeutic relationship. The milieu is planned in such a way that it is constantly supporting, guiding, and reinforcing the individual's ability to learn life tools, such as problem solving and coping skills, while at the same time offering a safe place for these skills to be practiced and integrated.

An example of the milieu approach is the Treatment Accountability and Safer Communities (TASC) program, which provided an alternative to incarceration by addressing the multiple needs of drug-addicted offenders in a community-based setting. TASC programs typically include counseling, medical care, parenting instruction, family counseling, school and job training, and legal and employment services. The key features of TASC include: (a) coordination of criminal justice and drug treatment; (b) early identification, assessment, and referral of drug-involved offenders; (c) monitoring offenders through drug testing and home visits; and (d) use of legal sanctions to remain in treatment (Hiller, Knight, Broome, & Simpson, 1996).

An ethnographic study analysis of the therapeutic practice was conducted at Canyon House, a residential social model treatment program (Weinberg & Koegel, 1996). Canyon House is a residential program in Los Angeles County designed specifically to treat clients with dual diagnoses and is highly regarded among mental health professionals throughout the country for its achievements with this difficult

population. For a period of 9 months, weekly visits were made to the study's residential site (Weinberg & Koegel, 1996). Part of the data collection involved spending the day with members of the program community and going through their routines with them. A total of 37 women and 76 men from a variety of ethnic backgrounds (66 whites, 37 blacks, 9 Hispanics, and 1 Asian) who became residents at Canyon House during the study period were included in the study. Participants' ages ranged from 25 to 40. All had dual diagnoses, with a broad range of psychiatric disorders. All participants had histories of serious mental health problems; however, levels of functioning varied. The majority of the participants ($n = 50$) had problems with alcohol and/or crack cocaine ($n = 60$) (Weinberg & Koegel, 1996).

At Canyon House, the therapeutic milieu approach incorporates the view that psychiatric and substance problems can be treated but never fully cured; rather, it is an evolving process. Therapeutic success is not measured according to standards of wellness consistent with those of the general population. Success is measured by the extent to which residents seem to be sustaining that process. The basic indicator of success at Canyon House is the extent to which residents are observed to exercise their ability to control behaviors that staff or their peers determine are inappropriate for them (Weinberg & Koegel, 1996).

Participants proceed through three successive phases of the program. Minimum stay in the program is approximately 6 months. Required activities and participation include 8 hours of community meeting per week. Participants also attend one hour of group (mood disorder group, stress and coping group, feelings group, alcohol/drug

dependency group, or family systems group) per week. In these groups, participants learn about their disorders from physiological and psychological points of view. The group process also allows the participants to share their own experiences and discuss how their families may have contributed to the development of their habits and coping styles. Although staff exercises ultimate authority at Canyon House and are heavily involved in the routine therapeutic work of the program, authority is often exercised to ensure that participants play an active role in influencing each other's growth and change. At different phases of the program the participants must develop a list of long-term personal goals at their 2nd, 9th, and 21st weeks in the program.

Approximately 15% of participants actually make it to graduation. It is not clear why some program participant do not graduate. The researchers indicated that efforts are made to place participants who do not graduate in outside treatment settings more appropriate to their needs and abilities.

Summary

There are compelling national statistics about the numbers of persons with mental illness who are incarcerated. The overuse of incarceration for large numbers of mentally ill individuals, some of whom need psychiatric hospitalization and others who could be safely diverted to community treatment and supervision, is a major concern for criminal justice and mental health advocates. Jails and prisons are critical venues in which to address mental health issues because of the overwhelming number of mentally ill persons

behind bars and many times jails serve as the first point of entry into the criminal justice system.

For individuals with serious mental disorders, the effects of being in jail or prison are most often a negative experience. Interestingly, many of those who claim that it was a positive experience do so because for them, being incarcerated was the only way mentally ill offenders were able to receive mental health treatment. Jails and prisons usually exacerbate symptoms in that mentally ill offenders often are not given the necessary interventions to control symptoms.

There was little in the literature about mentally ill offenders' personal perspectives of how they manage their illness or just how they value community-based or diversion programs such as the ones mentioned in the literature. More research needs to be done that describes the mentally ill offender's experience of having a chronic mental illness and just how the illness can be better managed. Thus, from a research point of view, further study of a qualitative nature, especially with mentally ill offenders who were participating in a community-based supervised program, was warranted to explore their experiences in depth. It was also deemed important to explore how the offenders' knowledge about mental illness affects their experiences in the program. The final quest was to explore how mentally offenders manage their illness in the community-based supervised treatment program. Findings from this study may help future researchers identify the major variables that correlate with adverse outcomes for those who suffer from a mental illness and their involvement in the criminal justice system.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This ethnographic study described the experiences of mentally ill offenders (MIOs) who participated in a community-supervised program. Ethnographic studies are used to describe the behaviors, values, and meanings of the group within its cultural contexts. Ethnography involves the study of a group of people in their own environment. In this respect, ethnography balances attention to the everyday detail of individual lives by asking questions such as "What does it mean to be a member of this group?" and "What is going on here?" (Goetz & LeCompte, 1984). Participant observation, field notes, and face-to-face semi-structured interviews using in-depth, open-ended, and probing questions were the primary methods of data collection (Lofland & Lofland, 1995). A clearer understanding of experiences of mentally ill offenders can facilitate interventions that are more appropriate.

Ethnography

Ethnography is naturalistic inquiry with roots in anthropology. It focuses on the culture of a group of people (Spradley, 1979, 1980). Ethnography assumes that every group evolves a culture that guides the individuals' views of the world and the way they structure their experiences. Ethnographic research usually involves the study of broadly

defined cultures. However, this study was focused on the more narrowly defined culture of mentally ill offenders' experiences in the selected community-based program.

Ethnography is the study of both explicit and tacit cultural knowledge. Much of any culture consists of tacit knowledge in which informants or interviewees often know things they cannot talk about or express consciously (Spradley, 1980). While explicit cultural knowledge can be communicated at a conscious level and with relative ease, tacit cultural knowledge remains largely outside of people's awareness. Thus, the role of the ethnographer is to carefully listen and observe in order to infer what people know (Spradley, 1980). Ultimately, the aim of the ethnographer is to learn from members of a cultural group in order to understand their worldview (Spradley, 1979). Ethnographic research offers an orientation to understanding the process and structure of a social setting and employs research techniques consistent with this orientation (Spradley, 1979).

Setting

A community-based supervised treatment program located in a large urban area in the Southwestern United States served as the site for this study. The selected community-based program is an intensive case management and rehabilitative program that provides 24-hour, 7-days-per-week accessibility to services. Client care is managed through a collaborative effort with the courts, probation/parole officers, and the jails. During probation, mentally ill offenders are placed under supervision in the program for a specified length of time, as ordered by a court, with court-imposed rules and conditions.

Under conditions of parole, some participants are required to attend the program daily, whereas others might be required to attend the program 2 to 3 days a week. Additionally, parolees must report on a regular schedule to a parole officer and must obey specific conditions of release until the original sentence is completed. Approximately 300 participants were enrolled in the program.

Population and Sample

Mentally ill offenders over the age of 18 years, English speaking, and currently participating in the program were recruited for inclusion in the study. Key informants from the clinical staff--one registered nurse, the program coordinator, and the program director--were interviewed about the philosophy of the program and types of services provided in the program. A purposeful sample of 12 mentally ill offenders and 3 key informants were recruited for this study. Sampling was purposeful in that only MIOs currently participating in the program and deemed to be reliable informants were recruited. A reliable participant is one who is undergoing the experience and is able to reflect and provide detailed experiential information. There were no restrictions in regards to gender, race, or ethnicity. Participants were recruited following approval of all concerned institutions and agencies. Participant selection was based on information gathered from program staff and review of the participant's records.

Protection of Human Subjects

Prior to data collection, approval from the Texas Woman's University Committee for the Protection of Human Subjects and Institutional Review Board approvals were

obtained (Appendix A). In addition, Internal Review Board approvals were also obtained (Appendix A). Signed informed consents to participate in the study and to be audio recorded were obtained from all participants prior to the start of the study (Appendix B). Risks of the study included participants' potential loss of confidentiality or potential anxiety about sharing their mental illness or criminal history. Potential loss of confidentiality was reduced by not using names or identifying information during audio taping or transcription. If names were inadvertently spoken during the interview, they were edited out of the transcription. Pseudonyms were used in the data analysis in place of participant names. Code numbers were used to identify interviews. Recorded audiotapes remained in the possession of the researcher and were used for research purposes only. Potential anxiety was reduced because participants could refuse to answer any questions with which they were uncomfortable and they could terminate the interview at any time without penalty. If the participant became upset at any time during the interview, the researcher or the participant would have elected to terminate the interview. If the participant elected to continue the interview, another time would have been scheduled. The researcher followed the established procedure protocol at all times (Appendix C).

Instrumentation

Semi-structured key informant and mentally ill offender interview protocols were used as guides for the purpose of the interviews (Appendix D; Appendix E). Additional questions for key informants and mentally ill offenders were added to the protocol as the

study evolved. Interview questions varied over the course of the study as the participants shared their experiences. Key informants, members of the program staff, were asked questions about the purpose and overall goals of the program and what roles they played in the treatment team (Appendix D). Mentally ill offenders were asked about their experiences in the program. A combination of open-ended and probing questions, such as "Tell me your story," "What helps you manage your illness?" or "Tell me more about your experience," were used to encourage participants to share additional information and to seek clarification and verification during the interview (Appendix E). Demographic data were collected for the program staff in terms of length of time of employment at the program and job title (Appendix D). Demographic data for the mentally ill offender included history of mental illness, legal history, type of offense, and legal status (parole or probation, length of probation or parole, and length of time attending the program) (Appendix E).

Participant Observation

Participant observation was one strategy used to gather data. Field notes were completed and used as a method for registering data collected during participant observation. The researcher occupied an outsider role whose presence became accepted as the study progressed. Observation involved gaining familiarity with the participants in their environment. Observation periods allowed the researcher to gather an overall view of the setting, the staff, clients, and type of activities that occurred in the program and individual behaviors during the interviews. Observation periods in the waiting areas,

nursing station, and lobby area lasted approximately 2 hours for each selected interval period. The researcher maintained regular, weekly attendance of two mentally ill offenders' therapy groups. The group sessions lasted about 45 minutes for each group.

Attendance at staffing rounds and participant staffing were maintained on a weekly basis. Observations were focused on nurses, case coordinators, therapists, probation, and parole officers who interact directly with mentally ill offenders. These observations occurred during the midmorning hours for 2 hours on Thursdays. Notes were done and typed up into detailed field notes within 24 hours of the observation. The researcher made a point of attending group each Thursday. Topics discussed varied according to the day of the week and included information about trauma, substance abuse, symptoms management, and anger management.

Interviews

Audiotape interviews were one of the primary data collection strategies for this study. Participants were asked to verbally respond to a list of semi-structured interview questions. An interview protocol was used to guide the interview. Each participant was interviewed one time. Interviews lasted approximately 45 minutes and took place in a private office (Lofland & Lofland, 1995; Morse, 1994a, 1994b).

Fifteen in-depth recorded interviews were conducted with mentally ill offenders and key informants: 12 with mentally ill offenders and 3 with program staff, including the program Director, the Program Coordinator, and the Registered Nurse. Interviews ranged from 45 minutes to 1 hour. Questions were designed to allow the key informant to

elaborate on the structure of the program and MIOs to share their experiences in the program. Participants were told that they could receive a copy of the transcription if they so desired. Only three participants indicated that they would like to have a copy. The participants were selected based on what they could share about their knowledge and experiences in the program. All research participants were interviewed on one occasion. The open-ended nature of questioning encourages research participants to say what they wanted to as they wanted to say it (Mishler, 1986, p. 235). Some participants started their story from the events that led up to their experience; others went as far back as their childhood. Participants were aware that the researcher was not part of the staff; however, that did not interfere with their willingness to share their experiences in the program.

Information was validated with what the participants told the researcher against their official records. The researcher did not find any discrepancies between official and self-reported information. However, the 46-year-old mentally ill offender who had been forthright about his mental illness and criminal history failed to disclose that he was also diagnosed with Axis II diagnoses of Borderline and Antisocial Personality Disorders.

The interviews were conducted on the premises of the program and were done in closed-door rooms that were vacant except for the researcher and the interview participants. Since the researcher could not hear the substance of conversation held in adjacent rooms, she was confident that neither could her interviews be heard. A micro-cassette recorder with a built-in microphone was used during the interviews. Most participants seemed to pay little if any attention to the recorder.

Field Notes

Field notes were written during each visit to the study site in an attempt to get the whole picture of what was happening. Notes included the researcher's personal reactions, self-reflection, memories, impressions, description of methods used, reasons for using those methods, and ideas for possible changes in methodology. Field notes may offer rationale for changes, including possible and actual adaptations of methods, emergent trends, and hypotheses. The researcher's involvement in the group sessions yielded field notes that recorded how the topics were covered.

Triangulation

Triangulation was accomplished by using multiple resources to confirm the information gathered. Other methods included reviewing the mentally ill offender's records and doing member checks. A member check would involve going back to the participant and clarifying any information. Field notes were read, and reread, and transcribed interviews were read for recurring patterns. Furthermore, the researcher listened to interview tapes while reading transcripts to ensure the validity of the transcripts and to serve as another layer of analysis. The researcher used an iterative, process analysis approach (Glaser & Strauss, 1967; Polit & Hungler, 1995). This approach called for the researcher to classify data texts into categories or themes, write memos about the meaning of these categories, and add new incidents to categories until they became "theoretically saturated." Throughout the analysis, the researcher was aware of the ways her research presence affected the scene. The researcher included reflective

memos in field notes about her research role, and these memos served as another source of data about how emotions, interactions, and identity were constructed within the program atmosphere.

Data Collection

Data sources for this analysis included field notes from participant observation of staff members as they went about their daily work, mentally ill offenders' activities in the program, and transcribed formal interviews. Data were gathered during 38 visits over an 11-month period (September 2002 through August 2003) totaling 183 research hours and yielding 201 single-spaced, typewritten pages of raw data.

Consents to participate were obtained prior to the interview. Participants were asked to respond to a semi-structured interview protocol. Data collection was accomplished using face-to-face, semi-structured in-depth, individual, taped interviews with key informants as well as mentally ill offenders. Review of mentally ill offenders' records and participant observation also were used. Twelve participants and three key informants were interviewed. Data collection ended when saturation was achieved or when the interviewer stopped hearing anything new (Morse, 1994a, 1994b).

Pilot Study

A pilot study was conducted to assess the proposed study methodology. Two persons, a key informant and a mentally ill offender, were interviewed. In addition, 6 hours of observation were completed.

Mentally ill offenders enter the program by various means; however, the most common method of entry into the program for mentally ill offenders is after release from prison. The mandated level of participation in the program is based on the participant's point of entry into the program and the degree of compliance with the treatment. For example, newly admitted mentally ill offenders are required to attend and actively participate in multiple modalities such as process groups and medication teaching 5 days a week. Groups are designed to help the mentally ill offender to cope with such issues as trauma or loss and to manage their anger. In addition, the mentally ill offenders must meet with their own treating psychiatrist, parole or probation officer, case coordinator, and nurse on a weekly basis.

The offenders' knowledge levels about the expectations affected their experience in the program. Important elements discovered included lack of understanding about mental illness, getting to know the system and feeling comfortable in the setting, and following the rules. Results of the pilot study did not affect the original design of the study or the interview guides. Therefore, no changes were made as a result of pilot study findings. However, a glossary of terms was established (Appendix F).

Treatment of Data

Analysis methods were based on process analysis (Polit & Hungler, 1995), a derivative of grounded theory (Bogdan & Taylor, 1990; Glasser & Strauss, 1967; Rubin & Babbie, 1993; Strauss & Corbin, 1990). Therefore, data analyses were concentrated on themes rather than the individuals. Process analysis is a form of qualitative research that

emerges from interviews, participants' observations, and other sources and offers "descriptive information about the process by which a program or procedure . . . functions in actual operation" (Polit & Hungler, 1995, p. 190). In process analysis, categories are developed based on recurrent themes, and typologies and illustrations of particular issues emerge. In addition, process analysis offers the flexibility of being able to add more data to the study as it progresses and being able to explore particular themes more extensively.

To ensure findings were grounded in the data, each transcribed interview was analyzed and coded line-by-line using the constant comparative method (Glasser & Strauss, 1967; Strauss & Corbin, 1998). Upon an initial coding of the data, the transcriptions revealed a number of core issues emerging. These core issues were discovered through a rigorous coding of the data, which was completed when no new properties or related issues emerged. Categories of data were developed in this way until the core issues required for further investigation were clear (Strauss & Corbin, 1990).

Audiotaped interviews and investigator's field notes were transcribed immediately following each interview. Data analysis was an ongoing process that involved looking for themes and using a constant comparative method in which the current interview was compared to prior ones (Lofland & Lofland, 1995; Wolcott, 1990, 1995). Data analysis was accomplished through: (a) summarizing transcriptions and field notes to make sense of the data and to restructure data collection plans; (b) identifying emerging themes that related to the research questions; and, (c) determining similarities and differences in themes. The intent of the analysis was to develop a typology to

organize the data into a meaningful, individualized interpretation, theory, or framework that described the participant's experience (Munhall & Boyd, 1999).

Trustworthiness of Data Interpretation

The concept of trustworthiness has its philosophical base in constructivism, and it consists of four elements: credibility, dependability, confirmability, and transferability (Goetz & LeCompte, 1984). Participant observation provides an opportunity for continual data analysis and comparison to refine constructs and to ensure the match between scientific categories and participant experiences. Participant observations are conducted in natural settings that reflect the life experiences of participants more accurately than laboratory setting. Informant interviews are less abstract and lend themselves to exploration of individual experiences (Goetz & LeCompte, 1984).

Credibility

Credibility refers to internal validity; it relates to how the reconstruction of the researcher fits the realities and views that the participants express in the process of the inquiry. Credibility was achieved by crosschecking the transcripts and field notes to determine whether the findings reflected mentally ill offenders' experiences in the programs. Review of personal field notes kept from the beginning of the study was done to determine how the data had influenced initial assumptions. A literature review of similar community-based interventions or treatments for the mentally ill were conducted. The interviewer included quotations from the description of the mentally ill offenders' experiences in the interview. Descriptive accounts and field notes were used to validate

information. If questions arose during the process, the interviewer did a member check by going back to the participants for further clarification or elaboration on the accuracy of the study results.

Dependability

Dependability refers to the replication of the study. It was expected that changing interactions between the researcher and participants would occur. All such changes were documented as the study proceeded.

Confirmability

Confirmability is concerned with establishing that the interpretations of the data are not figments of the researcher's imagination. Transcription of interviews and multiple listening to audiotape interviews to determine if accurate assumptions were being made supported dependability. Confirmability involved collaboration with the research committee members to determine if the pieces of the data validated each other. Did the story hold up and were the facts consistent (Eisner, 1981)? Confirmability was accomplished by having the research committee: (a) review cassette tapes of the interviews, (b) read interview transcripts, (c) review interview protocol, and (d) critique lists of categories and themes the researcher used while analyzing the data. Confirmability was shown primarily through the research report and included the ability of someone other than the researcher to follow the events and logic of the study (Syemes, 2000).

Transferability

Transferability refers to the possibility that the context of the study is applicable to another context (Guba & Lincoln, 1990; Lincoln & Guba, 1985). The responsibility of transferability lies not with the researcher but with the reader of the research report (Kennedy, 1979). It is the researcher's responsibility to produce and share the information, but the receivers of the information must determine whether interview data correlate with researcher's observation and chart review (Geertz, 1973). Transferability was achieved through a thick description within the context of the population (Geertz, 1973, 1980).

Summary

The domains of the study were stated as: What are the experiences of mentally ill offenders who participate in a community-based supervised program? How does the offenders' knowledge about mental illness affect their experience in the program? How do mentally ill offenders manage their illness in the community-based supervised treatment program? MIOs, 18 years of age or older, English speaking, who were currently participating in the New Start program, were interviewed and constituted a purposeful sample. Interviews were audiotaped and transcribed. The data were analyzed using the process typology approach to describe MIOs' experiences in the program. Findings are reported in chapter four. Chapter five contains a discussion of the findings and includes conclusions, implications, and recommendations for future studies.

CHAPTER 4

ANALYSIS OF DATA

The purpose of this study was to describe the experiences of mentally ill offenders (MIOs) participating in the New Start treatment program. Three research questions were posed for this study to gain a better understanding of how MIOs perceived their experiences in the program: (1) What are the experiences of mentally ill offenders who participate in a community-based supervised program? (2) Does knowledge about mental illness affect mentally ill offenders' experience in the program? (3) How do mentally ill offenders manage their illness in the community-based supervised treatment program?

An ethnographic approach was used to gather data information regarding how mentally ill offenders perceived their experiences in the program. Ethnography is used when the researcher wants to look at a group who shares a common culture. The focus is on the everyday behaviors of the people in the group, with the intent to identify cultural norms, beliefs, social structures, and other cultural patterns (Leedy & Ormrod, 2001).

In this chapter, a description of the participants is highlighted and relevant findings about the experiences of mentally ill offenders in the program were discussed. A process typology illustrated how participants move through the program. The processes of getting in the program, learning how the program operates, gaining an understanding of consequences of noncompliance, keeping their noses clean, maintaining focus, and learning the rules as MIOs move through the program were discussed. In addition, what

it takes for MIOs to manage their mental illness as they move through the program was discussed. Finally, a summary of the findings is presented.

Description of the Sample

Participants in this research study consisted of 12 mentally ill offenders (MIOs) currently participating in the program and 3 staff key informants, including the program director, employed with the program 10 years; the program coordinator, with the program for 11 years and a registered nurse, with the program within the past nine months. Demographic data were collected for both mentally ill offenders as well as the key informants. Of the 12 MIOs interviewed, 4 were females and 8 were males. Ages ranged from 18 to 62 years old, with a group mean age of 41 years. Three of the participants fell in the age range of 18 -25 which falls into the juvenile classification in the New Start Program. Eight of the MIOs were African Americans (6 of the 8 identified their ethnic identity as Black), 3 were Caucasians; and, 1 was a biracial adolescent who identified herself only as Hispanic. Three of the participants were eighteen and nineteen years old respectively. These characteristics are representative of the rest of the MIOs participating in the New Start Program.

Six of the MIOs had *Diagnostic & Statistical Manual of Mental Disorders* (DSM IV TR; American Psychiatric Association, 2000) Axis I diagnoses of Schizophrenia, two had diagnoses of Bipolar Disorder, two were diagnosed with Schizoaffective Disorder and one had a diagnosis of Major Depression. In addition to an Axis I diagnosis, one MIO also had an Axis II diagnosis of Antisocial as well a diagnosis of Borderline

Personality Disorder, respectively. Eight of the 12 MIOs admitted to a coexisting substance abuse disorder. Eight of the MIOs were on parole-- which meant they had spent time in prison--and four were serving probation. Six of the 12 were incarcerated for either cocaine use or distribution of cocaine (in addition to cocaine use, one of the six was also charged with child molestation); four were charged with felony assaults; one was charged for felony thief; and one was charged with rape and sexual assault. Frequently, mentally ill offenders have co-occurring substance abuse issues. The combination increases the level of difficulty in managing the mental illness.

Mentally ill offenders had spent time in either prison or jail or both. Five of the MIOs had served several prison terms by the time they had gotten to the program. The average prison length of stay was approximately 8 years. Three of the MIOs were required to wear leg monitors, as an added stipulation of their parole, due to the severity of there crimes (rape, child molestation and murder). The required length of parole or probation for participants in the program ranged from 5 to 15 years. Mentally ill offenders' interview for the study had been in the program ranging from 3 weeks to 10 years. Two of the twelve MIOs interviewed successfully completed the program during the study period. One female MIO was rearrested, 2 months after being interviewed, on aggravated assault charges. Another 62-year-old male absconded from the program (he fail to show at the program for a period of five days and did not call). This particular participant had stopped taking his medications and had become increasingly agitated and paranoid. However, he was located by his case manger and returned to treatment following a two-week of hospitalization.

Findings

Data for this study were gathered through interviews with MIOs and program staff informants, as well as through observation of program activities including groups. Ways of describing the process and experiences of being in the community-based treatment program were to have MIOs talk about their experiences and to observe the process of participants in various stages of the program. Mentally ill offenders who are just beginning the program have different needs and concerns compared to others who are in the middle or others who are about to exit. Issues are different for individuals as they progress along the continuum of the program. For example, getting into the program is an initial challenge. Mentally ill offenders new to the program are concerned about the nuances of fitting in, discovering the routine of the program, and more importantly, learning the rules. Fitting in was important. Mentally ill offenders wanted to be accepted by others in the group despite crimes they had committed or their diagnosed mental illness. MIOs who have learned how the program works may find other aspects of the program important, such as how to maintain focus for the period of time left in the program. However, as MIOs moved through the program, their needs changed, and earlier concerns were diminished. An overview of the New Start program will be followed by a description of MIOs' experiences in the program.

The New Start Program

The New Start program was developed in 1993 as an alternative-to-incarceration program for people with serious mental illnesses who are also charged with felony

offenses. The word *Start* is an acronym for *Specialized Team of Advocates and Rehabilitation Therapists*. The aim of the New Start Program is to stabilize seriously mentally ill offenders in the community by providing treatment through the health care system rather than punishment through the criminal justice system (Texas Council on Offenders with Mental Impairment [TCOMI], 2001). Participants are eligible for admission to the program if the following criteria have been met: have committed a crime (must be on either probation or parole), have a diagnosed mental disability (DSM IV, TR Axis I diagnosis), and are in need for intensive case management and rehabilitation (TCOMI, 2001; Texas Department of Criminal Justice [TDCJ], 2002).

Presently, the New Start program serves 375 mentally impaired offenders, 150 parolees and 175 probationers. In addition, beginning in fiscal year 2003, the *Youth Commission* portion of the program began serving 25 youth offenders--those 18 years of age--for a total of 400 participants. Program participants are comprised of 63% males and 37% females.

The program is designed only for those people who are somewhere within the criminal justice system, such as pre-trial, on probation, or on parole. Participants in the program are referred from either the Texas prisons system, the county jail (probation or under pre-trial release conditions from the courts), or the Council on Criminals with Mental Impairments. Referrals to the program also can be made from other sources, such as family, friends, or the Mental Health Mental Retardation Authority (MHMRA, 2001). Other referrals come from the Department of Criminal Justice, Substance Abuse Felony

Punishment Facilities (SAFEP), state jail, or jails in the local county district as well as the parole and probation offices (TCOMI, 2001; TDCJ, 2002).

Physical Layout

The New Start program was housed in an old brick, two-story building located in an urban area of a large metropolitan city. The program occupied the entire second floor; situated right above a program for the homeless population located on the ground floor. To reach the program, participants must walk up an indoor flight of stairs to the main waiting area. This area can accommodate up to 40 or 50 people and is usually full of MIOs during the morning hours. Lack of adequate physical space presents a challenge for the day-to-day operation of the program. Small offices line the three main hallways; because of limited space, sometimes two staff people have to share an office. The nursing office is located at the end of one hallway and is easily accessible from all directions. Due to the lack of space, many of the therapeutic groups and personal interviews are conducted in the staff offices. Because of the architectural nature of the building, several offices are located behind a code access locked door. Staff members are the only ones who have access to the code, and all others, including visitors and MIOs, must have permission to enter.

Bus lines allow convenient access to the facility. The building is usually open at 8 o'clock each morning, Monday thru Friday, unless something untoward happens. On one occasion during the period the researcher was on site, the building could not be opened until 12 noon due to a gas leak in the building the night before. Staff security

would not allow anyone (including staff) inside until it was deemed safe by the gas company to do so. Working hours are typically 8 a.m. to 5 p.m.; however, many times staff stay behind to do paper work or to work with a MIO who may have an emergency situation.

Components of the Program

Multiple services are provided through the New Start program and are facilitated through a comprehensive team approach. The program coordinator described the broad focus at New Start as follows.

> Whatever they [mentally ill offenders] may need . . . it is our job to link and coordinate. In addition, once we make appointments for the clients we just do not drop it right there . . . we do follow up . . . we provide a 30-day, 60-day, 90-day follow up to insure that this population is doing well and we are doing what we say the program should be doing.

The program consisted of eight service components. The first component, Continuity of Care (COC) Services, covers the entire state with a wide network of continuity of care workers. Initial assessments of participants are done in prison prior to admission to the New Start program. This component allows for seamless service for the mentally ill offender. From the moment the MIO is identified as a participant, COC services begin and remain in place until the participant is discharged or linked to follow-up services.

The second component, Intensive Rehabilitation, consisted of psychosocial and psycho-educational groups for this population. Master's level prepared counselors and registered nurses performed individual counseling with the participants in the field--

wherever the mentally ill offenders reside--as well as at the office. Approximately 175 groups were conducted each week. Groups included education on symptom management and development of effective coping skills.

A third component, Psychiatric Care, consisted of five psychiatrists working directly with participants in the program. Psychiatrists provide MIOs with medication maintenance and medication monitoring as well as psychotherapy. A history and physical are completed on all incoming MIOs to screen for any medical complications. All efforts are made to ensure that MIOs are medically stable. Each psychiatrist may carry a caseload of approximately 108 participants. The fifth doctor sees participants on Wednesdays for open assessment. He screens participants to determine whether they will need a supplemental supply of medications before their scheduled clinical appointments. In addition, the Youth Commission doctor carries a caseload of 25 18-year-old MIOs.

The fourth component of the program is Intensive Case Management. Program participants had many physical problems and therefore required a high level of service coordination to be in place to ensure that these needs are being met. Twelve case managers oversaw a caseload of approximately 28 clients each. They provided intensive linkage and coordinating of services, advocacy, and skills training--whatever the MIOs needed in order to keep them from re-offending. Case coordinators and counselors were on call 24 hours a day, 7 days a week.

A fifth component of the program is Nursing. Nurses are valued team members and played an important role in the community as well as in the clinic. Many of the MIOs, in addition to diagnoses of mental disorders, suffered with moderate to severe

health problems such as diabetes, HIV, lupus, or cancer. Therefore, careful screening and assessment were crucial and necessitated the nurses' input. Part of the nursing role was to educate mentally ill offenders about their illness. Nurses also were responsible for ensuring that mentally ill offenders took their medications as prescribed and for teaching about medications and associated side effects. Nursing responsibilities extend beyond the program participants. Nurses were responsible for educating other non- nursing staff about medication-related issues or side effects that could have impacted the MIOs' success in the program. One nurse viewed the nurses' role in the program.

> Our advocate role really comes into play a lot here, because a lot of the counselors...they don't know medical issues. They don't know the medications. So we have to be like a patient advocate and try to help the counselors understand. You can see for yourself, they're really a doing a good job. I guess we're really doing a good job because the counselors are starting be more aware of medications and stuff . . . and coming to [the nurses] when they [have] questions.

The sixth component of the program is the Benefits Coordination portion. Because so many program participants were disabled, about 80% to 90% received disability and social security income (SSI). Two case coordinators worked with mentally ill offenders to obtain benefits for those consumers who were eligible, which included benefits such as Veteran Association or social security benefits, disability and supplemental income (SI).

The seventh component, Wrap Around Services, has a goal of getting MIOs into the program at the very onset of criminal behavior. This expanded component of the program worked at the front end in terms of treatment. At the front end, the program caught mentally ill offenders at the entry in the court system. Mentally ill offenders may

have already been given a sentence to spend so many days in the county jail; nevertheless, the judge can take into consideration the severity of the offense. The judge then could make the determination whether or not to divert them out of the system and instead place them in an appropriate program within New Start, such as substance abuse treatment or group therapy.

The eighth component, the Court Resource Program or Jail Diversion Division, worked with MIOs who had committed a crime that led them to serve prison or jail time. The program staff collaborated with six judges in the county area to place MIOs in appropriate alternative treatment setting. Three court resource coordinators from the program each worked with two felon courts apiece. The primary goal of this component was to divert mentally ill offenders from the criminal justice system. A typical example of this diversion is a mentally ill offender who has had no previous criminal history may have assaulted someone. If the crime committed was not severe enough to warrant prison time, mental health treatment may be deemed more appropriate. The rationale is that MIOs benefit most from treatment in a supervised community treatment program where the main focus is to reintegrate them back into the community. It is evident that these components provide wrap around services for this population of MIOs.

Internal Structure

Approximately 50 employees comprised the treatment team that worked directly with mentally ill offenders in the program. The team consisted of one program director, one program coordinator, two registered nurses, one security guard, one receptionist, and

several parole and probation officers, case coordinators, therapists, and court advocates who all work with the offenders. All staff members come to the facility Mondays thru Fridays unless they are scheduled for visits or going to court to advocate for potential participants already in the program who have issues with compliance or for those who are potential candidates for the program.

Duties of the program director appeared to be quite extensive. One day the director might be in Austin at the TCOMI's office, while another day the director might be visiting one of the prisons or appearing in court on behalf of a client. The program director's primary function is to manage the program and the budget. Other responsibilities included supervising the staff and acting as consultant to those in the criminal justice system in the city and surrounding counties. The program coordinator was responsible for programming and educational curriculum development. The curriculum was comprehensive and included treatment modalities such as stress management and coping skills training.

Nursing responsibilities included assessment, health teaching, and monitoring of MIOs' physical and mental status. Nurses were available in the office from 8 a.m. to 5 p.m. Mondays through Fridays. Registered nurses assessed MIOs for any medical needs and referred them to the physician if needed. Nurses were also responsible for performing the EKGs, labs, monitoring of those MIOs who take their own medications, medication teaching, and the administration of intravenous injections of decanoate medications. Decanoates are the long acting forms of antipsychotic medications given to the individuals who have trouble remaining compliant (have trouble taking the

medication by mouth or remembering to take it) in taking their medications. Other nursing functions included coordinating the care of the participants with family members and caregivers and teaching home and personal safety. Nursing provided all the basic nursing functions at the clinic as well as in the home if necessary. According to one nurse,

> We go into the home when they [miss] their appointment here, or they haven't been able to come because of rain or something. Mostly it's the ones that can't come here; they have real heavy medical issues. We do medication education and just basic teaching, first aid, home safety. Whatever I see that they need or whatever we see that they need. There's one client who has a hernia . . . he's about to have surgery so he can't come all the time, I always go see him, make sure he's doing okay.

The parole and probation officers' overriding role was to make sure MIOs are compliant with the mandates of the program and to ensure that they followed the rules. The parole and probation officers functioned in a supportive role as well. They follow up with MIOs by making home visits and taking MIOs to scheduled court dates as well as appearing in court on the MIO's behalf. The case coordinators and therapist roles were very similar, and many times their roles overlapped. Case coordinators helped MIOs apply for all benefits, including housing, social security income, food, and/or medical insurance. They also assist MIOs with filing necessary paperwork for birth certificates, driving license, or whatever it took to facilitate MIOs getting needed benefits. The therapist's role was to work with the MIOs in developing adaptive coping skills so that they could deal with environmental stresses and other real life issues. Security is present on site each day from 8 o'clock until the last person leaves the building in the evening. The security guard maintains safety on the premises. The staff receptionist was

responsible for directing all of the program's incoming calls. Other duties included directing MIOs to their appointments, making sure each MIO signed in and out on time, and issuing bus tokens to those who utilized public transportation.

Team members worked closely together and collaborated in regards to the overall plan of care for MIOs. Staff demonstrated caring attitudes, and many went beyond their usual duties to support MIOs. Parties (food and activities) were routinely given for special holidays such as Thanksgiving and Christmas. Birthdays and other special occasions also were cause for celebration. For example, when MIOs successfully complete the program, the staff gives a party to celebrate. There was one tragic incident and a great sense of sadness was expressed when a MIO was killed by a hit and run driver. The whole staff and other MIOs attended the funeral with transportation provided for anyone who wanted to attend the funeral.

Over time, the program services and staffing have evolved. A 46-year-old male MIO, with a diagnosis of bipolar disorder, currently participating in the program has been on parole for the past 10 years since its inception in 1993 was knowledgeable of how the program works and indicated he had seen some major changes in the program in the past 9.5 years. This participant spent 10 months in prison for forgery and possession of cocaine. He viewed those changes as beneficial.

> I think one thing they [TDCJ] just started is moving the parole officers here. You don't have to go to the parole officer . . . you just go right here. And on the nursing staff, we just used to have one nurse, but we have two nurses now. And uh . . . we've got, let's see . . . we've always had two psychiatrists but now we got two more . . . we've got like a fleet of four. And I tell you [Something] else . . . it's amazing . . . I don't know the exact number but we've got a lot more . . . counselors and they call them . . . uh . . . "Service Coordinators". They've got a

> bunch more. They've got all these things here. It's . . . what's it's called . . . a treatment team. The internal structure is developed in such a way that it provides a safety net of resources

Keeping the Doors Open

The Texas Council on Offenders with Mental Impairments (TCOMI; 2001) is the primary funding agency for the New Start program. The state sets apart certain funds for individuals with mental impairments and the primary funding source for the program is through a state grant. Another division, the parole division, also provides funding to the Council in order to serve the 3-G criminals--those criminals with violent offenses (TCOMI, 2001). There were no perceived budgetary constraints at present. Staff members as well as participants perceived the program to be doing what it is supposed to do to meet the needs of the population. The program prided itself on being creative in finding funding sources at no cost in the community for the MIOs.

Because the overall aim was to provide mentally ill offenders with wrap around services, more grant money is being directed toward the program. The program director strongly supports the mission and philosophy of the program and believes that it is cheaper to treat the MIO in the community than in prison.

> When you provide intensive wrap around services, you can decrease the recidivism rate, which means that you also decrease the cost to the state for those people who are in need of intensive psychiatric services in the prisons.

In spite of apparent adequate funding, the program coordinator voiced some concern that in the event the grant money ran out, the program may be in jeopardy of closing. The biggest concern appeared to be politics between governing authority and the

funding agency surrounding the use of New Generation medications. The issue was who should manage the money for that facet of the program. Newer drugs used to treat psychosis cause less side effects than the older antipsychotic drugs; however, new generation drugs are more expensive and use a larger portion of the budget. Insurance companies are reluctant to cover the cost of the newer more expensive drugs, and most MIOs are unable to afford to pay for their medication. This cost depletes a larger portion of the program funds.

The New Start program is but one arm of MHMRA (2001). The Mental Health and Mental Retardation general service portion of the program was in jeopardy of facing budget cuts of up to 14% due to recent actions of the 78th Legislature. However, the New Start program appeared not to be affected because 100% of the program funding comes from TCOMI (2001). According to the program coordinator, because the program is so vital, the program is not currently in jeopardy of funding cuts.

> Money from the legislature goes specifically to TCOMI, in that little pot. They have different pots of money for different things . . . we got a lot of money last year.

Increases in the number of MIOs being referred to the program make adequate funding a top priority. Administration as well as MIOs felt that adequate funds were available. One 38-year-old male, who was formally diagnosed with paranoid schizophrenia a year after being in the program, perceived the following about the program and adequate funding:

> Well, I think the program is doing what it's suppose to do and I think they [the program] do have enough money for that . . . of course like uh . . . myself . . . there's so many of us you know . . . either locked up now or they're out on parole. They'll [MIOs will] be coming out [of prison] or getting off parole . . . they're going to need some type of help you know. You know, financially . . . mentally.

This particular MIO experienced difficulty in accepting the diagnosis and the severity of his illness. He had spent 18 months in prison for two felony assaults. He indicated that under normal circumstances, he would have never attacked someone. He feared that he would never be the man he once was before developing symptoms.

Although the program appeared to be running smoothly, there was, at one point, the possibility of having to relocate the program to another site. There were a number of sex offenders in the program and reportedly the present site may have been located near an area where there were children. State and federal guidelines prohibit sex offenders from being within a specified number of feet from where children are located. To stay within guidelines, the program coordinator investigated the issue. Another concern was geographical problems that would have made transportation to and from the program more difficult for MIOs. Fortunately, the concerns were addressed, and the program was able to remain in its current location until November 2003.

A Typical Program Day

In the New Start program the routine is consistent from day to day, and the schedule is well maintained. Staff members arrive at the site between 8:00 and 8:15 a.m. Participants tend to stream in the enclosed parking area at exactly 8 o'clock. Some MIOs arrive earlier because of traffic or transportation issues. Participants meander around talk with each before daily activities get started. The waiting room area was usually full of MIOs sitting while others milled about the hallways. The activities of the day are usually in full force by 9 a. m. and remained very busy until 11a.m. The small hallways and

seating areas can become cramped during this time. Security facilitates traffic control, both inside and outside the building, and permits entry through security doors for access to group sessions, appointments, or the use of the bathrooms. Some MIOs gathered in the same location or group each day and appeared to have their own informal group, depending on what was going on at the time. Interactions are spontaneous in nature with others joining the groups as situations and time allowed. To pass the time, participants stood around engaging in small talk about topics such as where they went the previous night, music, food or how long it took on the bus to get to the program that day. Drinking coffee, or smoking cigarettes were a regular routine.

For the most part, participants are self-reliant, but may still require supervision in some aspects of the daily routine. They know the time groups start and when the case coordinators or therapist will see them. Additionally, MIO's are expected to show up on time for groups and scheduled appointments and seldom will appointment times be adjusted. Participants are aware that they must be patient and wait their turn. Depending on the reason for being late and whether the group has begun, the MIO may be denied entry into a group. When this happens, the MIO must wait for the next group to start and attendance credit is not given for the group that was missed. Participants get upset when this happens because it means that their day will be extended beyond the time they must spend at the program for that day. These decisional actions are not intended to be punitive. However, it does send the message that MIOs are responsible and accountable for their behaviors. A few times a MIO may insist that he/she be allowed to go through the locked area to use the bathroom or to go in to see their doctor or case coordinator

before their scheduled time. But, because of safety reasons, access doors to the treatment areas are kept locked at all times and the whereabouts of all participants must be accounted for at all times. For example, permission must be granted to use the bathroom.

On some occasions, a parent might show up with her children in tow. This event may occur when the children were out of school or were ill or if there was no one to leave them with. The staff did not encourage this behavior because of limited space and safety concerns, and because the facility is not the ideal place for children; however, they do understand when it happens.

Mentally ill offenders are expected to actively participant in the program and must keep track of their assignments in the groups. A 38-year-old male MIO shared what a typical day is like for him.

> Well, a typical day is like uh . . . well . . . we get in groups you know . . . you'd be handed a folder and in that folder is . . . where you keep all the work that you've done. We've been doing a lot of reading . . . you're going to come here and there's always going to be something to do. [The counselors] see that you're doing what you are suppose to do you know . . . there's going to be something there to learn you know. It's just not going to be free time like coffee and cigarettes . . . you're here to work. The good thing about it as you stay with the program you learn.

Regardless of whether MIOs had been with the program for a week, months, or years, a sense of camaraderie existed. As far a 46 year-old male MIO, who had been in the program for almost 10 years, was concerned, everyone in the program now was a newcomer compared to the length of time he had been in the program. There were no apparent clickish behaviors among the group. Informal group membership could be obtained through initiating a random conversation or participating in a common activity

such as smoking or drinking coffee. Although most MIOs mingled with each other, there were a few who stayed to themselves or only associated with a particular individual. Although atypical, some MIOs tended to gravitate to the same group of people each day. One 18-year-old male, currently serving five years probation for felony theft, gave this explanation.

> I avoid certain people because they may be doing what they need to do, but it may not look like that to me; so, I just won't associate with them. I'll say hi, how's it going, nice and everything, but I mean, you know, I won't try to get too close to people in the program, especially the ones that aren't living with me [at the personal care home], because . . . .You know, I mean I'm nice . . . everybody that stays in my house that come[s] up here, you know, I hang out with them, you know, we stay at the same house and stuff. But I don't really hang out with that many people that don't live at the house. I mean, I just hang out with a certain few.

This MIO had been in the program only three weeks and had developed a friendship with another 18 year old on probation. He believed that it was in his best interest to stay away from parolees in the program because their parole status indicated that the crime were more serious. Mentally ill offenders do whatever is necessary to stay out of trouble even if it means avoiding association with other MIOs in the program.

Mentally ill offenders were frequently overheard talking about the days' routine or the groups they were supposed to attend that day. Some conversed about how they were doing with parole. They gave each other verbal encouragement. One MIO was overheard telling another MIO, who had one month of parole left, to " Just hang in there, it'll be over soon." The day-to-day routine of being in the program can became burdensome at some point. Many understood the benefit of the program but still disliked having to show up every week, three to five times a week, for the duration of their

probation or parole. Others joshed each other about their less than enthusiastic participation in the group the day before. Controlled liveliness was usually observed as clients signed in. MIOs were either waiting for appointments with one of the counselors or doctors or waiting to go to group. Mentally ill offenders had a calm purposeful look on their faces while waiting to be seen.

Most adult MIOs appeared to get along with each other. However, potentially volatile incidents can occur. The picture was different for the adolescents. One event where staff had to intervene occurred when one adolescent was aggressively harassing another adolescent. In this particular incident, the adolescents were cautioned by the security guard and a case manager about engaging in any aggressive behavior. More than likely, the first intervention consists of the rules being verbally reinforced. Confrontations usually did not go beyond this point, and verbal intervention was all that was needed.

The Process of Moving through the Program

There is a four-step process of moving through the program. The first step is to get in the program. The process of "Getting in" begins with the initial screening. An assessment is completed to determine if the MIO is a match for program services. Appropriateness is determined by the severity of the crime committed and the potential to follow program guidelines. "Learning the ropes" is the second step. Participants are given a sort of orientation to the program. This process includes going over the services that are to be provided, meeting staff that will be working with them and learning the expectations of participation. At this point MIOs are told how long they will have to

remain in the program, how many times a week they will have to attend and the modalities in which they must participate. "Keeping your nose clean" is the third step. This step was the most difficult in the process for most MIOs. They demonstrated compliance by following the rules, taking their medications and so forth; however, environmental factors and symptomalogy of the disease itself are so unpredictable, there was uncertainty about whether they would be able to stay out of trouble. The fourth and final stage is "Getting off paper." This was the scariest stage of the process for MIOs because it meant that they no longer had the safety net of the program.

The program was designed to help MIOs develop more adaptive coping skills for managing the symptoms associated with their illnesses. To that end, all efforts facilitated the MIOs' entry into the program. However, once in the program, the process is not self-explanatory. Mentally ill offenders still have to learn the practical rules for getting along in the program. Once in the program, mentally ill offenders need to learn the ropes to stay. Program duration can range from 6 months to 10 years, which means that MIOs must keep their nose clean for an extended period of time to maintain focus on their goals. However, once in the program, the MIO still has to learn how to fit in. Finally, MIOs are ready to move on once their time with the program is completed. Each of these phases has distinct tasks and characteristics.

Stage 1: Getting In

Entry through the prison system is not the only means of entering into the program. There are three mechanisms through which MIOs enter the program: the

criminal justice system, family referral or self-referral. There was not a lot of differentiation between the three modes of entry other than with individual or family referrals help was sought help early on to avoid going to prison. However, most MIOs enter the program through the court system. To enter the program, the MIOs' needs and the nature of program services needed to be congruent. If the participant has spent time in prison, an assigned parole officer usually makes the referral. A probation officer will make the referral for someone who has committed a crime but only spent time in jail or for offenders who, in order to avoid prison time, were given probation. Parole officers typically visited offenders in prison at some point before offenders are released in order to make the seamless transition from prison to the community setting. Scheduled visits usually occur 2 to 3 months before release. This process allows MIOs to be a part of the plan of treatment from the beginning, and the participant is made aware of exactly what is to be expected. One 38-year-old female MIO, on parole for 17 years, after serving 8 years of a 25-year conviction for distribution and abuse of cocaine, described how she got into the program.

> When I was in TDC [Texas Dept. of Criminal Justice] . . . before you come home, the psychiatrist tells you that someone is going to come out to talk to you to get some general information from you. Then when they come out they tell you that they want you to go [to the program] . . . they're going to set you up and stuff so you can go and get your medications started and . . . you know so they can help. So . . . that's how I got to this program.

One 18-year-old female related how her mom got her into the program. Her combative behavior at school was causing her to be kicked out of every school she had

attended. She had been placed in a boot camp and later placed in jail for 180 days. Her mom, with the help of the parole officer, made the initial program contact.

> My mom had to fill papers out and talk to the people to see which counselor I had, and which caseworker and which doctor they assigned me to.

Another mode of entry was self-referral. One 46-year-old female placed on parole in another city made a call to inquire about the program after moving.

> I [was] paroled back from Fort Worth. I came out of prison last year . . . when my mama got sick in December–they found out she had cancer–I came down here. My parole officer up there transferred me on an emergency [situation] so I could stay out here with my mama. So, for December, January, February, and March, I didn't have a parole officer. So, I started calling them, "Man, what's going on?" The end of March, Mr. _____ came to my house and let me know he was going to be my new parole officer. Then, he referred me to this program. Because I'm paroled out of prison as an MHMR client, so he said, "You've got to still go." I didn't have any medicine with me here; he got me on a permit to come here, and I've been coming here ever since.

Regardless of the mechanism of entry into the program, once there, all MIOs experienced similar processes. First, an initial staffing meeting is conducted to develop the plan of care upon the MIO's admission. Staffing includes the probation officer, the mentally ill offender, the service coordinator, the doctor, the counselor, and the nurse. If any changes need to be made in the initial plan of care, it is done at that time. This process ensures MIOs are aware of the plan of care. The 46-year-old female who self-referred to the program was surprised at how quickly things flowed from the moment she was admitted to the program.

> Some lady did an assessment on me . . . . From there, she told me before I leave I had to see the doctor. So, they let me see the doctor, and the doctor said I couldn't leave till I get some medicine, because I had took myself off my medicine, and I was beginning to fall apart. So, she put me back on my medication the same day I [came].

During the first year in the program, case management is focused on helping the MIOs apply for and receive Medicaid and other public benefits. Other service coordination includes obtaining stable housing, engaging the MIO in community-based treatment, and developing community-based links that would help mentally ill offenders achieve stability in the community. Mentally ill offenders are first seen by the Continuity of Care Coordinator to determine individual need, and then they are referred for an intake assessment with the psychiatrist. The psychiatrist, with the recommendation of the treatment team, makes the final acceptance of the MIO into the program. MIOs are then assigned a caseworker, and a counselor immediately begins making treatment plans in terms of frequency, duration, and expectations in the program. The MIOs then see the service coordinator or the case manager. The case coordinator assesses the individual MIO's situation and determines that individual's needs. A counselor determines what individual or group therapy would benefit the MIO.

The benefits coordinator starts the "Ball rolling" to get benefits in place. Doctors then assess the MIOs' psychiatric condition and prescribe any needed medication. An appointment is made to see the registered nurse (RN). The RN performs the EKGs, admission labs, and all basic nursing assessments to determine nursing services that could benefit the MIOs, such as medication education. Case coordinators then include all of the data in the plan of care.

Getting in is the first step in the process of moving through the program and MIOs felt supported as they try to manage their illness. Once in, MIOs moved on to gain knowledge of their expectations in the program.

Stage 2: Learning the Ropes--Understanding Consequences

Learning about the program and understanding the expectations are key to being successful in the program; MIOs must comply with the program rules. Failure to do so can bring about consequences. Mentally ill offenders understand the possible consequences of not complying with the mandates of participation in the program. There are formal and informal rules of conduct.

Formal rules of participation: Formal rules of conduct dealt with behaviors such as, showing up on time, taking medications as prescribed, and avoiding the use of drugs. Mentally ill offenders were aware of the daily routine of the program and of the rules of participation. Rules are explained on admission. MIOs must keep all scheduled appointments with the psychiatrist and probation or parole visits. Participants must stay on site for a specified period of time on the days they are scheduled to be there. Exceptions are made if there is a transportation or health issue. Clinic hours are typically from 8 a.m. to 5 p.m. and the program staff is available on site until closing. Participants are expected to be at the clinic and sign in on time. Sometimes participants have to leave home one to two hours before time to be there on time, therefore requiring time management on the MIO's part. Mentally ill offenders are not allowed in enclosed office areas until they are called. All scheduled appointments must be kept and, appointments must not conflict with any other mandatory activity. All participants are required to attend at least one group (usually two) and actively engage and contribute to the group. Each group lasts about 45 minutes. There are rules about when MIOs can leave the

facility for the day. They must remain on site until 11: 30 a.m. and cannot leave until they sign out. For those who utilize the bus, tokens are given when it is almost time for the participants to leave. Those who have their personal transportation must remain until 11:30 as well. Those leaving before that time or without signing in and out or without a valid reason will not be given credit for being at the program for that day. The aforementioned 38-year-old male MIO emphasized, that everyone knows what is expected and that thing goes a lot smoother for the individual if the rules are adhered to.

> You know what's to be expected of you with your home visits and the office visits. Keep all appointments . . . and pay your fees . . . you know . . . you understand.

When MIOs fail to keep their scheduled visits, immediate action occurs. Any member of the treatment team takes follow-up actions when MIOs do not show up. A phone call to the offenders' residence is usually the first course of action. If necessary, an unannounced visit to the MIOs' homes may occur. These actions are taken to make sure that the MIOs are okay and that they are compliant with treatment. A 19-year-old female MIO, diagnosed with paranoid schizophrenia at the age of twelve and a recent arrival to the program, indicated:

> They get worried, and they call monitoring for you. They will let your parole officer and [therapist] know. It's up to the parole officer. The parole officer is the one that deals with you. However, what they do is they will have a staffing, and they will try to work everything out. If the parole officer catches anything, if you don't show, they have to report you. [It is] not the first solution that they have in mind. They will either try to move you somewhere where somebody can watch you or just do something to help you out where you can stay out of that type of environment.

Tension existed between the enforcement role and the supportive role of the program. While structure and support benefit MIOs in the program, staff feels that severe consequences have no place in a program where the goal is supporting mentally ill offenders in becoming self-reliant and independent. The nurses felt a particularly strong sense of support and empathy for these mentally ill offenders and understand the degree of impairment that exists in this population as illustrated by the conviction of one nurse:

> They [MIOs] have to come to these groups because their parole officer [says they have to come]. They are almost under threat. "If you don't come to these groups you're going to get in trouble" and stuff. And my thing is like telling them, "No, I'm not. I'm not going to do that [report them], we're just here for you, if you want to benefit from the services then you can. If not I'm not going to force you to." Although we could, we really could. But I don't really want to do that. Oh I could say, "I could just talk to your parole officer and tell them you have a medical condition that really needs to be addressed and if it's not addressed, then you're going to go back to jail. Or we'll get a judge's order and have the judge to regulate your caffeine intake or something" But, that just doesn't seem right to me. I mean, we're trying to get them back to independent, trying to get them back to being their own person. They shouldn't have to do that.

Staffing and rounds are two means by which case planning and evaluation of progress are done for MIOs in the program. Both are considered very vital the program and are done to monitor MIOs' progress through the program.

Staffing: Staffing is a big deal to both the staff and to mentally ill offenders. Staffing constitutes a gathering of the treatment team and the MIO, and it is a big part of the management process. Routine staffing is done every 30 or 90 days and is actually mandated by the Council on Mentally Ill Offenders or by other state laws. If MIOs are having a problem, staffing would occur immediately to address concerns. In this case a staffing is done within 24 hours to intervene before the situation becomes worse.

Whatever the reason, some MIOs find staffing to be a positive experience as indicated by what this 62-year-old male with a long history of cocaine and other drugs of abuse, had to say:

> I was coming [only] two days [a week] . . . but I messed up. I went to my old neighborhood . . . met up with . . . a man I know and he gave me a rock. They [the case coordinator] took my urine . . . and they called me at home and say . . . "You've got to go to a staff meeting." But . . .you know . . . God works in mysterious ways. I am glad to be coming 4 days instead of 2. God gives me a chance. The doctors say if you come up dirty again . . . I would have to go into inpatient care . . . I ain't come up dirty again.

Rounds: Rounds are yet another multidisciplinary process that is conducted on a regular basis and occurs on Mondays, Tuesdays, Wednesdays, and Thursdays each week. Rounds are meetings between the case managers, parole or probation officers, and the doctors. The probation and parole officers, the psychiatrist, the case managers, and anyone else who plays a major role in that client's treatment attend rounds. The main objective of rounds is to give the doctors a progress report of how the MIOs are progressing that week and to make decisions about progress or lack of progress. Rounds begin between 8:35 a.m. to 8:45 a.m., and last from an hour to an hour and a half. The parole officers are usually there to discuss what is going on. This discussion is just a "heads up" for the psychiatrists before they see the participants. One such discussion surrounded a MIO who had not shown up to the program for two weeks despite numerous warnings and reprimands. The consensus was that the participant had gone back to his old environment and had started using drugs again. A decision was made to discharge the MIO from the program and have the courts issue a warrant for his arrest. The team felt like they had done all that they could do and it was now out of their hands.

Many times it takes this type of action before the MIO can fully comprehend the consequences. The team can decide at a later time to readmit a MIO who has not been compliant with the program or who have been sent back to jail. The MIO would be re-evaluated for appropriateness. In many cases the MIO would have to start over with the parole or probation requirements. In this case the time spent in the program prior to discharge would not count.

It was interesting to note that although nurses are perceived to be an integral part of the team, the nurses are never present during the rounds. This initial observation was confirmed after speaking to the nurses about their absence. They indicated they have tried in the past to attend; however, they were unable to regularly attend because of schedule conflict with other nursing duties. Both nurses agreed that the nurse's presence is paramount. However, the greater part of the mornings are spent drawing blood, collecting urine samples, performing EKGs, taking vital signs, or giving weekly antipsychotic injections. The intention was to make an effort for at least one nurse to attend in the future. However, the nurses were never present on the days that the researcher was present. Despite not being visible at the scheduled rounds, nurses were in frequent contact with mentally ill offenders on a daily basis.

Overall, MIOs viewed the structure and constraints of the program as supportive. A 19-year-old, in the program for only four and a half months, described it as follows.

> My caseworker said they found out all the information they could about me, about my background . . .found out how I could get here, if I was nervous about coming here. They try to make sure you are happy with coming here . . . if you understand why you need to come and everything. Once you get used to it, you like it. Everybody's [MIOs] very special. So, it's just like a little family here.

Informal rules of participation: The informal rules were more covert and difficult to detect. Informal rules were observed behind the scenes. For example, an informal rule was that MIOs are expected to be supportive of others, give words of encouragement, and try to keep each other out of trouble. Another example of this unspoken or informal rule was overheard in this conversation between an older female and an 18-year-old male participant who was trying to find a way out of having to go to his second group that day. The two were in the same groups and were sitting in the courtyard area waiting for the next group to begin.

> Boy...you better carry yourself to group. You know what they told you the last time...if you don't go to group, you can't bring your "*Game boy*" to the clinic. You know you want to play your games during the break. They will take it from you and make you leave it at home the next time. You need to be there, so you better go.

Another informal rule was that MIOs are expected to be supportive of other and to give words of encouragement if needed. An unspoken rule is that MIOs protected one another and tried to keep each other from getting into trouble.

Stage 3: Keeping Your Nose Clean

A structured curriculum is in place and helps MIOs maintain individual focus to keep their noses clean. When MIOs have been in the program for a while and are aware of the rules and consequences, many of them face significant challenges to stay clean and to meet the program rules. Although keeping your nose clean has several facets, not using drugs is one of the biggest concerns for MIOs. They equate "Keeping your nose clean" with staying out of trouble. But with chronic symtomatology associated with

mental illness as well as issues of medication compliance, staying out of trouble is a struggle. The 18-year- old female mentioned earlier shared an example:

> I've heard some talk, you know, but they weren't speaking directly to me about somebody [who] had been late and then like had, you know, not shown up a few times and then kept being late. I mean, they said it's kind of like almost a violation, but like they can tell your probation officer. Then they can put in a motion to revoke your probation . . . . I don't think I have anything to worry about though, because I'm doing a full 110%, and I'm sure these people see it. So, I'm just doing what I have to do for myself to get my life turned around and headed back on the right track I was once on before. There are some people I can tell that don't really want to do the program and may think that they don't need to do the program. I feel apparently that they do, because you wouldn't be here if you didn't need to do it. Because obviously there was something wrong.

The treatment team made a point of discussing mentally ill offenders who are having problems with meeting the requirements of the program. Mentally ill offenders might encounter problems because they continue to use drugs or alcohol despite repeated positive drug screens. The problems extend beyond just those associated with drug use. Some participants attend groups or keep scheduled doctors appointments inconsistently. Depending on the severity of the incident or failure of prior corrective interventions, mentally ill offenders are referred back to the court system where warrants are issued for arrests. When warrants are issued, it was likely that these participants will go back to jail to serve out the remainder of their term. In some cases, the program coordinator and probation officer can determine if, after a short containment in jail or prison, the MIO would still benefit from the program. Despite the ability of some MIOs to conform to the rules many struggle and therefore need the supportive structure of the program to develop the skills necessary to manage their illness. In spite of the support available, MIOs still

became frustrated with the system. An example of this frustration was evident by this interaction overheard between a student nurse (SN) and a MIO.

> I hate this fucking place...These people need to get their shit together. I got here on time for my meeting, but because they have their head up their "asses," they hadn't called me back for the meeting when it started.

He was upset become he was not allowed to enter the locked area to get to group. This is how the interaction proceeded.

SN: "Did you tell them [Security] what time your appointment was?"

MIO: "Yes, but you would think after coming here for a year, they would just let me come back, they know we get in trouble if we are late."

SN: "Do you have to sign in and go through a certain process each time?"

MIO: "Yes, but they threatened to call the police and get me thrown off the property. We are human beings, they have no right to treat u that way. Next time, I'm going to just knock on this window and have someone let me in."

SN: "What do they teach you in the anger management class to do in a situation that makes you angry?"

MIO: "They remind us that we aren't in control of every situation."

The MIO had only two more visits before completing the program, yet after 12 months in the program, it was hard for him to remain focus.

Despite the fact that MIOs cannot always comply, the treatment team made every effort to link MIOs with the services that they need to be successful. One 19-year-old female, admitted to the program 3 weeks prior to being interviewed for this study, had this view of staff efforts: "Being sent back to jail is not viewed as the first option used. Other interventions are usually explored." Mentally ill offenders can be sent to a drug treatment facility, inpatient hospitalization treatment, or program visits may be increased.

A 38-year-old female MIO, with 8 years in prison for cocaine and alcohol use, shared intimate knowledge of her prison experience.

> Well . . . would you like to be behind those cells that they got? You hear doors slamming all day long. Starting from 5:30 a.m. to . . .what, 10:30 at night. So . . . you know you hear doors slamming 24/7. Breakfast is at 4 o'clock, so you get up at 3 a.m. So . . . yeah, I'm here faithfully.

One of the strategies MIOs used to keep their nose clean was to maintain focus. It was easy to be distracted by the outside pressures of family, jobs, or fitting into the community and therefore it was important for MIOs to help each other stay focused in the program. Resiliency appeared to play some part in the MIOs' ability to maintain focus. Resilience is the process of struggling with hardship. The concept of resilience as struggle is in contrast to the idea of total recovery. Resilience in this population is not equated with the final endpoints of success such as total recovery from a mental disorder or an alcohol or drug problem.

The therapeutic group modality was one means of helping MIOs remain focused. These type groups are designed to assist the mentally ill offenders to develop skills to manage their illness. Issues of trauma and substance abuse were examples of some of the topics discussed. Three mentally ill offenders talked about how self-reflection and discipline helped them focus. A 48-year-old male MIO said:

> Oh, it's been discipline. There are things you wish you wouldn't have done . . . but it's too late now. You got to do the time for the crime, you know. I just say, "Well, I'll know next time. I know I got a lot of experience out of this [Program] . . . and I know a lot of things I didn't know [before]. She [my parole officer] put a lot in my head that let me know what to do . . . stay away from bad people . . . all the people that do drugs, alcohol, troublemakers and all that. I'll stay away from people like that. [For example], some dude calls me and say, "'Hey man, come here man' Uh-uh, [I say] you got the wrong person." I'm not lying. A dude

> wanted to buy me a beer because I had won a pool game. He said, "What you want man?" I said, "I don't drink beer. Buy me a soda pop." He bought me a soda pop.

Another 62-year-old male mentally ill offender, on parole for procession of cocaine, had this to say:

> One very important thing is dealing with drugs and alcohol. I haven't had any problem with that since I've been in the program. I always have a clear urine sample.

A 46-year-old male MIO, in the program now for almost 10 years, recounted how difficult it was for him at the beginning of the program.

> Years ago I had a problem with that [compliance]. I don't know . . . I was just lazy. I just didn't feel like coming. That was years ago. I guess it wasn't just my medications . . . my head wasn't screwed on straight.

Organizational support for keeping your nose clean: The programs at New Start were structured to help facilitate progress throughout the program. Organizational supports consist of a group curriculum that includes therapy and teaching about illness management. A structured group curriculum is developed for MIOs and is revised every 90 days by the program coordinator. The curriculum outlines the daily activities and topics to will be covered. Because space is tight, most groups are conducted right in the therapists' offices. A maximum of eight people are allowed in each group. Seating arrangements are open and group participants form a semicircle around the therapist's desk. Group cohesion was developed early on, and MIO actively participated. If not, they are asked to leave. During one group observation a male MIO who had fallen asleep was asked to sit out of the group. Mentally ill offenders, who were 15 minutes late, were not

allowed to enter and had to sit out until the next group. Each group last approximately 40 minutes and to avoid overtiring, MIOs are given a 10-minute break in between each group. Participants do not get to choose their therapist. They are assigned to a specific therapist based on the structure or need of the offender. Educational materials were distributed each day, and MIOs share their understanding of the focus of the discussion and how it relates to their situation.

The group talks about occurrences and traumatic events in their lives. One 36-year-old woman shared her experience of a rape event at gunpoint 12 years ago and the trauma of having to relive that each day and continues to feel victimized after all of those years. The therapist encouraged MIOs to share how they felt about were revealed in the group. Another 54-year-old man indicated that he has spent the better part of his life, 9 years of a 50-year sentence, in prison for a crime that he claims not to have committed. Several of the MIOs talked about how their anger had gotten out of control in the past and had gotten them into trouble with the law. The therapist gave scenarios where there are times that it is best to walk away.

It was interesting to observe the different facilitative styles between therapists to facilitate the needed structure. One therapist would put participants out of group for either being late, coming into the group room without permission, not paying attention to what was being said in the group, or any other disruptions. One 38-year-old female (on probation) in the program since November 2000, described the structure of one group by saying:

> You have to talk or . . . she'll put you out. You had better think of something to say. So . . . I try to read and I try to discuss whatever we're talking about. But when I listen to some of the other stories, they're very depressing. So, I whine because I have to come here twice a week . . . but I only have till May [of this year].

Another therapist used more of a nurturing approach with the MIOs. This therapist might ask participants why they were late and then give a gentle reminder to be there on time the next time. Another observation was that a number of MIOs in one group appeared to be at a higher level of functioning compared to MIOs in other groups. Mentally ill offenders in the first group would initiate discussion and give constructive feedback to each other without being prompted by the therapist.

Group members shared information on experiences in the program. One 65-year-old participant who has been to prison five times and has served a total of 12 years indicated that without the support of this program he "is not where [I] would be." The participant had a criminal history that went back to 1965. He was convicted of burglary and theft and had been to prison six times; however, the longest period spent in prison at any one time was 4 years.

> I have been to prison five times and each time I come out . . . I visit my parole officer like they say . . . but I got too much time on my hands and I would get into trouble again. This place and she (the therapist) really helped me.

While most of the mentally ill offenders demonstrate a desire to be successful in the program by understanding their mental illness and learning how to manage their symptoms, not all mentally ill offenders take the help they receive at the program seriously. This was the case with one 55-year-old male. During the interview, he talked

about his gang connection in prison and how this activity in prison added to his prison sentence.

> In TDC, I got a little old gang. You know, you can't smoke in TDC, but I was bootlegging cigarettes, tobacco, got in fights, and they set my time back, you know.

There are no indications that he has gotten in any trouble since entering the program. He indicated that he is doing what he supposed to do and has no intentions of not following the rules.

In summary, keeping your nose clean is an indirect process that is supported by organizational structure. Because of the duration of time in the program, this phase is the most extended.

Stage 4: Getting Off Paper

The primary mission of the program is to keep mentally ill offenders out of jail and keep them as stable and functional as possible. *"Getting off paper"* was a common term used by mentally ill offenders and staff in the program to indicate that the mentally ill offender has successfully completed their term of probation or parole. At this point MIOs have the freedom to leave the program. While there were several reasons a MIO could be discharged from the program, however, getting off paper indicated that the MIO successfully accomplished what he/she was supposed to do and was a significant goal for mentally ill offenders. It represented a sense of personal freedom--not having someone watch over their shoulders any longer. It also indicated that the mentally ill offender has done everything in accordance with the program. Participants not meeting treatment

plan goals were subject to re-arrest or re-incarceration. Factors contributing to lack of success were failure to come to program activities as mandated, using drugs, or committing or repeating a felony offense. Those completing the parole and probation are considered very successful in terms of outcomes. The program director emphasized that:

> It is cheaper to treat the mentally ill offender in the community than in TDC. They are very stable, their needs are met, and they just no longer need the intensity. They are ready to just move on to the regular clinic or other services.

The length of stay (LOS) in the program depends on whether the MIO is on parole or probation. Both probationers and parolees stay in the program an average of six months to three years. When asked about how long she had to be in the program, one 38- year-old mentally ill offender stated that she would be "getting off paper" in 2015. When MIOs get off parole or probation, they must be discharged because the program contract does not allow the program to serve them in the system anymore. Pre-trial is another criteria that determines LOS. If the case is still in the court but is dismissed, or the MIO goes to jail, then services are cut. In order to remain in the program and receive services, the MIO must be somewhere in the criminal justice system.

Another reason for getting out of the program is noncompliance. Mentally ill offenders who commit a new offense are sent back to jail. Some staff members felt this way:

> We've done just everything we can do . . . some have used drugs for so long . . . they've been inpatient, after inpatient, after inpatient and we feel like it's a matter of their life . . . you got to lock them up just to save them . . . plus probation and parole can only put up with so many you know . . . violations.

However, recidivism is low. The minimum stay in the program is at least 6 months because it takes a while to get stabilized and get to know each participant. Maximum stays are dependent on participant needs. As one staff member stated,

> The long end is as long as they need it. It is the opportunity to see the results in what I believe is one of the neediest populations there is.

One example of the long end of treatment is a 46-year-old male who has been in almost 10 years and is scheduled for discharge in 5.5 months. He indicated that he struggled with managing his illness early on in the program, and for a period of years he felt like he did not need help. He was able to gain insight and accept his illness. He took advantage of all that the program had to offer. He managed the illness by taking his medications as prescribed, going to substance abuse support groups, and attending anger management and trauma groups. Now as discharge looms near, he views himself as a success because he was able to use the program to help him manage his illness.

Many mentally ill offenders experienced fear about leaving the program because of uncertainty about the ability to manage symptoms. Those with the most chronic and pervasive mental illness exhibited a greater degree of fear and uncertainly about leaving. The 38-year-old MIO male about to exist the program felt like it was helping him cope with his illness. He was concerned whether he would manage on his own after he had completed the program. He related that he was not fully informed about the support of the program after discharge.

> From what I'm told . . . you wouldn't have the program to go on you know. After you have a successful discharge from the program and parole, you're free to come and go as you please. They're [the program is] no longer responsible for you.

Although MIOs have completed the criminal justice system, the New Start program is still there to help them. The program staff tries to re-link MIOs before discharge with family in their lives or to ensure that they have a support system they did not have before or to teach them how to access services. The program director commented that "they know they can call almost anytime."

Out the Door: Leaving the program is a mixed blessing for many of the MIOs. Feelings of sadness or joyfulness are the same for MIOs no matter how long they have been in the program because it meant leaving behind the wide array of available program resources. Approximately 11 MIOs complete the program each year. To facilitate closure for MIOs, a party is given to honor those who complete the program. It is a festive affair that has meaning for each participant. Participants got a certificate of successful completion from the parole or probation board given to them by their parole or probation officer. In addition, a certificate from the program is given. One jubilant MIO had this to say.

> I get a little certificate . . . [And] they're going to have a big party for me. They told me they're going to have a big party for me.

However, some MIOs are not so optimistic about leaving the structure of the program, as exemplified by one 38-year-old MIO.

> There'll come a time when the program tells you "Okay you're discharged from the program . . . here's a dinner for you; we've enjoyed having you uh . . . good luck to you." From now you're by yourself you know. There's no more spending the day up here at New Start . . . you're home 30 days out of a month. Uh, nothing to do you know . . . you done read all you can. So . . . all you can do is just stay clean [avoid the use of drugs and alcohol], take a shower, [fix] your clothes, and make sure you eat.

Chronicity of Mental Illness

The chronicity of mental illness impacted the ability of MIOs to function in the community, taking a toll on both their social and economic well-being. The stigma associated with mental illness also had a detrimental effect on recovery and access to services.

> When I [become symptomatic and aggressive] my whole thought process would be totally different. Even though I know that I should handle [the situation one] way, I won't think about the way I should handle it. I just straight get offended, and then I just started to get, you know, whatever. I'd turn into a different like attitude, you know. I'd handle things differently. I never really handled it the same until, you know, I mean I started going back to that same thinking process. I would get real aggressive, and either start, you know, want to fight or something like that.

Most mental disorders are treatable, and treatment can reduce or sometimes alleviate symptoms. However, certain disorders such as chronic schizophrenia are more difficult to treat than others, and some do not respond to the current medications. One 18-year-old reported his experience with trying to find the right mix of medications to stabilize his symptoms.

> At first, I was placed on Depakote and Risperidol. Then they took the Depakote away and just left me on Risperidol and Trazodone for sleep, because I totally lost sleep. I mean, I had real problems getting to sleep, and I had to go to school the next day, or whatever I was doing the next day, and you know my thoughts would race. So, I told the doctor, and he gave me some Trazodone. I tried some Trazodone, and I was taking Risperidol and Trazodone, and that wasn't working; so, they lowered the Risperidol and brought back the Depakote. [The medication] was increased three different times. First he put me on 50, and I still couldn't [function]. He told me to take it at 8:00 because I went to bed at 9:00. And sometimes, you know, it would be like Friday night, and you know, my mom didn't want to give it to me an hour before I went to bed; she just would give it to me at 8:00, and then I'd stay up because it's Friday night, and I wanted to hang out with my friends or whatever. So then it would not put me to sleep; I'd be kind

> of tired, and then I would wake up. It wore off. So, he [the doctor] kept increasing it.

This MIO is still struggling with finding the right mix of medications and feels like he still has a long way to go in managing his symptoms. Most MIOs are able to get the right combination of medications and the right dosage to control symptoms. However, one challenge is the time it takes to get the MIO adjusted to taking the medication.

> It [the medication]...helped with me controlling my impulsive stuff...I guess... I [can't] really tell. I'm still impulsive... just not as much. He [the doctor]... right now we're just playing it by ear to see if there's any problems... like if I'm depressed or anything, just speak to my counselor or my case manager, or maybe directly to him at the clinic. I'm supposed to have another appointment just to do a kind of checkup to see where I am at.

Getting the correct diagnosis itself is a challenge that MIOs face as they try to manage their lives. Many others experience what this 46-year-old male MIO described.

> The doctor said it was a little bit of schizophrenia . . . [At first] he wasn't really sure, and I wasn't really sure at that time. He at first had diagnosed me with bipolar. Then he put me on some medication for it, and I went through that, and it wasn't working. So then I went back, and then he changed it to a mood disorder. I actually went to another doctor.

The 46-year-old male perceived himself having a chronic mental illness and expressed how he felt about his own past misdiagnosis of schizophrenia and the most recent diagnosis of bipolar disorder.

> [From what] I understand . . . paranoid schizophrenia is hard to treat. But they have drugs for the bi-polar now . . . it's just easier to treat bipolar. I don't worry as much, I know it's chronic, but uh . . . I know it's also treatable. That it's an easier diagnosis to treat.

Many times the MIOs will just stop taking their medications once the symptoms are relieved, thinking that they no longer need the medicine. The problem with stopping

the medication is that symptoms reemerge. And sometimes the symptoms do not respond to the medications in the same way once they are restarted. Misunderstanding about management of mental illness will sometimes cause MIOs to respond inappropriately. An example of this misunderstanding is given by a 36-year-old MIO.

> What I understand is that I have a mental illness . . . And fortunately you know... it can be cured by taking medication. I don't believe I'll have to take medication for the rest of my life . . . you know. I did accept this here mental illness you know . . . unfortunately I'm diagnosed as a schizophrenic . . . which is someone with a thinking disorder you know. Like I say, you can be treated for it . . . you have a chemical imbalance in the brain. Hopefully . . . someday . . . [I will] not have to take the medication.

Unfortunately, another 62-year-old MIO with a diagnosis of paranoid schizophrenia had to be hospitalized about a month after his interview. He absconded (meaning that he did not show up to the program for 3 days and he failed to call in to the program). He had stopped taking his medications and became very agitated and paranoid. He was subsequently readmitted to the hospital for medication and psychiatric treatment, and was allowed to continue in the program.

Those who struggle with serious mental illness also face substance abuse problems of enormous proportions. Various factors account for their continued use despite the consequences of repeated usage. Some MIOs use drugs as an attempt to treat symptoms of the illness or the side effects of their medications. Environmental and interpersonal conflicts added to this 18-year-old MIO's inability to manage his disease.

> My father was coming around. He had been gone for good 5 or 6 years, and I hadn't seen him for that long . . . and then he started coming around, and I started . . . you know, there was just some stuff happening, you know, drama. My dad would tell me he wanted me to live with him, but then you know, my mom was saying that she don't want me to live with him, and that I just need to slow down.

> . . I was getting pulled, you know, like a tug of war. So, it just started causing problems. I've been using drugs since I was 12.

A history of violence was prevalent among mentally ill offenders. One 47-year-old male MIO described his thinking process of how mental illness affects his thinking, which then often leads to violence.

> I'm always thinking people are after me or out to get me. I'm always thinking that people don't care about me, or don't like me. I'm always trying to please people so they can be my friend, and it don't work like that, you know. Then with these voices, sometime I know I'm capable of killing you . . . and sometimes, I go there, you know . . . my thoughts will take me there.

Aside from having to deal with the mental illness, many mentally ill offenders must come to grips with other medical complications. Many MIOs are not prepared to handle living with debilitating or dreaded physical illnesses. A 48-year-old male reconciled what it is like to live with a diagnosis of HIV.

> When [the doctor] told me I had the diagnosis, you know, I looked and said, "What?" First, I thought he had said AIDS, you know. So when he said HIV, I said, "Okay," you know. People wanted to kill themselves . . . I say, "Well, no business doing that . . . you just got it, you know . . . you got it." The doctor said, "Well you don't have to worry about AIDS. If you had AIDS, you wouldn't last that long." Ain't no way you're going to get rid of it. The only thing to do is getting treated for it. So, I go to [the clinic] and the doctor gives me medicine and stuff like that.

Mentally ill offenders who have an understanding of their mental illness have less trouble maintaining compliance with medication and treatment. On the other hand, those who do not have adequate knowledge of the illness tend to make bad decisions that will interfere with their progress in the program.

Success in the Program

Program staff as well as mentally ill offenders viewed the program as being a huge success. Program directors described success in terms of an overall decrease in the number of re-arrests in the mentally ill offenders who enter the program. Mentally ill offenders felt success was the ability to manage their symptoms. Compliance with treatment and completion of probation or parole were also seen as positive outcomes for most MIOs. The 38 -year-old female MIO, discussed earlier in the study had this to say:

> Well, like everybody else, I will hope to have a successful discharge from parole. And I hope I have a successful discharge from the program. I say I hope to get out of here with a certificate, you know, from parole and from the program.

MIOs that complete the program are given certificates from the board of pardon and parole, or probation, and a certificate from the New Start program. Everyone is excited when the participant successfully completes the program, and this time calls for a celebration.

However, one concern shared by a staff coordinator was that while a small number of those in the criminal justice system making decisions about the population of mentally ill offenders are for the most part sensitive, there is still a large percentage of parole and probation officers who lack education about mental illness. Consequently, many parole officers and probation officers sometimes fail to understand stigma surrounding those who suffer from mental illness. This lack of understanding places MIOs more at risk for involvement in the criminal justice system. As the program coordinator stated,

> A lot of those [mentally ill offenders] without the wrap around service get rearrested . . . and I see a lot of parole officers just because the client is sick they consider them an absconder if they can't find them . . . "They're in the hospital," but the officers just say "Oh well." Either they do not recognize the mental illness or they just do not care . . . too much paper work you know . . . it is easier just to do the warrant and get them out of their hair . . . a lot of those [MIOs] end up in jail . . . and unfortunately, we do not have the time and resources to go and advocate for these clients.

Not all mentally ill offenders are successful the first time around. Some participants will be in the program for 4 months or more and start using drugs or refuse to keep appointments. In this instance, supportive measures are tried to avoid having the participant go back to jail. For example, participants may be required to increase the number of days that they have to attend the program. One 38-year-old mentally ill offender had to come to the program 5 days a week now because she started using drugs again. She stated that is not worth it and that it is best to "keep your nose clean." The participants indicated that they felt supported and to some degree understood that even when they "mess up," the program staff tries to help them to be successful. A 38- year-old female MIO reported that:

> Right now I on a little punishment . . . I messed up . . . using crack cocaine. They put me into a drug rehab . . . and so this is why I am here doing these 5 days [during the week] and 2 days on Saturdays and Sundays. I got to go to AA and CA meetings. It's a punishment . . . but then it[s] better than going back to TDC; you know what I'm saying. In the back of my head I know what I did was wrong. That's why I called . . . I had a lot of trust in (the case manager). She tries her best to help me . . . sometimes I might not want help . . . but she does. I was coming like . . . I was doing 3 days a week and I was just going to ask them to have 2 days . . . . So I gotta work my way back up again.

Unfortunately, 2 months after this interview, this participant was arrested for felony assault with two deadly weapons. She is currently in jail; however, the outcome of

the investigation is still pending. Since her admission to the program this incarceration will be the MIO's second time to spend time in jail. She previously spent 8 years of a 15-year prison sentence for the possession and distribution of cocaine and alcohol abuse.

While recidivism is the exception, some offenders who fail to comply with the treatment are sent back to jail. Incarceration occurs even though program staff examines all alternative interventions to prevent mentally ill offenders from returning to prison. According to the program director, the rate of recidivism of mentally ill offenders returning to jail was less than 2% in the pervious year (TCOMI, 2001). As stated by one participant, "It [is] important not to relapse . . . . So, yeah, I'm here faithfully."

Age and level of maturity appear to be factors associated with successfully completing the program. Some younger MIOs in the program, the 18- and 19-year-olds, need a different level of care and present a greater treatment challenge than the adult patients over the age of 25. For example, most adolescents in the program have drug usage and aggressive behaviors that have landed them in trouble with the law. One nurse had this to say:

> Seems like you can get a get a 25-year-old [Youth offender], put them in a 90-day treatment [and] they'll come out okay. They come out as if they did get some benefit out of it. But you put a 19-year-old in treatment, and they'll come out like nothing . . . like they were at home or something.

However, this was not the perception of one 18-year-old MIO interviewed.

> I just need to try to open it up more instead of closing down and they're helping me with that. They're just showing me that not everybody in this world are insane people and they're not out to hurt me.

Many adolescents suffer from symptoms they do not understand, and more often than not, these symptoms go unrecognized. One 18-year-old MIO experienced a sense of sadness and despair for most of her life (since the age of 2 years) and was unable to understand what was wrong with her. She shared her thoughts about her depression.

> Depression is . . . like something like . . . someone dies or something. You feel sad and lonely, that you don't want to be bothered with anybody. You don't feel like doing anything at all.

Coming to terms with the illness is seen as another important first step in accepting treatment. However, this acceptance of the disease and the behaviors compounded by the illness is a struggle for most MIOs in the program. One 19-year-old female described her struggle:

> I thought violence was the best way to solve my problems. That violence and the drugs I was starting to use ended up getting me raped and jailed, back and forth, and eventually I ended up at Texas Youth Commission (TYC) [program]. I could have gotten out in 9 months, but I chose to keep fighting, doing violence, and once I got out I still had anger problems. So, my parole officer decided to send me here so I could get anger management classes.

A 38-year-old male related that, for him, accepting that he had an illness was the first step:

> Some people drink and drink and drink . . . and they say "I'm not an alcoholic" . . . but then one day you wake up years later and you find that you're an alcoholic . . . and you find out it's a disease, you know.

Walking a Tightrope with a Safety Net

Being a mentally ill offender in a community based treatment program is like being a tightrope walker in a circus performance. The tightrope performance begins 60 feet above the ground on a platform, as hundreds of people watch and wait for the first

step out on the tightrope. Only a 1/2-inch metal wire is between the performer and the ground. A pole helps to balance the walker by lowering the center of gravity. Center of mass greatly affects the tightrope walker's performance on the rope. If the performer's center of mass is not directly above the wire (axis), the performer will begin to rotate about the wire, or fall of off it. Without the help of a long pole, the tight ropewalker's center of mass is at his waist, a rather high position that makes it difficult to achieve balance. If the walker leans even an inch to the right, the entire system is thrown off balance and the walker will tumble to a safety net (hopefully). The force of friction is a little more important in this act than in that of the trapeze. The walker may even wear sticky shoes to magnify the friction between his or her feet and the rope. With greater friction, the possibility of falling off the wire will be less. These are MIOs' experience of the high wire act of trying to manage the array of symptoms associated with mental illness and criminal behaviors in a community based treatment program.

Life is disciplined for both circle performers and MIOs. Exercise and practice begin early in the morning for those in the circus. Depending on the season, artists perform once or twice a day (Collins, 1994; Moss, 1987). Performers stay in a place for a month or two and as they spend more time together they become almost like one family. In every company the layout is planned in advance. Tents, fence, and ramps are erected in the same fashion in every place. They take only 2 to 3 days to settle down in the new camp and start performing. The exercise and practice of performing also begin early each morning. The program environment is highly structured for MIOs, and they

must adhere to schedules that have only a small degree of flexibility and appointments that have been developed in advance.

Tight ropewalkers have assistants (i.e. spotters, poles) to help maintain balance (Collins, 1994); similarly, MIOs have a safety network of resources available to catch them if they fall. After joining the circus it can take about 2 months of instruction before appearing for a performance. Special acts like tightrope walking can take longer--as much as 2 to 4 years. The mind and the body have to work together while performing, and it is a challenge coordinating with team members at every step. Moreover, the performers have to be alert, fit, and at their best all the time. Tightrope walkers require knowledge of the skill to do well and to remain in the circus (Collins, 1994). Developing trusting relationships are key success. To be successful, MIOs must learn what it takes to stay in the program. Formal learning through group sessions and informal education through other MIOs play a critical role. Like the tightrope walkers out on the wire, MIOs must learn whom they can count on and what can be counted on. Mentally ill offenders new to the program experience more risk than veteran MIOs. Those new to the program do not know what the rules are or what is expected. As MIOs become immersed in the program they get along better. However, in tightrope walking, the most precarious time is out in the middle away from the platform. For MIOs the scariest times are when they are the farthest from resources.

Like the circus, where there is a large crowd of people, the environment causes distractions. Going back to the old neighborhood or hanging with the old crowd distracts from the purpose of treatment. Mentally ill offenders must deal with the temptation to

use drugs or alcohol or to get involved in other criminal behaviors. Tightrope walkers perform in the middle of the crowd in the circus and are placed in a position to be observed by all (Rosenfeld, 1993). In the same way, the MIOs are placed in the middle of the very complex environment of the treatment program where they must deal with the combination of having a chronic mental illness, possible substance abuse problems, and potential return to jail. Tightrope walkers must be in tiptop shape in order to perform well. Mentally ill offenders must always be on their toes to avoid slip-ups.

Like the circus performer, each day brings on new and different challenges and there are no guarantees that the day will proceed as planned. Success in the program requires vigilance to maintain focus. Another time when MIOs are at risk is when they are about to leave the program. It is during this time that they must prepare to be discharged from the program–leaving the safety net behind. Although there are follow-up referrals after discharge, aftercare may not have the same intensity as the program, thereby shrinking the safety net. In an environment where there are no guarantees, mentally ill offenders are constantly trying to maintain their balance.

CHAPTER 5

SUMMARY OF THE STUDY

This study's purpose was to explore the experiences of mentally ill offenders (MIOs) as residents currently participating in an innovative and highly successful community-based program. Community based treatment programs providing intensive case management and rehabilitation positively influence the lives of MIOs. Findings may potentially improve the ability to provide better treatment options and improved services and treatment outcomes for mentally ill offenders. Understanding the experiences from the MIOs' perspective can help to identify potential interventions that support MIOs' specific needs as a means to decrease their contact with the criminal justice system.

Summary

An ethnographic method was used to explore the experiences of MIOs. A purposeful sample of 12 MIOs and 3 program staff members at a community based treatment program located in the Southwestern United States formed the sample for this study. Sampling ceased when redundancy in the data was achieved, or when new information began to fall into established categories. Mentally ill offenders and informants were interviewed by use of semi-structured interview protocol guides (see Appendix D; Appendix E). Each interview was flexible to allow participants and

informants fully describe their experiences. The open-ended nature of questioning encouraged the participants to say what they wanted to say. Each interview was audiotaped, transcribed, and reviewed prior to the next interview. Participant observation also was used to gather data. Field notes were completed and used as a method for registering data collected during participant observation. Analysis of the data used modified process analysis and grounded theory methodologies. Mentally ill offenders experienced different needs and had different levels of engagement over the duration of the program participation. MIOs experienced movement through the New Start Program as a four-stage process. Getting into the program was acknowledged by the MIOs to be of great importance. When entering the program, learning the ropes--the routine and rules of the program--was significant. As MIOs moved through, understanding consequences, fitting into the group, keeping their noses clean (staying out of trouble), maintaining consistent focus, and finally, facing the challenges of moving on to discharge were reiterated by the subjects as necessary to achieve the expected outcome.

Discussion of the Findings

In many ways this sample represented the general characteristics of MIOs found in the literature. Mentally ill offenders were predominantly middle age. Findings in this study supported reports that indicated that a growing number of MIOs are middle age or older with only three of the twelve MIOs between the ages of 18-19 years old. There was very little disparity in the number of female MIOs compared to male MIOs in the program; this supports the literature, which reflected a significant increase in women in

jails or prison. The proportion of incarcerated women is growing faster than men in the United States (Hartwell, 2001). Although not as prevalent as major depression or bipolar disorders in the general population, schizophrenia was a common diagnosis for the MIOs and was described as the most difficult diagnosis to manage in the program. This finding is congruent with the literature stating that individuals currently incarcerated in prisons and jails suffered from severe mental disorders, such as schizophrenia, with large proportions also suffering from alcohol or other drug abuse (Ditton, 1999; Substance Abuse and Mental Health Services Administration, 2000).

Mentally ill offenders intersected the program at numerous points but predominantly through an initial contact with the law. Self or family referrals were additional ways of getting admitted to the program. The diagnosis of a mental illness was associated with a substantial level of disability in terms of personal distress and suffering, and it presented disruption in occupational and social functioning; nonetheless, MIOs responded well to support. Mentally ill offenders experienced distortion and lack of ability to think clearly which caused them to lash out and to entertain thoughts of harming others. These behaviors were congruent with those described by Walsh, Buchanan, and Fahy (2001) that indicated individuals with a diagnosis of schizophrenia were strongly associated with personal violence and that those with psychosis were often driven to offend by their delusions. The findings of this study supports the literature that symptoms, rather than diagnosis, may be the most important in terms of clinical factors explaining criminal behaviors among persons with mental illness (Solomon & Draine, 1999).

Needs were different for MIOs at the beginning of the program than for MIOs about to exit. As MIOs moved through the program and experienced support, needs then centered on managing the illness and completing the program. Continual staff and peer support was an ongoing need. Acceptance was a concern when mentally ill offenders first entered the program. This study finding supported findings of Dvoskin and Steadman (1994) in that mentally ill offenders perceived the staff as more than agents of the law but rather as their advocates.

Evidence in the literature indicated that many of those with persistent and severe mental illness have responded poorly to traditional outpatient mental health care (Lurigio, Fallon, & Dincin, 2000). There is uniqueness about this particular program that separates it from similar programs. One such feature is the intensive case management, which is a particularly suited modality for MIOs. The program success allows for delivery of comprehensive, community-based psychiatric treatment. A broad range of offender services are implemented, including collaboration and coordination of mental health staff and parole for clients on parole or probation, to ensure success (Swanson et al., 1999). This program consists of eight components, Continuity of Care (COC) Services, Intensive Rehabilitation, Psychiatric Care, Intensive Case Management, and Nursing, Benefits Coordination, Wrap Around Services, and the Court Resource Program or Jail Diversion Division, that has evolved over time and allows for seamless service.

Community based treatment programs, most commonly referred to as Jail Diversion Programs, of severely mentally ill offenders are focused on stabilization of the illness, fostering independent functioning, and maintenance of internal and external

controls to prevent MIOs from further involvement in the criminal justice system (Solomon & Draine, 1999; Lamb et al., 1999). One differentiation between traditional community based services and jail diversion services is the specific focus on access to treatment as an alternative to arrest (Solomon & Draine, 1999). Mentally ill offenders are seen in the clinic as well at the outreach services provided.

The therapeutic milieu approach is another supportive environment. Characteristics of this community based program incorporated many facilitory aspects. Intensive linkage and coordinating of services and advocacy included psychiatric, rehabilitative, and social support. Groups conducted each day provided education on symptom management and development of effective coping skills. Wrap around services began at the entry in the court system with courts collaborating with the program to determine appropriate alternative treatment setting. Characteristics reflect Lamb, Weinberger, and Gross's (1999) suggestion that comprehensive services and intensive case management, whether mandated or voluntary, provides needed support and structure. Recent studies about similar programs have been consistent in reporting that intensive community based treatment works to reduce crime and recidivism and to improve symptom management (Lamberti, 2000; Roskes, Feldman, Arrington, & Leisher, 1999; Swartz et al., 1999; Ventura, Cassel, Jacoby, & Huang, 1998).

Most treatment programs consist of psychiatric and medical interventions, drug treatment, assertive case management, and integrated programs for offenders with psychiatric and substance abuse disorders. One treatment program that closely resembles the model of care currently in place in this study is the Assertive Community Treatment

(ACT) model; this was the intensive case management for the study program. The ACT model renders care to individuals with chronic and persistent mental illness. The shared goals of both this study program and ACT program are to improve the MIO outcomes by reducing the number of crisis incidences and to reduce the rate of recidivism. Both programs are focused on delivery of care to those with severe and persistent mental illness and providing services in all community settings whether it is in the person's own home or in the neighborhood (Lamberti, 2000; Roskes et al., 1999; Swartz et al., 1999; Ventura et al., 1998).

One major difference between the traditional mental health programs and this program is that MIOs, in this study, are legally bound to participate and must satisfy the legal requirements to successfully complete the program. Of significance was the level of interventions extended beyond the expected services. Staff is heavily involved in the personal milestones of the MIOs lives. When MIOs or even a family member gets married, becomes ill, have a birthday, the staff are there for them. Being there could mean attendance at the wedding, throwing a birthday party at the program and inviting all MIOs to participate.

Recidivism in populations of this type is a major concern when looking at success rates. However, the recidivism rate in this program was reported to be less than 2%, in fact lower than those in other programs of its kind (TCOMI, 2000). The findings of this study supported the idea that persistent outreach reduces recidivism by providing proactive interventions to deal with potential crises before they occur (Bonta, Hanson, & Law, 1998). Wexler, Melnick, Lowe, and Peters (1999) found a statistically significant

reduction in recidivism in the group of offenders at 3 years after release from a community based treatment program.

Educational activities in the program were congruent with the philosophy of mental health care proposed by Ditton (1999). Ditton indicated learning about the illness and accompanying symptoms gives mentally ill offenders insight to successfully self-manage the disease. Supportive therapy and teaching groups were interventions used to teach coping skills. Group interaction provided MIOs opportunities to examine their behaviors and discover new ways of coping with symptoms of the illness and allowed means of dealing with stressors. Compliance was tied to the MIOs knowledge of their mental illness.

In the beginning, MIOs lacked an understanding of the nature of their illness or their psychiatric diagnosis. Most people suffering from mental illnesses often do not recognize they may be suffering from a mental illness. Learning about the illness and its symptoms gives mentally ill offenders skills to self-manage the disease (Ditton, 1999; Wahl, 2002).

This program represented the first experience with mental health treatment for many MIOs, making it difficult for some to discern how their experiences would have been different had they been in another setting. The program was a lifeline for MIOs who have struggled with their illness for most of their lives. One example of how the program presents a lifeline was heard in one MIO's comment that his future "would be more uncertain if not for the support" and structure of the program.

There was a formal and informal participatory process in place. Mentally ill offenders in this program understand that they have little choice in the overall treatment decision; however, there was a degree of collaboration and mutual engagement between the program staff and MIOs. Criminal justice and mental health professionals create a combined effort to provide appropriate treatment for persons with serious mental illness and substance abuse problems. The group is highly structured. Each patient has a turn, which is followed by group feedback. Regular topics include concerns about safety, difficulties in relationships, substance abuse, feelings of inadequacy, interactions with families, intolerance of dependency, and fear of abandonment. Group discussion attempts to identify stressors or unrecognized emotions that may underlie symptomatic behavior. Group members are astute at recognizing subtle forms of manipulation, and patients seem more receptive to feedback and confrontation from each other than from clinicians. The group works best when patients hold each other accountable for maladaptive behaviors. Peer pressure is often an effective deterrent to destructive behavior.

Informal peer and self-regulatory behaviors were observed on the part of the MIOs. For example a MIO might remind another MIO to attend a mandatory group if that person appears hesitant to go. Many times all that was needed is a little push from a peer to stimulate motivation. Sometimes the motivation for compliance was as small as having the privilege to play a video game between groups. A few of the MIOs did not want to show up to the program, but they understood that it was a condition of their

parole or probation. So, they make every effort to comply. Attitude problems are often seen at the start of the program, but they are dealt with early on.

Resiliency: Resilience for MIOs was a process of accumulating small successes that occur side by side with failures, setbacks, and disappointments. Resilience develops as both the internal and external interact. Qualities of resilient MIOs include specific skills, behaviors that are internal to them such as coping and anger management as well as to factors such as caring individuals, and high expectations, and opportunities that are external. Caring relationships, for instance, can trigger a positive cycle in which MIOs gain a sense of connection and confidence, which increases their focus. When MIOs know that they are respected for their achievements, MIOs come to recognize the areas of their lives that need work and find motivation.

The Experience of the Program

The New Start program was similar to other community-based programs except that it has a higher degree of structure (Bonta et al., 1998; Ditton, 1999; Wahl, 2002; Wexler et al., 1999). The program's role within the larger system of care requires that it accept MIOs in crisis that urgently require more intensive intervention and those who have not been successful in less structured programs. Mentally ill offenders are triaged to various components of the program depending on individual need. Mentally ill offenders spend a minimum of 6 months in the program; however length of stay can be as long as 10 years, after which time they are expected to make a transition to less intensive outpatient services. Resources found in most programs include groups and medication

and medical management. There are many internal and external resources available such as housing placement, job skills development and financial services.

Boundaries are in place for behavior. Unlike many traditional treatment programs, where clients are discharged if they chose not to follow the program, this program offers no option to leave the program until the period of probation or parole has been successfully met. The therapeutic milieu is highly valued because of the strong interactive nature of the environment. In this approach individualized treatment plans are tailored as much as possible to meet the needs of MIOs, wherein definite structure, schedule, overall guidelines, and social controls are set forth. The milieu therapy encourages self-governance and fosters development of self-responsibility and appropriate interdependence with peers. Peer support is highly encouraged; however there is less time for introspection and time spent in treatment is more focused.

Milieu therapy is recognized as an effective therapeutic intervention for MIOs in promoting and facilitating positive change. The milieu is viewed as a secure environment from which MIOs can integrate back into the community knowing that they will be medically, physically, and emotionally supported (Jones, 1953). The integral part of the milieu approach for MIOs is that interventions address psychosocial and emotional adjustment while improving offenders' levels of insight and acceptance of their mental illness (Klonoff, 1997).

Milieu environmental approaches rest on assumptions that patients should be responsible for much of their own behavior and are willing to help each other (Weinberg & Koegel, 1996). One difference with milieu in this program environment compared to

other milieu is that treatment and attendance are not voluntary; nevertheless, all MIOs are treated with empathy and respect. The values and beliefs expressed in the milieu are that MIOs' difficulties are both expressed in, and arise in, relationships with other people. The milieu allows for understanding of how MIOs' relationships are derailed. The milieu environment offered MIOs opportunities to find better ways of relating. Therapy is essentially in the learning process and involves both MIOs and staff.

The therapeutic milieu provides the foundation for the provision of day treatment and differentiates these services from other specialty mental health services. The program is structured by well-defined service components with specific activities being performed by identified staff. This program provides a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction. The program also supports peer/staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

In the milieu environment a consistent routine is maintained which fosters predictability and trust. A milieu is considered therapeutic when there is a community that provides a sense of belonging and plays a central role in the individual patient's life. This centrality of the program and sense of belonging was expressed by the MIOs. The therapeutic community has a set of values and norms for behavior with an expectation that participants will become engaged in activities and values one another as individuals. The objective of the therapeutic community is to provide a safe, nurturing environment. Additional objectives are to provide a means for MIOs to integrate new and positive experiences, and then use these experiences to increase self-esteem and opportunities to

practice new, adaptive living skills, social skills, and empowerment for experiencing success.

In this environment, it is not unusual to observe some testing of the authority as the MIOs try to adjust to the system. This behavior can continue for weeks and months until the MIOs are convinced that in this milieu they will be cared for, that their aggressive behavior will be controlled, that symptoms will be treated, and that the level of caring is genuine.

Conclusions and Implications

The findings of this study reflect the experiences of only 12 mentally ill offenders and it can therefore not be concluded that these experiences are representative of all mentally ill offenders. This study presented perceptions of MIOs regarding their experiences in the program. Descriptions from the MIOs suggest the following conclusions and implications for nursing practice to promote the MIOs' ability to manage their mental illness and to offer services that supply their needs.

1. Mentally ill offenders who participated in the community-based supervised program experienced a sense of support.

Mentally ill offenders respond positively to interventions that are structured rather than punitive and are willing to engage in treatment that will help them manage their illness. Findings indicated that nurses as well as those who work in the criminal justice system need to be more informed about mental illness in general and need to gain an understanding of symptoms related to the disorders.

2. Mentally ill offenders had a desire to manage symptoms; however, they struggled with the illness due to lack of understanding of the disease.

It is difficult for MIOs to control symptoms of paranoia, hallucination, or agitation behaviors associated with mental illness, such as schizophrenia or bipolar disorder, if they have no understanding of why they are behaving in such a manner. Teaching MIOs about their illness is the first step in getting them to understand the importance of complying with medications and other therapies. Even with education about the illness, it is very hard for MIOs to accept the illness. Staff intervention when MIOs experienced relapses while in the program was critical to maintaining continued program participation.

Mentally ill offenders generally adapted to the demands and were willing to engage in the program in a way that suggested a type of resiliency. Many MIOs were dealing with the challenge of their mental illness or other traumatic events or crimes that they had committed. This sense of resiliency was displayed in several ways. Mentally ill offenders are willing to accept the help and support of the group and to accept responsibility for their own behavior. They accepted circumstances that could not be changed and instead focused on managing their illness. They were willing to move toward the goal of completing their term of probation or parole. Resilience is seen as an achievement of healthy levels of functioning despite the presence of biological or environmental risk factors. Resilience for MIOs has to do with taking one day at a time despite the uncertainty of the day would bring or what struggle that they would have to overcome. Resilience also meant having support and gaining knowledge and

understanding about the nature of the illness (Kaplan, 1999; Kumpfer, 1999; Roth & Ross, 2002).

The findings from this study indicated that MIOs valued the program and the people who worked with them; however, they did not want to have to come every day. Staff, because of their understanding of the nature and the chronicity of mental illness, worked to tailor the requirements of the program to the needs of the MIOs.

3. Mentally ill offenders manage their illness by following the treatment plans and adhering to the rules of the program.

Successful completion of parole or probation was a long term goal for many in the program and "*Getting off paper*" was very important for MIOs; however, this was not the only motivation for compliance. Mentally ill offenders looked forward to a less structured environment outside of the program. They viewed those working with them as advocates rather than adversaries. This view and level of motivation was consistent with the finding that MIOs with low motivation or lack of focus had a greater likelihood of being incarcerated for a technical violation. This finding seems to indicate that a lack of engagement with mental health services is associated with continued criminal behavior. Finding the right mix of medication, and taking the medications as prescribed to treat the symptoms was key to managing symptoms.

4. Practical knowledge of their mental illness helped MIOs come to terms with the illness and positively affected their experience in the program; they no longer felt victimized by the illness.

The study findings further reinforced the need to continue providing MIOs with wrap around community based services and intensive case management. Community mental health nurses are in an ideal position to help lead this process and can play an important role in the management of MIOs. Educating MIOs about their illness is important for nurses as well. Because of the nature of nursing and nursing education, nurses are well equipped with assessment skills necessary to work with the mentally ill offender population. Nurses provide a safe environment and structure. Structure allows boundaries and security, and therefore it enhances the sense of safety (Fontaine, 2003). Nurses provide education to both MIOs and to families to facilitate understanding of the illness, effects they will experience from the illness, and the medications as well as to what treatments and interventions are available.

Recommendations for Further Study

Recommendations for further research include:

1. Examine mentally ill offenders in other locations and other types of treatment programs should be studied. The demographic configuration of the MIOs may be different at another program or at other locations.
2. Examine the experiences of mentally ill offenders following discharge needs further study.
3. Conduct cost effectiveness studies are needed since the success of such programs have financial and policy implications.

4. Conduct a study using a more stratified sample of MIOs, those with a diagnosis of bipolar disorder, major depression and schizophrenia and those without a diagnosis of bipolar disorder, major depression and schizophrenia and how they move through the system.
5. Conduct a formalized study of factors associated with low recidivism.

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APPENDIX A

AGENCY APPROVALS

9TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
INSTITUTIONAL REVIEW BOARD
1130 John Freeman Blvd., Houston, Texas 77030 713/794-2074

MEMORANDUM

TO: Anne Young
Lucindra Campbell

FROM: IRB

DATE: June 26, 2003

SUBJECT: IRB Exempt Application

TITLE: Mentally ill offenders experiences in a community based supervised treatment program (Texas Department of Criminal Justice Project #207-R02)

This application is **approved.**

William P. Hanten
William P. Hanten
Chairperson

MENTAL HEALTH AND MENTAL RETARDATION
AUTHORITY OF HARRIS COUNTY

EXECUTIVE OFFICES-NPC
1502 Taub Loop
Houston, Texas 77030
P.O. Box 25281
Houston, Texas 77265-5281
713-970-7110

March 14, 2002

The Committee for the
Protection of Human Subjects

Notice of Approval to Begin Research

TITLE:	Mentally Ill Offenders Experiences in a Community-Based Supervised Treatment Lucindra Campbell, RN, MSN, APNPB Graduate Student-Texas Women's University Tuan D. Nguyen, Ph.D. REP—MHMRA of Harris County
STUDY NUMBER:	02-01
RECOMMENDED FOR APPROVAL:	Administrative Review
APPROVAL DATE:	March 14, 2002
EXPIRATION DATE:	February 28, 2003
CHAIRPERSON:	Robert Stakem, Jr.
PROVISIONS:	Notify CPHS of any substantive changes in study design or protocol and when the study terminates. **Provide the CPHS chair with: (1) annual progress reports; (2) publications and professional presentations emanating from the research; (3) an acknowledgment of MHMRA's sponsorship or collaboration in all publications of relevant research; and (4) changes in protocols and procedures.**
OTHER IRB APPROVAL:	None.

Subject to provisions noted above, you may now begin this research.

ETHICAL CONDUCT: **Researchers must adhere to guidelines of ethical conduct of their respective disciplines.**

CHANGES: The P.I. must receive approval from the CPHS before initiating any changes that would affect human subjects, e.g., changes in procedures, numbers or kinds of human subjects, or revisions to informed consent documents or procedures. The addition of co-investigators must also receive approval from CPHS. **ALL PROTOCOL REVISIONS MUST BE SUBMITTED TO THE SPONSOR OF THE RESEARCH.**

INFORMED CONSENT: Informed consent must be obtained by the P.I. or designee using the format and procedures approved by the CPHS. The P.I. must instruct the designee in methods approved by the CPHS for the consent process. The individual obtaining informed consent must also sign the consent document. The P.I. may only use the attached consent document(s). The P.I. may only use the consent forms until the designated expiration date on the document(s).

UNANTICIPATED RISK OR HARM OR ADVERSE DRUG REACTIONS: The P.I. will immediately inform the CPHS of any unanticipated problems involving risks to subjects or others, of any serious harm to subjects, and of any adverse drug reactions.

RECORDS: The P.I. will maintain adequate records, including signed consent documents if required, in a manner that ensures confidentiality.

RECOMMENDED FOR APPROVAL:

Robert Stakem, Jr. — 3.15.02

Robert Stakem, Jr.
Chair, MHMRA Committee for the Protection of Human Subjects

DATE

APPROVED:

STEVEN B. SCHNEE, Ph. D.
Executive Director, MHMRA of Harris County

3/18/02

DATE

TEXAS DEPARTMENT OF CRIMINAL JUSTICE

Gary Johnson
Executive Director

July 3, 2002

Texas Women's University, Houston Campus
Attn: Lucindra Campbell
10777 Richmond Ave. #515
Houston, Texas 77042

Dear Ms. Campbell,

The Texas Department of Criminal Justice (TDCJ), Executive Services Department received your application to conduct research. The proposed research entitled "Mental III Offenders Experience in a Community-Based Supervised Treatment Program" was reviewed and approved.

I have enclosed the "Texas Department of Criminal Justice's Research Agreement" and "Compliance of Agency Procedures and Policies While Conducting Research Agreement". Please review and sign the Research Agreement and initial to the left of each number on the Agency Procedures and Policies document and return to our physical address:

ATTN: Michele Connolly
External Research
8317 Cross Park Drive, Ste. 175
Austin, TX 78754

Or, you can fax the forms to our RED Group offices at (512) 977-9552. Once we receive the forms, you are ready to begin your research within the Texas Department of Criminal Justice

A project number has been assigned to your research, #207-R02. Please use the project number when referring to your project in the future. Our office requests an update of your research on a quarterly basis. Also, remember that under the terms and conditions for research you are required to submit the results of your studies for review and comment prior to publication/presentation. Please allow fifteen working days for this process. Additionally, TDCJ requests that you include the following disclaimer on all publications/presentations: The Texas Department of Criminal Justice supported this research under Research Agreement #207-R02. Points of view are those of the author(s) and do not necessarily represent the position of the Texas Department of Criminal Justice.

If you have questions or concerns, please contact me at (512) 406-5663.

Sincerely,

Michelle Connolly
Assistant Director

Enclosure(s)

DS:WI

Texas Department of Criminal Justice
Research Agreement

This document serves as a research agreement between the below listed Principal Researcher and the Texas Department of Criminal Justice (TDCJ). Failure to comply with this agreement may result in termination of the research project as well as future applications to conduct research. Upon approval of the proposed research, the RED Group will complete this agreement and forward it to the principal researcher.

This is an agreement between the TEXAS DEPARTMENT OF CRIMINAL JUSTICE (TDCJ) and the SPONSORING UNIVERSITY. Both are agencies of the State of Texas.

Principal Researcher

Name: Lucindra Campbell
Address: 10777 Richmond Ave., #515
Address: Houston, TX 77042
Phone: (281)649-3000 ext. 2492
Fax: (281)649-3340
E-mail: lcampbell@hbu.edu

Sponsoring University/Institution

Name: Texas Women's University, Houston Campus
Address: _____
Address: _____
Phone: _____
Fax: _____
E-mail: _____

Secondary Researchers: NA

Research Title: Mental III Offenders Experience in a Community Based Supervised Treatment Program

Research Logistics

Location(s): MHMRA Clinic-Harris County Subjects (type, #): 12

Project Begin Date: July 2002 Project Completion Date: July 2003

Methodology: A qualitative study will be conducted. An ethnographic study design will be used to describe the experiences of mental ill offenders who participate in the community-supervised program and to describe their experiences (Burns, 1989; Omery, 1983; Polit & Hungler, 1999). Unstructured participant observation, filed notes, and face-to-face semi-structured interviews using in depth, open0ended questions will be the primary method of data collection.

Data Services computer run: ☐ yes ☐ no Cost estimate: _____

Special Conditions

_____

_____

_____

_____

Final Reports

Final reports should discuss, in layman's terms, the research questions, methodology, provide detailed findings and conclusions/recommendations. A final report is required even in the event the research is not completed or written results are not published.

All publications produced from external research projects must contain the following disclaimer:

> *"The research contained in this document was coordinated in part by the Texas Department of Criminal Justice (Project Number). The contents of this report reflect the views of the author and does not necessarily reflect the views or policies of the Texas Department of Criminal Justice."*

Submission of Results

Two copies of all research results shall be provided to the RED Group at least 15 working days prior to submission for publication or presentation. The TDCJ is granted a license to use, without limitations, the materials developed as a result of the research conducted.

I have read, understand, and agree to abide by all requirements as stipulated in Administrative Directive (AD)-02.28. I agree not to deviate from approved methodology without first obtaining written permission from the RED Group. I will make a "good-faith" effort to abide by all rules, regulations, and policies applicable to the Texas Department of Criminal Justice.

This agreement shall remain in force for the duration of the project but is subject to revocation by either party at any time for any reason or no reason at all.

(Signature)

Date: 7/11/02
MICHELE M. CONNOLLY
ASSISTANT DIRECTOR
RED GROUP
TX DEPARTMENT OF CRIMINAL JUSTICE

(Signature)

Date: 7/11/02
LUCINDRA CAMPBELL
TEXAS WOMEN'S UNIVERSITY, HOUSTON CAMPUS

MHMRA
Administrative and Support Services
7011 Southwest Freeway
Houston, Texas 77074
P.O. Box 25381
Houston, Texas 77265-5381
(713) 970-7000
MENTAL HEALTH • MENTAL RETARDATION
AUTHORITY OF HARRIS COUNTY

February 4, 2003

Lucindra Campbell, R.N., M.S.N.
Texas Women's University
College of Nursing
1130 M.D. Anderson Blvd.
Houston, Texas 77030-2897

Subject: Mentally Ill Offender's Experience in a Community Based Treatment Program

Dear Ms. Campbell:

I am in receipt of your January 9, 2003 letter requesting an extension of the above referenced research protocol. This protocol had been approved by the MHMRA CPHS on March 14, 2002 for a time period not to exceed February 28, 2003. Since the content of the protocol has not changed your request for an extension is approved through August 29, 2003. If there are changes to the protocol you must have the protocol reviewed again by the MHMRA CPHS.

Please contact me if you have any questions or need additional information.

Sincerely,

Bob Stakem

Robert Stakem, Jr.
Director, Quality Management
Chair, CPHS of MHMRA of Harris County

Cc: Steven B. Schnee, Ph.D., Executive Director, MHMRA
Tuan Nguyen, Ph.D., Director of Research, Evaluation and Planning, MHMRA

2/03RS(L)1:bb

TEXAS DEPARTMENT OF CRIMINAL JUSTICE

Gary Johnson
Executive Director

May 13, 2004

Lucindra Campbell
10777 Richmond Ave., #515
Houston, Texas 77042

Re: "Mentally Ill Offenders Experience in a Community-Based Supervised Treatment Program"

Dear Ms. Campbell:

The Texas Department of Criminal Justice (TDCJ) Research, Evaluation, and Development Group received your research findings. We reviewed your final product titled "Mentally Ill Offenders' Experiences in a Community-Based Supervised Treatment Program" and have no objections to the overall content.

In the event you disseminate the findings through professional journals, books, and conferences, copies of such publications will be required to be sent to the TDCJ Research, Evaluation, and Development Group as they become available, even if they appear well after the project's expiration. The TDCJ imposes no restrictions on such publications other than the following acknowledgment and disclaimer:

> *The research contained in this document was coordinated in part by the Texas Department of Criminal Justice (Research Agreement # 207-R02). The contents of this report reflect the views of the author and do not necessarily reflect the views or policies of the Texas Department of Criminal Justice.*

If you have any questions, please contact me at (512) 406-5667.

Sincerely,

Christine Kahikina
Research Coordinator
Research, Evaluation and Development Group

Research, Evaluation and Development Group
8712 Shoal Creek Blvd., Ste 290, Austin, TX 78757 (512) 406-5658

APPENDIX B

HUMAN SUBJECT INFORMED CONSENT

Human Subject Informed Consent

"Mentally Ill Offenders Experiences In A Community- Based Supervised Treatment Program"

The purpose of this ethnographic study is to conduct an in-depth exploration of the experiences of mentally ill offenders participating in a supervised, community based treatment program.

I agree to take part in a study conducted by Lucindra Campbell, M.S.N, R.N., Adult Psychiatric Nurse Practitioner, Board Certified, who is a doctoral student at Texas Woman's University. I was told that the researcher might ask me some questions about my experience here in the program. If I agree, my interview will be audiotape recorded. If I do not wish to be audiotaped, my interviewer will write down everything I say. It is my understanding that the interview will last about one hour and take place where there is privacy.

The procedure for the interview and observation has been explained to me and Lucindra Campbell has answered all of my questions.

I understand that a possible risk to me is the loss of confidentiality. To avoid this, only my name will be on the consent forms. In the course of audio taping if my name is accidentally used, the name will be deleted from the transcript. The audiotapes will be secured in a locked box or in the researcher's possession. Only the investigator will have access to or be able to listen to the tapes. Only a number will be placed on data forms and audiotapes. All observation and interview data will be reported in aggregate format only. No one will be able to identify me anywhere in the report.

I understand that another possible risk to me is that I may experience some anxiousness during the interview. I know that if I experience some anxiety or have questions during the interview; enough time will be allowed for me to ask these questions or to discuss any concerns. I am free either to interrupt the interview at any time to rest or to stop the interview without penalty. If I have any questions or concerns, I may call the Office or Research and Grants Administrations at 713-794-2100. I may contact Lucindra Campbell at 281-649-3300, ext. 2492 during business hours.

I understand there are no direct benefits to me from participating in this study.

I was given a chance to ask any questions I had about the study. I understand that I may stop my participation in the study at any time without penalty.

_____ _____

Participant Signature Date

_____ _____

Authorized Representative's Signature Date

Consent To Record

Texas Woman's University

"Mentally Ill Offenders Experiences In A Community-Based Supervised Treatment Program"

I consent to the recording of my voice by Lucindra Campbell, acting under the authority of Texas Woman's University, for the purposes of the research project entitled "Mentally Ill Offenders Experiences In A Community-Based Supervised Treatment Program." I understand that the material recorded for this research may be made available for research purposes; and I hereby consent to such use.

_____ _____

Participant Date

The above form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge and understanding of its contents.

_____ _____

Authorized Representative
of the Texas Woman's University

Date

APPENDIX C

PROCEDURE PROTOCOL

Procedure Protocol

1. The investigator will introduce herself to the staff and/or participant and explain the purpose of the interview.

2. Each participant will be asked to read and verbalize his or her understanding of the purpose of the interview. Participant will be asked to sign the consent to participate form.

3. Each participant will read and verbalize his or her understanding of the Consent to record. Participant will be asked to sign the consent to record form.

4. The investigator will remind the participant that he or she may stop the interview at any point during the interview process, and resume at a time convenient to him or her.

5. The investigator will explain to the participant that he or she is free to refuse to answer any question that they feel is too difficult to answer, or that they do not feel comfortable answering.

6. The tape recorder will be placed between the participant and the investigator.

7. The investigator will explain to the participant that a list of prepared questions will be asked and that notes will be taken during the interview.

8. The tape recorder will be turned on once the participant indicates that he or she is ready to begin the interview.

9. The participant will be asked a list of previously constructed questions from the semi-structured interview schedule.

10. Each interview will last approximately 45 minutes.

11. At the completion of interview, the participant will be asked if there is anything that he or she would like to add.

12. Interviews and field notes will be transcribed within 24 hours after the interview.

APPENDIX D

PROGRAM KEY INFORMANT INTERVIEW PROTOCOL

Program Key Informant Interview Protocol

Title: "Mentally ILL Offenders Perception of The Community-Based Supervised Treatment Program"

Key Informant Participant I.D._____

Date Interviewed _____

Time Interview Started _____ (am/pm)

Time Interview Ended _____ (am/pm)

Demographic Data for Program Staff

1. Age_____
2. Gender_____
3. Ethnic identity_____
4. Length of term of employment_____
5. Job Title _____

Semi-structured Interview Schedule for Key Informants (Program Staff)

1. Tell me about your program.
2. What services are provided in the program?
3. How is the program structured?
4. What is your role in the program?
5. What does this program hope to accomplish (what are the goals of this program)?

Probe questions will be used to encourage the participant to provide additional detail of their experience.

Questions may include:

1. Tell me about funding for this type of programs.

- Constraints?
- Lack of medical care?

- Can you give me an example?
- Go on.

2. Tell me more about your experience.

Note: Additional questions may emerge as the interview proceeds. Questions may also be asked about things the researcher notice during observation periods. The study protocol may vary during the course of the study.

APPENDIX E

MENTALLY ILL OFFENDER PARTICIPANT INTERVIEW PROTOCOL

Mentally Ill Offender Participant Interview Protocol

Title: "Mentally ILL Offenders Perception of The Community-Based Supervised Treatment Program"

Mentally Ill Offender Participant I.D._____

Date Interviewed _____

Time Interview Started _____ (am/pm)

Time Interview Ended _____ (am/pm)

Demographic Data for Offenders

1. Age_____
2. Gender_____
3. History of mental illness. _____
4. Diagnostic and Statistical Manual of Mental Disorders TR Diagnosis_____
5. Ethnic identity_____
6. Legal history and type of offense_____
7. Type of prison sentence_____
8. Length of term_____
9. Parole____ probation_____ both_____
10. Length of probation or parole_____
11. Length of time attending program_____ Year started_____
12. How long have you been coming to the clinic? _____

Semi-structured Interview Schedule for Mentally Ill Offenders

1. Tell me your story.
2. Describe your illness.

3. Tell me what it is like having a chronic mental illness.
    - How do you manage you illness?
    - What helps you to manage your illness?
4. Tell me your view of how the program is structured.
    - Are there any specific components to the program?
5. Tell me what is it is like for you being in the program.
    - What is a typical day like here?
    - How do you get to the program each day?
    - What is the first thing you do when you get here?
    - What do you do while you are here?
    - Do you have to be here at a certain time?
    - What would happen if you were late?
5. What do you hope to get out of this program?

Probe questions will be used to encourage the participant to provide additional detail of their experience.

Questions may include:

1. Tell me about funding for this type of programs.

- Constraints?
- Lack of medical care?
- Can you give me an example?
- Go on.

2. Tell me more about your experience.

Note: Additional questions may emerge as the interview proceeds. Questions may also be asked about things the researcher notice during observation periods. The study protocol may vary during the course of the study.

APPENDIX F

GLOSSARY OF TERMS

GLOSSARY OF TERMS

1. *Community-based supervised diversion program*: A program that is an effective alternative to sending nonviolent offenders to prison; it offers literacy training, substance abuse treatment, and other rehabilitative services to offenders on community supervision.
2. *Mentally ill offender:* A participant with a documented major mental illness, who has committed a criminal offense; is in the community-based program in the study program; and is on either parole or probation under the supervision of the Texas Department of Criminal Justice or a Community Supervision and Corrections Department.
3. *Off paper*: successful completion of term of probation or parole in the study program for the mentally ill offender participating in the program.
4. *Recidivism:* A tendency to relapse into a previous condition or mode of behavior; especially: a falling back or relapse into prior criminal habits.
5. *Jail Diversion:* refers to specific programs that screen detainees in contact with the criminal justice system for the presence of mental disorder; they employ mental health professionals to evaluate the detainees and negotiate with prosecutors, defense attorneys, community-based mental health providers, and the courts to develop community-based mental health dispositions for mentally ill detainees.
6. *Milieu therapy*: A type of treatment in which the MIO's social environment is manipulated and structured for his or her benefit.