Community Treatment of Severely Mentally Ill Offenders Under the Jurisdiction of the Criminal Justice System: A Review

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Objective: **Very large numbers of severely mentally ill persons now fall under the jurisdiction of the criminal justice system. A number of conditions are placed on those who are returned to the community, including specific ones related to treatment. This paper reviews the principles and practice of forensic outpatient mental health treatment.** ***Methods:*** **MEDLINE,** ***Psychological Abstracts,*** **and the** ***Index to Legal Periodicals and Books*** **were searched from 1978, and all pertinent references were obtained.** ***Results and conclusions:*** **Community treatment of severely mentally ill offenders who fall under the jurisdiction of the criminal justice system has important differences from treatment of nonoffenders, which focuses on alleviation of symptoms. Patients must comply with legal restrictions on their behavior, and treatment first addresses a patient's risk of harm to the community. Mentally ill offenders are often resistant to treatment. The mental health system may be disinclined to treat them due to their resistance and their criminal history, especially a history of violence. It is critical to identify a treatment philosophy that strikes a balance between individual rights and public safety and includes clear treatment goals, a close liaison between treatment staff and the criminal justice system, adequate structure and supervision, treatment staff who are comfortable with using authority, interventions for managing violence, incorporation of the principles of case management, appropriate and supportive living arrangements, and a recognition of the role of family members and significant others in treatment. (*Psychiatric Services* 50:907–913, 1999)**

The treatment of severely mentally ill offenders in the community has become an increasingly important and urgent issue because of the greatly increased numbers of persons with severe mental illness who have found their way into the criminal justice system. Factors cited as causes for these increases are deinstitutionalization, more rigid criteria for civil commitment, lack of adequate community support for persons with mental illness, mentally ill offenders' difficulty gaining access to community mental health treatment, violence at the time of arrest, and the attitudes of police officers and society (1–4).

The purpose of this paper is to review the literature on community treatment of severely mentally ill offenders and to discuss the principles of treating this population as generally viewed by clinicians in forensic mental health care who conduct such treatment and by the criminal justice system under whose jurisdiction the treatment occurs. Many mental health professionals who previously may not have been involved in treating mentally ill offenders are now finding themselves with treatment responsibilities for this population. A need exists for a clear understanding of the criminal justice system's perspectives and goals related to the treatment of mentally ill offenders. The perspectives and goals include an emphasis on concerns about public safety, control of violence, extensive use of authority, and close cooperation between the mental health and criminal justice systems (5,6).

Community treatment of mentally ill offenders is conducted under a variety of circumstances. This paper focuses on offenders who remain under the jurisdiction of the criminal justice system. One such group consists of individuals given probation by the court that includes a condition of mandatory outpatient treatment. Another consists of individuals referred for treatment by their parole officer with the understanding that failure to comply may result in a revocation of parole and return to custody. In addi-

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tion, some offenders are diverted by the court from the criminal justice system to the mental health system; the prosecution of their case may be postponed by the judge until they successfully complete a specified treatment program, at which time criminal charges are dismissed.

Although practices vary from state to state, offenders who are acquitted as not guilty by reason of insanity are often placed in mandatory outpatient treatment (conditional release programs), as are persons found incompetent to stand trial and persons who fall under the jurisdiction of laws regarding dangerous mentally ill offenders. Another category of offenders who may be given outpatient treatment are sex offenders. Although a number of states have sexual psychopathology laws related to the treatment of these persons, a discussion of such treatment is beyond the scope of this paper.

Methods

MEDLINE, *Psychological Abstracts*, and the *Index to Legal Periodicals and Books* were searched from 1978, and all pertinent references were obtained.

Results

Treatment within a criminal justice context

Both the mentally ill offender and the therapist must satisfy legal requirements, such as regular attendance and periodic progress reports. The patient must comply with legal restrictions such as abstinence from drugs and alcohol. Moreover, mentally ill offenders must come to terms with the fact that they have committed an illegal act and that they have been judged to have a psychiatric disorder and to need treatment.

Both the criminal justice system and forensic clinicians generally expect that mentally ill offenders given treatment will gain some understanding of the role of their psychiatric disorder in past and potential future dangerous behavior and that they will avoid behavior or situations that might increase the risk for criminal activity or a deterioration in their clinical condition (7–9). Moreover, both society and the criminal justice system expect that treatment will be conducted under conditions that can, to the greatest extent possible, ensure public safety.

Thus a balance must exist between individual rights, the need for treatment, and public safety (7,10–12). However, it has been argued that courts place a greater emphasis on the potential dangerousness of the mentally ill offender than on the individual's rights (5,6). In so doing, the courts place the burden on the mentally ill offender to demonstrate that he or she no longer poses a danger to the community.

Outpatient treatment for severely mentally ill offenders is not designed to make presently dangerous individuals nondangerous. Rather, the criminal justice system presumes that mentally ill offenders placed in outpatient treatment will not be dangerous to others while under supervision and treatment in the community. A primary concern in outpatient treatment of these individuals is to assess any changes in mental condition that may indicate dangerousness and to reduce potential threat of harm. Therefore, features that contribute to a patient's risk of harm are addressed first in treatment. Miraglia and Giglio (8) note that "an ability to assess dangerousness and to incorporate this assessment into an intervention strategy is the single most important skill for the outpatient clinician to possess." Thus clinicians must have as great as possible an understanding of each patient's potential for violence as a function of his or her history and psychiatric condition (13,14).

In contrast, in nonforensic psychiatric treatment, the primary focus is usually on alleviation of symptoms. Clinicians who treat mentally ill offenders need to recognize that they have assumed responsibility not only to the patient but to society in ensuring the patient's safety to the community. This responsibility is not as central when clinicians are treating nonoffenders.

Challenges of community treatment of mentally ill offenders

Severely mentally ill individuals who have committed criminal offenses represent a challenge to outpatient clinicians. The problem lies not only in ensuring safety to the community but in working with individuals who may be resistant to treatment (12).

A large proportion of severely mentally ill persons who commit criminal offenses have a history of being highly resistant to psychiatric treatment before their involvement in the criminal justice system (15,16). They may have refused referral, may not have kept appointments, may not have been compliant with psychoactive medications, and may have refused appropriate housing placements. Problems of resistance may continue after release from incarceration even when the person remains under the jurisdiction of the criminal justice system (17,18). Moreover, for many individuals, the nature and extent of their mental illness and propensity for criminal behavior places them at risk to the community. This risk is heightened if they are resistant to treatment, a fact that the treating professional must always keep in mind.

To underscore this problem, much evidence has accumulated in recent years supporting a relationship between mental illness and violence, especially among persons who are currently psychotic, do not take their medications, and are substance abusers (19–26). The mental health system finds many resistant mentally ill persons extremely difficult to treat and is reluctant or unable to serve them (2,27). The reluctance becomes even greater after these persons have committed offenses, become involved in the criminal justice system, and are referred to community agencies.

The disinclination to serve these persons extends to virtually all areas of community-based care, including therapeutic housing, social and vocational rehabilitation, and general social services (2). Moreover, many mentally ill offenders are intimidating because of previous violent, fear-inspiring behavior. Treating them is very different from helping passive, formerly institutionalized patients adapt quietly to life in the community (28). Thus community mental health professionals not only are reluctant but may also be afraid to treat offenders with mental disorders (4). Professionals may work in treatment facilities that do not adequately provide for staff safety, do not possess the author-

ity and leverage of the criminal justice system, and do not provide treatment interventions with adequate structure for this population.

Another important obstacle to severely mentally ill offenders receiving outpatient treatment is that community mental health resources may be inappropriate (29,30). For instance, they may be expected to come to outpatient clinics, when the real need for many in this population is for outreach services where professionals come to them.

Identifying a treatment philosophy

To work effectively with this extremely difficult group of patients, several writers have emphasized the necessity of identifying and articulating a treatment philosophy of both theory and practice (8,31,32). This philosophy, as already mentioned, should strike a balance between individual rights and public safety and use treatment services that take both into account (12). A reality-based treatment philosophy is needed, one that includes clear treatment goals, with attention paid to goals expressed by the patient; a close liaison with the court or other criminal justice agency monitoring the patient, including access to each patient's database from the criminal justice and mental health systems; and an emphasis on structure and supervision.

The philosophy should also include the need for treatment staff who are comfortable using authority and setting limits, emphasis on the management of violence and recognition of the importance of psychoactive medication, and incorporation of the principles of case management. Appropriately supportive and structured living arrangements should also be a focus, with an emphasis on patients' ability to handle transition. Finally, the philosophy should recognize the role of family members and significant others in the treatment of patients.

It is also important to emphasize the legal and ethical aspects of treating persons under the jurisdiction of the criminal justice system. Before mentally ill offenders are asked to consent to outpatient treatment, they should be apprised of all the conditions and limitations that will be imposed on them, why they will be imposed, and what will happen if they do not comply (11). Areas to be addressed include limits to confidentiality, with respect to both past and present treatment and criminal history, and conditions under which such information must be shared with criminal justice system personnel (12); supervision and monitoring by various authority figures, such as probation or parole officers, judges, therapists and case managers; mandatory compliance with treatment and other imposed conditions; and residence in an appropriate living situation. The patient must understand that noncompliance with the terms and conditions may result in revocation of outpatient status. It is also imperative that the treatment staff understand fully the patient's legal status and conditions for community placement and agree to monitor and uphold them. Staff members must accept their role as agents of social control.

Behavioral contracting has gained many adherents (11,33,34). In a forensic setting, a behavioral contract may be developed with patients in which they are clearly informed about the treatment conditions to which they must adhere and the consequences for violating them. These conditions may include medication compliance; keeping therapy and case management appointments; refraining from alcohol and drug use, with blood and urine screening to monitor substance use; not possessing weapons; living in a specified and supportive housing situation; seeking and retaining employment; and having no contact with victims of their crimes (12).

Treatment goals

Generally, forensic mental health professionals believe that community treatment of severely mentally ill offenders should focus on stabilization of the illness, enhancement of independent functioning, and maintenance of internal and external controls that prevent patients from acting violently and committing other offenses. It is hoped that patients will share these goals. Patients should at least have the goal of avoiding further involvement with the criminal justice system (35). Important points for discussions between the clinician and the patient are the patient's understanding of which behaviors and symptoms are of concern, why they are of concern, what is expected of the patient both by the clinician and by the supervising criminal justice agency, and how the treatment can help the patient to meet these expectations (36).

Even patients with severe psychiatric symptoms may be able to understand these elements of treatment and adopt appropriate attitudes toward treatment (37). Thus a full resolution of symptoms is not always needed for treatment to be viable in a community setting. For some chronic and severely mentally ill persons, total elimination of symptoms is not a realistic goal. Rather, the primary prerequisite for safe and effective community treatment may be patients' ability to understand and accept their clinical needs and the system's legal requirements and to demonstrate compliance (7).

Liaison between treatment staff and the justice system

An essential aspect of treatment is a close liaison between treatment staff and the criminal justice system, including the court, the district attorney's office, the departments of probation and parole, and the patient's counsel (38). At the core of the liaison is a complete and relevant database, which is fundamental in understanding the extent of the patient's problems, determining whether outpatient treatment is appropriate for the patient, and developing a treatment plan. The database should include arrest reports, "rap sheets," hospital records, evaluations by court-appointed psychiatrists or psychologists, results of psychological testing, probation reports, and records from previous hospitalizations, outpatient treatment, and incarcerations.

A successful liaison requires open, frequent, and continuing contact between the two agencies. In addition, both must respect the other's perspective and accept that they are both working toward the same goals. Together the mental health and criminal justice systems lend their expertise in developing and modifying the most

effective community treatment program for patients. Both must accept that such a program cannot be effective for certain individuals.

The need for structure

Usually, patients referred for mandatory outpatient treatment lack internal controls; they need external controls and structure to organize them to cope with life's demands (39–41). For instance, forensic mental health professionals generally believe that staff should insist that patients' days be structured through meaningful, therapeutic activities such as work, day treatment, and various forms of social therapy (42). Another basic element of structure for this population is that treatment is mandatory and under the jurisdiction of the criminal justice system.

What effect does involuntary treatment have on severely mentally ill offenders? Compliance has been shown to increase when offenders are required to undergo involuntary treatment (43,12). Compliance is important because it is generally assumed that severely mentally ill offenders who do not comply with treatment present an increased risk to the community. Thus treatment noncompliance may in and of itself result in incarceration or rehospitalization.

In many ways, the criminal justice system tends to view outpatient treatment or conditional release programs as a privilege and as provisional; such programs are not regarded as the right of the mentally ill offender (5). Thus the courts are not obliged to grant such treatment. If granted, the courts allow the state to quickly and easily revoke it. The possibility of revocation of outpatient status gives the treatment staff powerful leverage to ensure adherence to the treatment conditions.

Using authority comfortably

A clear conception of the clinical uses and therapeutic value of authority appears to be a cornerstone of successful community treatment for severely mentally ill offenders (11,32,38). When treatment is effective, the staff are not ambivalent about the use of authority. They are comfortable about insisting consistently and reasonably that the imposed conditions be followed, monitoring patients' compliance with prescribed psychoactive medications, and monitoring patients to detect the use of alcohol or illegal drugs. They have no problems with insisting that patients live in appropriately structured and supportive residential settings as a condition for remaining in the community. They are willing to promptly rehospitalize patients in community facilities at times of crises and are willing to recommend revocation of patients' community status and return them to the responsible criminal justice agency with the opinion that community treatment is no longer appropriate.

Encouraging staff to use their authority and resolve whatever concerns they may have about doing so is essential for effective mandated outpatient treatment. Although there is far more to such treatment than simply setting limits and conducting surveillance, mental health professionals may feel ambivalent about enforcing the essential elements of this type of treatment (8) or may have a need to always be perceived positively by their patients. In some cases, difficulty in setting limits may indicate a lack of real caring for patients (11).

Management of violence

It is important that therapy focus on high-priority issues such as the need for the patient to control impulses and inappropriate expressions of anger (7). Persons whose violence is rooted in an axis I condition often experience their violence as a frightening loss of control (11). Because their violent acts often occur in the context of psychosis, they tend to perceive a clinician who is not aware of their destructive potential as unable to protect them. Likewise, persons whose violence is rooted in a personality disorder need the safety of knowing that the clinician is aware of their potential for violent behavior and will act to control it. They tend to establish that knowledge by testing the clinician for limits. The clinician must be continuously alert and firm in order not to risk being perceived as uncaring and unable to protect the patient from his or her own destructiveness. Wack (11) believes that treatment contracts that deal with expectations and consequences openly and from the beginning provide a helpful structure for working with these potentially violent patients.

Dvoskin and Steadman (9) have pointed out that persons with severe mental illness, especially those with histories of violent behavior generally need continuous rather than episodic care. Thus regular monitoring is needed, especially when symptoms are absent or at a low ebb, to deal with individual and situational factors that may result in violence.

For this mentally ill population, a large number of whom have problems involving control and violence, the importance of antipsychotic medications, including the atypical antipsychotic agents, cannot be overemphasized (44,45). Evidence also supports the use of other agents such as beta blockers, carbamazepine, selective serotonin reuptake inhibitors, and lithium (45,46). In addition, behavioral, cognitive, and psychoeducational techniques emphasizing anger management have been widely used in the treatment and management of violence (46–48).

In discussing problems of noncompliance, Diamond (49) states that a closely related issue is that of autonomy, or the need for individuals to feel free of disorder and in control of their lives. Severely mentally ill persons who have been incarcerated frequently enter outpatient treatment while still taking medication and may for the first time in years find themselves symptom free, in control of their violent impulses, and able to function in the community. After a while they may feel that they can succeed without medication; they discontinue its use, decompensate, and perhaps engage in violent behavior. For some, such an experience, more than anything a clinician may say to them, ultimately convinces them that they need to stay on medication even when asymptomatic. However if compliance is to be ensured, some patients must live in a community facility in which each dose is dispensed by staff.

Integrating treatment and case management

Solomon (50) has identified case management as a "coordinated strategy on behalf of clients to obtain the

services that they need, when they need them and for as long as they need these services." The integration of modern concepts of case management with clinical treatment is an important component of successful outpatient treatment for mentally ill offenders (31,51,9). Almost all these patients need the basic elements of case management, which starts with the premise that each patient has a designated professional with overall responsibility for his or her care.

The case manager formulates an individualized treatment and rehabilitation plan with the patient's participation. As care progresses, the case manager monitors the patient to determine if he or she is receiving treatment, has an appropriate living situation, has adequate funds, and has access to vocational rehabilitation (52). The treatment plan emphasizes helping the patient deal with practical problems of daily living. In addition, the case manager provides outreach services to the patient wherever he or she is living, whether alone, with family, in a board-and-care home, or in another residential setting.

Outreach services may take the form of assertive case management. An assertive case management program deals with patients on a frequent and long-term basis. It takes a hands-on approach that may necessitate meeting with patients on "their own turf" or even seeing a patient daily (53). This form of contact and familiarity with the patient helps the case manager anticipate and prevent a significant decompensation. Low caseloads for case managers of potentially violent mentally ill persons– probably not more than ten cases– have been recommended, as has 24-hour, seven-day-a-week availability (9). Many violent acts and arrests occur during evenings, nights, and weekends, when traditional treatment programs are closed.

Before accepting case management, some mentally ill offenders first ask, "What's in it for me?" (9). Patients who perceive the case manager as mainly an agent of the criminal justice system, whose primary intention is to make them "toe the line," will be less likely to form a positive relationship with a case manager. They may be guarded and defensive in their interactions. Patients may be less inclined to be candid and may feel a need to portray themselves in a good light, even though they have problems for which they need help. Therefore, patients must see the case manager as their advocate to further their treatment and rehabilitation, particularly when agencies in the criminal justice system are simultaneously dealing with them in more coercive or authoritarian ways.

Dvoskin and Steadman (9) discuss some of the stress and problems case managers experience. They may feel, with some justification, that they are in personal danger if they work with mentally ill offenders who have been violent in the past or if their work requires visits to high-crime areas, where many persons with serious mental illness live. Additional problems may include unusual working hours, which may disrupt their family and social relationships, and lack of upward career mobility. Finally, forensic case managers may feel mixed loyalties to their clients and the criminal justice system in terms of role contradictions (54).

Therapeutic living arrangements

Survival in the community for the great majority of offenders with serious mental illness appears to depend on an appropriately supportive and structured living arrangement (32). Such an arrangement can often be provided by family members. However, in many cases the kind and degree of structure the patient needs can be found only in a living arrangement outside the family home with a high staff-patient ratio, dispensing of medication by staff, enforcement of curfews, and therapeutic activities that structure most of the patient's day.

Some patients need a great deal of structure and supervision in their housing situation, others need only a minimal amount, and most fall somewhere in between. How much structure does a patient need? The treatment staff member assigned to the patient or the patient's case manager must decide whether a particular living arrangement has the appropriate amount of structure to meet the patient's needs. However, it is necessary to first discuss the suggested living arrangement with the responsible agent in the criminal justice system and obtain his or her approval.

A consideration for all patients who move from a closed or locked setting such as a forensic hospital, jail, or prison is the patient's ability to handle transition (55–57). It is generally not advisable for persons who have been hospitalized or incarcerated for a long time to be placed in the community in a living situation with little or no structure. Such individuals are frequently unable to cope with the immediate stress and demands of these arrangements, and they either decompensate or commit subsequent offenses.

Therefore, it is helpful to release many severely mentally ill offenders to graduated lower levels of structure– for example, from prison or a forensic hospital to a locked community facility to a halfway house and, when they are ready, to family or independent living. In the graduated release process, close attention must be paid to patients' coping skills and need for monitoring. A brief hospital stay may be necessary when patients decompensate under stress.

Working with the family

The role of family members or significant others can be critical in the treatment of mentally ill offenders (4). The treatment team should determine whether these individuals were the victims of the patient's aggression and whether they have maintained contact with the patient. The team should also learn whether other social support systems are available while the patient resides in the community. Social support can be an extremely important part of community treatment for mentally ill offenders (7,58). Assessing problems that may develop between the patient and family members or significant others is essential if contact between them is anticipated.

Another important consideration is the family members' needs for guidance and support, especially when they have been victimized by the patient. Clinicians should help them understand the patient's mental condition, teaching them to recognize symptoms of decompensation, dem-

onstrating methods for self-protection, and explaining the patient's current legal situation (4,59–61).

Moreover, family members should be involved in support groups to help them during crises; in self-help programs they can benefit from the experience of other families in similar situations (62).

Pitfalls

Mental health professionals must understand their potential liability for the actions of their patients who are on community status (5,63). They need to be aware that in some states, courts have imposed on therapists a duty of care that extends to foreseeability of harm. Moreover, the litigious nature of our society adds further pressures and risks. Treating clinicians may be held accountable for patients' suicides, assaults, homicides, and other crimes, even when treatment was mandated, sound, and met the professional community's standards of care. In both public agencies and private practice, malpractice insurance coverage must be adequate so that clinicians feel comfortable, personally and professionally, in undertaking the treatment of severely mentally ill offenders.

Another important concern of clinicians involved in the community treatment of mentally ill offenders– especially sex offenders and persons who have committed high-profile crimes– is the possibility of notoriety and unfavorable publicity. Clinicians may fear that if patients commit further sensational crimes, their professional reputation will suffer.

Rice and Harris (64) point out the conflicting pressures on professionals attempting to treat mentally ill offenders. The pressures may be unrelated to objective considerations about what is best for the patient and the treatment. On the one hand, a variety of formal and informal complaints and lawsuits may be lodged by patients about their detained (locked) status; they may argue that they no longer pose a danger to society and are ready for community rehabilitation. For such reasons, some mentally ill offenders may be inappropriately released to community treatment. On the other hand, if a mentally ill offender in community treatment commits a high-profile crime, the agency and the clinician may have to deal with an understandably angry community and devote much time and energy to defending themselves and perhaps preparing for litigation.

Furthermore, it must be recognized that not all mentally ill offenders can be treated effectively in the community. Tellefson and associates (65) emphasize the importance of identifying high-risk patients so that scarce treatment resources are used for those most likely to succeed and least likely to incur the high costs of hospitalization and rearrest for exacerbations of illness or aggressive behavior.

Conclusions

Creating a successful treatment program for severely mentally ill offenders is a difficult task that demands the input and cooperation of professionals who are knowledgeable and accepting of the tenets of both the criminal justice system and mental health treatment. The terms and conditions for community outpatient treatment imposed by the criminal justice system should not be developed in a vacuum. It is strongly recommended that mental health professionals familiar with forensic patients and issues be consulted from the beginning. That is, forensic clinicians should have input into determining under what conditions and when a patient is ready for outpatient status. If such conditions exist, and if they ensure that the patient does not pose a threat of harm, community treatment should be instituted.

As mentally ill offenders are treated in the community, it is hoped that a close liaison develops between mental health treatment staff and criminal justice system personnel to assess patients' progress and needs. With frequent consultation and respect between these two professional groups, a trusting relationship can be fostered that will ultimately benefit both patients and the community. ♦

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