Adult Probation Department Mental Health Unit: An Outcomes Investigation

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This study examined the outcome of probation cases (N=241) within the Cook County Adult Probation Department-Mental Health Unit (MHU) and followed the rates of recidivism among these cases from 2001 through 2004. The study was conceived to identify specific program operation areas in need of improvement within the Adult Probation Department-Mental Health Unit. From the inception of the unit, program operations changed little until the Illinois Office of Mental Health required that the unit become Medicaid certified (Title 59-Part 132 Medicaid community mental health services program) in 1997. This certification brought about wide, sweeping programmatic changes, which transformed the unit into a clinical unit comparable with very few in the country. This study found that 39% of the 241 cases did not re-offend in a three-year period. The study authors conclude that this positive result is due in large part to the case management style used by probation officers and the state oversight of the unit. This study demonstrates that planned programmatic improvements can have a positive effect in supervision of the mentally ill.

The Mental Health Unit (MHU) of the Cook County Adult Probation Department in Cook County, Illinois, serves probationers who have received a diagnosis of severe and chronic mental illnesses (e.g., schizophrenia, bipolar disorder, and major depression). Many of these probationers also have drug and/or alcohol addictions. In addition to the sophisticated case management required to alleviate these problems, probationers often have additional needs for housing, food, acquiring entitlements (social security income and medical coverage), and employment. Probation officers must possess knowledge in each of these disciplines (e.g., substance abuse, housing, Medicare and Medicaid funding, criminal law procedures, psychiatry, etc.) to interact effectively with the probationer to achieve a desired outcome. In effect, the MHU officers are what Steadman (1992) calls "boundary spanners"—individuals who must have firsthand knowledge in the fields of law enforcement, mental illness, substance abuse issues, and social work. This approach forms the core of the MHU case management approach, which includes interventions with probationers, constant resource maintenance and development, and clinical practice.

The case management style the unit employs is a unique mix of the criminal justice and mental health systems. Mental health settings typically view case management in terms of services provided and they refer to individuals as patients; however, the criminal justice system portrays management as supervision and refers to individuals as probationers. The former implies an agent at a designated treatment site performing services to improve symptoms. The latter implies court monitoring for purposes of rehabilitation and reduction of criminal recidivism. Case management services within the unit do not exactly mirror traditional community mental health models such as assertive community treatment (ACT) or intensive outpatient treatment. Nor does the unit's supervision fit with traditional risk/needs classifications of probation supervision models such as intensive probation supervision (IPS) or regular caseload. Rather, the style is an interrelated and multitiered system of case management practices that has evolved over the years. The MHU can be conceptualized as a fluid interaction of case management within both the criminal justice system and the mental health system with the criminal justice system as the outer parameter of case

management. All cases assigned to the unit have a mental health mandate from the court, which requires probationers to participate in mental health treatment. Additionally, the court may impose other special conditions on the probationer such as no contact with victim, random urinalysis testing, and payment of fees. The MHU adheres to phases as a method of supervision/case management. The phases provide a structured reporting requirement for probationers. Additionally, fieldwork is another component of policy that requires officers to engage probationers in their community, make resource contacts, and speak with family members.

The relationship between MHU probation officers and probationers is delicate and complex. The MHU philosophies (care and intervention versus surveillance) and the treatment options available to probationers influence treatment implementation and criminal activity outcomes (Skeem, Encandela, & Eno Louden, 2003). This study sought to understand the long-term outcomes of 241 probation cases within the MHU, specifically, the recidivism rate of probation cases terminated in 2001, along with understanding how the effects of treatment can have positive outcomes (e.g., remaining mentally stable and arrest-free through appropriate treatment) of mentally ill probationers. Unit managers can use the information gained from this study to improve the unit's effectiveness while helping to make the unit a model for other correctional departments dealing with the mentally ill.

Literature Review

In 1999, the U.S. Department of Justice, Bureau of Justice Statistics estimated that mentally ill people composed 16.0% of the American prison and jail population. This special report also noted that the percentage of probationers in the United States who were mentally ill was similar (16%). Slightly more than one half (56%) of these probationers but less than one half (41%) of the jailed probationers received treatment for their mental illnesses (Ditton, 1999). The failure to identify and treat the mentally ill who enter the criminal justice system perpetuates a cycle of symptomatic behavior, substance abuse, homelessness, and arrests (Lurigio & Swartz, 2000; Lurigio, Thomas, & Jones, 1996; Teplin, 1990). This pattern became established after the shift in public policy from the institutionalization of persons with mental illness to their release for treatment in the community. Although state hospitals had been ridiculed as inadequate, sufficient community-based care for the mentally ill was never established (Lurigio & Swartz, 2000). Lurigio et al. (1996) point out that patients without family and employment, or whose mental illness was poorly controlled by prescribed drugs, faced homelessness and criminal incarceration.

Diagnostic Limitations

Due to this unintended use of the criminal justice system for the management of mentally ill persons, their contact with service providers who can make diagnoses and provide treatment may be delayed, limited, or fail to occur (Lurigio, Fallon, & Dincin, 2000; Teplin, 1990). The priorities of the criminal justice system differ from the mission of treatment agencies. By necessity, the criminal justice system must focus primarily on public safety and probationer supervision rather than the provision of social services. For this reason, mental health assessments and treatments are often unavailable to criminal probationers. These problems are compounded for mentally ill probationers with substance abuse problems. Current methods for the assessment of substance abuse were not designed for use with mentally ill persons. They are inadequate

screens for this condition due to patterns of use and treatment processes that differ from those of persons who are not mentally ill (Wolford et al., 1999).

Treatment of the Noncompliant

A number of individual, societal, and systematic factors contribute to treatment noncompliance among mentally ill probationers. They include lack of entitlements, homelessness, poverty, poor insight into their illnesses, medication noncompliance, substance abuse, and lack of access to dual diagnosis treatment. In working with probationers, the Mental Health Unit helps negotiate each barrier to reduce the chance for noncompliance, particularly for two factors: the loss of entitlements and medication noncompliance. Probationers experience a discontinuation of benefits when they are incarcerated. Once released the probationer must see a psychiatrist again and start a regimen of psychotropic medications. Many psychiatric medications cause side effects such as facial tics, blurred vision, dry mouth, slurred speech, rapid weight gain, and slowed gait. These side effects cause discomfort and make the probationer less likely to continue use of these medications. Probationers often tell MHU officers that these side effects make other people react differently to them and cause them to isolate themselves from others. If the medications alleviate some symptoms, probationers may think they can stop the medications and maintain their current functioning. At that point, the probationer might require hospitalization to control symptom renewal.

Issues of Substance Abuse

Substance abuse has become an increasingly more significant factor in the mentally ill probationer's noncompliance with treatment and probation. Hartwell (2003) states that living in the community with the double stigma of mental illness and a criminal background is problematic for many probationers. High rates of substance abuse among this population compound the issues related to helping those with mental illness (Draine & Solomon, 1994; Solomon & Draine, 1999a; Swanson, Borum, & Swartz, 1996). As this study shows, 70% of the MHU census was classified as having a dual diagnosis (co-occurring mental illness and substance use disorder). It has become more and more important that each MHU officer be, first, familiar with the drug culture and then proficient in working with probationers with these dual diagnoses. We encounter mentally ill probationers in differing stages of their addiction (relapse, sobriety, maintenance, binge using, etc.), and our experience has shown us that we must intervene before they are arrested on a related offense, decompensate, and need to be hospitalized. One option is facilitating admission to detoxification and inpatient dual diagnosis treatment. One of the barriers we have encountered is drug treatment facilities that have few available dual diagnosis beds or few staff who can deal effectively with the dual diagnosis. A probationer must be stable enough to participate in the treatment environment. Some facilities require psychiatric clearance before an admission, which poses another barrier to addiction treatment. A probationer with a dual diagnosis may be slightly symptomatic, and believing the probationer would be disruptive, substance abuse professionals might deny that individual entry into treatment. These issues hinder access to those who need these services at such a critical time.

Methods

This study examined the long-term outcomes of each offender terminated from the Cook County Adult Probation Department-Mental Health Unit in 2001. Data were collected from probation records and the Law Enforcement Administrators Data System (LEADS). The probation data consisted of case history, record sheet, felony or misdemeanor arrest records, and mental health intake assessment. The mental health section assessment included a description of symptoms, drug and alcohol history, current mental status, prior psychiatric history, medications (current and past), social history, and social entitlements. It also included medical records that were obtained by the officer from previous treatment providers. The culmination of the information gathered in the mental health assessment results in the probationer receiving a clinical diagnosis from one of the MHU officers guided by the American Psychiatric Association's *Diagnostic Statistical Manual of Mental Disorders*, 4th edition (1994), or *DSM IV*.

A LEADS response was conducted on the 241 cases that terminated in 2001 to see whether any new arrests or convictions had been recorded. In the event of an arrest, the LEADS response was carefully reviewed to determine whether the arrest was a misdemeanor or felony arrest. These arrest types were then grouped into specific crime activity categories by specifying the type of crime that was committed.

Population Size and Sample Selection

The sample comprised 241 probationers whose cases were screened for eligibility or directly mandated to the MHU. The eligibility criterion was probationers with mental illness, both chronic and severe. Table 1 lists the mental health diagnoses of the participants in this study.

Table 1. *Primary Mental Health Diagnoses of Probationers*

Primary diagnosis	Number of Probationers (*n*)	Percent
Schizophrenia	57	24%
Major Depressive Disorder	49	20%
Bipolar Disorder	44	18%
Schizoaffective Disorder	34	14%
Alcohol/Drug Dependence	1	0.4%
Learning Disorder/Dementia	2	0.8%
Other Diagnosis	25	10%
Missing data	29	12%
Total	241	100%

Note. Missing data is defined as probationers that have either been incarcerated in prison, have absconded, and are deceased. This means the probationer's assessments were considered incomplete due to the above circumstances.

The first phase of the study also found that 82% of probationers had felony convictions; misdemeanor convictions totaled 17%. The Bureau of Justice Statistics (U.S. Department of Justice, 2004) reported the total number of adults sentenced to a term of probation in the United States totaled 49% for felony convictions and 50% for misdemeanor convictions. These notable differences suggest that MHU officers deal with a very difficult population. Supervising the vast majority of the MHU probationers involves a deep understanding of the criminal justice system as well as mental health issues.

Table 2. *Primary Charge: Offenses/Convictions Affecting Sentencing Outcomes*

Offense	Number of Probationers	Percent
Delivery/Possession of a Controlled Substance	73	30.3%
Theft/Forgery/Fraud	39	16.2%
Burglary/Possession of a Stolen Motor Vehicle	26	10.8%
Aggravated Robbery	12	5.0%
Threatening/Obstructing/Resisting a Public Official	2	0.8%
Stalking	2	0.8%
Assault/Battery	7	2.9%
Aggravated Assault/Battery	21	8.7%
Domestic Assault/Battery	17	7.1%
Unlawful Possession/Use of a Weapon	6	2.5%
Arson/Aggravated Arson	4	1.7%
Vandalism	3	1.2%
Trespassing	1	0.4%
Other	28	11.6%
Total	241	100%

Variables and Data Collection Procedures

In the first phase of the study, we chose the following variables in a case to measure a probationer's outcome:

- Age at time of sentencing,
- Sex and race,
- Length of sentence,
- Primary charge,
- Class of offense,
- Dual diagnosis or mental illness diagnosis only
- Primary diagnosis,
- Primary substance abused,
- Number of violations of probation (technical violations and new arrests),
- Residence at termination (including type of residence at termination),
- Number of jail stays while on probation,
- Type of termination, and
- Whether transferred from other probation units to the MHU.

We collected the majority of the information from a review of the adult probation case data sheets. Other data was collected from mental health assessments and medical records.

Some variables require further definition. The primary charge was broken down into 13 varied offenses plus an additional category (Other) (see Table 2). These offenses could have been categorized into drug offenses, property offenses, and assaultive (physically or verbally) offenses; however, categorizing these offenses into 14 separate ones gives a detailed view of the probationer's arrest.

This study reviewed whether a probationer had a dual diagnosis and what the primary diagnosis was. We determined a probationer's primary diagnosis by reviewing the probationer data sheet and the unit's mental health assessment (intake). The *DSM IV* (1994) defines the criteria for primary diagnosis. The criteria focused on the major mental illnesses (major depression, bipolar disorder, schizophrenia) and included alcohol and drug dependence.

Data Analysis

The variables were analyzed by using SPSS software to examine the probationer characteristics and sentence variables. Descriptive statistics along with ANOVA comparisons were conducted with the use of the SPSS software. Demographic characteristics are race, age, prior hospitalization, diagnosis, dual diagnosis, drug use, sentence type, offense type, and information concerning the index arrest and re-arrest. Analysis was done to examine the statistical relationship between these variables.

Limitations

One limitation of this study is that some arrest data were missing either from files or LEADS responses. While this investigation examined probation cases within the MHU of the Cook County Adult Probation Department, it did not evaluate a comparison group of other types of specialized probation cases within the Cook County Adult Probation Department.

Results

Results of this longitudinal study include analysis of the data from the 2001 study along with data from the 2004 investigation.

Probationer Characteristics

Most (72%) probationers assigned to the MHU were men. More than one half (58%) were African-American and more than one third (36%) were White. Only 5% of these probationers were Hispanic. On average, probationers were hospitalized for mental illnesses six times in their lifetimes. Only 15% of them had never been hospitalized for their mental illnesses. Table 3 shows area of interest in gender diagnoses for the MHU.

Table 3. *Areas of Interest in Gender Diagnoses of Mental Health Probationers*

Mental Health Diagnosis	Gender	Percent
Schizophrenia	Male	31%
	Female	16%
Bipolar Disorder	Male	21%
	Female	20%
Schizoaffective Disorder	Male	18%
	Female	10%

A larger percentage of White (30%) than African-American (15%) probationers had a diagnosis of bipolar disorder; however, more African-American (32%) than White (17%) probationers had a diagnosis of schizophrenia. Comparable proportions of White and African-American probationers had a major depressive disorder (25% and 22%, respectively) and schizoaffective disorder (15% and 16%, respectively).

Seventy percent of probationers had dual diagnoses of a mental illness and substance abuse. No significant differences existed between men and women in this regard. However, a greater proportion of African-American (77%) than White probationers (59%) had both these conditions. The primary substances of choice for this group of probationers were alcohol (28%) and cocaine or crack cocaine (31%). In addition, 21% of these probationers preferred marijuana, while 8% of them had a heroin addiction. Table 4 shows area of addiction for the MHU probationers.

Table 4. *Areas of Addiction for Mental Health Probationers*

Substance	Gender	Percent
Alcohol	Male	34%
	Female	15%
Marijuana	Male	24%
	Female	15%
Cocaine/Crack Cocaine	Male	30%
	Female	36%

Greater proportions of White (46%) than African-American (21%) probationers were addicted to alcohol. Instead, a greater percentage of African-American than White probationers abused cocaine or crack cocaine (36% and 17%, respectively) or marijuana (26% and 12%, respectively).

Most of the probationers (82%) were sentenced for felonies, but 18% received probation sentences for misdemeanors. Almost one third (30%) of the probationers were convicted of a drug offense. The same proportion (30%) had committed a violent offense. In addition, more than one fourth (27%) of the probationers were convicted of burglary, theft, forgery, fraud, or possession of a stolen motor vehicle.

A greater proportion of women (91%) than men (79%) were sentenced for felonies, but comparable proportions of men and women committed the various types of crime. A higher proportion of African-American (89%) than White (72%) probationers were convicted of felonies. Table 5 gives an itemization of certain types of crimes the MHU deals with.

Table 5. *Types of Crimes of Which Mental Health Probationers Were Found Guilty*

Types of Crimes	Race	Percent
Violent Crimes	White	22%
	African-American	22%
Drug Offenses	White	17%
	African-American	41%
Theft/Forgery/Fraud	White	25%
	African American	12%
Burglary/Possession of a Stolen Auto	White	6%
	African American	11%

Not surprisingly, a greater percentage of probationers with dual diagnoses (42%) than solely mentally ill probationers (12%) were serving sentences for drug offenses; however, a larger proportion of solely mentally ill probationers (33%) than dually diagnosed probationers (20%) had been convicted of violent crimes.

Recidivism Rates

As Table 6 shows, the number of new arrests after probation was terminated has significant meaning in relation to whether the MHU is doing a good job with difficult individuals who are sentenced to probation. The finding that 39% of probationers had no new felony or misdemeanor arrests after probation termination is a good indication that the MHU deals effectively with the mentally ill.

Table 7 shows the gender and race data of MHU probationers re-arrested after termination. More specifically, the data show a significant difference in the number of males and females who were re-arrested in each of the four ethnic groups. In each of the ethnic groups, more males than females were re-arrested after probation was terminated. The number of both male and female MHU probationers who were re-arrested after probation was terminated totaled 42 Whites, 92 African–Americans, 5 Hispanics, and 2 that were categorized as Other.

Table 6. *Number of New Arrests After Termination of Probation (from 2004 LEADS Response Data)*

Number of Arrests	Number of Probationers	Percent
0	93	39%
1	44	18%
2	37	15%
3	14	6%
4	7	3%
5	5	2%
6	11	5%
7	1	0.4%
8	2	0.8%
9	3	1%
10	2	0.8%
11	2	0.8%
13	3	1%
14	1	0.4%
16	1	0.4%
18	4	2%
19	2	0.8%
24	1	0.4%
65	1	0.4%
Missing from data	7	3%
Total	241	100%

Table 7. *Gender and Race of MHU Probationers Re-arrested after Termination*

Gender	Race	Number of Probationers	Percent
Male	White	30	21%
Female	White	12	9%
Male	African-American	75	53%

Female	African-American	17	12%
Male	Hispanic	4	3%
Female	Hispanic	1	0.7%
Male	Other	1	0.7%
Female	Other	1	0.7%
Total		141	100%

Tables 8 and 9 show the number of misdemeanor and felony arrests of individuals after probation was terminated. The percentage of individuals with no new misdemeanor arrests was 50% while the percentage of individuals with no new felony arrests was 67%.

Table 8. *Number of Misdemeanor Arrests After Termination of Probation*

Number of Arrests	Number of Probationers	Percent
0	120	50%
1	46	19%
2	18	8%
3	13	5%
4	7	3%
5	9	4%
6	4	2%
7	1	0.4%
8	1	0.4%
9	2	0.8%
10	2	0.8%
11	1	0.4%
13	2	0.8%
14	1	0.4%
16	1	0.4%
17	3	1%
18	1	0.4%
21	1	0.4%
64	1	0.4%
Missing from data	7	3%
Total	241	100%

The average age of MHU probationers re-arrested after termination of probation was 35.2 years. This investigation also coded the three types of termination of probation and whether those individuals were re-arrested after probation was terminated:

- The percentage of individuals who terminated their probation satisfactorily and were re-arrested was 40%;
- The percentage of individuals who terminated their probation unsatisfactorily and were re-arrested was 48%; and
- The percentage of individuals who terminated their probation cases with termination-closing interest in case was 12%.

Note: termination-closing interest in case is defined as a probation case that has not been designated as either terminating satisfactorily or terminated unsatisfactorily.

Table 9. *Number of Felony Arrests After Termination of Probation*

Number of Arrests	Number of Probationers	Percent
0	161	67%
1	39	16%
2	21	9%
3	7	3%
4	1	0.4%
5	3	1%
9	2	0.8%
Missing from data	7	3%
Total	241	100%

Finally, Table 10 shows the top three types of new arrests by race and gender after termination of probation from the MHU. In these three crime categories, 97 subjects (69%) were re-arrested.

Table 10. *Top Three New Arrest Types for MHU Probationers After Termination*

Gender	Race	Drug-Related Crimes	Number of Probationers	Violent Crimes	Number of Probationers	Property Crimes	Frequency
Male	White	20%	8	12%	5	12%	5
Female	White	10%	4	2%	1	5%	2
Male	African-American	26%	24	23%	21	9%	8
Female	African-American	7%	6	7%	6	1%	1
Male	Hispanic	40%	2	20%	1	20%	1
Female	Hispanic	20%	1	0%	0	0%	0
Male	Other	0%	0	100%	1	0%	0
Female	Other	0%	0	0%	0	0%	0

Discussion

The mission of the Mental Health Unit is not only to ensure each probationer's compliance with the court-ordered sentence but also to improve his or her quality of life (Cook County Adult Probation Department, 2005). Accomplishment of both goals is integral to the successful completion of a probation sentence for a mentally ill probationer. For this reason, the documentation of accomplishments with particular case management techniques is also important.

The distribution of types of offenses was found to be similar to that of cases seen in Intensive Drug Probation, Intensive Probation Services, and Domestic Violence. Therefore, the MHU case management technique can be applied to all types of offenses.

This study shows that the MHU manages individuals with a range of major mental illnesses. Schizophrenia, major depression, bipolar disorder, and schizoaffective disorders constitute the diagnostic classification for many probationers in the unit. The MHU officer provides unique and specialized treatment that includes case management and use of varied communication styles. A brief description of communication styles and case management objectives follows.

Case Management and Communication

Case management within the MHU has had to incorporate all of the legal aspects expected of every probation officer and the varied roles a community mental health worker uses in working with the seriously mentally ill. Officers working in the mental health unit become the point of contact for legal cases as well as the broker for mental health services and other mandated services; therefore, officers use their knowledge and expertise in communicating with attorneys, public defenders, judges, social workers, psychiatrists, and people in other disciplines. MHU officers must understand their audience and be able to articulate a message effectively to achieve a particular outcome.

As a key element of the MHU approach, officers' facility with various communication styles helps them get their message across effectively and understand the other parties' interests. The communication expertise officers' display comes from knowing their audience and tailoring the message to the individual, whether it is a client, attorney, psychiatrist, community mental health caseworker, public aid caseworker, or nursing home admissions director. This skill guides MHU officers in discussing a client's noncompliance or a proposed plan of action.

In working with a client who is severely mentally ill, the traditional probation approach is not often effective because the illness may affect the client's comprehension of information. Most of the clients supervised in the MHU have both a mental illness and a substance abuse problem. Officers may have to help reduce clients' paranoia and compel them to participate in the planned interventions. MHU officers must step into the role as mental health workers and communicate to the doctor the symptoms they observe and the urgency of moving the appointment to a sooner date. Lastly, officers must communicate to the detoxification center the nature of the client's mental health issues so they do not become a destabilizing issue during detoxification. Our end goal would be to manage the situation so it doesn't rise to a level that would require going back to court.

MHU officers must harness all the information to inform the judge where the client experiences problems and where they are succeeding. A judge has to rely at times on our assessment of the situation, which incorporates the information from psychiatrists, caseworkers, housing staff, and substance abuse providers. This information is essential for giving the judge a balanced picture of the probationer and his or her issues. At times it may be necessary to factor in the client's criminogenic factors that would interfere with an ideal recommendation by the officer. It is this level of competence the officer must demonstrate when communicating and interacting in the courtroom. In an arena where evidence, allegations, and witnesses

are the focus of daily proceedings in court, mental health officers must know how to communicate what they know in a concise and credible manner.

Aside from entitlements we are continuing efforts to communicate and develop resources with community providers. These providers vary greatly depending on what particular service we wish to explore. The most significant community providers, however, are the local mental health agencies. Officers frequently link, refer, consult, and advocate with these agencies. These community mental health centers in turn provide additional treatment services (day treatment, residential, assertive outreach) based on needs and level of care.

Skilled nursing facilities are another resource officers use. Some clients, based on their history of mental illness, may need a nursing home placement. The MHU uses various nursing homes throughout Cook County and frequently consults with staff regarding placement, monitoring, and treatment issues. Additionally, officers may have to hospitalize clients during crisis periods. Nursing home staff members often call on MHU officers for their knowledge of the MHU probationer committed involuntarily.

Another resource is substance abuse treatment. A significant number of mentally ill offenders have a co-occurring substance abuse disorder; however, integrated dual disorder treatment is lacking (Mojtabai, 2004; Lurigio & Swartz, 2000). It's therefore imperative for the unit to continue outreach possibilities to these limited agencies that provide this type of treatment. In addition staff has to be very knowledgeable about criteria and the necessary paperwork required for possible admissions.

Interventions

Interventions are a significant component to the unique case management style of officers in the MHU because of the number of interventions available and the frequency with which we can rely on them throughout the client's term of probation. On any given case, officers use myriad intervention options in either the criminal justice or mental health system. In general the following interventions within the mental health system occur: assessment, treatment plan development, counseling, monitoring, support, advocacy, crisis, staffing, collateral contacts, and consultation with other providers. In addition, officers can rely on the criminal justice system to intervene when other options fail. This reliance can take the form of returning to court for status reports, motions, violation of probations, terminations of probation, reporting options, urinalysis testing, and monitoring other conditions of probation.

Several variables come into play in determining what interventions to use and when to use them. Depending on the presenting problem(s) (e.g., non-reporting, acute symptoms, treatment noncompliance, recidivism, illegal drug use), the officer can choose mental health or criminal justice system related interventions. Other considerations that factor into selecting interventions are the client's overall history and the desired outcome. The intervention options vary on case-by-case basis. Officers must prioritize the presenting problem if it involves the client's mental/emotional condition. In a crisis situation with the presence of acute symptoms (e.g., danger to self/others, inability to care for self), an officer must pursue hospitalization.

Resource Development

Resource development is another component of case management within the Mental Health Unit and takes the following forms:

- Weekly staff meetings in which officers seek resource feedback from their peers. In this supportive environment, officers can problem solve regarding appropriate resources that benefit their clients' treatment plan development. In addition, the MHU distributes new resource materials and provides updates about particular agencies.
- Invitations to particular agency staff to talk about their services and its benefit to our clients.
- Staff and management meetings with community resource agencies to increase support and strengthen current working relationships.
- Development of new resources that enhance the quality of life for clients.

MHU clients reside within a wide geographic range in Cook County, IL, and they require a number of resources. MHU officers and management must continue and further expand relations (both informal & formal) with community providers who work with the mentally ill. Entitlements such as social security income/disability and medical coverage are basic needs for our population however jailed clients often lose their entitlements. As part of MHU case management effort, officers seek to re-establish these entitlements, and the unit's association with the Social Security Administration helps officers accomplish reinstatement of client benefits. In addition, the MHU has become familiar with required Illinois Department of Public Aid paperwork to help clients get basic medical coverage.

Supervision of dual disordered probationers presents a greater challenge. The focus for most officers has been primarily the management of a probationer's single mental illness. But the MHU's goal is to meet the challenges of those clients with substance abuse as part of the diagnostic picture.

State Oversight

The implementation of the MHU began in response partly to the increase in incarcerations instead of treatment recommendations for the mentally ill (Teplin, 1984). In addition, the criminal justice system was failing to identify and meet the needs of mentally ill offenders. A Governor's Task Force was implemented in 1985 to study and make recommendations regarding the plight of the mentally ill offender (Lurigio, Thomas, & Jones, 1996). As a result of the task force findings, the Cook County Adult Probation received a grant from the Illinois Department of Human Services, Office of Mental Health (OMH), to form the Cook County Adult Probation Department-MHU.

In 1997, the MHU became certified to provide mental health services under the state's Medicaid program. Since 1997 the MHU has had to adapt to Medicaid guidelines for community mental health services under Rule 132 (Illinois Administrative Code, 2000).

The state oversight has helped the unit focus on providing services to mentally ill offenders and acquire qualified staff to do so. The rule has provided the MHU with standard services for clients and placed more emphasis on clinical practices (e.g., diagnosis, treatment planning, staffing, and crisis response) among staff. This state oversight has also allowed the MHU to understand what is expected of them as case managers, which is similar to case manager responsibilities in other mental health centers in Illinois, and staff are more cognizant about identifying mental health issues and responding appropriately. This type of state oversight has allowed the MHU to become more involved in a client's treatment team along with other providers. In addition, the MHU has had to appropriately document the services it provides to ensure Medicaid reimbursement.

Qualified Staffing

Medicaid guidelines for community mental health services under Rule 132 (Illinois Administrative Code, 2000) has also allowed the MHU to employ qualified staff to work with mentally ill probationers. For several years, the MHU has had a licensed psychologist consult monthly to assist with difficult cases. The two supervisors helping to manage the MHU are licensed clinical social workers, five officers are qualified mental health professionals, and the remaining staff are mental health professionals with experience working with mentally ill clients. The OMH has auditors survey the unit annually to review staff credentials, verify documented services, review quality assurance, and ensure location site compliance. This type of rigorous review of the MHU by the state has allowed the Cook County Adult Probation Department to become a leader in the field of treating mentally ill offenders.

Conclusion

A growing number of probationers in jail, prison, and community corrections have severe mental illnesses. The criminal justice system has become the gatekeeper for the mental health system due to the criminalization of the mentally ill (Teplin, 1990). However, the criminal justice system has failed to properly identify and treat this special population. In addition, a gap remains between the criminal justice and mental health systems. Each system tends to remain within its boundaries and neglects the other systems' role and significance in assisting probationers with mental illnesses. To prevent criminal recidivism, the criminal justice system must make efforts to meet the needs of this special population by providing mental health treatment and related social services.

This study presents several important findings:

- The largest percentage of new arrests was for drug-related crimes. While this is not a shocking revelation, it shows the difficult tasks the MHU probation officers face in dealing with probationers who have a dual diagnosis.
- The majority of probationers have a co-occurring substance abuse diagnosis. The primary drugs of choice for probationers with a dual diagnosis were cocaine and alcohol. The supervision of this dual diagnosis population presents challenges in terms of proper assessment, treatment, and supervision. A smaller number of dually diagnosed probationers than probationers with mental illnesses only finished their sentences satisfactorily. Similarly, more dually diagnosed probationers received jail or prison time at termination compared with those with one mental illness. Additionally, the dually diagnosed probationer had a slightly higher average number of hospitalizations than mentally ill probationers during their sentences. Therefore, more effort is necessary within the MHU to meet the needs of this challenging population.
- A substantial percentage of probationers have committed a violent crime. Violent crime was defined under criminal offenses as both physical and verbal (threatening, stalking). As indicated in policy and procedures (10.06.01-05 eligibility criteria) a history of violence is generally an excluded category for acceptance into the MHU (Cook County Adult Probation Department, 2005). At times the judiciary directly mandates or refers violent probationers for supervision. Working with probationers who have a history of violence present unique challenges for officers, management, and the department as a whole. A number of factors can precipitate violence or potential violence,

including stress from one's environment, drug addiction, or symptoms of one's illness. The assignment of these probationers to the MHU necessitates the establishment of an approach to mediate any risk of violence and signifies the importance of ongoing officer training.

- The percentage of Hispanic probationers (5%) appears low in comparison with their percentage on regular probation. This number is lower than we expected and may be due to cultural factors such as language barriers or the stigma associated with revealing one's mental illness to his or her probation officer. Another point of interest is that almost one half of the probationers transferred into the MHU were internal transfers, suggesting the courts were unsuccessful in determining mental health issues. This finding suggests the poor identification of mentally ill probationers in pretrial court proceedings. Moreover, it highlights the substantial number of mentally ill probationers under supervision in regular probation units.

Several positive outcomes were evident from this study; for example, more than half of the probationers terminated their sentence satisfactorily. Less than one fourth received jail or prison time at the conclusion of their sentence. Additionally, more than one half ended their sentences with no violations for new offenses. More than half of all probationers were not hospitalized during the course of their probation. About three fourths of the probationers were domiciled at the conclusion of their sentence with most residing with family members. However, nearly one half of probationers were incarcerated at some point during their probation. This outcome suggests the court system uses incarceration as a method to manage mentally ill probationers who commit new offenses and fail to comply with court mandates. Additionally 60% ended their probation with no new offenses. Nearly 40% of the probation cases that terminated in 2001 did not re-offend and were not re-arrested for either a misdemeanor or felony arrest three years after probation was terminated.

These data suggest modest success in preventing recidivism and achieving positive sentence outcomes. However, additional research needs to be conducted to understand why some probationers didn't complete successfully and why others committed new offenses. Our findings further suggest that additional longitudinal studies for this population along with a comparison group (of a similar population) would greatly assist in this area. Moreover, this additional research would help guide correctional agencies in the development, practices, and needs related to treating the mentally ill.

Finally, this long-term study offers some guidelines as to how to maintain and produce positive results for the mentally ill probationer in a correctional setting. The level of communication between officers and service providers along with the state oversight of the MHU has produced a national model in supervising mentally ill probationers. This study will show other correctional agencies that they can construct a mental health unit that can manage mentally ill probationers effectively in an increasingly complex societal environment.

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