The Final Report of the Evaluation of the Court Support Services Division's Mental Health Case Management Pilot Project

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EXECUTIVE SUMMARY

In response to concerns over the growing mental health needs of offenders, the Judicial Branch's Court Support Services Division (CSSD) developed and piloted the Mental Health Case Management Project (MHCM). The MHCM project established a specialized unit of ten Mental Health Officers (MHOs) spread over eight probation offices. These probation officers supervised only SMI probationers and had caseloads of 35 clients. MHOs were provided training in mental health disorders as well as communications skills such as motivational interviewing (MI) and were expected to utilize their MI training in working with clients to better engage them in problem solving rather than relying on threats and sanctions. The pilot program mandated frequent MHO-client contact: at least three face to face appointments per month, as well as regular MHO-treatment provider contact: at least one phone or face to face appointment with client's mental health providers per month. In these respects, the pilot project closely resembled other agencies across the United States that have promoted heightened involvement and is currently viewed as a "promising approach."

Areas of Research

Faculty from the Department of Criminology and Criminal Justice at Central Connecticut State University were contracted to evaluate the Mental Health Case Management pilot project. The evaluation focused on two primary areas. First, we met with and interviewed Mental Health Officers regarding their attitudes about the MHCM project, their perception of its success, and barriers that hindered its ability to be successful. Second, data were collected for every client in the MHCM project and a comparable group of probationers on regular caseloads to assess program outcomes in terms of new arrests and technical violations one year after supervision start. We looked at whether clients were arrested or violated and attempted to determine what client factors were associated with being violated (e.g., LSI-R risk levels, criminal history, gender, age, marital status, education, and employment).

Conclusions

The evaluation of the MHCM produced three overall conclusions. First, the MHCM project closely resembled the prototypical specialized mental health unit: The probation officers in the MHCM project carried exclusive mental health caseloads, capped at 35 clients, and were provided with 20-40 hours of training in mental health issues per year. Interviews with officers indicated they were aware of their clients' diagnosis, symptoms, and in regular contact with their clients' mental health treatment provider, and for most officers, this contact was weekly. Officers reported that relationships with their clients were more collaborative and focused on increasing compliance with probation rather than enforcing the conditions of probation. They also reported that in their supervision they considered how their clients' thinking and behavior was influenced by mental illness.

Second, quantitative analysis revealed several significant predictors that could distinguish between MHCM probationers who were rearrested and those were not. We found that younger age, greater criminal history as assessed by the LSI-R and ASUS-R,

greater antisocial attitudes and financial need as assessed by the LSI-R, and less psychological distress as assessed by the ASUS-R were predictive of rearrest. The magnitude of these predictors was not large, and they are, with one exception, already established predictors of recidivism. Qualitative analysis suggested several two primary differences between MHCM probationers who completed the program and those did not: Motivation and drug use. In interviews, officers noted that successful clients tended to be those who entered participated in treatment programs, and were compliant with their medications while those who were unsuccessful tended to be those who were noncompliant/unmotivated. This suggests that motivation for compliance/treatment may be a significant predictor or success and failure in specialized programs.

Third, the project significantly reduced arrest rates: The results of the evaluation suggest that the MHCM project significantly reduced recidivism. MCHM probationers had a new arrest rate 25% lower than that of the matched comparison group. The program did not significantly reduce rates of technical violations, a finding common similar to intensive supervision programs, as the greater contact with officers makes it more likely noncompliance is discovered.

Recommendations

Our overall conclusion was the MHCM project was effective in reducing arrests of probationers with serious mental illness. The MHCM project was implemented according to the scientific literature and, subsequently, produced positive results. We do, however, offer the following recommendations to improve the delivery of the MHCM project:

1. CSSD should consider expanding this project to all probation offices in Connecticut and also adding Mental Health Officers to the existing offices. We must stress however, that any expansion of the MHCM project should follow the MHCM model as closely as possible and pay close attention to the basic principles associated with the scientific literature (low and specialized caseloads, significant mental health training for MHOs, and an emphasis on keeping clients in the community).

2. MHOs need to have clinical consultation available on an on-going basis. MHOs commented throughout the evaluation that they often had basic questions or needed clinical advice with specific clients but did not have anyone to consult. We recommend that CSSD consider having licensed clinical psychologists available on an ad-hoc basis for consultation.

3. CSSD should work more closely with DMHAS in identifying services for probationers with SMI and co-occurring substance abuse problems. MHOs stated they had limited treatment options available for clients with substance abuse problems. Programs that serve individuals with SMI and substance abuse problems are needed given that nearly 25% of MHCM clients had a secondary need for substance abuse treatment.

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INTRODUCTION AND BACKGROUND OF THE PROJECT

Research has indicated that persons with severe mental illness (SMI) are overrepresented in America's criminal justice system. Rates of SMI are several times higher among offenders than among the general population (Fazel, & Danseh, 2002; Fulton, 1996; Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, 1990; Teplin, 1994; Teplin, Abram, & McClelland, 1996). More than half (and perhaps as many as three quarters) of offenders with SMI also have a co-occurring substance use disorder (Abram & Teplin, 1991; Hartwell, 2004; Teplin et al., 1996). To further complicate an already complex clinical picture, as many as 50% of offenders with SMI may also have an antisocial personality disorder (Abram & Teplin, 1991).

Connecticut is not immune from this national problem. Several sources of data suggest that a disproportionately large number of offenders with SMI are being processed through the state's pretrial, prison, and probation systems. A recent study of undetected psychiatric disorders among Connecticut jail detainees who had not been identified as acutely mentally ill upon jail intake, found that 2% had an undetected psychotic disorder and 24% had an undetected affective disorder (Ford, Trestman, Wiesbrock, & Zhang, 2009). A 2004 report by Lieutenant Governor Kevin Sullivan noted that 16% of Connecticut prisoners had a mental illness and that this percentage had increased 40% since 2000 (Sullivan, 2004). The 2008 State of Connecticut Recidivism Study found that 19% of prisoners released into the community at the end of their sentence had a serious mental illness (Office of Policy and Management, 2008). With respect to probation, the rate of SMI among the state's probationer population was estimated at 23% in a survey by the American Probation and Parole Association (Fulton, 1996).

OVERVIEW OF CSSD'S MENTAL HEALTH CASE MANAGEMENT PROJECT

In response to concerns over the growing mental health needs of offenders, the Judicial Branch's Court Support Services Division (CSSD) developed and piloted the Mental Health Case Management Project (MHCM). The MHCM project established a specialized unit of ten Mental Health Officers (MHOs) spread over eight probation offices. These probation officers supervised only probationers with SMI and had caseloads capped at of 35 clients. MHOs were provided with training in mental health disorders as well as communication skills such as motivational interviewing (MI) and were expected to utilize their MI training in working with clients to better engage them in problem solving rather than relying on threats and sanctions. The pilot program mandated frequent MHO-client contact: At least three face to face appointments per month, as well as regular MHO-treatment provider contact: At least one phone or face to face appointment with their clients' mental health providers per month. In these respects, the pilot project closely resembled other agencies across the United States that have tried this "promising approach."

Faculty from the Department of Criminology and Criminal Justice at Central Connecticut State University were contracted in July of 2007 to evaluate MHCM.. This document presents the overall process and outcome findings of the evaluation. It begins with a discussion of the relevant research on best approaches to working with offenders with SMI and is followed by a description of the MHCM. The next part of the report presents an overview of the research methodology used to evaluate this project. The evaluation findings are presented in the next section that first discusses the results of the mental health officer interviews and is followed by the analysis of recidivism data. The final section of the report presents the overall conclusions and recommendations for future programming and practice.

PERSONS WITH SEVERE MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

The overrepresentation of individuals with SMI in the criminal justice has been attributed to changes in social policies over the past half century, starting with the deinstitutionalization movement, which moved mental health care for persons with SMI from inpatient hospitalization to outpatient care in under-funded and overburdened community mental health centers. The deinstitutionalization movement was accompanied by changes in civil commitment laws that raised the threshold of impairment required for involuntary hospitalization of persons with SMI. The natural consequence of these changes has been a greater number of persons with SMI in the community, where their behavior places them into contact with the police (Abramson, 1972; Lurigio, 2000; Lurigio, Rollins, & Fallon, 2004; Teplin, 1983). An additional factor contributing to the relatively large number of persons with SMI in the criminal justice system is the high rate of co-occurring substance use disorders among this population (Regier, Farmer, Rae, Lock, Keith, Judd, et al. 1990) as the exacerbation of psychiatric symptoms by illicit substances only makes arrest more likely. The reluctance of psychiatric facilities to treat persons with SMI who have a co-occurring substance use disorder, and the reluctance of substance use disorder treatment facilities to take addicted persons with SMI results in a Catch-22 for these individuals, and ultimately reduces their likelihood of obtaining appropriate treatment, and increases their likelihood of arrest (Abram & Teplin, 1991; Lurigio, 2000; Lurigio et al., 2004).

The criminal justice system outcome of offenders with SMI tends to be poor. For example, the 2008 State of Connecticut Recidivism Study found that 60% of prisoners with SMI were rearrested within two years of their release of custody, and 22% received a new prison sentence (Office of Policy and Management, 2008). Not surprisingly, the criminal justice outcome for offenders with SMI and a co-occurring substance use disorder tends to be even worse: Offenders with SMI and a co-occurring substance use disorder have higher rates of recidivism and probation violations and a greater risk for violence than offenders with only SMI (Hartwell, 2004; Steadman, Mulvey, Monahan, Robbins, Grisso, Roth, & Silver, 1998; Swartz, Swanson, Hiday, Borum, Wagner, & Burns, 1998).

Not only does the criminal justice outcome of offenders with SMI tend to be poor, but their quality of life tends to be poor as well. Offenders with SMI typically have significant psychosocial needs including poverty, homelessness, and unemployment in addition to their need for mental health and/or substance abuse treatment (Hartwell, 2004); Latessa, 1996; McCoy, Roberts, Hanrahan, Calay, & Luchins, 2004; McNiel & Binder, 2007; Steadman, Cocozza, & Veysey, 1999; Watson, Hanrahan, Luchins, & Lurigio, 2001). Interviews with offenders with SMI conducted by McCoy and colleagues (2004) illuminated how these needs were directly associated with recidivism. For example, offenders with SMI described committing offenses for subsistence, following periods of psychological decompensation that occurred after their lack of access to medication and treatment, and while under the influence of drugs or alcohol, or to obtain money to support their addiction. Offenders with SMI also described being arrested for civil order violations such as trespassing that were directly linked to their homelessness.

In summary, shifts in social policy have resulted in a shift from long-term institutionalization of persons with SMI to outpatient care. An unintended consequence of this shift has been an increasing number of persons with SMI becoming arrested, which, in turn requires state criminal justice systems to manage a large number of offenders with SMI. These offenders also often present with co-occurring substance use disorders, personality disorders, and significant psychosocial stressors such a poverty and homelessness. Given the high rate of recidivism and failure on community supervision of this group of offenders, states have sought new strategies to effectively manage these challenging clients and balance attention to their treatment needs as well as with the public's need for safety.

Strategies to Effectively Supervise Offenders with SMI in the Community

Reflecting on the high rate of supervision failure among probationers and parolees with SMI, Skeem and Eno Louden (2006) hypothesized that an interaction of psychological and community supervision factors were likely to blame. Among the psychological factors were the severe symptoms of the mental illness, and the poor life skills and coping abilities associated with the illness. These factors could understandably, in and of themselves, make a probationer's compliance with the conditions of supervision difficult. Among the community supervision factors were poor officer-probationer relationships, a lack of available treatment resources for probationer, and an officer's use of punitive supervision strategies. It is not difficult to imagine how the psychological and community supervision factors could also interact to produce a poor supervision outcome: A lack of treatment availability for a probationer with SMI results in worsening symptoms and coping, which make a productive officer-probationer relationship untenable, and consequently, more adversarial and punitive.

Recommendations for improving the community supervision of offenders with SMI have included 1) the development of more diversion programs that offer mental health treatment in lieu of prosecution or incarceration (e.g., mental health courts, prebooking diversion programs) (Lurigio, 2000; Thompson, Reuland, & Souweine, 2003), 2) training supervision officers in recognizing the signs and symptoms of severe

mental illness, and in skills to interact with this population (Lurigio, 2000; Slate, Feldman, Roskes, & Baerga. 2003; Slate, Feldman, Roskes, & Baerga. 2003), 3) the modification of Assertive Community Treatment (ACT) type programs for forensic purposes (Lamberti, Weisman, & Faden, 2004; Lurigio, 2000; Lurigio et al., 2004; Morrissey, Meyer & Cuddeback, 2007), 4) greater coordination of services between the criminal justice and mental health care systems so that prisoners released into the community have treatment already in place (Abram & Teplin, 1991; Lurigio, 2000; Thompson et al., 2003), and 5) the establishment of specialized probation and parole units to work with offenders with SMI (Lurigio et al., 2004; Skeem & Eno Louden, 2006; Thompson et al., 2003). These recommendations are not mutually exclusive, and implementing one recommendation may naturally result in implementing others. For example, the establishment of a mental health court or other diversionary program will likely improve the coordination of local criminal justice and mental health providers, and may involve the training of supervision officers to better communicate with offenders with SMI and alter traditional punitive supervision practices.

While the research into effective strategies for improving the outcome of community supervision of offenders with SMI is still in a relative infancy, there have been encouraging findings. For example, studies of mental health courts have found them to be associated with reduced recidivism, especially among those offenders who complete the program (McNiel & Binder, 2007; Moore & Hiday, 2006). Studies of Forensic Assertive Community Treatment teams (FACT) have been linked with improved quality of life indicators such as reduced hospitalization and an increase in stable housing (Drake et al., 1998) as well as retention in mental health treatment (McCoy et al., 2004). The impact of FACT on reduced criminal justice involvement has not been adequately evaluated. One review found mixed results (Marshall & Lockwood, 1998), and other studies have found significant decreases in arrests and incarceration (Lamberti, Weisman, & Faden, 2004; McCoy et al., 2004). Specialized mental health probation units have received even less attention in the published literature than either mental health courts or FACTs, but the small (and growing body) of literature suggests this is a promising approach toward improving the criminal justice outcome of probationers with SMI.

Specialized Mental Health Probation Units

When the Council of State Governments Criminal Justice/Mental Health Consensus Project issued their 50 recommendations for improving the processing of offenders with mental illness through the criminal justice system, they considered all phases of the system from arrest to trial/plea to incarceration and reentry. Targeting probation specifically in Policy Statement 16, they recommended probationers with mental illness be assigned to "probation officers with specialized training and small caseloads" and for agencies to "develop guidelines on compliance and violation policies regarding offenders with mental illness" (Council of State Governments, 2002).

A subsequent national survey assessing specialized mental health probation units found 73 such units in the United States (Skeem, Emke-Francis, & Eno Louden, 2006). Through interviews and questionnaires with probation supervisors, the researchers found

that while the operation of these units differed from jurisdiction to jurisdiction, there were five prototypical characteristics that distinguished them from traditional probation units. First, specialized mental health units tended to be staffed by what will hereafter be referred to as mental health probation officers (MHOs), that is, officers with a caseload exclusively devoted to probationers with SMI. Second, the caseload of MHOs was capped at a lower number than that of the nonspecialized probation officers (NPOs). The average cap for a MHO caseload was 43 probationers, but as is common in traditional probation units, many MHOs carried more clients than their cap. Third, MHOs were provided with specialized training such as recognizing signs of SMI, and strategies for communicating with persons with SMI. Fourth, case management expectations for MHOs were oriented to a greater degree toward treatment and advocacy than that of NPOs. For example, MHOs were expected to assist their probationers in obtaining appropriate mental health care, coordinating their probationers' diverse treatment and service needs, and even collaborating with their probationers' mental health treatment providers. Fifth, the expected method for handling client noncompliance was different between specialized and traditional units. MHOs were expected to respond to their probationers' noncompliance with problem solving rather than threats of incarceration (Skeem et al., 2006). Overall, the prototypical operation of a specialized mental health probation unit appeared distinct from a traditional probation unit.

Beyond these broad differences between specialized mental health and traditional probation units, the programmatic research of Skeem and colleagues have revealed more subtle differences between the two units (Eno-Louden, Skeem, Camp, & Christenson, 2008); Skeem, Encandela, & Eno-Louden, 2003). Through focus group research with specialized and traditional probation officers and probationers, Skeem and colleagues (2003) found that the needs and presentation of probationers with SMI made a poor fit with the emphasis on law enforcement, community safety, and control of the probationer that marked traditional probation units. In contrast, the needs and presentation of probationers with SMI were seen as routine in specialized units, and the unit emphasized mental health care as much as law enforcement/community safety.

Given these philosophical differences, perhaps it is not surprising that MHOs perceived treatment and treatment compliance differently from NPOs and responded to noncompliance with treatment differently (Skeem et al., 2003). NPOs tended to view their probationer's treatment through a lens of law enforcement and social control, perceiving treatment as a tool to keep the probationer stable and easier to control. In contrast, MHOs tended to view their probationer's treatment as a part of their supervision responsibilities, not an ancillary responsibility or a means to another end. They tended to have an active interest in their probationer's treatment and typically assisted their probationers in obtaining mental health services to a greater degree than NPOs. Compared to NPOs, MHOs also more commonly communicated and collaborated with their probationer's mental health providers.

With respect to treatment compliance, Skeem and colleagues (2003) found that NPOs had a less demanding and more mechanical view of treatment compliance than MHOs. NPOs perceived treatment compliance as involving the probationer taking

medication and attending their appointments. MHOs, on the other hand, expected more from their probationers such as active participation in treatment. They also tended to regularly monitor their probationer's treatment, and obtained releases of information that allowed them to share and obtain treatment progress reports from their probationer's treatment providers.

With respect to addressing treatment noncompliance, Skeem and colleagues (2003) found that NPOs reported few strategies to effectively address treatment noncompliance with their probationers with SMI. Consequently, they tended to rely on threats of incarceration. This was not perceived as effective by NPOs or their probationers. In fact, the probationers perceived the threats as creating more anxiety and distress, thus, potentially creating more problems in complying with the conditions of probation. MHOs, on the other hand, had more strategies for coping with probationer noncompliance with treatment. They tended to address treatment noncompliance with problem solving strategies, attempting to work with the client in identifying the problem and collaborating on a solution, and positive pressure (encouragement, reinforcement). Consequently, they were less likely to rely on threats of incarceration.

In a follow up to their 2003 survey, Eno Louden, Skeem, Camp, & Christensen (2008) found differences between NPOs and MHOs in how they allocated their time, the number of contacts per month with their probationers, and their strategies for addressing supervision noncompliance. Through interviews and questionnaires with probation supervisors, Eno Louden and colleagues (2008) found that MHOs allocated more time to their probationer's treatment team meetings, made more monthly contacts with their probationers (face to face, and by phone), and made more monthly contacts with their probationer's treatment providers (face to face, and by phone). Overall, MHOs tended to meet with their probationers more often than NPOs meet with traditional high risk probationers, whereas NPOs tended to meet with their probationers with SMI about as often as their probationers with no special needs. Mirroring their earlier finding that MHOs were more likely than NPOs to use problem solving strategies to address treatment noncompliance, Eno Louden and colleagues (2008) found that MHOs were also more likely than NPOs to use problem solving strategies to address supervision noncompliance, and were less likely to use punitive sanctions.

In summary, the existing body of research suggests that specialized mental health units differ from traditional units in quantitative aspects of operation (e.g., caseload size, number of contacts per month) as well as qualitative aspects of operation (e.g., perception of treatment, strategies to address noncompliance). Whether these differences translate into improved outcomes for probationers with SMI has yet to be reported in the published literature. In Skeem and colleagues (2006) survey of traditional and MHO supervisors, they found that MHO supervisors were more likely than traditional supervisors to perceive their unit as effective in reducing probation violations in the short term among their probationers with SMI, and improving the life functioning of probationers with SMI. However, the survey was unable to assess actual reductions in new arrests or actual improvements in quality of life between probationers assigned to specialized versus traditional units.

IMPLEMENTATION OF THE MENTAL HEALTH CASE MANAGEMENT PROJECT

The primary component of the MHCM was the creation of "Mental Health Officers" (MHOs) in eight probation offices across Connecticut. MHOs were located in Bridgeport, Hartford, Middletown, New Britain, New Haven, New London, Norwich, and Waterbury. MHOs had caseloads no higher than 35 clients at any given time and only supervised clients referred and accepted into the MHCM project. The underlying philosophy was that MHOs would be able to better understand the needs of their clients and have time to work closely with them and service providers. MHOs were expected to work collaboratively with the Connecticut Department of Mental Health and Addiction Services (DMHAS) to help clients obtain necessary services for psychiatric and co-occurring disorders (see Appendix A contains CSSD's policy and procedures for the MHCM project).

The MHCM project was based upon scientific literature suggesting that probation programs specifically designed for mental health probationers should consist of the following components:

1) officers need to be assigned only mental health cases;
2) officers should have reduced caseloads, averaging no more than 45 clients;
3) officers should be provided with 20-40 hours of training in mental health issues per year;
4) officers should be expected to be intimately involved in their client's treatment engagement;
5) officers should be expected to rely on engagement and problem solving with clients rather than admonitions and threats in working through problems with their client's noncompliance with treatment and supervision (Skeem et al., 2006).

SELECTION AND SUPERVISION OF MHCM PROBATIONERS

Identifying clients for the pilot program generally occurred through two avenues: 1) new probationers scoring a 15 or higher on the Mood subscale of the Adult Substance Use Survey-Revised were referred for a mental health evaluation, which triggered a review of their suitability for the pilot program, and 2) existing probationers that were actively in mental health treatment or who appeared to be in need of treatment, could be referred to determine their suitability for the pilot program. Probationers under Sex Offender Supervision were not eligible for referral unless he/she had already completed sex offender treatment or had been deemed inappropriate for sex offender treatment.

After being referred, supervisors of MHOs determined whether to assign clients to MHOs based on several criteria:

- MHO's caseload was under 35 clients;
- verification of client's mental health referral;

- supervisor believed client would be best served by MHO;
- client was in mental health treatment;
- client had a recent mental evaluation;
- exigent circumstances existed.

Once probationers were accepted into the program and assigned to a Mental Health Officer, their case was reviewed after 4 months to determine if MHO-client meetings could be safely reduced from 3 to 2 per month. Every 6 months, their case was to be reviewed to determine their need for continued participation in the MHCM project. Clients deemed to no longer require the specialized supervision were transferred to a traditional officer.

MHOs were required to follow strict contact standards while clients were under their supervision starting with their initial contact. MHOs had to meet with new clients within five business days of receiving the case assignment. Following this first meeting, MHOs had to have a minimum of three monthly face-to-face contacts with clients and it was highly recommended that one of these contacts occurred in clients' homes. MHOs were also required to give his/her contact information to all "appropriate persons" (i.e., family members and significant others). In addition, MHOs were to have at least one contact per month with a client's mental health service providers to discuss the client's treatment adherence and progress, changes in behavior and diagnosis, medication compliance, and substance abuse issues.

CSSD policy also provided guidelines for when MHOs should violate a client for not following his/her conditions of probation. It stressed that in situations where clients were participating in behaviors that could lead to a violation, MHOs would first discuss the problems with his/her supervisor and the client's primary service provider to develop a response that focused on keeping the client in the community and in treatment. A client would be violated only after he/she refused all treatment, had persistent non-compliance, or if the MHO had safety concerns for the client or others associated with the client.

MHCM OFFICER SELECTION AND TRAINING

The MHOs were adult probation officers who volunteered for this project. The exact criteria used to select MHOs varied by location with the final decision resting with the regional manager and office supervisor. Many of the MHOs had prior experience working with people with mental health issues. In addition, regional managers attempted to select probation officers who had a counseling-type supervision style.

MHOs received specialized training on working with clients with serious mental illness. Specifically, MHOs attended separate five day training sessions. One was a Provider training facilitated by the Connecticut Department of Mental Health and Addiction Services (DMHAS) and the other was Crisis Intervention Team (CIT) training from the Connecticut Alliance To Benefit Law Enforcement (CABLE). In addition to the

training, all MHOs met on a monthly basis to discuss project implementation and case conferencing.

MHCM CLIENT CHARACTERISTICS

There were 710 clients selected to participate in the MHCM project between the project's inception in March of 2007 and September 1, 2009. The Hartford probation office had the most clients (163) followed by New Britain (115) and New Haven (103)(Table 1). The Waterbury office had the fewest clients (46).

Table 1. MHCM Clients by Office

	Number of MHOs	Number	Percentage
Hartford	2	163	23%
New Britain	1	115	16%
New Haven	2	103	15%
Norwich	1	89	13%
New London	1	80	11%
Middletown	1	61	9%
Bridgeport	1	53	8%
Waterbury	1	46	7%
Total	10	710	100%

Table 2 presents the demographic characteristics of MHCM clients. The majority of MHCM participants were males (73%) with 48% being white, 28% African-American, and 22% Hispanic. MHCM clients tended to be older, with the majority over 30 years old (60%) and a small percentage under 21 years old (10.3%). The average age was 37 years old.

The majority of the MHCM clients were single (72%) and did not have a high school diploma (58%). Also, most clients were unemployed (50%) or were receiving financial support from a disability (38%).

Table 2. Demographic Characteristics of MHCM Clients

	Number	Percentage
Gender		
Males	521	73%
Females	189	27%
Race/Ethnicity		
White	343	48%
Black	201	28%
Hispanic	157	22%
Other	3	0.40%
Age		
16 through 17	2	0.30%
18 through 21	71	10%
22 through 29	144	20%
30 through 39	183	26%
40 and Older	310	44%
Marital Status		
Single	509	72%
Divorced/Separated	162	23%
Married	36	5%
Employment		
Unemployed	358	50%
Other Income	267	38%
Part-time Employment	27	4%
Full-Time Employment	55	8%
Education		
Less than High School	412	58%
High School Diploma	188	27%
More than High School	107	15%

In terms of assessed supervision levels, the majority of MHCM clients were high risk with the average Level of Service Inventory-Revised (LSI-R) total risk score being 31 (Table 3). As expected, the most prevalent primary need on the LSI-R among MHCM clients was Emotional/Personal (67% of the clients had this as their primary need) with Alcohol/Drug as the most common secondary need (21%).

Table 3. LSI-R Supervision Levels and Needs of MHCM Clients

	Number	Percentage
Supervision Level		
Sex Offender	5	1%
High	561	79%
Medium	120	17%
Administrative	19	3%
Primary Need		
Emotional/Personal	474	67%
Family/Marital	92	13%
Attitude/Orientation	38	5%
Alcohol/Drug	36	5%
Companions	34	5%
Criminal History	31	4%
Secondary Need		
Alcohol/Drug	147	21%
Criminal History	125	18%
Emotional/Personal	117	17%
Attitude/Orientation	114	16%
Family/Marital	110	16%
Companions	92	13%

MHCM clients had a high number of prior arrests (Table 4). The average MHCM client had 14 prior arrests before being accepted into the MHCM project (this number represents individual situations that resulted in an arrest; for example, if a client was arrested on January 2nd with five charges and again on February 1st with three charges, this was counted as two separate arrest incidents). Only 5% of MHCM clients had no prior arrests before the offense that led to their MHCM referral. Further, over one-half of MHCM clients had more than 10 prior arrests (54%), with 15% have 25 or more prior arrests.

Table 4. Number of Prior Arrest Incidents of MHCM Clients

	Number	Percentage
No Priors	28	5%
1 Prior	42	7%
2 thru 10 Priors	298	49%
11 thru 25 Priors	239	39%
Over 25 Priors	103	15%

EVALUATION METHODOLOGY

The evaluation employed both qualitative and quantitative research methods in assessing the overall effectiveness of the MHCM project. The methods centered on two aspects of this program. First, we examined the implementation of the program within and across the individual probation offices in order to better understand the daily activities of probation officers assigned to these units. Without knowing how well the program was implemented, we would have been unable to draw firm conclusions regarding any results they produced (positive or negative). Second, we collected and analyzed data on all MHCM probationers and created a historical comparison group of probationers on regular caseloads to determine the effects of the MHCM project on recidivism. This analysis included a detailed comparison of probationers who recidivated one year after the start of MHO supervision and MHCM clients who were not arrested or violated.

AREAS OF RESEARCH

The evaluation focused on two primary areas. First, we met with and interviewed MHOs regarding their attitudes about the MHCM project, their perception of its success, and barriers that hindered its ability to be successful. Second, data were collected for every client in the MHCM project and a comparable group of probationers on regular caseloads to assess program outcomes in terms of new arrests and technical violations one year after supervision start. We looked at whether clients were arrested or violated and attempted to determine what client factors were associated with being violated (e.g., LSI-R risk levels, criminal history, gender, age, marital status, education, and employment).

RESEARCH DESIGN AND DATA

The evaluation incorporated both qualitative and quantitative methods within the research design. The qualitative methods consisted of face-to-face and telephone interviews with MHOs conducted during the Fall of 2008 and the Spring of 2010. All MHOs were contacted by evaluation staff and were invited to participate in the interviews. The interviews lasted approximately 45 minutes to one hour and consisted of a series of open and closed-ended questions pertaining to the various aspects of the MHCM project (see Appendix B for the interview instrument).

The quantitative aspect of the evaluation utilized a secondary analysis of existing data. Specifically, data from the Court Support Services Division's case management information system (CMIS) were collected for all clients entering the MHCM project between March 1, 2007 and August 31, 2008. We limited our sample to clients entering the MHCM project prior to September 1, 2008 so that we would be able to have a follow-up period of one year for all MHCM clients. The CMIS data contained the following information:

- Demographic information (age, gender, race/ethnicity, marital status, education level obtained, employment)
- Date of probation violation (if one occurred)
- Nature and disposition of probation violation
- Criminal history (bail charges, prior arrests and convictions, age at first arrest)
- Current offense (offense type, number and types of charges, number and types of convictions)
- Level of Service Inventory Revised scores (LSI-R)
- Adult Substance Use Survey Revised scores (ASUS-R)

We also collected arrest data from the Department of Public Safety's Connecticut Criminal History database (CCH). These data were used to compare recidivism rates (primarily new arrests) between MHCM participants and probationers in the comparison group. This step was accomplished by matching probationers in our study to the CCH using their CSSD assigned client number. The information from the CCH consisted of:

- Arrest date
- Arrest charge
- Court disposition (e.g., guilty, not guilty, nolle, dismissed)
- Court sentence and sentence length

EVALUATION FINDINGS

The evaluation of the MHCM project focused on four major research questions. These were: (1) was the program implemented in a way to maximize its' potential for successful outcomes; (2) were there differences in the arrest and technical violation rates of MHCM probationers and a similar group of probationers not being supervised by Mental Health Officers; (3) were there specific probationer characteristics related to success; and, (4) what were the overall effects of the MHCM project on recidivism. This section presents the findings to these questions. The first part summarizes the MHO interviews and is followed by the analysis of recidivism rates of MHCM clients. The last part of this section compares the recidivism rates (arrests and technical violations) between MHCM clients and a comparison group.

MENTAL HEALTH PROBATION OFFICERS' PERCEPTIONS

We conducted an initial round of interviews with MHOs in 2008 and a follow up round of interviews in 2010 in order to obtain qualitative data on the officers' perceptions of the MHCM project. To ensure that we assessed the full range of officer perspectives, we sought interviews with each officer for each round of interviews. We successfully obtained interviews with all of the officers during the initial round, while five officers did not respond to requests for an interview during the follow up round.

The initial round of interviews (N = 11) were conducted in MHO offices and lasted 40 to 75 minutes. At the time of the initial round of interviews, the officers had been working in the program from periods of time ranging from two months to a year. The follow up round of interviews (N = 11) were conducted over the phone and lasted 40 to 50 minutes. At follow up, officers had been working in the program for periods of time ranging from three months to two years. Most had been working in the program for a year or more.

Within each round of interviews, officers were asked the same questions; however, questions asked during the initial round of interviews were different from those asked at follow up, with a few exceptions. Most questions were open ended, although officers were sometimes asked to rate their level of agreement with a particular statement or attitude. The initial round of interviews focused on the officers' prior experience, attitude toward supervision, and knowledge of the MHCM project. The follow up round of interviews focused on officers' knowledge of their clients' mental health problems, degree of collaboration with their clients' mental health providers, perceptions of effective versus ineffective supervision strategies, and perceptions of their successful versus unsuccessful clients. Both rounds of interviews provided officers with an opportunity to reflect on difficulties they had encountered implementing the program and to contribute their recommendations for the program's improvement.

Prior Experience, Attitude Toward Supervision, and Knowledge of the Program

Overall, we found that officers began their new duties experienced in conducting community supervision. All of the officers began the program with at least of 3 years of experience as a probation officer, and several had more than 10 years of experience. Officers also appeared to be well informed about the nature and purpose of the MHCM project, and were able to articulate the program's goals. When asked what they thought the ultimate goal of the program was, officers stated that they were trying to help clients with mental health problems become stabilized and settled in the community, and to ultimately reduce recidivism among mentally ill probationers. Officers were likewise knowledgeable about, and able to articulate, how the program could potentially help mentally ill probationers (e.g., providing smaller caseloads to officers allowing them to provide greater attention to individual probationers; an emphasis on facilitating the probationer's treatment in the community).

During initial interviews, we assessed officers' attitudes toward supervision by asking them to rate their agreement with a series of statements on the proper role of the probation officer. Overall, officers tended to have an appreciation for the balance of "social work" and "law enforcement" roles that accompany the duties of a probation officer. Few seemed to approach supervision rigidly in either role. For example, only 18% of officers agreed with the statement "Probation officers should function as social workers," and 91% disagreed with the statement "You should be as tough as you can with probationers, and when they screw-up, make them pay." Instead, officers appeared to see their role as one that involved actively helping their clients, as well as protecting the public. For example, 100% of the officers agreed with the statement "Probation officers should help offenders by referring them to appropriate community resources," and 100% of officers agreed with the statement "Probation officers should actively monitor the offender's activities and ensure that the conditions set forth by the court are met." Officers seemed to perceive their relationship with the client as an important part of their role in helping the client change, but they did not necessarily see themselves as counselors. For example, while only 18% agreed with the statement "Counseling is the most important part of the probation officer's job," 82% of officers agreed with the statement "The probation officer's goal should be to change the offender's behavior through a helping relationship." Thus, while officers may not have seen themselves as counselors per se, they did seem to see their relationship with clients as being therapeutic.

Knowledge of Clients' Mental Health Problems and Degree of Contact with their Clients' Mental Health Providers

Officers perceived the MHCM project as one that allowed for an in-depth knowledge of, and supervision of, their clients, and they seemed to take advantage of this unique opportunity by learning about clients' symptoms and staying in regular contact with their clients' mental health providers. All officers indicated they were aware of their clients' diagnoses (with schizophrenia and bipolar disorder being the two most common diagnoses they encountered in their clients), treatment plan, and mental health history. All officers also indicated they were in regular contact with their clients' mental health

treatment provider. For most officers, contact with their clients' treatment providers was weekly, and was no less than monthly. Information shared between officers and treatment providers included clients' symptoms, degree of compliance and engagement with treatment, and changes in behavior. All officers perceived their contact with treatment providers as helping them to work more effectively with their clients. Some officers, however, encountered problems collaborating with treatment due to providers' lack of knowledge about the role and responsibilities of probation officers.

Overall, officers believed their clients were receiving adequate treatment from mental health providers, although this was not universal. Some noted there were delays in getting clients into treatment (due to inadequate resources), or that treatment providers were not seeing clients frequently enough. Furthermore, many officers noted difficulty obtaining inpatient services and dual diagnosis services for their clients.

Perceptions of Effective Versus Ineffective Supervision Strategies

When asked to consider the differences between enforcing conditions of probation with mental health clients versus regular probation clients, officers described a unique consideration with their mental health clients: a need to differentiate between a client whose problematic behavior reflected noncompliance versus a client whose problematic behavior reflected symptoms of a mental illness. In describing supervision of mental health clients, officers spoke of the need to "understand the cognitive impairments that go with mental health issues" and the need to understand that "the disorder can hinder the thought process." This suggests that officers were sensitive to the effects of psychological symptoms on their clients' behavior, including compliance with the conditions of probation.

Most officers reported that the MHCM project had led to changes in how they supervised clients. Overall, these changes can be characterized as a shift toward greater understanding of, and collaboration with, their clients. Officers used words like "clinical," "therapeutic," and "relational" to describe the changes in their supervision as a result of being a MHO. They reported that relationships with their clients were more collaborative and focused on increasing compliance with probation rather than enforcing the conditions of probation. They also reported that in their supervision they considered how their clients' thinking and behavior was influenced by mental illness.

The reasons behind this shift in supervision appeared to be directly due to some of the unique features of the program, such as the smaller caseloads and specialized training. Officers noted that they had obtained more knowledge of mental health problems, which resulted in greater patience and empathy with their clients. Officers also noted that the reduced caseloads translated into lengthier office visits, more home visits, and more contact with people in their clients' lives (e.g., treatment providers, family), and this in turn, allowed them to get to know their clients with a greater depth than when they had a regular caseload.

In terms of enforcing the conditions of probation, officers seemed to find more "social worker" or therapeutic approaches more useful than "law enforcement approaches." Officers cited the use of positive reinforcement and motivational interviewing skills as effective supervision strategies for enforcing the conditions of probation. Officers also described a number of effective strategies that can best be described under the heading "patience and understanding." For example, officers noted it was helpful to frequently remind their clients of conditions of probation, to explain things slowly and repeatedly, and to carefully explain to clients the link between compliance of probation and increases in their quality of life. In contrast, officers cited being rigid, threatening, and punitive as ineffective strategies for enforcing the conditions of supervision.

Perceptions of Client Success and Failure

When asked to reflect on the reasons behind clients' successful completion of the MHCM project, officers cited both treatment and supervision factors. With respect to treatment factors, officers noted that successful clients were those who entered appropriate treatment programs, participated in those programs, and were compliant with their medications. With respect to supervision factors, officers noted that the flexibility afforded to them as MHOs as well as their smaller caseloads allowed for more personal attention to their clients. Some officers noted there may have been a synergistic effect of treatment and supervision, whereby as clients benefited from treatment and supervision, their quality of life improved, leading to improved motivation for treatment and improved supervision compliance.

When asked to reflect on the reasons behind clients' unsuccessful completion of the MHCM project, officers also cited treatment factors and drug use. Officers noted that unsuccessful clients tended to be those who did not comply with treatment, were unmotivated for treatment, or for whom appropriate treatment was unavailable. Officers also noted that unsuccessful clients tended to be those who used illicit substances.

Strengths of the MHCM Project and Recommendations for Improvement

While officers described many positive aspects of the MHCM project, three particular strengths of the program appeared to be 1) the small caseload size, 2) specialized training, and 3) support from supervisors. Officers cited the smaller caseloads (most were carrying 35-40 clients on their caseload) as an important tool for achieving the goals of the program. The smaller caseloads allowed the officers to spend more time with each client, which in turn allowed them to build rapport and better assess the clients' needs. Officers also reported that having more frequent contact with the clients seemed to make the clients feel more accountable for their actions.

Officers perceived the specialized training they had received as helpful. The suicide prevention, crisis intervention, mental health, and substance abuse trainings were particularly cited by MHOs as helpful. Even those officers who had a background in the

mental health field and for whom the trainings were repetitive perceived them as useful for the officers who did not have a background in the mental health field.

All officers perceived their supervisors as supportive of their special assignment. Supervisors appeared to be perceived as a resource for ideas and support. Officers also noted that supervisors encouraged them to "think outside the box" with their mental health clients, encouraging creativity.

Officers provided a number of recommendations for the program's improvement, which can be divided into two categories: treatment-related and non-treatment related. Many of the treatment-related recommendations were variations on the same topic: More dual diagnosis and inpatient service options as there was a perceived shortage of these programs. Other treatment-related recommendations cited by multiple officers were 1) greater speed in obtaining evaluation/treatment/medication for clients, and 2) a clinician available for MHOs to consult with when they had questions or concerns about specific clients.

With respect to non-treatment related recommendations, multiple officers recommended the assignment of more officers to the program, noting that they were slightly over their cap and believed that some clients who may have benefited from the MHCM project may not be in it due to caseloads that were already full. Multiple officers also recommended that supervisors of MHOs receive training similar to that of the MHOs to provide them with a better understanding of the population that the program is serving. Finally, it was recommended that more information about the program be made available for other probation officers so that they would have a better understanding of the type of client that would best be served by the program, improving the number of appropriate referrals.

OUTCOME ANALYSIS

While the qualitative analysis found that the MHCM project closely followed those principles identified in the scientific literature as important to working with probationers with serious mental illness (e.g., MHOs assigned only mental health cases with caseloads under 45 clients, MHOs received specialized training for working with serious mentally ill clients, MHOs engaged in clients' treatment, and relying less on law enforcement type supervision and more on positive and problem solving techniques), the outcome analysis assessed the one year effects of MHO supervision.

The outcome analysis was comprised of two parts. First, we assessed the arrest and technical violation rates on all MHCM probationers and compared those clients who were arrested or violated to those who were not. Second, we created a historical comparison group by matching MHCM clients to a similar group of probationers who were on probation prior to the piloting of the MHCM project (this matching process is described in more detail later in this section). Following the matching process, we

compared the arrest and technical violation rates of MHCM clients to comparison group probationers.

This analysis primarily used CMIS data collected on all MHCM clients entering the program between March 1, 2007 and August 31, 2008. We limited the study group to August 31, 2008 to allow for a one year follow-up period. Once the initial MHCM study group was created, we were able to collect arrest data from the Division of Public Safety's Connecticut Criminal History database (CCH).

Arrest and Technical Violation Rates of MHCM Clients

Out of the 710 MHCM clients, 223 were arrested (31%) and 66 received a technical violation (10%)(Table 5). The majority of MHCM clients were neither arrested nor violated one year after beginning their supervision by a MHO.

Table 5. Number of Arrests and Technical Violations for MHCM Clients

	Number	Percent
None	421	59%
Arrest	223	31%
Technical Violation	66	10%
Total	710	100%

Table 6 shows the arrest and technical violations by MHCM office. Overall, the New Britain office had the highest percentage of MHCM clients who were neither arrested nor violated (67%) followed by New London (64%) and Norwich (63%). The offices with the highest arrests and technical violations were Waterbury (50%), Middletown (49%), and Bridgeport (47%).

Table 6. Arrests and Technical Violations by MHCM Office

	None	Arrest	Technical Violation
Hartford (n=163)	58%	29%	13%
New Britain (n=115)	67%	27%	6%
New Haven (n=103)	58%	33%	9%
Norwich (n=89)	63%	29%	8%
New London (n=80)	64%	34%	2%
Middletown (n=61)	51%	41%	8%
Bridgeport (n=53)	53%	34%	13%
Waterbury (n=46)	50%	33%	17%

Next, we compared those MHCM clients who were arrested or violated to those who were not across demographic variables, LSI-R subscale scores, and Adult Substance

Use Survey Revised (ASUS-R) subscale scores. Table 7 presents the comparisons of demographic information. There were no statistically significant differences in arrest and technical violation rates for gender, race/ethnicity, and employment. There were differences for age, marital status, and education. For age, younger clients had higher arrest rates than older clients, with clients 40 years old or older having the lowest arrest rate (25% compared to 44% for 16 to 21 year olds). MHCM clients who were single had the highest percentage of arrests (34%) and technical violations (11%) compared to married or divorced/separated clients. With education, MHCM clients with more education than a high school diploma had the lowest arrest and technical violation rates.

Table 7. Demographic Comparison of MHCM Recidivists and Non-Recidivists

	None	Arrest	Technical Violation
Gender			
Males (n=521)	60%	31%	9%
Females (n=189)	58%	33%	9%
Race/Ethnicity			
White (n=343)	63%	30%	7%
Black (n=201)	51%	37%	12%
Hispanic (n=157)	59%	29%	12%
Other (n=3)	67%	33%	0%
Age*			
16 through 21 (n=73)	45%	44%	11%
22 through 29 (n=144)	48%	40%	12%
30 through 39 (n=183)	56%	30%	14%
40 and Older	70%	25%	5%
Marital Status*			
Single (n=509)	56%	34%	11%
Divorced/Separated (n=162)	69%	25%	5%
Married (n=36)	67%	28%	6%
Employment			
Unemployed (n=358)	55%	33%	12%
Other Income (n=267)	64%	29%	7%
Part-time Employment (n=27)	56%	37%	7%
Full-Time Employment (n=55)	69%	26%	5%
Education*			
Less than High School (n=412)	57%	33%	10%
High School Diploma (n=188)	57%	31%	11%
More than High School (n=107)	72%	24%	4%

Table 8 presents the recidivism differences for the LSI-R. The average overall risk score for MHCM clients who were rearrested was higher than that of MHCM clients

who did not recidivate. Clients who were rearrested also had higher scores on the Criminal History, Education/Employment, Financial, Companions, Alcohol/Drug, and Attitude/Orientation subscales than clients who did not recidivate. The differences indicate that clients who were rearrested tended to begin the program with a more extensive criminal history, greater socialization with antisocial peers, more antisocial values, more substance use, and more need for employment and financial assistance than clients who were not rearrested. The average overall risk score of MHCM clients who went on to have a technical violation was identical to that of MHCM clients who went on to rearrest, and they differed from those who were not rearrested only by their significantly higher score on the Employment/Education subscale. Their scores on several of the other LSI-R subscales indicated similar or greater risks/needs than that of the clients who were rearrested, but these differences did not reach statistical significance, likely due to the small size of the group.

Table 8. LSI-R Comparison of MHCM Recidivists and Non-Recidivists

	None	Arrest	Technical Violation
Criminal History	5.0	5.7*	5.8*
Education/Employment	5.2	5.9*	6.2*
Financial	1.6	1.7*	1.6
Family/Marital	2.4	2.5	2.7
Accommodations	1.3	1.5	1.6
Leisure	1.6	1.6	1.8
Companions	2.7	3.0*	3.0*
Alcohol/Drugs	4.5	5.1*	5.1
Emotional/Personal	4.2	4.3	3.9
Attitude/Orientation	1.4	1.7*	1.3
Total Risk	30.1	33.1*	33.0*

*Indicates difference from "None" at p. <.05

Table 9 presents the recidivism differences for the ASUS-R. The only significant differences emerged on the Antilegal and Strengths subscales. MHCM clients who went to the recidivate or have a technical violation scored higher on the Antilegal scale than MHCM clients who did not get rearrested. Clients who went to have a technical violation scored higher on the Strengths subscale than clients who were and were not rearrested, a finding which is counterintuitive as it might be expected that clients who go on to have technical violations would perceive themselves to have fewer strengths than clients who avoided further trouble with the law.

Table 9. ASUS-R Comparison of MHCM Recidivists and Non-Recidivists

	None	Arrest	Technical Violation
AOD Involvement	9.6	9.4	10.6
AOD Disruption	22.6	22.3	21.0
AOD 6	9.6	11.0	12.4
AOD Benefits	10.3	10.1	8.8
Antisocial	10.1	10.6	11.3
Antilegal	13.0	14.8*	15.9*
Antilegal 6	4.0	4.7	4.8
Mood	13.8	12.4*	11.7*
Psychosocial	56.1	54.6	54.3
Defensive	9.5	9.7	10.2
Motivation	11.0	11.2	12.8
Strengths	14.0	13.3*	16.0*
Psychosocial Disruption	11.6	11.3	10.0
Social Disruption	5.0	5.2	4.7

*Indicates difference from "None" at p. <.05

Factors Affecting Recidivism

While the previous analyses looked at which factors were different it did not allow for determining which factors had the most influence on arrests or violations. To do this, we use a multinomial regression analysis that statistically shows the amount of effect each factor had on arrests and violations. We first used demographic variables and the LSI-R subscales (Table 10). We found that age, LSI-R criminal history, LSI-R attitude/orientation, and LSI-R financial risks were predictive of being arrested. In other words, those MHCM clients most at risk of being arrested while under the supervision of MHOs were younger, high a number of prior arrests, had a poor attitude, and high financial needs. The results were slightly different for predicting technical violations. For these, MHCM clients who were younger and already had a high number of prior arrests, and poor family/marital relationships were most likely to be violated.

Table 10. Multinomial Regression Analysis For Arrests and Technical Violations with Demographic Variables and LSI-R Subscales

		B	Std. Error	Wald	Sig.	Odds Ratio
Arrest	Intercept	-.963	.689	1.952	.162	
	Age	***-.046***	***.010***	***22.570***	***.000***	***.955***
	Gender	-.360	.214	2.841	.092	.698
	Marital Status	-.061	.168	.133	.715	.941
	Criminal History	***.164***	***.045***	***13.402***	***.000***	***1.178***
	Education/Employment	.036	.038	.917	.338	1.037
	Financial	***.398***	***.171***	***5.397***	***.020***	***1.489***
	Family/Marital	-.020	.081	.063	.801	.980
	Accommodations	-.035	.098	.131	.718	.965
	Leisure	-.009	.142	.004	.951	.991
	Companions	-.028	.082	.119	.730	.972
	Alcohol/Drug	.057	.034	2.755	.097	1.059
	Emotional/Personal	.061	.092	.440	.507	1.063
	Attitude/Orientation	***.172***	***.071***	***5.879***	***.015***	***1.188***
Technical Violation	Intercept	-1.182	1.107	1.139	.286	
	Age	***-.059***	***.016***	***13.337***	***.000***	***.942***
	Gender	-.229	.337	.465	.496	.795
	Marital Status	-.317	.316	1.010	.315	.728
	Criminal History	***.207***	***.072***	***8.201***	***.004***	***1.231***
	Education/Employment	.025	.060	.167	.682	1.025
	Financial	-.018	.254	.005	.943	.982
	Family/Marital	***.301***	***.138***	***4.780***	***.029***	***1.351***
	Accommodations	.079	.158	.246	.620	1.082
	Leisure	.447	.273	2.673	.102	1.563
	Companions	-.132	.132	1.006	.316	.876
	Alcohol/Drug	.094	.056	2.820	.093	1.098
	Emotional/Personal	-.182	.128	2.036	.154	.833
	Attitude/Orientation	-.144	.115	1.552	.213	.866

Cox and Snell R^2=0.13, Nagelkerke R^2=0.16

We also conducted a multinomial regression analysis to examine the relationship between ASUS-R subscale scores and subsequent arrests and violations. The results of this regression, presented in Table 11, indicated that scores on the Antilegal and Mood subscales were predictive of being arrested, but in opposite directions. Higher scores on the Antilegal subscale (which indicate more extensive involvement in the criminal justice system), and lower scores on the Mood subscales (which indicates less psychological distress), were predictive of being arrested. Higher scores on the Antilegal subscale were also predictive of technical violations.

Table 11. Multinomial Regression Analysis For Arrests and Technical Violations with ASUS-R Subscales

		B	Std. Error	Wald	Sig.	Odds Ratio
Arrest	Intercept	-.283	.523	.293	.588	
	Defensive	-.008	.027	.094	.759	.992
	Disruption	.000	.005	.006	.940	1.000
	Antilegal	***.042***	***.015***	***7.463***	***.006***	***1.043***
	AntiSocial	-.003	.021	.024	.878	.997
	Mood	***-.040***	***.017***	***5.888***	***.015***	***.961***
	Strengths	-.020	.014	2.215	.137	.980
Technical Violation	Intercept	-2.989	.884	11.442	.001	
	Defense	.013	.045	.085	.771	1.013
	Disruption	-.007	.009	.626	.429	.993
	Antilegal	***.059***	***.024***	***6.106***	***.013***	***1.060***
	Social	.028	.032	.771	.380	1.029
	Mood	-.044	.027	2.584	.108	.957
	Strengths	.040	.022	3.441	.064	1.041

Cox and Snell R^2=0.05, Nagelkerke R^2=0.06

Analysis of MHCM Project Effects

The final part of our outcome analysis consisted of comparing the arrest and technical violation rates of MHCM clients to a similar group of probationers who did not participate in the MHCM project. Since the MHCM project was available to all probationers with mental health needs in eight probation offices starting in March of 2007, we needed to create a comparison group that consisted of probationers with mental health needs in these same eight offices prior to the piloting of the MHCM project (this group is commonly referred to as a "historical comparison group" and represents "probation as usual"). To create this comparison group, we collected CMIS and criminal history data on all probationers who began probation supervision in the calendar year of 2005. These probationers were selected because it would be unlikely that they would have been exposed to any MHCM supervision or treatment. They may have had treatment, but would not have been under MHCM supervision and expedited referrals.

Once we collected CMIS and criminal data on all 2005 probationers, we needed to narrow this group down so that they were as similar to the MHCM group as possible. This step consisted of employing propensity score matching techniques that statistically matches individuals in one group to another based on specific criteria. Propensity scores were computed using age, all of the LSI-R subscales, and the disruption subscale of the ASUS and ASUS-R. Once the propensity scores were computed, individuals with similar scores were hand-matched by gender and race/ethnicity. Of the 710 MHCM clients, we were able to match 566 of them to the 2005 probationers. Further statistical testing found no statistically significant differences between the MHCM study group and the newly created comparison study group in terms of gender, race/ethnicity, age, LSI-R subscales,

or ASUS disruption (see Appendix C for the detailed summary of MHCM clients and comparison group probationers).

The primary component of the outcome analysis was to assess differences between the two study groups for arrests and technical violations one year after the start of probation supervision. There were statistically significant differences between these groups for arrests but not for technical violations (Table 12). The comparison group had a higher arrest rate than the MHCM group (41% versus 30%). The differences for technical violations were not significant (8% of the comparison group and 10% of the MHCM group were violated).

Table 12. Arrests and Technical Violations between Comparison and MHCM Groups

	Comparison	MHCM	Total
None	294 (51%)	339 (60%)	633
Arrest	235 (41%)	172 (30%)	407
Technical Violation	45 (8%)	55 (10%)	100
Total	574	566	1,140

Chi-Square=13.90, p.<.05

Since one year recidivism differences were found between MHCM probationers and the comparison group, we next calculated the actual effects of MHCM participation. Multinomial logistic regression was used to determine these effects (Table 13). The overall results mirror Table 12, in that, the MHCM project had significant effects for arrests but not technical violations. An odds ratio was used in this analysis for determining the actual effects of the MHCM project. For new arrests, the odds ratio of 0.635 indicates that MHCM clients were 1.6 times less likely to be arrested than those probationers in the comparison group. The effects were not statistically significant for technical violations.

Table 13. Odds Ratios for Arrests and Technical Violations

		B	Std. Error	Wald	Sig.	Odds Ratio
Arrests	Intercept	-.224	.088	6.553	.010	
	MHCM	-.455	.128	12.581	.000	.635
Technical Violations	Intercept	-1.877	.160	137.483	.000	
	MHCM	.058	.216	.073	.788	1.060

Table 14 shows the time to arrest or technical violation. The average days to arrest were statistically similar between the two study groups (approximately 130 days or four months). MHCM clients were violated sooner than comparison group probationers. MHCM clients averaged 130 days (four months) until they were violated versus 180 days (six months) for the comparison group.

Table 14. Average Days to Arrest or Technical Violation

	Arrest	Technical Violation*
Comparison	134	180
MHCM	124	130

Averages were statistically different at p.<.05

Summary of Evaluation Findings

The evaluation of the MHCM project centered on four primary questions: (1) was the program implemented in a way to maximize its' potential for successful outcomes; (2) were there differences in the arrest and technical violation rates of MHCM probationers and a similar group of probationers not being supervised by Mental Health Officers; (3) were there specific probationer characteristics related to success; and, (4) what were the overall effects of the MHCM project on recidivism. We used a combination of qualitative (interviews with MHOs) and quantitative methods (analysis of CMIS and criminal history data) to address these questions.

Program Implementation. Interviews with MHOs indicated that officers who entered the program tended to be experienced in community supervision and balanced in their attitude toward their role, neither highly oriented toward the "social worker" or "law enforcement" aspects of their duties. The small caseload size inherent in the program allowed officers to allot more time to clients and understand their clients' mental health conditions in depth and collaborate with their client's mental health providers, which officers found to be helpful in supervision.

Over the course being an MHO, supervision styles became more therapeutic, as officers discovered that supervision strategies effective for their mental clients were different from their traditional clients. MHOs believed that supervision strategies that emphasized collaboration, positive reinforcement, and motivational interviewing skills were more successful than punitive strategies. Officers noted a direct relationship between treatment compliance and participation with program success, and a corresponding relationship between treatment noncompliance with program failure. Overall, from the perspective of MHOs, the strengths of MHCM project appear to be its reduced caseload size, specialized training, and supportive supervisors, while the area in need of most improvement concerns the availability of dual diagnosis and inpatient services.

Outcome Analysis. The outcome analysis produced three primary findings. First, there were some differences in the arrest and technical violation rates across the eight MHCM probation offices. The New Britain probation office had the lowest arrest rate and the second lowest technical violation rate. Whereas, the Waterbury office had the highest technical violation rate and Middletown had the highest arrest rate. Overall, these differences were relatively small, which leads us to believe the MHCM project was implemented fairly consistently across probation offices and MHOs. Second, the MHCM clients most likely to be arrested and/or violated were younger, had a high number of

prior arrests, and were under-education (most likely did not have a high school diploma). Clients least likely to be successful also were the highest risk clients (based on the LSI-R total risk score). Third, after creating a historical comparison group that was very similar to the MHCM group, we found that the MHCM group had much lower arrest rates than the comparison group but similar technical violation rates.

CONCLUSIONS AND RECOMMENDATIONS

CSSD's Mental Health Case Management project was first implemented in March of 2007 and was aimed at decreasing the recidivism rates of probationers with serious mental illness (SMI). The project centered on creating ten specialized probation officers (e.g., Mental Health Officers) in eight probation offices who received significant training on working with persons with SMI, had caseloads of 35 mental health clients, and had multiple face to face contacts with clients and service providers every month. The evaluation of the MHCM project addressed three questions regarding the implementation and outcomes of the project. These were: (1) Was the program implemented in a way to maximize its' potential for successful outcomes? (2) Were there specific probationer characteristics related to program failure (rearrest/technical violations)?; and, (3) Were there differences in the arrest and technical violation rates between MHCM probationers and a similar group of probationers not being supervised by Mental Health Officers? We address our conclusions to each of these questions and offer recommendations for future policy and programming.

CONCLUSIONS

(1) Was the program implemented in a way to maximize its' potential for successful outcomes?

While the Council of State Governments (2002) has recommended the implementation of specialized mental health probation units, there is, as yet, scant literature on how they should be implemented. As noted earlier, one of the few peer reviewed articles to that have examined these specialized units noted that they have 5 distinct characteristics: MHOs are 1) specially designated probation officers who carrying a caseload exclusively of probationers with mental illness, 2) capped with a smaller case load than regular probation officers, 3) provided with specialized training in working with persons with SMI, 4) more focused on treatment and advocacy than traditional probation, and 5) more likely to use problem solving than threats and sanctions when it comes to handling probationer noncompliance (Skeem et al., 2006). In both policy and interviews with MHOs, the MHCM project closely resembled the prototypical specialized mental health units outlined above: The probation officers in the MHCM project carried exclusive mental health caseloads, carried no more than 35 clients, and were provided with 20-40 hours of training in mental health issues per year. Interviews with officers indicated they were aware of their clients' diagnosis, symptoms, and in regular contact with their clients' mental health treatment provider, and for most officers, this contact was weekly. Officers reported that relationships with their clients were more collaborative and focused on increasing compliance with probation rather than enforcing the conditions of probation. They also reported that in their supervision they considered how their clients' thinking and behavior was influenced by mental illness.

(2) Were there specific probationer characteristics related to program failure (rearrest/technical violations)?

Quantitative analysis revealed several significant predictors that could distinguish between MHCM probationers who were rearrested and those were not. We found that younger age, greater criminal history as assessed by the LSI-R and ASUS-R, greater antisocial attitudes and financial need as assessed by the LSI-R, and less psychological distress as assessed by the ASUS-R were predictive of rearrest. The magnitude of these predictors was not large, and they are, with one exception, already established predictors of recidivism. The only finding which was striking was that lower scores on the ASUS-R's measure of psychological distress (Mood subscale) were associated with rearrest, rather than higher scores as might be expected. The difference in the average Mood score of those who were rearrested with those who were not was small. The finding may be statistically significant, but clinically insignificant. The finding may also be a function of the type of psychological distress most strongly measured by the Mood subscale. The symptoms assessed by the Mood scale primarily concern anxiety and depression (rather than psychosis/depersonalization/paranoia), which are may be less likely to be associated with recidivism than the more severe symptoms that characterize schizophrenia and other signs of SMI.

There were fewer predictors of technical of violations, none of which were striking or of a large magnitude: Younger age, greater criminal history as assessed by the LSI-R and ASUS-R, and poor family/marital relationships as assessed by the LSI-R were associated with technical violations. All of these factors are well established predictors of poor criminal justice outcome.

Qualitative analysis suggested several two primary differences between MHCM probationers who completed the program and those did not: Motivation and drug use. In interviews, officers noted that successful clients tended to be those who entered participated in treatment programs, and were compliant with their medications while those who were unsuccessful tended to be those who were noncompliant/unmotivated. This suggests that motivation for compliance/treatment may be a significant predictor or success and failure in specialized programs. This variable could be systematically explored through future research and targeted for change in future revisions of the program. For example, clients could be assessed using one of the existing readiness to change assessment instruments, and clients' motivation could be improved through the use of a brief motivational enhancement intervention. With respect to drug use, officers noted the continued drug use, and a lack of dual diagnosis treatment options were hindrances for clients' successful completion of the program.

(3) Were there differences in the arrest and technical violation rates between MHCM probationers and a similar group of probationers not being supervised by Mental Health Officers?

We compared the one year arrest and technical violation rate of MHCM probationers with a comparison group that underwent probation as usual and matched on

age, LSI-R subscales, and ASUS-R subscales. The rearrest rate of the comparison group (41%) was significantly higher than the rearrest rate of the MHCM probationers (30%). Thus, MHCM probationers had a rearrest rate about 25% lower than that of the comparison group.

In examining those who were rearrested, the number of days from the beginning of probation to rearrest were not different between the comparison group and MHCM probationers. The technical violation rate of the comparison group (8%) was not significantly different from that of the MHCM probationers (8%). Among those who did receive a technical violation, the number of days from the beginning of probation to violation were greater for the comparison group (180 days) than for the MHCM probationers (130 days). The fact that the program did not reduce rates of technical violations is not surprising: A common finding across intensive supervision programs is an increase in technical violations (Petersilia, 1999), as the greater contact between probationer officer and probation make it more likely that noncompliance will be discovered.

RECOMMENDATIONS

Our overall conclusion was the MHCM project was effective in reducing arrests of probationers with serious mental illness. The MHCM project was implemented according to the scientific literature and, subsequently, produced positive results. We do, however, offer the following recommendations to improve the delivery of the MHCM project:

1. CSSD should consider expanding this project to all probation offices in Connecticut and also adding Mental Health Officers to the existing offices. There appears to be a large need for this type of program. The MHO caseloads were mostly at or slightly above 35 clients throughout the evaluation. In addition, the probationers participating in this program were clearly different than other probationers. MHCM clients were older, not married, under-educated, unemployed, more habitually criminal, high risk, and had high emotional risk scores. A higher percentage of MHCM clients were also females (27% compared to approximately 15% of the general probation population). We must stress however, that any expansion of the MHCM project should follow the MHCM model as closely as possible and pay close attention to the basic principles associated with the scientific literature (low and specialized caseloads, significant mental health training for MHOs, and an emphasis on keeping clients in the community).

2. MHOs need to have clinical consultation available on an on-going basis. MHOs commented throughout the evaluation that they often had basic questions or needed clinical advice with specific clients but did not have anyone to consult. We recommend that CSSD consider having licensed clinical psychologists available on an ad-hoc basis for consultation. Any arrangement should be flexible

where MHOs could meet monthly as a group with the clinician and also be able to contact this person for one-on-one advice.

3. CSSD should work more closely with DMHAS in identifying services for probationers with SMI and co-occurring substance abuse problems. MHOs stated they had limited treatment options available for clients with substance abuse problems. This issue was also frequently stated in the scientific literature: treatment facilities for mental health issues typically will not accept clients who also have a co-occurring substance abuse problem or substance abuse treatment programs will not accept clients who are serious mentally ill. Programs that serve individuals with SMI and substance abuse problems are needed given that nearly 25% of MHCM clients had a secondary need for substance abuse treatment.

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APPENDIX A – CSSD MENTAL HEALTH CASE MANAGEMENT POLICY

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1. **Policy** The Court Support Services Division (CSSD) will establish Mental Health Probation Officers to provide intensive supervision for clients with identified mental health disorders. These officers will work collaboratively with DMHAS staff to ensure access to an expanded service continuum for psychiatric and co-occurring disorders.

2. **Definitions**

   A. Adult Substance Use Survey- Revised (ASUS-R) A self-administered questionnaire completed by probationers during the risk/needs assessment process that describes their substance use habits and emotional disruption.

   B. Case Plan The process of collaborating with the probationer to develop strategies and actions to address their needs and facilitate law-abiding behavior and compliance with court conditions.

   C. Classification Override A decision made by a Supervisor to assign a probationer to a classification other than that determined by either the LSI-R score or the sex offender definition.

   D. Collateral Contact A contact between a probation officer and any person or agency that provides information about a CSSD client, their activities and/or adherence to conditions of probation.

   E. Contracted Program/Services For the purpose of this policy, any program or service that is directly funded by the Court Support Services Division.

   F. Department of Mental Health and Addiction Services (DMHAS) State agency responsible for providing comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut.

   G. DMHAS Eligibility A guideline established by DMHAS to target the mental health population it serves. DMHAS eligibility requires a diagnosis of a severe mental illness.

   H. Exigent Circumstances Compelling information that a delay in action poses a danger to any individual.

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I. Face-to-Face Contact A personal meeting between a probation officer and a probationer.

J. High A probation supervision classification consisting of probationers who are at high-risk to reoffend based on results of the LSI-R.

K. Home Visit A contact conducted at the client's residence that when possible, involves meeting with the client. This may also include contact with family members / significant other.

L. Level of Service Inventory – Revised (LSI-R) The risk and need assessment instrument used by the CSSD to assess and classify supervision cases.

M. Local Mental Health Authority (LMHA) DMHAS funded provider offering wide range of therapeutic programs and crisis intervention services throughout the state.

N. Mental Health Disorder An abnormal mental condition or disorder associated with significant distress and/or dysfunction. This can involve cognitive, emotional, legal, vocational, behavioral and interpersonal impairment.

O. Mental Health Officer (MHO) A Probation Officer assigned to the supervision of clients with mental health disorders.

P. Mental Health Stability A state of emotional and psychological well-being in which a person is able to use his or her own cognitive capabilities to cope with the ordinary demands of every day life.

Q. Sex Offender For the purpose of this policy, a probationer who has been classified as a Sex Offender in accordance with CSSD Policy and Procedure 4.18, Sex Offender Supervision.

R. Special Program Screen (SPS) A data screen within CMIS designed for use with special projects.

3. **Procedures**

A. Eligibility and Referral This program will serve clients who have been identified by the Department of Correction (DOC), Department of Mental Health and Addiction Services (DMHAS) or any other licensed mental health provider as having a mental health disorder. Probation clients who have not previously been identified through a

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clinical evaluation as having a mental health disorder but have a raw score of 15 or more on the ASUS-R Mood Scale, will be referred for a comprehensive mental health evaluation through DMHAS, the Local Mental Health Authority (LMHA), the CSSD contracted provider, or an approved private provider for this service. The results of the mental health evaluation will serve as a guide to determine if placement with a Mental Health Officer is appropriate. At a minimum, clients, who have had a recent mental health evaluation or are receiving mental health services, must be DMHAS eligible to remain on supervision with the Mental Health Officer (MHO). Mental health supervision will only be available in locations where an MHO is assigned, and when the client is 18 years of age or older.

B. Exclusions Administrative Monitoring and Sex Offender cases as defined by CSSD Policy and Procedure 4.18, Sex Offender Supervision will not be referred to a mental health caseload unless the client has completed sex offender treatment or was deemed inappropriate for sex offender treatment by Special Services.

C. Cases Received from IAR

(1) The Supervisor of the Mental Health Officer will review all files that have been identified as potential candidates for mental health supervision as stated in Policy 4.2, Post-Conviction Intake, Assessment and Referral, Section 3.B.(2).

(2) The Supervisor of the Mental Health Officer will assign clients to the Mental Health Officer for screening and evaluation when all of the following exist:

a. The MHO's caseload cap of 35 clients has not been reached;

b. The Supervisor of the Mental Health Officer is able to verify the validity of the mental health referral by the IAR Unit;

c. The Supervisor of the Mental Health Officer believes that the client would be best served by mental health services and supervision.

(3) Within the first 20 days of supervision by the MHO, clients referred from IAR who are in need of a mental health evaluation will, in accordance with Section 3.A. in this policy, be referred to DMHAS, the LMHA or the CSSD contracted provider for this service. The results of the mental health evaluation will serve as a guide to determine if the client should remain on supervision with the MHO.

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(4) Within the first 20 days of supervision by the Mental Health Officer, the MHO, his/her Supervisor and a representative from DMHAS will review files of clients who are receiving mental health services/treatment to determine if continued supervision by the MHO is appropriate. At a minimum, the client must be DMHAS eligible to remain on supervision with the MHO.

(5) After consultation with probation staff and a DMHAS representative as stated in Sections 3.C. (3) and 3.C. (4) above, the MHO will access the Special Program Screen in CMIS and select from the drop down options under "Discharge Outcome" that documents whether the client will remain on supervision with the MHO ("MH Supervision Accepted"), or if supervision with the MHO is not continuing ("MH Supervision Denied").

(6) Clients who are not assigned to a Mental Health Officer will be assigned to another Probation Officer and to the appropriate supervision level, based on the results of CSSD's risk and needs assessments. The supervisor can approve any case to be overridden to a higher supervision level.

(7) The supervisor/designee will access the Special Program Screen (**CSSD Attachment A**), in CMIS and select "MH Supervision Denied" in the drop down for "Discharge Outcome" when the case is not assigned to a Mental Health Officer.

D. Cases Received from Adult Supervision

(1) The referring Probation Officer will identify the case as a candidate for Supervision by the MHO by documenting in the CMIS Case Notes the reason the client was identified as a candidate for Mental Health Supervision, and by completing the CSSD Mental Health Referral Form (**CSSD Attachment B**). This form should be stapled to the inside cover of the clients' file. The file will be forwarded to the Supervisor of the Mental Health Officer for consideration.

(2) The Supervisor of the Mental Health Officer will review clients files identified by the current probation officer as candidates for mental health supervision when any of the following exist:

a. The client is in mental health treatment;

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b. The client had a recent mental health evaluation through DMHAS, the LMHA or the CSSD contracted provider for mental health services; or

c. Exigent circumstances exist.

(3) While still under the supervision of a probation officer not specializing in mental health cases, the DMHAS representative, the current supervision officer, the MHO and the Supervisor of the Mental Health Officer will discuss the case and determine the most appropriate services for the client, which may include supervision by a Mental Health Officer. At a minimum, the client must be DMHAS eligible to be accepted for Mental Health Supervision.

(4) The supervisor/designee will access the Special Program Screen (SPS) in CMIS and select "Mental Health" in the "Program Type" dropdown, and "MH Referral" in the "Discharge Outcome" for any case that was presented to the Supervisor of the Mental Health Officer as a candidate for supervision by a Mental Health Officer.

(5) Clients who are reviewed for placement with a Mental Health Officer but are not assigned to the MHO will remain with their current Probation Officer.

(6) The supervisor/designee will access the Special Program Screen in CMIS and select "MH Supervision Denied" in the drop down for "Discharge Outcome" when the case is not assigned to a Mental Health Officer.

(7) The supervisor or a designee will access the Special Program Screen in CMIS and select "MH Supervision Accepted" in the drop down for "Discharge Outcome" when the case is assigned to a Mental Health Officer.

E. Supervision Activities / Standards

(1) The MHO will adhere to the following supervision standards for all assigned cases:

a. Prior to the first supervision meeting with the client, the MHO will review the clients' CSSD file, the evaluation for mental health services, current mental health records, as well as any other relevant and available reports.

b. Meet with the client within five (5) business days of being assigned the case. The initial supervision contact should be in the probation office

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or at the LMHA.

c. Have a minimum of three (3) face-to-face contacts with the client per month. When reasonable, at least one (1) of these contacts will occur in the home. When possible and appropriate, the home visit will be conducted at a time when family members or significant others can be present. During the initial contact with family members or significant others, the MHO will leave his or her contact information with all appropriate persons.

d. Have a minimum of one (1) collateral contact per month with persons or agencies providing mental health treatment to the client. With informed consent from the client, this contact should include, but will not be limited to:

i Adherence to treatment
ii Progress in treatment
iii Concerns of the provider and probation officer
iv Behavioral changes noticed
v Readiness for change
vi Substance abuse issues
vii Medications prescribed and compliance
viii Changes in diagnosis
ix Review of treatment plan

e. When the client is not engaged in mental health treatment, have a minimum of one (1) collateral contact with persons or agencies providing other treatment, or a significant person(s) who can provide information about the clients' activities (e.g., employer, relative, sponsor, etc.).

f. After the first 4 months of supervision, if the MHO determines that sufficient progress has been made and the client's mental health is stable the minimum number of face-to-face contacts may be reduced to two (2) per month. Input from the mental health treatment provider should be taken into consideration prior to reducing the face-to-face contacts.

g. A case review will be conducted every six (6) months to appraise the

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client's progress and current situation. The case review will include, but will not be limited to discussions with the primary treatment provider.

(2) When possible and appropriate, the MHO should carry out the following activities during each face-to-face contact:

a. Assess the degree of general danger that the client poses to him/herself and others.

b. Identify any areas in which the client may need assistance (e.g., obtaining medical assistance, disability income, housing, or vocational training).

c. Be familiar with the clients' psychotropic medications to enable a discussion on the clients' medication regime, to include encouraging the client to take their medication(s) and discussing the effects of the medication(s).

d. Elicit the clients' assessment of treatment and the effect it is having on their life.

e. Discuss the client's current social support system and how it is impacting their situation.

f. Discuss any risk factors or symptoms as described by the mental health provider (e.g., is the client hearing voices; does the client believe that someone is out to get them; etc.).

g. Discuss current stressors in the clients' life and elicit potential remedies.

h. Review the clients' progress in meeting goals and activities of their Case Plan, and if necessary help the client make adjustments.

i. Discuss the clients' progress and involvement in any required programs, services, or supervision conditions.

j. Discuss any problems or concerns the client may have.

k. When necessary, set appropriate limits and provide clear direction to

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the client.

1. Conclude by summarizing and reinforcing any positive progress and behavior, and review any client responsibilities that need to be completed before the next contact.

F. Case Plan All cases assigned to a Mental Health Officer, regardless of the clients' assigned supervision level, will have an Automated Case Plan created as outlined below:

(1) The MHO will collaborate with the client in developing a Case Plan and when possible, complete the Plan within twenty (20) business days after receiving the case.

(2) When meeting with the client to complete the Case Plan, the MHO will:

a. Explain the role of the MHO which is to assist the client by providing appropriate resources that can help stabilize their situation and meet their basic and criminogenic needs, as well as to monitor their compliance with any court conditions.

b. Thoroughly review the results of any assessments (LSI-R, ASUS-R) with the client, including their criminogenic and non-criminogenic needs.

c. Discuss issues that need to be addressed to facilitate successful completion of the clients' term of probation, and help to improve daily functioning.

d. Collaborate with the client to develop a Case Plan and summarize the Plan in Case Notes.

e. When possible, the Case Plan should incorporate aspects of the mental health treatment providers' clinical plan for the client.

f. Once the Case Plan has been created, the MHO will review it with the client and discuss the progress toward achieving the established goals and activities during each supervision visit.

g. The Case Plan should be updated to address additional needs and whenever the client begins or completes a treatment program.

h. The MHO will request that the client sign a copy of the Automated Case Plan when it is first created, and every time modifications are made to either the goal or treatment sections. The client should sign and receive a copy of the Automated Case Plan each time a modification is made.

G. Violation Process When there is violation activity, the MHO will have a discussion with his/her supervisor and the primary treatment provider (when the client is in treatment), to develop a response that will, when possible, keep the client in the community and in the appropriate treatment. Violations of Probation should only be initiated when the client refuses all treatment, has demonstrated a history of persistent non-compliance, or when the MHO is concerned for the imminent health or safety of the client or others.

H. Transition to Regular Probation Caseload / Probation Completed

(1) If a MHO determines that a client no longer needs to be supervised on a Mental Health caseload, the client may be transitioned to a regular caseload after consultation and approval from the Supervisor of the Mental Health Officer. Input from the mental health provider should be considered when making this decision.

(2) Transition to a regular probation caseload will be based upon progress toward completing the Case Plan. The following guidelines may be indicators that the client can be transitioned to a regular caseload:

a. The client has successfully completed or is actively participating in mental health treatment.

b. The client has stable housing and is employed or actively seeking employment.

c. The client is not currently abusing drugs to the MHO's knowledge.

d. The client is attending probation supervision meetings to the satisfaction of the MHO.

e. The MHO is obtaining positive information from treatment providers and other collateral contacts that indicate progress.

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f. When applicable, the client has demonstrated a history of taking his/her prescribed medication(s).

(3) Prior to transferring a case to a Probation Officer, the Mental Health Officer will discuss with the receiving officer the clients' mental health disorder, co-occurring disorders, overall progress, medication compliance, Case Plan goals and other salient factors related to stabilization and risk reduction. This information should be documented in CMIS Notes.

(4) The MHO will access the Special Program Screen in CMIS and select "MH Successful/Transition" in the dropdown for "Discharge Outcome" whenever a client is transitioned from the Caseload of the MHO to another probation officer other than TVU.

(5) The MHO will access the Special Program Screen in CMIS and select "MH Successful/Completion" in the dropdown for "Discharge Outcome" whenever a client successfully completes their term of probation under the auspices of the MHO.

(6) The receiving Probation Officer will meet with the client within ten (10) business days after being assigned the case. When possible, the MHO will escort and introduce the client to the new Probation Officer.

(7) Unless otherwise approved by a supervisor, the client will be transitioned from Mental Health Supervision to a Classification Level of High on a regular caseload.

4. **Exceptions** Any exception to this policy will require prior written approval from the Division's Executive Director.

APPENDIX B – MHO INTERVIEW INSTRUMENT

1) What are the most common psychological disorders you work with?

2) How much do you learn about any given's mental health history? Are you typically aware of their diagnosis? symptoms? treatment?

3) If a client seems particularly unstable or bizarre, what do you do? Where do you go for help?

4) How much contact do you have with the mental health providers of your clients? Of your caseload right now, what percentage have involved some contact between you and the mental health provider?

5) What information do the mental health providers share with you? Is it adequate? If not, what would make it more helpful? Does contact with the providers help you work more effectively with your clients?

6) Do you believe that your clients are getting enough treatment, in terms of quality and quantity? If not, what do you believe is the barrier?

7) Since your initial training, what additional trainings have you had? Have they been useful?

8) Do you supervise clients differently now compared to before you became a part of this program? If yes, how so?

9) In terms of enforcing the conditions of probation, what strategies have you found to be effective with your mental health clients? Which have not been effective? What difference do you notice in enforcement challenges between mental health clients and regular probation clients?

10) For those successful discharges, what do you think was the primary reason the clients were successful?

11) For those unsuccessful discharges, what do you think was the primary reason the clients were unsuccessful?

12) Do your supervisors seem supportive of your special assignment? If not, can you describe a situation where they were not supportive?

13) What barriers do you think exist in effectively implementing this program?

14) What recommendations do you have that would improve this program for clients?

15) What do you think this program has done well?

16) How many clients have you typically had on your caseload since you became a mental health PO?

17) How many clients did you typically have before when you had a regular caseload?

APPENDIX C – SUMMARY OF MHCM CLIENTS AND COMPARISON GROUP PROBATIONERS

Table 15. Gender by Study Group

	Comparison	MHO	Total
Female	178 (31%)	151 (27%)	329
Male	396 (69%)	415 (73%)	811
Total	574	566	1,140

Chi-Square=2.61, p.=.11

Table 16. Race/Ethnicity by Study Group

	Comparison	MHO	Total
White	282 (49%)	274 (48%)	556
Black	152 (26%)	159 (28%)	311
Hispanic	137 (24%)	126 (22%)	263
Other/Unknown	3 (1%)	7 (2%)	10
Total	574	566	1,140

Chi-Square=2.28, p.=.52

Table 17. Averages by Age, LSI-R Subscales, and ASUS-R Disruption

		Comparison (n=574)	MHCM (n=566)	t-score	p. value
Age		36.19 (10.11)	36.83 (11.40)	-0.995	0.32
LSI-R	Criminal History	5.12 (2.26)	5.22 (2.22)	-0.706	0.48
	Employment/Education	5.32 (2.73)	5.49 (2.63)	-1.053	0.29
	Financial	1.60 (.59)	1.61 (.60)	-0.437	0.66
	Family	2.32 (1.20)	2.39 (1.17)	-1.09	0.28
	Accommodations	1.33 (.96)	1.33 (.96)	-0.2	0.98
	Leisure	1.63 (.64)	1.63 (.64)	0.044	0.97
	Companions	2.77 (1.30)	2.80 (1.25)	-0.356	0.72
	Alcohol/Drug	4.65 (2.66)	4.83 (2.68)	-1.14	0.25
	Emotional/Personal	4.15 (1.02)	4.16 (1.05)	-0.179	0.86
	Attitude/Orientation	1.55 (1.32)	1.49 (1.29)	0.746	0.46
	Total Risk	30.45 (7.02)	30.96 (6.91)	-1.24	0.21
ASUS-R	Disruption	21.72 (19.28)	22.11 (20.80)	-0.331	0.74