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Problem-Solving Supervision:
Specialty Probation for Individuals with Mental Illnesses

Jennifer Skeem & John Petrila

One of the most important developments in American law over the last decade has been the exponential growth of problem-solving courts. Such courts achieve efficiencies by consolidating certain types of cases before specially designated judges. Additionally, in many instances, problem-solving courts adopt a therapeutic focus by attempting to achieve outcomes (*e.g.*, obtaining treatment for a defendant) that go beyond the traditional goals of the judicial system. A recent commentary in this journal noted that "problem-solving courts generally focus on the underlying chronic behaviors of criminal defendants."[1] These courts include, but are not limited to drug courts, mental health courts, domestic violence courts, and teen smoking cessation courts. Perhaps the first prototypical problem-solving court was the juvenile court. Today, problem-solving courts exist in many countries throughout the world.[2]

Typically, problem-solving courts are designed to respond to larger social problems that impinge on the justice system. Drug courts and mental health courts in particular have emerged because of the disproportionately high prevalence of substance use and mental health disorders among criminal defendants.[3] As judicial caseloads and correctional populations swelled with individuals charged with drug offenses, some judges and court administrators concluded that at least some defendants would be better served by treatment programs than incarceration. In addition, it was assumed that the creation of special courts would take pressure off other courts by removing certain types of cases (e.g. typical first-time, nonviolent drug offenders in drug court cases) from their dockets. As a result, drug courts were created: the first in Dade County, Florida, in 1989. Such courts proved immensely popular. Today there are more than 1,200 drug courts in existence or in planning, and more than 226,000 defendants have participated in drug-court-related programs.[4]

Mental health courts have been created more recently. Like drug courts, they are designed to divert certain individuals with mental illnesses into treatment while consolidating their cases before designated "mental health court" judges. These courts are one response to the prevalence of mental disorders among defendants, which creates a burden that "threatens to overwhelm the criminal justice system."[5] In its *Criminal Justice/Mental Health Consensus Project,* the Council of State Governments recognized mental health courts as one of several "workable options" that communities with limited resources have developed to better fit the system to the needs of these defendants.[6] The first mental health court of this era was created in Broward County, Florida, in 1997.[7] Today it is estimated that there are approximately 80 mental health courts of various types throughout the United States.[8] While at this point it is difficult to characterize the "typical" mental health court,[9] most mental health courts appear to have a consolidated docket of cases involving mental illness, operate under a judge specially assigned to that docket, and attempt to divert defendants into treatment and other services. It appears that mental health courts are in a state of flux, with more recently created courts willing to take jurisdiction over some felony cases. This is in contrast to the "first generation" of courts that tended to limit jurisdiction to misdemeanors.[10]

Both drug courts and mental health courts are based on the theory of "therapeutic jurisprudence." This theory assumes that legal principles and processes should be examined for their therapeutic or non-therapeutic effect on individuals.[11] Advocates for therapeutic jurisprudence generally assume that traditional adversarial court processes create impediments to achieving therapeutic outcomes for defendants. As a result, drug courts and mental health courts are usually less formal than traditional criminal court, with judges and lawyers committed to finding the best outcome for the defendant in concert with other parties in the community, including social service and treatment agencies.

Footnotes

1. Daniel J. Becker & Maura D. Corrigan, *Moving Problem-Solving Courts Into the Mainstream: A Report Card From the CCJ-COSCA Problem-Solving Courts Committee,* COURT REVIEW, Spring 2002, at 4.
2. John Petrila, *An Introduction to Special Jurisdiction Courts,* 26 INT'L J. LAW & PSYCHIATRY 3 (2003).
3. A 1999 report of the United States Department of Justice estimated that there are approximately 2 million individuals with mental illnesses under the control of federal, state, and local criminal justice authorities. BUREAU OF JUSTICE STATISTICS. U.S. DEP'T OF JUSTICE, MENTAL HEALTH & TREATMENT OF INMATES AND PROBATIONERS (1999). It is also estimated that more than 700,000 arrestees each year have a serious mental disorder, with 75% of them having a substance abuse disorder. BUREAU OF JUSTICE STATISTICS. U.S. DEP'T OF JUSTICE, PRISON & JAIL INMATES AT MID-YEAR (1997).
4. Aubrey Fox & Greg Berman, *Going to Scale: A Conversation About the Future of Drug Courts,* COURT REVIEW, Fall 2002, at 4.
5. COUNCIL OF STATE GOVERNMENTS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 6, 2002. *Available at* http://www.consensusproject.org (last visited Dec. 21, 2003) [hereinafter CONSENSUS PROJECT].
6. *Id.*
7. John Petrila, Norman Poythress, Annette McGaha, & Roger Boothroyd, *Preliminary Observations from an Evaluation of the Broward County Mental Health Court,* COURT REVIEW, Winter 2001, at 14.
8. COUNCIL OF STATE GOVERNMENTS, CONSENSUS PROJECT, *supra* note 5.
9. Henry J. Steadman, Susan Davidson, & Collie Brown, *Law & Psychiatry: Mental Health Courts: Their Promise and Unanswered Questions,* 52 PSYCHIATRIC SERVICES 457 (2001).
10. Henry J. Steadman, Allison D. Redlich, Patricia A. Griffin, John Petrila & John Monahan, *From Referral to Disposition: Case Processing in Seven Mental Health Courts,* BEHAV. SCI. & LAW (in press).
11. Christoper Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder,* 1 PSYCHOL., PUB. POL'Y & LAW 193 (1995).

Drug courts are now assumed by most to accomplish their goal of obtaining treatment for defendants, and preliminary research suggests that mental health courts also may serve as an effective gateway to treatment services.[12]

The development of problem-solving courts is sufficiently advanced that discussions have begun about how to spread the principles that underlie them more broadly through the legal system.[13] These discussions are occurring simultaneously with discussion about the changing role of trial judges, which has been hastened in part by the creation of problem-solving courts.[14]

Although these developments within the judiciary have occasioned healthy debate about their implications for the courts, the impact on other parties has received less notice. Drug courts and mental health courts may indeed facilitate access to treatment for defendants, and even influence the success of treatment through continued monitoring and the use of sanctions for noncompliance.[15] However, the courts by necessity depend on others, including social service agencies, treatment providers, and probation officers, to *implement* the mandate to participate in treatment. Like the courts, these parties have been influenced by broader social phenomena and have adopted strategies to cope with the demands of maximizing dwindling resources to serve and supervise a growing high-risk population.

One particularly promising strategy is the development of specialty caseloads for probationers with mental illness (hereafter, PMI). Probation officers with specialty caseloads play a central role in monitoring and enforcing the conditions of probation, including the mandate to participate in treatment. Thus, these officers combine two functions: they seek to assure public safety (the traditional probation officer role), but also attempt to assure the rehabilitation of the probationer (a therapeutic role). Although such specialty agencies emerged at least two decades ago, nearly half have been created over the past five years, mirroring the growth of problem-solving courts.[16] In the rest of this article, we describe the demands on probation officers of supervising PMIs, the unique response of specialty probation agencies to these demands, and the relation between these agencies and the courts. In doing so, we draw on recently conducted research that elicited the views of probation supervisors, probation officers, and probationers with mental illnesses regarding the management of PMIs. We conclude with a summary of issues that must be addressed if specialty agencies for PMIs are to continue growing and succeed.

One particularly promising strategy is the development of specialty caseloads for probationers with mental illness.

I. THE UNIQUE DEMANDS OF SUPERVISING PROBATIONERS WITH MENTAL ILLNESS

In 2002, nearly four million probationers were supervised in the community, easily making probation *the* prototypic correctional disposition.[17] Although no methodologically sound estimate of the national prevalence of mental disorder among probationers is available,[18] the results of a self-report survey suggests that over one-half million (16%) of these probationers suffered some form of mental illness.[19] For the typical officer carrying a caseload of 125 probationers, then, facing the unique demands of probationers with serious mental illness is an inescapable fact of practice.

These demands were described in two studies conducted by one of the authors (JS): one study involved a series of focus groups with PMIs and with their specialty and general probation officers in three major cities (Phoenix, Philadelphia, and Las Vegas, N= 52);[20] the other was a national survey of specialty and traditional probation agency supervisors (N=91).[21] These studies suggest that probationers with mental illnesses create four significant demands beyond traditional probationers. First, PMIs often have pronounced needs for treatment and other social services (*e.g.*, housing, SSI). These services not only fall outside the range of officers' ordinary practice, but also are difficult to access from underfunded and overburdened treatment and social service systems. Second, some PMIs' functional abilities are limited, such that they are unable to follow the basic conditions of probation (*e.g.*, working, paying fees, reporting to their officer's office), let alone navigate the complex social service system. Third, probation officers are expected to monitor

12. Roger Boothroyd, Norman Poythress, Annette McGaha, & John Petrila, *The Broward Mental Health Court: Process, Outcomes and Service Utilization*, 26 INT'L J. LAW & PSYCHIATRY 55 (2003); Merith Cosden, Jeffrey K. Ellens, Jeffrey L. Schnell, Yasmeen Yamini-Diouf, & Maren M. Wolfe, *Evaluation of a Mental Health Treatment Court with Assertive Community Treatment*. 21 BEHAV. SCI. & LAW 429 (2003).
13. Fox & Berman, *supra* note 4.
14. Roger Hanson, *The Changing Role of a Judge and Its Implications,* COURT REVIEW, Winter 2002, at 10. Hanson notes a number of developments over the last few decades, including case management and the development of alternative dispute resolution processes as contributing to the current debate over the role of judging, along with the emergence of problem-solving courts. *See also*, Arthur H. Garrison, *Drug Treatment Programs: Implications for the Judiciary,* COURT REVIEW, Winter 2002, at 24.
15. Patricia A. Griffin, Henry J. Steadman, & John Petrila, *The Use of Criminal Charges and Sanctions in Mental Health Courts,* 53 PSYCHIATRIC SERVICES 1285 (2002).
16. Jennifer Skeem, Paula Emke-Francis, & Jennifer Eno Louden, Probation, Mental Health, and Mandated Treatment: A National Survey, (unpublished manuscript) (2003) [hereinafter *National Survey*].
17. Lauren Glaze, *Probation and Parole in the United States, 2002*. Available at http://www.ojp.usdoj.gov/bjs (last visited Dec. 31, 2003).
18. Harry Boone, *Mental Illness in Probation and Parole Populations: Results from a National Survey,* PERSPECTIVES, Fall 1995, at 32; James Byrne, *Mentally Ill Offenders: An Overview of Issues,* PERSPECTIVES, Fall 1995, at 41.
19. PAULA M. DITTON, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS, NCJ No. 174463 (July 1999).
20. Jennifer L. Skeem, John Encandela, & Jennifer Eno Louden, *Perspectives on Probation and Mandated Mental Health Treatment in Specialized and Traditional Probation Departments,* 21 BEHAV. SCI. & LAW 429, 440 (2003) [hereinafter *Perspectives on Probation*].
21. Skeem, *et al.*, *National Survey, supra* note 16.

Probation officers may find these demands formidable, particularly while juggling a caseload of 125 or more probationers.

and enforce PMIs' compliance with the general conditions of probation as well as special conditions of treatment participation.[22] Although probation personnel assume that treatment compliance is essential to successfully maintaining a PMI in the community,[23] the probationer's complex service needs render it relatively difficult and time consuming for an officer to monitor and assure compliance.[24] Fourth, PMIs often have substance abuse problems. For probationers with both a mental illness and a substance abuse disorder, the two problems can interact with and exacerbate one another, rendering drug abstinence and treatment response less likely.[25]

Probation officers may find these demands formidable, particularly while juggling a caseload of 125 or more probationers. This context lends credibility to the widespread perception that PMIs are at relatively high risk for probation violation and criminal recidivism.[26]

II. MEETING THE DEMANDS: SPECIALTY CASELOADS

One response to these demands has been the creation of specialty probation caseloads designed exclusively for those with mental illness. Given the complexities of supervising PMIs, the Council of State Governments, in its *Criminal Justice/Mental Health Consensus Project*, recommends explicitly the creation of such specialty caseloads.[27]

Probation agencies have a relatively long history of creating specialty caseloads for individuals perceived as having more complex needs than other probationers. For example, special caseloads or conditions of probation have been created for sex offenders,[28] domestic violence offenders, drug offenders, gang offenders, youthful offenders, Spanish-speaking offenders, and the like.[29] Other relevant examples include the imposition of special conditions for individuals found "guilty but mentally ill,"[30] and for juveniles under the jurisdiction of a juvenile mental health court.[31] Several jurisdictions use drug offender probation, often in conjunction with drug courts, and evidence suggests that properly designed probation programs can reduce recidivism and drug use.[32]

Like mental health courts and drug courts, mental health probation has emerged as part of a larger movement in the criminal justice system toward specialization and problem-solving for defendants with needs that do not respond to traditional approaches. A recent survey of probation agencies in the U.S. suggests that today nearly 100 probation agencies have adopted specialty caseloads for PMIs, with 66 specialty agencies having more than one exclusive mental health caseload.[33] This survey compared the 66 specialty agencies with more than one mental health caseload with a sample of 25 traditional agencies matched by population size and geographic region. These survey results, combined with other work,[34] suggest that the prototypic specialty agency is unique in structure and function in four important respects: caseload structure, case management approach, the relationship between probation officers and probationers, and the use of problem-solving strategies when conditions of probation are violated. Each is discussed in turn below.

A. CASELOAD STRUCTURE

The foundation of the prototypic specialty probation agency consists of caseloads that are composed exclusively of PMIs, limited in size, and assigned to interested and specially trained probation officers. These caseloads' most distinctive and perhaps most important feature is their reduced size. Average caseload sizes for officers in specialty agencies (N=40) are less than one-third that of officers in traditional agencies (N=130).[35] In some agencies, mental health caseloads are considered "high risk" caseloads in need of intensive supervision, with appropriate

22. *Id. See also* U.S. Probation and Pretrial Services, Court and Community (fact sheets on probation, Washington DC: Federal Judicial Center) (2001).
23. Dennise Orlando-Morningstar, Glen Skoler, & Susan Holliday, A Handbook for Working with Mentally Disordered Defendants and Offenders (1999).
24. Steven Wormith & Frances McKeague, *A Mental Health Survey of Correctional Clients in Canada,* 6 Criminal Behav. & Mental Health 49 (1996).
25. *See, e.g.*, Robert E. Drake, Fred C. Osher, & Michael A. Wallach, *Alcohol Use and Abuse in Schizophrenia: A Prospective Community Study,* 177 J. Nervous & Mental Disease 408 (1989); *and* Roger Peters, William Kearns, Mary Murrin, & Addis Dolente, *Psychopathology and Mental Health Needs Among Drug-involved Inmates,* 11 J. Prison & Mental Health 3 (1992).
26. Council of State Governments, Consensus Report, *supra* note 5.
27. *Id.*
28. Kim English, *Special Theme: Sex Offenders: Scientific, Legal, and Policy Perspective: The Science of Sex Offenders: Risk Assessment, Treatment, and Prevention: The Containment Approach: An Aggressive Strategy for the Community Management of Adult Sex Offenders,* 4 Psych. Pub. Pol'y & Law 218 (1998).
29. Unpublished data from Jennifer Skeem, Paula Emke-Francis, and Jennifer Eno Louden, *see National Survey, supra* note 16, indicate that various probation agencies possess specialty caseloads of each type. For example, of traditional agencies surveyed, 76% had caseloads for sex offenders and 32% had caseloads for domestic violence offenders.
30. *Comment: People v. Lloyd: Michigan's Guilty But Mentally Ill Verdict Created with Intention to Help Is Not Really a Benefit at All,* 79 U. Det. Mercy L. Rev. 75 (2001).
31. Agata DiGiovanni, *The Los Angeles County Juvenile Mental Health Court: An Innovative Approach to Crime, Violence, and Delinquency Among Our Youth,* 23 J. Juv. Law 1 (2002/2003).
32. Joan Petersilia, *Probation in the United States,* 22 Crime and Justice 149 (1997).
33. Skeem, *et al.*, *National Survey*, *supra* note 16.
34. Council of State Governments, Consensus Project, *supra* note 5; Eric Roskes & Richard Feldman, *A Collaborative Community-Based Treatment Program for Offenders with Mental Illness,* 50 Psychiatric Services 1614 (1999); Skeem, *et al.*, *Perspectives on Probation, supra* note 20.
35. Skeem, *et al.*, *National Survey, supra* note 16.

caseload caps set by agency policy.

Reduced caseloads are responsive to all four of the demands associated with supervising PMIs described earlier. Individuals with serious mental illnesses typically require substantially more time from the probation officer than other individuals. While this may not be true in every case, in general, a probation officer must exert sustained effort to implement both the general conditions of probation and special conditions that mandate treatment, especially with probationers who have serious mental health and substance abuse problems, and who need treatment and other social services that may be difficult to access and limited in capacity. Given these difficulties and their impact on the time an officer must spend on the case of an individual probationer, it is presumptively appealing to assign smaller caseloads to expert officers who carry these probationers exclusively. In traditional agencies, PMIs may be perceived as atypical "problems to the system" that drain resources from other cases. Reduced mental health caseloads provide officers with the time to develop and implement difficult social service referrals, handle crises, and intensively supervise these high risk individuals. As specialty officers gain experience, training, and connections with the social welfare systems, PMIs are transformed from "problems to the system" to routine cases with an array of workable options. As explained below, however, maintaining smaller specialized and exclusive mental health caseloads in the face of pressing demand for probation services is one of the most significant challenges facing the legal system today.

B. CASE MANAGEMENT APPROACH

Mental health caseloads, the foundation of the prototypic specialty mental health agency, are associated with a unique case management approach. First, as suggested earlier, these caseloads create important administrative efficiencies. Unlike traditional agencies, where officers attempt to find a way to fit round PMIs into a square supervision system on a case-by-case basis, officers in specialty agencies follow or develop routines and procedures tailored to the PMI. For example, specialty agencies often apply explicit definitions to determine which probationers are eligible for specialty supervision, and impose special conditions by which these probationers must abide. Although referral processes and eligibility criteria may vary from agency to agency, probationers must be mentally ill to be assigned to the prototypic specialty agency. Broward County, Florida, provides an example of how eligibility for mental health probation may be defined. The administrative order establishing mental health probation provides that "if deemed appropriate by the presiding Judge and otherwise permitted by law, and with the specific agreement and consent of the defendants themselves, defendants suffering from mental illness or mental retardation, as diagnosed by a qualified mental health expert, may be sentenced to a probationary period entitled 'Mental Health Probation' to be supervised by specially designated Probation Officers within the Department of Corrections."[36] Additionally, a defendant placed on mental health probation in Broward County may be required to comply with some or all of the following conditions:

[M]aintaining smaller and exclusive mental health caseloads . . . is one of the most significant challenges . . . . today.

- Sign an authorization for release of all medical and psychological records as deemed necessary for the treatment of mental illness and/or supervision by the Department of Corrections (in Florida, the State Department of Corrections oversees probation);
- Comply with a treatment plan approved by the court;
- Enter and actively participate in inpatient mental health and/or drug and alcohol treatment or other facility deemed appropriate by the Probation Officer;
- Enter and actively participate in outpatient treatment as deemed appropriate by the Probation Officer;
- Submit to random drug and/or alcohol testing;
- Take all medications prescribed for the treatment of mental illness;
- Not operate a motor vehicle;
- Submit to a mandatory curfew;
- Have no contact with the victim, directly or indirectly, unless approved by the victim, therapist and sentencing court;
- Be responsible for payment for programs and services if financially able.

Second, in addition to creating administrative efficiencies, the prototypic specialty agency's case management approach *integrates* internal (probation) and external (community) resources to meet the PMIs' needs. The specialty officer is not merely an agent who "refers out" and then monitors compliance with the conditions of probation. This officer also uses his or her acquired skills and relationships with treatment providers and other social service agencies to help address the PMIs' needs. Specialty officers typically work closely with treatment providers as part of a team. They attend team meetings, help secure social resources, and generally form connections with agencies that facilitate efficient work with PMIs.

These close working relationships are crucial because probation officers oversee compliance with treatment typically provided by other entities. Thus, communication with providers is essential for monitoring and ensuring treatment compliance. The nature of close provider-officer relationships, however, is critical. Close collaboration between treatment providers and officers relates to low rates of probation violation—*if* the provider does not merely become an extension of the oversight role provided by the officer.[37] When case managers become an "extra pair of eyes" for officers, however, probationers are much more likely to be threatened by their officer with incarceration for noncompliance.[38]

36. Broward County, Florida, Admin. Order No. III-02-N-1A, In Re: Order Concerning Creation of the Mental Health Probation Program Within the Circuit Court Criminal Division (17th Cir. Jan. 9, 2002).
37. Roskes & Feldman, *supra* note 34.
38. Jeffrey Draine & Phyllis Solomon, *The Use of Threats of Incarceration in a Psychiatric Probation and Parole Service,* 71 AMER. J. ORTHOPSYCHIATRY 262 (2001).

[I]t appears that problem-solving is the hallmark strategy of specialty officers for addressing probationer non-compliance . . . .

C. RELATIONSHIP BETWEEN THE PROBATION OFFICER AND THE PROBATIONER

In addition to close collaboration with treatment providers to meet PMIs' needs, the prototypic specialty officer typically has a different view of his or her role and relationship with the PMI than the traditional officer. First, traditional probation officers tend to emphasize public safety ("control") as the primary goal of probation, whereas specialty officers tended to emphasize meeting the rehabilitative needs of probationers ("care") as well.[39] These two roles are not completely at odds. For example, specialty officers may assume that treatment and rehabilitation lead to more independent functioning on the part of the probationer: as the probationer becomes more stable and assumes responsibility for his or her conduct, he or she presumably becomes less likely to engage in antisocial conduct. Public safety may be particularly enhanced when the now-treated mental illness played a causative role in the probationer's prior criminal behavior.[40]

Second, in the focus groups conducted with officers and probationers, specialty probation officers with mental health caseloads defined their relationships with probationers differently than traditional officers in three ways.[41] First, specialty officers reported adopting a more friendly, less authoritarian relationship with probationers than traditional officers; probationers in turn tended to characterize their relationships with specialty officers as more caring, supportive, and flexible. Second, maintenance of such a relationship was perceived as being less contingent on good behavior and compliance than was the case with more traditional probation officers. Third, specialty officers were more concerned with establishing boundaries in their relationship with probationers in order to maintain a distinction between the support offered as part of the professional relationship (which was permissible) and friendship (which was not). This is not dissimilar to the boundaries that therapists establish with patients for ethical reasons.

Given this, the quality of relationships between officers and probationers may be defined by two related constructs: an alliance (bond, partnership, and confident commitment) and a "firm but fair" approach (clarity and voice, considerate respect, and flexible consistency).[42] The preliminary research described above suggests that relationships in specialty agencies may more often be characterized by a strong alliance and fairness than those in traditional agencies. These differences in relationships contribute significantly to a fourth unique feature of specialty agencies: officers' strategies for implementing the conditions of probation, especially mandated treatment.

D. PROBLEM-SOLVING STRATEGIES AS A RESPONSE TO VIOLATIONS

A traditional response to violation of conditions of probation is the imposition of sanctions, for example, threatening to revoke or revoking probation. In contrast, it appears that problem-solving is the hallmark strategy of specialty officers for addressing probationer noncompliance, with sanctions generally used only if other strategies failed.[43] In both the focus group and survey studies described earlier, specialty officers were much more likely than traditional officers to respond to a PMI who was noncompliant with treatment by talking with him or her to identify any obstacles to compliance (*e.g.*, he or she might prefer a different medication than the one prescribed), resolving these problems, and agreeing on a compliance plan. The officer would often include the probationer's treatment provider in this discussion. In contrast, officers in traditional agencies were significantly more likely than specialty officers to respond to noncompliance by reminding the probationer of the rules or by threatening to pursue incarceration if the probationer continued to disobey. In short, traditional officers tended to respond to noncompliance with threats of sanctions and pursuit of sanctions, whereas specialty officers called on a more varied set of strategies and used a more graduated approach before pursuing revocation as "absolutely the last resort."[44]

The effect of problem-solving and other enforcement strategies on PMIs' treatment adherence and outcomes compared to the use of sanctions such as probation revocation is unclear. However, probationers and many probation officers in focus groups viewed problem-solving approaches as more effective than threats in securing compliance. Probationers appreciated that their officers would have "fair conversations" with them about noncompliance, be reasonable in accommodating legitimate problems with adherence, and be open and honest about potential consequences. This sentiment is consistent with research on procedural justice, which suggests that individuals feel less coerced when they are treated with respect and allowed to state their views.[45] In contrast, probationers believed that threats often created fear and avoidance, or alternatively, anger

39. Jon F. Klaus, Handbook on Probation Services: Guidelines for Probation Practitioners and Managers (1998).
40. Skeem, *et al.*, *Perspectives on Probation, supra* note 20.
41. *Id.* at 444-445.
42. Jennifer L. Skeem, Probation Officer-Probationer Relationships (2003) (unpublished measures for officers, probationers, and observers). *See also* D.A. Andrews & Jerry J. Kiessling, *Program Structure and Effective Correctional Practice: A Summary of CaVic Research*, *in* Effective Correctional Treatment 439-463 (R. Ross & P. Gendreau eds., 1999); Christopher Trotter, Working with Involuntary Clients: A Guide to Practice (1999).
43. Skeem, *et al.*, *Perspectives on Probation, supra* note 20; Skeem, *et al.*, *National Survey, supra* note 16.
44. Skeem, *et al.*, *Perspectives on Probation*, *supra* note 20, at 449-452; Skeem, *et al.*, *National Survey, supra* note 16.
45. Charles Lidz, Steven Hoge, William Gardner, Nancy Bennett, John Monahan, Edward Mulvey, & Lauren Roth, *Perceived Coercion in Mental Hospital Admission: Pressures and Process*, 52 Archives of General Psychiatry 1034, 1039 (1995); Norman Poythress, John Petrila, Annette McGaha, & Roger Boothroyd, *Perceived Coercion and Procedural Justice in the Broward County Mental Health Court,* 25 Int'l J. Law & Psychol. 517 (2002).

and further noncompliance ("the more they threaten you, the less a person will do").[46]

In summary, the prototypic specialty agency is unique in (a) its caseload structure (exclusive, reduced mental health caseloads managed by "expert" officers), (b) its case management approach (creation of administrative efficiencies and integration of internal and external resources to meet PMIs' needs), (c) the roles of probation officers (emphasizing "care" as well as "control") and their relationships with probationers (strong alliances and a "firm but fair" approach), and (d) officers' use of problem-solving strategies to address probationer noncompliance. Notably, the prototypic specialty agency defines a category with indistinct boundaries: some specialty agencies share few features with the prototype, and thus are more similar to traditional agencies (and vice versa). Several features prototypic to specialty agencies parallel features of problem-solving courts. In the next section, we describe these parallels and address issues associated with linking specialty probation with mental health courts.

III. SPECIALTY MENTAL HEALTH PROBATION CASELOADS AND PROBLEM-SOLVING COURTS

Both specialty mental health probation and mental health and drug courts are confronting issues in the delineation of appropriate relationships with clients and in the use of sanctions for noncompliance with treatment conditions. First, both specialty probation agencies and problem-solving courts work with clients who are required to attend treatment. Specialty officers and judges alike may struggle to reconcile their "helping, therapeutic, or problem-solving role" with their "legalistic, or surveillance, role."[47] There are divided opinions about the extent to which judges should embrace each role. Some judges who administer treatment courts assume explicitly that it is appropriate for judges to assume a "therapeutic relationship" with the defendant because the goals and values of such courts are explicitly therapeutic.[48] Others argue that this may create boundary issues if the judge later has to impose sanctions or that seeking to create this type of relationship with a defendant is at odds with the nature of judging.[49]

The probation literature (if not agencies) appears to assume that both therapeutic and legalistic roles are an inescapable aspect of supervision, and that reconciling them is both the most difficult and most important component of effective probation work.[50] In fact, according to Carl Klockar's theory of probation supervision, effective officers synthesize treatment and control by making it clear to probationers over time that officers must abide by departmental rules, but want the probationer to succeed and will offer him or her every reasonable aid to do so. The legalistic, surveillance element of the officer's role is transferred to the (largely fictional) oversight powers of the department, allowing a second critical tool for securing compliance, *i.e.*, rapport between the officer and probationer, to remain intact:

[I]t may be . . . [wise] to rely on the power of the probation officer or court to impose sanctions, leaving the provider out of the fray.

> I tell my probationers that I'm here to help them, to get them a job, and whatever else I can do. But I tell them too that I have a job to do and a family to support and that if they get too far off the track, I can't afford to put my job on the line for them. I'm going to have to violate them.[51]

The dual nature of the relationship between probation officer and probationer, or between court and defendant, is made even more complex by the expectations of other parties that may be involved in the client's treatment. This is true particularly of treatment agencies that may wish to use the court or probation officer to exert leverage on the client to comply with treatment. Treatment providers may value coercive strategies for clients who are acutely ill or do not adhere to treatment.[52] The therapeutic relationship between treatment provider and client may, however, be compromised if the provider issues threats or applies sanctions for noncompliance with mandated treatment. In such circumstances, it may be in the interest of both the provider and client to rely on the power of the probation officer or court to impose sanctions, holding the provider out of the fray. Transferring the controlling aspect of these relationships to the probation department may preserve the provider's therapeutic alliance with the client, and the therapeutic alliance has been shown to strongly influence treatment outcomes.[53]

46. Skeem, *et al.*, *Perspectives on Probation, supra* note 20, at 454.
47. TROTTER, *supra* note 42, at 3.
48. Judge Peggy Hora and her colleagues write, for example, "[We] propose to establish therapeutic jurisprudence as the [Drug Treatment Court] movement's foundation." Peggy F. Hora, William G. Schma, and John T. Rosenthal, *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 440 (1999).
49. Judge Morris Hoffman asserts, "The scandal of America's drug courts is that we have rushed headlong into them—driven by politics, judicial pop-psychopharmacology, fuzzy-headed notions about 'restorative justice' and 'therapeutic jurisprudence,' and by the bureaucrats' universal fear of being the last on the block to have the latest administrative gimmick." Morris B. Hoffman, *Commentary: The Drug Court Scandal,* 78 N. C. L. REV. 1437 (2000).
50. *See also* Andrews & Kiessling, *Effective Correctional Practice, supra* note 42; Carl Klockars, *A Theory of Probation Supervision,* 63 J. CRIM. LAW, CRIMINOLOGY & POLICE SCI. 550 (1972); TROTTER, *supra* note 42, at 3.
51. Carl Klockars, *supra* note 50, at 554.
52. Charles Lidz, *Coercion in Psychiatric Care: What Have We Learned from Research?,* 26 J. AMER. ACAD. PSYCHIATRY & LAW 631 (1998); Edward P. Mulvey, J. Geller, & Lauren Roth, *The Promise and Peril of Involuntary Outpatient Commitment,* 42 AM. PSYCHOL. 571 (1987).
53. Ted P. Asay & Michael J. Lambert, *The Empirical Case for the Commo Factors in Therapy: Quantitative Findings, in* THE HEART AND SOUL OF CHANGE: WHAT WORKS IN THERAPY 23-55 (Mark A. Hubble, *et al.* eds., 1999).

The overall volume of probation cases means that vigilance will be required to maintain reduced mental health caseloads.

Second, like specialty agencies, problem-solving courts must address the appropriateness of applying sanctions, including incarceration for noncompliance. Drug courts are based explicitly on the use of a "carrot and stick" approach in which the offer of treatment is conditioned by the threat of punishment if the defendant does not comply with treatment.[54] There is also evidence that the threat of sanctions by the court may increase defendant compliance with drug treatment.[55] Mental health courts were initially more ambivalent about the use of punishment, though this ambivalence may be eroded as mental health courts increasingly assume jurisdiction over felonies.[56] What is clear is that we do not yet know the comparative impact of sanctions, inducements, or a mixture of the two on client compliance with treatment. There is anecdotal evidence on all sides of the question, but until more definitive research is done, the adoption of one or another strategy regarding the use of sanctions will be guided as much by intuition and philosophy as empiricism.

Given parallels between specialty probation agencies and problem-solving courts in their basic goals and approaches, it is not surprising that the two are sometimes linked developmentally. For example, in our national survey of the use of specialty probation, 15% of specialty supervisors described being affiliated with a mental health court.[57] In Maricopa County, Arizona, the mental health court was created years after specialty mental health probation was established. As another example, in Broward County, Florida, a felony mental health court was created after the adoption of mental health probation, in part so that specialty officers would only have to deal with one judge rather than several judges and in part so that a uniform philosophy would govern the use of mental health probation in the county.[58] In other instances (*e.g.*, Seattle), specialty probation officers were hired and trained specifically to work with referrals from the mental health court.

Although the implications of these linkages are not yet clear, logic and anecdotal evidence suggest that there may be both advantages and disadvantages. Specialty probation officers who work with a mental heath court might enjoy the affiliation for its air of authority; familiar, team-based approach to ongoing problem-solving; and relatively predictable decisions. As court and probation personnel became more familiar with one another and with their shared caseloads, decision making may become more efficient. On the other hand, specialty officers may view the mental health court as a time-consuming process that increases the risk that PMIs will be sanctioned. Because status hearings are a form of monitoring, their use may detect more violations. If more violations are detected and specialty officers' discretion to apply problem-solving strategies and graduated approaches is reduced, sanctions may become more likely with the linkage. Further research undoubtedly will reveal more about the relationship between specialty probation and mental health courts.

IV. THE FUTURE OF SPECIALTY MENTAL HEALTH CASELOADS

As noted earlier, specialty probation for those with mental illnesses first emerged 25 years ago, with accelerating use in the last 5 years. Although it is unclear whether specialty probation will become a permanent part of the legal landscape, the average age of specialty probation agencies (approximately 10 years) suggests that they have some "staying power." Moreover, certainly there is little evidence that the prevalence of mental illnesses among criminal defendants will abate in the near future, or that the trend toward specialization within the legal system to meet those needs has run its course.

As jurisdictions consider developing mental health agencies, four issues in addition to those already discussed will need to be considered. First, if specialty probation agencies have a "necessary ingredient," that ingredient is probably structural, having to do with the size of the caseload. Available data suggest that virtually all probation supervisors, traditional and specialty alike, believe that a reduction in mental health caseloads with specialty officers is useful for supervising PMIs.[59] In fact, the ability of specialty agencies to succeed may well depend upon the department's ability to maintain *small*, specialized caseloads handled by specially trained probation officers. In the national survey, the vast majority of traditional and specialty supervisors viewed reduced mental health caseloads as "very" useful, but the majority (56%) of traditional supervisors perceived reduced caseloads as "not at all" practical in their department. Similarly, some specialty agencies were being pushed toward larger caseloads. Although the majority (61%) of specialty supervisors perceived reduced caseloads as "very" practical, officers in nearly one-quarter (23%) of specialty agencies were carrying higher caseloads than those set forth in their policies. As explained earlier, larger caseloads necessarily limit officers' resources for supervising and meeting the needs of high-risk PMIs. Notably, specialty agencies with larger caseloads shared relatively few features with the prototypic specialty agency. For example, large caseload specialty agencies are significantly less likely than other specialty agencies to use problem-solving approaches to address probationer noncompliance.[60]

The overall volume of probation cases means that vigilance will be required to maintain reduced mental health caseloads. For example, in Broward County, Florida, an initial agreement to limit caseloads for five officers who volunteered and were

54. Heather Mactavish, *Profile: Janet Reno's Approach to Criminal Justice*, 4 UCLA Women's L. J. 113, 116 (1993).
55. Sheila Maxwell, *Sanction Threats in Court-Ordered Programs: Examining Their Effects on Offenders Mandated into Drug Treatment*, 46 Crime and Delinquency 542 (2000).
56. Griffin, *et al.*, *supra* note 15.
57. Skeem, *et al.*, *supra* note 16.
58. Broward County, Florida, Admin. Order No. III-03-S-1, In Re: Creation of a Mental Health Court Subdivision Within the Circuit Court Criminal Division (17th Cir. Oct. 17, 2003).
59. Skeem, *et al.*, *National Survey, supra* note 16.
60. *Id.*

trained to handle mental health cases was abandoned because the state Department of Corrections insisted that caseload ratios for probation officers be maintained at the level required for DOC funding. As a result, caseloads are now larger, mixed between mental health and general cases, and dispersed among twelve officers who volunteered or were "drafted." It may be that legislative recognition of a special category of mental health probation is necessary in some jurisdictions to assure that reduced caseload size and specialization can be maintained. Indeed, some states have created line items in their budgets for supervising PMIs and parolees with mental illness in the community.[61]

Second, probation has long been a "practitioner-led"[62] enterprise where the organizational culture of an agency and characteristics of individual officers strongly influence daily practice. Thus, there is today little uniformity in training offered to either traditional or mental health probation officers on topics associated with mental illnesses. Yet such training is essential, on a wide variety of topics, including signs and symptoms of mental illness; medications and their effects and side-effects; and creating and maintaining a relationship with an individual with a mental illness. Similarly, articulated philosophies or standards of practice for supervising PMIs would be helpful. Federal handbooks[63] and large, well-developed specialty agencies in the nation (*e.g.*, Maricopa County, Arizona, Cook County, Illinois) provide examples of philosophies, policies, and training programs that could serve as models.

Third, the issue of confidentiality is a significant one that has become even more complicated with the adoption of the Health Insurance Portability and Accountability Act (HIPAA) regulations on protecting the privacy of individual health information.[64] There are provisions of HIPAA that permit the use and disclosure of protected health information as "required by law" including by court order.[65] In addition, conditions of probation may be written to require that the probationer consent to the disclosure of medical and mental health records. Given that the number of parties involved in specialty probation may include the court, the probation officer, and multiple treatment and social services agencies, however, it will likely become necessary in most jurisdictions to create formal agreements between the various parties, consistent with HIPAA and applicable state law, to govern the exchange of information. Alternatively, in the prototypic specialty agency, the probation officer often becomes part of the treatment team, such that as a practical matter "confidentiality ceases to exist."[66]

Finally, the recent explosion of mental health courts may facilitate the growth of specialty probation agencies in many jurisdictions, just as the creation of specialty agencies has prompted some jurisdictions to move toward problem-solving courts. As the opportunities to join these problem-solving agencies arise, communities must strive to maximize the administrative efficiencies and unique therapeutic potential of both systems while avoiding the possibility of merely increasing surveillance of probationers. Achieving increased monitoring in the absence of increased treatment access may do little to address the serious treatment and social service needs of PMIs.

The unprecedented volume of individuals with mental illnesses and substance use disorders in the criminal justice system has resulted in sweeping philosophic and operational changes throughout that system. Specialty mental health probation is a clear example of the continuing struggle to integrate concerns with public safety and a more therapeutic approach to the needs of defendants with serious mental illnesses.

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61. Harry Boone, *supra* note 18.
62. KLAUS, HANDBOOK ON PROBATION SERVICES: GUIDELINES FOR PROBATION PRACTITIONERS AND MANAGERS (1998).
63. ORLANDO-MORNINGSTAR, *ET AL.*, *supra* note 23.
64. "HIPAA" refers to the Health Insurance Portability and Accountability Act of 1996. Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C.). The Department of Health and Human Services promulgated rules governing the privacy of health care information effective October 16, 2000. The regulations, as initia 45 C.F.R. § 164.512(a)(1) (2002).
65. 45 C.F.R. § 164.512(a)(1) (2002).
66. Skeem, *et al., Perspectives on Probation, supra* note 20, at 448.