What Probation in The United States Can Learn From Emerging Practices in Mental Health Treatment

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Historically Western society has dealt with crime and mental illness very similarly. Both were often seen as moral failings on the part of the individual, as a breach in societal norms of the community and as a threat to the safety or stability of the state. As such for most of history the response to crime and mental illness was to treat each behavior punitively and harshly. Nevertheless with the advent of the Enlightenment and especially in the nineteenth century, progressive thinkers began to examine the causes of crime and mental illness with the hope that criminals could be rehabilitated and the mentally ill treated and cured. While the goals of rehabilitation for criminals and treatment for the mentally ill continued in tandem during the early and mid-twentieth century in the United States, by the latter twentieth century these two goals began to diverge. From the 1970s and on, criminal justice policymakers increasingly took the position that rehabilitation did not work and that mass incarceration was the best approach to reducing the crime rate in communities. Nevertheless during this same period, the approach to the mentally ill was to deinstitutionalize their care and treat them in the community.

Finally, in the last decade of the twentieth century and the first decade and a half of the twenty-first century, criminal justice policymakers found that the approach of relying heavily on incarceration was not working. First, the costs for constructing and operating prisons on such a large scale were no longer sustainable. Second, the cost benefit in relying on mass incarceration to achieve a reduction in the crime rate was greatly diminishing. Thus many states were beginning to adopt innovative strategies for reducing crime without the need for greatly expanded prisons. During this same period in the field of mental health treatment the problem was that although deinstitutionalize was largely successful, federal, state and local governments had failed to provide sufficient funding to treat the mentally ill in the community.

As a result of unsustainable costs in criminal justice and the lack of adequate funding for mental illness, the general attitude to dealing with these two issues in the United States was that society did not want the criminal to be a threat to the public and the mentally ill to be a nuisance, and the public wanted to address these problems as cheaply as possible. Therefore, our current response to crime has been to attempt to divert as many as possible "low risk" offenders from prison and place them on probation, where hopefully they could be safely supervised in the community. Likewise, for those with mental health problems the response has generally been to medicate them – sometimes heavily – so that they could remain in the community without bothering anyone and not incurring any additional hospitalization costs. As these responses to crime and mental illness

were being developed over the last several decades, nowhere was the question asked as to how to improve the quality of life for the individual. However, over the last several years in this country, new approaches have been proposed for dealing with those suffering from mental illness that place the individual in the forefront of the treatment process. It is now time that these new approaches should also be considered in the context of criminal justice.

Recovery-Oriented Systems of Care (ROSC)

Over the last several years the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services has been advocating a Recovery-Oriented Systems of Care (ROSC) approach to dealing with both substance abuse and mental health issues. SAMHSA defines ROSC as a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems [or mental health problems] (ROSC Resource Guide, 2010). The principles of ROSC apply equally to substance abuse and mental health issues.

Recovery is the operative word for ROSC. Recovery means improvement in the condition of the patient with the possibility of complete recovery. This is opposite of the traditional notion in mental health treatment, that the patient could not be cured but the best to hope for was some type of maintenance or stasis. SAMHSA defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Despite the false and still persistent myth that mental health patients cannot recover, recent statistics show that approximately 33% of patients make a full recovery and another 33% make substantial improvements in their lives (SAMHSA, 2009). There are twelve guiding principles of recovery:

1. there are many pathways to recovery;
2. recovery is self-directed and empowering;
3. recovery involves a personal recognition of the need for change and transformation;
4. recovery is holistic;
5. recovery has cultural dimensions;
6. recovery exists on a continuum of improved health and wellness;
7. recovery emerges from hope and gratitude;
8. recovery involves a process of healing and self-redefinition;
9. recovery involves addressing discrimination and transcending shame and stigma;
10. recovery is supported by peers and allies;
11. recovery involves (re)joining and (re)building a life in the community; and
12. recovery is a reality (SAMHSA, 2009).

Another major concept of ROSC is that the goal of treatment is to improve the quality of the individual's life. Quality of life consists of such significant factors as living independently, having adequate housing, residing in a safe neighborhood, having friendships and intimate relationships with a wide range of people, working in regular employment settings in meaningful

jobs, and participating in school, worship, recreation, and other pursuits alongside other community members (Connecticut Department of Mental Health and Addiction Services, 2008).

One other key component under ROSC deals with the administration of assessments. Assessments are widely used in a variety of social and medical fields and are a vital part of evidence-based practices in community corrections. However, under ROSC, assessments need to gauge a person's strengths and not just identify any deficiencies in a person's life. A strength based assessment makes inquiries into the person's individual resources and capacities (Connecticut Department of Mental Health and Addiction Services, 2008). ROSC emphasizes individual strengths, assets, and resiliencies. The strength's perspective emphasizes building on the client's assets, desires, abilities, and resources to assist in the recovery process. Additionally, the strength's perspective demonstrates the importance and respect for the client's way of thinking and dealing with life situations. This perspective assumes that each individual has the capacity to draw from a variety of resources, skills, and motivations to focus on their strengths and create change in their lives (SAMHSA 2009).

Person-Centered Care

Person-centered care or planning occurs in a number of contexts, including aging and disabilities services. It generally means that the patient has a central role in shaping the treatment options or whether treatment should even be given for the care of the individual. In the context of ROSC, person-centered care describes the effort to ensure that mental health care is centered on the needs and desires of the consumer. It means that consumers set their own recovery goals and have choices in the services they receive, and they can select their own recovery support team. For mental health providers, person-centered care means assisting consumers in achieving goals that are personally meaningful (SAMHSA 2009; Connecticut Department of Mental Health and Addiction Services, 2008).

In addition to making the patient a full partner in his or her recovery, the family and community is also incorporated as part of the recovery plan. Person-centered care recognizes as a basic principle that a treatment provider is treating the person and not just the symptom or diagnosis. ROSC is premised on the understanding that when a person's self-autonomy is recognized and that the person retains his/her self-determination in the treatment process, that individual is far more likely to respond much more positively to treatment than one whose autonomy or self-determination is ignored. Thus ROSC not only articulates a set of humanistic values but it also has the practical effect of demonstrating successful and long-term health outcomes (SAMHSA, 2009).

The Medical Model – A Paradigm Shift

One recent and extremely important change in this country in addressing health concerns such as substance abuse and mental health as well as other public health problems is to re-define the medical model of treatment much more broadly than had previously been understood. Traditionally, health care issues were narrowly concerned with simply treating the condition and nothing more. Now health care providers are increasingly becoming aware that health issues, especially public health concerns, entail much more than examining the symptoms, making a

diagnosis, and then prescribing a course of treatment. Serious health issues in the United States such as diabetes, heart disease, and obesity involve multiple factors, including government policies, culture, economics, education, the environment, etc. For example, with obesity, not only must medical care be taken into consideration, but it must be recognized that governmental policies that subsidize certain grain and sugar products to lower food costs for high caloric/low nutritional foods, the unavailability of healthy foods in poorer neighborhoods, the economic necessity of purchasing cheaper if more unhealthy foods, and the lack of knowledge about nutrition all contribute to obesity in our society. Thus the medical profession is finally recognizing that serious health problems in our society cannot be solved unless other factors are taken into consideration and also resolved.

Trauma Informed Care

Trauma-informed care recognizes that many individuals have suffered some form of trauma in their lives. Children may have suffered trauma from neglect, abuse, parent divorce; women may have suffered trauma through sex abuse; adults may have suffered trauma from being in an accident, witnessing a violent event, or serving in combat. This trauma is often acted out in many ways, including substance abuse, mental health problems, risky behavior, and anger issues. In order to effectively treat what may be described as "symptoms" of trauma, the treatment provider or social worker must identify the underlying traumatic event. Moreover, in order to effectively deal with individuals suffering from the effects of trauma, not only must the underlying traumatic event be addressed but also the organization must create a trauma-informed atmosphere of care that is conducive to effective treatment and counseling.

According to SAMHSA's Trauma and Justice Strategic Initiative, "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being." Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. Many people who have substance use disorders have experienced trauma as children or adults. Moreover, people who are receiving treatment for severe mental disorders are more likely to have histories of trauma.

Trauma informed care is an intervention and organizational approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health services from prevention through treatment. A trauma-informed approach incorporates three key elements:

1. realizing the prevalence of trauma;
2. recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and
3. responding by putting this knowledge into practice.

Trauma-informed care also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and as with ROSC, it upholds the importance of consumer participation in the development, delivery, and evaluation of services (SAMHSA, 2014).

Studies of people in the juvenile and criminal justice systems reveal high rates of mental and substance use disorders and personal histories of trauma. The use of coercive practices, including intimidating practices in the criminal justice system, can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus people with traumatic experiences do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system. While various jurisdictions, including the states of Texas and New York have been implementing trauma-informed care in the juvenile justice system, implementation of trauma-informed care in the adult justice system is still woefully lacking.

Applying Emerging Practices in Mental Health to Probation

Community corrections, as practiced in much of the United States, has been going in a different direction than that now being advocated in the field of mental health. Probation is narrowly focused on the "criminogenic" needs of the offender, supervises probationers based on a statistical risk assessment, several elements of which may be racially and economically biased, and follows supervision strategies that identify deficiencies in the offender that must be "filled" through the right program, service, or approach to supervision. Consideration of the circumstances of the person's life, the community in which the person resides, and any challenge or problem that is not identified as a criminogenic need is not taken into account in the supervision of the probationer. Finally, the probationer essentially plays a passive role in his or her supervision. The probationer is not engaged in mutually establishing goals and developing solutions to address the factors that contributed to the commission of the criminal offense; rather, the probationer is simply told what to do by his/her officer in order to avoid incarceration, and often is required to fulfill obligations that are beyond the person's economic, emotional, social, or occupational abilities to accomplish.

Hence there needs to be a new vision in probation, one that not only considers recent trends in the treatment of mental illnesses but also embraces these emerging practices. For probation to have a long-term and continuous impact on the criminal conduct of offenders it must recognize that the current model of supervision is inadequate. Just as an increase in incarceration had a diminishing return in crime reduction over a period of time, if new strategies for the supervision of probationers are not adopted, then the impact in reducing recidivism will gradually diminish and any additional resources that could be made available to probation agencies will not be deemed cost effective.

What would a model of probation that embraced the principles of ROSC, patient-centered care, and trauma-informed care resemble? This model would first and foremost acknowledge that probationers are people and as such, despite what their have done in their lives and to the lives of others, they are entitled to dignity and respect. Moreover, the approach to supervision would be one that recognizes that people have the capacity for positive change. Supervision outcomes would be geared toward not only reducing re-offending but to improving the quality of life of the offender and the community in which the offender resides. A probationer without hope for

betterment in his or her situation in life and whose only goal is to stay out of prison is not going to be an individual motivated to change.

It would give the offender a much more significant role in determining the priorities that need to be established in order to address conduct that leads to criminal activity. In addition to allowing a probationer to participate in the establishment of supervision goals, the probationer would also play a central part in determining the strategies for correcting criminal behavior. Under this new model a supervision plan would be based on the joint efforts of the supervision officer and probationer that optimally would reach a consensus for setting goals and achieving results. This new model would recognize that the probationer does have a choice in the matter of his or her supervision even if the resulting outcome based on that choice does not appear from the perspective of the supervision agency as a desirable or beneficial outcome for the probationer.

This model would recognize that many offenders, especially those with mental health or substance abuse problems, have experienced trauma in their past lives. It would require probation agencies to actively screen for trauma in the lives of the probationers they are supervising. If trauma is determined to be an underlying cause that contributed to the commission of the offense, then before secondary factors could be treated, the trauma would first be addressed. Under a probation supervision model that incorporated trauma-informed care, the officer would no longer ask the probationer "What is the matter with you?" but instead would ask "What happened to you?"

If properly utilized in the criminal justice arena, ROSC would offer a more effective approach to dealing with the co-occurring disorders of mental illness and substance abuse. While it is fairly obvious to treatment providers in the fields of mental health and substance abuse that there is a strong correlation between one condition and the other, this is not so obvious to practitioners and policy makers in the field of criminal justice. Thus at the state level policy makers may craft responses to mental health at the exclusion of substance abuse treatment and vice versa. By incorporating the principles of ROSC, funding to local probation departments would more likely be made available to treat co-occurring disorders and funding would not be limited for treatment for one or the other condition but not for both.

The other significant concept that supports following a ROSC model is the recognition that many of the challenges that people suffering from mental illness or substance abuse have will be on-going and reoccurring. There is no short term solution or treatment that will immediately "fix" the individual. Hence, mental health problems as well as substance abuse issues need to be seen as chronic conditions, akin to conditions such as diabetes or high blood pressure. These conditions can be successfully treated so that the individual can live a long and healthy life but, the person will always have the condition that has to be constantly monitored and treated.

As such, a probationer needs to draw upon social capital in order to maintain long-term desistance from criminal activity. Under a ROSC model a supervision officer would place a priority on encouraging a probationer to engage in healthy family relationships, participate in positive social activities, and network with supportive friends and associates. In addition, in order to maintain the gains of treatment, especially for mental health and substance abuse problems, the probationer must rely on the resources and support of the community. Adopting a model similar to ROSC could utilize community based resources in a manner that reinforces the resiliency of the

individual and builds on the strengths that a probationer has acquired pursuant to a person-centered form of supervision.

Finally, probation has not followed the medical community's expansive notion of medical treatment. Probation has largely ignored such factors that contribute to recidivism as poverty, poor neighborhoods, inadequate schools, broken families, etc. Instead of being an integral part of a larger movement to address persistent societal ills, probation has largely been on the sideline. This lack of involvement can also been seen in the area of academics. The academic foundation for probation in this country is extremely narrow and generally focuses only on explaining "criminogenic" needs, developing risk assessments, and advocating program evaluations for fidelity, responsivity, and outcomes. It seldom incorporates broader ideas found in the fields of sociology, psychology, economics, and urban studies in its research projects and the instruction it provides to students.

The new paradigm of probation would be actively engaged in the community and draw from a wide array of disciplines to have a lasting impact on society and improve the lives of probationers and their families. By adopting similar principles as now being proposed through ROSC, person-centered care, and trauma-informed care, and by seeing the purpose and role of probation in a much larger social context, probation in the United States could achieve something that it has failed to achieve in the past – living up to its potential.

What are the Obstacles in Utilizing this New Approach to Probation in the United States?

Before this new paradigm could be implemented, one would first have to examine the obstacles or challenges hindering the application of ROSC, patient centered care and trauma informed care to probation in the United States. One could examine this matter in two ways: 1) why probation in the United States has adopted a model based on evidence based practices; and 2) why the United States has not followed the Europeans in utilizing the theory of desistance in dealing with probationers. Finally, since this article is limited to practices in the United States and not to emerging practices in Europe, it may be helpful to briefly explain evidence based practices as understood in the United States.

Evidence based practices is largely driven by risk/needs assessments, along with responsivity, i.e., the placement of a probationer in a proper treatment program with a proper treatment provider. Risk/needs assessments were originally developed by Canadians and migrated across the border to the United States. Risk/needs assessments generally are based on four "large" factors and four "lesser" factors. The "big four" factors are: 1) a history of antisocial behavior; 2) antisocial personality pattern; 3) antisocial cognition; and 4) antisocial associates. The secondary four factors are: 1) family/marital circumstances; 2) school/work; 3) leisure/recreation; and 4) substance abuse. Risk factors are used for determining the level of treatment and criminogenic needs focus on the appropriate treatment needed to reduce the risk of future criminal behavior and involvement with the criminal justice system. (Utah Criminal Justice Center, 2012). Finally evidence based practices specifies that even if an offender has a variety of problems and issues in that person's life, the supervision approach is to only address those problem areas

identified as a medium or high risk by the risk/needs assessment instrument. (Latessa, Edward J. and Lowenkamp, Christopher, 2005).

One of the appeals of evidence-based practices in the United States is that it reflects certain structural realities in our country. The first is that in many places in the United States we have weak social services and inadequate health care. This causes particular problems in dealing with offenders with mental health problems and substance abuse issues. The second reality is that the United States has a fairly weak family structure and therefore family support is often lacking. Finally, many offenders on probation live in very dysfunctional neighborhoods in which basic aspects of civil society are missing. (Goffman, Alice, *On the Run: Fugitive Life in an American City*, 2014). Considering these factors, it is understandable why probation in the United States would tend to focus narrowly on the criminogenic risks and needs of the offender and seldom takes into account factors beyond what is identified in a risk/needs assessment instrument, much less regard the probationer in the context of his or her community or person as a whole.

These same societal factors also explain why the theory of desistance is not widely recognized, much less practiced in the United States. Nevertheless, while evidence based practices, if properly utilized, can demonstrate a statistical reduction in recidivism, at least for a certain period of time after treatment, it has its limitations. It does not promote the access to social capital that would support a long term decrease in recidivism, especially for offenders suffering from mental health problems or substance abuse. Moreover, the efficacy of many of the programs recommended to address the risk and needs of offenders is either supported by insufficient or mixed/promising evidence. (United Kingdom Ministry of Justice, *Transforming Rehabilitation: A Summary of Evidence on Reducing Reoffending* (second edition), 2014). Finally, the benefits of evidence-based practices have appeared to have reached a plateau. Thus new approaches need to be identified if further progress in the diversion of persons from incarceration is going to be made in this country.

This still begs the question – would the adoption of ROSC, patient informed care, and trauma informed care be effective in a criminal justice setting? There would be several challenges in implementing a model based on ROSC. The first is that it would take time and effort to identify and develop the necessary resources to support such a model. In addition such a model would entail a huge cultural shift in the practices of probation departments across our nation. Despite several decades of criminal justice reform in the country, the focus of many departments in this country and their staff is still to monitor the conditions of probation set by the courts with the objective of ascertaining whether the offender violated one or more of the conditions with the purpose of imposing a sanction, including a sentence to prison. Finally, it would require probation in this country to re-definite its purpose and maybe even necessitate that the criminal justice system as a whole re-examine its scope and mission.

Nevertheless, considering the limitations of the current approach to probation in this country, a model of probation that incorporates the practices of ROSC, patient centered care, and trauma informed care, still seems worth attempting to implement. The factors mentioned above that would be challenges for implementation in a criminal justice context were also challenges for implementing this model in the health system. Moreover, adopting such a model in probation would promote the recognition that many if not most of the issues probationers in our country face

are more akin to public health problems than crime problems and should be dealt with accordingly. Finally, there are criminal justice experts in this country who are advocating that the theory of desistance be utilized in probation practices. (Laub, John H. and Sampson, Robert J., *Understanding Desistance from Crime*, 2001). A model incorporating ROSC, patient informed care, and trauma-informed care could serve as a platform for bringing desistance into the forefront of probation practices in the United States.

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