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PROGRAMS FOR SPECIAL POPULATIONS OF OFFENDERS (NATIONWIDE)

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NOTE:

This working paper provides research information for
the New Mexico Criminal and Juvenile Justice Coordinating Council
It is **not** a statement of the Council's views or opinions.

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EXECUTIVE SUMMARY

This report focuses on providing information to the Criminal and Juvenile Justice Coordinating Council regarding programs in other states that are offered to special populations of offenders. The report provides an overview of programs around the nation that have been developed for the following special populations of offenders: sex offenders, offenders who have been sexually abused, offenders with substance abuse problems, offenders with mental health problems, domestic violence offenders, technical violators (probation and parole) and mentally ill juveniles.

Programs for Sex Offenders often require one or a combination of three types of treatment methods. Offenders may use biological/organic treatments which include methods such as surgery or hormonal treatment. Offenders can also use group, individual, or family therapy. California and Vermont have implemented two effective programs for Sex Offenders. The California program focuses on relapse prevention training with intensive counseling, aftercare supervise and followup therapy. The Vermont program develops an individual treatment program for the offender and also gradually admits the offender back into the community. Vermont also provides follow up therapy and aftercare for the offender.

Appendix One shows the result of a recent survey conducted by *Corrections Compendium* of sex offender programs in 52 Department of Corrections nationwide. Twenty-eight states have special facilities for their sex offender prison populations. Other states have post-release provisions for their sex offenders. For example, the offender may have to register with the law enforcement agency within the town where he/she intends to reside. Unfortunately, New Mexico did not participate in the survey, thus we are unable to compare New Mexico's programs with programs in other states.

All types of childhood abuse and neglect put the victims at a higher risk for criminal behavior later in life. However, the victims of sexual abuse are no more likely than other victims of abuse to become involved with crime later in life, nor are they put at a higher risk of arrest. Based on the fact that not all types of maltreatment and sex abuse are the same, treatment may have to adapt to the individual circumstances of the crime.

a variety or model programs exist ror onenaers wnn suosiance aouse prooiems. The Drug Treatment Alternative to Prison Program in New York focuses on prison cost-saving by sending prison- bound offenders through therapeutic community drug treatment programs. Successful completion of the program results in the charges being withdrawn. The Treatment Alternatives to Street Crime is another model program which provides case management for drug-abusing defendants and offenders. Studies on boot camps for drug offenders have shown that substance abuse education and treatment programs actually implemented in boot camps are not likely to result in the rehabilitation of boot camp participants. Other programs include specific drug courts and residential treatment centers for drug abusing offenders.

For purposes of evaluating programs for offenders with mental health problems, this paper focused on programs in four states. Ohio, which is rated as one of the model states in providing treatment to mentally ill offenders, uses outpatient and community support programs rather than hospitals to rehabilitate their mentally ill populations. Colorado is also another state who ranks well in their services to the mentally ill. Once again, Colorado uses outpatient and community support programs in lieu of the more traditional in hospital care. New Mexico and Texas both rank poorly on treatment programs for mentally ill populations. New Mexico may be ranked low because of its lack of funds, however Texas appears to rank low as a result of lack of interest in implementing programs for the mentally ill.

Programs for domestic violence offenders include self-help programs, educational programs, and programs that combine the two. Some states are creating specialized courts to deal with domestic violence offenders and other states are developing specialized prosecution units. The Violence Against Women Act provides support to the States through law enforcement and prosecution grants to reduce violence against women. Finally, some states are implementing programs to educate children in their classrooms about domestic violence.

Technical violators are supervised either through intensive supervision, house arrest and electronic monitoring. For offenders who violate their programs, some states are sending them back to prison, others are calibrating the violations along a graduated scale. Still other states are establishing statewide guidelines to respond to technical violations. Washington has established an innovative program which requires that prison cannot be used as a sanction for technical violations The maximum sentence in Washington for technical violations is 60 days in jail.

To assist mentally ill juveniles Ohio identifies and treats the most disabled children first. Ohio also uses residential treatment centers and group homes to service

mentally ill juveniles. Ohio's programs have proven to be very effective. Colorado does not have adequate programs for their juveniles. Colorado depends upon hospitals rather than community treatment. New Mexico is beginning to establish case management programs for their juveniles. This program is likely to be effective in the future. Once again, Texas is seriously deficient in their programs for seriously mentally ill juveniles.

II. PROGRAMS FOR SEX OFFENDERS

Biological/Organic Treatments

There are three forms of organic treatment for sex offenders (Becker, 1992). These are: antiandrogens and other hormonal treatments, surgical castration, and stereotaxic neurosurgery (Becker, 1992). The latter two are rarely employed in North America because there is very little scientific or ethical basis to support the theory that these methods lower recidivism (Becker, 1992).

The most extensively used antiandrogenic medications include Medroxyprogesterone Acetate (MPA) and Cyproterone Acetate (CPA). These two medications represent a pharmacological method for reducing the sexual drive and thereby affecting the sexual behavior of offenders. Data has shown that sex offenders who continue taking antiandrogenic medications appear to have lower rates of recidivism (Becker, 1992).

Group Therapies

Romero and Williams (1983) reported on a ten year study of 231 male sex offenders who were randomly assigned to either group therapy and probation, or probation only (Becke] 1992). The results indicated that 13.6% of the men in group therapy recidivated, compared to 7.2% of the men who received probation only. This study apparently indicates that probation, and the supervision that it affords the perpetrator, appear to be effective in the majority of cases in assisting sex offenders in not responding to their atypical sexual urges while on probation. Therefore, in some cases, probation may be more important than therapy in reducing recidivism among sex offenders. However, the authors of this study pointed out that although the probation-only group did not participate in group psychotherapy, its members were not excluded from potential "treatment" and may have received some therapy (Becker, 1992).

In another study comparing incest offenders and heterosexual pedophile, all subjects had acknowledged their sexual offenses and had volunteered to participate in the treatment (Becker, 1992). Treatment was on an inpatient basis and consisted of group psychotherapy. Both groups showed improvement. Compared to pedophile, the incest offenders showed marked treatment improvement on five factors: trait anxiety, fear of negative evaluation, social-skills deficits, indirect hostility, and irritability (Becker, 1992). Pedophile appeared to be more treatment resistant. By the end of a three year follow-up study, only 7% of the incest offenders and 18% of the pedophile had re-offended (Becker 1992).

Family Therapy

Giarretto, Giarretto, and Sgroi (1978) conducted a study of families in which incest had occurred, using a community-based treatment program. The treatment program combined individual therapy with group therapy and self-help groups (Becker, 1992). The study found that no recidivism was reported in more than 600 families who had received a minimum of 10 hours of treatment and whose cases had been formally terminated (Becker, 1992).

California's Relapse Prevention Program

In 1985, the California Department of Mental Health initiated the Sex Offender Treatment and Evaluation Project (Laws, 1989). The goals of the program include: (1) the development and operation of a small, innovative treatment unit for sex offenders, and (2) the evaluation of the effectiveness of the treatments provided in the experimental program, The program began in a 46-bed unit at Atascadero State Hospital. The project was initially staffed by a treatment director, one psychiatrist, three clinical psychologists, three social workers, six social work associates, two rehabilitation therapists, and 28 nursing personnel. The study participants are male inmates, in the custody of the California Department of Corrections, who have been convicted of one or more offenses of rape and child molestation. During the treatment phase, group members participate in an intensive relapse prevention program for two years (Laws, 1989).

The program begins with an orientation and assessment period, during which the offender is assisted in making the transition from prison to hospital (Laws, 1989). Based on the assessment results, a structured program is prescribed specifically to address the offender's identified recursors of relapse. The primary treatment structure involves a core relapse prevention group which meets for five hours each week throughout the program. This group provides a familiar and secure environment within which participants can openly confront the personal, social, and sexual difficulties that place them at risk for re-offending. The goals of the core relapse prevention group are to have the offender: (1) recognize the decisions and conditions that place him at risk for re-offending; (2) plan, develop, and practice a range of coping responses to his identified high-risk elements and situations; (3) restructure his interpretation of urges; (4) develop strategies for reducing the likelihood that a lapse will result in a full blown relapse; (5) increase his empathy toward victims and modify the cognitive distortions that are likely to facilitate future victimization; (6) make lifestyle modifications designed to promote continued abstinence; and (7) learn that the prevention of relapse is an ongoing process in which he must take an active and vigilant role (Laws, 1989).

In addition to the relapse prevention training, subjects participate in a wide range of other treatment activities designed to modify various aspects of sexual offending. Each

treatment group member participates in at least one hour or individual psychotherapy per week with the clinical psychologist or psychiatric social worker who conducts his core relapse prevention group, and one hour of individual counseling with each of the two nursing staff who co-facilitate the group. Group members also participate in approximately 67 hours of structured leisure activities and four hours of rehabilitation therapy each week. Individual behavior-therapy sessions in the sexual behavior laboratory are offered to offenders who show deviant sexual arousal patterns (Laws, 1989).

The Sex Offender Aftercare Program is a condition of parole for the first year (Laws, 1989). Offenders in this program are supervised by state aftercare programs or private clinicians, depending on the needs of the offender and the availability of state providers in the community.

Pre-release data indicate that the relapse prevention program is producing expected treatment effects. However, sufficient follow-up data is not yet available to determine if treatment is successful in reducing recidivism among these offenders (Laws, 1989).

Vermont Treatment Program for Sexual Aggressors

The Vermont Treatment Program for Sexual Aggressors (VTPSA) was created in 1982. The program currently encompasses three residential and 20 outpatient treatment sites, which provide services to 192 offenders in prison and in the community (Laws, 1989). The following criteria are used to screen offenders:

1. Candidates must be willing to enter the program.
2. Career criminals, with a history of multiple and varied offenses, are inappropriate candidates.
3. Individuals whose offenses involved sadistic aggression are excluded.
4. Prospective clients must agree to participate in a thorough assessment procedure.
5. The structure of the offender's sentence should provide adequate time for inpatient treatment and parole supervision after his return to the community.

Offenders who meet these screening criteria are referred for thorough psycho-sexual evaluations. Following the assessment of the offender, a treatment program is prescribed by selecting an appropriate subset of intervention techniques from the battery of available treatment components. Treatment components include individual and group therapies and individual psychotherapy (Laws, 1989). If an individual is making insufficient progress, they are put on one-month probation within the program (Laws, 1989).

At an appropriate stage or treatment and under adequate supervision, each offender is granted limited passes to practice his newly acquired behaviors in the community. This enables the offender to obtain employment in the community but requires him to return th(to the correctional facility during non- work hours. The offender also begins to attend outpatient therapy groups (Laws, 1989).

VTPSA also provides outpatient therapy for individuals receiving probationary sentences from the court and for the long-term follow-up of offenders discharged from residential treatment. The Vermont Department of Corrections subsidizes all outpatient treatment of sexual offenders through contracts with vendors in the public and private sectors. Recommendations for outpatient versus inpatient treatment are made on a case-by-case basis. Generally, incest offenders and many extra-familial child abusers are considered appropriate candidates for outpatient treatment. Inpatient treatment is recommended most frequently for rapists and for pedophile who demonstrate preference for sexual acts with children rather than adults (Laws, 1989).

Vermont has an external supervisory group that follows up on any relapse among offenders. This relapse prevention program along with the other elements of the sex offender program, is apparently effective in controlling and rehabilitating sex offenders in Vermont (Laws, 1989).

Corrections Compendium Statewide Survey of Sex Offender Populations and Treatment.

Corrections Compendium recently began a study of sex offender populations and treatment in prisons throughout the United States. *Corrections Compendium* surveyed 52 departments of corrections (50 states, the District of Columbia, and the Federal Bureau of Prisons). The survey was sent in October 1995 and responses were collected through March 26, 1995. Results, including a narrative, will be published in the May *Corrections Compendium.* Preliminary results of the survey are presented in Appendix 1. The study shows the inmate sex offender population in each jurisdiction together with a list of any special facilities for the offenders and available treatments. The study also details whether the treatment programs are mandatory or not. New Mexico did not respond to the survey

Of the states that responded, 28 have special facilities for their sex offender prison populations. These facilities range from special barracks, to therapeutic facilities and residential treatment units. Treatment programs available in the prisons included: individual and group counseling, inmate support groups, medical treatment, and victim/offender reconciliation. Eight states have made treatment programs mandatory, either by court order or statute. However, it appears that the majority of the state's sex offender treatment programs are voluntary.

The survey also examined states' post-release monitoring or sex offenders. Apart from corrections monitoring, most states also monitor the released sex offender through community and victim notification. Some states also require that offenders register with the law enforcement agency in the city they will reside in, and that they attend counseling and therapy. The survey also looked at whether sex offenders were eligible for parole. In some states the sentencing guidelines deny parole for sex offenders. In others, the offender is not eligible for parole until he has completed treatment.

Many states are also enacting new policy revisions for sex offenders. For example, in 1995 New York enacted the Sex Offender Registration Act which requires all offenders released after January 21, 1996 to be registered in the community. The Act also requires the establishment of a Board of Examiners to determine the risk to public safety of those released.

The results of the *Corrections Compendium* survey therefore show that many states are taking some noteworthy steps in treating, and tracking their sex offender populations.

III. PROGRAMS FOR OFFENDERS WHO HAVE BEEN SEXUALLY ABUSED

Later Criminal Consequences of Victims of Childhood Sexual Abuse

"In general, people who experience any type of maltreatment during childhood-whether sexual abuse, physical abuse, or neglect—are more likely than people who were not maltreated to be arrested later in life (Widom, 1995)." Thus, all types of childhood abuse and neglect put the victims at higher risk for criminal behavior later in life. However, the victims of sexual abuse are no more likely than other victims of abuse to become involved with crime later in life, nor are they put at a higher risk of arrest (Widom, 1995). Nevertheless, people who were victimized during childhood by either physical abuse or neglect in addition to sexual abuse were more likely than those subjected to other types of maltreatment to be arrested as runaways during their juvenile years (Widom, 1995).

Studies have shown that children who have been victimized in these ways are 4.7 times more likely to be arrested for sex crimes (Widom, 1995). Thus, the experience of any type of abuse or neglect in childhood increases the risk for sex crimes. Various types of sex crimes also reveal a link to sexual abuse as a child. Child sex abuse victims are more likely to be charged with prostitution than are victims of physical abuse and neglect (Widom, 1995).

In 1995, Cathy Spatz Widom reported on the results of a study which focused on the long-term consequences of childhood abuse and neglect (Widom, 1995). There appears to be a link between childhood sexual abuse and later "acting-out behaviors," such as running

away, truancy, conduct disorder, delinquency, promiscuity, and inappropriate sexual behavior (Widom, 1995) Studies of prostitutes have also shown a link between sexual abuse during childhood and deviant and criminal behavior. In fact, the odds of being arrested for prostitution as an adult are 27.7 times higher among children who have been sexually abused (Widom, 1995).

The subjects of the study were 908 individuals, 11 years of age or younger, who were subjected as children to abuse, either physical or sexual, and whose cases were processed through the courts between 1967 and 1971 (Widom, 1995). This group was then matched with a control group of children who had not been abused or neglected. Both of the groups were followed into adolescence and young adulthood to determine if they engaged in delinquent behavior or committed crimes as adults.

The study found that 5.8 percent of abused and neglected children became runaways, as compared with only 2.4 percent of the controls. As noted earlier, among children who were sexually abused, the odds are 27.7 times higher than for the control group of being arrested for prostitution as an adult. The similarity among all three groups of maltreatment victims (abused, neglected and sexually abused) suggests that for sexual abuse victims the criminal effect later in life may result not from the specifically sexual nature of the incident but from the trauma and stress of the early childhood experiences or society's response to them (Widom, 1995).

The study also found that childhood sexual abuse victims were not at greater risk later in life of arrest for rape or sodomy. The findings revealed an association between these crimes and childhood physical abuse, not sexual abuse (Widom, 1995). Also, males who were physically abused in childhood showed a greater tendency than other abused and neglected children and the controls to be arrested for these type of sex crimes.

Criminal behavior is not the inevitable outcome of childhood sexual abuse. Long term consequences of childhood sexual abuse may manifest themselves in psychological distress and dysfunction, but not necessarily in criminal behavior. Delinquency and criminal behavior are one type of outcome. Other outcomes include depression, anxiety, self-destructive behavior, and low self esteem (Widom, 1995).
In planning and implementing treatment and prevention programs for children who are or were sexually abused, it must be kept in mind that these victims are at increased risk for criminal involvement compared to non-victims (Widom, 1995). It is also important to remember that victims are at a greater risk of becoming juvenile runaways and later entering prostitution (Widom, 1995). Therefore, one important issue to keep in mind is the health threat posed, such as sexually transmitted diseases and HIV infection, and the need for preventive interventions directed at victims of childhood sexual abuse. Further, it is important for practitioners to craft responses that meet the particular needs of the

childhood sex abuse victim because not all types of childhood maltreatment are alike (Widom, 1995).

Therefore, when one works with a sexually abused victim, the interview with the victim is very important for bringing information to light about the nature of the abuse. Furthermore, the interviews may also shed light on the intervening factors that mediate between the experience of victimization in childhood and behavioral outcome in adulthood. "While early sexual abuse places a child at increased risk, many other factors play a role, and these factors may emerge in the interviews" (Widom, 1995). The factors identified will then affect the way practitioners intervene with child victims (Widom, 1995).

Based on the fact that not all types of maltreatment and sex abuse are the same, treatment may have to adapt to the individual circumstances of the crime. This may explain why there are few programs for victims of childhood sexual abuse. Often, the latter may only receive attention in the criminal justice system if they reappear as sex offenders. Alternatively, their victimization through sexual abuse may emerge in general needs assessments, but may not lead to specific intervention programs in response. Apparently, the criminal justice system has yet to pay specific attention to the victims of sexual abuse.

IV. PROGRAMS FOR OFFENDERS WITH SUBSTANCE ABUSE PROBLEMS

Drug Treatment Alternative to Prison (New York)

The Drug Treatment Alternative to Prison Program (DTAP) began in 1992 and aims to stem escalating prison costs and crowding caused by waves of drug offenders (Young, 1995). The program stresses treatment as a response to drug crime rather than punishment, on the principle that treating offenders' substance abuse will make them less likely to return to drugs and crime when they re-enter the community (Young, 1995). DTAP appears to be working. Through mid-May of 1995, 715 defendants had been diverted to community-based drug treatment by the four DTAP programs. Sixty-one percent of those individuals either successfully completed or remained in treatment - a retention rate at least one and a half times that typically found for the kind of long-term, intensive drug treatment used by DTAP (Young, 1995).

DTAP places a strong focus on prison cost-saving, targeting only prison-bound defendants. Thus, all DTAP participants are defendants who, under state law, are facing prison terms as repeat felons. DTAP targets more serious offenders than most drug courts and other diversion programs.

All treatment in DTAP is delivered in long-term (14-30 month) residential therapeutic community (TC) drug treatment programs. Each DTAP site arranges with private, community based treatment providers to screen and admit DTAP referrals (Young, 1995).

Successful completion of treatment results in the charges being withdrawn and dismissed. Failure to comply with the program leads to imprisonment. The minimum sentence imposed on participants who fail the program varies from one and one-half to three and one-half years (Young, 1995).

There is little public safety risk with DTAP. Only 15% of DTAP participants in the expansion sites have been arrested for committing a crime after admission to the program, and there have been no violent felony arrests. Across the four sites, 80% of all DTAP failures have been returned to custody (Young, 1995).

Treatment Alternatives to Street Crime (TASC)

TASC is a successful vehicle for diverting many drug-using offenders from incarceration (Lipton, 1995). TASC provides case management for drug-abusing defendants and offenders, serving as a bridge between criminal justice agencies (courts and probation) and treatment providers (Lipton, 1995). At this time there are 180 TASC projects in 27 states and 2 territories. The projects provide screening, assessment, treatment planning, monitoring, urinalysis, and court liaison functions (Lipton, 1995).

TASC is based on research showing that treatment is more effective in settings in which legal sanctions and close supervision provide incentives for clients to conform with treatment program protocols and objectives. Furthermore, the longer duration of treatment is consistently associated with better treatment outcome, and clients under legal coercion stay in treatment longer than those who are not (Lipton, 1995).

Case management in TASC includes support, staff training, data collection, client identification based on eligibility criteria, assessment and referral, urinalysis, and monitoring. Clients in the TASC program remain in treatment six to seven weeks longer than other criminal justice clients, whether referred to residential or outpatient programs (Lipton, 1995).
Several studies have shown that TASC has been successful in reducing prison crowding and facilitating treatment through the TASC and parole partnership (Lipton, 1995).

Boot Camp Drug Treatment and Aftercare Interventions: An Evaluation Review

There are few descriptive or evaluative studies on the nature of boot camp substance abuse programs, their impact on offenders, or the effectiveness of specific treatment strategies (Cowles, 1995). The limited information available suggests that the programs

currently available in correctional boot camps are not likely to result in reduced recidivism or drug dependence among "graduates" who have been returned to the community (Cowles, 1995). Cowles' study found that the substance abuse education and treatment programs actually implemented in boot camps are not likely to result in the rehabilitation of boot camp participants. Thus, the study evaluators made some suggestions for programs in boot camps to maximize the effectiveness of substance abuse treatment:

1. Include substance abuse education and treatment programs involving psychotherapeutic-based interventions, such as individual and small group therapies, with a focus on multi-model approaches that are relevant to the offender population.
2. Use comprehensive planning processes that are sensitive to the unique environment and offender population of the facility and include input from substance abuse treatment professionals.
3. Use standardized assessment processes to place inmates in individualized treatment programs.
4. Employ or contract with well-trained, qualified substance abuse treatment providers to run facility programs and ensure that the ratio of inmates assigned to each of these professionals is sufficiently low to permit individualized approaches.
5. Adopt the therapeutic community model, involving frequent staff/inmate interaction, the use of peer pressure to reinforce positive behavior and eliminate negative behavior, and a de-emphasis on the punitive aspects of boot camp experience.
6. Include pre - release and post - release programming to ensure a continuity of care throughout the institutional and aftercare phases of the program.

Delancey Street Foundation

The Delancey Street Foundation is a residential treatment center for ex-addicts, alcoholics convicts, and prostitutes (Justice Research and Statistics Association, 1994). The foundation receives no government funds, and its financial support depends upon its residents. Delancey Street's philosophy is that the individual must take the responsibility for his own actions so that he can exert some control over himself and create some viable options. The residents gain the vocational, personal, interpersonal and social skills necessary to make restitution to the society from which they have taken illegally, for most of their lives. In return, Delancey Street demands from society access to the legitimate opportunities from which the majority of residents have been blocked for most of their lives (Justice Research and Statistics Association, 1994).

Everyone who attends Delancey is tutored in the basics of education until they receive a high school equivalency certificate. Delancey also maintains training schools, which serve

as the businesses by which the foundation earns its living. The training schools include a restaurant, a catering business, a moving and trucking school, terrarium and sand painting production and sales, furniture and woodwork production and sales, specialty advertising sales, antique car restoration, the operation of outdoor Christmas tree lots, and a print shop (Justice Research and Statistics Association, 1994).

Delancey Street also focuses on social or community training and interpersonal skills. Residents are encouraged to help others in the community, such as senior citizens, the handicapped and juveniles (Justice Research and Statistics Association, 1994).

Anti-Chemical Dependency Program (Idaho)

The goals of the Anti-Chemical Dependency Program are to alleviate the problems of substance abuse and chemical dependency, to build a strong and healthy community which promotes self respect, and to help individuals with substance abuse problems become contributing members of the community (Justice Research and Statistics Association, 1994). The program was implemented with a Project Director and a Staff Assistant who were responsible for developing a comprehensive anti-drug program by coordinating all available resources. A formal structure was developed defining the process a client is required to follow when seeking assistance from an agency if alcohol or drugs are involved. A prevention component of the program was developed, including a DARE project for the schools, increasing alcohol and drug education, and making information available to students and youth. The therapeutic component was developed for individuals who have not received treatment and are in need of services. The program provides individual counseling, group therapy and other activities which help develop self esteem, clarify values, and enhance decision making in order to avoid relapse (Justice Research and Statistics Association, 1994).

Jefferson County Drug Court/Diversion Project (Kentucky)

The Jefferson County Drug Court Diversion Project (JCDC) is a court-managed drug intervention treatment program designed to provide a cost-effective alternative to traditional criminal case processing (Justice Research and Statistics Association, 1994). The program targets individuals arrested for cocaine-related offenses that are user, rather than dealer - related. If the individual is at least 18 years of age and has no history of violent crime, they may be offered the opportunity to participate in a minimum one-year treatment program rather than be prosecuted for their charges. Compliance with the treatment program results in the dismissal of charges. However, at any time during the year the individual can be prosecuted if he/she does not comply with the treatment regime. Treatment includes individual counseling, group therapy, HIV and AIDS counseling, Alcoholics Anonymous and Narcotics Anonymous meetings, social and welfare services, job training, educational services, and follow-up services. A master treatment plan for

each client is developed. The program also includes acupuncture and meditation in addition to traditional chemical dependency treatment. The program is an intensive outpatient program with aftercare services. A preliminary evaluation indicates that the program is apparently having some success.

V. PROGRAMS FOR OFFENDERS WITH MENTAL HEALTH PROBLEMS

Care of the Seriously Mentally 111: A Rating of State Programs

No information is readily available on the treatment of offenders with mental health problems in the criminal justice system. The following are the results of a survey conducted in 1990 which evaluated the mental health programs provided by each state (Torrey, 1990). Some of these programs would serve offenders committed to them by the courts, others would provide services for offenders on probation or parole. All programs would also serve the mentally ill who have not committed crimes. The survey was exclusively concerned with services for people with serious mental illnesses and did not include services for the mentally retarded or for individuals with drug and/or alcohol problems. Furthermore, this information covers only public services and does not attempt to assess private psychiatric services of any kind. Services in selected states are described, including Ohio (generally considered to be a model state), New Mexico, and the neighboring states of Colorado and Texas. Appendix Two provides information on the survey's ranking of all 50 states in terms of their mental health services.

Ohio is rated number four in the nation for mental health services. In 1988, Ohio passed a landmark Mental Health Act which essentially transformed the mental health system into one that is almost entirely community-based (Torrey, 1990). For example, when a judge commits a mentally ill person, the commitment is now made to a community mental health board rather than to a state hospital. The board then is responsible for meeting the committed person's service needs. The arrangement is both innovative and risky. This is because, while community control of state hospital use promises to greatly improve continuity of care, it also has the potential to deny inpatient care to some people who need it, since the boards have strong incentives to avoid the expense of hospitalization.

Ohio has also developed a strong mental health program for children. (See the section on Mental Health Programs for Juveniles, later in this working paper.)

Hospitals: Ohio's decreasing its reliance on state hospitals. Currently, there are 16 hospitals with 3,619 beds. All of the mental health hospitals are JCAHO accredited and

HCFA certified. Despite the accreditations, the hospitals still have some problems, such as in the recruitment of good psychiatrists, which limits the quality of services (Torrey, 1990).

Outpatient and Community Support: Ohio is one of the few states to receive almost a full score for its outpatient and community support services. One of the reasons for Ohio's success is the use of Robert Wood Johnson Foundation grants to improve and innovate programs. Columbus used the grant money to fund a number of PACT-model continuous treatment teams and an excellent housing development corporation. Cincinnati used its grant money to create a managed system of care with clinicians as gatekeepers for all services. Cincinnati also provides an excellent training program at the University of Cincinnati School of Social Work. Other cities are providing good community programs, including the Columbian County Mental Health Clinic and service board, which provide case management for nearly 100 percent of seriously mentally disabled clients. The mental health center in Dayton, on the other hand, remains a problem because it recently failed to gain JCAHO accreditation and has been the target of consumer and family complaints.

One of Ohio's problems is the inconsistency in community services across the state and the lack of services in some areas, particularly rural areas. For example, while Columbus, Cincinnati and some other areas have good programs, statewide only about two-thirds of public sector mental health clients have case managers, caseloads average an unreasonably high 46 and only about half of the case managers' work is conducted outside their offices. Crisis services are similarly uneven, such that some areas have 24-hour hotlines while other areas have mobile crisis teams. Ohio is aware of these deficiencies and is working steadily and creatively to address them. But, like many states, Ohio has a long way to go.

Ohio also has weak day programs and clubhouses. The state is planning to transform them into acute crisis-oriented services for people recently discharged from hospitals, or al risk ofhospitalization. This plan shows a shift away from long-term programs toward time-limited, acute-care services.

Ohio's services to special populations of mentally ill, such as the homeless or substance abusers, are still better than in most states. The state is working with mental retardation agencies to better serve people with a dual diagnosis of mental illness and retardation. The state is also improving services to mentally ill deaf people so as to provide special professional training and create a statewide information and advocacy center, specializing in programs that work. Ohio has also funded two model programs, one urban and one rural to serve mentally ill senior citizens. Another particularly interesting program, called Friends Can Keep You Healthy, provides support groups and an annual retreat for the children of mentally ill parents. Another good state-run program focuses on mentally ill individuals' access to medical and dental care (Torrey, 1990).

Vocational Rehabilitation: Ohio has put less emphasis on vocational rehabilitation. However, the Rehabilitation Services Commission has recently undertaken cross-training programs with the Department of Mental Health to promote more local collaborative projects. One such program, called "It Pays to Work," educates individuals with serious mental illness and their families about the advantages of working. Other noteworthy programs include, the Kevin Colemant MHC, which operates a variety of job training and supported employment programs; the Center of Vocational Alternatives in Columbus; and MERIT in Toledo. At the hospital level, Project Workable at the Western Reserve Psychiatric Hospital has been commended for helping individuals nearing discharge to access community jobs programs. (Torrey, 1990)

Housing: Housing for people with mental illness has been improving. Cincinnati and Columbus both have housing development corporations. One corporation developed 111 independent living beds in its first 18 months of operation and both corporations plan to develop several hundred more beds in the next few years. Other cities have set aside federal Section 8 rent subsidies. The state itself has also $4.6 million dollars in rent subsidies programs, called the Housing Assistance Programs, which service approximate!) 1,500 people. Overall, supported housing serves 3,000 individuals.

Aside from the obvious need for more housing, Ohio also needs to improve and expand it; supervised living situations. The state also needs more case management to supervise independent living. (Torrey, 1990)

Colorado is ranked sixth in the survey. The most impressive aspect of Colorado's mental illness services system is the state's leadership in hiring consumers to work within the system. The state has a well-established program to train consumers as assistant case managers.

Hospitals: Colorado has two state psychiatric hospitals with a 732 bed capacity. An association between the hospital and the University of Colorado's Department of Psychiatry has been helpful in improving the quality of care in the hospitals. The hospital has good programs for all groups of patients, including those with mental illness and substance abuse.

Outpatient and Community Support: Colorado's outpatient and community support programs for the mentally ill are in a state of chaos. Outpatient (clinical) services are separate from community support services, which means that clients suffer from a lack of coordinated care. Thus, many people with serious mental illness receive outpatient care but do not receive community support services. However, Colorado continues to use the case management program in various cities in the state and this helps alleviate the

problems. Case management is in a state of chaos in Colorado because the state is currently redefining the services. Caseloads average a tolerable 30 to 35. However, the role of case management is currently unclear.

Crisis services have not progressed beyond the 24-hour crisis hotline and day programs foi their clients. There are no special mobile units, although these are needed in rural areas.

Day programs use a traditional day treatment model, designed to maintain very low-functioning mentally ill individuals, rather than a psychosocial model designed to enable rehabilitation. The state has decided to shift a psychosocial model, with pilot clubhouses in 10 sites, but these are just beginning. Although many consumers find the existing day programs boring, they are required to attend. Hopefully the move toward clubhouses will be more responsive to consumers' needs.

Denver provides some programs to special populations including deaf mentally ill patients and homeless patients. Denver also has special services for Asian American and Hispanic populations. Outreach to jails and prisons is generally inadequate, except in Boulder, where the mental health center has a good program providing services in the county jail.

Vocational Rehabilitation: Colorado's vocational rehabilitation services have improved since the signing of a cooperative agreement between Rehabilitation Services and the Division of Mental Health in 1987. One of the most impressive vocational programs for mentally ill clients is in the rural northeastern corner of the state, where clients can work al a consumer-run 20-unit motel. Additionally, clients work in clothing stores, work crews, car repair shops, a 160-acre organic farm and a consumer job coach. Colorado has two training centers where clients are able to train for various jobs.

Housing: Colorado has limited housing available for people with serious mental illnesses. However the state has created a Department of Institutions which acts as a housing authority. Thus, the Department is eligible to receive federal housing subsidies directly and can then use the money to create housing for individuals with mental illnesses.

Colorado is currently attempting to create supported housing, although this will only succeed with strong case management and other community support services. Only a few areas of the state can support this type of housing. Colorado also needs long-term group homes and residences willing to accept symptomatic and difficult clients.

New Mexico

New Mexico is rated 38 in the survey and is characterized as a relatively poor and fiscally conservative state. The state must ensure that its available resources are well spent.

Hospitals: New Mexico has a 523-bed state hospital at Las Vegas. Las Vegas is continuing to improve and is quite respectable by national standards. The hospital is JCAHO accredited and partially HCFA certified. The hospital has an "800" number for consumers, families, law enforcement officials, and mental health professionals who seek information. Patients from Albuquerque also use beds at the University of New Mexico Hospital and those near the border may be admitted at the Gila Regional Medical Center or other local hospitals.

Outpatient and Community Support: The Las Vegas hospital has moved into the community with a social club and consumer-run gift store downtown. The hospital has also taken over responsibility for running the San Miguel and Mora County mental health centers, the local community mental health centers that cover 1.5 percent of the state population but produce 15-20 percent of hospital admissions. The quality of the state's community mental health centers varies widely. Roswell and Las Cruces are the best, with Farmington, Santa Fe, and Silver City also very respectable. At the other end of the spectrum are the community mental health services in McKinley, Colfax, and Curry Counties and the Bemalillo center run by the University of New Mexico.

Case management services have been developed with the Medicaid option and are well established in only a few places, such as Las Cruces. A curriculum for training case managers is being developed by the New Mexico Highlands School of Social Work. Coordination between the state hospital and community mental health services is poor and crisis services are also weak. Native Americans are not served in most areas.

New Mexico has some innovative programs, such as the Explorers Club, which is a program for individuals with mental illness and substance abuse. Also, some clubhouse facilities have been added at Los Lunas and Silver City. Albuquerque has a Recreation, Housing and Occupation Center. New Mexico's state hospital in Las Vegas has also begun to address rural needs by sending staff on a regular basis to visit discharged patients.

Vocational Rehabilitation: New Mexico is one of the few states that by 1990 had not implemented the federal supported employment program because it was not funded. Thus, there are few vocational opportunities for mentally ill individuals in the state. The state hospital has an Industrial Rehabilitation Program employing 163 persons, and there are a few small programs such as New Vistas and the vocational program at Roswell.

Housing: Six dozen group home beds and a roughly equal number of apartment beds are the sole substance of the state's housing program. The state has not created one long-term housing slot of any kind for people with mental illness. All group homes and apartment programs are transitional, regardless of the residents long-term needs. Furthermore, the

state has made no effort to secure permanent, low-income housing fur people with mental illness.

For the most part, people in New Mexico rely on poorly supervised, poorly maintained boarding homes with an especially large cluster near the state hospital in Las Vegas. New Mexico needs intensive case management, collaboration with housing authorities, initiation of state rental subsidies, and other necessary reforms. The state needs to abandon its insistence on transitional housing and begin to build a continuum of flexible, permanent housing with varying levels of supervision and support.

Texas is ranked 45 by the nationwide survey and is spending very little on its mentally ill. The report describes an environment of corruption and apathy in the state's mental health programs and much is needed if lasting positive changes are to be made.

Hospitals'. Texas has eight state hospitals ranging in size from 360 to 673 beds. All hospitals are JCAHO accredited and most are HCFA certified. Terrel state hospital runs an innovative Family Center, where families can visit privately with patients, and a good psychosocial rehabilitation unit. There is a waiting list at the state hospitals, with very few individuals in mental health treatment centers.

Outpatient and Community Support: In Texas, continuity of care is a positive characteristic. The state has worked hard to ensure that every individual discharged from a state hospital sees a continuity of care staff person within 10 days. However, the program's effectiveness is only guaranteed if the individual can also see a psychiatrist. Texas is trying to improve continuity of care with a single-point-of-entry project, to be piloted in three areas. Case management loads are within an acceptable range and the service is intensive, mobile and community-based, but it is not designed as a lifetime service, because clients are discharged after an average of two and one-half years. Case managers also have a very high turnover rate, further weakening continuity in service provision.
Each local authority is required to have a 24-hour hotline for crisis services, a mobile team and local crisis stabilization beds, but despite this mandate, many localities have only the phone line and perhaps one or two beds.

Day programs vary statewide and there are some consumer-run services and drop- in centers. Two of the state's biggest problems are services in jails and prisons and dual-diagnosis services to mentally ill substance abusers. The county jail systems uniformly lack decent mental health services. The Texas Council on Offenders with Mental Impairments has created a program in Houston providing alternatives to incarceration. In

addition, there is a program that trains sheriffs' deputies to participate as members of 24-hour mental health crisis response units.

Vocational Rehabilitation: Texas has recently adopted a points system which rewards vocational rehabilitation counselors for working with mentally ill clients. Pyramid House, Opportunity House and the Conroe psychosocial rehabilitation program also offer good vocational services. Another program is the Independent Development Center at Wichita Falls, which has individuals with mental illnesses and other disabilities working at Sheppard Air Force Base and in other programs.

Housing: Texas has very little commitment to housing. There are a few isolated housing programs, apartment programs and a community of board and care homes. However, these services do not necessarily provide psychological, social or rehabilitation services.

- The authors of the 1990 nationwide survey developed six proposals which they fell would improve state mental health services (Torrey, 1990). These six proposals are:

1. Public mental health programs must serve people with serious mental illness as a priority. If less than 75% of a program's resources are going to this group, its state and federal subsidies should be terminated.
2. All psychiatrists, psychologists, and psychiatric social workers should be required to donate, pro bono, one hour a week of work to public programs. Federal and state-supported training programs for such professionals should include an automatic payback obligation.
3. Since psychiatrists have abandoned the public sector, psychologists, physician assistants and nurse practitioners should be given special training and allowed to prescribe psychiatric medication. This program should initially be piloted in three to five states.
4. The chaotic funding of public services for individuals with serious mental illnesses needs a total overhaul.
5. Budgets of public mental illness programs should be examined for possible theft.
6. All administrators of public programs for people with mental illness should spend at least one half day each week working with mentally ill people.

VI. PROGRAMS FOR DOMESTIC VIOLENCE OFFENDERS

The Criminalization of Domestic Violence: Promises and Limits

There are a variety of treatment interventions for batterers with varying results (Fagan, 1996). Most of the treatment options are court-mandated programs, some are self-help,

and others operate under the sponsorship of social services or private agencies. The operation and characteristics, including the duration and frequency of contacts for treatment, vary as well. Most of the programs address the need for anger control or dissipation techniques. They also address the relationships of power and control to the use of violence.

There are three types of programs for batterers: self-help programs that emphasize anger management strategies and personal responsibility, educational programs that teach through passive learning about the sources of violence and the techniques of anger control, and programs that combine the two methods. However, there are very few studies evaluating these programs. In addition, the studies that have been conducted are not useful for examining the relative effects ofbatterer treatment because they have no comparison group (Fagan, 1996).

Despite the lack of systematic evaluation, there are some recent administrative innovations that look promising (Pagan, 1996). These innovations focus on the creation of specialized courts to process domestic violence cases and intensive systemic reforms designed to align the components of the civil and criminal legal system so as to ensure that the batterers comply with the sanctions and relief involved in domestic violence cases. The specialized courts provide substantive dispositions, batterer treatment programs and probation supervision. In addition, some courts have specialized prosecution units that evaluate domestic violence cases in the light of other similarly structured cases (Fagan, 1996).

The Dade County, Florida, Domestic Violence Court (DCDVC) best illustrates these initiatives. DCDVC is a criminal court with a civil component which responds to domestic violence cases (Fagan, 1996). It began in November, 1992, and currently handles only misdemeanor domestic violence cases. The members of the court, led by the judiciary, work together toward the goal of reducing family violence. Their hope is that through the combination of intensive victim services, treatment for batterers, and an active judicial role in the social context of the community, control can be achieved over misdemeanor domestic violence so as to avoid its escalation to more serious violence and injuries. The court is based on the following principles:

> • *"The administration of therapeutic jurisprudence creates an expansion of the traditional role of the criminal justice system, which historically has been concerned wi th punishment but has failed to consider the role of treatment in domestic violence cases.* Defendants are required to successfully complete a batterer's treatment program, complete substance abuse treatment and meet other case-specific requirements such as mental health counseling. All cases are monitored by the court after imposition of the sentence, and the defendant is required to return to court periodically during probation to discuss progress in counseling and compliance with the sentence" (Fagan, 1996).

• *There is an emphasis on the needs of children who live in violent homes.* Parents are educated about the effects of domestic violence on their children. The court — in partnership with a facility associated with the University of Miami School of Medicine — makes completion of the group counseling by the defendant's children a condition of the defendant's probation" (Fagan, 1996).

• *"The members of the court acknowledge and accept the responsibility, both in the courtroom and in the community, to educate the public about domestic violence and the/act that domestic violence is a crime.* The role of 'judge as teacher' in the courtroom is tested, and judges have a responsibility to make public appearances at community meetings and in the popular media and to educate the public about the court and about domestic violence" (Fagan, 1996).

• *"The court serves as a catalyst/or change as a community leader by coordinating a community wide approach and community wide participation in a local campaign to combat family violence" (Fagan, 1996).*

• *"Judicial education and training in family violence is mandatory/or all judges and prosecutors and some public defenders assigned to DCD VC.* Victim advocates are employed in the court to facilitate the victim's participation in the court process and to make services available and accessible to the victim" (Pagan, 1996).

Data to evaluate the program's success or failure are not yet available. (Fagan, 1996). When comparative information is available, Dade County hopes to determine whether legal sanctions are more likely and more severe in a court dedicated to domestic violence cases. Additionally, the evaluations should assess the effectiveness of sanctions fashioned in the context of the broader concerns of victim and child safety, plus treatment intervention for assailants (Pagan, 1996).

Violence Against Women Act

Millions of women each year are victims of domestic violence. Through the National Crime Victim Survey, we know that nearly five million women experience violence annually. More than three out of four victims were related to, or knew, their attacker, and injuries occurred significantly more often when the offender was an intimate (National Institute of Justice, 1995). Title IV of the Violent Crime Control and Law Enforcement Act of 1994 is the Violence Against Women Act (VAWA). The VAWA responds to the needs of millions of women who are the victims of violence each year. The VAWA also

Addresses the fundamental changes in addressing violence against women (National Institute of Justice, 1995).

Chapter Two under Subtitle A of the VAWA constitutes an effort to provide support to the States and Indian tribal governments for criminal justice responses and victim assistance efforts (National Institute of Justice, 1995). Chapter Two provided $26 million in FY 1995 (with more authorized for subsequent years) for law enforcement and prosecution grants to reduce violence against women. These grants are called the VAWA block grants. The grants are intended to lay the foundation for ongoing interventions that promote and increase an effective criminal justice system response to violence against women and to increase the range of services for the victims of such violence (National Institute of Justice, 1995).

Under the program, each state may apply for a base amount of $426,364. The State must then allocate 25% of the funds to law enforcement, 25% to prosecution, and 25% to victim services. The remaining 25% may be allocated at the State's discretion within the parameters of the VAWA.

The Federal Government is also providing Violence Against Indian Women Discretion Grants. These grants are directed toward reducing violent crime against Indian women, and aim to develop and strengthen the responses of the tribal justice systems to violent crimes committed against Indian women (National Institute of Justice, 1995). Four percent of the amount appropriated each year under the VAWA will be made available to Indian tribal governments through the discretionary grants program. For FY 1995, approximately one million dollars were available and federally recognized Indian tribal governments are eligible to apply for grants of up to $75,000 (National Institute of Justice 1995).

The Violence Prevention Program

In 1991, the Massachusetts Criminal Justice Training Council and the Framingham Police Department joined with local educators and victim advocates to create a proactive program that addresses the causes of domestic violence (Baker, 1995). The result was the Violence Prevention Program, which stresses prevention rather than reaction (Baker, 1995).

The program educates young students in the seventh and eighth grades about domestic violence and also provides them with skills to help them avoid destructive behavior. The program is structured into five one-hour blocks which can be delivered in health classes as part of the students' regular curriculum (Baker, 1995). Classes are taught by a two-member team made up of a police officer and an educator; ideally a male teacher and a

female officer so as to reverse the common stereotype of these professionals (Baker, 1995).

Before the officers and the educators begin teaching the course, they receive special instruction on domestic violence. The educators participate in a three day train-the-trainer course, which is taught by professional counselors in the areas of teen dating violence and battering. The student program is then divided into five different sessions. The sessions cover topics such as defining the different types of abuse, advertising's message on sexual stereotypes and guest speakers.

Student reaction to the program was positive. Coordinators evaluated the impact of the program by measuring students' attitudes prior to taking the course and after completion (Baker, 1995). Surveys showed that nearly 92% of females and 84% of males felt that school was an appropriate place to learn about domestic violence. The surveys also indicated improvement in the students' ability to define and identify abusive behavior. Thus, the Violence Prevention Program was found to deliver a proactive message, involving mutual respect and conflict resolution, to counter the mixed signals and negative messages that young people often receive concerning interpersonal relationships (Baker, 1995).

VII. PROGRAMS FOR TECHNICAL VIOLATORS (PROBATION AND PAROLE)

Methods for Supervising Offenders

For both adult probationers and parolees, community supervision represents a period of testing (Jankowski, 1990). Approximately 85% of those released from prison receive supervision in the community. Prisoners enter parole supervision either by a discretionary parole board decision or by fulfilling the conditions for a mandatory release (Jankowski, 1990). Community supervision includes intensive supervision, house arrest and electronic monitoring (Jankowski, 1990).

Intensive Supervision

Probation and parole agencies often have several levels of supervision, according to the offender's sentence and criminal history. The highest level of supervision, usually referred to as intensive supervision programs (ISP), varies from jurisdiction to jurisdiction, but generally includes frequent contact between officers and offenders (Jankowski, 1990). Many ISPs are modeled after the Georgia program, which keeps the offender under curfew, employed, drug- and alcohol-free, and performing community services while under close surveillance. The programs calls for five face-to-face contacts per week in Phase I, mandatory curfew, mandatory employment, a weekly check of local arrest records, statewide notification of arrests via State Crime Information Networks, and

routine drug and alcohol screens. The standards are enforced by a team consisting or a probation officer and a surveillance officer, as well as an alternative team consisting of one probation officer and two surveillance officers. The probation officer is in charge of case management, treatment and counseling services and court-related activities (Bureau of Justice Assistance, 1988).

House Arrest

House arrest sentences the offender to confinement in his/her home, with authorizations to leave only for work and emergencies (Maddy, 1984) The scheduling of checks and contacts is one method whereby house arrest can be monitored (Hofer, 1987). In some jurisdictions, computerized calling systems can be programmed for random checks throughout the day and week, to determine if the offender is at home. Then, officers can be equipped with beepers, so that they can be contacted if the computer notes a violation. Random calling and contacting can also be effective (Hofer, 1987).

Electronic Monitoring

There are two types of electronic monitoring devices One type, capable of programmed contact, is a receiver which requires the offender to respond on cue as directed. The other type has a miniaturized transmitter which emits a continuous signal. The availability of a telephone in the offender's home is a basic element of most monitoring devices (Bureau of Justice Assistance, 1994). Electronic monitoring frequently employs programmed contact models which operate from a central computer, and contact offenders at random, or at specified times (Bureau of Justice Assistance, 1994). Types of equipment required for electronic monitoring include coded wristlets/anklets, voice verification, visual verification and pagers (Bureau of Justice Assistance, 1994).

Methods for Sanctioning Offenders who Violate Early Release Program Requirements

When offenders violate either their intensive supervision program, house arrest or electronic monitoring program, jurisdictions need to sanction the offender. The most common response is to send, or return, the offender to prison. However, this strategy may increase the very prison overcrowding problem that community supervision programs are partly designed to alleviate.

Researchers in California and Texas studied rates of violation of intensive supervision programs, and found that a larger treatment component tended to improve behavior while under supervision. Thus, offenders who received counseling for drugs or alcohol, held jobs, paid restitution, and performed community service appeared to have a 10% to 20%

lower recidivism rate in their intensive supervision programs than those who did not participate (Gowdy, 1993).

For offenders who violate their house arrest program, some states have found that a strict and widely publicized policy of swift and certain revocation and imprisonment following the first violation would be a deterrent. Other states have considered calibrating the violation along a graduated scale (Hofer, 1987). For example, the first absence might elicit a warning, the second a warning and an increase in contacts, the third a court appearance, and the fourth a revocation (Hofer, 1987). Other states, such as Florida, have established statewide guidelines concerning response to technical violations in order to provide more guidance (Hofer, 1987).

When offenders violate their electronic monitoring program, states need to develop a clear, concise, policy directive so as to guide the agency's response to a reported violation (Bureau of Justice Assistance, 1994). First, there must be a procedure to differentiate true violations from equipment "glitches." This is usually solved by telephoning the offender, going to the offender's residence or both. Also, the degree of discretion in responding to a verified violation must be clearly stated. This means that the arrest or no arrest must be clearly articulated in the policy and procedure. Furthermore, all violations, and the subsequent responses, must be documented and reviewed by administrators to maintain program accountability. Additionally, if private monitoring services are being used, they should have the violation procedures clearly documented and set forth (Bureau of Justice Assistance, 1994).

In an attempt to avoid technical violations of electronic monitoring programs, some states have developed stringent criteria for entering and remaining in the program. For example New Jersey has the following requirements: full-time employment; a 6:00 P.M. curfew; a daily diary and a weekly budget; weekly community service; frequent drug and alcohol testing; a minimum of 20 contacts per month between officer and participant; payment of all financial obligations, including contributing to program costs; and participation in ISP weekly group meetings and treatment programs, including mandated and verified attendance at Alcoholics Anonymous or Narcotics Anonymous (Bureau of Justice Assistance, 1994). However, the fact that, by May, 1988, 73% of offenders on electronic monitoring had been sent to prison for rule violations (Bureau of Justice Assistance, 1994), suggests that stringent standards may paradoxically increase the rate of technical violations.

De-emphasizing Technical Violations

One strategy for responding to technical violators may be to reexamine the assumption that technical violations are a proxy for criminal behavior (Petersilia, 1993). Offenders who commit this type of violation constitute a considerable proportion of the prison

population. On any given day, about 20 percent of new admissions nationwide consist of parole or probation violators and the resultant crowding means early release for the offenders" (Petersilia, 1993). The use of alternatives to imprisonment for technical violators would therefore decrease the pressure on prison beds.

Based on this perspective, the State of Washington has developed new rules for responding to the heavy flow of technical violations (Petersilia, 1993). The rules require that conditions be set according to the specific offense and the offender's past criminal behavior. In addition, prison cannot be used as a sanction for technical violations; the maximum sentence is 60 days in jail (Petersilia, 1993).

No empirical studies have yet been performed, but Washington officials believe that, as a result of the new rules, revocations for technical violations have decreased while arrest rates for new crimes have remained roughly the same (Petersilia, 1993). Washington's success may mean that jurisdictions will have more prison space for serious offenders. Thus, a decrease in the number of people sent to prison for technical violations of parole and probation may lead to an increase in public safety (Petersilia, 1993).

VII. PROGRAMS FOR MENTALLY ILL JUVENILES

Care of the Seriously Mentally III: A Rating of State Programs for Children

The following are the results of a survey conducted in 1990 which evaluated mental health programs for children in each state (Torrey, 1990). The survey was exclusively concerned with services for children with serious mental illnesses and did not include services for mentally retarded children, or for children with drug and/or alcohol problems. Furthermore, the survey only examined public services and did not attempt to assess private psychiatric services of any kind (Torrey, 1990). Once again, we have chosen to describe New Mexico, two neighboring states (Colorado and Texas), and an exemplary program in a state of approximately the same size as New Mexico (Ohio).

Ohio has developed and expanded services for seriously emotionally disturbed children with the same energy and creativity it has devoted to adult services (Torrey, 1990). The state has recently implemented a certification process to identify the most disabled children. The certification process, along with the availability of a large number of residential treatment centers and group homes, has greatly enhanced Ohio's ability to treat seriously emotionally disturbed children. Inpatient services for children are largely community-based. Ohio has the capacity to house 128 children in hospital beds; however, only 55 beds are in use on an average day. The relatively low demand for hospital beds

may partly be a result of a program entitled Without Walls, which provides intensive support for the children in their community.

The state has a large number of residential treatment centers and group homes for mentally ill children, and is also expanding therapeutic foster care, crisis and respite services. The foster care programs, unlike those in may states, are funded through the mental health system rather than the child welfare system, and are therefore designed specifically for emotionally disturbed children.

Additional treatment programs include case management and day treatment. Finally, the Cluster system is an innovative program, involving interagency groups that meet regularly to plan services and funding for multi-need children. These groups assess needs and create new services from their own flexible pool of funds (Torrey, 1990).

Colorado's services for seriously emotionally disturbed children are inadequate (Torrey, 1990). This inadequacy can be seen, for example, in Colorado's use of state hospitals to treat seriously emotionally disturbed children. Once in the hospital, children tend to stay too long, and thus there is rarely enough room for the many children who need treatment.

Crisis services for children are also deficient, amounting to little more than a 24-hour crisii hotline for children.

Day treatment, school services, and a few home-based services are available to children in some areas of the state. However, school services are inadequate, because they are focused on behavior modification and not on the needs of the child. Children are frequently evaluated in the detention home, but they never get the services that are recommended for them. The biggest flaw is the lack of case management, which does not exist except insofar as therapists can provide some oversight from their offices. The absence of case management means that children leaving very intensive services, such as residential or home-based treatment, are essentially dropped into a void with little follow-up.

One of the bright spots is that half of Colorado's counties have Placement Alternative Commissions to fund alternatives to out-of-home placement, and the state also has the Grey-Area Intersystem Project for children who are served by multiple agencies. There is also an Adolescent Treatment Program at a special school and an intensive treatment program for younger seriously emotionally disturbed children at mainstream elementary school. The state has also started funding for child and adolescent service specialists in sh mental health centers with duties that include interagency coordination and case management (Torrey, 1990).

NEW MEXICO

New Mexico is beginning to develop a system of services for seriously emotionally disturbed children (Torrey, 1990). The state has mandated that the most intensive services will only be funded for children diagnosed as seriously emotionally disturbed. Among the services established, case management is likely to succeed. Case management has two levels depending on the child's needs and has a no-discharge policy for the more intensive type. Case management is not available in all parts of the state, but should continue to expand. Day treatment and home-based services are also expanding.

One urgent need in mental health services for juveniles is for more inpatient beds for children and adolescents. The state refuses to pay for private inpatient beds, which prevents children from being hospitalized in or near their home communities. Another problematic policy is the refusal of the mental health department to pay for independent living or vocational services for clients under age 18. Residential treatment centers also have a waiting period of several months for admission and serve only adolescents. Therapeutic foster care and respite services are nonexistent and crisis services consist of 24-hour phone lines with no coordinated intervention services to back them up. Finally interagency coordination is weak, with little joint planning or funding (Torrey, 1990).

Services for seriously emotionally disturbed children are even fewer than for mentally ill adults in Texas (Torrey, 1990). The state has approximately 500 inpatient beds for children and adolescents, which means that inpatient services are overcrowded, with many children discharged too soon and without follow-up in order to make room for new cases. Residential treatment is also overloaded and understaffed.

Case management, therapeutic foster care, respite beds, day treatment and home-based services all exist, but with such small capacities that they are almost invisible. Also, these services are not exclusive to seriously emotionally disturbed children (Torrey, 1990).

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