Perceived Shortcomings of Mental Health Delivery Systems in North Carolina
Community Corrections

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Executive Summary

Policy Question (Page 3)
What shortcomings do stakeholders, particularly parole and probation officers (PPOs), perceive in the current delivery of mental health services to probationers with serious mental illness (SMI)? The targeted client for this policy question is the North Carolina Department of Corrections, which employs PPOs and which has the most ability to influence the care of probationers with SMI.

Background (Page 6)
The North Carolina Department of Corrections supervises not only those persons imprisoned for their offenses, but also a number of individuals who have been released on probation or parole (for persons sentenced before NC shifted to determinate sentencing). The Department of Corrections seeks to reduce the recidivism rate for convicted persons on supervised release, but their ability to control these persons is limited. The DOC faces particular challenges when supervising people with mental illness – people who may be incapable, without additional help beyond regular probation supervision, of meeting the requirements of their supervised release. Persons with mental illness make up a significant and growing percentage of the population on probation. Up to 73% of incarcerated women and 56% of incarcerated men have some form of mental health concern. For those people not sentenced to prison, but released back into the community on probation, concerns arise about probationers’ ability to receive treatment and successfully reintegrate into society. Probation officers who interface with probationers regularly attest to difficulty in helping persons with serious mental illness.

The paper seeks to give detailed background information on two fields of study that are well-developed vis-à-vis the criminal justice system’s current treatment of convicted persons with mental illness. The first field is the legal question: what is the standard duty owed to probationers (and other stakeholders, including the public) by the Department of Corrections? Secondly, a large body of research has examined the clinical side of treating convicted persons with mental illness. The legal research contextualizes “why” – why DOC should be more or less proactive in its handling of mental illness, while the clinical research furnishes the “how” – what programs have been shown to be most effective in carrying out the DOC’s goals of lowering recidivism and encouraging probationers to re-enter society as healthy individuals.

Methods (Page 12)
This paper examines survey data from probation and parole officers in North Carolina. Officers responded to an online questionnaire about their caseloads; they were asked to list the biggest or most important challenges they encountered when trying to supervise probationers with mental illness. Probation officers reported experiencing difficulty managing cases of probationers with mental illness, but they largely refrained from blaming the probationer him- or herself for inability to complete probation successfully. Rather, officers named systematic and environmental factors as their problems. Lack of good mental health treatment was the most-commonly cited reason for problems arising in the probation experience. The perceived needs
and systematic shortcomings noticed by the probation officers serve as a springboard in this paper; against the backdrop of other literature and legal analysis, this paper suggests “next steps” for the North Carolina Department of Corrections, including areas for future research and potential policy changes. “Next steps” are geared mostly towards the creation of public-private partnerships.

Results and Recommendations (Page 15)

It is evident that larger structural changes need to occur in the mental health delivery system in order for probationers to be served more appropriately. PPOs do apparently require some more instruction in interacting with persons with MI. However, as they note, it is unrealistic to expect that they will become mental health professionals with any real diagnostic and treatment ability. For that reason, it is vital to increase probationers’ access to mental health professionals regardless of insurance status or individual financial position.

Local mental health providers may be asked to take a more active role in the supervision of probationers. Courts should not place the whole burden of supervising a person with MI onto a potentially under-trained PPO. Health care providers should be expected to meet with probationers on a regular basis to ensure compliance with medical directives. A benefit of splitting supervision between PPOs and clinicians is that clinicians may feel free to take a more cooperate approach to probation supervision.

Courts may choose to partner with private or non-profit firms – for example, they may work with Habitat for Humanity to improve housing options for probationers or with Goodwill to offer work opportunities – although the state will have to vet potential partnerships very carefully to assure the protection and privacy of the probationers. Non-profit organizations like Disability Rights NC or the NC Medical Society may offer courses to PPOs to inform them on the warning signs of mental illness. Granted, a few seminars will not make PPOs mental health professionals. The goal of such a partnership would be to increase PPOs’ awareness of MI symptoms and improve their ability to refer probationers to qualified mental health care providers.

The restructuring of LMEs in NC is currently underway, to be completed by summer 2012. The effect that this restructuring will have on care for probationers is yet to be seen. The Department of Corrections must be vigilant in assuring that no probationers lose contact with mental health care providers when the structure of their health care system is changed or integrated into a larger multi-county area. However, the restructured LMEs may also now have the organizational flexibility to do more public-private partnerships and referrals to community services, such that the needs of probationers will be better served.
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Abstract

This paper examines survey data from probation and parole officers in North Carolina. Officers responded to an online questionnaire about their caseloads; they were asked to list the biggest or most important challenges they encountered when trying to supervise probationers with mental illness. Probation officers reported experiencing difficulty managing cases of probationers with mental illness, but they largely refrained from blaming the probationer him- or herself for inability to complete probation successfully. Rather, officers named systematic and environmental factors as their problems. Lack of good mental health treatment was the most-commonly cited reason for problems arising in the probation experience. The perceived needs and systematic shortcomings noticed by the probation officers serve as a springboard in this paper; against the backdrop of other literature and legal analysis, this paper suggests “next steps” for the North Carolina Department of Corrections, including areas for future research and potential policy changes. “Next steps” are geared mostly towards the creation of public-private partnerships.

Introduction

The North Carolina Department of Corrections supervises not only those persons imprisoned for their offenses, but also a number of individuals who have been released on probation or parole (for persons sentenced before NC shifted to determinate sentencing). The Department of Corrections seeks to reduce the recidivism rate for convicted persons on supervised release, but their ability to control these persons is limited. The DOC faces particular challenges when supervising people with mental illness – people who may be incapable, without additional help beyond regular probation supervision, of meeting the requirements of their supervised release. Persons with mental illness make up a significant and growing percentage of the population on probation. They may endanger themselves or others if they are not referred to care or supervised properly by the criminal justice system and the public mental health system. They often lack the support in their home environments to seek help on their own, or they are (sometimes as a result of their illness) unable to hold down a job that would allow them to afford health care. In the interests of public safety, and to minimize the suffering of persons with untreated illnesses, it behooves the DOC to examine existing problems in the delivery of mental health services to probationers. They can most effectively determine the root problems and
brainstorm solutions through a dialogue with front-line justice-system workers, particularly probation officers.

The first part of the paper clarifies and contextualizes the precise policy question – what do probation and parole officers see as major impediments to successful completion of probation by probationers with mental illness, and what can the Department of Corrections do to remove those impediments?

Secondly, the paper seeks to give detailed background information on two fields of study that are well-developed vis-à-vis the criminal justice system’s current treatment of convicted persons with mental illness. The first field is the legal question: what is the standard duty owed to probationers (and other stakeholders, including the public) by the Department of Corrections? Secondly, a large body of research has examined the clinical side of treating convicted persons with mental illness. The legal research contextualizes “why” – why DOC should be more or less proactive in its handling of mental illness, while the clinical research furnishes the “how” – what programs have been shown to be most effective in carrying out the DOC’s goals of lowering recidivism and encouraging probationers to re-enter society as healthy individuals.

The meat of this paper, and the third and longest section, attempts to reconcile the gaps between existing policy and ideal policy. Legal norms have set a “floor” of accountability and have set up the bare minimum required of the criminal justice system in delivering health care. Controlled studies of persons with mental illness have created some ideal programs that have been shown to be effective in reducing recidivism and illness remission. Yet in daily practice, many problems remain before probationers with mental illness are adequately cared for and guided towards successful completion of probation. This third section of the paper examines survey data from probation officers across North Carolina. These officers listed their greatest challenges in helping probationers complete their supervised release successfully. The responses given illustrate specific shortfalls of the existing care system.

Lastly, this paper suggests limitations of the study and what further research needs to take place. By combining the probation officers’ suggestions with effective legal and clinical strategies from other states, the paper attempts to create some general ideas for public-private partnerships and other methods by which the DOC can more effectively work with probationers with mental illness.
Client and Policy Question

Mental illness is an increasingly well-documented concern in the American criminal justice system, as up to 73% of incarcerated women and 56% of incarcerated men have some form of mental health concern.¹ For those people not sentenced to prison, but released back into the community on probation, concerns arise about probationers’ ability to receive treatment and successfully reintegrate into society.² Probation officers who interface with probationers regularly attest to difficulty in helping persons with serious mental illness. The public policy problem presented, then, is:

What shortcomings do stakeholders, particularly parole and probation officers (PPOs), perceive in the current delivery of mental health services to probationers with serious mental illness (SMI)? The targeted client for this policy question is the North Carolina Department of Corrections, which employs PPOs and which has the most ability to influence the care of probationers with SMI.

This policy question is open to various approaches, from cost-benefit analysis to more general stakeholder analysis. This paper has elected to use stakeholder analysis as a means of addressing the most pressing shortcomings of the probation system. Cost-benefit analysis will probably have to be done in the future, but because the cost structure system of mental health delivery is in a state of flux in 2012-2014, it is not appropriate as the general basis of this paper. Stakeholder analysis begins with an identification of the client – here, the NC Department of Corrections. Then, the client’s relationships to probationers and probation officers (the two major stakeholders at issue here) are examined in this paper as a legal matter to set a “floor” of duty and the minimal acceptable level of intervention. Background literature on stakeholders’ outcomes from interventions in other states will also be discussed as a way of contextualizing the broader question. Finally, the probation officers as stakeholders are examined through survey responses; these responses will give the reader an indication as to the most pressing problems for stakeholders.

The Community Corrections Division is the part of the Department of Corrections that supervises probation officers and directs supervised release for offenders convicted of crimes and

released on probation or parole. The mission of the Community Corrections Division includes behavioral modification and treatment that will positively affect the behavior patterns of individuals in contact with the criminal justice system. Interventions for individuals must be evidence-based and demonstrated to be effective before being implemented officially by the division.

To determine whether probationers (along with convicted prisoners and persons awaiting trial in jails) have a “severe” mental illness, the Department of Corrections uses a 5-point scale ranging from M1 (no mental health issue) to M5 (acutely ill or suicidal). Persons with SMI rate at M3 or above; the designation of “severe” mental illness is set by the Department of Health and Human Services. Generally, SMI include psychotic disorders and mood disorders, while personality and adjustment disorders are not considered severe. The total number of persons in the criminal justice system with SMI has increased more quickly than the rate of SMI in the population at large, although the DOC does not break down the diagnoses between probationers and non-probationers within the system.

Generally, persons with mental illness have higher-than-average contact with law enforcement. One study found that almost half of persons with schizophrenia had had at least one interaction with law enforcement; most were actually victims of crime, but being on parole or probation was also a very common situation. These numbers only included persons who had previously been treated for schizophrenia, and they might be higher if untreated or undiagnosed persons could be included in the calculations, but this is not feasible. After the initial contact with law enforcement, probationers are a high-need population; one study estimated that probationers had significantly higher rates of substance abuse and psychiatric disorders than the general population. Probationers with dual diagnoses, especially psychiatric disorders occurring with substance abuse problems, had a higher than expected rate of violent crime commission.

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4 Id.
6 Id.
For persons who went to prison but were later paroled, a single diagnosis did not necessarily increase risk of parole revocation. However, dual-diagnosed parolees had a substantial risk of either having parole revoked or committing a new criminal offense. These parolees were 1.7 times more likely than a single- or no-diagnosis individual to commit a technical parole violation and 2.8 times more likely to commit a new crime. Specifically, a combination of substance abuse, SMI, and prior history of criminal behavior greatly increase risk for re-arrest and subsequent revocation of supervised release. Another study found that parolees with serious mental illness spent half as much time on parole as non-mentally ill parolees before returning to prison on a parole violation. Given that the study estimated 23% of parolees had serious mental illness, this discrepancy has grave consequences for the success of any parole system.

Particularly when addressing the needs of probationers with SMI, the DOC has conflicting interests and incentives. The DOC operates within a limited budget and constrained universe of public policy options. Although the organization may strive to reduce recidivism and may improve the lot of both corrections officers and probationers with a mental health service, benefit may not outweigh the cost of extending an already overburdened public health system. Whether the DOC has a legal responsibility to provide mental health services to the probationers is a question largely untouched by law, but it is an important consideration for the structuring of services. The extent of legal responsibility for a probationer, once diagnosed and offered services, determines how many resources would have to be allocated to mental health programs,
or whether the DOC would have an incentive to not provide programs at all (to avoid civil liability, for instance).

The responsibility of the government to help integrate the mentally ill (including, but not exclusive to, probationers) into the community is outlined in a number of Supreme Court cases, most notably Olmstead v. L.C., which holds that mentally ill persons must be treated in the most integrated setting possible. The Department of Corrections and medical care providers also have a number of responsibilities towards inmates as a result of the Civil Rights of Institutionalized Persons Act, itself built upon the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The question of responsibility of the corrections system vis-à-vis the public is also a question meriting brief discussion, although this responsibility has largely been dismissed through the line of cases following Castle Rock v. Gonzales.13

To begin thinking about how to reform the DOC’s existing method of caring for probationers with mental illness, it is important to analyze exactly what the department is required by law to provide for probationers. Legal doctrines of duty demonstrate how the Department of Corrections should relate to persons in its care – if that duty is being unfulfilled, then fixing the gap between duty and actual performance will be the first step to any reform.

**Background Information**

*Duty and Probationers with SMI – Legal Review*

The legal relationship between the criminal justice system and the probationer is characterized by duty – duty in the sense of civil liability and duty arising from Constitutional analysis of the fair treatment of individuals convicted of a crime. Civil liability may arise from the interactions between probationers and their probation officers (PPOs) or their mental health care providers, or between health care providers or PPOs and the sentencing court. Eighth Amendment claims in particular may relate to probationers’ access to care. Even limited duties exist to a third party – the public – when a probationer is potentially dangerous. The relationship between probationers, the public, and the criminal justice system is rather more poorly defined than the relationship between the criminal justice system and prisoners. Some aspects of the relationship may be extrapolated from law about prisoners, but others evade analogy and have yet to be heard in courts.

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Courts’ duties to probationers with mental illness seem limited to the fair hearing of those probationers’ violation of probation terms. Courts must determine that a violation of probation was willful, and therefore should hear testimony about a probationer’s mental illness if that mental illness has contributed to the violation.\textsuperscript{14} The North Carolina Court of Appeals held, “Where a defendant presents competent evidence of his inability to comply with the conditions of probation, we have further held that the court's findings must reflect its consideration thereof.”\textsuperscript{15} No appellate court decisions seem to have addressed whether the court must actively investigate the possibility of a mental health diagnosis, where that diagnosis was not raised at initial trial or offered by the probationer as a reason for the probation violation. Given that probation may be revoked by preponderance of the evidence standard, there is little reason for judges to investigate the mental state of the probationer.

There is no concrete reason for a probation or parole officer to investigate mental illness of probationers, either. According to the terms of North Carolina law, the duty of a probation or parole officer to a probationer is relatively vague: “Such officer shall use all practicable and suitable methods, not inconsistent with the conditions imposed by the court or the Secretary of Correction, to aid and encourage persons on probation to bring about improvement in their conduct and condition”.\textsuperscript{16} Neither statute nor case law has held that PPOs are required to diagnose probationers or encourage them to seek treatment – nor would such a requirement necessarily even be “practicable” or “suitable” for a non-medical professional. Case law has not discussed whether it is within the statutory requirements of a PPO position to offer mental health care referrals to probationers who request them. The only certain way to channel a probationer into mental health care is to have a judge order them into treatment.

In fact, absent a court order, the community corrections division has very little obligations vis-à-vis probationers, even by the terms of the Eighth Amendment. The South Carolina Supreme Court held that it was not a violation of rights for probation officers to fail to offer housing, security, or transportation to a probationer (who was tortured by an older man

\textsuperscript{14} State v. White, 129 N.C. App. 52, 57 496 S.E.2d 842, 846 (1998)
\textsuperscript{16} NC Gen. Stat. §15-205.
when he left police custody).\textsuperscript{17} If even these basic needs do not have to be furnished by community corrections divisions, then mental health care probably is not required.

If a probationer has already been diagnosed and referred for treatment, his or her treating physician will have to abide by medical standards of care which are separate from Eighth Amendment analysis. Physician duties are generally more stringent than the duties of PPOs. Beyond other duties to provide appropriate care (the breach of which would constitute medical negligence or malpractice), mental health care professionals have a duty to responsibly and accurately report to the courts on the condition of the probationer. Suit may be brought against a practitioner for not accurately reporting on the appropriateness of civil commitment for a probationer.\textsuperscript{18} Inaccurate reporting gives rise to a claim on the part of persons harmed by the probationer as well.\textsuperscript{19}

However, in general terms, the community corrections division of a prison system has no duty to protect third persons from the hypothetical threat posed by a probationer. The most widely cited case in the “duty to protect” category is \textit{Castle Rock v. Gonzales}, 545 U.S. 748 (2005), in which the Supreme Court ruled that police do not have a duty to protect any given individual. Notably, the police did not have a duty to arrest even a person against whom a restraining order had been issued and who was suspected of having broken that restraining order. Known proclivity for violence does not seem to create liability on the part of the criminal justice system vis-à-vis any individual person, so it holds that a member of the public would not be able to sue a PPO for inability to restrain or monitor a probationer known to be mentally ill. Indeed, previous case law has generally held that PPOs and community corrections divisions cannot be expected to protect all people a probationer comes into contact with.\textsuperscript{20}

Duty to third persons potentially exists on the part of therapists and health care providers treating probationers. If a probationer has no history of violent crime or psychosis, the general rule is that the health care provider has no duty to the public.\textsuperscript{21} Where a probationer is convicted of past violent crime, and is institutionalized as part of court-ordered treatment, psychiatrists are

\textsuperscript{19} Id.
\textsuperscript{20} \textit{McIntyre v. St. Tammany Parish Sheriff}, 844 So. 2d 304 (La. Ct. App. 1st Cir. 2003)
\textsuperscript{21} \textit{King v. Durham County Mental Health Auth.}, 113 N.C.App. 341, 345, 439 S.E.2d 771, 774, disc. rev. denied, 336 N.C. 316, 445 S.E.2d 396 (1994)
expected to protect the public. An institution, and by extension professionals working for an institution, must take “reasonable care” to protect the public from potentially dangerous patients. Lack of care gives rise to a claim of negligence.22

The mental health caretaker exception to the general lack of duty derives from the obligations of “custodians” or people exerting considerable control over a dangerous person. The Restatement of Torts includes prison officials in the description of custodians of dangerous persons, and in fact the imprisonment of a criminal is the quintessential example of a custodial relationship.23 Importantly, parole and probation officers are not considered custodians in most cases interpreting the custodial obligation. According to courts, PPOs perform “ministerial” functions rather than custodial ones; additionally, courts are constrained by reluctance to interfere with the daily decision-making of community corrections organizations.24

In short, the justice system’s duty to probationers and to the public vis-à-vis probationers with mental illness is vague and rife with perverse incentives. While PPOs may not be sued for the criminal acts of the probationer, a mental health care provider may be sued. This rise of liability provides an incentive for community corrections divisions not to identify and treat mental illness, as they may admit liability on the part of treating psychiatric professionals. The probationer him- or herself may not be able to sue for proper diagnosis and treatment, as the probationer’s rights to treatment under the Eighth Amendment are much less expansive than those of prisoners. A public policy shift to improve treatment of probationers with mental illness will likely have to arise from concern about the rate of recidivism or about human rights, rather than from legal duties arising from either tort law or Constitutional analysis.

Treatment of Probationers – Literature Review

The previous sections have examined why the DOC might, as a legal matter, be required to be proactive in their treatment of probationers with mental health disorders. They do illuminate why the DOC might be reluctant to take on additional liability, particularly in an economically-strained environment, but the law does create liability nonetheless. The legal analysis, as well as setting the background for why mental health care is important to the DOC,

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23 REST 3d TORTS-PH § 42
24 Id.
sets a floor of basic care that the DOC must provide. However, legal analysis does not offer helpful alternatives to the problems that it has set up. The law has essentially said – “here’s your burden, now take care of it” – without necessarily giving any specific policy guidelines.

Literature review on the clinical side of probationer mental health care helps complete the background picture. Studies of health care delivery in other jurisdictions are partly aspirational. They show what can be done even with limited funds, and they show what works well to achieve the goals of the DOC. They are also a reflection of how badly probationers may fail at re-integrating into society if no proper intervention takes place. In sum, treatment of probationers in clinical and experimental literature helps to contextualize the policy suggestions of lawyers, judges, and (as will be illustrated later) probation and parole officers. Although there has been much research about the treatment of prisoners with SMI, less has been done specifically with regard to persons on probation. Only a handful of studies even attempt to classify the types of mental illness and mental health service use among probationers as compared to non-probationers. Data from 2001 show that probationers are more likely than people who have never been on probation to report psychosis and mania – but rates of milder MI like moderate depression were roughly the same for both groups. The study based on this data found no statistically significant difference in the use of mental health care for probationers and nonprobationers. Data seem to indicate, then, that probationers are seeking mental health care at the same rate as nonprobationers despite having a higher incidence of SMI.

Probationers’ ability to stay in treatment once it is sought is dependent on a number of factors, including the size, composition, and quality of the probationer’s social network. Good relationships with treatment providers enhance probationers’ success, especially if the clinician allowed the probationer to take some role in determining the path of treatment. Participation in mental health courts instead of the general court system also decreases the rate of recidivism and

26 Id.
encourages social reintegration.\textsuperscript{28} Housing and social life instability increases dual-diagnosed probationers’ rate of re-arrest, although persons who were homeless prior to the first arrest do not have significantly worse outcomes than people who have stable housing.\textsuperscript{29}

Nationwide comparison of traditional and mental-health-only probation systems reveal some of the most useful features of a probation system for reducing recidivism and providing care for probationers with SMI. Specialty agencies that are successful in providing treatment for probationers with SMI share a set of characteristics: small caseloads for PPOs, caseloads focused solely on probationers with SMI, specific training for PPOs in mental health needs, use of resources inside and outside of the DOC, and cooperative rather than punitive means of addressing probation violations.\textsuperscript{30}

However, mental health court interventions are not universally worth the cost of maintenance. For women with a substance abuse disorder, participation in a mental health court instead of a traditional probation court did not increase rates of success or decrease rates of recidivism.\textsuperscript{31} It is important to note that the women included in the drug-abuse study did receive counseling and referrals to community treatment through their traditional probation programs, so the study should not be read to indicate that referrals to treatment are without use.

Some analysis has already taken place in specific states’ probation systems, especially in areas that have undergone reconstruction of the probation/parole process. In Maryland, Illinois, and Tennessee, probation officers receive specific crisis intervention training that allows them to identify mental illness and refer probationers to appropriate care providers. Although little hard data exist to show the training’s effect on recidivism, the so-called “Memphis Model” based on Tennessee’s probation approach has become popular as part of PPO training in other states.\textsuperscript{32}

\footnotesize
\begin{itemize}
\item \textsuperscript{29} Id.
\end{itemize}
Texas survey of PPOs showed an increasing desire for mental health treatment of probationers. In Missouri, a 2005 survey of treatment providers asked for the providers’ experiences and opinions regarding the state probation system. In the years prior to this survey, Missouri had enacted a new interdisciplinary Reentry Program (MRP) that connected probation officers, courts, and mental health treatment providers. The goal of this new program was to resolve conflicting interests and incentives among stakeholders in the probation process. While treatment providers had a generally positive view of probation officers, they highlighted the following areas needs: more education for PPOs about substance abuse treatment, more defined treatment plans, and more explicit goals for treatment from the court system.

NC’s Areas of Need – Probation Officer Caseload Study

Stakeholders are the actors within a public policy’s sphere of influence; they are the individuals or entities that have particular interests in the outcome of any policy shift. If mental health care delivery to probationers changes, stakeholders affected by the changes will include: probationers themselves, supervising probation and parole officers, mental health clinicians, judges and attorneys, and the members of the public.

For each particular aspect of the community corrections mental health system, different types of stakeholders will place different stress on perceived advantages or shortcomings. Each group of stakeholders has a particular identified interest which often conflicts directly with the interests of another group of stakeholders. This is, in part, why the delivery of health care in general to persons within the criminal justice system has been a politicized and contentious issue. Analysis of the current system of health care delivery will have to rank the importance of a particular stakeholder’s interest in order to help resolve conflicts.

Resolving the differences among stakeholders will also involve legal research and the application of legal principles. The relationship between law enforcement and probationers, for example, is partly a matter of public policy (and therefore the subject of political vicissitudes) and partly a regimented legal relationship defined by both statute and common law.

The background information above has presented a large and growing body of work that analyzes the interests of probationer, clinician, and judicial stakeholders. However, probation and parole officers, who work on the front lines and interact with probationers regularly, are overlooked in existing literature. Additionally, probation officers, with their experience with persons with mental illness, can give insights into the needs of people who might otherwise be overlooked in non-clinical settings (because of inability to articulate their own needs, or because of ethical issues that might prevent their being studied more in depth).

**Methodology**

The paper uses data from the University of North Carolina School of Social Work’s Probation Officer Caseload Study to add to the current literature by focusing on the often neglected interests and perceived needs of probation and parole officers (PPOs) – the personal representatives of the justice system vis-à-vis probationers. PPOs are the employees of the Department of Corrections who interface most regularly with persons on supervised release. Often, they are the officers most able to identify changes in behavior or erratic behaviors that are symptomatic of an underlying illness, simply because they are relatively familiar with persons under their supervision. While PPOs are not clinicians and should not be expected to perform diagnostics for all supervisees, they are in many ways the gatekeepers for treatment. They keep probationers accountable for breaches of probation conditions; they also able to refer probationers to needed services in a clinical setting. The experiences and perspectives of probationers themselves, mental health providers, and public policy workers have been the focus of much work as presented above. The perceptions of PPOs are less well-represented, despite their personal experiences on the front lines of criminal justice work. Survey data about PPOs in NC is available and will provide enough insight and discussion to form the nucleus of a public policy investigation. Analyses focus particularly on understanding what problems PPOs claim to encounter most frequently in their supervision of probationers with MI.

PPOs from across the state were asked to participate in an online survey about their caseload standards and practices. Of 657 surveys issued, all but 38 respondents completed the questions asked. One set of questions asked about PPO experiences supervising the cases of probationers with mental illness. These questions asked about the PPOs’ perceptions of the biggest challenges in supervising probationers with MI, as well as whether they perceived that
their supervisees would be successful in following probation conditions. The answers to these questions will be organized through descriptive statistical analysis and used to illustrate the shortcomings of the mental health system that prevent the effective interface of PPOs with probationers.

Finally, the paper will provide a series of suggested “next steps” for the DOC. Those may include alternatives to the current mental health system, or they may be to research further the financial and political constraints of an expansion of care for probationers. The primary difficulty in making a concrete set of policy alternatives is the current state of flux of the NC mental health services system. The state budget allocations to the DOC are not constant, especially for probation services. Public mental health entities available to all persons, which often receive referrals from the criminal justice system, are re-organizing. A financial and structural outlook for local mental health entities will not be available until sometime between July 2012 and January 2013. Any alternatives proposed involving this system will necessarily be broad-based responses to PPO perceived needs rather than a cost-benefit analysis of changes to the DOC and/or DHHS structure.

**Survey Design**

Survey responses included numerical and non-numerical data. Some questions were numerical with the potential for multiple numerical responses. These questions were:

- How many years a respondent had worked in corrections
- Average caseload of each respondent
- How well a respondent felt able to supervise probationers with mental health problems (on a scale of 1-5, with 5 being “perfectly trained/able to supervise” and 1 being “not at all trained/able to supervise”)
- How difficult each respondent found supervising probationers with mental illness (on a scale of 1-10, with 10 being “extremely difficult” and 1 being “not at all difficult”)
- How many offenders under a respondent’s supervision were receiving services for mental health problems
- What percentage of supervisees would commit probation violations within the first year on probation
- What percentage of supervisees would commit new violations within the first year
Questions answered yes/no were considered numerical data for the purposes of analysis. “Yes” answers were given a value of 1, while “no” was assigned a value of 0. Yes/no questions reflect a respondent’s selection of a particular issue as an important one for the supervision of probationers with MI. Respondents were asked “What are your biggest challenges to supervising probationers with mental health problems?” and then given the option to select “yes” or “no” for a given type of challenge. A respondent might select “yes” to indicate that “employment” or “housing” was an important challenge for probationers with MI, or “no” to indicate that these categories were not important. Each particular yes/no question was tabulated via STATA to determine the frequency of the response.

Yes/no responses were also cross-tabulated and correlated in STATA to determine whether the perceived needs of the PPOs were related to the PPOs’ years of experience and experience with probationers who have had probation revoked (that is, if PPOs who have seen many probationers re-arrested perceive different needs than PPOs with more compliant supervisees).

PPOs were also allowed to select “other” as an option when asked about their greatest challenges in supervising probationers with MI. If “other” was selected, respondents could then provide a write-in answer detailing their perceived needs as PPOs. These write-in responses are excerpted below. These responses, not suitable for numeric analysis, are grouped according to the basic content of the reply (institutional or personal traits). The responses are then read as a whole to determine where PPOs with write-in responses have identified the greatest need.

**Results**

*Numerical Survey Responses*

Almost no respondents indicated that they had no problems supervising probationers with MI. Only 12 respondents answered “none” to the question “what are your biggest challenges to supervising offenders with mental health problems?” There was no correlation between answering “none” and “years of experience in corrections”, as “none” answers were fairly evenly spread across years of experience.

In fact, years in corrections and PPOs’ work experience had almost no relationship with the responses each PPO gave as to the biggest challenges of supervising probationers with MI. We can most likely take the PPOs’ survey responses at face value as reactions to their own
individual work experiences. The most useful calculation with this data is to determine the relative popularity of each yes/no answer and the most common responses to multiple-response questions and determine which problems are perceived to be the most common across the board with PPOs.

PPOs generally found working with probationers with MI challenging. When asked “how difficult do you find working with probationers with mental health problems?”, about half answered that it was very difficult. On a scale of 1-10, with 1 being very easy and 10 being very difficult, most answered above a 5, and the most common response was an 8.

PPOs did not feel perfectly equipped or trained to monitor probationers with MI, but they also did not feel wholly unprepared or untrained. Most respondents answered that they felt moderately well trained to deal with probationers with mental illness.

The following are the yes/no responses given most frequently, in descending order, along with the percentage of respondents answering “yes” (that is, that the factor named was an important factor contributing to the difficulty of supervising probationers with MI).

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent Responding “Yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of employment options for probationers</td>
<td>75</td>
</tr>
<tr>
<td>Lack of treatment</td>
<td>73</td>
</tr>
<tr>
<td>Lack of support system for probationers</td>
<td>68</td>
</tr>
<tr>
<td>Probationers’ lack of comprehension of probation requirements</td>
<td>49</td>
</tr>
<tr>
<td>Noncompliance</td>
<td>46</td>
</tr>
<tr>
<td>High-risk environment</td>
<td>42</td>
</tr>
<tr>
<td>Lack of housing options</td>
<td>30</td>
</tr>
<tr>
<td>Difficult to enforce probation requirements</td>
<td>25</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
</tr>
<tr>
<td>None/no problems</td>
<td>12</td>
</tr>
</tbody>
</table>

“Lack of treatment” was a problem identified multiple times in the survey, in both multiple-choice/numerical and free-form responses. When PPOs were asked how many of their
supervisees with MI were engaged in treatment, many answered “none”. Most PPOs supervised 10 or fewer probationers undergoing treatment for the mental health problems.

Most respondents had actual caseloads of 50-100 probation supervisees. If other studies’ estimates of the rate of mental illness among convicted persons is correct, a caseload of 50 probationers should include 20 or more persons with MI. In that case, having only 10 persons in treatment represents a 50% failure rate of the probation system vis-à-vis referring patients to appropriate treatment.

Respondents were not optimistic about the future success of their supervisees with mental health problems. Three-quarters of the respondents thought that their supervisees with MI would commit probation violations in the first year on probation. Most respondents thought that between 20 and 60 percent of probationers would violate the terms of their probation.

When asked if their supervisees would commit new violations in the first year of probation, respondents estimated that more of the probationers would be in legal trouble. Almost a third of respondents estimated that 40-60% of probationers were likely to commit new violations. Two-thirds of respondents thought that 40% or more of their supervisees would commit new violations. Ten percent of respondents thought that 80-100% of the probationers were commit new violations.

**Write-in Responses**

To elaborate upon the experiences of PPOs, the survey also solicited open-ended responses to the question “what is your greatest difficulty in serving persons with mental illness?” The written comments given to supplement answer choice “other” in Question 6 generally relate to one of two problems: infrastructure weakness and qualities inherent to the experience of mental illness. Infrastructure problems include heavy caseloads and unrealistic expectations of PPOs; more personal qualities include the difficulty of relating to persons who are delusional and/or developmentally disabled. Some of the PPOs’ comments related to both problem categories, others to only one or the other. The two categories are not mutually exclusive and in fact seem to enhance each other in a vicious circle.
Responses from PPOs that indicated structural problems included:

“I feel I could assist much more if I wasn't so overwhelmed with reviews, paperwork and carrying a [higher than normal] caseload.” [125]

“Mental health funds being drained. If an offender needs 20 hours per week of treatment, he is only approved [to spend money] for 5 [hours of treatment].” [241]

“Lack of good treatment resources such as access to physicians. Most are seen by local mental health and have too long to wait to get services. No health insurance is an obstacle in obtaining private and better care.” [89]

“[D]ue to the fact that we are not trained to diagnose mental health issues, if offender does not mention that they have mental health condition, then sometimes supervising doesn’t know there is a mental health issue.” [327]

“[O]ur mental health system in this county has crumbled with the economy and therefore options are limited.” [350]

“We are not trained nor should we be trained to supervise people with mental health issues. [The courts] want us to be able to deal with every person that is placed on supervision [and] this is much too difficult.” [70]

Some PPOs also noted that the personal characteristics of probationers with MI were difficult to deal with, especially given the limited oversight that a PPO can realistically be expected to exercise over a probationer:

“One offender with mental issues […] forgets who I am along with [forgetting] probation conditions. Offender should have never been put on probation and belongs in a home.” [355]

“Many of the offenders will not admit they have a mental illness. Some refuse to take their medication subsequently they are incapable of following condition of probation. They are not mental stable while off medication.” [172]

Discussion of Responses

Many of the problems that PPOs selected as “most challenging” are related to social problems faced by probationers, rather than problems that the probationers have created themselves. The most popular response was “lack of employment”, followed by “lack of

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35 The following quotations are derived from write-in answers to Question 6, in which PPOs could name “other” problems they faced when supervising probationers with MI. Responses are anonymous, but the number of the survey response is listed in brackets for each response.
treatment”. These responses indicated problems that extend beyond the criminal justice system per se. Shortages of employment and affordable housing are problems faced by a growing number of people inside and outside the probation system because of broad unfavorable economic conditions. Lack of treatment options is also an economic problem, in that probationers without jobs do not have private employer-based health coverage and have to compete for limited public health delivery resources.

Greater socio-economic trends working against probationers with MI are not easily solvable by any one organization or piece of legislation. What the Department of Corrections will have to do is improve the rapport among PPOs, probationers, and service providers such as private charities or LMEs. The DOC cannot expect to solve all the needs of their PPOs and probationers by themselves when such large multi-faceted problems have presented themselves. Some problems, however, are within the domain of DOC’s probation administration. The third-most common “biggest challenge” to supervising probationers with MI was that the probationers did not understand the terms of the probation. DOC may work with clinicians and patient advocates to determine how best to convey the terms of probation to persons with MI. Additionally, DOC may give more support to PPOs with high caseloads and high numbers of supervisees with MI. The department may offer those PPOs more training, or reduce their caseloads by hiring more officers, or streamline paperwork so that PPOs can spend more face-time with their supervisees.

**Suggestions for Future Reform**

There is also a balance to be struck between increasing the diagnostic and care power of mental health providers and PPOs and the right of individuals to refuse treatment. The one probationer “who should be in a home” might indeed function better in a long-term care facility, but given the dismal state of such facilities, it is certainly understandable that the probationer would prefer to live on her own. As patient-directed care also tends to function better than top-down care, it is questionable whether forcing treatment decisions onto probationers would have any real positive effect on recidivism or health measures.
From the write-in responses, it is evident that larger structural changes need to occur in the mental health delivery system in order for probationers to be served more appropriately. PPOs do apparently require some more instruction in interacting with persons with MI. However, as they note, it is unrealistic to expect that they will become mental health professionals with any real diagnostic and treatment ability. For that reason, it is vital to increase probationers’ access to mental health professionals regardless of insurance status or individual financial position.

More funding for local mental health entities is an obvious solution to the problem, but it is one that is difficult to put into place given the financial problems of governments at the state and county levels. Low-cost clinics and local mental health organizations need to be able to employ more physicians. Medicaid and other insurers need to clear probationers for more billable hours with their care providers.

Additionally, local mental health providers may be asked to take a more active role in the supervision of probationers. Courts should not place the whole burden of supervising a person with MI onto a potentially under-trained PPO. Health care providers should be expected to meet with probationers on a regular basis to ensure compliance with medical directives. A benefit of splitting supervision between PPOs and clinicians is that clinicians may feel free to take a more cooperate approach to probation supervision. While PPOs are frequently stuck in the role of punishing noncompliant probationers, clinicians can play the “good cop”. They can help create a more flexible treatment routine that works for the probationers.

Another issue that the PPOs note is the difficulty in identifying probationers with mental illness. Unlike prisoners, probationers generally do not have access to diagnosis or mental health screenings. Courts could require that mental health practitioners screen a person before he or she is granted probation – but this is an invasive and costly measure.

Some changes will probably occur in 2014 when the PPACA comes into full effect – assuming that the law is not struck down in summer 2012 when the Supreme Court rules on its constitutionality. Access to physicians will probably increase as the ACA includes more people in the Medicaid program and requires individuals to sign up for health care programs. The insurance mandate could improve the flow of money going into mental health treatment and allow probationers to access services more frequently. Insured probationers will also have the
right to external review if their insurers deny mental health treatment, so that they may be able to overturn some adverse insurance rulings.

**Limitations**

The conditions above – the potential effect of “Obamacare”, the restructuring of large mental health entities, and so forth – are big “what if” questions that ought to be researched further before the Department of Corrections takes on concrete policy changes. In particular, future research needs to focus on funding models for mental health care that is delivered through the criminal justice system. This study has not attempted any cost-benefit analysis, in large part because of the shifting nature of pay structure and the lack of currently-applicable data.

The data above is not necessarily applicable to PPOs dealing in all states, or even in all areas of North Carolina. In Native American tribal areas of Western North Carolina, probation is generally administered by tribal authorities or by the federal government. Furthermore, the background research in this paper examined mostly white, black, and Latino populations rather than any groups of Native Americans. Tribal groups may have different rates of mental illness, different criminal-justice needs, and different structures in place to address those needs. The DOC should look more deeply into Native population data and federal probation regulations before attempting to apply the study results above to Native-populated areas of the state. For these counties, inter-governmental cooperation and cross-study is necessary to reduce recidivism and improve access to care for probationers.

Even where information seems complete, in the area of PPOs’ expressed needs and impressions of mental health services, the data has its own limitations. The data was entirely self-reported by PPOs who opted to write in and complete an online survey. PPOs who felt that their needs were adequately addressed by the status quo may have not taken the time to fill out the survey. Fortunately, this particular limitation does not cripple the survey, since a very small portion of those asked for a response declined to give one.

The small number of “write-in” survey responses limits their general ability to be applied statewide, even though the responses themselves were helpful in rounding out the larger picture of the PPOs’ experiences. Generally, “write-in” responses gave anecdotal evidence of problems, which is not reliable when generalized to the entire population of PPOs. These anecdotes should be considered primarily as illustrations to buttress the numerical survey data.
Write-in responses and numerical data combined, however, are a good launch point from which to begin brainstorming ideas for future reforms. The “next steps” listed below in this paper are inspired by the PPOs’ responses as well as evidence-based reforms in other states and legal reforms suggested by the courts and legal academics.

**Next Steps**

This paper outlines a few alternatives for the improvement of mental health delivery for probationers, namely:

- Improved funding for LMEs and Medicaid programs for persons with MI
- Specialized training for PPOs, including basic skills in recognizing signs of mental illness and communicating with people with reduced intellectual capacity
- Coordination of probation offices and courts with housing programs, employment initiatives, and mentoring programs in order to remove probationers from high-risk environments that increase risk of recidivism or aggravation of mental illness

The implementation of the suggested improvements is beyond the scope of this paper, although potential implementation has to keep in mind the limited budget of the government and/or non-profit organizations working in conjunction with the court system. To reduce costs and increase efficiency, the Department of Corrections may choose to take a number of different approaches to the problem of providing better care.

Courts may choose to partner with private or non-profit firms – for example, they may work with Habitat for Humanity to improve housing options for probationers or with Goodwill to offer work opportunities – although the state will have to vet potential partnerships very carefully to assure the protection and privacy of the probationers. Non-profit organizations like Disability Rights NC or the NC Medical Society may offer courses to PPOs to inform them on the warning signs of mental illness. Granted, a few seminars will not make PPOs mental health professionals. The goal of such a partnership would be to increase PPOs’ awareness of MI symptoms and improve their ability to refer probationers to qualified mental health care providers.

The Department of Corrections may be able to work within the new health care structure offered by the PPACA to expand mental health services delivery. Medicaid waivers are
available to test out better programs of service delivery for persons on Medicaid; the state may use this source of funding to innovate ways of paying for care.

The restructuring of LMEs in NC is currently underway, to be completed by summer 2012. The effect that this restructuring will have on care for probationers is yet to be seen. The Department of Corrections must be vigilant in assuring that no probationers lose contact with mental health care providers when the structure of their health care system is changed or integrated into a larger multi-county area. However, the restructured LMEs may also now have the organizational flexibility to do more public-private partnerships and referrals to community services, such that the needs of probationers will be better served.

The “next steps” required of the Department of Corrections, then, is to decide which of the needs highlighted by PPOs is the most pressing and which can be addressed with the most benefit for the least amount of money. Cost-benefit analysis will be the final piece of the diagnostic puzzle before the DOC engages in the lengthy process of rehabilitation and reform.