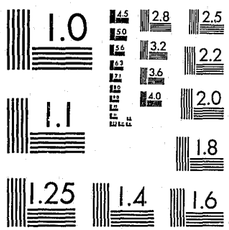

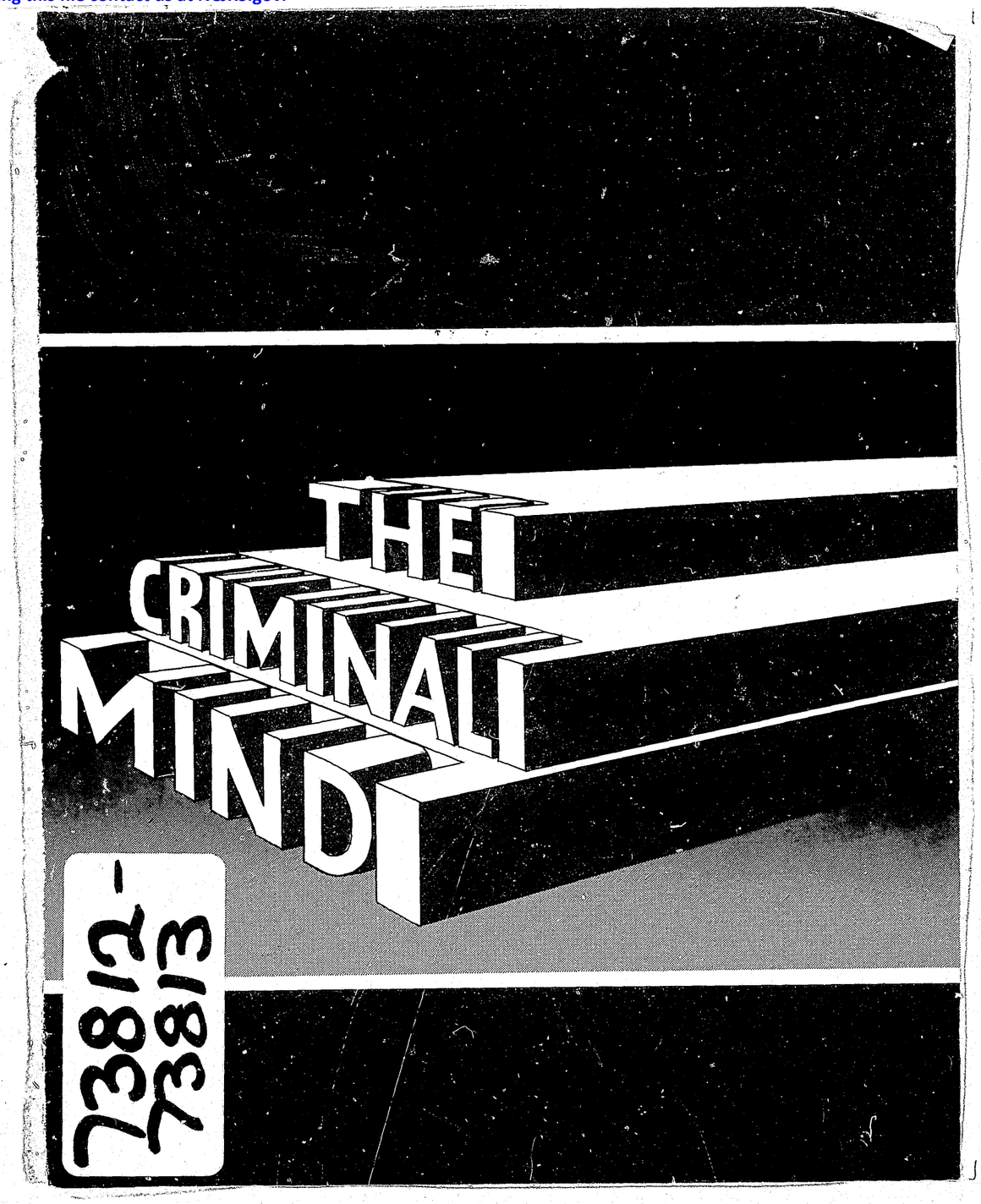

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Probation and MENTAL HEALTH

You are the experts on the mental health of probationers and are in the best position to intervene positively at a time of crisis.

by Jim Mullen, Ph.D.
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As a probation officer you are called upon to do many things you never dreamed would be part of your job description. Among the many hats you wear, whether or not you may acknowledge so, you also wear a mental health cap. In such a role, the challenge is: What can you reasonably expect to do in order to promote the mental health of your clients?

To hear of another role in your job as a probation officer may not be a welcome message for you. Perhaps the only thing such a statement says to you is that now you are aware of one more thing that is impossible for you to accomplish in your job, a job with too many built-in frustrations. In keeping up with an overload of case referrals, much of your psychic energy is dispersed into the awesome task of simply managing your case load, with varying demands of "paper work" requirements for clients under maximum, medium or minimum supervision. Then too, you serve a clientele frequently unappreciative of your services, which may provide you with little personal satisfaction for your efforts to assist your clients. Such pressures may raise the question of how worthwhile is the work of the probation officer, and, of course, the frustrations may easily lead to the "staff burnout" syndrome, measured by the turnover rate of probation personnel.

The emphasis today in health care is on the holistic approach, which, in reference to mental health, stresses the promotion of good mental health habits and positive intervention more than it focuses on identifying severe emotional problems and providing appropriate treatment for emotional disorders. The old maxim "an ounce of prevention is worth a pound of cure" continues to be true.

In the practical order, then, you do wear a "mental health cap." Your attitudes and actions toward your client have an impact for better or worse. No matter how overburdened you may be with a case load of clients, it makes a difference whether you treat a client as a person or as "paper work." No matter how brief and infrequent the time may be in which you are in actual contact with a client, you want that time to be "quality time."

What is called for first is some self-reflection on how you relate to probationers, and, perhaps, a re-ordering of priorities. Do you promote an attitude of self-respect in your client, enhancing a sense of self worth and human dignity? If you like your work, care about people, then you are already contributing to the mental health of your clients. The point here is: Don't sell yourself short by thinking of others as "the experts" on the mental health of probationers. You are the experts on the mental health of probationers and are in the best position to intervene positively at a time of crisis.

From your experience and intuition you can learn the art of intervening on behalf of a client when an emotional crisis erupts. The focus of the present talk is in this area: developing the art and skill of intervening before an emotional crisis explodes into some insurmountable, irreversible problem. What have you learned from your experience in the probation field that tells you a client needs immediate intervention for a serious problem? Another way of putting this is, "Are there some *signs* which can be recognized in others that provide us with clues that a client is in imminent danger of an 'emotional blowup,' some signs of a serious emotional crisis, particularly the kind in which the client may harm himself or others?" How do we go about the task of reasonably identifying some criteria to assist the probation officer?

Texas Dangerousness Project

Before addressing such a complex issue, I would like to digress a bit to suggest how we might best approach the problem at hand, based upon my experience over the past three years. I have worked as principal investigator of the Texas Department of Mental Health and Mental Retardation Research Project on Dangerousness, funded also with a grant from the Hogg Foundation for Mental Health, a study of 400 maximum security male mental patients at Rusk State Hospital. The project has examined maximum security patients committed by court order as incompetent to stand trial or as not guilty by reason of insanity. Such patients are periodically reviewed by a board of psychiatrists to determine their manifest dangerousness (Code of Criminal Procedures, Texas Laws Relating to Mental Health and Mental Retardation, Articles 46.01, 46.02, 46.03). The purpose of the project has been to develop criteria to assist review board members in determining dangerousness. The Maxi-

mum Security Unit, Rusk State Hospital, is a facility with approximately 250 patients and an annual admission rate of 800.

Over half (52 percent) of patients in the Texas Dangerousness Project are from our six largest metropolitan counties, with Houston (21 percent) and Dallas (14 percent) accounting for over one-third of the sample. The average patient age is about 30. Ethnically the population is 48 percent caucasian, 39 percent black, and 12 percent Latin. The childhood and adolescent years of the patients appear to be unexceptional, although a significant number of individuals have been referred for emotional problems during this period. As adults, most are deprived or substandard in social, intellectual or cultural dimensions and have a history of four or five arrests.

Over one-half (57 percent) have never married; only seventeen percent are currently married; and only 8 percent were living with their spouses before admission to the hospital. About 16 percent have less than a seventh grade education; only 29 percent have completed grades 7-9; and 45 percent have completed grades 10-12. As for their psychiatric diagnoses, 14 percent have a diagnosis of no mental disorder; 46 percent have a primary diagnosis of schizophrenia; and 10 percent have a diagnosis of mental retardation. Most have received treatment for emotional problems, with 64 percent receiving previous inpatient care and 31 percent receiving previous outpatient care. Occupationally, most patients have few job skills: 45 percent are unskilled laborers and 33 percent report they are not in the work force. Not surprisingly, 78 percent of the patients reported being unemployed for several months before admission.

The overall picture, then, is of a group of individuals who have shown an increasing tendency to social failure or they have grown older and had more demands made by them by society. Nearly half (48 percent) were still living with their parental families when admitted. Failure in educational and occupational areas is the norm in this group, while socialization skills seem limited.

The Texas Dangerousness Project also includes studies of Texas prison inmates, juvenile offenders from the Texas Youth Council, general psychiatric hospital patients in Texas, as well as maximum security patients from Massachusetts and Illinois; so the project has studied the problem of dangerousness in some 600 individuals. The results have statewide as well as some national implications.

When compared to general psychiatric patients and to correctional institution inmates in Texas, Rusk State Hospital maximum security patients clearly seem to be more like patients than they do criminals. In intellectual function, occupational accomplishment, and history of emotional difficulty, the patient groups are very similar, and substantially inferior to the prisoner group. The major difference between the two psychiatric groups is the larger number of arrests shown by the maximum security patients. In this regard, they fall between the two groups, with more arrests than general psychiatric patients but fewer than prisoners. Nearly 40 percent of the Texas maximum security patients are charged with violent crimes (murder, rape, robbery, aggravated assault), while the remainder are charged with non-violent crimes, particularly auto theft and drug violations. In summary, Texas maximum security patients resemble general psychiatric patients more than they do prisoners and their classification as a special kind of patient (rather than as a special kind of prisoner) is appropriate.

Study Relevant for Probation Officer

Description of the patient population in the Texas Dangerousness Project is to provide a frame of reference and to suggest that such an extensive study of criminal mental patients may have some relevance for the probation officer. For example, consider the manner in which we addressed patient dangerousness. We began by examining the judgments of hospital clinicians, the recognized "experts" on patient behavior. We attempted to refine the judgments of clinicians by measuring the many psychological and sociodemographic factors which the research literature has identified as associated with violent behavior. Our approach has been to develop an actuarial prediction model in which the clinicians' judgments of dangerousness will be validated by examining the arrests of discharged Texas maximum security patients. Actuarial tables may provide probability estimates of a patient engaging in future violent behavior.

It is important here to acknowledge the many complex issues of predicting violent behavior so that we do not give the probation officer the erroneous impression that it is possible to create a kind of "laundry list" of factors, which we can check off as positively predicting a probationer's behavior. Perhaps some examples may make my point clearer.

In examining the research literature which addresses the source of violence we know that violence is not the result of a single factor, but rather multiple factors: namely, the interaction between biological, psychological and socio-cultural influences. Furthermore, when we discuss "behavior," psychology has defined behavior as the function of an individual's personality traits with the interaction of environmental cues. In other words, it is not enough to simply identify an individual's personality profile, because of equal importance are the environmental cues which also determine the behavior. An intoxicated man shoots his wife during a domestic quarrel. In searching for an explanation for such a tragedy, we may want to identify the personality profile of the man, but must also examine environmental influences which contributed to the behavior — e.g. abuse of alcohol, availability of the weapon, the occasion of the argument.

We have very inadequate tools to develop criteria to predict *violent behavior.*

Although I have submitted a definition of behavior that is generally acceptable, I have not given a definition of violence. Here there is little agreement among researchers over a precise definition. Secondly, the problem of measuring violence is even more difficult to resolve. Most studies of violent behavior are retrospective, not prospective. They are studies of prison inmates and hospital patients carried out after the violence. There is ordinarily no opportunity to assess or measure the violent behavior through the method of natural observation. It would be unethical to design some kind of experimental conditions to study violent behavior. The fact is that we have very inadequate tools to develop criteria to *predict* violent behavior.

There are additional statistical complications in the measurement of violence. We are talking about a behavior which has a very low base rate. One estimate suggests that only seven out of every 100,000 arrests is for a violent crime. Any statistical prediction also includes the problem of false positive and false negative judgments. Some individuals will have a high probability of committing a violent act but will not do so; others will have a low probability to

commit a violent act, but will do so. Because of the many complexities involved in the prediction of violent, dangerous behavior, clinicians have tended to over predict violence as much as a 2:1 ratio. This is why researchers suggest that the use of an actuarial method as the best way of improving the judgments of decision makers.

For the practitioner, all of this must be very confusing. It is evident that we know little about violence despite the large number of published studies. There is an abundance of useless studies on prison inmates and hospital patients which appear to identify variables associated with violence. Studies are often misleading and contradictory ("cheap research"), because there just happens to be some "data" available on the subjects in the institution. The research designs may be poor, the case numbers too low, and the statistical method may examine univariate rather than multi-variate relationships. Such studies add nothing to our general knowledge of violence among prison inmates and hospital patient populations.

In summary, researchers have tended to ignore the environmental cues which affect an individual's violent behavior, and have concentrated on developing personality profiles of violence prone people in institutions to explain retrospectively their past violent behavior. Efforts to develop some kind of meaningful personality profile of violence prone individuals have been fruitless, because too many variables remain uncontrolled, especially environmental factors. It is impossible, then, to create a list of factors which predict violent behavior with a high degree of probability. The value of an actuarial approach is that the judgments of clinicians can be refined by studying the behavior of discharged individuals. What is true for hospital clinicians is true for probation officers. The task of identifying high risk probationers demands caution, and the judgments of probation officers need to be validated by follow-up of probationers.

Signs of Emotional Problems

Our discussion on the Texas Dangerousness Project and of the complex issues of predicting behavior has provided an appropriate context and frame of reference for this discussion. I would like now to address the task of identifying signs of serious emotional problems in a probationer. What follows is not offered as a definitive statement, but rather recommends a process for the probation officer

Probation and Mental Health

to go about such a task. What is offered for your consideration is personal opinion, based upon my work as a researcher on violence and experience as a clinician talking with many violence prone individuals. I have no experience or expertise as a probation officer.

First I would categorize probationers into high risk and low risk groups. This decision would be based upon information obtained from the probationer's presentence evaluation or other documents which provide social history information. Some of the factors which may suggest a high risk classification include the following: (1) a history of past violent behavior, as indicated in arrests for violent crimes (murder, rape, robbery, aggravated assaults), and frequent fighting as reported by arrests for simple assault and other reports of violence prone behavior. The most important single index of future behavior is one's past behavior. (2) a history of abuse of drugs or alcohol; (3) the sex of the probationer; males have a much greater incidence of violent, emotionally-disturbed behavior than females; (4) probationers within the age range from 15 to 35 years; (5) probationers who are not married; (6) probationers who live alone; (7) probationers who are unemployed; (8) probationers who have received excessive punishment as children; (9) probationers who have attempted or seriously threatened to commit suicide; look for signs of unusual scars, such as on the wrists, and ask them; people are often surprisingly willing to discuss suicide attempts; (10) probationers who have received mental health services as inpatients or outpatients.

Although we have talked about the many problems of predicting behavior with inherent problems of making erroneous decisions, I believe the task of placing probationers into high and low risk categories is defensible, even at the expense of overpredicting the number of probationers identified in the high risk category. The purpose here is to assist the probation officer in identifying these individuals in his/her case load who may possibly need special attention. Errors in judgments will not adversely affect probationers.

Secondly, I would make an assessment of a probationer's present life-situation. The focus of concern is the probationer's environment. Are there signs of some serious crisis? Some examples may include: (1) a broken relationship with a significant person in the probationer's life; (2) a bad break on a job which may place the job in jeopardy; (3) some external evidence that a drug or alcohol problem may be out of control, suggestive by tardiness or frequent absences from work, unexplained overnight absences from home; (4) recent involvement in fights. These are a few examples suggesting a probationer may be experiencing some serious stress. It is, of course, not the crisis itself that is a matter of concern for the probation officer, but rather how well the probationer is coping with problems.

You are not being asked to "play" psychiatrist, but to identify signs of serious internal stress.

Thirdly, I would make an assessment of the probationer's present internal state. The focus of concern here is how the probationer presents himself to the probation officer. You are not being asked to "play" psychiatrist, but to identify signs of serious internal stress. Some examples may include: (1) thoughts about suicide expressed directly or indirectly; (2) complaints of depression with its usual symptoms of poor appetite, inability to sleep, listlessness, etc.; (3) signs of serious delusions — namely deep-seated erroneous beliefs, especially the paranoid type; the probationer may appear suspicious, concerned about "enemies" or "plots" against him; delusions are not easily detected, as a true paranoid is usually intelligent, and presents a plausible story about his pseudo-community of enemies; (4) signs of serious hallucinations — namely, the experience of being directed by "inner voices" or "visions." Such experiences can sometimes be related to drug-induced states. Of particular concern is the kind of behavior suggested by the inner forces.

The process recommended here involves an assessment of the probationer's internal and external life situation. I would not hesitate to involve the probationer himself in your assessment process. If you see some problems from the probationer's past history, become aware of a present crisis situation, and recognize some indicators of the probationer's internal stress, convey your concern to the client. Directly ask questions, such as: Do you think you are having a serious problem for which you need help? Do you feel so overwhelmed by your present circumstances that you might lose control, perhaps hurting yourself or someone else?

It is well to include the probationer in your thought processes, for your purpose is not to act as some kind of guru predicting a future tragedy, but to convey your concern to the client, to acknowledge that the present behavior of the probationer may be some kind of "cry for help," and to intervene by defusing a crisis before it explodes. By involving the probationer in your concern, you are developing greater rapport, and have already begun to help the probationer recognize problems and consider possible solutions.

Crisis Intervention

Learning to intervene at a time of crisis is an art, but one that may be developed through experience and the learning of crisis intervention techniques. Moreover, there is much research which underscores the value of crisis intervention. In the mental health field we have solid evidence of its positive benefits, for in a crisis we are particularly vulnerable and more open to accept help. In criminal justice research there is also evidence to suggest that the one-to-two-year period after discharge from prison is the most significant time in determining future incarceration. The probation officer, then, has a unique opportunity to be a powerful resource for a probationer, defusing serious problems, and helping to keep the probationer out of prison. Probation officers sometimes observe that these probationers on a misdemeanor convictions later become clients on felony convictions. From what we know about the benefits of crisis intervention, perhaps a greater emphasis should be placed on the efforts probation officers expend on probationers with misdemeanor convictions.

The issues of reconciliation between offenders, victims and society are the concern of all citizens.

We have discussed the processes of identifying high risk of probationers and the benefits of crisis intervention, as a way of improving services to probationers. To conclude our discussion here, however, would be incomplete. For what has been said may imply that the job of rehabilitating discharged offenders rests solely with criminal justice personnel, especially the probation officer. On the contrary, the issues of reconciliation between offenders, victims and society are the concern of all citizens. At one level, the probation officer serves as a referral source, knowledgeable of public and private community programs which offer an array of services: mental health, family counseling, drug and alcohol rehabilitation, spiritual and pastoral counseling, job training and employment counseling.

At another level, often neglected, the probation officer should help raise public consciousness on injustice in our society. We tend to mouthe simplistic cliches about law and order rather than confront the many problems which contribute to crime — the way crime is affected by our economy, our values, our health as a nation, inequalities in jobs, housing, education, etc. We are talking about social justice. Ultimately our civilization will be judged on the way we treat our most alienated members.

TCA member Jim Donahue helps field questions for former first lady Betty Ford in a presentation for the Austin Council on Alcoholism in Austin.

Jim Mullen, Ph.D.

About the Author

Jim Mullen, Ph.D., is chief clinical psychologist for Texas Department of Mental Health and Mental Retardation. He is the principal investigator of Texas Dangerousness Project, a study of some 400 maximum security patients at Rusk State Hospital, developing criteria for the prediction of dangerousness.

Mullen has worked previously as director of Maximum Security Program in Raleigh, North Carolina. He has made presentations at many national conferences on issues of violence in mental health and prison population as well as authoring a number of publications on the subject.

Mullen earned his B.A. degree in philosophy at St. Bonaventure University, his M.A. in psychology from DePaul University and his Ph.D. in clinical psychology from North Carolina State University.

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