

## **Community Intervention with the Mentally Ill Offender: A Residential Program**

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The shortage of shelter as an alternative to continued hospitalization has been identified as a major reason for the retention of up to 57 per cent of currently hospitalized patients (Pollack and Taube, 1975). This shortage has serious ramifications for certain populations at risk, particularly mentally ill offenders for whom careful planning upon release from a hospital is especially critical. This paper will describe the plan of community intervention developed by one hospital for mentally ill offenders, Clifton T. Perkins State Hospital Center, with special focus on services provided by a halfway house, Hamilton House, operated by the hospital. Additional services provided by the hospital such as its outpatient clinic, and its work-out program with which close liaison is maintained, have already been the subject of other reports (see Goldmeier, Patterson and Sauer, 1972). This paper will focus first on important concepts of treatment in a community mental health setting. These concepts provide the philosophical base for the halfway house program. Then the program of the house will be described. Finally, a summary of outcomes will be presented.

### **Concepts of Treatment**

*Concept of Mental Health:* The guiding view of mental health in a residential setting should include considerations having to do with both personality and situation. A community residential facility should put special focus on environmental concerns and on the quality of life, areas that have been identified by Brown as critical (Brown, 1972). Thus mental health should be seen in the context of how a person functions in crucial life roles, not in terms of pathology alone. Progress is then seen in the relearning of these crucial roles, including the social skills involved, as recovery proceeds. The validity of community supports at important points in the recovery process is also recognized.

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*Dangerousness:* Consonant with this view of mental health, dangerousness is also seen as a function of the situation, not of personality alone. In the course of recovery from mental illness not only must changes in personality be continually assessed, especially when there is increase or decrease in paranoid ideation, but social situations that could potentially stimulate aggression must be closely monitored. Situations critical in this regard may be relationships at work, in the halfway house itself, and possible conflict with family members with whom the former patient may be trying to re-initiate contact. The stance of the halfway house staff was that much of the guesswork in the prediction of dangerousness (see Rappeport, 1967) can be eliminated when potential dangerousness is seen in the context of the social demands with which the patient has to cope. Through the halfway house program these demands are presented in a way which permits the resident's adjustment to be closely monitored in what might be termed the "buffer-zone" created by the residential setting (Kinzel, 1970).

*Human dignity and self-determination:* These values dictate that clients retain the maximum possible control over their lives. Patients, to the extent possible, must be involved in setting up their own plan of residence along with other post-discharge arrangements. By offering trial visits and part-time residence the halfway house program enabled both residents and staff to make more valid assessments of the potential value of the program to the patient.

*Least restrictive alternative:* The halfway house program is also premised on the notion that residents, even those who were once dangerous, should be afforded as much freedom as possible. This notion is derived from the concept of "least restrictive alternative," stemming from the *Dixon v. Weinberger* court decision (405 F Supp. 974, DDC, 1975). This court decision dictated that controls could only be exercised to the extent that they assured the safety of patients and those with whom they came into contact.

*Vocational and avocational support:* The normalizing effects of work or an otherwise constructive activity should be stressed in residences. Residents, in addition to having to take care of their personal needs and the day-to-day tasks of living, need access to work, training, and recreational opportunities. Many residents and facilities providing long-term care do not have access to such opportunities, a failing which the Hamilton House tried to remedy. Thus, efforts were made to connect the former patient with such vocational or avocational work opportunities as day programs so as to counteract the tendency to regress in situations that make few demands.

*Stigma:* The concept of stigma is here used to draw attention to two considerations in residential living that are important in planning for those who have been mentally ill. One consideration has to do with the severely damaged self-concept of the person who has been in a mental hospital (Goffman, 1963). The mentally ill offender is doubly handicapped

in this respect because, in addition, he is shunned because he has violated society's norms. By encouraging relatively independent behavior in the community residence and avoiding the depersonalization of large institutions, the self-concept of residents can, however, be much enhanced. The other consideration having to do with stigma relates to biased community attitudes towards the mentally ill and offenders. These attitudes have often resulted in discriminatory housing practices which make it difficult to establish a halfway house in the first place. Residential planning must be sensitive to all these aspects of stigma. Stigma-prone situations can be avoided by imaginative planning and sensitive public relations.

*Continuity of care:* The concept of continuity of care has been a much misused concept in community mental health in that it has often been misunderstood to mean life-long dependence on a hospital for the mentally ill. This misunderstanding is crucial especially in a halfway house program that is closely linked to a hospital. Residents generally wish to start a new life, be like other people, and forget their past associations with a hospital. This can come about despite the presence of an administrative tie between halfway house and hospital. Continuity of care, in this sense then, simply recognizes the responsibility of the hospital for the former patient through the provision of an additional service, community residential care, during the critical period of recovery. The communication network that is set up between hospital and halfway house in a situation where responsiveness in a crisis is critical more than compensates for any disadvantage stemming from the kind of administrative arrangement described.

*Gradualism:* The concept of gradualism is closely related to the notion of continuity of care in that it accents the various levels of residential care to which the recovering mental patient must have access. Access to a variety of services in the community about which halfway house staff is knowledgeable is a necessary part of helping the resident adapt and to move beyond a particular level of care. Similarly, patients from Clifton T. Perkins have to graduate through programs there which increasingly afford the opportunity for self-dependent functioning. Community programs, beginning with halfway house residence, have to offer similar opportunities. The halfway house is seen as the first step in the move out of the hospital. That move is then followed by a further move either to another semi-protected living-situation or to an independent living arrangement.

*Prevention:* The preventive thrust of Clifton T. Perkins Hospital as a whole and its halfway house program in particular may best be described in terms of its emphasis on primary, secondary, and tertiary prevention (Caplan, 1964). In the course of primary prevention, the staff of the halfway house provide consultation services to other agencies, such as the prisons, the courts, and other hospitals, with a view to averting a potential admission to a hospital for mentally ill offenders, or at least shortening

the period of hospitalization when it occurs. At times, patients who are seen as potentially dangerous, but not yet in need of hospitalization, are accepted in the halfway house program as a preventive measure. As for secondary prevention, the focus of this type of intervention is mainly on the patient, his family if accessible, his employer, and other significant environmental and hospital supports. In secondary prevention, efforts are made to treat the illness that has already surfaced, *i.e.*, to prevent the exacerbation of the illness, avert further regression, and to assist the patient in reaching an optimum psychic equilibrium once again. Secondary prevention, particularly with the mentally ill offender, usually takes place in the hospital for the protection of the patient as well as society. Tertiary prevention has, over the years, been the main focus of a halfway house program in that, by the time a patient is referred, the mental illness and, in this instance, the accompanying offense, have usually taken their course. Tertiary helping efforts are implemented by providing the opportunity for psychotherapeutic and other relationships, work and training opportunities, monitoring of medication, and socializing experiences. However, if these efforts are not successful, a return to the hospital may well be indicated, though the criteria of possible danger to self or others are nevertheless uppermost.

### **The Program**

*Establishing the House:* Clifton T. Perkins Hospital Center is the sole maximum security psychiatric hospital for men for the State of Maryland with a capacity of 246 beds. Its main function is to provide pre-trial psychiatric evaluation of those persons entering an insanity defense to major felony charges and to serve as a treatment facility for those men actually adjudicated as Not Guilty By Reason of Insanity. The hospital also accepts inmates from the correctional institutions for treatment if they meet the State standards for involuntary civil commitment, as well as patients being transferred from the less secure State hospital when their aggressive and violent behavior interferes with their ability to be treated successfully in the programs of the more open hospitals. Those patients found Not Guilty By Reason of Insanity must continue to meet the standards for civil commitment in order to remain inpatients. However, when discharged from the hospital, they can remain under the Court jurisdiction on a conditional release basis for up to five years from their release from the hospital.

The halfway house program was developed because of the conviction of present and past superintendents, as well as staff, that the hospital needed to undertake community-oriented rehabilitative efforts in order to help patients make the doubly difficult transition from a maximum security setting to community living. Accordingly, a work-out program, to which reference has already been made, was first developed at the hospital. When it quickly became apparent that residential settings for patients on trial visits to the community and about to be discharged also were needed,

a halfway house was established.

The realities of funding, including the possibility of a federal grant, (NIMH, 1972) dictated that the halfway house should be administratively linked to the hospital. The decision to operate the house as an arm of the hospital was not, however, undertaken lightly. One major disadvantage of this arrangement was the possibility that a halfway house thus tied to a hospital might become a mere satellite of the hospital, extending an insitutional philosophy into the community. This did not, however, occur. In fact, the tie facilitated communication necessary to speed up discharges, and made possible the provision of certain back-up services when needed.

*Goals:* The program of Hamilton House sought to adapt a number of goals consonant with the community mental health concepts and principles outlined earlier. The goals of the house as originally developed and then elaborated are that:

1. The house serve former mental patients or those for whom admission to a mental hospital is a distinct possibility. While not all residents had to be former offenders, all did need to acquire basic social skills in order to lead productive lives.

2. A high proportion of the men be offenders who were at one time considered dangerous. Thus a strong preventive thrust would be necessary.

3. Residence be temporary with an optimum period of six months recommended.

4. The house be intended particularly for men who might otherwise have to remain in the hospital for a longer period.

5. Acceptance of residents be without regard to ability to pay, although there was a clear expectation that the resident would help defray the cost of his stay from earnings or other income.

6. Temporary residence be provided for patients who come on weekends to test their readiness to leave the hospital.

7. Services be offered in such a way that a resident could, if necessary, continue a counseling relationship, developed in the house, while he was followed in the after-care clinic located on the premises.

8. Residents be afforded a home-like environment in which to live.

*Interventions:* There is little precedent regarding the specific nature of services to be offered a population consisting of mentally ill offenders. The early literature suggested that many halfway houses have no clearly designed therapeutic program because health rather than pathology is emphasized (Rothwell and Doniger, 1963). This trend has continued into the 1970's with halfway houses now seen as replicating a family situation (Budson, 1978). The Hamilton House program developed, featured a minimum of structure, the allocation of specific responsibility to staff, a guiding philosophy that the resident be responsible for himself, and direct intervention with the resident in a counseling relationship when necessary and in group sessions. Time-limited activities, such as art therapy and an

occasional work experience linked to an industrial therapy program at the hospital, were also offered from time to time as staff became available. The staff included a director, a live-in resident manager, trained counselors who were on duty around-the-clock, social workers, and a psychiatric consultant.

It was necessary to be particularly aware of potentially explosive situations that could quickly spell doom for the house and its high-risk population. Signals that alerted staff included serious violations of the rules, unexplained absences, or signs of the reoccurrence of mental illness. Whenever possible, a staff meeting would be called to discuss these kinds of situations. During these staff reviews the resident himself took responsibility for presenting his point of view. There were also routine staff reviews at the end of the third or sixth month of residence. There could be several possible outcomes, one of which was re-hospitalization for preventive purposes. In this respect the staff was mindful of the fallacy identified by Kubie (Kubie, 1968) that hospitalization *per se* is bad for patients. In fact, as it turned out, timely re-hospitalization may have averted a number of possible offenses. In other instances, the resident might have been unable to articulate a desire to leave but was demonstrating this desire by acting out. When this occurred, a suitable plan for release from the house, sometimes involving the court, would be worked out. Usually, however, departures from the house were jointly planned by the resident and staff, and took place without incident.

The importance of medication should also be noted. In any halfway house, residents must be able to assume responsibility for taking their own medication. When Hamilton House residents faltered, or abused their medication, staff members intervened quickly. The preferred course was to exert group pressure. Nevertheless, however, crises occurred. Staff viewed common crises such as the loss of a job or rebuff in a relationship, as not necessarily negative in that, with timely help, the resident could often develop new ways of coping. However, what staff did fear was a possible calamity like the recurrence of a serious crime. To forestall calamities the staff resorted to what may be termed critical incident techniques. The common thread in these techniques was that they called for confrontation; the spelling out of consequences of certain behaviors, and the demonstration of the intention to intervene promptly in threatening situations. Re-hospitalization, when it was necessary, was usually achieved through a two-certificate admission signed by the consulting psychiatrist and a physician in the emergency room of a nearby community hospital or community mental health center.

*Vocational emphasis:* The expectation was that the resident either have a job, actively look for one, or be in attendance at a day-center. When a man could work, staff members were especially alert to two aspects of behavior. One was job-seeking behavior. In individual counseling, as well as in group meetings, support, stimulation, and

confrontation were used to help the men grapple with their discouragement and with their sometimes unrealistic expectation of prospective employers. The second aspect of vocational adjustment that received staff attention was actual behavior on the job when it could be identified. It was apparent that many difficulties arose because the men felt stigmatized and reacted impulsively to real or imagined slights. This was also dealt with. Ultimately, the two major criteria for assessing job performance were continuity of employment (defined as a work-week approaching forty hours), and job stability, *i.e.*, continuing on the same job for a reasonable period of time. When a man had achieved stable and continuing employment, readiness for discharge from Hamilton House was automatically considered. Sometimes the imminence of leaving propelled a resident into a regression, but the risk of this occurring had to be taken.

*Partial residence:* Partial residence in a halfway house is essentially a community equivalent of partial hospitalization.

The partial residence program of Hamilton House had two major components. One was weekend visits for men hospitalized but nearly ready for discharge. The other consisted of the provision of temporary assignments at the house for those men able to work or to participate in a recreational plan. The assignment could, for example, be a plan for a job search lasting all day or overnight, with the patient checking in with staff for accountability purposes and for transportation. Either way, the men experienced life in the community, free of the controls of a maximum-security hospital, and ties to the community could be renewed gradually rather than precipitously. Also, partial residents could make an informed decision about whether living at Hamilton House would be an appropriate discharge plan for them. A majority of the partial residents did eventually choose to become full-time residents. Partial residence thus seemed to accelerate recovery for mental illness. For example, after some experience with this mode of intervention, it was discovered that sometimes it was possible for the patient to become sufficiently accustomed to community living that halfway house residence could be eliminated entirely as a step in his progress. The patient might then either return directly to his family in a familiar neighborhood or live somewhere else where his criminal record would not be known and feared.

*After-care Services:* The additional function of after-care for former hospital patients appears to be a responsibility that a halfway house might well assume. In the case of Hamilton House, however, it was decided that the after-care clinic should be a separate unit with its own director and a separate office in the house. This way house staff would be left with primary responsibility for the residential service and the out-patient clinic staff could concentrate on after-care beyond the resident's stay at the house. This arrangement made it possible for former residents to nevertheless remain in touch with previously supportive persons at the house, a feature of successful community adjustment that has been discovered to be increasingly vital (Holman and Shore, 1978).

Fears that after-care patients (about 50 were seen intermittently at the Hamilton House clinic) would somehow contaminate the halfway house environment also proved to be unfounded. The experience of Hamilton House thus seemed to indicate that residential care and after-care are compatible functions that can be consolidated to provide a wider range of services even when they are kept administratively separate.

### **Outcomes**

At the end of every fiscal year an evaluation of the program of the halfway house is conducted. In 1978, this evaluation also included a follow-up of former halfway house residents about eighteen months after discharge from the house. In the fiscal year that ended June 30, 1978, 47 residents were served in full-time residence at Hamilton House, 61 were partial residents who came on visits from Clifton T. Perkins and from other hospitals either to see if they wanted to live in Hamilton House or because part-time residence was all that was needed. The average daily census was almost 16 residents throughout the year.

Residents also came from regional state hospitals and from private psychiatric hospitals because the space available at the house was more than ample for the needs of Clifton T. Perkins and because a mix of residents was considered desirable. Those sent to Hamilton House constituted about a third of all Clifton T. Perkins patients granted a release through the courts with the requirement that they be supervised in out-patient care. Mixing patients with a history of serious offenses with others who had not had such difficulty presented no problems. In fact, it turned out to be a positive feature of the program in that it permitted a wider variety of exposure to people.

A change in the year ending in June 1978 was that the practice of providing partial residence, like week-end visits, to patients currently hospitalized, became more extensive. This change was consistent with increasing emphasis on providing the least restrictive setting possible after discharge. While partial residence had always been an important feature of the house program, in that year, efforts were made to reach out increasingly to those who might not need full-time residence at all if they could first prove that they could cope with life on the outside — in this case in the halfway house. Thus, patients who came from Clifton T. Perkins Hospital averaged about 22 days each at Hamilton House before being released, a sufficient period in most cases to permit a more balanced judgment of the risks of dangerousness after discharge. That year, therefore, a considerable number of partial residents completely by-passed the halfway house, going directly to their families or to an independent arrangement.

It also became increasingly apparent that the halfway house was serving a group of particularly high-risk patients from Clifton T. Perkins who tended to be young (average age about 25), single or unattached (32 of the 33 admitted to the house in 1977-1978), and with a history of



serious crimes. The high-risk mental status of young, unattached patients has been well documented in the literature (Mannino and Shore, 1974). As for crimes of a high-risk nature, 5 of the 7 patients accepted from Clifton T. Perkins during the year had been charged with murder, rape, or the intent to commit these crimes. Their psychiatric diagnoses also tended to be predominantly paranoid schizophrenia.

*Recidivism:* Under circumstances where difficulty with the law is prominent in addition to mental illness, recidivism should be distinguished from re-hospitalization. Recidivism in this context, therefore, refers to the repetition of an old offense or the commission of a new one. Re-arrest records, rather than convictions were used to establish recidivism at Hamilton House because the authorities frequently do not further pursue a case active in the hospital. National recidivism rates for offenders who have not been adjudged mentally ill have been reported to be about 33 per cent within a five-year period following institutionalization (The President's Commission, 1967). For former patients, arrest records have generally gone up by almost 50 per cent between 1968 and 1975 (Steadman, Cocozza, and Melich, 1978). With this as backdrop, the record of Hamilton House was noteworthy. No one was re-arrested while living in Hamilton House, despite the relative freedom afforded there. The average length of stay at Hamilton House, it should be added, was about 4.5 months. Twenty-seven of the most recently discharged residents of Hamilton House who had been patients at Clifton T. Perkins were followed up during a period of about 22 months following hospital discharge. Included were 16 who had committed serious offenses against persons such as murder or rape, and 11 who had committed serious property offenses. Four men did commit new offenses, though not of the gravity of those committed earlier. While any recidivistic act is to be deplored, these findings nevertheless compare favorably with national figures. They also add substance to the notion that prediction of future criminal behavior can be made with greater confidence when safeguards, such as exist in a professionally supervised residential setting, can be applied early in the patient's rehabilitation.

*Re-hospitalization:* A fairly high proportion of former Clifton T. Perkins' patients, but one comparable with national figures for less difficult populations, had to be re-hospitalized during the 22-month period following hospital discharge. The proportion of Hamilton House residents was 11 out of 27, or 40.5 per cent. This compares with the up to 50 per cent readmission rates reported for equivalent post-hospital periods in national studies (Paul and Lentz, 1977). A number of residents were returned to the hospital from the halfway house as a preventive measure to avert the possibility of a new offense, and some of these patients were able to return again to live in the house. While in previous years Hamilton House had had readmission rates as low as 20 per cent for a similar post-hospital period (Goldmeier and White, 1977), the higher figure in this more recent evaluation seems to reflect a greater willingness

to take risks with those patients who can be maintained in a less restrictive environment, where any tendency to revert to previous criminal behavior can nevertheless be minimized.

*Costs:* The total cost of the program at Hamilton House was \$155,255 for the fiscal year ending in 1978. This amounted to a *per diem* rate of \$27.38. Despite an increase in costs over previous years, mostly due to inflation, expenses are still in line with national figures. For example, an authoritative survey of halfway houses reported an average *per diem* of \$19.00 in 1974 (Piasecki, Pittinger, and Rutman, 1978). Such a *per diem* would have amounted to \$32.95 in 1978 when the 15 per cent inflation factor commonly used in the health sector is added. The cost of Hamilton House residence is still only about a third of what would have to be spent for hospitalization in a maximum security setting.

### Conclusion

This paper has outlined a number of basic concepts in the treatment of the mentally ill offender in a residential setting. The program of Hamilton House, a halfway house for mentally ill offenders, was described and certain outcomes were presented. Though the concept of halfway house residence for the former mental patient has now gained acceptance, the potentials of this treatment modality for certain high-risk populations, for example, mentally ill offenders, still needs to be more fully exploited.

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