Behavioral Sciences and the Law
Behav. Sci. Law **21**: 429–458 (2003)
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/bsl.547

Perspectives on Probation and Mandated Mental Health Treatment in Specialized and Traditional Probation Departments

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Despite the prevalence of mentally ill probationers, and probation officers' (POs') central role in their supervision, this is the first reported study to investigate how POs implement mandates to participate in psychiatric treatment. Five focus groups were conducted in major cities with 32 POs and 20 probationers representing a mix of traditional and ''specialty'' probation agencies. Three key findings resulted. First, there were considerable differences between POs in specialty and traditional agencies in the nature, range, and timing of strategies applied to monitor and enforce treatment compliance. Second, the quality of PO–probationer relationships colored POs' use of these strategies and was perceived as central to probationer outcomes. Relationships characterized by a respectful, personal, approach were perceived as more effective in achieving desired outcomes than those that were more authoritarian. Third, specialty agencies strongly emphasized offender rehabilitation whereas traditional agencies focused more exclusively on community safety. These agencies differed in how well probationers with mental illness ''fit'' their standard operating procedure. Implications for future research and directions for probation practice are discussed. Copyright © 2003 John Wiley & Sons, Ltd.

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Work on this paper was supported by the MacArthur Foundation Network on Mandated Community Treatment. We thank John Monahan and Hank Steadman for their assistance in designing this project, as well as other members of the network, who provided helpful comments throughout the course of the study. We thank Eliot Hartstone for moderating the focus groups.

Contract/grant sponsor: MacArthur Foundation Network on Mandated Community Treatment.

Over recent decades, communities increasingly have relied upon the criminal justice system to address the sometimes disruptive behavior of people with serious mental illnesses. When overtaxed mental health systems do not meet these people's needs, this ''not only exacts a toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system'' (Council of State Governments, 2002, p. 6). The enormity of this problem triggered the *Criminal Justice/Mental Health Consensus Project* (Council of State Governments, 2002) to formulate specific recommendations for improving the criminal justice system's response to people with mental illness. Given the prevalence of seriously mentally ill offenders on probation, the report of the *Consensus Project* explicitly recommended that these offenders be assisted in complying with the conditions of probation (Policy Statement 16, p. 141).

Each year in the U.S., as many as one-half million offenders with mental illnesses are placed on probation (Ditton, 1999; see also Dauphinot, 1997; Roberts, Hudson & Cullen, 1995; U.S. Probation and Pretrial Services, 2000; Wormith & McKeague, 1996). Probation officers (POs) have long been responsible for monitoring and enforcing these probationers' compliance with the conditions of probation, which often require probationers to participate in mental health treatment in the community (Ditton, 1999; U.S. Probation and Pretrial Services, 2001). Because these probationers often have pronounced needs for various social services (Ditton, 1999; Wormith & McKeague, 1996) and a relatively high risk for recidivism (Council of State Governments, 2002), POs may find it a formidable task to fulfill this challenge while juggling other job requirements.

Despite the prevalence of mental health treatment mandates and POs' central role in implementing them, little is known about how POs monitor, encourage, and enforce treatment compliance. In fact, we identified only two lines of research relevant to this issue. The first line suggests that POs tend to use confrontational techniques to increase compliance, and that this behavior is not altered by brief training. Some probation departments have begun training POs in ''motivational interviewing'' (Miller & Rollnick, 2002) to address probationers' general noncompliance by using evocative techniques (e.g. reflection, affirmation) rather than confrontational ones (e.g. direction, warnings, threats). Although Harper and Hardy (2000) found that probationers supervised by MI-trained POs manifested more change in their criminogenic attitudes than those supervised by untrained POs, subsequent research suggests that such effects may be time limited. Specifically, Miller and Mount (2001) found that POs' use of confrontational techniques resurfaced four months after MI training, and probationers manifested no change in their level of resistance.

The second line of research is consistent with these results, but more specific to mentally ill probationers and treatment mandates. Based on interviews with POs, Draine and Solomon (2001) found that POs threatened two-thirds of their mentally ill probationers with incarceration for noncompliance with the conditions of probation, including treatment mandates. POs were much more likely to use such threats, and more likely to incarcerate probationers on technical violations, when they reported collaborating with case managers (Draine & Solomon, 2001; Solomon, Draine, & Marcus, manuscript under review). In this ''resource-poor'' environment, case managers apparently became extensions of the PO, who merely monitored for noncompliance. This experience differs somewhat from that reported

by Roskes and Feldman (1999). These authors found low rates of probation violation when POs and therapists collaborated on mentally ill probationers' cases. In this agency, however, therapists explicitly avoided the ''treater-turned-monitor'' phenomenon (Roskes, Feldman, Arrington, & Leisher, 1999).

Despite the limited amount of information available on the implementation of treatment mandates in probation, there are other suggestions that this process varies widely across departments and POs. First, there are no uniform standards of practice or systematic training programs for POs who supervise the mentally ill.[1]Probation is essentially a ''practioner-led'' enterprise (Klaus, 1998), where the characteristics of individual POs strongly influence daily practice. Second, given political and scientific developments over the past decade,[2] probation departments have come to differ considerably in their core philosophies. Some departments emphasize offender rehabilitation (''care'') whereas others focus more exclusively on community safety (''control,'' Klaus, 1998).

This polarization in philosophies is uniquely relevant to the supervision of offenders with mental illness. Over recent years, several departments have developed ''specialty'' agencies that assign mentally ill probationers to particular POs as part of a mental health caseload. This is a significant departure from ''traditional'' departments that assign such probationers to any PO as part of a general caseload. Although there are important differences among specialty probation agencies,[3] prototypic agencies (i) hire POs with specialized training or experience in mental health, (ii) assign these POs only probationers with serious mental illness, and (iii) limit the size of these POs' caseloads (see, e.g., Council of State Governments, 2002; Roskes et al., 1999). Theoretically, specialty POs have both the tools for effectively addressing the individual needs of mentally ill offenders and the time for intensive supervision. These features could improve probationers' adherence to treatment, improve their functioning, and reduce their risk of recidivism.

Although the report of the *Criminal Justice/Mental Health Consensus Project* explicitly recommended the adoption of such specialty probation agencies (Policy Statement 16.c), it acknowledged that such initiatives ''are so new that they have yet to be evaluated to certify their impact'' (Council of State Governments, 2002, p. 16). To remedy this problem, the report stressed the importance of assessing program

[1]When officers obtain training on mental health and treatment compliance issues, they apparently do so through local agencies (e.g., the American Probation and Parole Association and Federal Judicial Center provide no such training). In addition, there apparently are no clearly articulated policies for handling the mentally ill probationer. The most organized policy-related efforts occur at the federal level. Federal probation officers are required to follow policies and procedures summarized in ''Chapter 11, Mental Health Supervision,'' which closely follows the Federal Judicial Center's *Handbook for Working with Mentally Disordered Defendants and Offenders* (Orlando-Morningstar, Skoler, & Holliday, 1999). Most of the supervision-related material in these documents focuses on monitoring and enforcing compliance with treatment stipulations. However, there is very little discussion of *how* officers should handle resistant probationers, including strategies for increasing compliance or guidelines about when to use sanctions.

[2]Recent calls for accountability and scientific advances have sparked a movement toward ''reinventing probation'' (Brad Bogue, personal communication, 16 April 2001) in some departments. First, policy-makers have been questioning whether probation should continue to exist, given that the return on their investment has been unclear. Thus, there has been increasing pressure to develop and implement ''coherent management systems and accountability structures'' in probation (Klaus, 1998, p. 63). Second, a series of studies published in the 1990s on ''what works'' (e.g. Andrews et al., 1990) in correctional treatment suggests that some rehabilitative approaches are particularly effective in reducing recidivism.

[3]For example, in some specialty programs, POs work in teams with in-house case managers. In others, they work with surveillance officers.

outcomes (Policy Statements 44, 45, and 46). This recommendation is consistent with recent calls for increased accountability and use of ''evidence-based practices'' in probation (e.g., Klaus, 1998).

In accord with these recommendations, this study is the first phase of a research program designed to describe how POs in specialty and traditional agencies implement probation with seriously mentally ill offenders, and, ultimately, to assess the effect of that implementation on outcomes for SMI probationers. For two reasons, special emphasis is placed on characterizing and evaluating the way in which POs monitor and enforce probationers' adherence to mental health treatment. First, treatment mandates often are considered central to effectively maintaining seriously mentally ill offenders on supervised release (see, e.g., Council of State Governments, 2002; Orlando-Morningstar et al., 1999). In fact, advocates of mandated community treatment for mentally ill offenders have argued that probation provides the most secure legal authority currently available for ensuring treatment to prevent psychiatric crises and recidivism (Silberberg, Vital, & Brakel, 2001). Second, the relationship between POs and probationers provides a unique opportunity to better understand the pressures used to increase treatment compliance, and how these pressures affect individuals' treatment adherence and outcomes.

With respect to the latter point, little is known about how treatment mandates are implemented in outpatient contexts and what strategies work best. However, recent studies by the MacArthur Network on Mental Health and the Law indicate that the way in which inpatient hospital admissions are implemented is crucial. First, these studies indicate the importance of ''procedural justice'' during the hospital admission process, or patients' experience of being treated with respect and allowed to state their views. Patients experienced admissions, including involuntary admissions, as less coercive when they were implemented with procedural justice (Lidz et al., 1995). Second, these studies indicate that patients' perceptions of coercion are unrelated to clinicians' use of ''positive pressures'' (persuasion, inducement, asking preferences), but are strongly associated with use of ''negative pressures'' (orders, deception, threats, shows of force; Lidz et al., 1995). The extent to which such findings will generalize to outpatient contexts is unclear, as inpatient admission differs from mandated outpatient treatment in several important respects (e.g. familiarity of authority figures, duration of treatment mandate; see Monahan et al., 2001).

If coercion and resistance are conceptualized as dynamic, ongoing functions of key relationships (Miller & Mount, 2001; Lareau, unpublished doctoral dissertation), the way in which a mandate to outpatient treatment is enforced may strongly affect perceptions of coercion, levels of resistance, psychiatric functioning, and recidivism. Probation settings provide a unique opportunity to study these issues. POs are professional enforcers, whose job is to insist consistently that the conditions of probation, including treatment mandates, are followed (Orlando-Morningstar et al., 1999). Moreover, POs have direct, ongoing relationships with probationers that involve regular contact.

In summary, the immediacy of the PO–probationer relationship and the variability across departments in philosophies (care versus control) and structures (specialty versus traditional) provide an excellent opportunity to identify, describe, and evaluate a wide range of processes that influence the way in which treatment

mandates are implemented. This was the general goal of this study. The specific aims of this study were to (i) identify methods that traditional and specialty POs use to monitor and enforce probationers' participation in mandated treatment and explore explanations for their use, and (ii) describe the perceived effects of these methods on probationers' experience of coercion, treatment adherence, and outcomes.

METHOD

Given the lack of systematic information on probation and mandated mental health treatment, our general goal was broad, and our aims were open ended and interconnected. Thus, we began with a qualitative approach to prepare conceptually and methodologically for a later quantitative outcome study. The centerpiece of the first of this two-phase approach was a series of focus groups conducted with POs and probationers. As noted by Tyrrell (1998), the ''intention of focus groups is not to infer but to understand, not to generalize but to determine range, and not to make statements about the population but to make insights about how people perceive a situation'' (p. 1; see also Morgan, 1988; Krueger, 1994). Our goal in conducting focus groups was to obtain a rich understanding of the range of influences that POs and probationers viewed as crucial to the process and outcome of mandated treatment. We wished to allow participants to talk in their own language about influences of central significance to them rather than impose closed-ended questions about factors we presumed were important (Tyrrell, 1998). This process of ''fact-finding'' was designed to support the development of an ecologically valid outcome study. Learning the relevant vocabulary and thinking pattern of POs and probationers was particularly vital for developing valid measures for this study.

These strengths of focus group methodology are associated with weaknesses. First, the results of focus groups cannot be generalized to the population given such factors as small, potentially unrepresentative samples, and the highly flexible, context-bound nature of focus group discussions. Nevertheless, because our purpose in this first phase of study was to understand rather than infer or predict, focus groups were appropriate. The second major weakness of focus groups is their potential for participant and researcher bias. Our chief concern in designing this study was to protect against this risk of bias. To minimize the likelihood that the results would reflect the views of particular outspoken participants, we (i) selected PO participants from multiple probation agencies to minimize the likelihood that agency dynamics would affect some participants' candor, (ii) employed an experienced and skilled moderator who elicited comments from all participants, and (iii) during data analysis, considered the extent to which a given perspective was shared by multiple participants. To protect against researcher bias, we (i) developed a comprehensive coding system and coded all focus group data, (ii) used qualitative software to systematically test hypotheses by assessing the internal consistency of participants' responses, (iii) integrated the analyses of three expert raters to arrive at ''consensus themes,'' and (iv) checked the consensus themes against an independent expert and original focus group participants.

The study method consisted of two general steps. First, we conducted focus groups and brief surveys with POs and probationers to identify and describe the

methods and perceived effects of enforcement strategies. Second, we coded these data using qualitative analysis software to aid three expert raters in extracting key themes. These raters then met to reach a consensus on these themes, which ultimately will be translated into measures of probation implementation to use in the future outcome study. In this section, we describe these two steps of data collection and data analysis.

Focus Groups and Surveys

Site Selection

Three study sites were selected, including two with specialty probation departments in the region (Phoenix and Philadelphia), and one with traditional probation departments (Las Vegas). Site selection criteria included the availability of (i) prototypic ''specialty mental health'' or ''traditional'' probation departments, and (ii) multiple specialty or traditional probation departments.[4] The latter criterion was intended to permit POs from multiple departments to participate in focus groups, thereby avoiding intra-agency dynamics from interfering with participants' candor. The Phoenix site included two specialty Southern Arizona probation departments (i.e. Maricopa and Pima counties); the Philadelphia site, six specialty Southeastern Pennsylvania probation and parole departments (i.e. Chester, Delaware, Lancaster, Lehigh, Montgomery, and Philadelphia counties); and the Las Vegas site, three traditional Southern Nevada probation and parole departments (i.e. Central, Eastern, and Western Las Vegas). Although several traditional probation sites were available, we chose Las Vegas based on its geographic similarity and proximity to Phoenix.

Procedure

We conducted a total of five focus groups, including two with probationers who were mandated to mental health treatment as a condition of specialty (Phoenix) or traditional (Las Vegas) probation, and three with POs experienced in supervising such probationers in specialty (Phoenix, Philadelphia) or traditional (Las Vegas) departments. We spoke with POs and probationers in separate groups to protect confidentiality, encourage open discussion, and obtain different perspectives on the issues of interest. Notably, we conducted two focus groups with specialty POs in an effort to represent the full range of these departments' strategies for managing mentally ill probationers.

The focus groups were moderated by an experienced focus group facilitator from a research firm. The first author acted as recorder for each group, which lasted

[4]First, we excluded ''specialty'' programs that did not have reduced mental health caseloads or caseloads specific to mental health (e.g. those that included sex and/or drug offenders), as well as traditional departments that informally designated one or two officers as ''mental health'' officers. Second, although we identified several exemplary specialty probation departments (e.g. Mental Health Unit, Cook County Adult Probation Department), we selected only sites where *multiple* specialty departments were available to increase the likelihood of obtaining valid focus group results.

approximately 2 h and was audiotaped. The focus groups were held at neutral research facilities that were rented for this purpose. At the close of each focus group, participants completed a brief survey that described their demographic characteristics, background, and probation-relevant attitudes. All participants were provided refreshments, reimbursed for travel, and paid $50–75 for participating.

Participants

Approximately ten POs or probationers participated in each of the five groups, for a total of 32 POs and 20 probationers. Of POs who were randomly selected and invited to participate in the study, 0% (Phoenix), 6% (Philadelphia), and 37% (Las Vegas) declined participation or failed to appear for the focus group. Notably, traditional POs (Las Vegas) were screened to ensure that they had experience in supervising probationers with SMI mandated to treatment. The lower rate of PO participation at the traditional than specialty sites may be partially attributable to (i) group differences in POs' interest in the topic of probationers with mental illness, and (ii) scheduling conflicts, in that the traditional group was held after work hours based on administrators' preferences. Although the effect of this lower participation rate cannot be known, the most obvious risk is that traditional POs who participated in this study had an atypically high level of interest in the topic of mental illness. To the extent that this is true, the results presented below could underestimate differences between the perspectives of specialty and traditional POs.

Probationers were eligible for the study if they had a serious mental illness (Axis I disorder) and were required to participate in mental health treatment as a condition of probation. Probationers who met these eligibility criteria were identified by the Maricopa and Las Vegas probation departments based on a review of records. Of probationers who were randomly selected and invited to participate in the study, 35% (Phoenix) and 17% (Las Vegas) declined participation or failed to appear for the focus group.

The PO sample consisted of predominantly middle adulthood ($M = 38$ years, $SD = 9.5$), White (72%; Hispanic, 13%; Black, 7%; Other, 9%), men (55%) and women (45%). Most (74%) POs had attained a bachelor's degree. The median and modal length of time that POs had worked in probation and/or parole was 7 years, with a median time spent in their current department of 5 years. There were four noteworthy differences between specialty and traditional POs. Although 75% of the specialty officers were women (all Phoenix POs were women), 75% of the traditional officers were men. These gender statistics were consistent with the probation departments from which we sampled (e.g. 77% of eligible Las Vegas POs were men), suggesting that women tend to be more drawn toward these specialty than traditional offices.[5] Specialty officers' median caseload size was 40, whereas traditional POs' was 73. Specialty officers typically (82%) reported that over three-quarters of their caseload was mandated to mental health treatment, whereas traditional officers typically (80%) reported that less than 5% of their caseload

[5]Although one may argue that the differences between traditional and specialty POs identified in this study was partially a function of gender rather than types of departments *per se*, the gender composition of the sample was consistent with the composition of types of probation departments (i.e., women tended to staff specialty departments more often, and men staffed traditional departments more often).

was mandated. The majority (55%) of specialty officers had a history of working for a mental health or substance abuse agency, compared with only 10% of traditional officers.

The probationers were predominantly young ($M = 26$ years, $SD = 6.2$), White (75%; Black, 10%; Hispanic, 5%; Other, 10%), unemployed (75%) men (85%). With the exception of race/ethnicity, these statistics are consistent with those on the entire probationer pool from the sites at which we sampled. Our sample appears somewhat less racially and ethnically diverse than the population from which it was drawn.[6] The majority of these probationers cited ''psychiatric problems'' (30%) and ''being on disability'' (25%) as their reason for unemployment. Although reliable diagnostic information was unavailable, the majority (70%) of probationers reported a history of hospitalization for serious psychiatric and/or substance abuse problems. Moreover, 40% endorsed both items of a screening test for substance abuse disorder (Brown, Leonard, Saunders, & Papasouliotis, 2001) by indicating that, over the past year, they had both used more alcohol or street drugs than they intended *and* wanted to cut down on their use. Typically, probationers described serving sentences for felony person- (40%; assault, robbery, kidnapping) or drug-related (40%; possession, distribution) crimes. The majority (60%) reported having been arrested at least once in the past. At the time of the study, probationers' modal and median length of probation was two years.

Surveys

Both probationers and POs completed brief surveys that described their demographic characteristics and relevant history (e.g. work, mental health, substance abuse, and legal history). Probationers' surveys assessed attitudes toward treatment, whereas POs' surveys assessed attitudes toward mental illness (based on questions drawn from Taylor & Dear, 1981). The latter results were integrated with the information obtained from the focus groups.

Focus Group Discussion Guides

At the initiation of the study, discussion guides for the focus groups were developed based on iterative feedback from practicing POs, mental health experts who train POs nationally, and experts in qualitative methodology and analysis. These guides are available from the first author. The discussion guide for the POs addressed their (i) general experiences in supervising treatment-mandated probationers with SMI (TMPs), including the special challenges posed by, and services required by or

[6]Specifically, executives at the specialty site estimated that their population of probationers were young ($M = 31$ years) men (77%), the majority of whom were White (63% White, 18% Hispanic, 10% Black, 6% Native American; 3% Other; Sue Stodola, personal communication, 8 April 2003). With respect to the traditional probation site, demographic characteristics of general probationers may differ from those of probationers with mental illness who are mandated to treatment. Nevertheless, because statistics on the latter population were unavailable, figures on the general probationer population are provided for the purpose of gross comparison. Of the 5,370 probationers supervised in Clark County, Nevada in early April 2003, most were young ($M = 34$ years) men (75%), as in our sample. However, the racial/ethnic distribution of general populations was more diverse than our sample (52% White, 29% Black, 14% Hispanic, 5% Other; David Sonner, personal communication, 4 April 2003).

provided to TMPs; (ii) professional and other potential sources of support (e.g. clinicians, family members) in working with TMPs, including the role of these other individuals and their perceived helpfulness; (iii) impressions of the nature and quality of mental health treatment received by their TMPs; (iv) descriptions of their general interactions and relationships with TMPs; (v) focus in monitoring treatment compliance (e.g. what is monitored), monitoring strategies (e.g. frequency, nature, source of information), and perceived obstacles to monitoring; and, most importantly, (vi) focus in enforcing treatment compliance (e.g. what triggers enforcement strategies), enforcement strategies (e.g. nature, timing, variation across probationers), and perceived effect of different strategies of probationers' compliance and outcome.

The discussion guide for the probationers generally paralleled that of POs so that researchers could compare and contrast perceptions of probationers and POs in a number of interest areas. Specifically, the guide addressed TMPs' (i) perceptions of the frequency, nature, and quality of their contacts with their POs and their relationships with their POs; (ii) description of professional and other parties involved in their mandated treatment; (iii) opinions about the types and quality of their mandated treatment services; (iv) perception of POs' focus and strategies for monitoring treatment compliance; and, most importantly, (v) perceptions of POs' focus in enforcing treatment compliance and the range of enforcement strategies used, including their effect on probationers' treatment compliance and general feelings of well-being.

Analysis of Focus Group Data

After each focus group, the focus group facilitator and recorder met for a debriefing to identify consistencies and inconsistencies across focus group participants, vague explanations that required clarification in subsequent groups, and unexpected reactions. This permitted some adjustment of the line of questioning in subsequent groups. Once the focus groups were complete, audiotapes of each group were transcribed. Three investigators (the first three authors) refined codes and themes before working toward generalizations that form the basis for the present report. After pseudonyms had been assigned to identify each participant in the transcripts and the transcripts had been annotated with the recorder's notes, these investigators independently reviewed the transcripts. Beginning with the refined topics from the discussion guides, each investigator independently read for patterns, themes, and distinct differences between subgroups (PO and probationer; specialty and traditional). They then met in a ''consensus session'' to compare their analyses of focus group content and themes and note any disagreements (Miles & Humberman, 1994). After discussion, consensus was reached regarding a coding scheme (available from the first author) to capture issues worthy of further exploration or refinement.

Two investigators used a qualitative-data software program, N5 (Richards, 2000), to apply the agreed-upon scheme to code each transcript, and then provided the coded data to the third investigator. The three investigators then independently used this program to organize the specific content of all of the focus groups (by

content and speaker), and to systematically search the data to develop, test, and refine themes and examine their consistency across subgroups (PO and probationer; specialty and traditional). Then, all three investigators met again to arrive at a consensus on the general themes and final findings. These findings were then checked for validity against the impressions of the focus group facilitator who had analyzed the data independently. Finally, the findings were carefully checked with a small subgroup of POs and probationers who had participated in the original focus groups.

RESULTS AND DISCUSSION

This is the first reported study of how specialty and traditional POs implement treatment mandates with seriously mentally ill probationers. The substantive findings of this study are organized into three points about individual PO (*strategic*), PO–probationer dyad (*relationship*), and probation agency (*contextual*) levels of influence on the implementation of treatment mandates. First, there were considerable differences between specialty and traditional POs in the nature, range, and timing of *strategies* applied to monitor and enforce treatment compliance. Specialty POs generally possessed a more complete ''compliance toolkit,'' used more positive pressures, and intervened earlier than traditional POs to foster treatment compliance. Second, in both specialty and traditional agencies, the quality of the PO–probationer *relationship* colored these strategies and was perceived as central to treatment adherence and general outcome. Relationships characterized by a respectful, personal approach tailored to the needs and capabilities of the probationer were perceived as more effective than those that were uniform and authoritarian. Third, there were clear *contextual* differences between specialty and traditional probation agencies, with specialty agencies emphasizing offender rehabilitation (care and casework) and traditional agencies focusing more exclusively on community safety (control). These differences between agencies related to how well seriously mentally ill probationers ''fit'' standard operating procedure, and, therefore, how these probationers were supervised.

In the remainder of this article, we describe these three findings, working from general to specific sources of influence on mandate implementation. Specifically, we discuss (i) contextual factors, including the type of probation agency (specialty versus traditional) as well as the state of the mental health care system, (ii) the PO–probationer relationship factor, and (iii) the nature and variability of specific strategies that POs use to monitor, encourage, and enforce treatment compliance. After describing these sources of influence, we conclude by discussing their perceived effect on probationers' treatment adherence and outcome.

While reading these results, two points should be borne in mind. First, the perspectives of probationers on these issues were quite consistent with those of POs (we note where this is not the case below). Second, although there were pronounced *general* differences between specialty and traditional probation agencies, there was variability among *individual* POs within these agencies. For example, there was a relatively ''control-oriented'' specialty PO and a relatively ''care-oriented'' traditional PO (whose opinions often were contested by their

colleagues).[7] Similarly, two probationers with the same PO described her approach to supervision differently. In short, although there were no absolute dichotomies between the types of approach used within agencies, some patterns of differences were apparent.

Contextual Influences on Mandate Implementation

Clearly, POs' implementation of treatment mandates does not occur in a vacuum. This study suggests that were two important contextual influences on this process, including (i) the general disarray of the mental health system and associated difficulties in accessing care, and (ii) the nature of the probation agency (specialty versus traditional).

The Mental Health System

The disarray of the public mental health system was a prominent theme in all five focus groups. Although POs and probationers described some variability across treatment providers, they generally perceived the dominant system as underfunded, overburdened, impersonal, programmatically limited (typically to medication management), and particularly reluctant to provide services to individuals with legal problems. For example, POs noted that "the resources are definitely a problem here . . . we don't have many resources" (Las Vegas/Jane), and described the mental health system as "this huge monolithic corporation that turns out . . . I mean how *many* people each day, you know . . . " (Philadelphia/Ben). (Again, all names are pseudonyms.) This was consistent with probationers' perceptions ("They schedule appointments I believe 15 minutes apart. You just—you know, he'll ask you how you're doing, any problems, write out your meds and you're gone," Phoenix/Colin).

The state of the mental health system typically was perceived as a significant barrier to implementing probationers' mental health treatment mandates. However, the locus of responsibility for negotiating this system to access care was perceived somewhat differently in specialty and traditional agencies. As shown later, specialty POs typically adopted an advocacy role to obtain treatment resources for probationers. In contrast, traditional POs reacted with more apparent resignation, perhaps providing probationers with referrals, but leaving them to navigate the system on their own. In fact, the majority (60%) of traditional probationers were expected to pay for their own care ("And if you don't have the finances . . . they say that's too bad," Las Vegas/Jerry).

Nevertheless, probationers typically obtained some type of treatment. Most traditional and specialty probationers described taking psychiatric medication

[7] One care-oriented traditional PO worked with one client to obtain social security disability. Similarly, one very control-oriented specialty PO noted, "let's say [a probationer is] belligerent and has a bad attitude and isn't ultra-compliant, I might get him locked up, put him in jail, go talk to him at the jail and say, 'How long do you plan on sitting here?' And if he agrees to be a good boy and do what he's supposed to do the next time, I'll go back to the courthouse and do a release order—he gets out. The next time he screws up he's looking at me like, 'Oh—this is the guy that sends me to jail and decides if I stay or leave.' And it gives me—in his mind—a great amount of control over his future happiness or unhappiness . . . . I keep asking them to say uncle . . . "Are you going to take your pills, yes or no? . . . When they say uncle, I let them out."

during the month before the focus group (70 and 80%, respectively), although traditional probationers were substantially less likely than specialty probationers to have seen a case manager or therapist during this period (30 and 80%, respectively). Moreover, POs and probationers typically valued treatment. Specifically, POs typically (87%) agreed that ''medication and therapy are the most important aspects of working with probationers who are mentally ill.'' POs described being satisfied that their cases ''were at least being maintained'' (Las Vegas PO) and believed that their minimally treated probationers were doing ''better than if they had none'' (Phoenix PO). Probationers were somewhat more optimistic. For example, according to their surveys and focus group responses, the majority (60%) of traditional probationers and virtually all (90%) specialty probationers believed they were being helped by treatment (''They finally got me on medication. It was hard work to get it. Yeah, I've been out of the mental hospital now for a year so . . . pretty good,'' Las Vegas/Rickie; ''It's just put my life back in order,'' Phoenix/Dan).

The Type of Probation Agency

In addition to the mental health system, the procedures and philosophy of the probation agency were perceived as important contextual influences on the implementation of treatment mandates. First, specialty and traditional agencies differed in the extent to which their standard operating procedures ''fit'' probationers with SMI. Second, specialty and traditional agencies differed in their philosophical emphasis on care and control.

The first key probation agency influence involved the extent to which standard probation procedures ''fit'' probationers with SMI. Generally, specialty and traditional POs agreed about the challenges associated with supervising SMI probationers. POs believed that, unlike traditional probationers, SMI probationers had a limited ability to comply with the standard conditions of probation (e.g. working, paying fees, completing community service), and a pronounced need for a range of social welfare benefits (e.g. medical insurance, disability income, subsidized housing). In their view, SMI probationers required substantially more time and attention from, and became more dependent on, their POs than non-SMI probationers. Notably, most SMI probationers were perceived as less openly defiant and ''more submissive'' than traditional probationers.

Despite agreement about these needs and challenges, there were important agency-related differences in the extent to which SMI probationers fit POs' ''typifications'' or ideas of the typical or routine probationer. Typifications may be understood as common sense constructs through which humans organize perceptions of others (Cicourel, 1968; Sudnow, 1965). We use typifications in everyday life to make sense of and respond to interactions quickly, without having to process each new interaction from the standpoint of a blank slate.[8] We also use typifications in professional contexts to conduct work more smoothly. The classic

[8]So, if a stranger dressed in a suit, holding a briefcase, and pulling a suitcase walks up to you on a busy street and asks for directions, you immediately conclude in your thinking that this is an out-of-town businessperson on the way to a meeting. (If s/he is sweating profusely, you conclude that s/he is anxious because s/he is late for the meeting.) You then get on with the business of giving her or him directions without having to figure out whether or not s/he is trying to con you or if s/he has some other vested interest.

sociological example of typifications is that of criminal court rooms in which public defenders (PDs), prosecutors, and judges agree on typifications so that they may process the more routine cases with the least amount of work and conflict (Sudnow, 1965). These actors organize a variety of offenses into homogeneous categories to efficiently process cases, typically through the use of plea bargain. When a defendant exhibits certain characteristics that ''match'' the type of offense for which he or she is prosecuted, these actors understand that this case involves a ''normal crime'' enacted by a ''normal or typical'' criminal. Without having to say much to one another, the PD, prosecutor, and judge understand that a plea bargain is in order and may even understand the parameters for the plea bargain itself. This typification process is a form of ''shorthand'' that permits overworked and understaffed court personnel to save time and other resources. From the standpoint of efficiency, these professionals appreciate ''normal crimes'' and ''normal defendants'' and dislike having to process cases that do not fit this routine. The non-routine case becomes a problem to the efficient operation of the system.

In our study, both sets of POs seemed to have a sense of the ''typical'' or ''routine'' probationer. For traditional POs, the routine probationer is a non-mentally ill person who may be resistant to probation, but is willing to ''play along'' with the requirements because he or she wants to spend the least amount of time possible interacting with the PO and hopes to ''get off of probation'' as quickly as possible. This person tends not to bring personal, health, and other types of need to the attention of the PO, knowing that doing so may create a problem to the efficient processing of the probationer. The SMI probationer, in contrast, is an atypical case that creates ''problems to the system'' in that their mental health needs are perceived as non-routine and, therefore, time and resource consuming. Unlike traditional POs, specialty POs created categories of typical, routine probationers with SMI and atypical, problem clients with mental health needs. For specialty POs, the routine probationer is a person with SMI who *expects* and seeks assistance from the PO around mental health needs and exhibits some level of compliance with mental health treatment. The non-routine probationer that presents problems for the specialty PO is non-compliant with treatment, tends *not* to discuss mental health needs or issues with POs, and exhibits little motivation to seek a level of treatment that would, in term, help them to comply with their other probation requirements (atypical cases included malingering clients and personality disordered clients).

These agency-related differences in typifications of SMI probationers were related to differences in the way that these probationers were supervised. In specialty agencies, SMI probationers were handled relatively easily as routine cases for whom the agency was structured (e.g. ''The sick people—they're a piece of cake,'' Philadelphia/Ed). Specialty POs were equipped with resources to address the challenges posed by SMI probationers (e.g. needs for social services) and were expected to do so. As one specialty officer noted, ''in this position we're expected to know coming in that we're to take an advocacy role . . . we're supported in drawing limits, but we're supposed to be more of their advocate and are given the time to do that kind of thing'' (Phoenix/Mary). However, SMI probationers in traditional agencies were processed as problem cases that poorly fit the standard supervision structure. This structure provided traditional POs with little or no time, training, or guidelines for supervising SMI probationers differently than other probationers. As one traditional PO noted,

> we have got to fit them into a square, and there's no separate one for mental health. In other words, we can declare that they're a minimum supervision level [to] a maximum supervision level . . . and basically they're done on a . . . score sheet that we do on everybody else. So basically you have to fit them in—put them into that. Any time you spend in addition to the level that you've declared them . . . is off another offender's case because of the limited amount of time' (Las Vegas/Ernie).

Other traditional officers asked rhetorically ''How does one go about supervising that type of thing, with all this extra attention they got to have?'' (Sam) and asserted ''We do not have the ability to deal with it. Our agency does not have the ability to deal with it'' (Beth). There was no organizational expectation that traditional POs address the social service needs of SMI probationers (e.g. ''that's an exception—going above and beyond the requirements'' Jane).

Agency-related differences in typifications of the ''routine'' case appeared related not only to the processing of SMI probationers, but also more generally to differences in the objectives of probation. The general goal shared by POs and probationers alike was for probationers to ''get off of'' or complete probation. In fact, some probationers worked hard to achieve decreased monitoring or early release that POs offered as incentives. However, the specific objective for most traditional POs was to maintain the SMI probationer safely until this problem case could be either (i) transferred to another officer as quickly as possible (e.g. ''If there's a nutso on my case and he's just taking up too much of my time, when there's an opportunity to transfer to another officer, I'll transfer him,'' Las Vegas/Rodney; ''Therefore they never get help,'' Las Vegas/Beth), or (ii) terminated from probation somehow (e.g. completion, dishonorable discharge, revocation). Traditional POs generally appeared ill at ease with supervising these problem cases—they were aware of their essential duty to protect public safety and often perceived SMI probationers as unpredictable, potentially dangerous, entities, who presented a significant risk of liability. Although they rarely could provide different services to SMI probationers than more routine probationers, traditional POs used a cautious, watchful approach with the former cases until supervision could be ended. As summarized by one traditional PO, ''all we're doing is relieving liability off of us:''

> No, [we haven't found anything that works] . . . we're stalling. We're baby-sitting until we get them off of our caseload whether we're stalling them out, throwing them in and out of jail to get them through their minimum [sentence] or we're ignoring them or we're handing them off to different officers (Las Vegas/Beth).

In contrast, the specific objectives for specialty POs with SMI probationers was not only to protect public safety, but also to obtain rehabilitative services that would gradually lead the SMI probationer to better functioning, more independence, and more ''responsibility for their own actions'' (Phoenix/Sandy). SMI probationers were routine cases around whom specific services had been structured to achieve this objective. One PO described that officers were trying to ''get people on their feet and self-supporting'' (Phoenix/Nancy). Another PO explained

> It's kind of like we're raising a child—and we're providing the resources and we're kind of leading them in the right direction, and . . . then we want them to get to the point where first they're depending on us and then afterwards we want them to get to a point where they can do everything on their own . . . So I think the goal for me is to enable these people to be able to function on their own with just their case manager . . . (Phoenix/Mary).

After differences in typifications of the ''routine'' case, the second key feature of the probation system that influenced the implementation of treatment mandates was the relative emphasis the agency placed on control versus care of the probationer. The objective of most traditional POs was to maintain SMI probationers safely in the community until supervision could be ended, whereas most specialty POs also were striving to improve SMI probationers' independent functioning. These differences in objectives seemed to express agency-related differences in the extent to which the agency's supervision services were oriented toward law enforcement and community safety (''control''), treatment and probationer rehabilitation (''care''), or both. Although there were no clear dichotomies, specialty agencies tended to emphasize both care and control of SMI probationers, whereas traditional agencies more exclusively emphasized control.

As described by one PO, specialty agencies ''focus more on treatment and . . . jail is the last possibility'' (Phoenix/Deb) or last resort. Another PO contrasted this approach with when she ''was in general, it was more of a scare tactic—''Jail, blah, blah, blah'' (Philadelphia/Ben). Most specialty POs went beyond a simple treatment orientation to one of actively advocating for services for their SMI probationers, including housing, social security benefits, mental health treatment, and sometimes transportation (''I take him to the doctor's appointment—because he's so paranoid he won't go,'' Phoenix/Nancy). These POs described ''fighting'' with beleaguered mental health systems to access appropriate care for these probationers:

> We spend a lot of our time educating the case managers in exactly what their job is. We know exactly what services are available and what should be happening—so it's a constant battle. It's like people ask me, what did you do today? I say, ''Well I been fighting with [mental health] since eight o'clock this morning. It's eleven and I've been on for, you know whatever, two-and-a-half hours and just trying to get these services for the clients (Phoenix/Lisa).

In these specialty agencies, both POs and probationers perceived treatment and probation as fundamentally connected. POs sometimes were members of probationers' mental health treatment teams. In fact, in at least three specialty offices, POs worked side by side with specific case managers as part of an explicit team. In another office, POs had lobbied with their county to obtain money to create forensic case manager positions. Most specialty probationers (80%) said they liked their PO working closely with their treatment providers and viewed this as ''coordinated care.'' Although specialty POs clearly were concerned about and aware of community safety issues, care and treatment were fundamental components of the specialty supervision philosophy.

In contrast, the traditional agency focused more exclusively on law enforcement and public safety. Treatment and probation were linked loosely and solely by the mandate to participate in treatment. Treatment, in turn, was regarded by POs chiefly as a tool for ensuring that probationers remained ''stable.'' As summarized by one probationer,

> Honestly, one of the things that I realized pretty quickly once I was on probation is that there's nothing about social work and probation officers that seem to coincide—they're not actually there to facilitate you in any manner in making any type of transition in life . . . [they just] threaten that if you don't do what they say that they'll revoke your probation (Las Vegas/Michael).

Another probationer observed ''He's not going to call me and ask me how I'm feeling today. He's just . . . he's a recording person, you know. It's his job to make sure I'm doing what the judge told me to do'' (Las Vegas/Val). Notably, several traditional probationers preferred that the linkage between their POs and treatment providers remain weak. Almost half (45%) of these probationers disliked the idea of their POs working together closely with their treatment providers (''it's none of their business what you say to the [therapist]''). In fact, some described a specific wish to keep these aspects of their lives separate.

Relationship Influences on Mandate Implementation

In addition to contextual factors associated with the mental health and probation system, the nature of the ongoing relationship between POs and probationers was perceived as a pivotal source of influence on the implementation of treatment mandates. Notably, ''caring'' and ''controlling'' are expressed not only in whether probationers are provided with particular services (the ''content'' of probation), but also in the nature of the ongoing relationship between POs and probationers (the ''process'' of probation). Despite clear agency-related differences in the services obtained from POs, the majority of both traditional (60%) *and* specialty (70%) probationers characterized their overall relationship with their PO as more ''caring'' than ''controlling.'' Even within agencies, participants agreed that PO–probationer pairs varied considerably in the quality of their relationships.

Probationers in both groups placed a premium on more relational, less authoritarian relationships with their POs. The former relationships were characterized by both a friendly style and a relatively flexible supervision approach. First, traditional probationers prized POs who used a personal, ''decent,'' ''nice,'' or ''friendly'' style while carrying out the necessities of monitoring and enforcing the conditions of probation (''Actually the first question he asks me when I step into his office is, 'How you doing? . . . he really wants to know . . . '' Las Vegas/Val). They dreaded what they perceived as the more prototypic PO, who bossed, intimidated, ridiculed, threatened, and asserted ''ownership'' of them (''The first time I met him, he threatened to put me in prison . . . I got so damned scared, okay . . . and I didn't do anything,'' Phoenix/Roger). One probationer explained

> My PO—I sometimes have the feeling he's kind of looking down his nose at me—and then again I get that feeling from just about everybody at that office . . . [Once], there was those two people standing right in the doorway, practically letting themselves in the room almost when I'm talking to my PO. And when we come out of the room here they are. We practically got to squish against the doorway to get past them—and one of them is chuckling to the other one . . . and nods his head over towards me and says, 'You can tell when he's lying cause his lips are moving' (Las Vegas/Eric).

Despite such experiences, the majority of traditional probationers believed that they had ''lucked out'' and currently had a more caring, relational PO. In addition to having a friendlier style, probationers perceived these POs as flexible and understanding of probationers' limitations. For example, these POs required less frequent reporting over time, did not make them wait in the office for long periods, and occasionally altered standard requirements of probation in order to meet their needs

(e.g. ''I'm exempted from supervision fees . . . I guess because I'm on SSI,'' Las Vegas/Jerry). Notably, however, some traditional probationers perceived the quality of their relationship with their PO as contingent upon compliance with probation. As noted by one probationer,

> Well, the whole thing is a control mechanism—that's what it is—so it's whether they're nice or they're mean. They're generally nice when they get what they want and they tell you ahead of time the next time you come, what to bring . . . as long as you do exactly what they want they're friendly and if you don't do what they want they're . . . they can do different things (Las Vegas/Tim).

Like traditional probationers, specialty probationers also valued relationships with relatively friendly, flexible POs. Specifically, specialty probationers appreciated POs who they believed were interested in them as a person and treated them nicely (''My PO doesn't come at me . . . aggressive. She's nice to me. She knows . . . something's wrong with me so she talks to me the right way,'' Phoenix/Romeo). They also valued POs who adapted their supervision approach to their individual strengths and needs, while being honest about limits (''you have so many chances, but if you continue to do this, this is what will happen,'' Phoenix/Jill). One probationer explained

> [She] is caring in the fact that she actually has taken the time to understand my personality traits. She knows, you know, what uh, let's say my triggers are; what my problems are; and what my assets are—and she does as much as she can, you know, do . . . so just the fact that she's taking the time to understand me as a person and try to focus her treatment—her plan—her probation plan—in accordance with my successful completion—that's caring. She's a little controlling in terms of when she says something that is really like her bottom line—that is her bottom line—and she's established a boundary that I cannot cross (Phoenix/Colin).

Despite these similarities, there were three differences between specialty and traditional agencies with respect to relationships. First, in contrast with traditional agencies, ''relational'' relationships were perceived as more the norm than the exception in specialty agencies. In fact, specialty POs sometimes went beyond a relational supervision approach to provide support (''if there was anything she could do to help she always told me to call her,'' Dan) and outright altruism (''my PO took up a collection in her office to pay to have my bad tooth pulled,'' Shelly). Second, ''relational'' relationships in specialty agencies were perceived as somewhat less contingent upon good behavior than in traditional agencies. In fact, POs' non-bureaucratic reactions to potential violation incidents (e.g. a dirty urinalysis) were sometimes cited as acts of understanding and caring. Third, more than traditional POs, specialty POs were concerned about establishing appropriate ''boundaries'' with probationers to make clear the distinction between their supportive working relationship and a personal friendship. They also seemed to struggle with dual role conflicts, as explained by one PO:

> So it's hard because you have to be the case manager and be helping them and like nurturing them and doing all this. And then all of a sudden, you know, you realize that, okay now I've got to switch roles here and I've got to be stern—and it's kind of tough because you've got to do that reversal (Phoenix/Debra).

As shown below, the quality of the PO–probationer relationship contextualized the strategies that POs use to monitor and enforce treatment adherence, as well as the effect of these strategies on probationers' adherence and outcomes.

Strategic Influences on Mandate Implementation

Contextual factors and relationship factors were perceived as key sources of influence on the implementation of treatment mandates. Strategic factors, or the actual strategies used to apply treatment mandates, were perceived as the third and final key source of influence. This section describes differences between specialty and traditional POs in their range of available strategies, followed by a discussion of the breadth of strategies that POs and probationers described for monitoring and enforcing compliance.

Compliance Toolkits

According to cultural anthropologists and sociologists, a ''toolkit'' describes a set of perceptions, appreciations, and actions that are available to members of particular groups or societies. Individuals draw from these toolkits to help construct social reality, negotiate relationships with others, and, in professional settings, make decisions about how work is to be accomplished (Bourdieu, 1977; Silverman, 1985; Swidler, 1985). Human resource departments and professional service organizations have adopted the concept of toolkits, which they make available in the form of orientation packages and professional literature, to provide employees or members with ideas, models, and options for conducting work and practice.

In this study, POs seemed to have toolkits available to them to assist them in more efficiently and/or effectively perform their jobs. Because a large part of POs' responsibility was to gain compliance from probationers, these kits included tools for monitoring and enforcing treatment compliance. However, the range of tools available in POs' ''compliance toolkits'' (CTs) varied across departments. Specifically, specialty POs seemed to have many tools available from past experiences with mental health, substance abuse, and other social service programs; collaborative (and adversarial) involvement with mental health providers; camaraderie with specialty colleagues; and familiarity with formal and informal departmental strategies for addressing noncompliance. Traditional POs seemed to have fewer tools available in their CTs, most of which were designed to address noncompliance with the ''routine,'' non-mentally ill case. Thus, relative to specialty POs, traditional POs depended more on a small number of tools such as threats of incarceration to enforce treatment compliance.

Traditional POs seemed aware of the limitations of their CTs. They complained that their lack of ''special training to deal with people with mental difficulties'' (Las Vegas/Jason) compromised their ability to monitor and enforce treatment mandates. As one officer noted, ''I came Maricopa County and they have specialized caseload mental health and they have a lot more resources, a lot more programs and they're very much more proactive. And I can see a big difference between them and us—we're still in the Stone Age when it comes to the mental health'' (Las Vegas/Sam).

While traditional POs decried their limited understanding of psychotropic medication, treatment programs, and social service systems, specialty POs were more familiar and involved with these issues. This was apparent in the nature of specialty POs' language, which was peppered with mental health jargon (e.g. "partial hospitalization," "NAMI," "PDR") and labels for specific compliance tools, such as "staffings," "compliance facilitation," and "innovation" or "re-engagement" strategies. In fact, specialty POs sometimes were perceived by mental health providers as overinvolved intruders (When we "tell them that this [type of treatment] is what we're suggesting, we're almost like an intruder who's sticking our nose into their business," Phoenix PO).

Treatment Monitoring Tools

The tools included in specialty officers' CTs for monitoring probationers' compliance with treatment mandates were broader in range than those in traditional officers CTs. Notably, these groups of POs also seemed to define treatment adherence differently in a manner that influenced the behaviors they monitored. Most traditional officers defined treatment adherence as taking prescribed medication and, to some degree, attending scheduled treatment appointments. As noted by one traditional probationer, "[what my PO] wants me to do the most, more than anything, is to take pills—that's what it seems to me. More than community services, they want pills, pills, pills" (Las Vegas/Jerry). Some traditional POs perceived medication as an essential ingredient for guaranteeing probationers' stability and safety in the community ("they seem normal as long as they stay on the medications. But once they go off, they go off the deep end," Las Vegas/Ernie). In contrast, specialty POs defined treatment adherence not only as taking medication and attending appointments, but also as actively engaging in the treatment process, i.e., participating in group therapy, working hard on treatment goals, completing treatment programs. As one officer noted, "if they're just going to sit there [in therapy], that's noncompliance" (Phoenix/Jill). These POs seemed to perceive participation in therapy as important to the overarching goal of rehabilitation.

Given these different definitions of adherence, specialty POs generally monitored treatment adherence more frequently, more proactively, and based on more sources of information than did traditional POs. First, specialty POs described monitoring treatment adherence more often and more consistently than traditional POs. Several specialty POs described obtaining information about probationers' treatment adherence via at least monthly "face to face" contacts with probationers in the office and at home, and at least monthly contacts with a collateral informant (e.g. treatment provider, family members). Most traditional POs seemed to rely more exclusively on probationers' at least monthly office contacts to obtain such information, and made only "occasional" attempts to contact collateral informants. Nevertheless, both groups of officers indicated that they increased the frequency of monitoring with probationers who they believed were noncompliant and/or at risk for reoffense, typically by requiring probationers to report to their office more often than monthly.

Second, specialty POs also described monitoring treatment adherence more proactively and based on more sources of information than traditional POs.

Although both PO groups described significant barriers to obtaining needed information about treatment adherence from mental health providers, specialty POs typically persistently and doggedly attacked the problem, whereas traditional POs capitulated to it. According to one PO, "with mental health, it's like pulling teeth trying to get good information" (Las Vegas/Sam). The primary barriers were providers' (i) requirement that probationers provide written permission for them to release confidential information to POs, (ii) general mistrust of POs' intentions, and (iii) reluctance to inform POs about noncompliance until the problem was "out of control." POs made similar complaints about family members, who "sometimes call too late. They don't want to let you know because they don't want something bad to happen" to the probationer (Philadelphia/Ed). Specialty officers tended to attack such barriers directly by obtaining the appropriate releases of information from probationers, contacting providers on a regular basis by telephone, and sometimes sending forms ("ticklers") to providers to obtain progress reports repeatedly, until they obtained a response. Most notably, several of these POs described attending regular treatment team meetings with providers:

> We actually attend treatment meetings every week—we meet with the therapist and the [case managers] and the probation officer . . . And so we're there every week, you know, meeting with our clients and the whole treatment team, so they know us so well (Philadelphia/Stacy).

When a PO becomes part of the treatment team, "confidentiality ceases to exist" (Philadelphia/Ed). More generally, specialty POs typically attempted to establish collaborative relationships with providers (or at least select staff at agencies) to increase the ease of communication.

In addition to obtaining collateral information from treatment providers, specialty POs also described monitoring probationers' treatment adherence by asking probationers about their adherence, monitoring probationers' behavior and demeanor for changes in emotional stability or symptoms of psychosis, talking with family members, counting pills during home or office visits ("people that don't take their meds correctly don't even think to throw pills away," Philadelphia/Ed), and, occasionally, asking providers to draw blood to check medication levels. Their approach was very proactive and oriented toward carefully tracking and "verifying everything."

In contrast, traditional POs typically relied more exclusively on probationers to monitor treatment adherence. During their office contacts, these POs asked probationers about their compliance, obtained probationers' documentation that they had scheduled treatment appointments or filled prescriptions for psychotropic medication, and checked probationers' demeanor for any significant changes. Occasionally, POs would consult with family members during a home visit. As described by one PO, "Ninety per cent of what we know is self-reported . . . I ask them, 'Are you taking your meds? Are you still in counseling?' And I don't verify it every single month—maybe quarterly" (Sam). Typically, information about treatment adherence flowed to POs from outside sources (e.g. probationers, family, providers). In fact, most POs denied that they had ever tried to obtain updates or progress reports from providers ("Never," Beth; "No way," Jason).

The broader range of tools available to specialty POs seemed to permit them to more efficiently and effectively monitor SMI probationers' compliance with treatment than traditional POs. By using these tools on a regular basis, specialty POs

seemed (i) to obtain more accurate and complete information about probationers' medication adherence, treatment attendance, and treatment participation, and, perhaps more importantly, (ii) to identify any noncompliance quickly. Probationers readily acknowledged that they were not always truthful with their POs about their treatment compliance (e.g. "Even if you didn't go, you're not going to tell them, 'No, I didn't go'... I could see the rope around my neck right now!" Las Vegas/Rickie). However, specialty probationers appeared aware that their POs would quickly discover the truth:

> There's no way to get around it. If I don't go to my appointment at [mental health], if I don't go to my appointment with my PO, I mean it's back-to-back. They're calling each other so quick it's unreal—I mean, there's no way to get around it (Phoenix/George).

Given their reliance on probationers' self-report and their use of other tools on only an *ad hoc* basis, traditional POs often detected noncompliance "too late," after the probationers' mental state had deteriorated or one or more negative events (e.g. probationer "disappearance;" a family fight) had occurred. As explained below, earlier identification of treatment noncompliance appears associated with a broader range of available strategies for encouraging compliance and enforcing treatment mandates.

Treatment Enforcement Tools

Relative to traditional officers' CTs, specialty POs' CTs included a much broader range of tools for encouraging and enforcing adherence to treatment. Specialty POs' assortment of tools provided them with a choice of strategies to apply in particular situations: "It's like your little bag of tricks, you know, you have to resort to" (Phoenix PO). These tools included prevention strategies, problem-solving strategies, and pressures (positive and negative). First, at their initial meeting, specialty POs often discussed the treatment mandate with probationers, partially in an attempt to identify and remove any potential obstacles (e.g. transportation, scheduling conflicts) to compliance. As noted by one PO, "you're going to find something that needs to be addressed right then and there—and you make that initial phone call" (Phoenix/Jill). POs also strove to prevent noncompliance by "working with the individual" to create a reasonable treatment plan ("you don't want to set them up for failure by adding too much," Philadelphia/Deonne).

Despite these prevention efforts, specialty officers sometimes encountered noncompliance with treatment. In these situations, POs often met with probationers to apply an individualized, problem-solving approach that some called "compliance facilitation" (Phoenix) or "innovation strategies" (Philadelphia). This approach involved discussing noncompliance with probationers in an attempt to identify its causes (e.g. adverse medication effects; problems with a treatment program or staff member; transportation or scheduling problems). As explained by one PO, the goal is to "get out of the way anything you can, the obstacles that the probationer is putting in his way as to why he couldn't get there. You remove those obstacles for him and say, 'This is how you will get there'" (Phoenix/Kathy). Sometimes, the approach also involved teaching probationers such "adult skills" as rescheduling appointments and trying "to deal with the problem, rather than just blowing things off" (Phoenix/Jill). As summarized by one probationer, "they want to know why

you're not going . . . I mean, 'Was there a problem? Transportation? Can we help you?' . . . They want to know why—because [treatment is] important for you and it's important for them'' (Phoenix/George).

In addition to such problem-solving approaches, POs also applied a range of pressures (positive, mixed, and negative) to encourage and enforce treatment compliance. Positive pressures included *inducements* and *persuasion* (see Lidz et al., 1995). Specifically, POs sometimes offered less intensive supervision (e.g. less frequent reporting) or early release to probationers as an inducement for adhering to treatment. Some POs also attempted to persuade probationers that adhering to treatment was in their best interest: ''I encourage them. I sit down and talk to them about why treatment was required, you know. 'You're hearing voices—do you understand?''' (Philadelphia/Deb). One officer explained '' . . . you tell them, you know, 'When you don't show up for an appointment, when you do drugs, when you do this that or don't go to group, you're not taking good care of yourself.' And, you know, a lot of times they haven't heard that before. They think, 'Gosh, I'm worth taking care of.' It's a refreshing little thought that they never mulled over'' (Phoenix/Lucinda).

POs also applied two ''mixed'' pressures that included features that were both appealing and unappealing to probationers: reminders and staffings. First, POs frequently used *reminders* of the treatment mandate, both during regular contacts with probationers, and when there were incidents of noncompliance. For example, at the end of each monthly contact with their PO, specialty probationers described reading and signing a ''written directive,'' or document that reviewed the conditions of probation, including the command to adhere to treatment. Similarly, after an act of noncompliance, one officer said, ''I immediately take over the rules and regulations and review . . . what they are here for . . . and that seems to work with them because that's like a wake up call . . . just recommit to the rules and regulations'' (Philadelphia/Paula). Second, POs often attempted to increase compliance by calling *staffings* in which the PO, probationer, and treatment provider met to discuss the treatment plan, modify the plan when necessary to increase compliance, and agree upon certain limits and consequences for future noncompliance with the revised plan. These staffings were designed to uncover and address the reasons for probationers' noncompliance with treatment and to ''get everyone on the same page'' about the treatment and supervision strategy.

POs also used negative pressures that were relatively unappealing to probationers, including small penalties and threats. Specialty POs seemed to use increasingly negative, but relatively *small penalties* when they detected a pattern of treatment noncompliance. In these situations, POs typically increased the intensity of supervision by more frequently requiring probationers to report to their offices (e.g. twice weekly), verifying compliance by contacting providers or even initiating medication monitoring, or conducting home visits. In addition, specialty POs occasionally worked with treatment providers to take small privileges (e.g. a day pass to leave an inpatient ward) away from probationers for refusing or missing treatment. POs also used a range of graduated *threats* or ''ultimatums'' (Las Vegas/George) in an effort to increase probationers' compliance. One PO described making a small threat: '''You're not going to get the travel permit to go wherever it is you want to go if you don't make it in here and go to your appointments and take your medications, cause we won't be able to trust that you are going to take care of yourself over there'''

(Phoenix/Kylie). A moderate threat might be to force a probationer to move out of her own apartment back to a residential care facility if she continued to refuse treatment. The ultimate threat, of course, was that of incarceration: ''I always tell them, 'I don't want to put you in jail.' . . . 'I don't want to see you there.' And they usually come around'' (Philadelphia/Deb).

Notably, most specialty POs described threatening probationers with incarceration in a manner that seemed designed to preserve their care-oriented relationship with probationers. For example, several POs described enacting a ''good cop/bad cop'' routine with their supervisors where they told probationers that their supervisors periodically reviewed their cases and would demand an explanation if the probationer had been noncompliant with treatment and the PO had not arrested him or her. As one PO noted, ''And then they get nervous because they don't want you to get in trouble'' (Phoenix/Mary). Some specialty POs reframed threats of incarceration as non-personal, matter-of-fact reminders to probationers that *they* ultimately were responsible for abiding by the conditions of their probation. If the probationer chose to continue violating the mandate to participate in treatment, he or she eventually would return to jail. A representative threat was provided by one PO: '' . . . 'You're not compliant with your medication; you're not attending program; your behavior is out of control. You're putting me in a situation where I need to either lock you up or you need to sign into treatment'' (Philadelphia/Tracy). Specialty probationers seemed aware of their POs' power to incarcerate them, but believed that their POs didn't ''*really want*'' to do so: ''it's very rare that . . . if you miss a couple appointments, that they're going to roll out there and pick you up and you're going to go to jail'' (Phoenix probationer). In fact, specialty POs described revoking probation only when the probationer was a threat to public safety or it was an intractable case of ''flat out noncompliance.''

In contrast, most traditional probationers believed, ''violate your probation and they take you to jail . . . I know that's what's going to happen.'' This may be in part because most traditional POs seemed to rely chiefly upon one tool for increasing treatment adherence: threats of incarceration.

> Bark at him . . . You just bring him in there and . . . you chew him up one side and down the other. A lot of these people want to be compliant. They're not necessarily, you know, the biggest bad asses in the world, so you sit them in the office and you tell them—You basically lie to them, ''You're looking at prison. If I have to get you before the judge; if he finds out that you've been missing your counseling''—Of course that's not true but . . . (Las Vegas/Greg).

> You bluff . . . (Las Vegas/Jason).

> You bluff. [all talking at once] . . . Yeah, but when your bluff is called, you have nothing left (Las Vegas/Greg).

Apparently, judges typically were reluctant to incarcerate SMI probationers for treatment noncompliance. Thus, POs perceived their primary tool as largely ineffective. In fact, POs believed that, even when they had diligently worked to build a case for revocation based on factors beyond treatment noncompliance (e.g. substance use; failure to report), few judges would incarcerate SMI probationers. This made the ''big bluff'' a risky venture. In short, traditional POs longed for, but

did not have a ''big stick'' in their toolkits. Probationers seemed unaware of this shortcoming, and convinced that if they missed an appointment, their PO would arrive on their doorstep to take them downtown. As one probationer summarized, ''basically the bottom line'' is, '''We got a gun to your head. You're either going to do what we say or you're going to prison,'' (Irving).

Notably, a few traditional POs described using two other pressures to increase treatment adherence: the inducement of ''getting off probation a bit early'' for compliance, and the small penalty of increased monitoring (''Report every other day; report weekly,'' Las Vegas/David) for noncompliance. Nevertheless, most probationers believed that traditional POs provided little in the way of ''encouragement'' to participate in treatment: ''The only way I've ever seen probation ever encourage me was to threaten to take away some privilege, put me on tighter security, charge me a fine, search my house more often—that's pretty much the extent of the encouragement I've gotten'' (Las Vegas/Michael).

Most traditional POs seemed to believe that the few tools in their compliance toolkit were insufficient: their hands were tied and ''nothing worked.'' Thus, rather than attempt to increase treatment adherence, they sometimes focused on transferring problem SMI cases off their caseload or incapacitating these probationers until their sentence expired. Strategies included instituting house arrest, obtaining periodic 30 day jail stays until the minimum sentence was reached, and having the probationer committed to the state hospital as incompetent to stand trial on probation violation charges.

Notably, traditional and specialty POs differed not only with respect to the *range* of tools that they used to increase treatment adherence, but also in *when* and how they applied these tools. Perhaps because their monitoring tools allowed them to detect treatment noncompliance earlier, specialty POs tended to use certain enforcement tools ''from the first indication that something [was] going wrong—you need to get a handle on it right away or else it... goes from bad to worse pretty quickly, usually'' (Philadelphia/Deonne). In contrast, traditional POs applied enforcement tools when they saw ''signs of instability'' during contacts with probationers or received reports of bizarre behavior, fights, or encounters with law enforcement. Given such signs of prolonged noncompliance (whatever its basis), most traditional POs applied their limited range of tools for increasing compliance in a relatively uniform, straightforward fashion (e.g. threatening incarceration or attempting to remove the probationer from one's caseload or the community). However, specialty POs seemed to use a graduated approach of problem-solving strategies and increasing pressures for addressing noncompliance, perhaps beginning with a reminder and ''recommitment,'' and then proceeding to a staffing, increased monitoring, and, if necessary, small punishments and threats. Their use of this graduated approach often seemed to forestall the use of negative pressures including threats.

Perceived Effect of Contextual, Relationship, and Strategic Influences on Adherence and Outcomes

The contextual, relationship, and strategic influences identified in this study seemed to have important effects on probationers. As explained previously, macro-level contextual factors including the accessibility of mental health treatment resources,

the probation agency's "typification" of the routine case, and the probation agency's supervision emphasis (control, care, or advocacy) strongly influenced the manner in which POs handled SMI probationers and implemented their treatment mandates. However, POs and probationers alike perceived the more proximal nature of the PO–probationer relationship and the strategies that POs applied within that relationship to encourage, monitor, and enforce treatment participation as central influences on probationers' treatment adherence and outcome.

Although a minority of POs believed that obtaining treatment adherence by whatever means would improve probationers' outcomes, most believed that forcing an unmotivated person into treatment would produce few lasting benefits ("If you don't want treatment, it's not going to do you any good . . . you might go everyday and show up and just sit there but not . . . take anything in," Phoenix/Lisa). Therefore, they believed, the goal was to work with and "motivate" probationers to obtain treatment. As noted by one PO, "I'd rather have them go to a counseling session . . . saying, 'Yeah, I want to do it myself,' rather than, 'My PO just told me to go here or I'm going to jail'" (Las Vegas/David). This sentiment is consistent with most probationers' beliefs that participating in treatment and "working on" themselves ultimately were their choice, regardless of the treatment mandate. It also is consistent with past findings that parolees' perceived need for treatment is only modestly related to their perceived coercion (Farabee, Shen, & Sanchez, 2002), and that alcoholic outpatients with little intrinsic motivation to attend treatment respond poorly to treatment, regardless of their level of extrinsic motivation (Ryan, Plant, & O'Malley, 1995).

Use the Right Tools in an Appropriate Manner

Both POs and probationers seemed to believe that the best means of achieving treatment adherence *and* positive outcome were to establish a "relational" or collaborative working relationship with probationers, and use problem-solving approaches and pressures "in the right way" to address any noncompliance. The "right way" for using pressures was described as fair, respectful, frank, and motivated by caring. Notably, these are aspects of "procedural justice," which have been found to temper psychiatric patients' perceptions of coercion during the hospital admission process (Lidz et al., 1995). Specialty participants, in particular, discussed the importance of listening to and having a "fair conversation" with probationers about noncompliance, being reasonable in accommodating any legitimate problems with treatment adherence, and being honest and truthful about potential consequences. The importance of such interchanges was described by one probationer:

> For me, we all need encouragement sometimes to do the right thing—and it's okay with me as long as it's done in the right way . . . I speak English and Spanish, so you can *talk* to me first of all—you don't have to grab me, or come get me, or send, you know, the paddy wagon. You can call me up on the phone—I have one. I can talk to you in your office if you think that I'm going in a direction that you feel is going to be harmful to me . . . (Phoenix/Colin).

Notably, specialty POs applied a variety of problem-solving approaches (e.g., mediation, compliance facilitation, innovation strategies, re-engagement) that

directly incorporated such principles of procedural justice as providing probationers with ''voice'' or an opportunity to say what they wanted about their noncompliance. For example, when a probationer was noncompliant, they might ''have a treatment team with him and ask him what's going on—what the problem is; what he sees as a solution, where we expect him to be and how we can get there together'' (Philadelphia/Stacy).

Participants seemed to believe that such problem-solving strategies and pressures were most effective when applied in the context of a care-oriented working relationship. As one probationer noted, ''you realize . . . they're basically there helping you. You know if you don't take your medicine . . . things happen'' (Phoenix/George). POs believed that such relationships could be established based on ''kind words,'' ''praise'' and ''congratulations'' for accomplishments, ''humor,'' and ''relating'' to the probationer as a person (e.g. finding out ''what motivates them'' and ''using that to help them,'' Phoenix/Mary). Specialty POs noted that they sometimes were the ''most stable person'' in the probationers' life and marveled that many probationers had ''found some kind of bond'' and just wanted ''to please you as an individual.'' They spoke about probationers who called them to ask them to solve problems that had ''nothing to do with probation,'' or to check in with them long after completing probation. Specialty and traditional probationers alike reported that ''relational'' relationships with their POs (i) encouraged them to trust their POs and to be more open with them about their needs and problems, (ii) made them more willing to comply with their POs' requests, and (iii) gave them confidence in their own abilities. It was important, they believed, to know that their PO was ''working with'' them toward their shared goal of success.

In contrast, probationers and several POs believed that authoritarian relationships characterized by many demands, little flexibility, and negative or belittling interactions were considerable stressors for probationers that made probationers feel anxious and apprehensive, ''shut down'' their communication with POs, function more poorly, and, occasionally, resist POs' requests. These participants believed that threats of incarceration were particularly harmful in such relationships. Such threats might exacerbate anxiety and lead to withdrawal, as observed by one PO:

> Because what happens is you create more anxiety when you're threatening to send them to jail. They don't want to go to jail—they're not stupid—they're a little bit crazy. And then they'll stop coming in because they're afraid—''I talked to a policeman last week and my probation officer knows about it, and he'll probably be mad at me, so he'll probably arrest me'' (Las Vegas/David).

These threats might instead cause anger and noncompliance, as observed by one probationer: ''[When they] personally threaten you— . . . when you have a sickness, it's like, well, you have that ''F''—you attitude. And the more they threaten you, the less a person will do'' (Phoenix/Eli). More generally, the ongoing stress of a negative relationship with a PO who noisily jangles the keys to one's freedom might compromise an SMI probationers' mental state and functioning. As explained by one probationer,

> My mental condition is something of a severe emotional turbulence . . . and anything that causes me an additional bit of unease or anything, you know, additionally bad in my life, contributes to the strain of a situation that is already teetering on the brink of

> suicide. So I do have to say that . . . it seems like it would make sense for my probation officer, you know . . . maybe even have his supervisor put pressure on him to be very decent in his treatment of me, saying, you know, "As unstable as Eric is, do what you can to see to it that you're not a contributing factor if he teeters over the edge" (Las Vegas/Eric).

Address a Contextual "Wish List"

POs and probationers had opinions about "what works" not only with respect to PO–probationer relationships and CTs, but also for the mental health and probation systems. First, these participants clearly wished for a more accessible, less authoritarian mental health system with a greater range of treatment options. Traditional and specialty POs alike wished for more collaborative, less adversarial relationships with mental health providers. Notably, when POs worked as part of probationers' treatment teams, some of the philosophical and practical barriers between the correctional and mental health systems were reduced. Second, specialty and traditional POs alike wished for smaller caseload sizes. The caseload size of POs in some specialty agencies (e.g. 65–70) was nearly as large as that of POs in our traditional agency (e.g. 75–80). POs in these departments complained that their increasing caseload size made it difficult to provide their specialized services to probationers. Third, POs and probationers alike seemed to lack clarity on whether or not POs had the legal authority to force probationers to attend treatment and take medication. This issue was spontaneously discussed in three groups, and opinions were divided. POs in traditional departments particularly wished for more judicial support in revoking probation for probationers' noncompliance with treatment mandates.

CONCLUSION AND IMPLICATIONS

In summary, the results of this study suggest that (i) there are considerable differences between specialty and traditional POs in the nature, range, and timing of strategies available to monitor and enforce treatment compliance, (ii) the nature of the PO–probationer relationship (respectful versus authoritarian) contextualizes POs' use of these strategies and strongly influences probationer adherence and outcome, and (iii) there are distinct programmatic differences between specialty and traditional agencies in their supervision philosophies (care versus control) and routine services (casework versus supervision) that influence the way in which SMI probationers are processed.

These generalizations are limited by the fact that this first phase of study was exploratory. These focus groups were designed to understand the range of influences that POs and probationers viewed as crucial to the process and outcome of mandated treatment. The results cannot be generalized to the population, in part because in some cases, only one focus group "represented" a population of probationers or POs in a particular type of agency. In fact, this study was designed to prepare conceptually and methodologically for a quantitative outcome study of probation. Although the data gathered in this study offer detailed descriptions of the experiences of probationers mandated to mental health treatment and their

supervising POs, additional phases of study are required to permit inference and prediction.

Research Implications

This study has two specific implications for research. Given our finding of key differences both between and within specialty and traditional probation agencies, it would be useful to conduct a national survey to characterize the prevalence, nature, and variability of specialty probation agencies. Isolating particular types of specialty agency (based on such variables as typical caseload size, officer training, and collaboration with ''in-house'' or outside caseworkers) would permit future comparisons of these agencies' relative effectiveness and could inform program development and refinement.

Second, the present study was designed to conceptually and methodologically prepare for an ecologically valid outcome study. In fact, a working group is in the process of translating the results into specific measures of probation implementation, and plans to validate a measure of PO–probationer relationship quality, given its perceived centrality to adherence and outcome. Use of well validated measures in a prospective study would more definitively indicate the effect of particular strategic, relationship, and contextual variables on SMI probationers' treatment adherence and clinical and criminal outcomes. This type of research could help to isolate some ''necessary ingredients'' for effectively supervising probationers with SMI who are mandated to treatment.

Practice Implications

Until such outcome research is completed, we provide preliminary ''directions'' for practice that may be enhanced and refined by future work. First, probation supervisors and department administrators may consider systematically providing POs with tools and resources that seem effective in gaining treatment compliance and desired outcomes among probationers with SMI. For example, training and other resources could be provided to upgrade POs' compliance toolkits to include a broader range of tools for monitoring and encouraging treatment compliance (i.e. prevention strategies; problem-solving strategies; positive, mixed, and negative pressures). This might provide POs with multiple options for quickly and effectively identifying and addressing noncompliance. Probation administrators, supervisors, and even individual officers may also strive to develop more relational and less authoritarian interactions between POs and probationers. In doing so, they may wish to increase awareness of the usefulness and drawbacks of using ''typifications'' of probationers to serve the efficient operation of probation work.

Second, probation supervisors and administrators may take into consideration the effect of caseload size on the ability of POs to meet the demands of monitoring and gaining treatment compliance from probationers with SMI. Probationers and POs alike seem to recognize that the SMI population has relatively intensive needs that require a reduced caseload. Third, probation system personnel may work with personnel in the mental health and related social service systems to develop more

collaborative, less adversarial relationships with one another to assure greater compliance and more positive treatment outcomes of probationers. As noted in the report of the *Consensus Project*, ''the greatest challenge to initiating successful cross-system collaboration is simply getting prospective partners to the table'' (Council of State Governments, 2002, p. 17).

In short, the results of the present study suggest that involved personnel should consider taking action to improve probation–mental health collaborations, reduce probation caseloads, increase the relational qualities of PO–probationer interactions, and provide POs with a broader range of tools for monitoring and gaining treatment compliance. However, these suggestions are offered provisionally until they can be tested and refined through a systematic follow-up study of SMI probationers who are mandated to mental health treatment. This study will allow us to determine whether such suggestions are successful and how they can be improved.

REFERENCES

Andrews, D., Zinger, I., Hoge, R., Bonta, J., Gendreau, P., & Cullen, F. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology, 28*, 369–472.

Bourdieu, P. 1977. *Outline of a theory of practice.* Cambridge: Cambridge University Press.

Brown, R., Leonard, T., Saunders, L., & Papasouliotis, O. (2001). A two-item conjoint screen for alcohol and other drug problems. *Journal of the American Board of Family Practice, 14*, 95–106.

Cicourel, A. (1968). *The Social Organization of Juvenile Justice*. New York: Wiley.

Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project.* Retrieved August 15, 2002, from http://www.consensusproject.org

Dauphinot, L. (1997). The efficacy of community correctional supervision for offenders with severe mental illness (abstract). *Dissertation Abstracts International, 57*, 5912.

Ditton, P. (1999). *Mental health and treatment: Inmates and probationers.* Washington, DC: Bureau of Justice Statistics.

Draine, J., & Solomon, P. (2001). The use of threats of incarceration in a psychiatric probation and parole service. *American Journal of Orthopsychiatry, 71*, 262–267.

Farabee, D., Shen, H., & Sanchez, S. (2002). Perceived coercion and treatment need among mentally ill parolees. *Criminal Justice and Behavior, 29*, 76–86.

Harper, R., & Hardy, S. (2000). An evaluation of Motivational Interviewing as a method of intervention with clients in a probation setting. *British Journal of Social Work, 30*, 393–400.

Klaus, J. (1998). *Handbook on probation services: Guidelines for probation practitioners and managers.* Rome: United Nations Interregional Crime and Justice Research Institute.

Krueger, R. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Newbury Park, CA: Sage.

Lidz, C., Hoge, S., Gardner, W., Bennett, N., Monahan, J., Mulvey, E., & Roth, L. (1995). Perceived coercion in mental hospital admission: Pressures and process. *Archives of General Psychiatry, 52*, 1034–1039.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook.* Thousand Oaks, CA: Sage.

Miller, W., & Mount, K. (2001). A small study of training in Motivational Interviewing: Does one workshop change clinican and client behavior? *Behavioural and Cognitive Psychotherapy, 29*, 457–471.

Miller, W., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford.

Monahan, J., Bonnie, R., Appelbaum, P., Hyde, P., Steadman, H., & Swartz, M. (2001). Mandated community treatment: Beyond outpatient commitment. *Psychiatric Services, 52*, 1198–1205.

Morgan, D. (1988). *Focus groups as qualitative research.* Newbury Park, CA: Sage.

Orlando-Morningstar, D., Skoler, G., & Holliday. (1999). *Handbook for Working with Mentally Disordered Defendants and Offenders.* Washington, DC: Federal Judicial Center.

Richards, L. (2000). *N5.* [computer software]. Victoria, Australia: QSR International.

Roberts, C., Hudson, B., & Cullen, R. (1995). The supervision of mentally disordered offenders: The work of probation officers and their relationship with psychiatrists in England and Wales. *Criminal Behaviour and Mental Health, 5*, 75–84.

Roskes, E., & Feldman, R. (1999). A collaborative community-based treatment program for offenders with mental illness. *Psychiatric Services, 50*, 1614–1619.
Roskes, E., Feldman, R., Arrington, S., & Leisher, M. (1999). A model program for the treatment of mentally ill offenders in the community. *Community Mental Health Journal, 35*, 461–472.
Ryan, R., Plant., R., & O'Malley, S. (1995). Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement, and dropout. *Addictive Behaviors, 20*, 279–297.
Silberberg, J., Vital, T, & Brakel, S. (2001). Breaking down barriers to mandated outpatient treatment for mentally ill offenders. *Psychiatric Annals, 31*, 443–440.
Silverman, D. 1985. *Qualitative Methodology* and *Sociology.* Aldershot: Gower.
Sudnow, D. (1965). Normal crimes: Sociological features of the penal code in a public defender office, *Social Problems, 12*, 255–276.
Swidler, A. 1985. *Culture in action: Symbols and strategies.* Paper presented at the Annual Meeting of the American Sociological Association.
Taylor, S., & Dear, M. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin, 7*, 225–240.
Tyrell, C. (1998). What are the strengths and weaknesses of the focus group interview? Retrieved 30 March 2003, from http://www.spinworks.demon.co.uk/pub/focus1.htm
U.S. Probation and Pretrial Services. (2000, 2001). *Court and community.* ["fact sheets" on probation]. Washington, DC: Federal Judicial Center.
Unknown. (1993). Chapter 11: Mental health supervision. *Guide to Judiciary Policies and Procedures, Volume X.* Washington, DC: Federal Judicial Center.
Wormith, J., & McKeague, F. (1996). A mental health survey of community correctional clients in Canada. *Criminal Behaviour and Mental Health, 6*, 49–72.

