

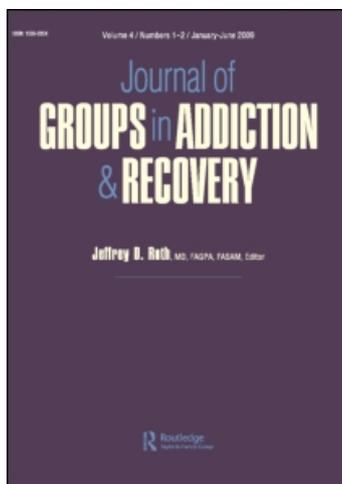
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### Citizenship, Community, and Recovery: A Group- and Peer-Based Intervention for Persons With Co-Occurring Disorders and Criminal Justice Histories

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## **Citizenship, Community, and Recovery: A Group- and Peer-Based Intervention for Persons With Co-Occurring Disorders and Criminal Justice Histories**

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*Group interventions for persons with co-occurring disorders of serious mental illness (SMI) and alcohol or other substance use disorders may positively affect participants' substance use, criminal justice contacts, and transition to community supports and community living. We report on a group intervention with wraparound peer support that, in earlier research, has shown promise regarding*

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*these domains. We provide a detailed description and discussion of the intervention, including case vignettes. We also discuss future research on this intervention and offer recommendations for additional research in this area and with this target population.*

**KEYWORDS** *group interventions, criminal incarceration, mental illness, substance abuse, citizenship, peer mentors*

## INTRODUCTION: CRIMINALITY, BEHAVIORAL HEALTH DISORDERS, AND GROUP INTERVENTIONS

The President's New Freedom Commission on Mental Health (2004) cited estimates of as many as 16% of the 1,175,000 federal and state prison inmates in the United States having a documented mental illness. In addition, estimates of prisoner release rates are at 600,000 per year, with many people returning to the community with alcohol or other drug use and mental health treatment needs (National GAINS Center, n.d.). Over the past decade, some programs—dual recovery therapy, 12-step integration, “staged” or “readiness” approaches, and others—have been shown to be effective in addressing many of the needs of persons with co-occurring disorders (Drake, Mueser, Brunette, & McHugo, 2004; Mueser, Torrey, Lynde, Singer, & Drake., 2003), yet these programs do not appear to reduce contacts with the criminal justice system (Calsyn, Yonker, Lemming, Morse, & Klinkenberg, 2005; Essock et al., 2004). Jail diversion programs are successful in “diverting” clients to the mental health system at the time of arrest or arraignment (Steadman, Morris, & Dennis., 1995), but show mixed results in terms of criminal recidivism and substance use over time (Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe., 2003; Draine and Solomon, 1999; Frisman, Lin, Sturges, Levinson, Baranoski, & Pollard, 2006).

Groups are a primary method of treatment used in many drug treatment and drug court programs and in psychosocial rehabilitation programs for persons with mental illness (Bellamy et al., 2006; Caspi, Fournier, and McCarty, 2003; Panas, Yael, Fournier, & McCarty, 2001; Taxman and Bouffard, 2003). Advocates for the use of group treatment note their effectiveness, regarding social coping and skills development in the following: (a) reducing members' sense of isolation when they discover that others are struggling with similar problems, and instilling hope for recovery; (b) providing an opportunity for members to learn how to cope with addictions, mental illness, and other problems by observing how others cope with their problems; (c) helping members develop enhanced self-concepts based on feedback from other members regarding their worth and abilities; (d) providing reparative family experiences as group members offer each other support and nurturance that may be lacking in their own families, and encouraging members

to work on improving family relationships; (e) providing emotional support to members when they undertake difficult tasks outside the group; and (f) helping members to acquire social skills through coaching and trying out new approaches in a safe and supportive environment (Flores, 1997; Fram, 1990; Garvin, 1992, 1997; Kurtz, 1997; Vannicelli, 1992). Group clinical interventions generally involve time-limited programming, however.

Regarding recovery from addiction, nonclinical alternatives include Alcoholics Anonymous (AA), and other self-help groups (Kurtz, 1997). AA has been recognized for contributing to achievement of abstinence (Connors, Tonigan, & Miller., 2001; Humphreys, 1999; Humphreys, Moos, & Cohen., 1997; Kaskutas, Bond, & Humphreys, 2002; McKellar et al., 2003; Moos and Moos, 2005, 2006). Many persons with mental illness report being uncomfortable participating in AA groups, however, in part because their psychiatric symptoms or reduced social skills can limit their ability to interact in large groups, or because many of these groups still stake strong antimedication stances (including psychiatric medications), or both (Polcin and Zemore, 2004). Twelve step groups for persons with co-occurring disorders have been developed (Laudet, Magura, Vogel, & Knight., 2000; Magura et al., 2003), but most communities do not have Double Trouble in Recovery (DTR) or other such specialized groups. Since addiction resources such as 12-step and other self-help groups are widely available within the community, many believe that programs need to be designed to prepare individuals with serious mental illness to transition into these programs (Hatfield, 1993; Herman, Frank, Mowbray, Ribisl, & Davidson, 2000; Kurtz, 1997; Moos and Moos, 2005).

In a previous study, we tested a novel group-based intervention (in addition to standard services) that is based on a theory of citizenship, and found it to be significantly more effective in reducing alcohol use in persons with criminal justice histories and co-occurring serious mental illness and substance use disorders, when compared to standard treatment alone (Rowe et al., 2007). In this article we give a detailed description of the theory of citizenship that formed the basis for the above-mention intervention. While this article, and our research to date, does not fully link the elements of this theory to elements of the intervention, we view this as an important next-stage goal, which we will discuss in the "Future Steps and Model Development" section following discussion of citizenship theory, a detailed description of the group-based intervention (the Citizens Intervention), and case vignettes on intervention participants.

## CITIZENSHIP THEORY

Starting more than a decade ago with research on outreach to homeless persons with behavioral health disorders, we identified a gap between the capacities of even the most community-oriented clinical and rehabilitation services, on one hand, and clients' transition to stable community living,

on the other. In subsequent work with persons with mental illnesses and, in most cases, co-occurring substance use disorders who had negative contacts with the criminal justice system, we found that many of their arrests for petty crimes involved what could be regarded as, or what reflected, attempts to contribute to society. A woman arrested for trespassing to retrieve redeemable cans, for example, was working for a living, a key factor we associate with being a responsible citizen, and she was recycling. A man arrested at a bus stop for talking too loudly and standing too close to others was attempting to make contact with his fellow citizens. (We note that a number of our clients have been arrested for more serious crimes such as possession or sale of drugs.)

Based on these experiences, we developed a theory of citizenship in regard to persons with behavioral health disorders and criminal justice histories. We define citizenship as a measure of the strength and form of the individual's connection to the rights, responsibilities, roles, and resources that society offers to people through public and social institutions and through the informal, "associational" life of neighborhoods and local communities (Rowe, 1999; Rowe and Baranoski, 2000; Rowe, Kloos, Chinman, Davidson, and Cross, 2001). This theory draws mainly on social science theories of citizenship that emphasize civic participation (De Tocqueville, 1994; Durkheim, 1933) and the theory of social capital, involving the assets that accrue to individuals through their direct and indirect relations with others and their membership in social networks or other social structures (Bourdieu, 1983; Coleman, 1990; Portes, 1998). Our theory, while not building specifically on these, shares some common ground with the theory of social integration, involving access to normative opportunities of housing, work, and social activities (Carling, 1993; Hannum et al., 1994; Kopelowicz and Liberman, 1994), and identity theory, which emphasizes the ways in which roles and group membership shape people's social integration (Carling; Hannum et al.; Kopelowicz and Liberman Thoits, 1986), determine their self-conceptualizations (Hall and Cheston, 2002), enhance their commitment to each other (Stryker and Burke, 2000), foster self-esteem (Cast and Burke, 2002), and solidify their claim to a particular social identity (Deaux and Martin, 2003). In addition, the concept of citizenship has recently been applied to research on community reintegration of discharged criminal offenders (Uggen, Manza, and Thompson, 2006).

Distinct from and potentially enhancing these approaches, our theory of citizenship includes a social-contextual emphasis on the interlocking rights, roles, and responsibilities of full membership in society (Rowe et al., 2001), elements that interact with the goal of abstinent lifestyles and reduced symptoms for persons with co-occurring disorders (Drake et al., 2001). To achieve the goal of full membership in society, we believe, people must attend to both the instrumental aspects of citizenship—acquiring practical knowledge and skills for gaining access to opportunities and resources—and the

ffective aspects of citizenship, experiencing membership in a community by developing relationships and roles within it.

## THE CITIZENS INTERVENTION

We developed a group intervention with wraparound peer mentor support for persons with co-occurring mental illness and substance use disorders who had criminal justice histories within 2 years prior to enrollment. This 5-month program involves a group intervention with wraparound support from peer mentors. The development and design of the program were prompted and influenced by our ongoing development of the citizenship theory we outlined above. Here, we describe the program from referral through post-graduation support, and include case vignettes.

### Referral and Enrollment

Information on the program is distributed to clinicians, posted at the local mental health center, and provided to local agencies and consumer groups. Once potential participants express interest, they are screened for membership in the target population and for risk factors such as violence. A history of violence, in and of itself, is not cause for automatic exclusion. Rather, we conduct a current risk assessment, taking into consideration past history, for determining eligibility. Following this screening, participants meet with the project director, who orients them to the program. Participants then meet with a peer mentor, are given a date to begin, and attend a weekly pizza party where participants share personal news and have an additional place to go for social support.

### Group Component: Course and Valued Roles Project

The primary objectives of the group component of the Citizens Intervention are to (a) enhance participants' knowledge of and skills for gaining access to and using community resources, (b) enhance their ability to establish supportive social networks with members of their local community and gain access to needed services, (c) give them an opportunity to work together toward the achievement of a collective goal and become part of a network of relationships based on mutual trust and shared interests, and (d) give them the opportunity to demonstrate to themselves and the community their ability to take on valued roles in society. Participants receive stipends for participation.

### COURSE

The course shares similarities with social rehabilitation and social skills programs, but also embodies an emphasis on both group support and community contacts via class presentations by community members. Participants

are treated as individuals with unique strengths and skills who are capable of exercising rights, roles, and responsibilities and of developing personal identities as valued members of society. A Project Director facilitates twice-weekly, 2-hour classes. In keeping with the community orientation of the program, the group component is held at a local church that hosts a soup kitchen. Participants develop group rules and norms and help shape the content of the classes through requests for outside speakers. The project director invites participants to talk about personal experiences, interests, and skills and encourages discussions and expressions of support among participants.

Each class, as well as each meeting of the valued role project that follows the course, begins with a “What’s up?” discussion. Participants talk about their activities during the past week, including their struggles and successes regarding recovery from behavioral health disorders and other problems. There is an informational, “community check-in” tone to these discussions, which the project director introduced as a structured response to participants’ desire to catch up with each other. Participants use “What’s up?” time to problem-solve, learn about trust and trustworthiness, empathize with others and learn to be tolerant of differences, and to confront and criticize each other constructively and accept criticism themselves. Participants talk about a wide range of topics, from relationships to employment, housing, and schooling, their struggles with staying clean, and their psychiatric symptoms.

Following the “What’s up?” discussion is a recap of the last class and an overview of the current one. Classes involve both didactic presentations and class exercises that stress the application of knowledge and skills. Outside speakers from area agencies, businesses, churches, and other sources teach many classes, while the project director and peer mentors teach others. The curriculum currently includes 21 classes on a wide range of topics:

Class 1: Citizenship, community, and neighborhood. The didactic portion of this class includes a presentation on neighborhood, community, and citizenship, including the impact of race, gender, class, cultural, racial, and ethnic differences, and stigma on each. Participants discuss their definitions and understandings of neighborhood, community, and citizenship and of rights and responsibilities within each of these areas.

Class 2: Assertiveness. This class is designed to enhance communication skills by teaching participants the differences among passive, aggressive, and assertive styles of communication. The presenter models examples of assertive responses during staged, verbal enactments to hypothetical situations. During role-play, participants rehearse and receive feedback on new behaviors for interacting with service providers and other community members.

Class 3: The criminal justice system. This class is designed to facilitate participants' skills in interacting with members of the criminal justice system. Participants hear a presentation on the court system and share their personal experiences. The class also addresses the stages of arrest and personal rights and responsibilities in court.

Class 4: Problem solving, and the American with Disabilities Act (ADA). In this class, participants learn about their rights under the ADA. They also identify problems they face when interacting with community members and service agencies, ways to identify and categorize problems by type (big, small, solvable, and unsolvable), and effective responses.

Classes 5 and 6: Public speaking. In these classes, participants learn how to organize and express their thoughts in front of others. Participants individually develop and present speeches on things they want to say about themselves, their community as they define it and ways in which they feel a part, or not a part, of it, their goals and how they plan to attain them, and what they have learned from classes and other participants. Participants review their videotaped speeches and critique one another. These classes help participants get to know one another and to accept and give constructive criticism. They also help them prepare for employment, housing, and other interviews.

Class 7: Relationship building. The didactic portion of this class is a presentation on social skills. Participants then identify qualities of relationships that are important to them and common problems they face in social interactions. Through role-playing they rehearse new behaviors and give and receive constructive feedback. This class also addresses different types of relationships and how to develop and maintain them and how to improve listening and observational skills.

Class 8: Entitlement Programs. This didactic class is designed to increase participants' knowledge of entitlement programs and how to gain access to them. It also addresses issues that may affect their benefits. Participants also discuss their current situations and experiences regarding these programs.

Classes 9 and 10: Jobs and education. These classes are designed to increase participants' knowledge of local vocational and educational programs and how to gain access to them. Participants discuss costs and benefits associated with working and their individual work experiences and goals. They complete résumés, fill out job applications, and role-play job interviews. They also discuss their past educational experiences and current goals.

Class 11: Housing. The goal of this class is to increase participants' knowledge of local housing options. A didactic presentation includes a description of independent and supported housing programs, sober housing, and current waiting lists. Students discuss their past experiences with housing and homelessness as well as tenant and landlord rights and responsibilities.

Class 12: Community integration. This class is designed to increase participants' knowledge about and comfort with participating in social events.

- Use of leisure time is discussed, and the group takes a community outing. The class addresses the importance of social relationships and activities and provides information on free or low-cost activities.
- Class 13: Sabotaging Success. This class draws on participants' real-life experiences to help them identify ways they have sabotaged their success in the past and how to substitute behaviors that work.
- Classes 14 and 15: Stress and anger management. These classes teach participants about the emotional, physiological, and behavioral manifestations of anger. Participants explore how they react to their own anger and the anger of others and ways to improve their responses. They also explore a variety of stress management tools such as breathing exercises, music, aromatherapy, and writing.
- Class 16: Healthy alternatives. This class focuses on feelings, thoughts and behaviors that lead to drug or alcohol use. Participants explore how they managed those feelings and thoughts in the past and discuss healthy alternatives they have learned from a recovery perspective. Participants also are given information on self-help groups, including difficulties associated with participating in them and strategies for overcoming these difficulties.
- Class 17: Patient advocacy. This class educates participants about their rights and responsibilities as patients receiving behavioral health care. Formal grievance procedures and self-advocacy methods are discussed, along with participants' personal experiences.
- Class 18: Legal issues. A lawyer from the local legal assistance program presents on available legal services and eligibility for them. Discussion topics include family and child law, housing law, consumer law, benefits and employment, and disability law.
- Class 19: WRAP. The Wellness Recovery Action Plan (Copeland, 2002) class is designed to address self-management of mental health symptoms. Participants are given the written tool with suggested strategies to reduce, modify or eliminate symptoms. The presenter helps participants develop individual plans, which may include advance directives.
- Class 20: AIDS Prevention. An HIV/AIDS educator teaches this class, which is designed to dispel common myths and provide factual information about HIV/AIDS. Participants are invited to share their own personal experiences and ask candid questions. The presenter also provides the class with information regarding prevention strategies and testing.
- Class 21: Intimate relationships. This class encourages participants to reflect on intimate relationships, including individual rights and responsibilities in such relationships. Participants develop a list of needs and wants, identify negative and positive ways in which intimate relationships have had an impact on their personal recovery, and examine possible changes in attitude and behaviors that will help them in their personal relationships and recovery processes.

The course is the most highly structured component of the Citizens Intervention. Its focus on topics such as living in the community, practical skills for daily living, and participants' interaction with outside speakers distinguish it, participants often note, from other groups they have attended. In addition, most participants come to the project without consistent social support systems, and the classes appear to facilitate the development of a mini-community of peers that support each other in their individual attempts to connect with the community at large. This group support is sustained through the valued role projects that follow them. Finally, based on observation and discussion with participants and staff, it appears that the public speaking component, which involves the opportunity and challenge of speaking in front of one's peers, helps participants learn to accept criticism as well as take pride in the accomplishment of speaking to and educating others. These and other classes may also contribute to the development of trust relationships within the group and to what the project director has identified as a tendency of more isolated participants to open up to their peers over time.

#### VALUED ROLE PROJECT

The classes and the valued role project give participants the opportunity to put their learning into action and begin to develop new and positive social networks and niches outside the behavioral health system. Following the "What's up?" discussion, participants work with a group facilitator to plan and complete an education-focused project in the community that embodies the goal of establishing meaningful social roles for themselves as contributing members of society. Projects have included meeting with police cadets to talk about participants' experiences of dealing with police officers, speaking to disadvantaged youth about how they have learned from their past mistakes, and conducting a fundraiser for a local nonprofit organization.

Valued role projects help participants step outside of the relatively closed system of relationships they have developed in treatment settings and into the larger community. The group develops a scrapbook that speaks to their experiences, impressions, and feelings. Participants also identify up to three people in each of their lives who have helped them in their lives and their recovery. They write letters and present them to these people at the graduation ceremony. Participants report that this activity helps them to realize that there are people who care about them. It also gives them the satisfaction of thanking and giving to others.

While most cohorts complete their valued role projects successfully, participants sometimes feel their community audience did not respond as favorably or quickly as they had hoped—did not donate as generously to a food drive project as anticipated, for example. However, such experiences

also become a source of group support and learning about the frustrations of translating personal growth into positive action and acceptance in the social world.

Valued role projects are collective enterprises, but individual participants may take on specific roles on collective projects or develop their own projects. An example of the latter is the valued role project of D., an African American single male in his late 30s who had spent much of his adult life in and out of jail or homeless. When he enrolled in the intervention, D. was staying at a local shelter and struggling with his drug addiction and mental illness. Although he contributed at times in class, communication with others was generally difficult for him. One day, D. commented that he was a poet and that his love of poetry had inspired him to seek recovery. He decided that his value role project would consist of giving a poetry reading and class to persons with traumatic brain injuries at a nearby rehabilitation facility. His reading and teaching were so well-received that he was asked to come back to speak with other patients at the facility.

To sum up the group component of the Citizens Intervention, participants are explicitly viewed as persons with inner strengths and capabilities and as valued members of a community who are capable of exercising their rights and responsibilities and of developing and taking on positive roles and identities in the community. A key principle and strategy in enhancing participants' abilities to gain access to community resources and supportive relationships has been that of facilitating the development of a small community—the intervention cohort—that allows participants to develop personal identities as valued members of that community, both in itself as an ongoing sub-community and as a departure point for individuals' efforts to find and develop for themselves other opportunities and niches in the larger community.

The project director and other group leaders, including an assistant to the director who is the class facilitator for the valued role component, work with each cohort to create a setting in which participants are accepted for who they are and for their unique contributions to the group. The curriculum for the group component can and should be modified based on a given cohort's needs and interests. Each group develops its own ground rules and holds all participants responsible for their actions, thus enhancing participants' sense of ownership of a program that develops and pursues collective goals.

### Wraparound Peer Mentor Support

The peer mentor component offers ongoing mentorship, counseling, and support to participants as they make their way through the group component and, for some, after they leave the intervention. Peer mentors are persons with mental illness and/or substance use disorders or both, and most have

a history of criminal incarceration. Peer mentors complete an eight-module training course that includes information about the participant population and topics such as confidentiality, setting boundaries and goals for themselves and their assigned participants, respecting participants' choices, safety policies, and available local resources for participants. The project director and a clinician who is the director of the community mental health center's jail diversion project, meet weekly with peer mentors to review their individual work with participants and support them in their work and their own recovery processes.

Mentors have cumulative knowledge and experience as people who have dealt with the burden of living with behavioral health disorders, the stigma related to these disorders, and the social disenfranchisement that comes with having criminal backgrounds. Working part-time, they support participants in face-to-face meetings by helping them identify goals and set priorities for achieving them, sharing their own perspectives and coping strategies as people who have "been there," and advocating for their access to social services, employment, education, and housing. Mentors also encourage participants to maintain their sobriety by offering the examples of their own struggles and recovery work. Peer mentors, drawing on and disclosing their personal experiences and struggles and the gains they have made, work to build trusting relationships with participants. Peer mentors appear to combine the functions of a case manager with consumer experience, role model, and "paid friend" in a distinctive way that facilitates relationships that are less formal than those of case managers with their clients but more formal than in friendship.

## Graduation

Graduation gives participants the opportunity to celebrate each other's accomplishments. The graduation takes place at city hall with refreshments and framed certificates. Several participants speak about their experiences in the class. Outside speakers whom participants respect give brief talks. Participants invite family members, friends, clinicians, case managers, and others. A recurring theme among those who talk about the importance of the program and their graduation is that this is the first major project they have ever completed as an adult.

## Post-Intervention Support

Post-intervention contact with participants, and vice versa, does not constitute a program component per se. Some graduates maintain contact with their peer mentors and the project director following graduation. They may also drop in for a weekly pizza lunch for participants or visit a class to talk to new participants about their experiences and teach one of the classes. Some

graduates have moved on to become participants of the authors' "leadership project" that trains homeless and formerly homeless persons to sit on the boards and action committees of agencies that provide services to homeless people (Rowe, et al., 2003). Others have completed their GEDs or other educational programs. Others still have gone on to part- or full-time work. To date, we have not been able to conduct research on participants' long-term occupational, community, and behavioral health or criminal justice status beyond the 12-month interviews we conducted as part of the randomized clinical trial (RCT) we noted above.

### PARTICIPANT VIGNETTES

The stories of individual participants illustrate aspects of how the group component and peer mentorship appears to have helped people in their recovery and other aspects of their personal and social lives, including dealing with the effects of criminal incarceration. Here and elsewhere, we have changed potentially identifying information to protect participants' confidentiality.

C.'s story illustrates the sociocultural and identity issues that may come into play in for individual participants. C., an African American male who had grown up in a large housing project where drug use and sales were rampant and who had a history of selling and using drugs, had learned to express sadness, fear, or anger through violence toward others. As time went on in the group, however, he began learning new ways of dealing with and expressing his feelings. One day outside the mental health center, a man he knew walked by and taunted him, then showed him the knife he was carrying. C. walked away and found a police officer, a response he would have scorned in the past. Other situations, including the death of a close childhood friend, tested him, but he came to the group with them, even dropping into the class once to seek support a year after graduating from the program. C. has held down two legitimate part-time jobs, and says that the program has helped him to clean, out of jail, and stay off the streets.

S.'s story illustrates the theme of finding new uses for and enhancing personal strengths that participants have not used in positive ways before. S. is an African American woman who had been in and out of treatment programs and jail for years. Although S. offered creative ideas about community issues in class discussions, she never talked about herself or the recent death of her brother or her abuse at the hands of her father and the post-traumatic stress disorder (PTSD) from which she suffered. As she attended classes and received feedback from her peers, S. began to talk more about herself and her needs. She decided to research family support programs in Connecticut for her valued role project and began to talk with other women about their struggles and successes in intimate relationships. S. gave an eloquent speech at her graduation on building community starting with relationships and family. She has made plans to attend community college in order to obtain an

associates degree in human services. She credits the Citizens Intervention and her fellow participants in helping her make these changes in her life.

D.'s story illustrates different stages of motivation that may be in play for participants over time, and how a group intervention can have an impact on motivation. D. is an African American single male in his early forties who struggled with a psychiatric disability and alcoholism and had been jailed a few times, mostly for petty crimes. The first time he came to the program he attended only a few classes. At this point, he was not ready to look at his substance abuse or his mental health issues. D. was back in jail a few weeks after dropping out of the program. After being released to a residential program, he sought out the project director and asked to come back. This time he attended classes regularly "to catch up on all the time I missed because of my drinking." D. was quite focused on the tasks he needed to accomplish, and at times perhaps drove himself too hard. His fellow participants talked to him about slowing down and relaxing a little, and he responded well to their advice and support. "This program taught me how to speak with people and have empathy," he said. "It also taught me how to deal with my depression and anger." D. completed the classes. About a year or so after he graduated, he came to a pizza party and talked with people about his plan to enter inpatient treatment. He had made all the arrangements and was waiting for a bed. He had started to slip again and said he wanted to address this before he ended up in jail or worse.

The group as a whole, including both the course and valued role project, appears to be a supportive—if initially challenging—intervention for participants. Many admit to being intimidated at first, but most are able to connect with others eventually because of their shared experiences around mental illness, substance use, and criminal justice contacts.

## PREVIOUS RESEARCH

Our study of the Citizens Intervention revealed that persons with severe mental illness and criminal justice histories and, in most cases, co-occurring substance use disorders benefited not only from standard treatment but also from the intervention in particular. Following approval from our institutional review board and informed consent procedures, we randomly enrolled 73 persons within an experimental condition (citizenship with standard services), and 41 within a standard services condition (standard services alone), with three assessment periods (baseline, 6 and 12 months). Standard services included individual and group treatment, medication management, case management, and jail diversion services in which clinicians assigned to the local criminal court worked with defendants, judges, and public prosecutors to divert defendants with mental illness and mostly nonfelonious charges to mental health treatment. The Citizens Intervention is described in detail above.

Participants in both conditions completed interviews at baseline, six, and 12 months, responding to questionnaires that included considerations of alcohol and drug use and criminal justice histories. The inclusion criteria for the intervention and the research to test its effectiveness were intentionally broad, reflecting both the breadth and range of the population of clients of the jail diversion program of the local mental health center from which we recruited our research participants, and the exploratory nature of our research. We enrolled 114 participants. Average age of participants was 39, and 68% were men. Participants' racial background included 66 African Americans (58%), 35 Caucasians (31%), and three Native Americans (3%). Nine participants endorsed an "Other" category (8%) and one person electing not to identify a racial ancestry (1%). Seventeen participants endorsed Hispanic ethnicity (15%). All participants were receiving outpatient psychiatric treatment with 70% having co-occurring alcohol and/or other substance use disorders. Diagnostic information is summarized in Table 1. All participants had a recent criminal history. Baseline criminal justice events were chiefly misdemeanors, followed by felonies, infractions, and violations, respectively.

We examined between these two groups (citizenship with standard services and standard services alone) comparative levels of alcohol use, drug use, and criminality. While both groups showed decreased drug use and had fewer contacts with the criminal justice system, the Citizenship Intervention appeared to be uniquely effective in reducing alcohol use over time. Specifically, a mixed model analyses controlling for baseline levels showed a time by group interaction in which alcohol use decreased in the experimental relative to control group from 6 to 12 months, where  $F(1,227) = 12.12, p < .05$ , with variance explained effect size = .05. For further details on methodology and results, interested readers are referred to our previously published work

**TABLE 1** Study Participants' Primary and Secondary Diagnoses

	Diversion + citizens		Diversion only		Overall	
	N	%	N	%	N	%
Primary diagnosis <sup>a</sup>						
Major mood disorder	29	40	17	42	46	40
Psychotic disorder	26	36	17	42	43	38
Other disorder	9	12	3	7	12	10
Substance use Disorder	5	7	3	7	8	7
Alcohol use disorder	4	6	1	2	5	4
Secondary diagnosis <sup>a</sup>						
Substance use disorder	27	37	13	32	40	35
Alcohol use disorder	17	23	13	32	30	26
Other disorders	12	16	5	12	17	14
Major mood disorder	6	8	2	5	8	7
Psychotic disorder	2	3	1	2	3	3

<sup>a</sup> Ninety-eight (or 86% of) participants carried a secondary diagnosis.

containing this finding (Rowe et al., 2007). We also refer interested readers to a study by Drake and colleagues where the use of alcohol by persons with co-occurring disorders was significantly associated with higher use of street drugs, social difficulties, increased symptoms, medical problems, and lower community tenure (Drake et al., 1989). Thus, considering the added benefit of reduced alcohol use, it is possible that with modifications that research and further observation may suggest, interventions such as this one can complement standard mental health treatment services in supporting community tenure and recovery across other domains.

## FUTURE STEPS AND MODEL DEVELOPMENT

We plan to conduct additional research to specify the factors of the Citizens Intervention that facilitated reduced alcohol use among participants, and the impact of protective factors on long-term alcohol use, psychiatric symptoms levels, social functioning, and community tenure for persons with alcohol use disorders, co-occurring SMI, and criminal justice histories. We also hope to develop a model and a manual intervention for continued sobriety using an applied theoretical framework of citizenship. Here, we discuss briefly our current thinking on three elements: the possible efficacy of the Citizens Intervention as a 12-step facilitation group (Humphreys, 1999), the link between the four R's and intervention ingredients, and model development.

### Twelve-Step Facilitation

Post-hoc examination of our pilot data suggests that elements of the peer mentor and group components of the Citizens Intervention mirror components of AA. At the group level, the intervention includes discussion of AA and models of AA principles by focusing first on one's own recovery and taking recovery one day at a time. It also strives for honesty toward self and others, and making amends. The Citizens Intervention differs from AA, however, in that the Citizens Intervention is designed explicitly for those with severe mental health problems and criminal justice backgrounds in addition to substance abuse, is intended as a short-term transitional intervention, and focuses on the person rather than his or her alcohol use per se. Table 2 provides further points of similarity and distinction between the Citizens Intervention and AA.

Many Citizens Intervention participants experience difficulty getting started in or returning to AA. One noted that upon returning to AA following a psychiatric hospitalization, fellow AA members commented that she "did not look 'right.'" She also said that she felt ostracized "because I looked peculiar. . .my symptoms stood out. My sponsor didn't want to deal with me. 'Just do the fifth step,' he told me." Several participants noted that

**TABLE 2** Citizens Intervention, AA, and Points of Overlap

Citizens Intervention	Shared qualities	Alcoholics Anonymous
Focus on person and context	Honesty	Focus on alcohol use
Emphasis on understanding	Fellowship	Emphasis on abstinence
Invitation for “cross-talk”	Giving back	Standard meetings/format
Short-term/transitional	Spirituality	Long-term
Structured Classes	Peer Support/influence	Individual sponsor
Consistent Consultation and individual contact	Reframing difficulties and potentials	
	Acceptance/patience	

they were able to progress from this point of extrusion and eventually fit in to AA, leading us to hypothesize that the Citizens Intervention may provide for participants an important portal back into the community, one through which they can gain access to 12-step groups and other community supports.

### The Four Rs: Rights, Responsibilities, Roles, and Resources

We hope to conduct further and more specific study on the ways in which the four Rs of our citizenship theory—right, responsibilities, roles and resources—are reflected in and supported by elements in the group component of the intervention. We present in Table 3 an initial formulation of some of the links between the fours Rs and specific group activities. We give these hypothesized links between theoretical and intervention elements only as examples and for illustrative purposes.

Using the roles and public speaking link as an example, we have been impressed by the impact of the public speaking classes on participants. It appears that the preparation and delivery of the speech goes beyond the topic of public speaking itself, helping prepare people for their participation in a valued role project. We think the learning and skill development that

**TABLE 3** Citizenship Intervention Ingredients

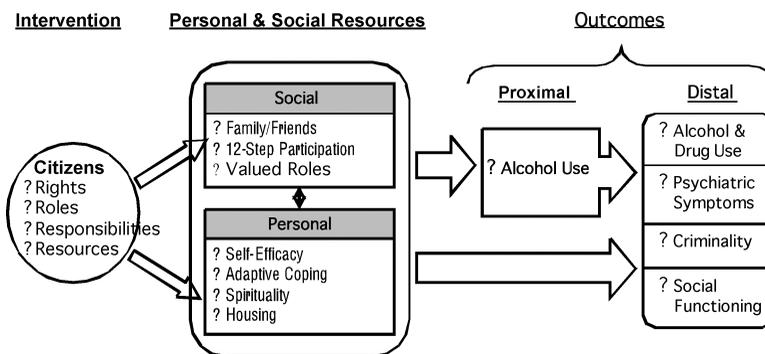
Theoretical component	Examples of specific corresponding intervention activities	
	Class topics	Project
Rights	Americans with Disabilities Act Housing	Speaking with Officers
Roles	Public Speaking Relationship Building	Speaking with Youths
Resources	Entitlement Program & Self-Help Vocational/Educational Development	Obtaining a Certificate
Responsibilities	Negotiation Stress and Anger Management class	Fundraiser

is inherent in successful completion of the public speaking activity may facilitate the adoption of broader roles, perhaps as teacher, that can in turn foster both an enhanced understanding of self and greater points of healthy entry into the broader community. (We do not include wraparound peer support in this table. We conceive of it, instead, as a pervasive entity that informs each activity in ways particular to each individual Mentor-participant relationship.)

## Model Development

We show a working model by which we hypothesize the Citizens Intervention to facilitate positive client outcomes in Figure 1 below. Given its targeted programmatic components, we suggest that the Citizens Intervention, including programmatic emphasis upon participants' rights, roles, responsibilities, and resources, first leads to improvements across social and personal domains.

Social improvements include increased contact with family and friends who do not use alcohol and/or illicit drugs, increased participation in 12-step group initiatives in the community including AA and DTR, and increased sense of having valued roles in the community. Personal improvement includes an increase in self-efficacy, adaptive coping, spiritual pursuits, and the acquisition of more suitable housing arrangements. The bi-directional arrow in Figure 1 connecting social and personal resources suggests that these features interact. For example, increases in one's perceived sense of self-efficacy may lead people to spend more time, without major conflict, with their families, caring for them or requesting support or care, and this may lead in turn to further increases in self-efficacy. As such resources interact, they may lead to proximal decreases in alcohol use that may in the long run lead to sustained recovery from alcohol and substance use disorders, decreased psychiatric symptoms, decreased criminal behavior, and increased



**FIGURE 1** Citizenship intervention mechanisms of improvement.

social functioning. Finally, we hypothesize that there is also a direct (non-mediated) impact of personal and social resources on such outcomes as well. We offer this conceptualization as a starting point only for further elaboration in our future research specifying the components of the intervention.

## CONCLUSION

As we have noted elsewhere, the criminal justice system marks one point at which the relationship between the person and society is mediated (Rowe and Baranoski, 2000). Group-based interventions based on citizenship theory may contribute to new collaborations between behavioral health systems and the courts and between professionals and community members and institutions, to new training for criminal and behavioral health professionals, and to more effective policies for care of persons with mental illness and dual disorders of mental illness and substance use disorders within a managed care framework that does not, at present, adequately fund rehabilitation efforts. Initiatives organized around this theory might have other, long-term benefits. They could contribute to a reduction in crime through institution of a concept of shared responsibility—between the behavioral health system and the community at large—for the target population. They might also contribute to a reduction in criminal justice costs through implementation of less costly interventions and through putting money and resources back into the community in the form of the increased productivity of currently disenfranchised individuals with behavioral health disorders.

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