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Supporting People with Serious Mental Illnesses and Reducing Their Risk of Contact with the Criminal Justice System:

A Primer for Psychiatrists

AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION
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About JPLI: The Judges' and Psychiatrists' Leadership Initiative (JPLI) aims to stimulate, support, and enhance efforts by judges and psychiatrists to improve judicial, community, and systemic responses to people with behavioral health needs who are involved in the justice system by creating a community of judges and psychiatrists, increasing the reach of trainings, and developing educational resources. For more information about JPLI, visit https://csgjusticecenter.org/courts/judges-leadership-initiative/.

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Introduction

People who have serious mental illnesses (SMIs) are increasingly overrepresented in the criminal justice system. At any given time, while only about 4 percent of the general U.S. adult population has an SMI,[1] approximately 17 percent of adults booked into jail have an SMI.[2] In addition, three-quarters of people in jail who have SMIs also have co-occurring substance use disorders,[3] and 1 in 3 Americans has a criminal record.[4] Considering these statistics, psychiatrists need to be aware that people who are in the criminal justice system or have a criminal justice history who have SMIs are very likely part of their patient population, and they are uniquely positioned to help these patients avoid future contact with the criminal justice system.

Often, psychiatrists are not adequately trained to identify and address the clinical and forensic needs associated with these patients' criminal behavior. Psychiatrists are rarely familiar with the Risk-Needs-Responsivity (RNR) principles[5] that guide criminal justice professionals in identifying and targeting interventions that can help reduce recidivism for this population. This primer provides psychiatrists with an overview of the RNR model, information on how they might inquire about a person's criminal history, and ways they can help address the particular needs of this population.

At-a-Glance: A Glossary of Terms

criminogenic needs. Static or dynamic characteristics, traits, problems, or issues that contribute to the person's likelihood of engaging in criminal behavior.

criminogenic risk. The likelihood that a person who has committed a crime will recidivate with a new crime or by violating the conditions of his or her supervision.

recidivism. A common term and key metric for criminal justice systems typically used to describe the rearrest, reconviction, and/or reincarceration of a person.

For the purposes of this primer, *patients* refers to people who have SMIs who have had contact with the criminal justice system. There are three main scenarios in which psychiatrists will encounter these patients in the community: 1) The patient is directly referred to the psychiatrist by a criminal justice agency for treatment that is a requirement of the conditions of his or her release or supervision; 2) the patient may be referred by a criminal justice agency, but treatment is not a requirement; and 3) the patient seeks out the psychiatrist on his or her own without any referral from a criminal justice agency.

When working with these patients, psychiatrists should remember the following three principles from what is known as the *Gap manual* (a collection of letters and recommendations written by psychiatrists for psychiatrists): 1) that the criminal justice system and the people it serves are part of their community; 2) that psychiatrists and criminal justice personnel share a mission to support a community's public health and public safety; and 3) that appropriate care and treatment will lead to better outcomes than arrest and incarceration alone.[6] Psychiatrists in the larger community can best help these patients by partnering with their criminal justice counterparts to obtain information that will help them address their patients' needs. Partnering with criminal justice agencies will not only help psychiatrists be better informed of this population's particular needs, but it can also help them begin to address factors that may contribute to their patients' future contact with the criminal justice system and improve their chance of recovery—an individualized approach to improve a person's health and wellness.[7]

1. Center for Behavioral Health Statistics and Quality, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*, HHS Publication No. SMA 16-4984, NSDUH Series H-51 (2016), http://www.samhsa.gov/data/.
2. HJ Steadman, et al., "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 6, no. 60 (2009): 761-765.
3. Karen M. Abram and Linda Teplin, "Co-occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* 46, no. 10 (1991): 1036–1045.
4. Maurice Emsellem and Michelle Natividad Rodriguez, *Advancing a Federal Fair Chance Hiring Agenda: Background Check Reforms in Over 100 Cities, Counties, and States Pave the Way for Presidential Action* (New York: National Employment Law Project, 2015), http://www.nelp.org/content/uploads/2015/01/Report-Federal-Fair-Chance-Hiring-Agenda.pdf.
5. R. Karl Hanson et al., *A Five-Level Risk and Needs System: Maximizing Assessment Results in Corrections through the Development of a Common Language* (New York: The Council of State Governments, 2017). https://csgjusticecenter.org/wp-content/uploads/2017/01/A-Five-Level-Risk-and-Needs-System_Report.pdf
6. Group for the Advancement of Psychiatry, *People with Mental Illness in the Criminal Justice System* (Arlington, VA: American Psychiatric Association, 2016), 11.
7. "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/recovery.

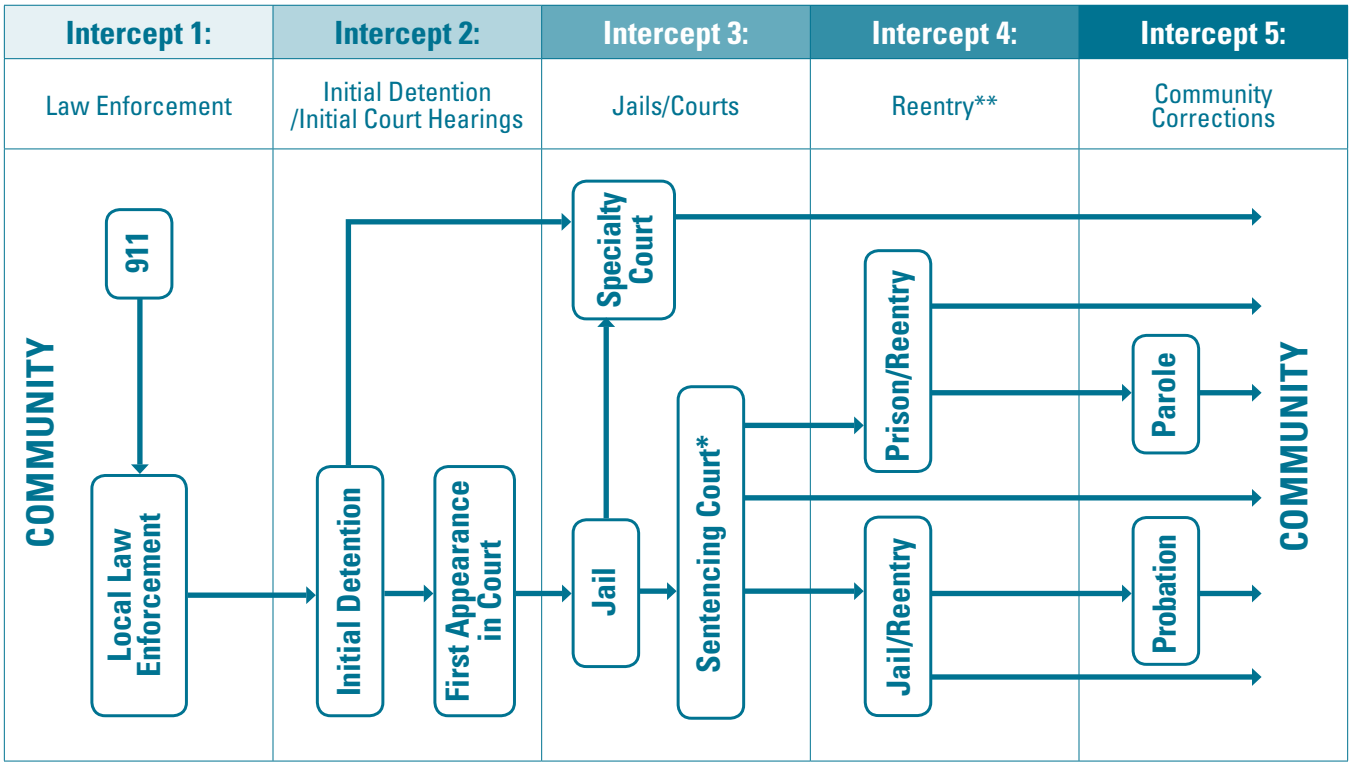
Systems Collaboration

As leaders in behavioral health care, psychiatrists are in a unique position to improve the collaboration across the behavioral health and criminal justice systems that is necessary to effectively respond to people with SMIs. Cross-system collaboration can be challenging in day-to-day practice when coordinating to help people reach their recovery goals, as it can involve multiple meetings with criminal justice and behavioral health teams. In many jurisdictions, however, psychiatrists are leading systems-change efforts to reduce the prevalence of people who have mental illnesses in jails by participating in criminal justice and behavioral health task forces as part of the national *Stepping Up* Initiative.[8] This initiative engages criminal justice and behavioral health professionals in efforts such as collecting baseline data, developing plans with measurable outcomes, and implementing research-based approaches to reduce the number of people who have mental illnesses who cycle through the criminal justice system.

How a Person Moves through the Criminal Justice System

To assist patients who are trying to navigate the criminal justice system and avoid future contact with the criminal justice system, psychiatrists need to understand how a person moves through the system. Figure 1 provides an overview of this process that is oriented around the points (intercepts) at which a person who has behavioral health needs might be screened, assessed, and connected to treatment that could be provided while incarcerated or after incarceration.[9] Psychiatrists are critical to ensuring a patient has a continuity of care and treatment that may have taken place while he or she is in the criminal justice system.

FIGURE 1: THE SEQUENTIAL INTERCEPT MODEL



*Criminal justice agencies often use the term "dispositional" to describe the court that sentences a person convicted of a crime.

**The Reentry Intercept encompasses both a person's time in prison or jail and the period immediately following his or her release.

8. "The *Stepping Up* Initiative," https://stepuptogether.org.

9. This Sequential Intercept Model is adapted from the following: 1) Mark Munetz and Patricia Griffin, "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness," *Psychiatric Services* 4, no. 57 (April 2006): 544-549; and 2) Substance Abuse and Mental Health Services Administration's (SAMHSA) GAINS Center for Behavioral Health and Justice Transformation, *Developing a Comprehensive Plan for Mental Health & Criminal Justice Collaboration: The Sequential Intercept Model*, http://www.criminaljustice.ny.gov/opca/pdfs/5-GAINS_Sequential_Intercept.pdf.

Discussing a Patient's Criminal Justice History: Screening and Assessment

In the same way that psychiatrists ask questions to determine a patient's treatment history and family history, they should also ask questions to determine if a patient has a criminal justice history. At intake, community psychiatrists who work in the community should ask whether a patient has a criminal justice history, and if so, follow with questions that cover topics such as current/pending charges, probation or parole requirements, orders of protection, child support, and prior convictions (e.g., they can ask "Have you ever requested an order of protection against someone?" and then ask "Are there any current orders of protection against you?" which may help the patient feel less defensive). They should regularly ask these questions to obtain relevant updated information to assess for any changes that may affect the patients' treatment plans (e.g., "How was your last court appearance?" or "When do you have to report to your probation officer next?").[10]

When a patient is referred by a criminal justice agency, psychiatrists may have access to the results of the behavioral health and criminogenic risk screening and assessments that took place at one or more intercept points. If a patient is referred by a criminal justice agency that does not routinely send this information along with the patient, psychiatrists should ask the referring agency for these screening and assessment results at the beginning of a therapeutic relationship. If the patient is currently on probation or parole, they can ask his or her supervision officer for the results even if the patient was not referred to treatment by that supervision agency. In many cases, criminal justice agencies and behavioral health care providers may already have information-sharing agreements in place, which can help psychiatrists obtain these results more easily. If there is not an existing agreement in place, psychiatrists may obtain the patient's consent depending on the referring agency's information-sharing protocols. This information can inform and support appropriate treatment planning and assist psychiatrists in addressing certain factors that may contribute to the patient's potential future criminal behavior.[11]

The Risk-Need-Responsivity Model

Involvement with the criminal justice system—especially incarceration—can cause particular problems for people who have SMIs, including interruption of treatment, lapse in medication, and disruption of case management services and other critical supports. To address the factors that can contribute to criminal behavior that may result their patients' incarceration, psychiatrists should seek to understand the Risk-Need-Responsivity (RNR) model. According to this model—which is outlined in Table 1 and includes three principles: risk, need, and responsivity—assessing criminogenic risk and need involves identifying static (unchanging) and dynamic (changeable) factors which contribute to the likelihood of a person recidivating as a result of a new crime and/or supervision violation and tailoring interventions based on the identified factors. Validated risk and needs assessment instruments are utilized to assess a person's risk of recidivism.[12]

The *risk principle* encourages criminal justice and behavioral health care providers to match interventions to a person's assessed risk of recidivism ("criminogenic risk"), with people assessed as being at the highest risk receiving the most intensive interventions.[13]

The *need principle* holds that each risk factor has associated needs ("criminogenic needs") that are the target for interventions focused on mitigating criminogenic risk factors, such as developing prosocial attitudes, developing prosocial peers, reducing substance use, and increasing self-control.[14]

10. Group for the Advancement of Psychiatry, *People with Mental Illness in the Criminal Justice System* (Arlington, VA: American Psychiatric Association, 2016), 151.
11. Fred Osher et al., *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery* (New York: The Council of State Governments, 2012), https://csgjusticecenter.org/wp-content/uploads/2013/05/9-24-12_Behavioral-Health-Framework-final.pdf.
12. D. A. Andrews, James Bonta, and R. D. Hoge, "Classification for Effective Rehabilitation: Rediscovering Psychology," *Criminal Justice and Behavior* 17, no.1 (1990): 19-52.
13. Sarah L Desmarais and Jay P Singh, *Risk Assessment Instruments Validated and Implemented in Correctional Settings in the United States* (New York: 2013), https://csgjusticecenter.org/wp-content/uploads/2014/07/Risk-Assessment-Instruments-Validated-and-Implemented-in-Correctional-Settings-in-the-United-States.pdf.
14. Harvey Milkman and Kenneth Wanberg, *Cognitive Behavioral Treatment: A Review and Discussion for Corrections Professionals* (Washington, DC: US Department of Justice, National Institute of Corrections, 2007).

The *responsivity principle* promotes tailoring interventions to a person's individual characteristics. There are two types of responsivity: general and specific. For *general responsivity*, social learning and cognitive behavioral interventions (CBIs)—described in Table 2—are used to address dynamic risk factors. *Specific responsivity* refers to incorporating an understanding of the person's culture, gender, motivation, strengths, and learning style into the supervision and treatment approach.

Table 1. The RNR Model

Risk: Match the intensity of a person's supervision and treatment to his or her risk of recidivism (*i.e., WHO to target*)

Need: Target criminogenic needs, such as antisocial behavior, substance use, and antisocial attitudes and peers (*i.e., WHAT to target*)

Responsivity: Tailor the intervention to the person's learning style, motivation, culture, demographics, and abilities (*i.e., HOW best to target*)

Static Factors	Dynamic Factors
Criminal history, including: • Number of previous arrests • Number of prior convictions • Type of previous offenses	History of antisocial behavior (including early and continuing involvement in antisocial acts)
Current Charges	Antisocial personality pattern
Age at first arrest	Antisocial cognition
Current age	Antisocial associates
Gender	Family and/or marital discord
	Poor school and/or work performance
	Few leisure/recreation outlets
	Substance use

While having an SMI does not make someone more likely to commit a crime than someone who does not have an SMI, people who have SMIs have been found to have as many or more criminogenic risk factors and needs as people in the criminal justice system who do not have SMIs. People who have SMIs are typically incarcerated longer, and when released, recidivate more frequently due to violating the specific conditions of their supervision, or as a result of technical violations such as loitering.[15] Psychiatrists can help these patients engage more meaningfully with interventions that address their criminogenic risk by helping to stabilize their symptoms and incorporating the interventions into their treatment planning. Once patients are stabilized psychiatrically, they are likely to be less distracted by the symptoms of their mental illness and can receive the full benefit of the interventions.

Interventions to Address Criminogenic Risk

Familiarity with the RNR model gives psychiatrists a way to think about tailoring interventions to these patients' needs and help them reduce their chances of or end their contact with the criminal justice system. Just as some psychiatrists use cognitive behavioral therapy (CBT) to address certain clinical conditions, CBIs specifically developed to address criminogenic needs are evidence-based approaches that have been found to help reduce recidivism.[16] While these CBIs are sometimes offered within a correctional facility, psychiatrists who work in the community can also implement these tailored interventions for these patients.

15. Jennifer Eno Louden and Jennifer L. Skeem, "How Do Probation Officers Assess and Manage Recidivism and Violence Risk for Probationers with Mental Disorders? An Experimental Investigation," *Law and Human Behavior*, 37, no. 1 (2012): 22-34.

16. Milkman and Wanberg, *Cognitive Behavioral Treatment.*

Some examples of group and individual CBIs that have been tailored to this population are listed in Table 2.

TABLE 2. COGNITIVE BEHAVIORAL INTERVENTIONS[17]

Program Description	Length and Capacity
Thinking for a Change (T4C) teaches participants to examine their thoughts, feelings, beliefs, and attitudes. The goal is to increase awareness of both self and others.	Groups of 8 to 12 people meet for a total of 22 sessions, each lasting 1 to 2 hours. The length of the program may vary depending on how many sessions are offered per week.
Reasoning and Rehabilitation (R&R) focuses on the areas of self-control, interpersonal problem solving, social perspectives, and prosocial attitudes. This program was developed to be facilitated by line staff as well as highly trained clinicians.	Groups of 6 to 8 people meet 35 times over the course 8 to 12 weeks.
Moral Reconation Therapy (MRT) was originally developed for adults in the criminal justice system who have substance use disorders, but this program—which is focused on helping participants make more prosocial decisions—is now also used to address general antisocial thought processes, especially for people charged with driving while intoxicated and domestic violence.	Groups varying in size from 5 to more than 20 people meet once a month or up to five times per week. The length of the program may vary depending on how long participants take to complete the program's required 16 steps.
Interactive Journaling is an individual intervention that addresses needs through a process of written self-reflection. Developed to address substance use, this program incorporates principles of Motivational Interviewing as well as CBT.[18]	Journals vary in length depending on the person's needs. This intervention can be given as a self-guided program or facilitated through one-on-one sessions in a group setting.

Whether psychiatrists are personally delivering these interventions or is overseeing treatment for someone in this population, they should be looking for opportunities to incorporate CBIs into these patients' treatment plans or refer these patients to appropriately trained CBI providers.

Conclusion

Psychiatrists who recognize that their patient population includes people who have SMIs and previous contact with the criminal justice system, and understand the ways in which these patients' needs are informed by their criminal justice history, are uniquely positioned to address their patients' complex needs. When psychiatrists familiarize themselves with the principles of the RNR model and incorporate interventions that address these patients' criminogenic risks and needs into their treatment plans, they help these patients achieve their recovery goals and reduce their likelihood of future contact with the criminal justice system.

Psychiatrists who work in the community should seek out opportunities to partner with criminal justice agencies, especially for training and potential system collaborations (such as participating in local criminal justice and behavioral health task forces together). These partnerships can be great opportunities for psychiatrists to increase their understanding of the ways to help address the particular needs of this population and have a meaningful impact in these patients' lives and the public health and safety of the communities they serve.

17. *Ibid.*

18. "Interactive Journaling," SAMHA's National Registry of Evidence-based Programs and Practices, http://legacy.nreppadmin.net/ViewIntervention.aspx?id=333.

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