The Application of Evidence-Based Practices to Justice Involved Persons with Mental Illnesses

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Director, National Initiatives
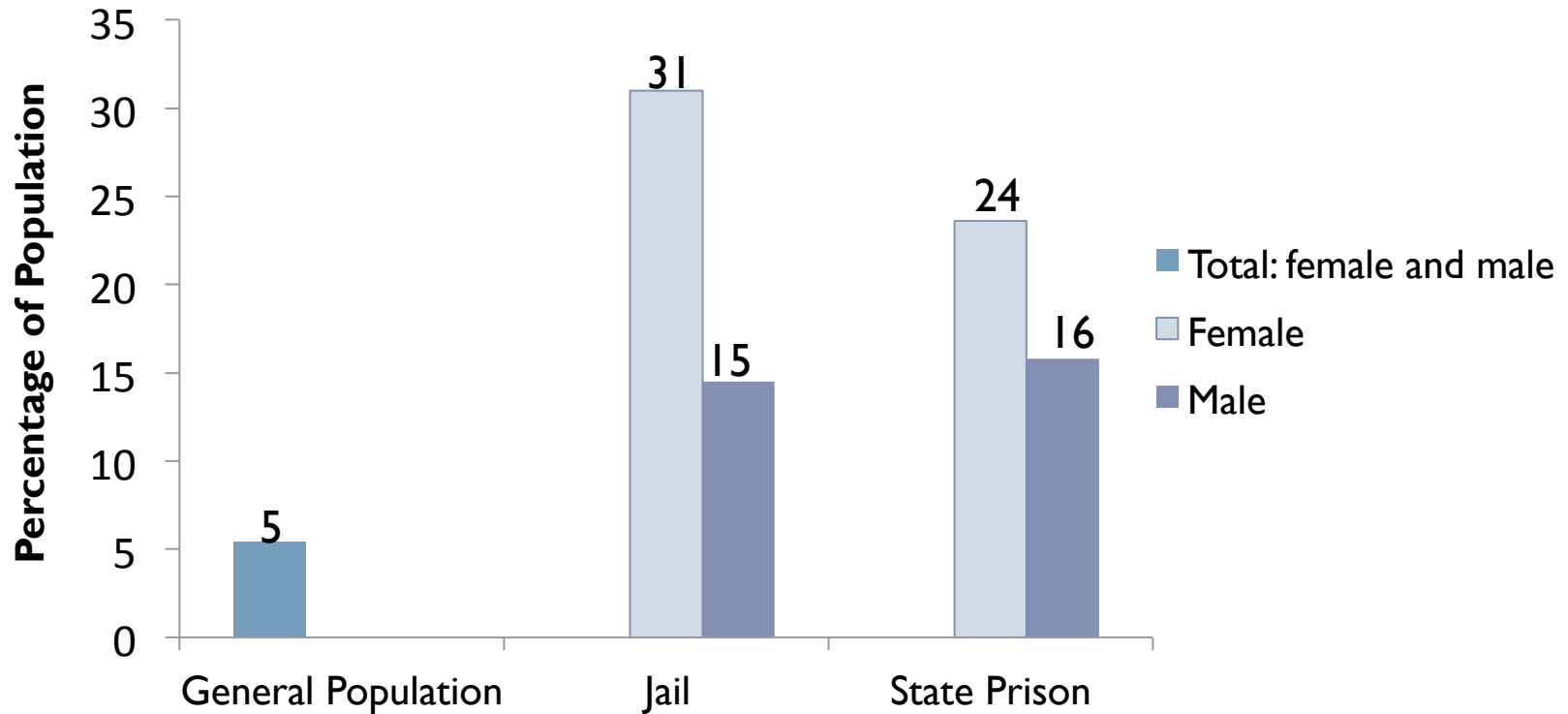
Council of State Governments Justice Center

JUSTICE ★ CENTER
THE COUNCIL OF STATE GOVERNMENTS
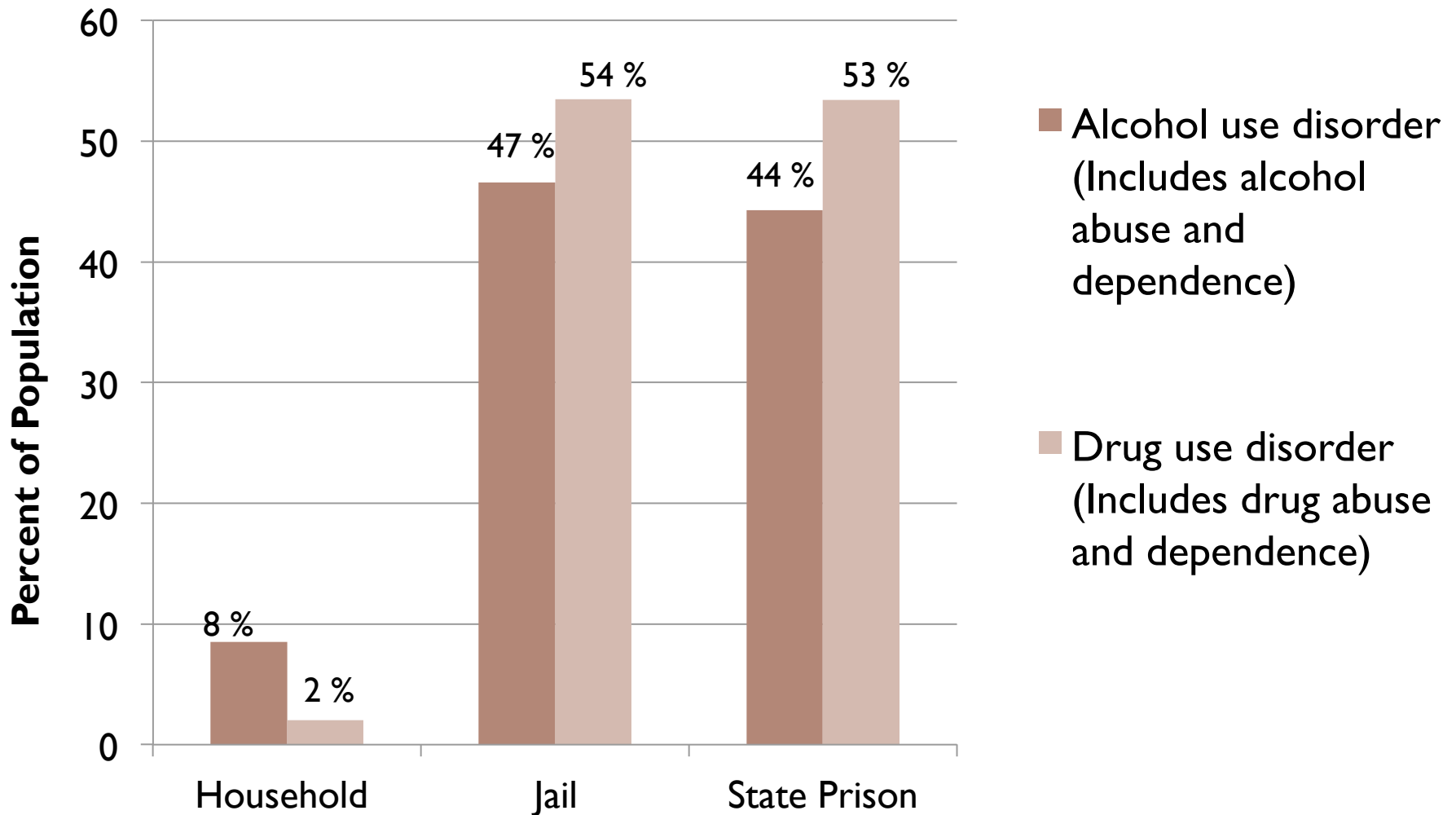*Collaborative Approaches to Public Safety*

Serious Mental Illnesses (SMI): An Issue in Jails and Prisons Nationwide

Serious Mental Illnesses in General Population and Criminal Justice System
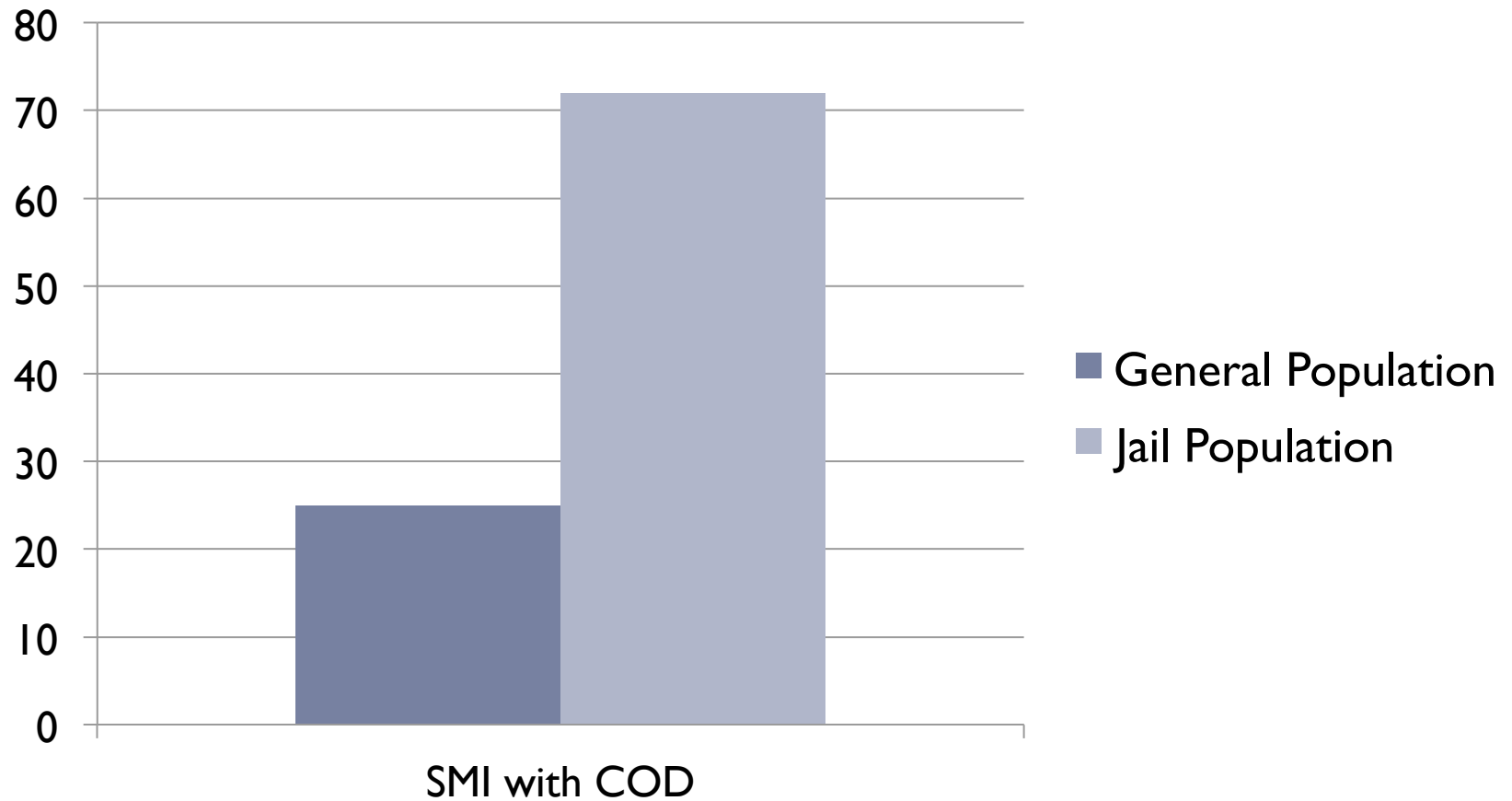

Source: General Population (Kessler et al. 1996), Jail (Steadman et al, 2009), Prison (Ditton 1999)

Alcohol and Drug Use Disorders: Significant Factor in Jail and Prisons

Source: Abrams & Teplin (2010)

Co-occurring Substance Use and Mental Disorders are Common

Source: General Population (Kessler et al. 1996), Jail (Steadman et al, 2009), Prison (Ditton 1999), James (2006)

Risk-Need-Responsivity Model as a Guide to Best Practices

▸ RISK PRINCIPLE: Match the intensity of individual's intervention to their risk of reoffending

▸ NEEDS PRINCIPLE: Target criminogenic needs, such as antisocial behavior, substance abuse, antisocial attitudes, and criminogenic peers

▸ RESPONSIVITY PRINCIPLE: Tailor the intervention to the learning style, motivation, culture, demographics, and abilities of the offender. Address the issues that affect responsivity (e.g., mental illnesses)

What do we mean by **Criminogenic Risk?**

▸ ≠ Crime type

▸ ≠ Failure to appear

▸ ≠ Sentence or disposition

▸ ≠ Custody or security classification level

▸ ≠ Dangerousness

Risk =
How likely is a person to commit a crime or violate the conditions of supervision?

What Do We Measure to Determine Risk?

▶ Conditions of an individual's behavior that are associated with the risk of committing a crime.

▶ **Static factors –** Unchanging conditions

▶ **Dynamic factors –** Conditions that change over time and are amenable to treatment interventions

Static Risk Factors

▸ Criminal history (number of arrests, number of convictions, type of offenses)

▸ Current charges

▸ Age at first arrest

▸ Current age

▸ Gender

# Dynamic Risk Factors

- Have had a historic focus on bottom four
- Need for focused effort to address anti-social risks
- More recent focus on co-occurring disorders

Dynamic Risk Factors

Anti-social attitudes
Anti-social friends and peers
Anti-social personality pattern
Substance abuse
Family and/or marital factors
Lack of education
Poor employment history
Lack of pro-social leisure activities

Those with Mental Illness Have Significantly *More* "Central 8" Dynamic Risk Factors
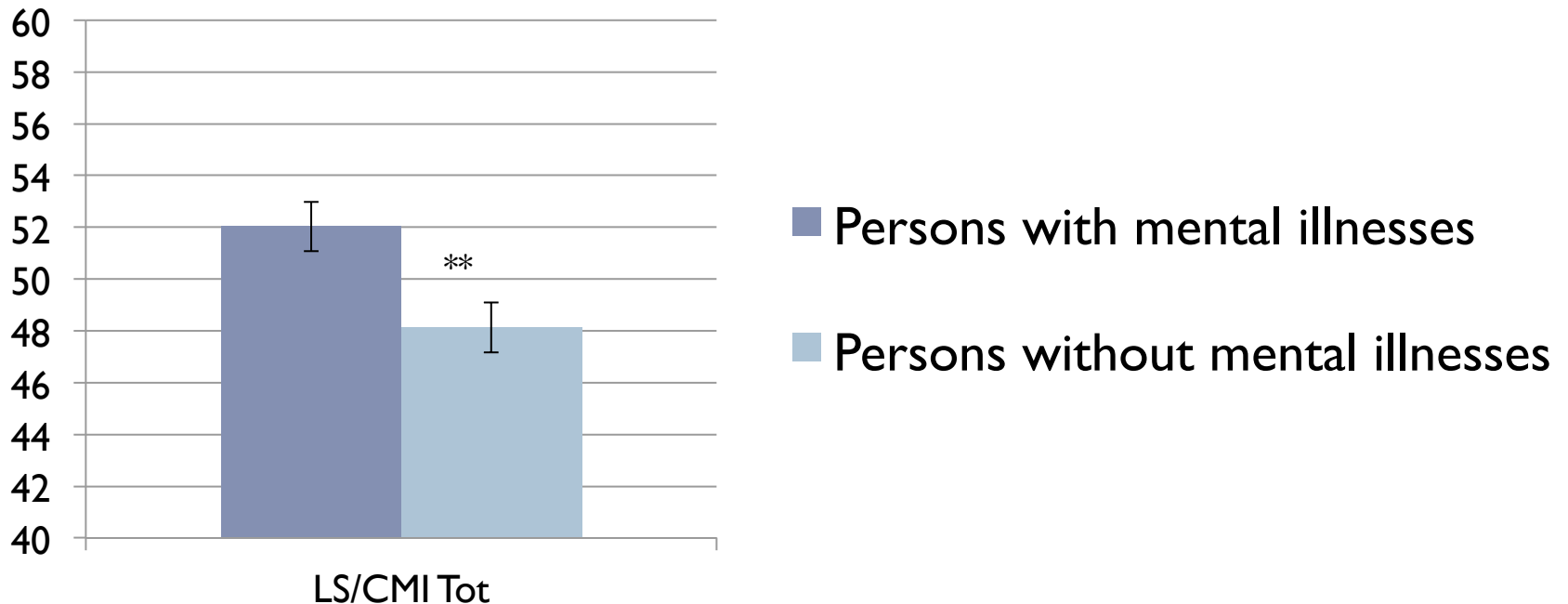
….and these predict recidivism more strongly mental illness

Source: Skeem, Nicholson, & Kregg (2008)
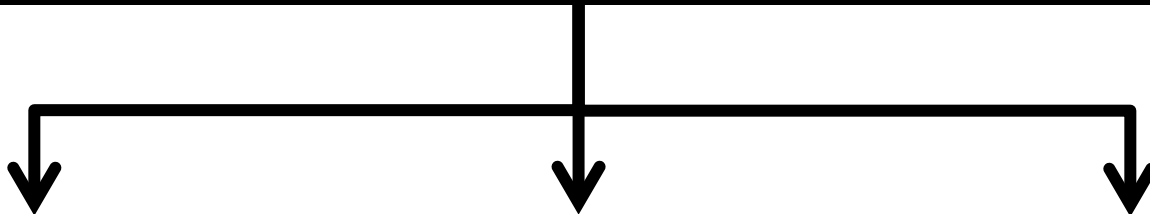
Effective Risk Assessment

100 people on supervision

↓

50% re-arrested

OR

100 people on supervision

LOW RISK   **MODERATE RISK**   **HIGH RISK**

Risk Impacts Program Outcomes

100 people released from prison

30 Low Risk | **40 Moderate Risk** | **30 High Risk**

Recidivism rate **without** intervention

| 20 percent | 40 percent | 60 percent |
| 6 people | 16 people | 18 people |

Recidivism rate **with** intervention

| 22 percent | 38 percent | 51 percent |
| 6-7 people | 15 people | 15 people |

For every 100 all risk levels served, 3-4 fewer people will be reincarcerated.

3x bigger impact

For every 100 high risk served, 9 fewer people will be reincarcerated.

Responsivity: You can't address dynamic risk factors without attending to mental illness

Mental Illness

- Antisocial Attitudes
- Antisocial Personality Pattern
- Antisocial Friends and Peers
- Substance Abuse
- Family and/or Marital Factors
- Lack of Prosocial Leisure Activities
- Poor Employment History
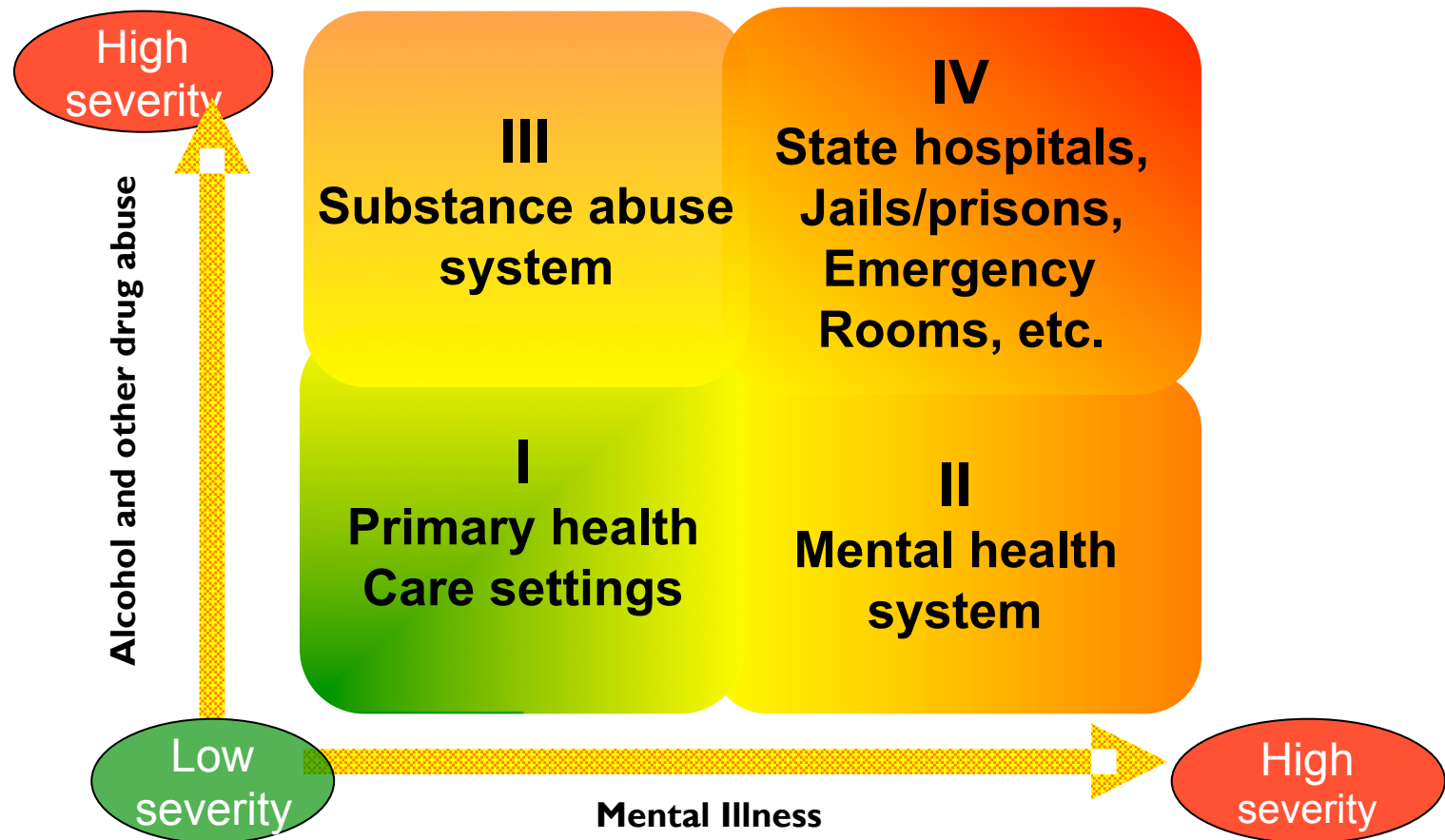- Lack of Education

Not all Mental Illnesses are Alike

Not all Substance Use Disorders are Alike

Not all Justice-Involved People are Alike

Framework for Addressing Population with Co-occurring Disorders (NASMHPD-NASADAD, 2002)

Alcohol and other drug abuse (vertical axis, Low severity → High severity)

Mental Illness (horizontal axis, Low severity → High severity)

III — Substance abuse system

IV — State hospitals, Jails/prisons, Emergency Rooms, etc.

I — Primary health Care settings

II — Mental health system

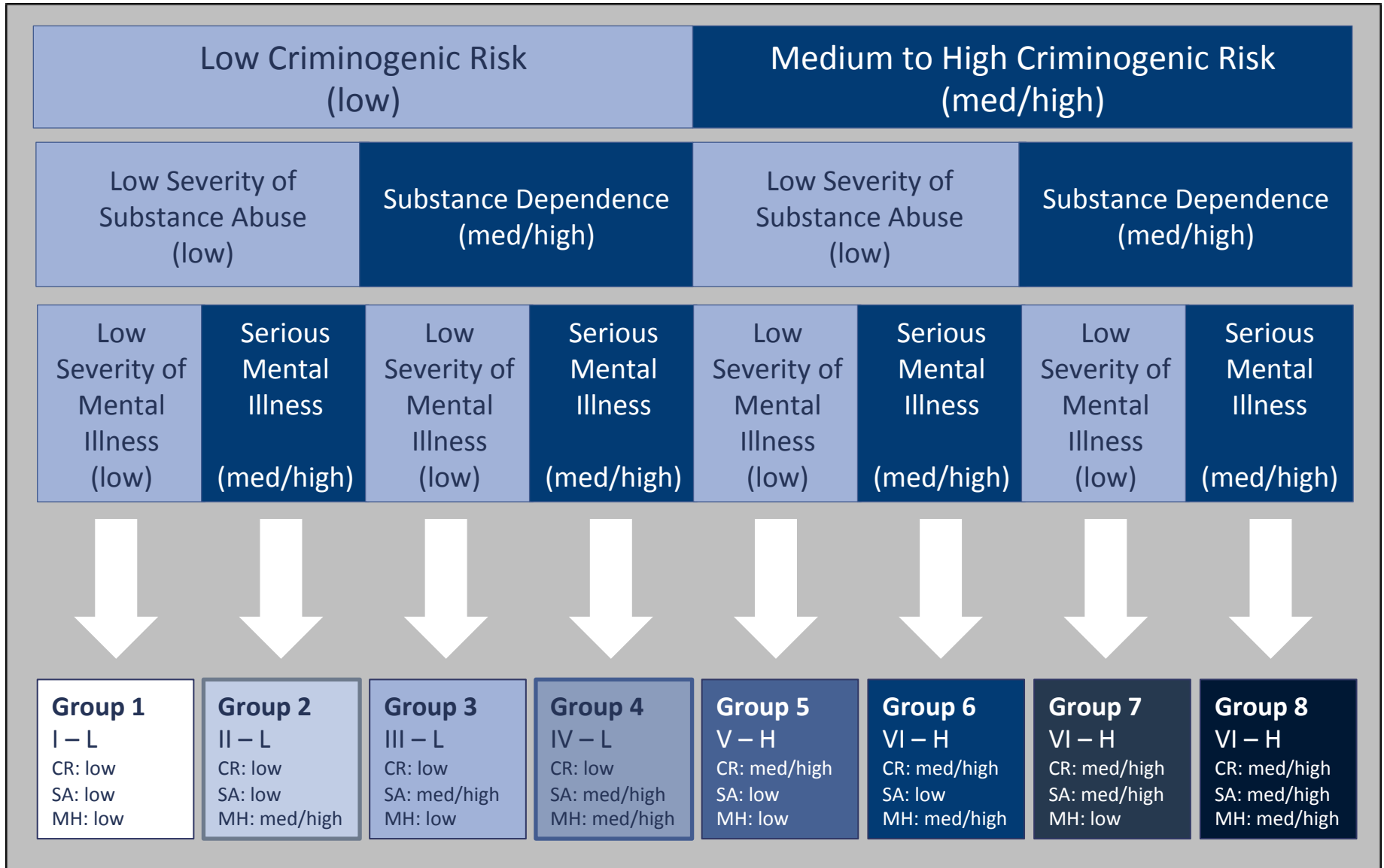JC Adults Behavioral Health Cover Design • July 24, 2012 • Mina Bellomy

Why We Created a Framework

▸ It is important to integrate criminogenic risk factors with mental health and substance abuse need

▸ As a guide to help systems allocate scarce resources more wisely

▸ To maximize the impact of interventions on public safety and public health

▸ BUT…

We Realized We Also needed to:

- Help the various systems develop a common language.
- Help each system understand the capacities and limitations of the other systems.
- Help the mental health system develop a more nuanced understanding of the criminal justice population.
- Help the criminal justice system understand a more nuanced understanding of the role mental illness and substance abuse play in criminal activity.
- Fight the myth that because one's personality may not change, neither can their behavior.

Criminogenic Risk and Behavioral Health Needs Framework

Low Criminogenic Risk (low)				Medium to High Criminogenic Risk (med/high)			
Low Severity of Substance Abuse (low)		Substance Dependence (med/high)		Low Severity of Substance Abuse (low)		Substance Dependence (med/high)	
Low Severity of Mental Illness (low)	Serious Mental Illness (med/high)	Low Severity of Mental Illness (low)	Serious Mental Illness (med/high)	Low Severity of Mental Illness (low)	Serious Mental Illness (med/high)	Low Severity of Mental Illness (low)	Serious Mental Illness (med/high)
Group 1 I – L CR: low SA: low MH: low	**Group 2** II – L CR: low SA: low MH: med/high	**Group 3** III – L CR: low SA: med/high MH: low	**Group 4** IV – L CR: low SA: med/high MH: med/high	**Group 5** V – H CR: med/high SA: low MH: low	**Group 6** VI – H CR: med/high SA: low MH: med/high	**Group 7** VI – H CR: med/high SA: med/high MH: low	**Group 8** VI – H CR: med/high SA: med/high MH: med/high

Low Criminogenic Risk
Without Significant Behavioral Health Disorders

Group 1

CR: LOW

SA: LOW

MI: LOW

▸ Lowest priority for services and treatment programs.

▸ Low intensity supervision and monitoring.

▸ When possible, separated from high-risk populations in correctional facility programming and/or when under community supervision programming.

▸ Referrals to behavioral health providers as the need arises to meet targeted treatment needs.

High Criminogenic Risk
Without Significant Behavioral Health Disorders

Group 5

CR: MED/HIGH
SA: LOW
MI: LOW

▸ High prioritization for enrollment in interventions targeting criminogenic needs, such as those that address antisocial attitudes and thinking.

▸ Lower prioritization for behavioral health treatment resources within jail and prison.

▸ Intensive monitoring and supervision.

▸ Participation in community-based programming providing cognitive restructuring and cognitive skills programming.

▸ Referrals made to community service providers on reentry as needed to address targeted low-level mental health/substance abuse treatment needs.

Low Criminogenic Risk with
High Behavioral Health Treatment Need

Group 2	Group 3	Group 4
CR: LOW	CR: LOW	CR: LOW
SA: LOW	SA: MED/HIGH	SA: MED/HIGH
MI: MED/HIGH	MI: LOW	MI: MED/HIGH

▸ Less intensive supervision and monitoring based

▸ Separation from high-risk populations

▸ <u>Access to effective treatments and supports</u>

▸ Officers to spend less time with these individuals and to promote case management and services over revocations for technical violations and/or behavioral health-related issues.

High Criminogenic Risk with
High Behavioral Health Treatment Needs

Group 6

CR: MED/HIGH

SA: LOW

MI: MED/HIGH

Group 7

CR: MED/HIGH

SA: MED/HIGH

MI: LOW

Group 8

CR: MED/HIGH

SA: MED/HIGH

MI: MED/HIGH

▸ Priority population for corrections staff time and treatment

▸ Intensive supervision and monitoring; use of specialized caseloads when available

▸ Access to effective treatments and supports

▸ Enrollment in interventions targeting criminogenic need including cognitive behavioral therapies

Developing Effective Interventions for Each Subgroup

Grouping based on combinations of all three measures	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8
CR:	LOW	LOW	LOW	LOW	MED/HIGH	MED/HIGH	MED/HIGH	MED/HIGH
SA:	LOW	LOW	MED/HIGH	MED/HIGH	LOW	LOW	MED/HIGH	MED/HIGH
MI:	LOW	MED/HIGH	LOW	MED/HIGH	LOW	MED/HIGH	LOW	MED/HIGH

- It is assumed these responses will:
  - Incorporate EBPs and promising approaches
  - Be implemented with high fidelity to the model
 - Undergo ongoing testing/evaluation

Framework Implementation Challenges

▸ Assessing risk and behavioral health needs soon after someone is charged with a crime

▸ Packaging assessment results for decision-makers and sharing this information appropriately

▸ Using information to inform services and supervision provided

▸ Encouraging treatment providers and supervising agents to serve "high risk" populations

▸ Ensuring treatment system has capacity/skills to serve populations they would not otherwise see as a priority population

Implementation Opportunities...

▸ New commitment to the need for collaboration between health and corrections systems

▸ Renewed interest in rehabilitation and "evidence-based" criminal justice programs.

▸ Risk-Need-Responsivity model helps drive effective collaboration

▸ Shared Vision for Moving Forward

Two Critical Components

Target Population → **Comprehensive Effective Community-based Services**
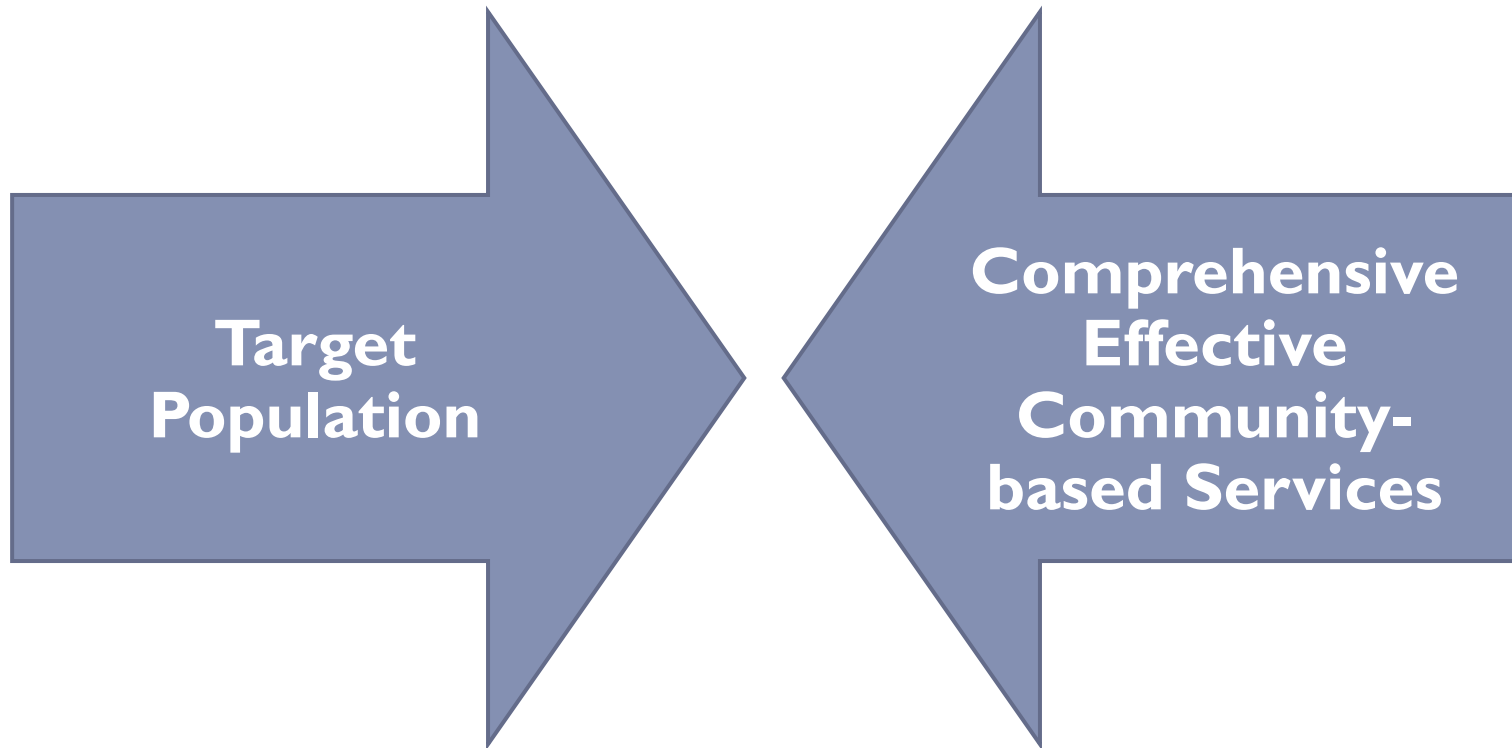
What is Evidence-Based Practice ?

▶ **Evidence-Based Practice is**

  ▶ "the integration of the best research evidence with clinical expertise and patient values."

Institute of Medicine, 2000

What is Fidelity?

▸ Fidelity is the degree of implementation of an evidence-based practice

▸ Programs with high-fidelity are expected to have greater effectiveness

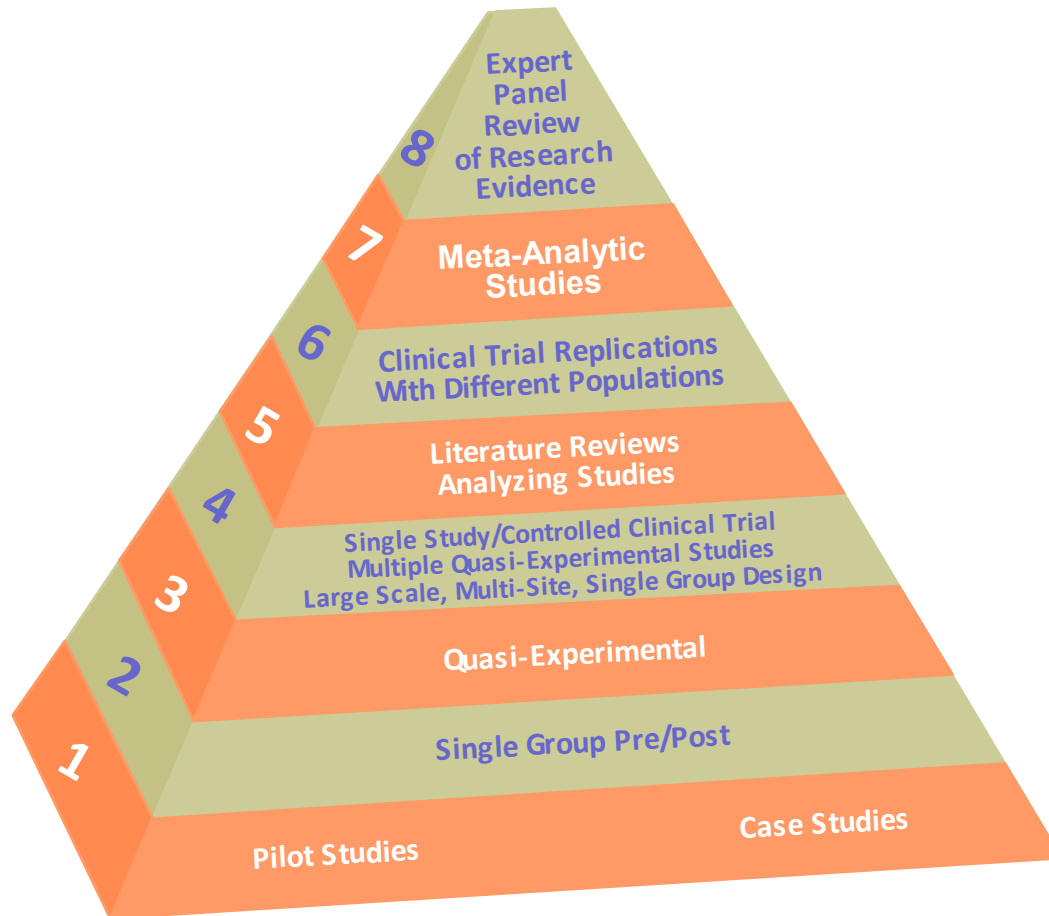▸ Fidelity scales assess the critical ingredients of an EBP

Why care about fidelity?
Fidelity improves outcomes

Percent of Participants in Stable Remission for High-fidelity ACT Programs (E:n=61) vs. Low-fidelity ACT Programs (G: n=26)
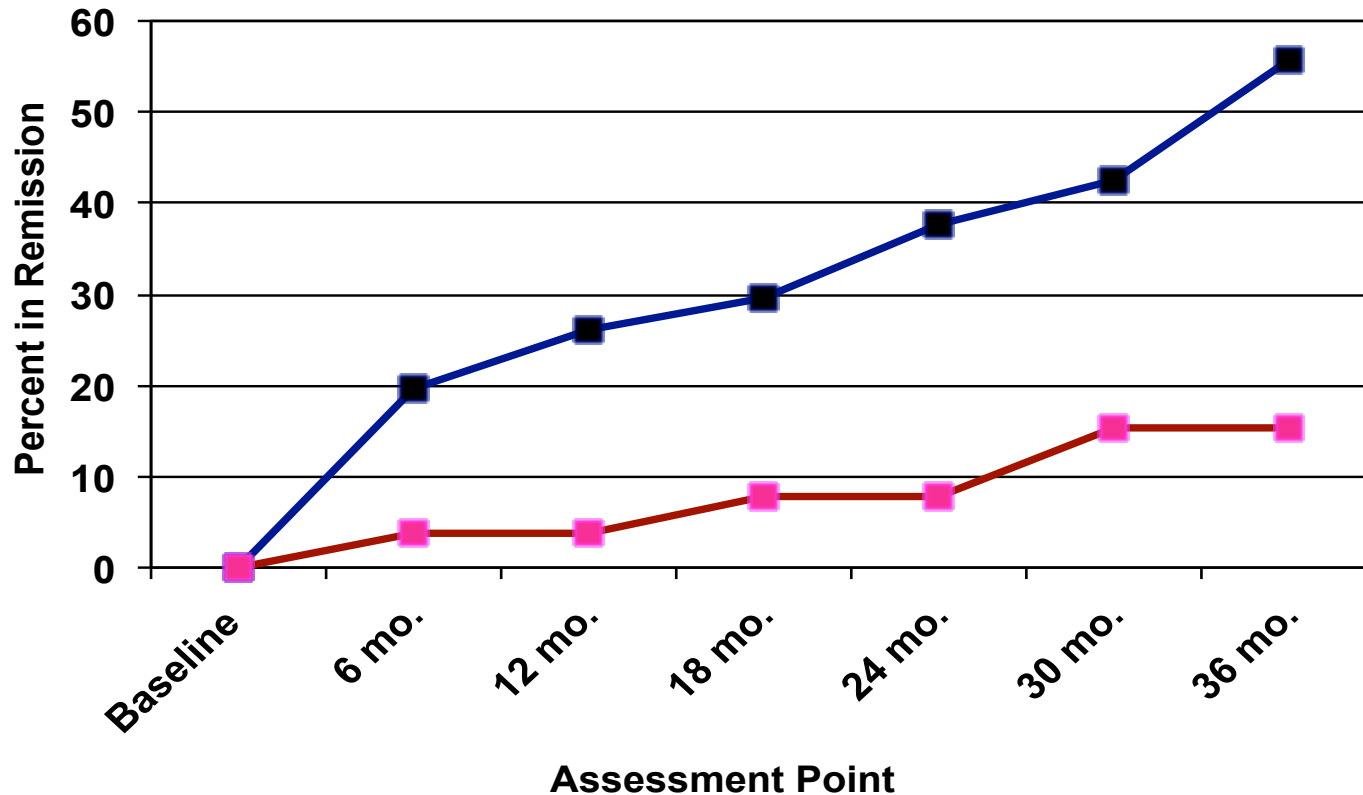
Pyramid of Research Evidence

Source: SAMHSA, 2005

Research Limitations

- **Lack of specificity of the intervention**
  - Programs vs. Techniques
  - Types vs. Brands

- **Lack of generalizability**
  - From severity and types of disorders and types of offenses studied
  - From non justice-involved-COD samples
    - Justice involved singly dx samples
    - Non-justice involved COD samples

- **Lack of research ------- period**

Comprehensive, Effective Community-Based Services

EBP	Data for JI	Impact
Housing	++	+++++
Integrated Tx	++++	++++
ACT	+++	+++
Supported Emp.	+	+++
Illness Mgmt.	+	++
Trauma Int./Inf	++	+++
CBT	++++	++++
Medications	+++++	+++++

Challenges

▸ Conducting Accurate Assessments

▸ Agreeing on Appropriate Placement

▸ Full Continuum of Services Required in Key Communities

▸ Integrated Approaches to Use of Supervision and Treatment

Challenges to EBP Implementation

▸ Target population characteristics

▸ Staff attitudes and skills

▸ Facilities/resources (Physical environment, staff and staffing patterns, funding resources, housing, transportation)

▸ Agency Policies/Administrative Practices

▸ Local/State/Federal regulation

▸ Interagency networks

▸ Reimbursement

Evidence-based services for individuals with SMI

▸ **Assertive Community Treatment –**

> ▸ coordinated by multidisciplinary team, high staff-to-client ratios, assume 24/7 responsibility for client case management and treatment needs

▸ **Illness self-management and recovery**

> ▸ Teaches clients skills to minimize the interference of psychiatric symptoms in daily life

▸ **Integrated treatment**

> ▸ Provision of treatment and services for co-occurring disorders through a single agency or entity

▸ **Supported employment**

> ▸ Matches and trains individuals for jobs where their specific skills and abilities make them valuable assets to employers

Evidence-based services for individuals with SMI

▸ Psychopharmacology
  ▸ Use of one or more medications to manage and reduce psychiatric symptoms

▸ Supported housing
  ▸ Housing that includes professional and peer supports to enable the individual to live independently

▸ Trauma interventions
  ▸ Designed to specifically address the consequences of trauma in the individual

▸ Cognitive behavioral therapies
  ▸ Approach to restructure client thinking, typically time-limited

Evidence-based services for individuals with substance use disorders

▸ **Cognitive behavioral therapy**

  ▸ Approach to restructure client thinking, typically time-limited

▸ **Motivational enhancement therapies**

  ▸ Client-centered directive method for enhancing motivation to change

▸ **Contingency Management**

  ▸ Approach that uses positive and negative reinforcements to reduce drug use

▸ **Pharmacological therapies**

  ▸ Use of one or more medications to manage and reduce psychiatric symptoms

▸ **Community reinforcement**

  ▸ Community-based method to achieve abstinence by eliminating positive reinforcement for consumption and enhancing it for sobriety

Evidence-based program models for justice-involved persons with co-occurring disorders

- ▸ **Integrated treatment and programs**
  - ▸ Provision of treatment and services for co-occurring disorders through a single agency or entity

- ▸ **Modified Therapeutic Community**
  - ▸ Residential program for population with co-occurring disorders

- ▸ **Integrated Dual Disorder Treatment**
  - ▸ Simultaneous treatment of substance use and mental illness

- ▸ **Assertive Community Treatment**
  - ▸ coordinated by multidisciplinary team, high staff-to-client ratios, assume 24/7 responsibility for client case management and treatment needs

Integrated Public Health-Public Safety Strategy (NIDA 2006)

Community-based treatment

Close supervision

Blends functions of criminal justice and treatment systems to optimize outcomes

Opportunity to avoid incarceration or criminal record

Consequences for noncompliance are certain and immediate

Currently…

- There is a growing evidence base that suggests
  - Some interventions and strategies do not lead to the desired outcomes
  - Some interventions and strategies do!

Cognitive-Behavioral Responses

▸ Cognitive Skills Training and Interventions

▸ Cognitive-Behavioral Therapy

Cognitive Interventions

▸ **Cognitive Skills –** The ability to focus and give offenders the opportunity to model and practice certain social skills and problem solving skills that allow them to be more successful and reduce problems.

  ▸ Some specific social skills may include: active listening, responding to the feelings of others, responding to anger and dealing with an accusation.

  ▸ Some specific problem solving skills may include: stop and think, describe the problem, get information to set a goal, considering choices and consequences, action planning and evaluation.

▸ **Cognitive Restructuring –** The ability to focus on an offender's beliefs and thinking in order to replace ineffective beliefs and thinking with more effective ways; this in turn replacing anti-social values and morals with more pro-social values and morals.

  ▸ Some specific skills may include: self-regulation and self- management skills, social skills, problem solving skills and critical thinking/reasoning skills.

Examples of Cognitive Interventions

▸ Thinking for a Change

▸ Moral Reconation Therapy

▸ Reasoning and Rehabilitation

Cognitive-Behavioral Therapy

▶ **Cognitive behavioral therapy** (CBT) is a blend of two therapies: *cognitive therapy* (CT) and *behavioral therapy*.

  ▶ **CT** focuses on a person's thoughts and beliefs, and how they influence a person's mood and actions, and aims to change a person's thinking to be more adaptive and healthy.

  ▶ **Behavioral therapy** focuses on a person's actions and aims to change unhealthy behavior patterns.

(NIMH)

Examples of Cognitive-Behavioral Therapies

▸ **Dialectical Behavior Therapy**

  ▸ Combines CBT techniques with distress tolerance and mindfulness techniques

▸ **Interpersonal Therapy**

  ▸ Short-term supportive psychotherapy focusing on interpersonal interactions and the development of psychiatric symptoms

▸ **Trauma-Focused CBT**

  ▸ Designed to specifically address the consequences of trauma in the individual

Examples of Cognitive-Behavioral Therapies

▶ Relapse Prevention Therapy

  ▶ Focuses on teaching individuals to anticipate and cope with the potential for relapse

▶ Exposure Therapy

  ▶ Treatment for anxiety disorders that involve exposure to the feared object or context without any danger

Steps in CBT

1. **Identify troubling situations or conditions in your life.**
2. **Become aware of your thoughts, emotions and beliefs about these situations or conditions.**
3. **Identify negative or inaccurate thinking.**
4. **Challenge negative or inaccurate thinking.**

Research Behind the Goals

Focusing on Higher Risk Individuals

Halfway Houses to Promote Reentry: Efficacy as a Function of Offender Risk*

Better outcomes

Poorer outcomes

10%

0%

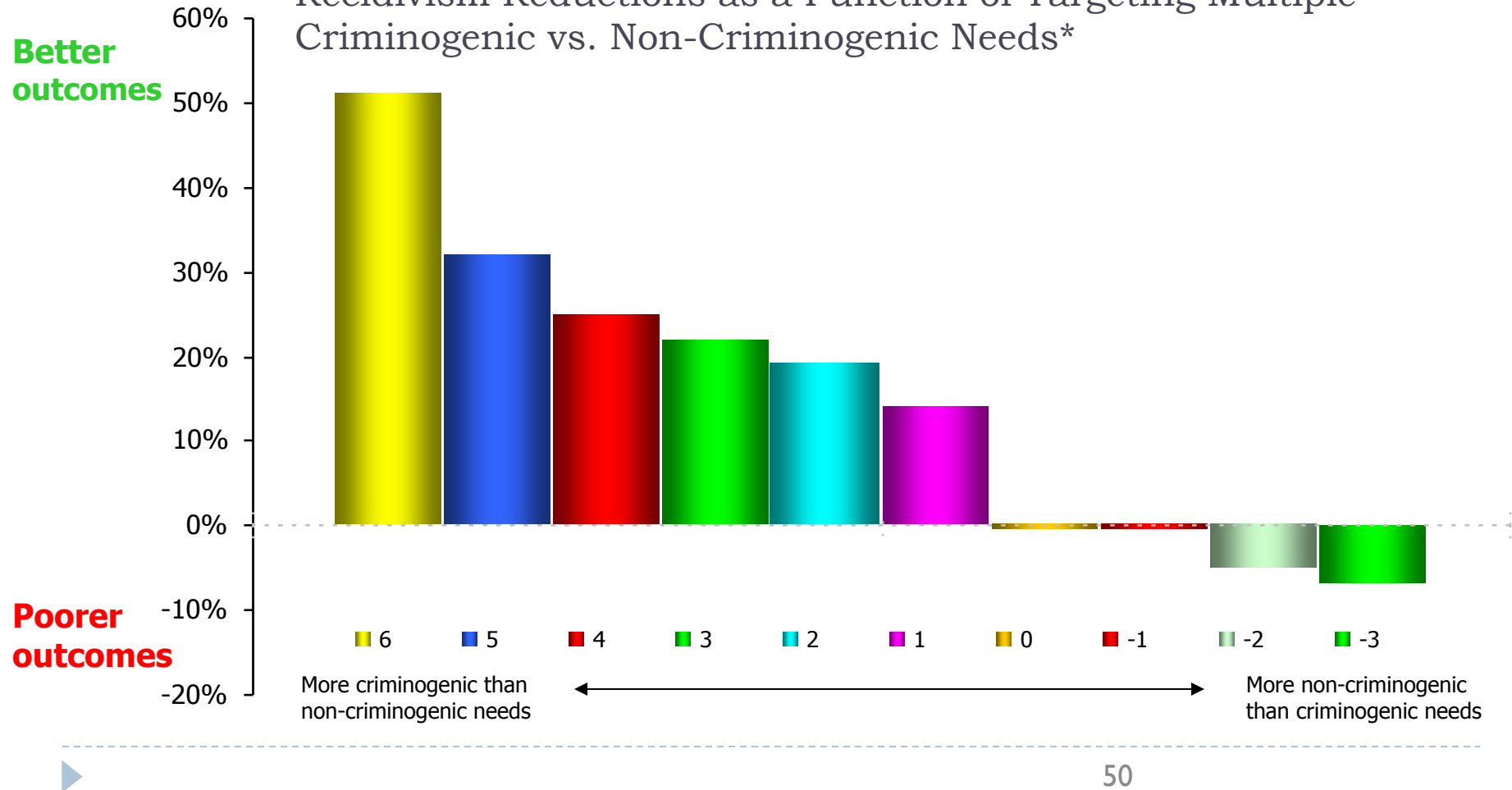-10%

Legend: Low, Low/moderate, Moderate, High
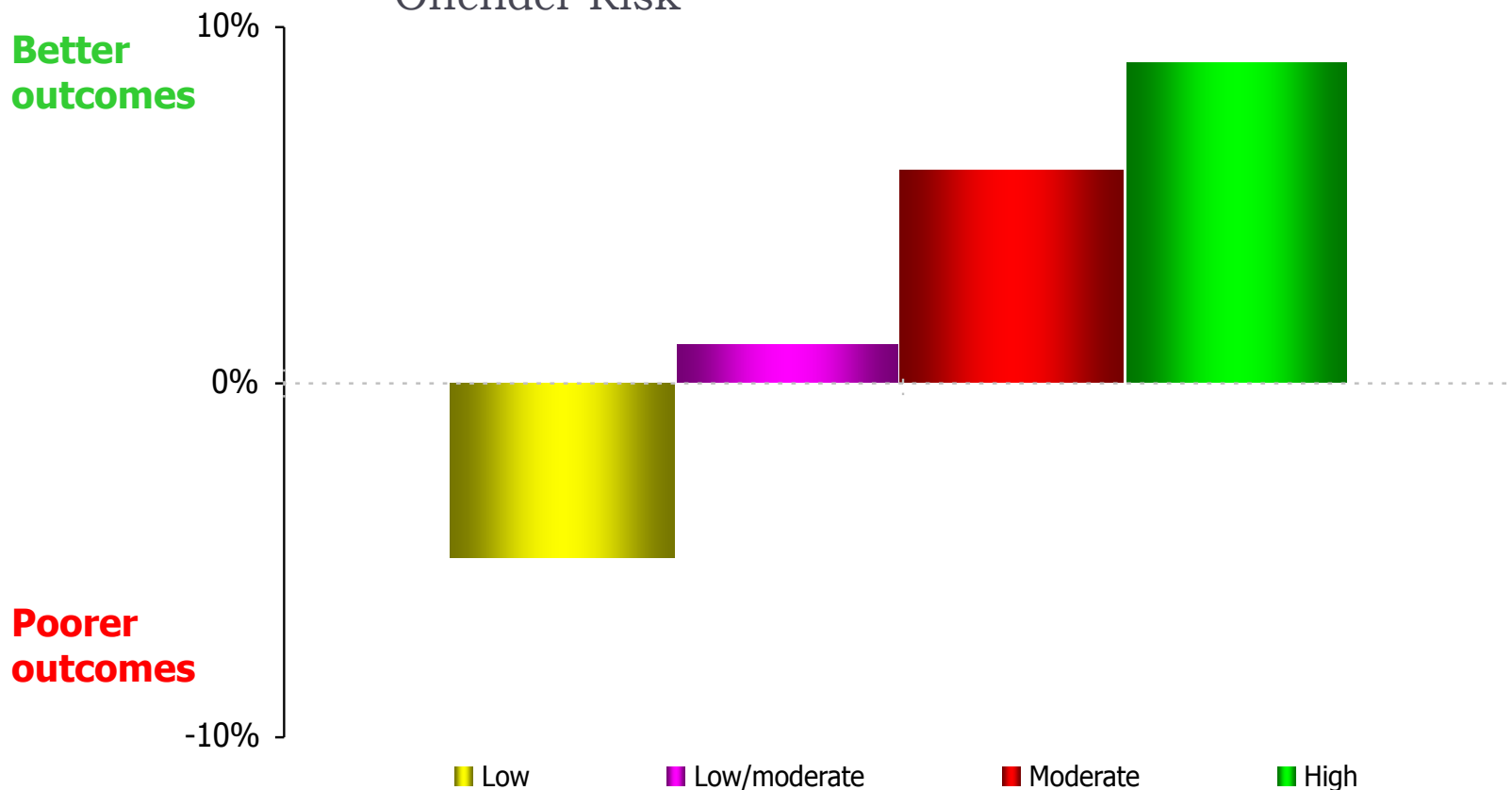
* Approx. 3,500 offenders placed in halfway houses, compared to 3,500 not placed in a halfway house

(Lowenkamp & Latessa, 2005b)

Research Behind the Goals
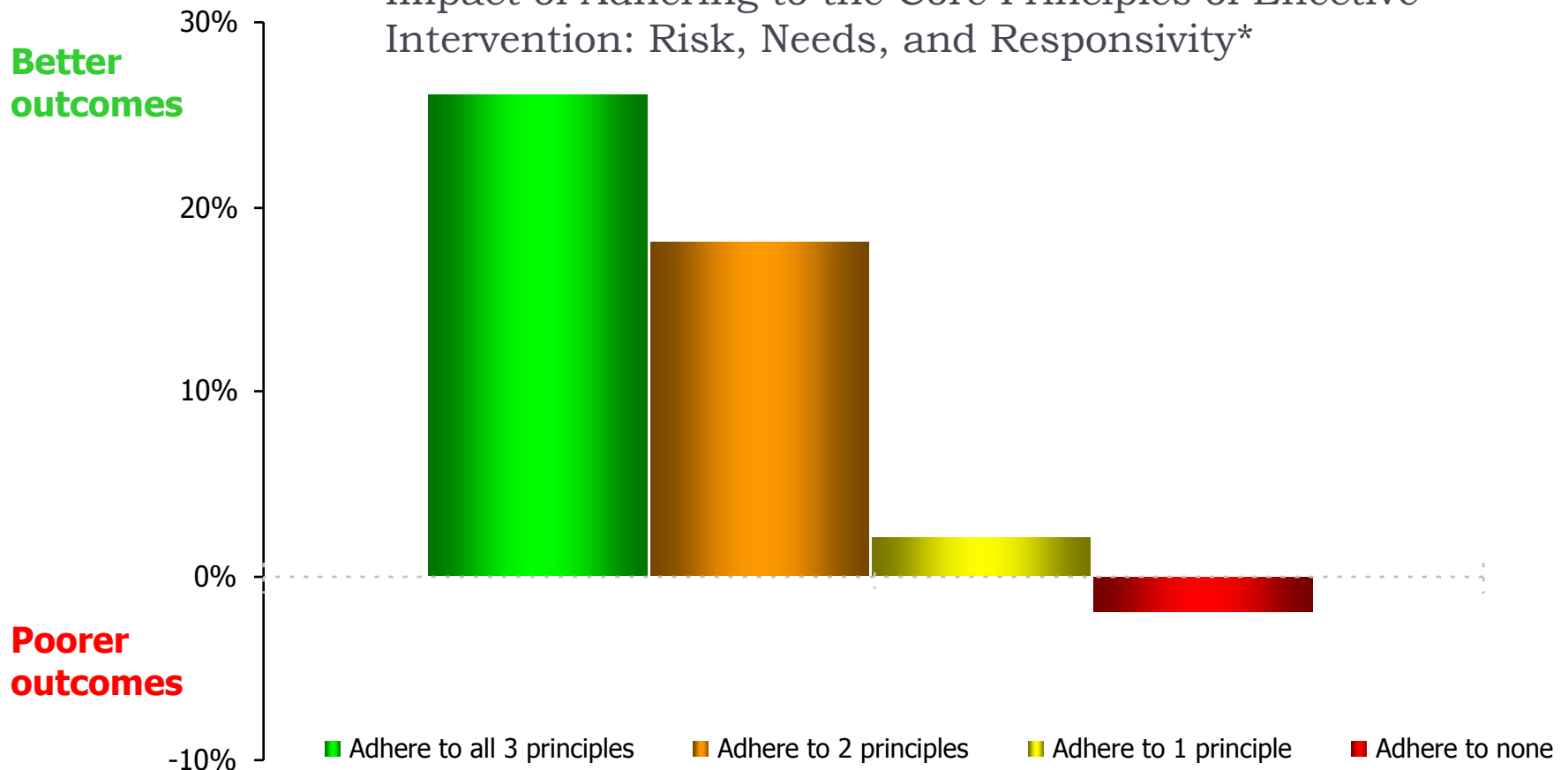
Addressing Criminogenic Needs

Recidivism Reductions as a Function of Targeting Multiple Criminogenic vs. Non-Criminogenic Needs*

Better outcomes

Poorer outcomes

Legend: 6, 5, 4, 3, 2, 1, 0, -1, -2, -3

More criminogenic than non-criminogenic needs

More non-criminogenic than criminogenic needs

Research Behind the Goals

The Risk, Need, Responsivity Principles

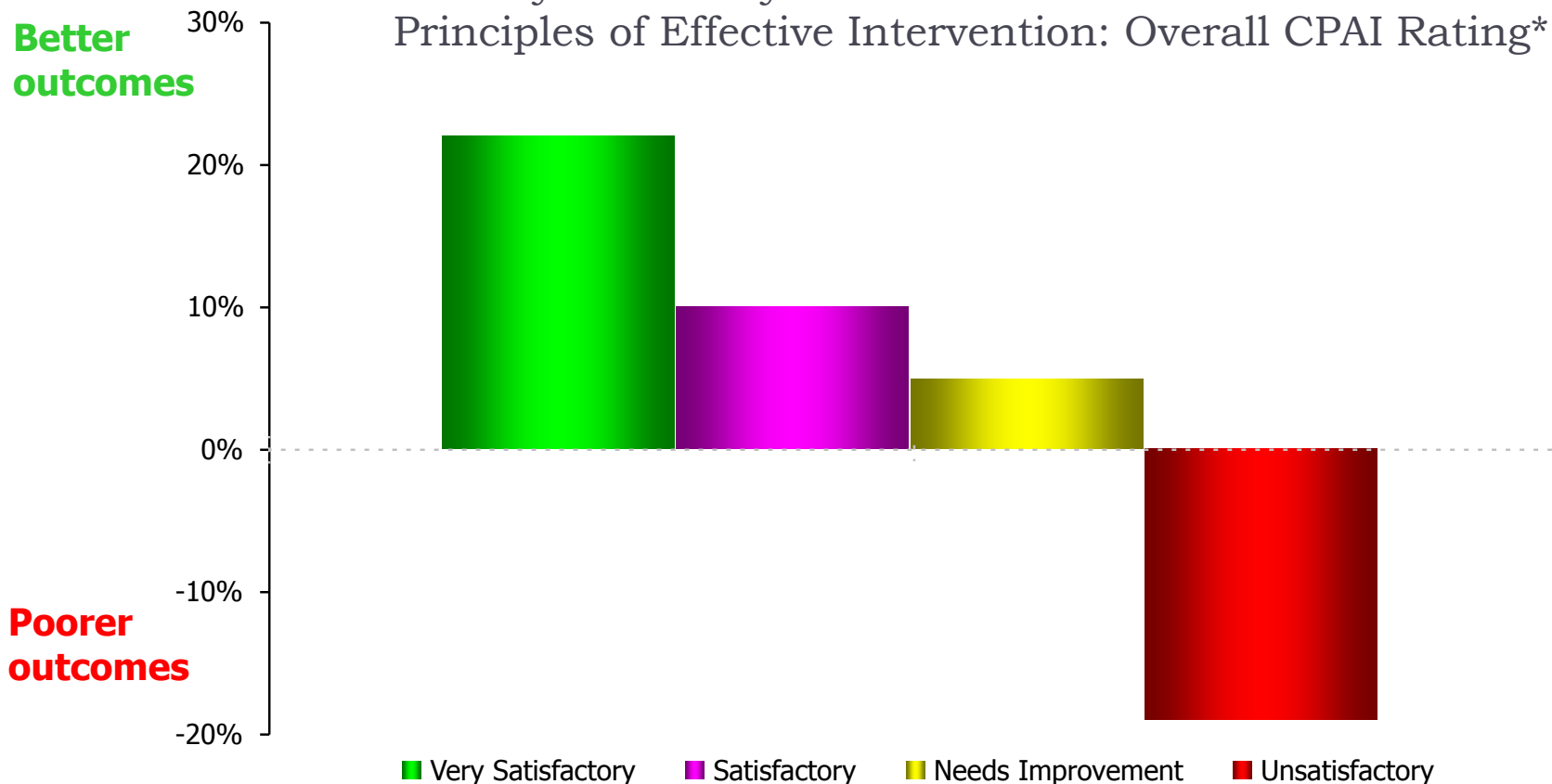Impact of Adhering to the Core Principles of Effective Intervention: Risk, Needs, and Responsivity*

Better outcomes

Poorer outcomes

- ■ Adhere to all 3 principles
- ■ Adhere to 2 principles
- ■ Adhere to 1 principle
- ■ Adhere to none

30%

20%

10%

0%

-10%

* meta-analysis of 230 studies (Andrews et al., 1999)

Research Behind the Goals

Program Quality and Fidelity

Efficacy of Halfway Houses as a Function of Adherence to the
Principles of Effective Intervention: Overall CPAI Rating*

Better outcomes

Poorer outcomes

■ Very Satisfactory ■ Satisfactory ■ Needs Improvement ■ Unsatisfactory

* Approx. 7,300 offenders placed in halfway houses, compared to 5,800 not placed in a halfway house

(Lowenkamp & Latessa, 2005a)

Additional Principles

▸ Link institutional programs and services to community-based interventions

    ▸ Continuity of care

▸ Engage prosocial community influences to support interventions

    ▸ Foster positive ties in the community

(see, e.g., Andrews, 1994, Andrews & Bonta, 1998, 2003; Bogue et al., 2004; Clawson et al., 2005; Cullen & Gendreau, 2000; Gendreau, 1996)

Additional Principles (cont.)

- Ensure program integrity
  - Solid program theory
  - Fidelity of implementation
  - Program climate
  - Well-trained staff

(see, e.g., Andrews, 1994, Andrews & Bonta, 1998, 2003; Bogue et al., 2004; Clawson et al., 2005; Cullen & Gendreau, 2000; Gendreau, 1996)

Additional Principles (cont.)

‣ Monitor and evaluate

  ‣ Staff performance (provide feedback and reinforcement)

  ‣ Within-treatment changes

  ‣ Outcome evaluations

(see, e.g., Andrews, 1994, Andrews & Bonta, 1998, 2003; Bogue et al., 2004; Clawson et al., 2005; Cullen & Gendreau, 2000; Gendreau, 1996)

The Challenges of Implementing Evidence-Based Practices

- Requires a dedicated commitment to change by managers, line staff, and everyone in between
    - Not just in corrections agencies, but in all service delivery agencies
- Requires an increased emphasis on accountability for our work – individual and collective
- Requires us to reconsider current practices and let go of the "that's always how we've done it" philosophy
- Requires us to confront and address resistance

Factors Correlated with Positive Outcome

▸ **PERSONAL STRENGTHS** – beliefs, talents, supports

▸ **RELATIONSHIP** – perceived empathy, acceptance, and warmth

▸ **EXPECTANCY** – optimism and self-efficacy

▸ **MODELING** – theoretical orientation and intervention techniques

Some Key Suggestions

▸ Be aware of the "what works" literature and its special application

▸ Become familiar with programs/services within your institutions and local communities

▸ Develop collaborative case management plans that can serve as a roadmap for offenders and system actors from the point of entry into prison through reentry

▸ Ensure critical sharing of information/documentation about offenders' participation and progress in prison-based services

▸ Link offenders with parallel services in the community post-release

Some Key Suggestions

▸ Dedicate more intensive resources for offenders who pose a greater likelihood of recidivism

▸ Remember that "more" is not necessarily "better" for every offender

▸ Consider responsivity factors when developing and implementing case management strategies

▸ Build incentives into case management plans and reward positive behaviors

▸ Evaluate what is and is not "working" for offenders in your jurisdiction – prioritize for change those strategies demonstrated to be most effective in reducing recidivism

▸ **And remember – one size does not fit all and gender matters**

But, my Jurisdiction will never..

▸ **CT DMHAS POLICY:** DMHAS clients who are under the supervision of CSSD/DOC are provided the same array of clinical and support services as those without such supervision. (2011)

▸ **CT CSSD POLICY:** The Court Support Services Division will establish Mental Health Probation Officers to provide intensive supervision for clients with identified mental health disorders. The officers will work collaboratively with DMHAS staff to ensure access to an expanded service continuum for psychiatric and co-occurring disorders.