Coordinating a Systems Approach to Behavioral Health and Justice

Hallie Fader-Towe, Program Director
CSG Justice Center

National Association of Counties
Justice & Public Safety Symposium
Thursday, January 23, 2014
1:45-3:15pm

Fulton County, GA
Loews Atlanta Hotel
1065 Peachtree Street NE
Atlanta, Georgia, 30309

Photo source for Fulton County Courthouse:
https://familysearch.org/learn/wiki/en/Fulton_County,_Georgia
• National non-profit, non-partisan membership association of state government officials

• Engages members of all three branches of state government

• Justice Center provides practical, nonpartisan advice informed by the best available evidence

<table>
<thead>
<tr>
<th>Corrections</th>
<th>Courts</th>
<th>Justice Reinvestment</th>
<th>Law Enforcement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Reentry</td>
<td>Substance Abuse</td>
<td>Youth</td>
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</table>
Criminal Justice/Mental Health at the CSG Justice Center

Criminal Justice/Mental Health Learning Sites Program

Developing a Mental Health Court: An Interdisciplinary Curriculum

Statewide Law Enforcement/ Mental Health efforts

Implications of The Affordable Care Act on People Involved with the Criminal Justice System

the NATIONAL REENTRY RESOURCE CENTER
A project of the CSG Justice Center
Today’s Discussion

• Behavioral Health Disorders in the Criminal Justice System

• Systems Approaches for Public Safety & Recovery

• County Leadership to Improve Outcomes
Prevalence of Serious Mental Illness and Co-Occurring Disorders in Jail Populations

**General Population**
- Serious Mental Illness: 5%
- No Serious Mental Illness: 95%

**Jail Population**
- Serious Mental Illness: 17%
- No Serious Mental Illness: 83%
- Co-Occurring Substance Use Disorder: 28%
- No Co-Occurring Substance Use Disorder: 72%
Alcohol and drug use disorders: Significant factor in jail and prisons

Source: Abrams & Teplin (2010)
Impact on Counties: Why are there more people with mental health needs in Riker’s when the jail population is decreasing?

Average Daily Jail Population (ADP) and ADP with Mental Health Diagnosis

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>ADP with Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>13,576</td>
<td>10,257 (76%)</td>
</tr>
<tr>
<td>2012</td>
<td>11,948</td>
<td>7,557 (63%)</td>
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Source: The City of New York Department of Correction
County officials: “Jails are the wrong place to treat mental illnesses”

“Our jails are increasingly a place of last resort for offenders who are mentally ill. Even as the department’s total inmate population continues to fall, this group is unable to get out or stay out.”

– Commissioner Dora Schriro, Department of Corrections, New York, NY

“[There is] a growing number of mentally ill inmates housed in general population quarters as well as a[n] increase in suicides...A jail that can adequately treat those offenders is a better investment.”

– Assistant Los Angeles County Sheriff Terri McDonald, Los Angeles, CA

“I would welcome the chance to take all of our mentally ill and medically challenged inmates...and put them somewhere they could get programming, but I haven’t heard anyone stepping up to do that.”

– Sheriff David Mahoney, Dane County, WI

“In every city and state I have visited, the jails have become the de facto mental institutions...there are not enough resources out there to care for them [mentally ill].”

– Sheriff Tom Dart, Cook County, IL
Not all Mental Illnesses are Alike: Mental Illness in the General Population

- Diagnosable mental disorders: 16%
- Serious mental disorders: 5%
- Severe mental disorders: 2.5%
Not All Mental Illnesses are Alike: NYC Case Study

M Group - Disaggregated

- Non-M Group  79%
- M Group  21%

Bar Chart:

- M Group, SMI:
  - 43%
  - ALOS: 91 Days

- M Group, Non-SMI:
  - 57%
  - ALOS: 128 Days

- Non-M Group:
  - ALOS: 61 Days

Source: The City of New York Department of Correction & New York City Department of Health and Mental Hygiene 2008 Department of Correction Admission Cohort with Length of Stay > 3 Days (First 2008 Admission)
Not all Substance Use Disorders are Alike

The Substance Abuse Continuum

Social Use  Heavy Use  Hazardous Use  Problem Use  Abuse

Abstinence  Dependence
Framework for Addressing Population with Co-occurring MH & SU Disorders

(NASMHPD-NASADAD, 2002)
We increasingly know “what works”

• Case management
  – E.g. Forensic Intensive Case Management (FICM), Forensic Assertive Community Treatment (FACT), and Assertive Community Treatment (ACT)
• Supportive housing
• Peer support
• Accessible and appropriate medication
• Supported employment
• Cognitive behavioral interventions targeted to criminogenic risk factors
• **Integrated Dual Diagnosis Treatment (IDDT)**
The right treatment rarely happens. . .

Past Year Mental Health Care and Treatment for Adults Aged 18 or Older with Both Serious Mental Illness and Substance Use Disorder

- Mental Health Care Only: 45.2%
- Both Mental Health Care and Treatment for Substance Use Problems: 11.4%
- Treatment for Substance Use Problems Only: 3.7%
- No Treatment: 39.5%

Source: NSDUH (2008)
But even that isn’t enough

How likely is it that the inmates’ offenses were a result of serious mental illness (SMI) or substance abuse (SA)?

- Direct Effect of SMI: 4%
- Indirect Effect of SMI: 4%
- Direct Effect of SA: 19%
- Indirect Effect of SA: 7%
- Other Factors: 66%

Recidivism Is Not Simply a Product of Mental Illness: Criminogenic Risk

Risk:

- ≠ Crime type
- ≠ Dangerousness
- ≠ Failure to appear
- ≠ Sentence or disposition
- ≠ Custody or security classification level

Risk = How likely is a person to commit a crime or violate the conditions of supervision?
Using Criminogenic Risk To Sort Makes A Big Difference in Recidivism Reduction Outcomes

Average Difference in Recidivism by Risk for Ohio Halfway House Offenders

- Low Risk: +3%
- Moderate Risk: -6%
- High Risk: -14%

*Presentation by Latessa, “What Works and What Doesn’t in Reducing Recidivism: Applying the Principles of Effective Intervention to Offender Reentry”*
Without Assessing Risk of Re-Offending...

- **High** Supervision/Program Intensity
- **Moderate** Supervision/Program Intensity
- **Low** Supervision/Program Intensity
Assess for Risk of Re-Offending

- **High**
  - Supervision/Program Intensity
  - Typically 1/3 of the population
  - LOW RISK: 10% re-arrested
  - MODERATE RISK: 35% re-arrested
  - HIGH RISK: 70% re-arrested

- **Moderate**
  - Supervision/Program Intensity
  - Typically 1/3 of the population

- **Low**
  - Supervision/Program Intensity
  - Typically 1/3 of the population
Sort Based on Risk; Supervise Accordingly

- **High Risk**: 10% re-arrested
  - Typically 1/3 of the population
  - Supervision/Program Intensity: Low
  - 20-30% reduction

- **Moderate Risk**: 35% re-arrested
  - Typically 1/3 of the population
  - Supervision/Program Intensity: Moderate

- **Low Risk**: 70% re-arrested
  - Typically 1/3 of the population
  - Supervision/Program Intensity: High
Poor Recidivism Results When Risk Principle Not Applied

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Supervision/Program Intensity</th>
<th>10% Re-arrested</th>
<th>35% Re-arrested</th>
<th>70% Re-arrested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>Low</td>
<td>0-5% increase</td>
<td>0% reduction</td>
<td>0% reduction</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>Moderate</td>
<td>20-30% reduction</td>
<td>0-5% increase</td>
<td>0% increase</td>
</tr>
<tr>
<td>High Risk</td>
<td>High</td>
<td>0-5% increase</td>
<td>0% reduction</td>
<td>0% reduction</td>
</tr>
</tbody>
</table>

Typically 1/3 of the population
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 Measure to Determine Criminogenic 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
How has Behavioral Health Addressed Dynamic Risk Factors?

**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**
- Antisocial behavior
- Antisocial attitudes
- Antisocial cognitions
- Antisocial personality pattern
- Substance abuse
- Family and/or marital factors
- Lack of education/poor employment history
- Lack of pro-social leisure activities
Risk-Need-Responsivity Model as a Guide to Best Practices

- **RISK PRINCIPLE**: Match the intensity of individual’s intervention to their risk of reoffending.

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- **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).
# Addressing Criminogenic Risk Factors

## Individual Risk Factors for Criminal Recidivism

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of antisocial behavior</td>
<td>Build alternative behaviors</td>
</tr>
<tr>
<td>Antisocial personality pattern</td>
<td>Problem solving skills, anger management</td>
</tr>
<tr>
<td>Antisocial cognition</td>
<td>Develop less risky thinking</td>
</tr>
<tr>
<td>Antisocial attitudes</td>
<td>Reduce association with criminal others</td>
</tr>
<tr>
<td>Family and/or marital discord</td>
<td>Reduce conflict, build positive relationships</td>
</tr>
<tr>
<td>Poor school and/or work performance</td>
<td>Enhance performance, rewards</td>
</tr>
<tr>
<td>Few leisure or recreation activities</td>
<td>Enhance outside involvement</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Reduce use through integrated treatment</td>
</tr>
</tbody>
</table>

Source: Andrews (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)
Responsivity: You can’t address dynamic risk factors without attending to mental illness
Risk-Need-Responsivity Model as a Guide to Best Practices

• Focus resources on high **RISK** cases

• Target criminogenic **NEEDS**, such as antisocial behavior, substance abuse, antisocial attitudes, and criminogenic peers

• **RESPONSIVITY** – 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)
Creating Cross-System Collaboration

What Works in Mental Health Treatment

What Works in Substance Abuse Treatment

What Works in Recidivism Reduction

Behavioral Health Framework
Why a Shared Framework Was Needed

• Develop a shared language around the risk of criminal activity and public health needs

• Integrate the best practices in mental health treatment, substance abuse treatment, and recidivism reduction

• Help system administrators allocate scarce resources more wisely

• Maximize the impact of interventions on public safety and public health
ADULTS WITH BEHAVIORAL HEALTH NEEDS UNDER CORRECTIONAL SUPERVISION:
A Shared Framework for Reducing Recidivism and Promoting Recovery

National Institute of Corrections

Bureau of Justice Assistance
U.S. Department of Justice

Substance Abuse and Mental Health Services Administration

NASMHPD

Community Justice & Safety for All

PA

Justice Center
The Council of State Governments

BIA

Unicum sed Unitum
## Criminogenic Risk and Behavioral Health Needs Framework

<table>
<thead>
<tr>
<th>Low Criminogenic Risk (low)</th>
<th>Medium to High Criminogenic Risk (med/high)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Severity of Substance Abuse (low)</td>
<td>Substance Dependence (med/high)</td>
</tr>
<tr>
<td>Low Severity of Mental Illness (low)</td>
<td>Serious Mental Illness (med/high)</td>
</tr>
<tr>
<td>Low Severity of Mental Illness (low)</td>
<td>Serious Mental Illness (med/high)</td>
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### Groups

<table>
<thead>
<tr>
<th>Group 1</th>
<th>I – L</th>
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<tbody>
<tr>
<td>CR: low</td>
<td>CR: low</td>
</tr>
<tr>
<td>SA: low</td>
<td>SA: low</td>
</tr>
<tr>
<td>MH: low</td>
<td>MH: med/high</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 2</th>
<th>II – L</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR: low</td>
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</tr>
<tr>
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<td>SA: med/high</td>
</tr>
<tr>
<td>MH: med/high</td>
<td>MH: med/high</td>
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<table>
<thead>
<tr>
<th>Group 3</th>
<th>III – L</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR: low</td>
<td>CR: low</td>
</tr>
<tr>
<td>SA: low</td>
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<tr>
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<table>
<thead>
<tr>
<th>Group 4</th>
<th>IV – L</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR: low</td>
<td>CR: low</td>
</tr>
<tr>
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<td>SA: med/high</td>
</tr>
<tr>
<td>MH: med/high</td>
<td>MH: med/high</td>
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<table>
<thead>
<tr>
<th>Group 5</th>
<th>V – H</th>
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</thead>
<tbody>
<tr>
<td>CR: med/high</td>
<td>CR: med/high</td>
</tr>
<tr>
<td>SA: low</td>
<td>SA: med/high</td>
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<td>MH: low</td>
<td>MH: med/high</td>
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<table>
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<tr>
<th>Group 6</th>
<th>VI – H</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR: med/high</td>
<td>CR: med/high</td>
</tr>
<tr>
<td>SA: low</td>
<td>SA: med/high</td>
</tr>
<tr>
<td>MH: med/high</td>
<td>MH: med/high</td>
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<table>
<thead>
<tr>
<th>Group 7</th>
<th>VII – H</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR: med/high</td>
<td>CR: med/high</td>
</tr>
<tr>
<td>SA: med/high</td>
<td>SA: med/high</td>
</tr>
<tr>
<td>MH: med/high</td>
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<thead>
<tr>
<th>Group 8</th>
<th>VIII – H</th>
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<td>CR: med/high</td>
<td>CR: med/high</td>
</tr>
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High Criminogenic Risk with
High Behavioral Health Treatment Needs

- 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
Low Criminogenic Risk with High Behavioral Health Treatment Need

- Less intensive supervision and monitoring based
- Separation from high-risk populations
- **Access to effective treatments and supports**
- 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.
Low Criminogenic Risk
Without Significant Behavioral Health Disorders

- 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.
Developing Effective Interventions for Each Subgroup

It is assumed these responses will:

– Incorporate EBPs and promising approaches
– Be implemented with high fidelity to the model
– Undergo ongoing testing/evaluation
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Leadership by local government in NYC

New York’s Citywide Justice & Mental Health Initiative

“Five Boroughs, One City”

Citywide Stakeholders
- Mayor’s Office: Deputy Mayors for Health & Human Services, Criminal Justice Coordinator & Senior Policy Advisor
- City Council
- Dept. of Correction
- Dept. of Health & Mental Hygiene
- Dept. of Probation
- Dept. of Housing
- Dept. of Homeless Services
- Dept. of Human Resources and Administration/Dept. of Social Services
- Administration for Children’s Services
- NYPD

County-specific Stakeholders
- Judges from each borough (+ State Chief of Policy & Planning)
- Elected District Attorneys from each borough
- Contracted public defenders
- Community-based treatment providers
- Community-based alternatives to incarceration (ATIs)

State-level stakeholders
- Office of the Governor
- Office of Mental Health
- Office of Court Administration
- House of Representatives
County Support in Bexar County (TX)

County Commission
County Management
Sheriff
District Attorney
Public Defender
Courts
Community Mental Health
Judicial Services (Pretrial & Probation)
Community Substance Abuse
Local Law Enforcement
Innovative CJ/MH Collaborative Programs

- **ARREST**
  - Specialized Policing Responses
  - Assessment to Inform In/Out Decision
  - Diversion/Deferred Prosecution
  - Specialized Pretrial Supervision & Treatment
  - Mental Health/Holistic Defense
  - Mental Health Courts
  - Reentry Planning
  - Specialized Probation

- **INITIAL DETENTION**

- **COURT (ARRAIGNMENT)**

- **JAIL**
  - Hearings
  - Disposition/Sentencing
  - Reentry Planning
Initiatives from Arrest through Reentry

ARREST

INITIAL DETENTION

COURT (ARRAIGNMENT)

JAIL

HEARINGS

DISPOSITION/SENTENCING

REENTRY

Manhattan Arraignment Diversion Project (MAP)

Court-Based Intervention & Resource Teams (CIRTs):
- Post-arraignment alternatives to detention
- Alternatives to incarceration
- Reentry planning

Problem-solving courts

CIT
Crisis Receiving Center

Screening at magistration

CIT

Pretrial Improvement Project

Municipal Court Specialized Dockets

Problem-solving courts

ORAS for PSIs

Risk-based probation
Going from Principles to Policy and Practice

- Instruments to identify levels of need in three areas
- Information-sharing processes
- Decision-makers to use information about need
- Diverse options for treatment, supervision, case management to address different needs
- Collaboration, IT, training, data collection, performance measurement
Mayor announces the allocation of nearly $10 million to create “Court-based Intervention and Resource Teams” (CIRTs) to serve over 3,000 clients with mental health needs annually.

Information Available to Decision Makers

**Criminal Charge**

- Failure to Appear Risk Assessment
  - Mental Health Indicator
  - Criminogenic Risk Assessment
  - Substance Abuse Indicator

Dispositional Options

- **Cash Bail**
- **ROR**
- **Incarceration**
- **Alternative to Detention & Alternatives to Incarceration**
  - Additional capacity for pretrial supervision & community-based treatment in *every borough*
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
Opportunities for Counties

- Bring together the right people
- Understand how your system currently works
  - Screening? Assessment?
    - For what?
    - When?
  - Data
- Frank conversations about system goals, priorities, and resources
- Plan for implementation
- Stay in touch
Thank you!!!