

Coordinating a Systems Approach to Behavioral Health and Justice



Photo source for Fulton County Courthouse:
https://familysearch.org/learn/wiki/en/Fulton_County,_Georgia

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

Hallie Fader-Towe, Program Director
CSG Justice Center

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

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

JUSTICE CENTER

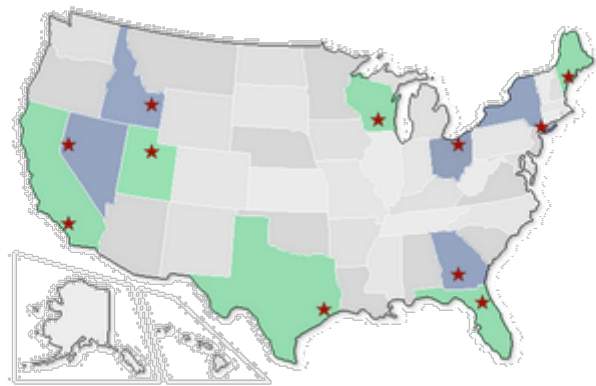
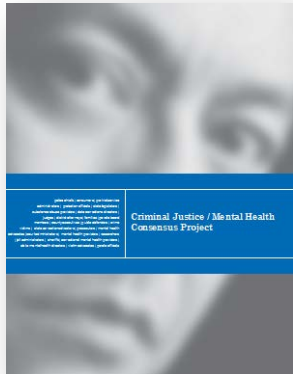
THE COUNCIL OF STATE GOVERNMENTS

Collaborative Approaches to Public Safety

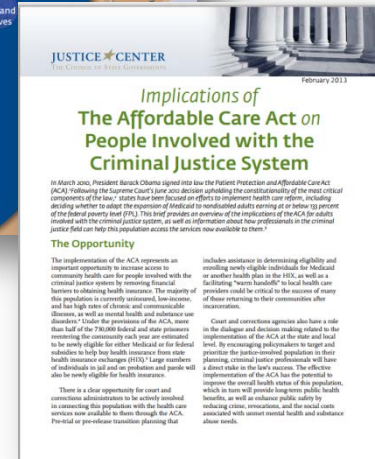
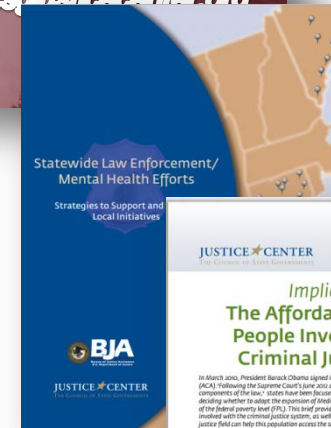
- National non-profit, non-partisan membership association of state government officials
- Engages members of all three branches of state government
- Justice Center provides practical, nonpartisan advice informed by the best available evidence



Criminal Justice/Mental Health at the CSG Justice Center



Criminal Justice/Mental Health Learning Sites Program



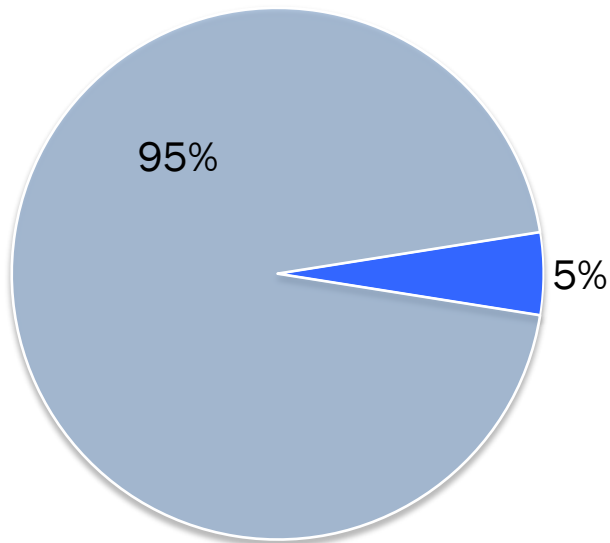



Today's Discussion


- **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

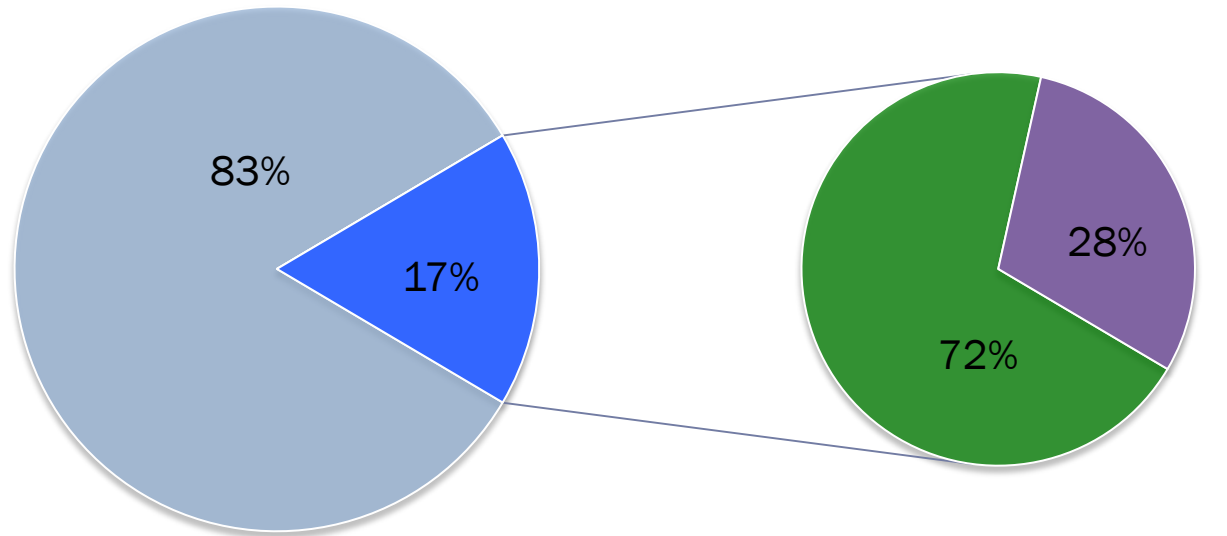
General Population





 Serious Mental Illness


 No Serious Mental Illness


Jail Population



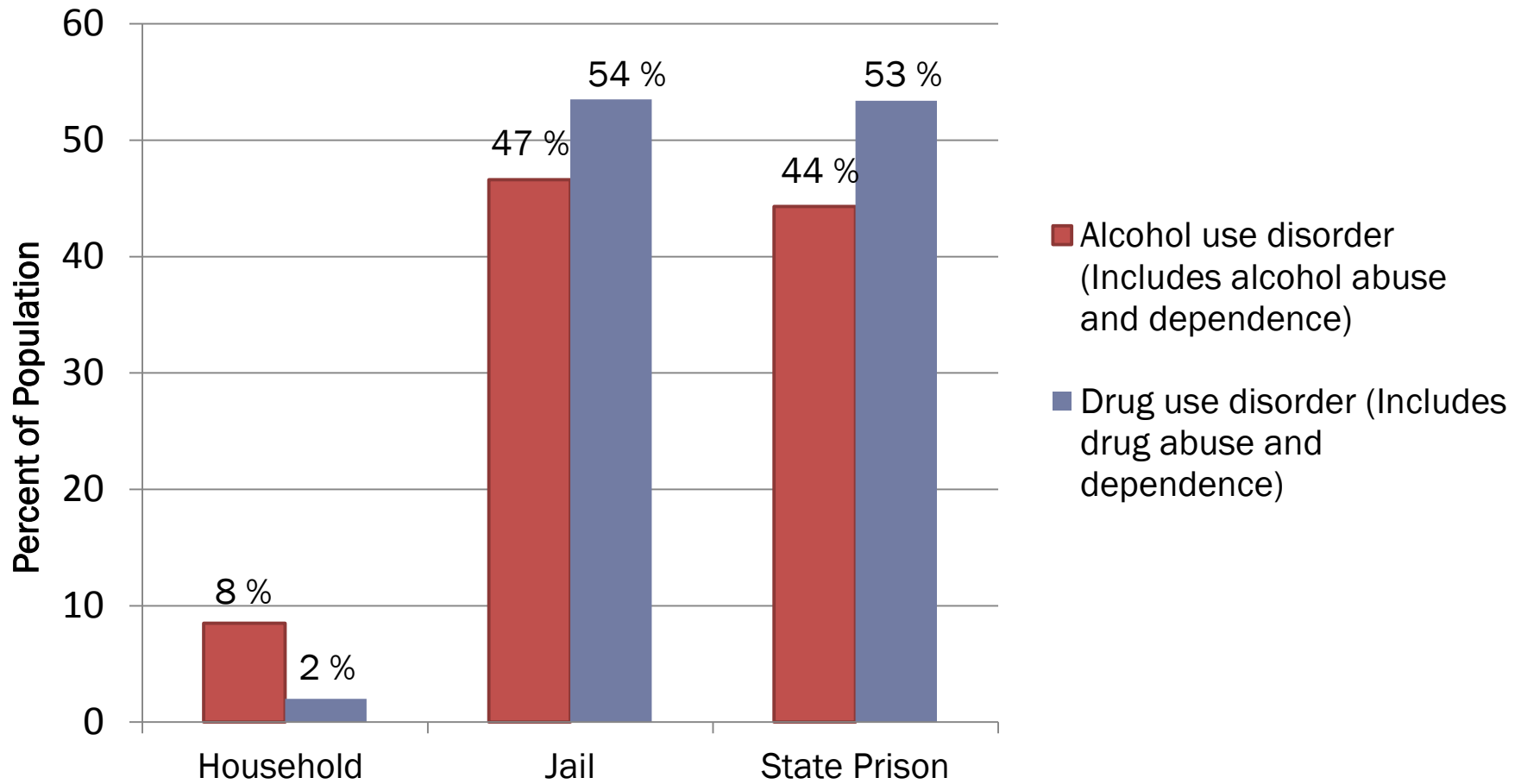
 Serious Mental Illness

 No Serious Mental Illness

 Co-Occurring Substance Use Disorder

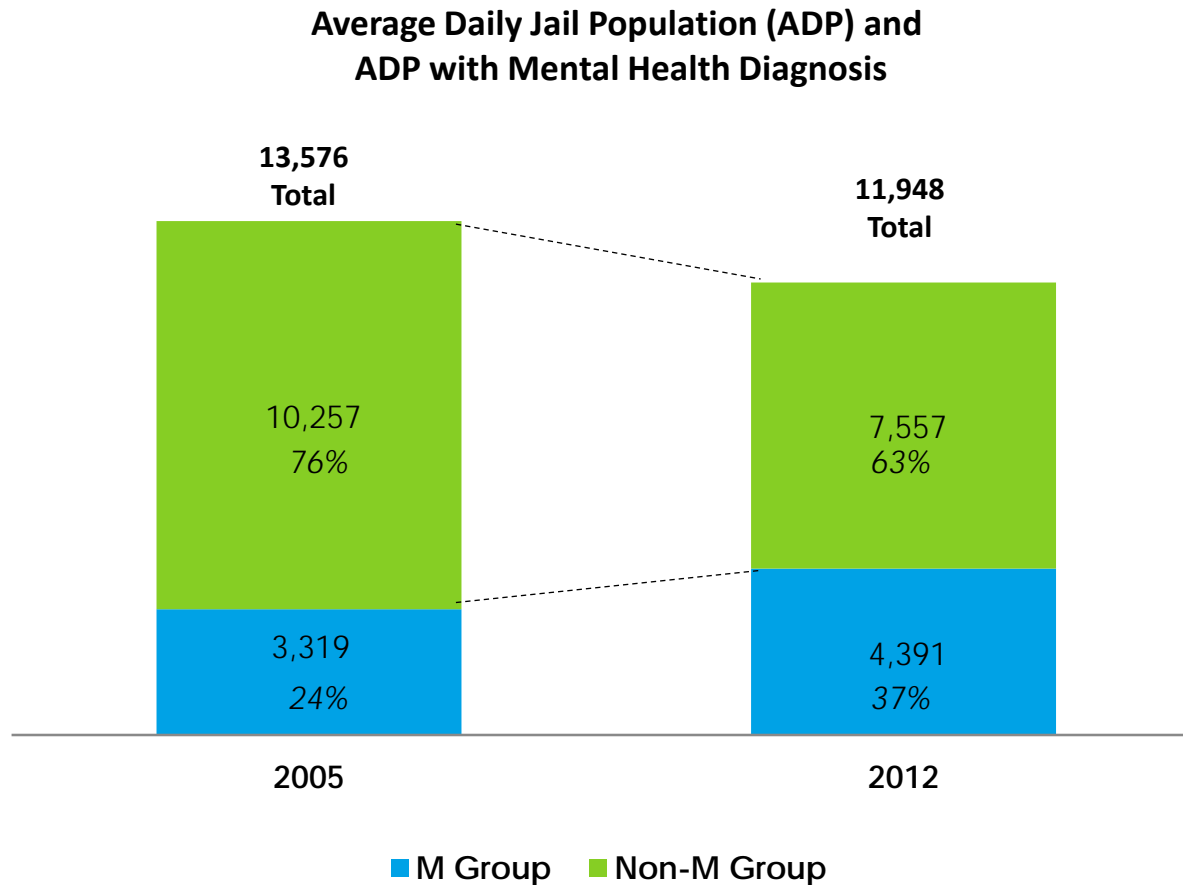
 No Co-Occurring Substance Use Disorder

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?



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,
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“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.”

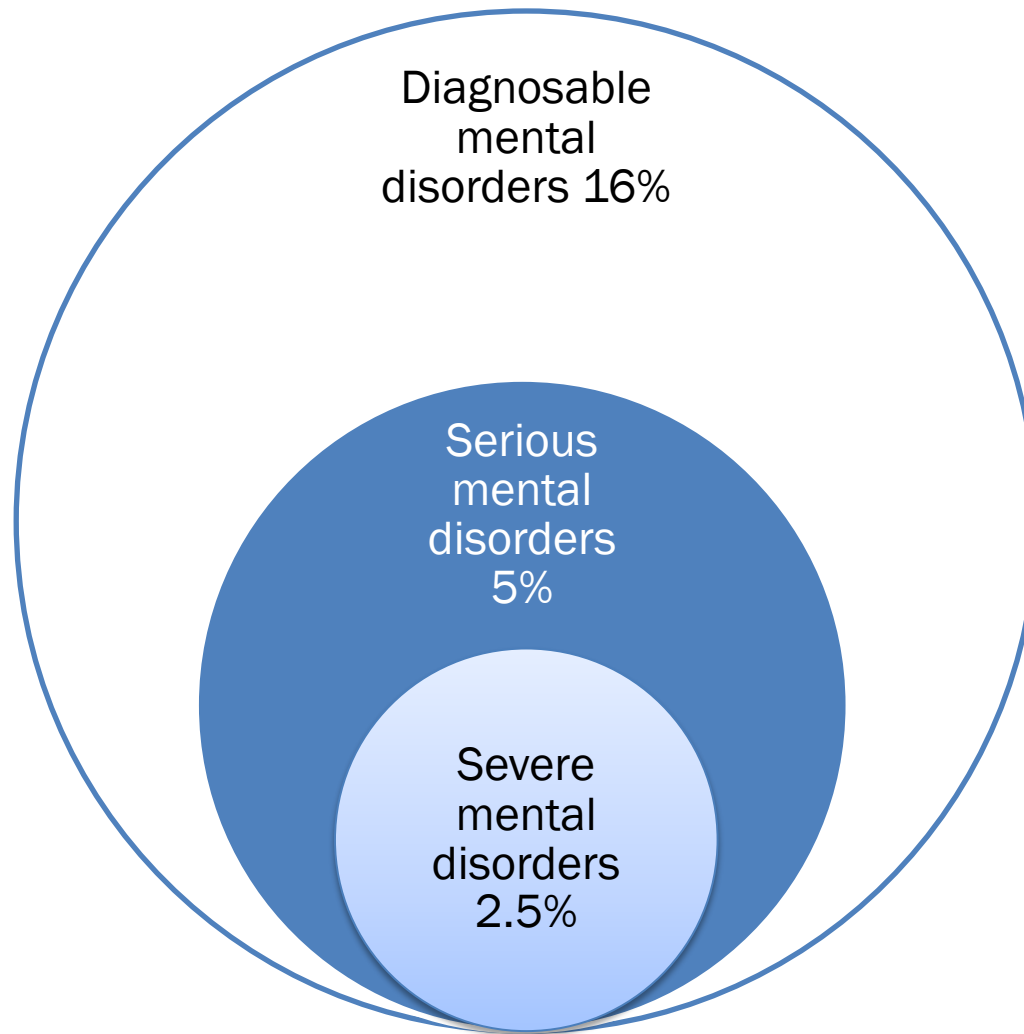
– Sheriff David Mahoney, Dane
County, WI



“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].”

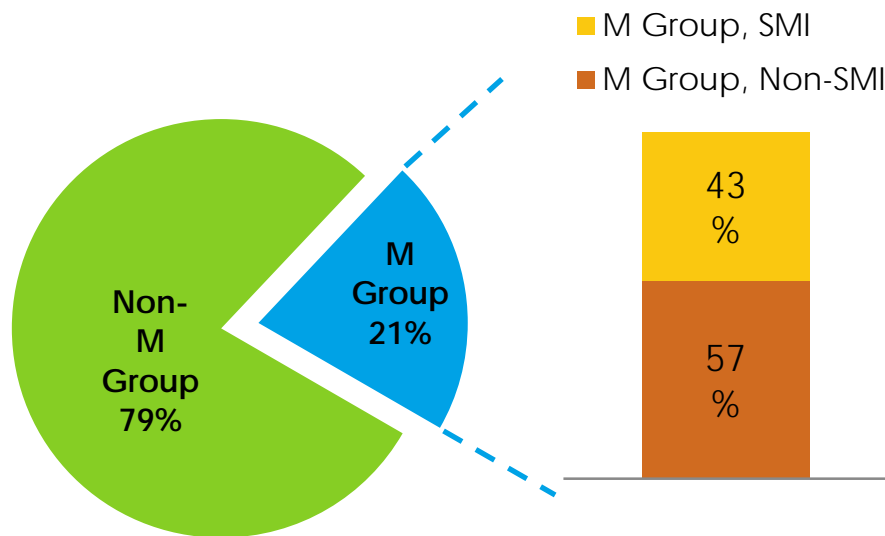
– Sheriff Tom Dart, Cook County, IL

Not all Mental Illnesses are Alike: Mental Illness in the General Population

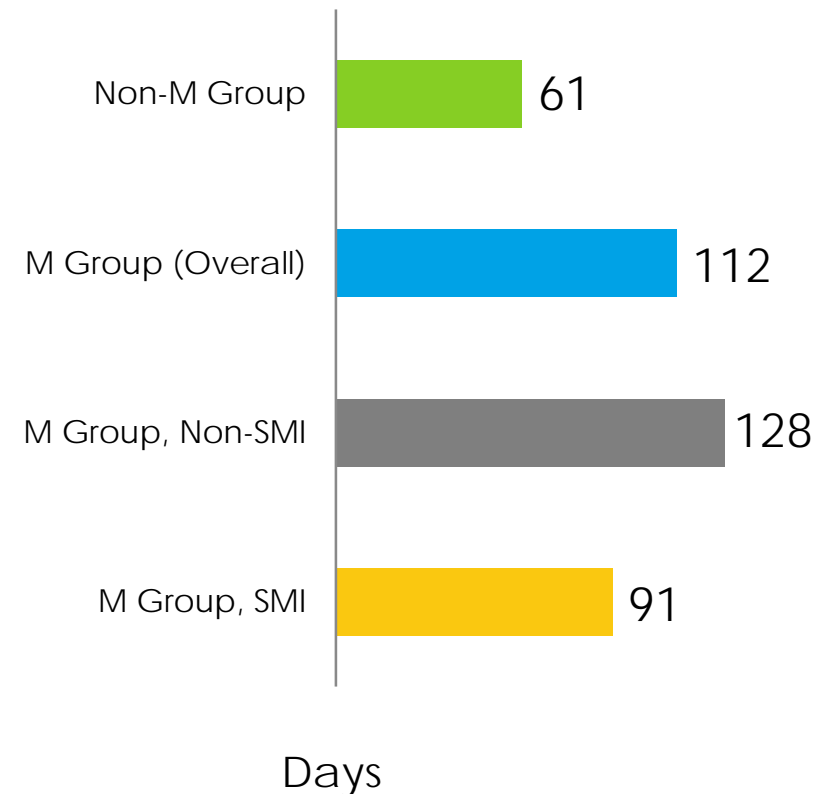


Not All Mental Illnesses are Alike: NYC Case Study

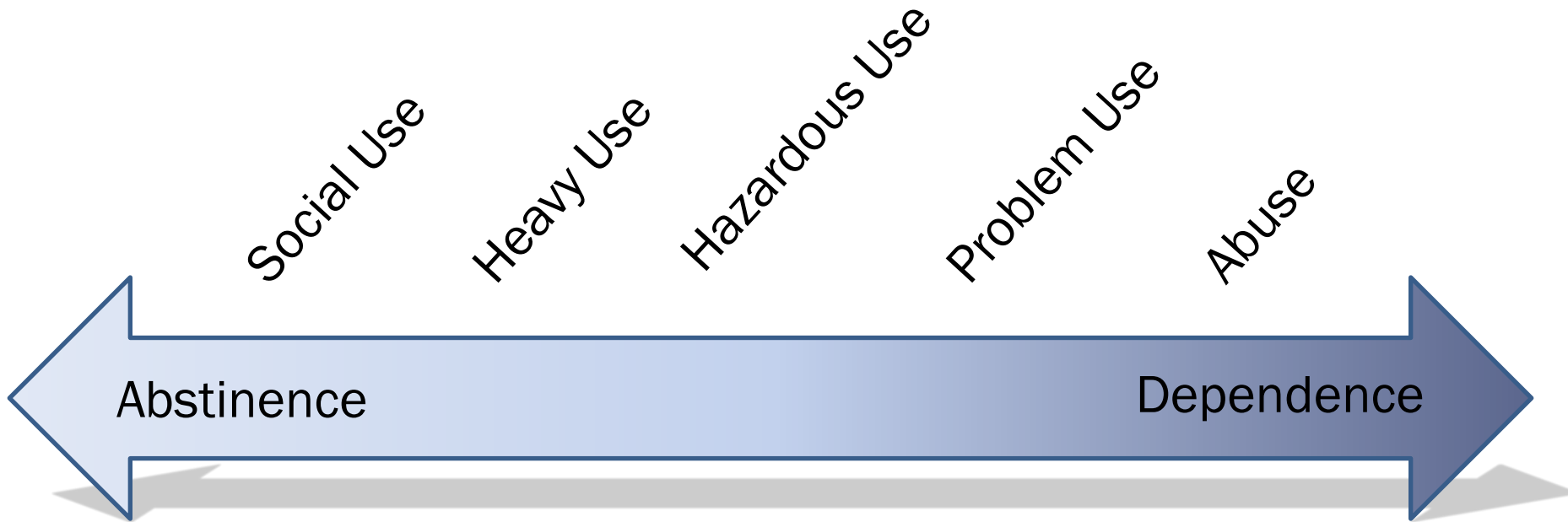
M Group- Disaggregated



ALOS



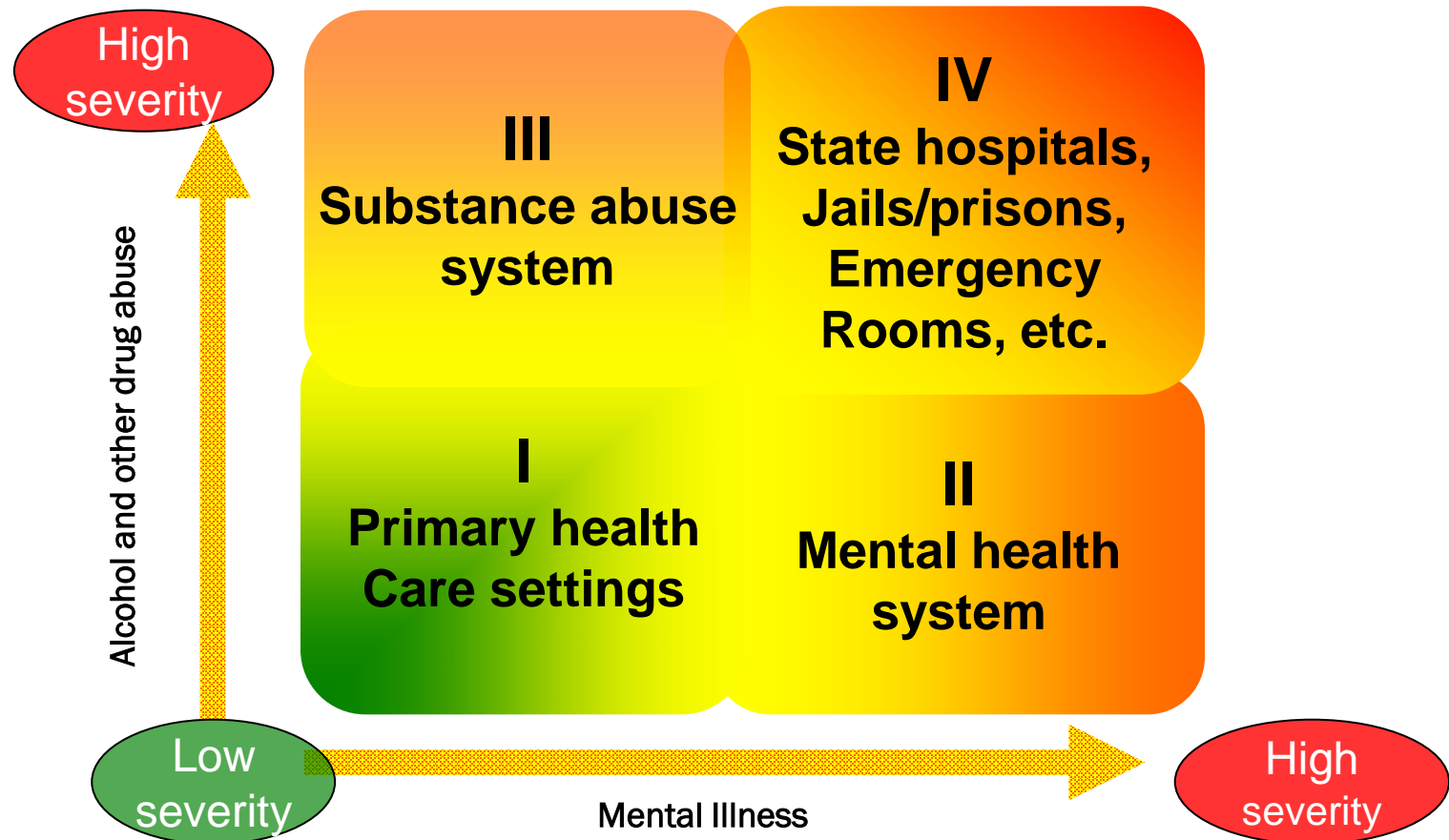
Not all Substance Use Disorders are Alike



The Substance Abuse Continuum

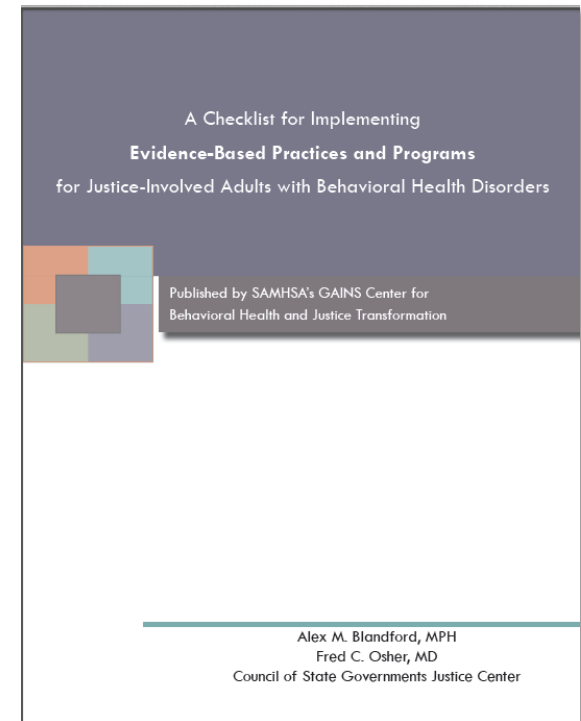
Framework for Addressing Population with Co-occurring MH & SU Disorders

(NASMHPD-NASADAD, 2002)



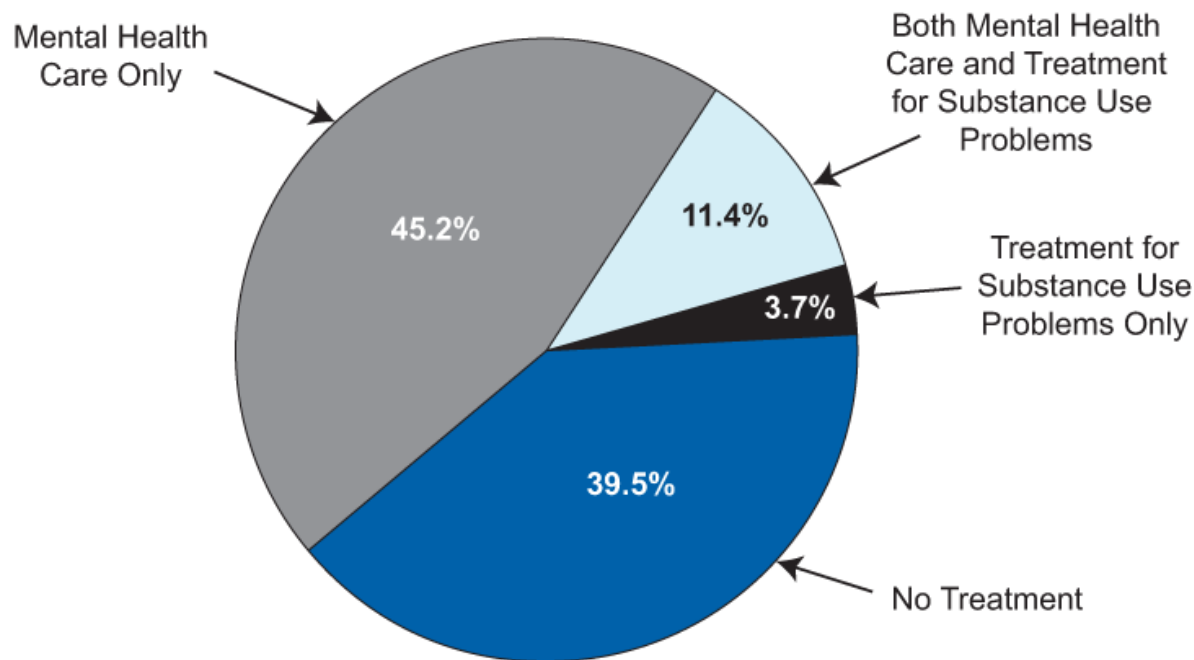
We increasingly know “what works”

- 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

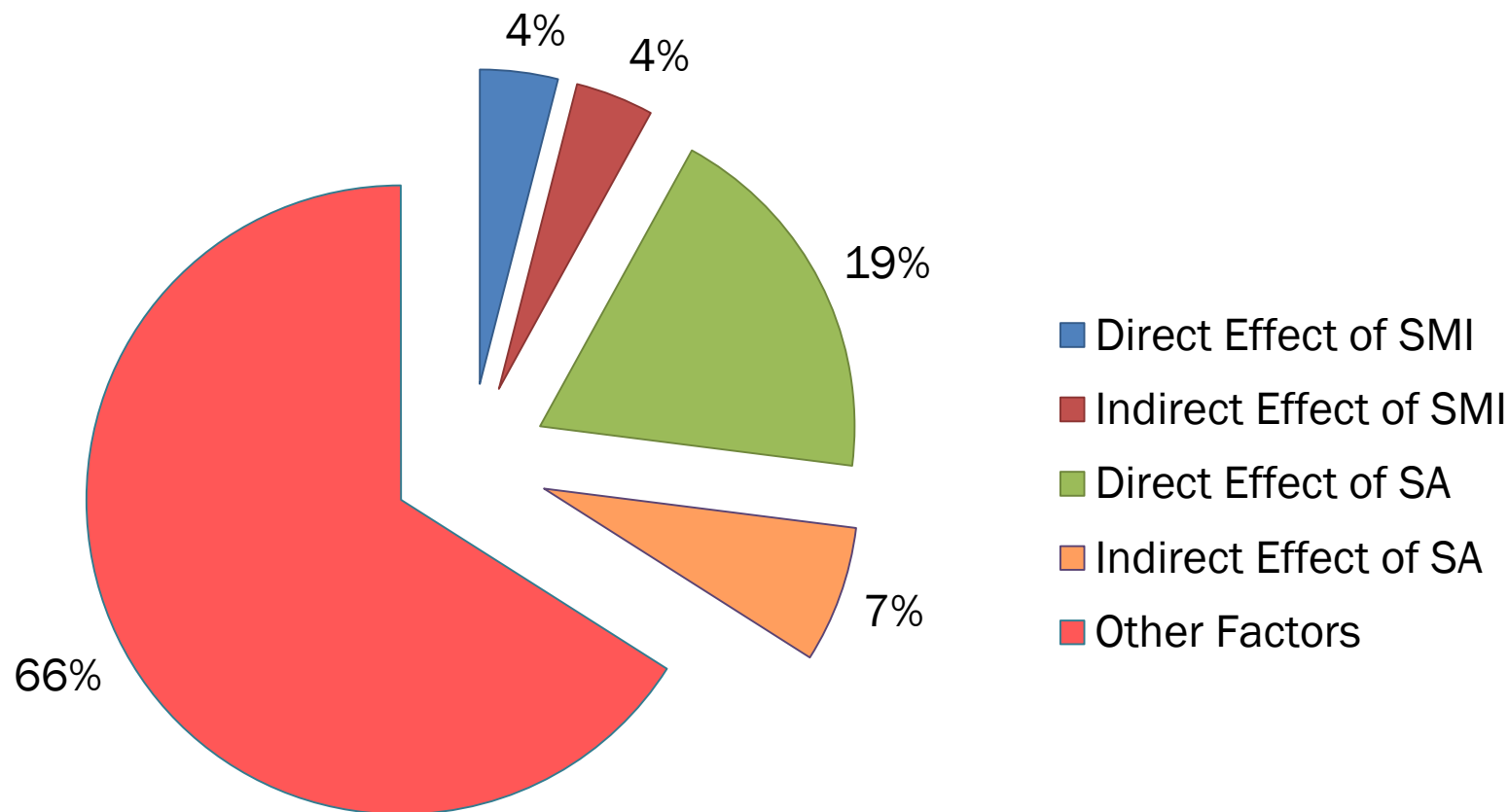


2.5 Million Adults with Co-Occurring SMI and Substance Use Disorder

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)?



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

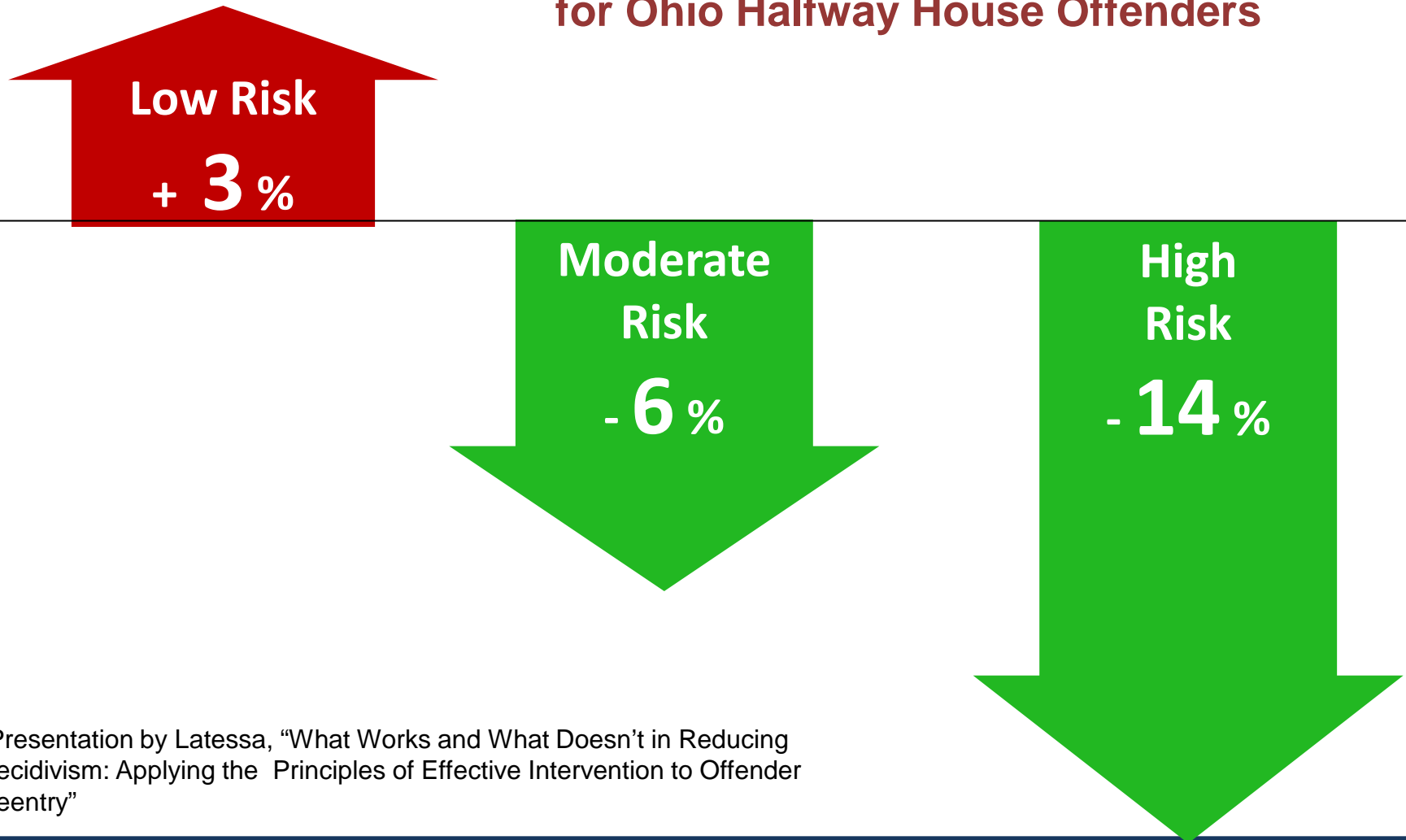
Risk:

- ≠ 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?

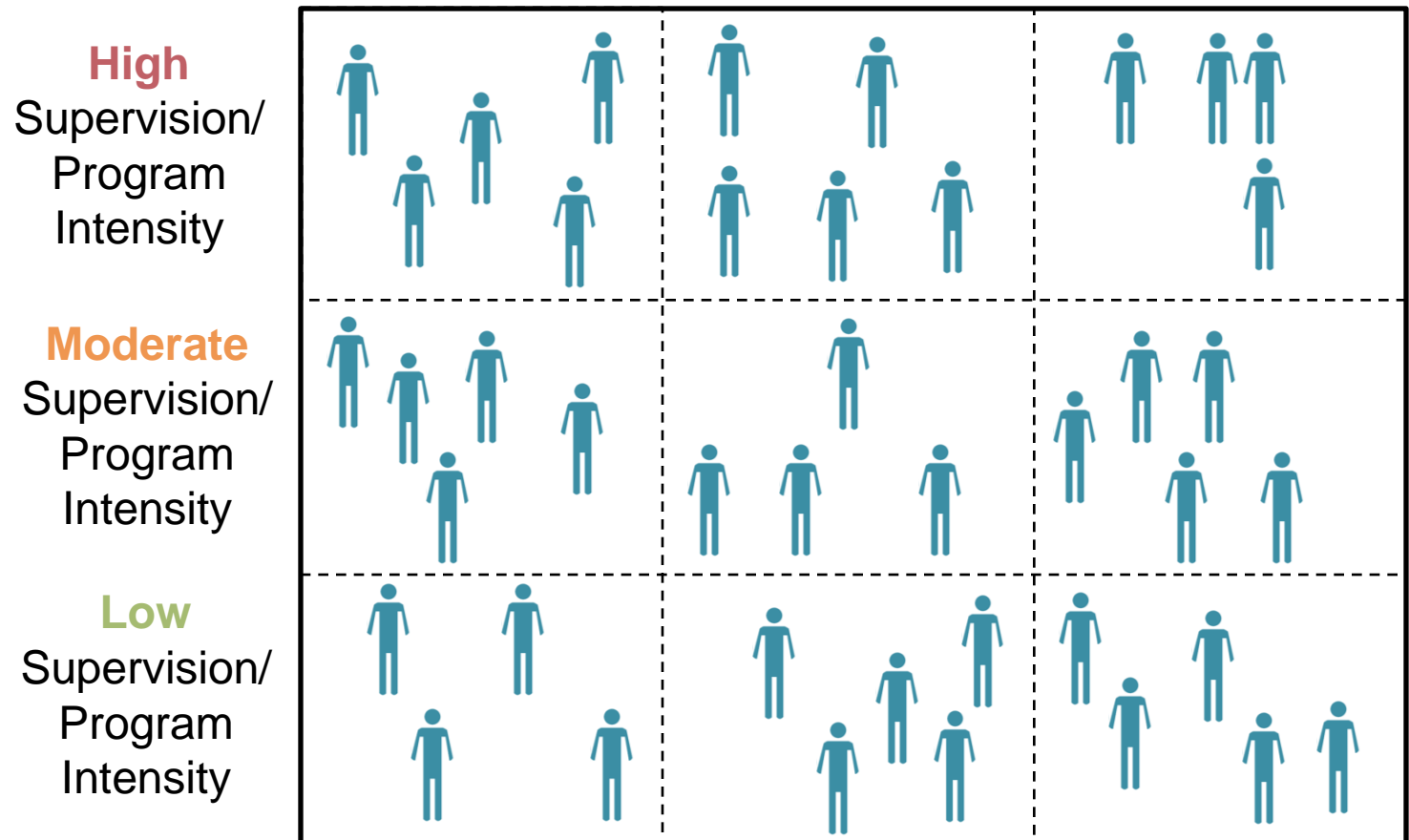
Using Criminogenic Risk To Sort Makes A Big Difference in Recidivism Reduction Outcomes

**Average Difference in Recidivism by Risk
for Ohio Halfway House Offenders**

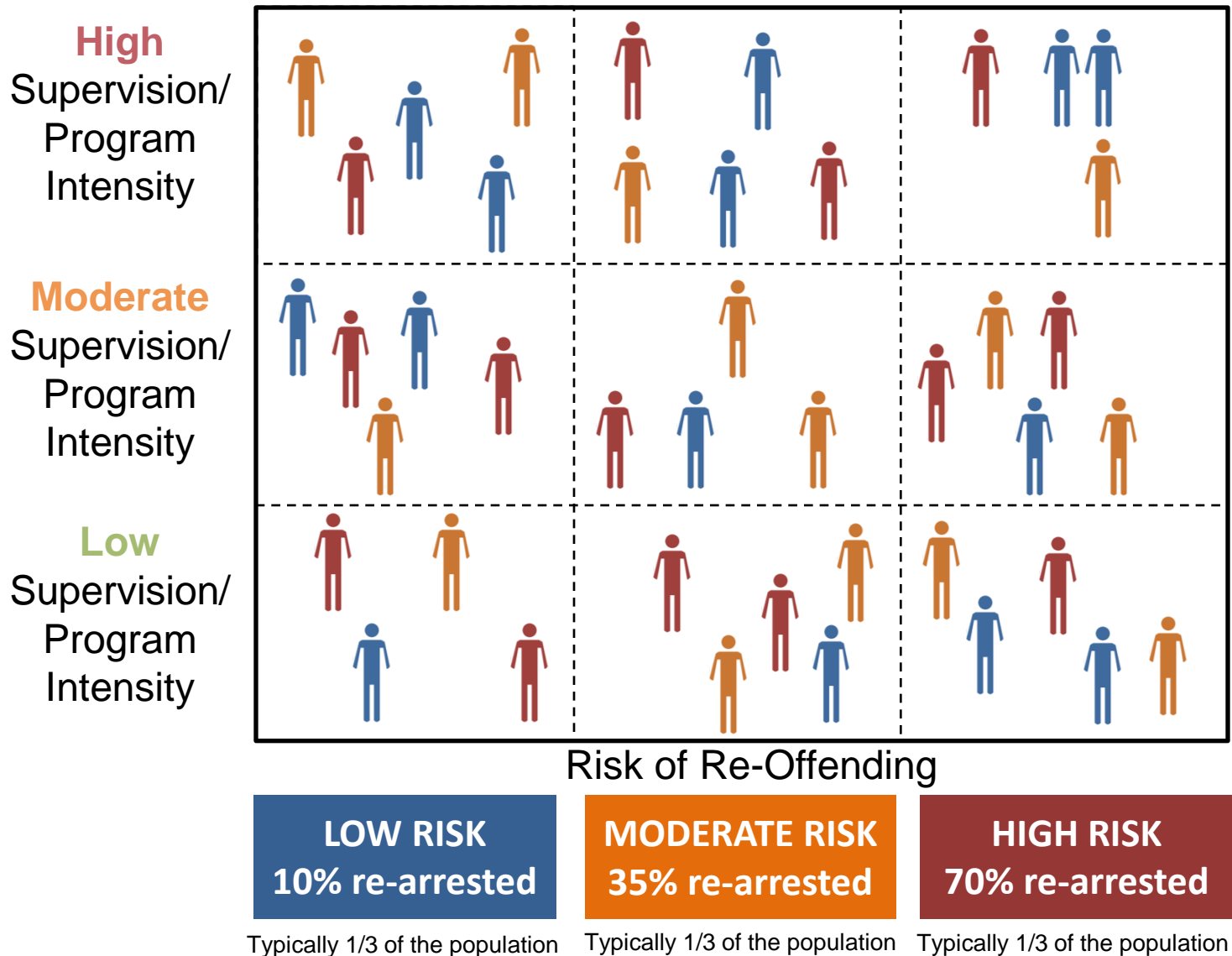


*Presentation by Latessa, "What Works and What Doesn't in Reducing Recidivism: Applying the Principles of Effective Intervention to Offender Reentry"

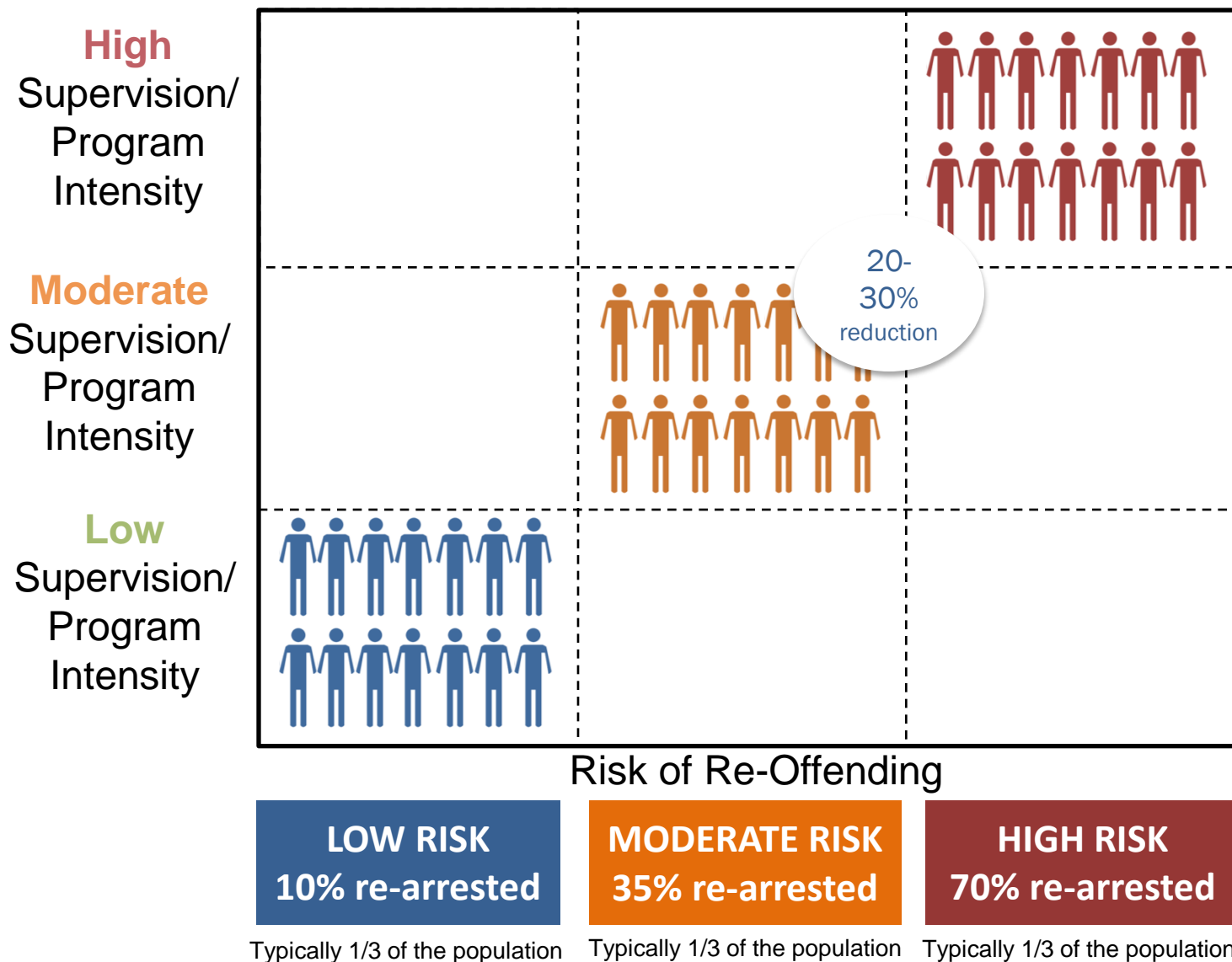
Without Assessing Risk of Re-Offending...



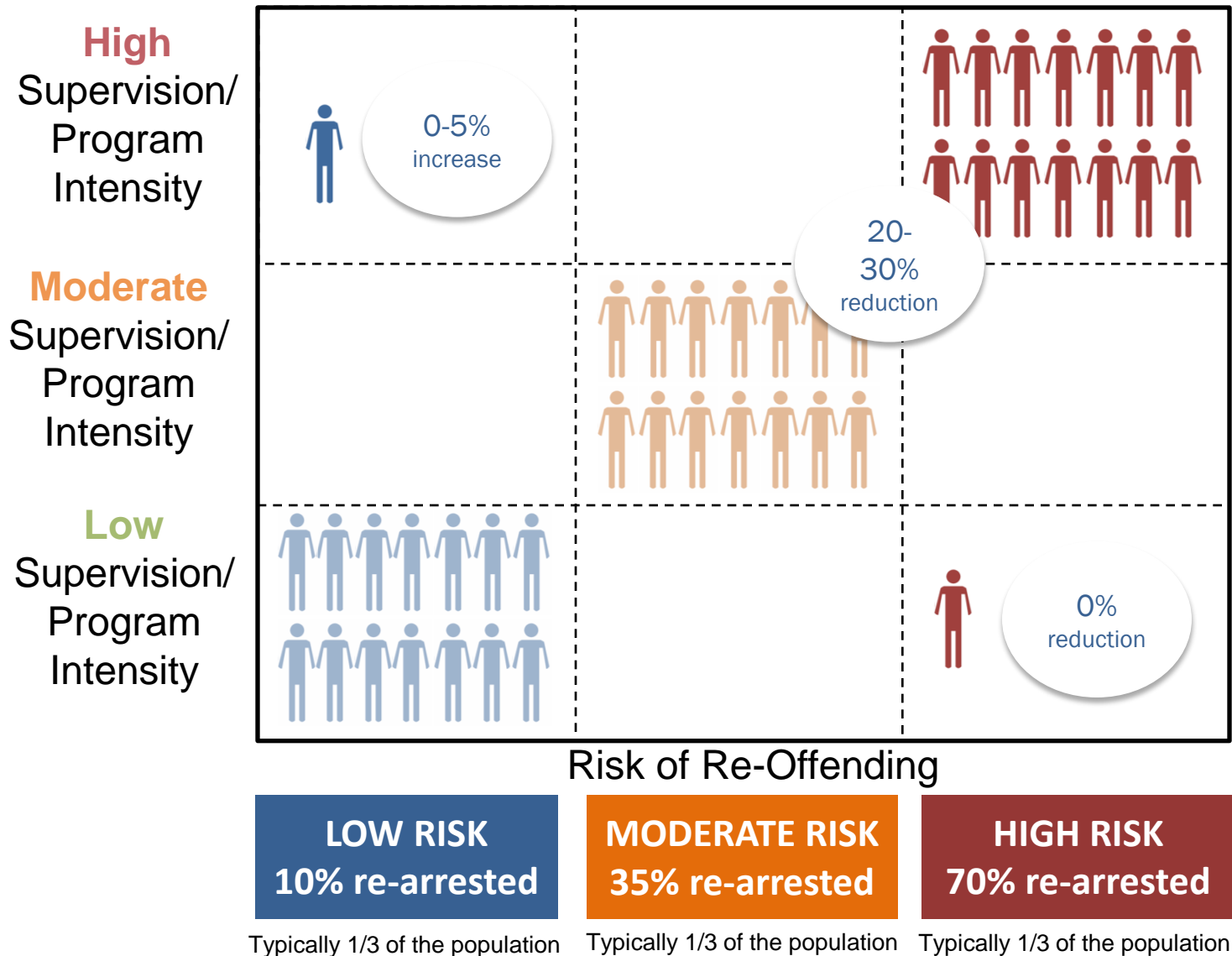
Assess for Risk of Re-Offending



Sort Based on Risk; Supervise Accordingly



Poor Recidivism Results When Risk Principle Not Applied



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

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Addressing Criminogenic Risk Factors

Individual Risk Factors for Criminal Recidivism

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

Source: Andrews (2006)

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

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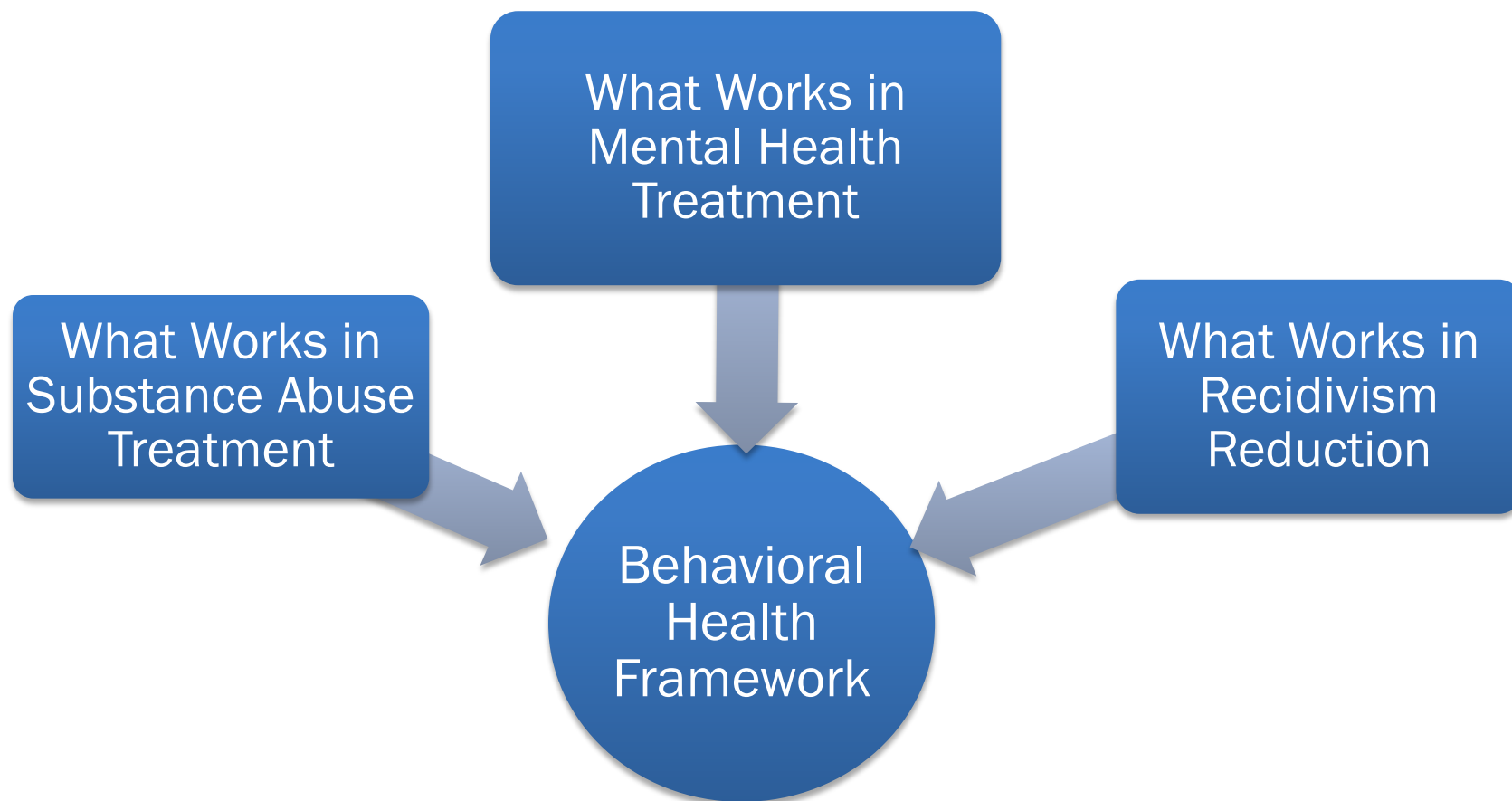
Responsivity: You can't address dynamic risk factors without attending to mental illness



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



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:

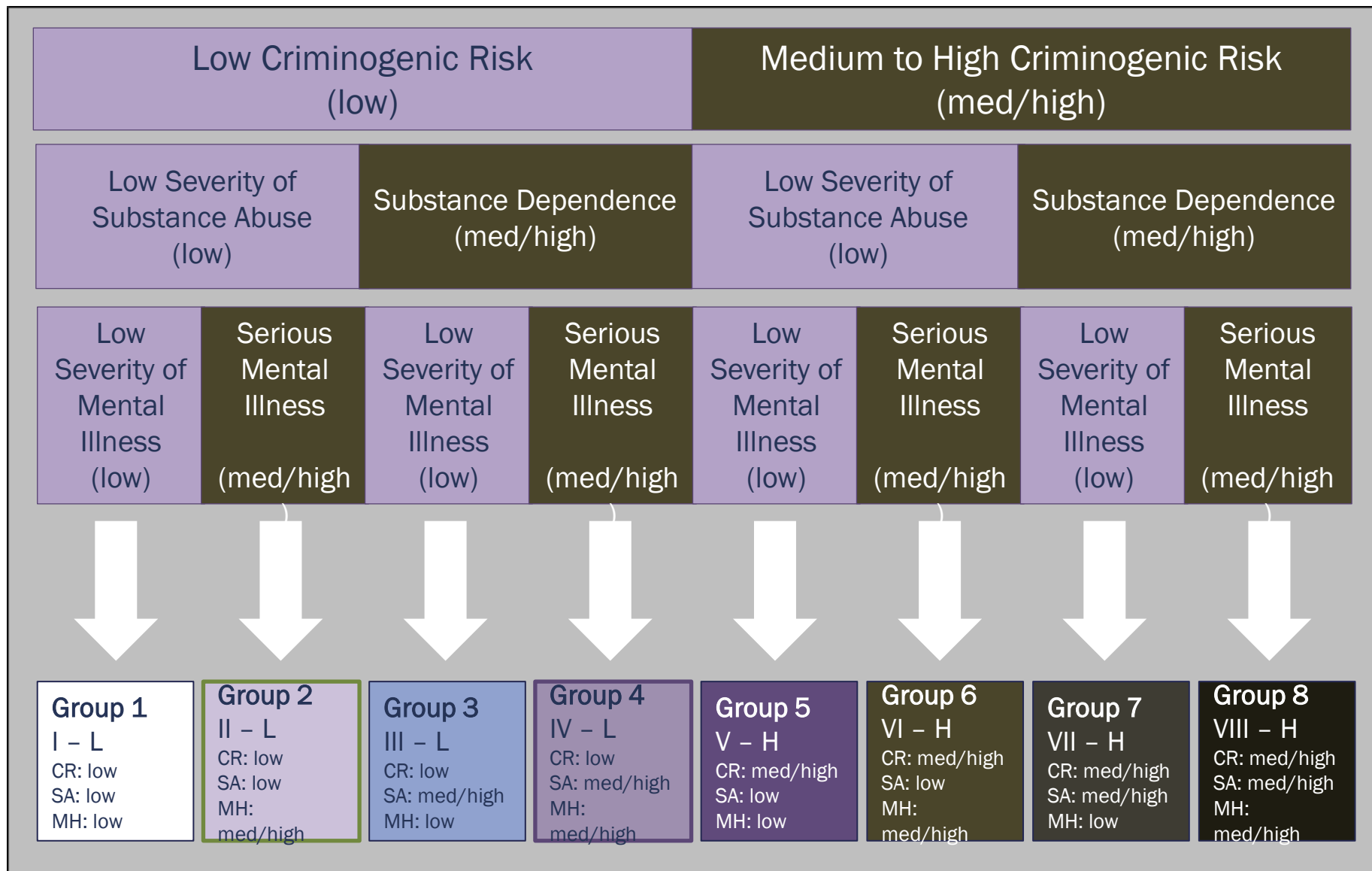
A Shared Framework for Reducing Recidivism and Promoting Recovery



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Criminogenic Risk and Behavioral Health Needs Framework



High Criminogenic Risk with High Behavioral Health Treatment Needs

Group 6	Group 7	Group 8
CR: MED/HIGH	CR: MED/HIGH	CR: MED/HIGH
SA: LOW	SA: MED/HIGH	SA: MED/HIGH
MI: MED/HIGH	MI: LOW	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

Low Criminogenic Risk with High Behavioral Health Treatment Need

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

- 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

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.**

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 SA: LOW MI: LOW	CR: LOW SA: LOW MI: MED/HIGH	CR: LOW SA: MED/HIGH MI: LOW	CR: LOW SA: MED/HIGH MI: MED/HIGH	CR: MED/HIGH SA: LOW MI: LOW	CR: MED/HIGH SA: LOW MI: MED/HIGH	CR: MED/HIGH SA: MED/HIGH MI: LOW	CR: MED/HIGH SA: MED/HIGH MI: 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

County officials: “Jails are the wrong place to treat mental illnesses”



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– Sheriff Tom Dart, Cook County, IL

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)

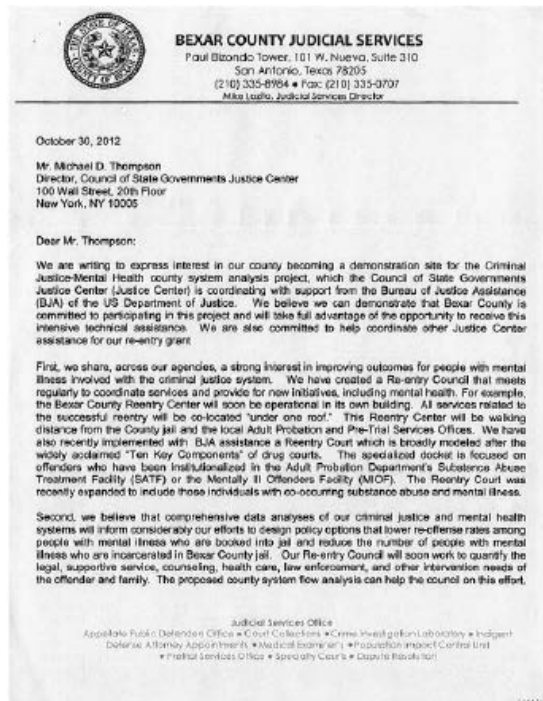
State-level stakeholders

- Office of the Governor
- Office of Mental Health
- Office of Court Administration
- House of Representatives

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County Support in Bexar County (TX)



Third, we will provide Justice Center staff with access to relevant information systems, consistent with state and federal laws regarding the privacy of these data. We have already instructed information technology staff to start working on extracting the databases needed for the project under the direction of Justice Center staff.

Fourth, we are committed to using this information constructively and collaboratively. We will meet periodically to guide the analyses that Justice Center staff conduct and the policy options they generate for our consideration.

Should you have any questions about our request, please contact Mike Lozito, Director, Judicial Services Office at 210-335-8932 or mlozito@bexar.org

The following Bexar County leaders are key stakeholders in this process and with this letter indicate their full support of this project and look forward to a productive partnership with the Council of State Governments Justice Center and the Bureau of Justice Assistance.

Tommy Addison
Tommy Addison
Bexar County Commissioner

David L. Smith
David L. Smith
Bexar County Manager

Ernie L. Glenn
Ernie L. Glenn
Bexar County Family Drug Court

Anna Sanchez
Anna Sanchez, Director
Bexar County Community Resources

Missa Barlow-Fischer
Missa Barlow-Fischer
Criminal District Court Administrator

Dianne Garcia
Dianne Garcia
Criminal County Courts Administrator

Mike Lozito
Mike Lozito, Director
Bexar County Judicial Services

Jarvis Agaferson
Jarvis Agaferson, Director
Bexar County Community Supervision and Corrections Department

Judicial Services Office
Appellate Public Defender Office • Court Collectors • Crime Investigation Laboratory • Indigent Defense Attorney Appointments • Medical Examiners • Population Impact Control Unit • Pretrial Services Office • Specialty Courts • Supportive Services

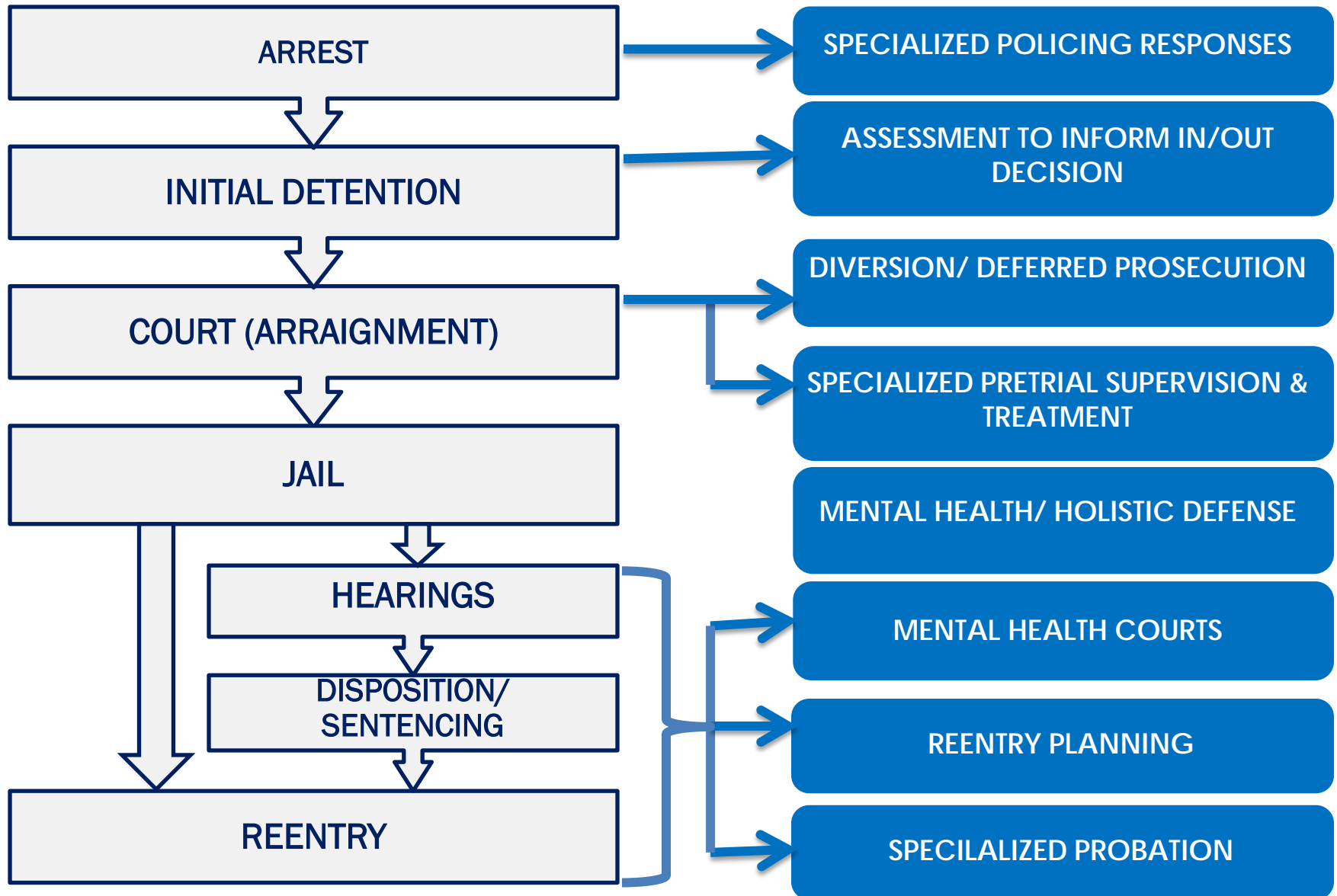
County Commission
County Management
Sheriff
District Attorney
Public Defender
Courts
Community Mental Health
Judicial Services (Pretrial & Probation)
Community Substance Abuse
Local Law Enforcement



BJA
Bureau of Justice Assistance
U.S. Department of Justice

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Innovative CJ/MH Collaborative Programs



Initiatives from Arrest through Reentry



CIT
Crisis Receiving Center

CIT

Screening at magistration

Pretrial Improvement
Project

Municipal Court
Specialized Dockets

Problem-solving courts

ORAS for PSIs

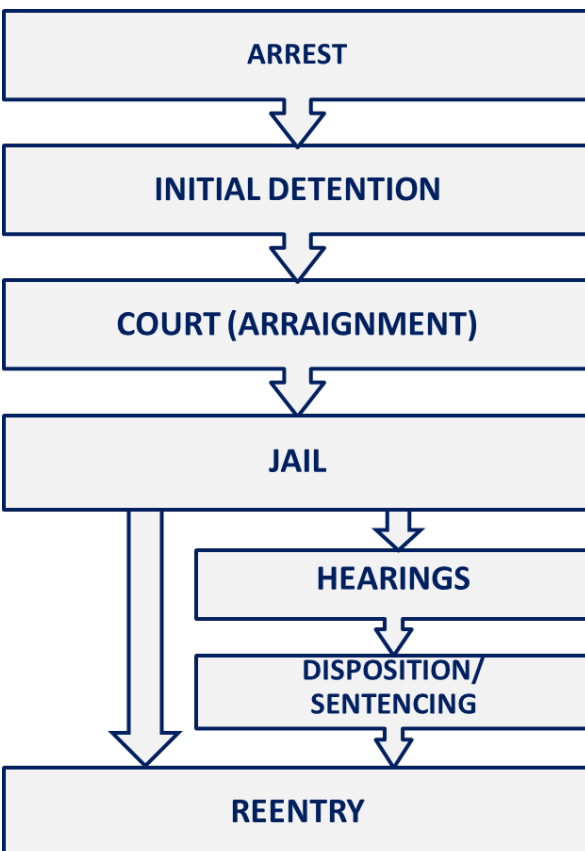
Risk-based probation

Manhattan Arraignment
Diversion Project (MAP)

Court-Based Intervention &
Resource Teams (CIRTs):

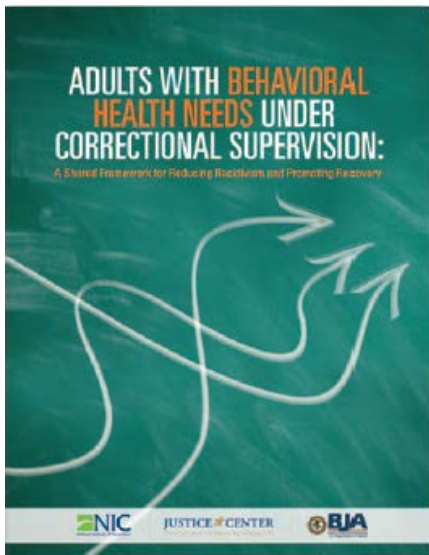
- Post-arraignment alternatives to detention
- Alternatives to incarceration
- Reentry planning

Problem-solving courts



Going from Principles to Policy and Practice

Instruments to identify levels of need in three areas



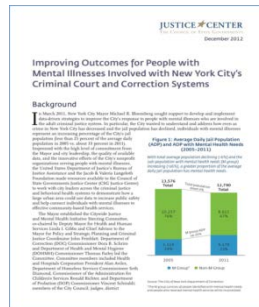
Information-sharing processes

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

Dispositional Options

Criminal Charge

+

Failure to Appear Risk Assessment

+

Mental Health Indicator

+

Criminogenic Risk Assessment

+

Substance Abuse Indicator

Proposed community-based treatment and supervision plan developed by borough “Court-based Resource & Intervention Team” (CIRT)



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*

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NACO National Association of Counties
The Voice of America's Counties

Thank you!!!

Hallie Fader-Towe
hfader@csg.org



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