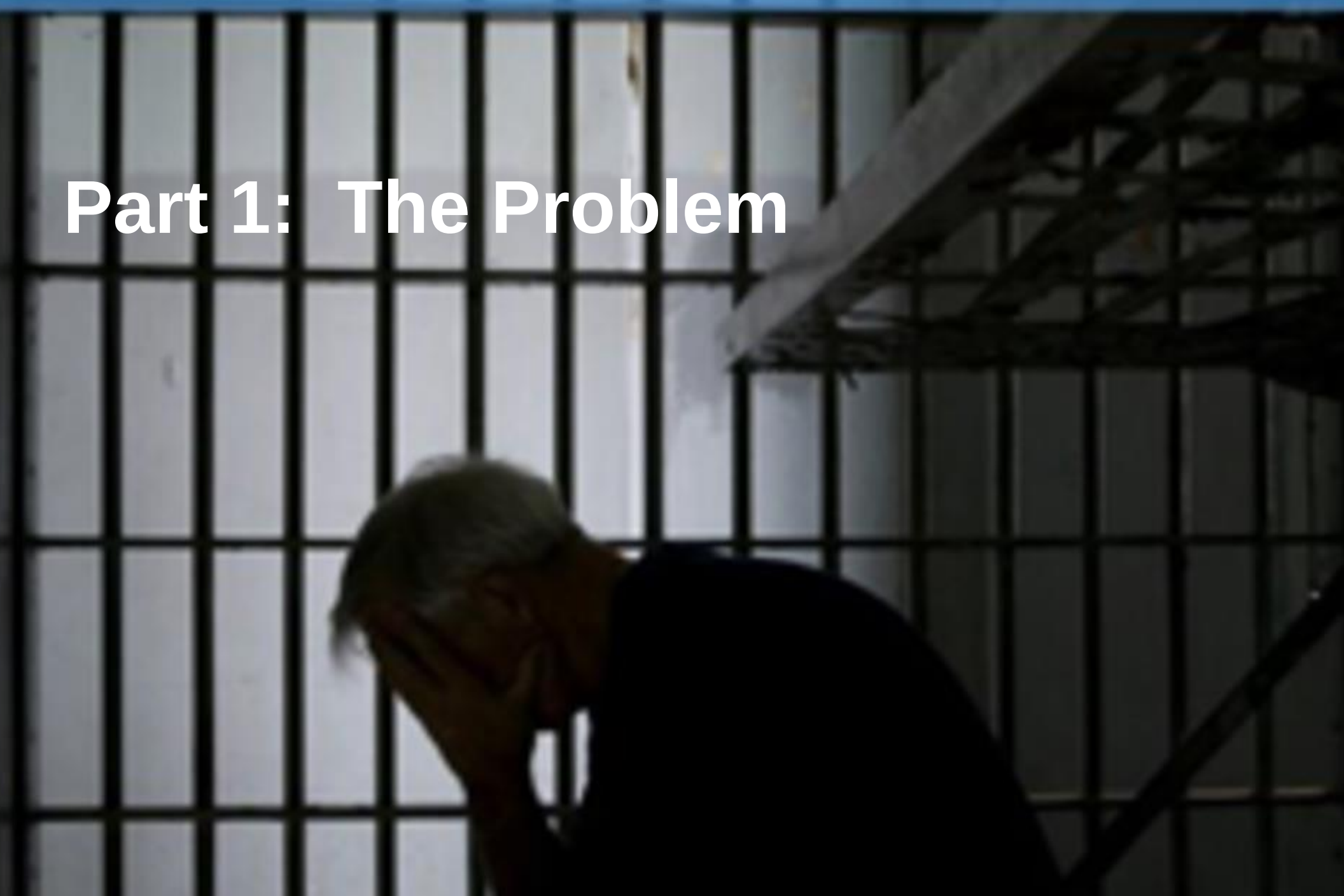
Understanding and Preventing Criminal Recidivism among People with Serious Mental Illness

J. Steven Lamberti, MD
Professor of Psychiatry
Academic Chief, Community Division
Chair, Research Subject Review Board for
Behavioral and Social Sciences
University of Rochester Medical Center

Declaration of Interest

- Dr. Lamberti is co-founder of Community Forensic Interventions, LLC



Part 1: The Problem

"All the News That's Fit to Print"

The New York Times

Late Edition
New York: Today, a mix of sun and clouds. High 45. Tonight, becoming mainly clear. Lows in the lower 30's. Tomorrow, sunny, high 45. Yesterday, high 51, low 40. Details on page D26.

VOL. CXLVII . . . . No. 51,087 NEW YORK, THURSDAY, MARCH 5, 1998 © beyond the greater New York metropolitan area. 60 CENTS

Prisons Replace Hospitals for the Nation's Mentally Ill

By FOX BUTTERFIELD

LOS ANGELES — Michael H. had not had a shave or haircut in months when he was found one recent morning sleeping on the floor of St. Paul's Episcopal Church in suburban Lancaster, next to empty cans of tuna and soup from the church pantry.

There was little to suggest that he had once been a prosperous college graduate with a wife and two children — until he developed schizophrenia, lost his job and, without insurance, could no longer afford the drugs needed to control his mental illness.

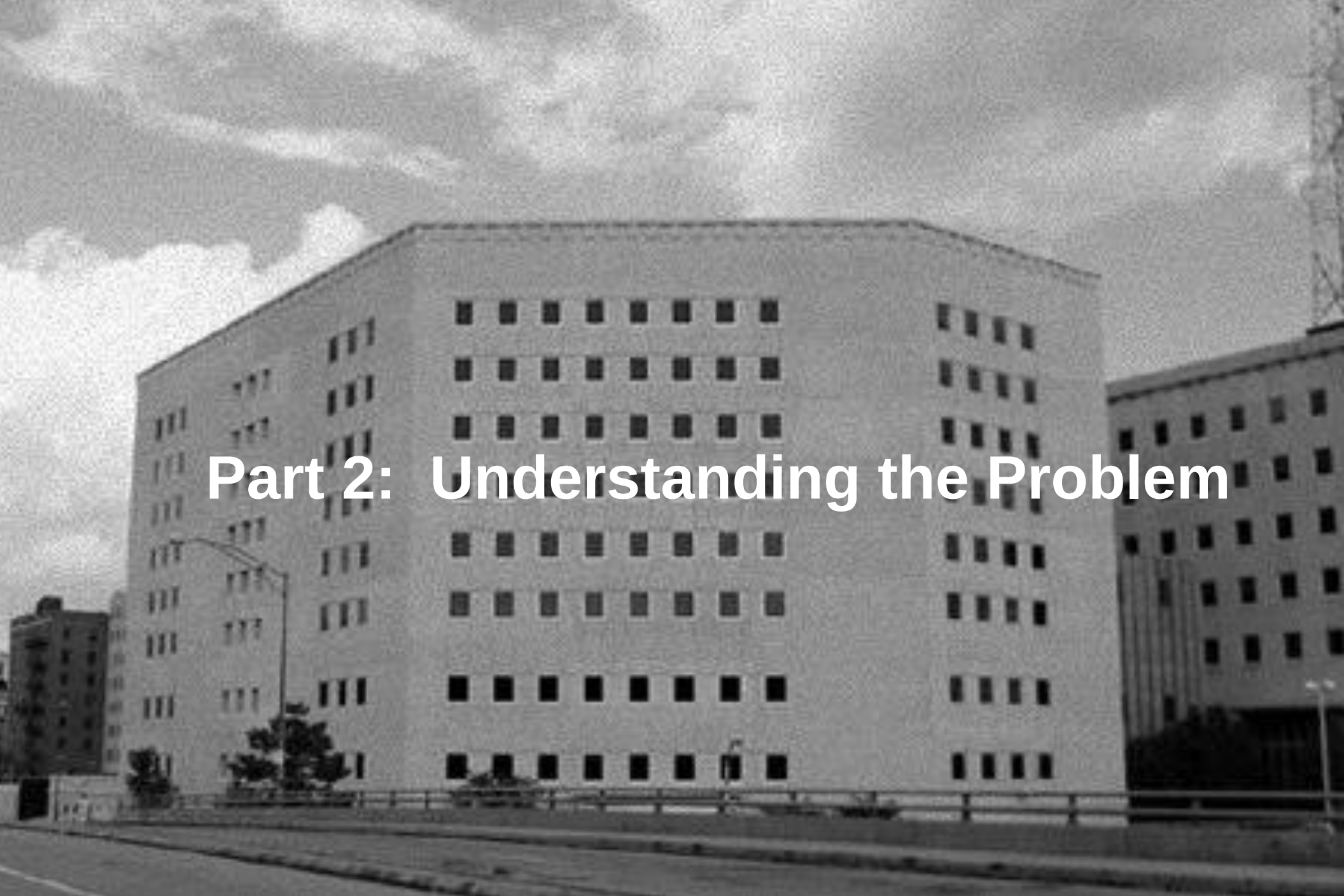
Charged with illegal entry and burglary, Michael H. was taken to the Los Angeles County Jail. The jail, by default, is the nation's largest mental institution. On an average day, it holds 1,500 to 1,700 inmates who are severely mentally ill, most of them detained on minor charges, essentially for being public nuisances.

The situation in the jail, scathing-

WHY?

True or False:

- The main reason mentally ill individuals end up in the criminal justice system is because of lack of mental health services.



Part 2: Understanding the Problem

- *Why are people with mental illness over-represented in the criminal justice system?*

Risk – Needs – Responsivity

“RNR”

Criminogenic Risk Factors

The "Central Eight"

1. History of Antisocial Behavior
2. Antisocial Personality
3. Antisocial Cognition
4. Social Support for Crime
5. Family/Marital Problems
6. Work/School Problems
7. Lack of Healthy Recreation
8. Substance Use

True or False:

- Mental illness is a risk factor for crime.

Psychosis and Mania

Increasingly Recognized as Risk Factors

- McNiel et al 2000
- Hodgins et al 2003
- Joyal et al 2004
- Wallace et al 2004
- Modestin and Wuermie, 2005
- Quanbeck et al 2005
- Swanson et al 2006
- Junginger et al 2006
- Coid et al 2007
- Christopher et al 2012
- Peterson et al 2014
- Lamberti et al 2017

- **Psychotic Symptom Examples:**
  - Command Auditory Hallucinations
  - Persecutory Delusions
  - Agitation and Violence

- **Manic Symptom Examples:**
  - Reckless Driving
  - Impulsivity
  - Agitation and Violence

Criminogenic Risk Factors

In People with Serious Mental Illness

1. History of Antisocial Behavior
2. Antisocial Personality
3. Antisocial Cognition
4. Social Support for Crime
5. Family/Marital Problems
6. Work/School Problems
7. Lack of Healthy Recreation
8. Substance Use
9. Psychosis and Mania

→ **Only 10% of arrests**

Criminogenic Risk Factors Are More Common Among Adults With Serious Mental Illness

Recidivism Risk Factor	Schizophrenia Prevalence Rate	General Population Prevalence Rate
Substance Use	40%	10%
Antisocial Personality	6%	3%
Unemployment	73%	5%
Dropping Out of High School	50%	25%

Miklowitz et al. 2003, Moran & Hodgins 2004; Rosenheck et al. 2006; SAMHSA 2011; BJS 2016; NAMI 2013

Adults with Severe Mental Illness Also Have **Responsivity Factors**

- History of Trauma
- Cognitive Impairment
- Lack of Energy and Motivation
- Paranoia

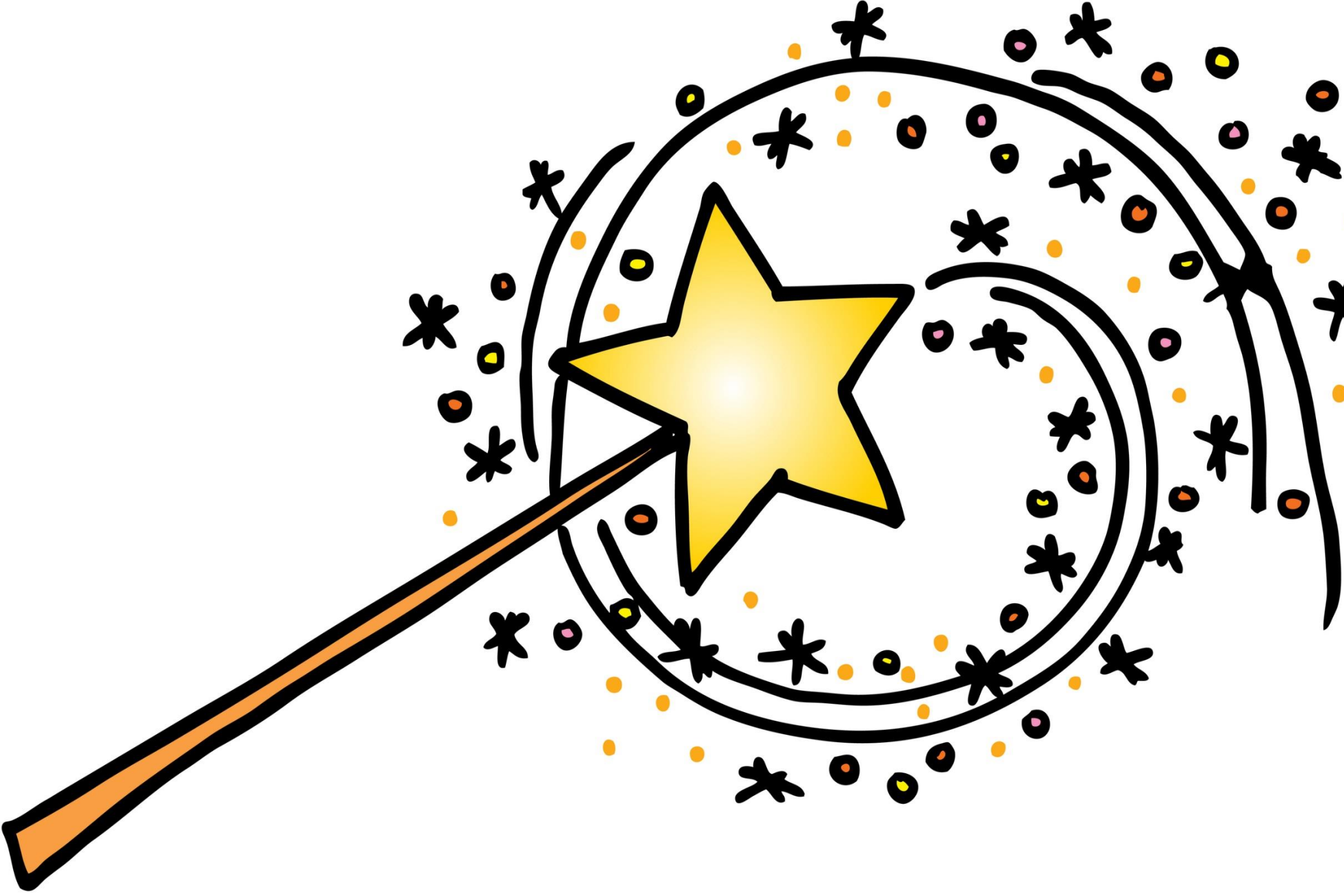
People With Severe Mental Illness are **Stigmatized**

- Portrayed by the media as unpredictable, dangerous and evil.
- Such implicit beliefs can affect how criminal justice professionals interact with mentally ill persons.
- Stigma also influences public policy decisions about access to treatment, housing and other services that bring people with mental illness into closer contact with the criminal justice system.

Why are people
with psychosis and mania
over-represented
in the criminal justice system?

Four Reasons

1. They have an extra risk factor
2. They have more of the other risk factors
3. They have responsivity factors
4. They are stigmatized



The Key to Prevention

- The key to preventing criminal recidivism among people with serious mental illness is to engage them in interventions that target the risk factors driving the cycle.

Lamberti 2007, Andrews and Bonta 2010, Latessa et al 2014

Understanding and Preventing Criminal Recidivism Among Adults With Psychotic Disorders

J. Steven Lamberti, M.D.

The high prevalence of adults with psychotic disorders in the criminal justice system has received much attention recently, but our understanding of this problem is marked by diverging opinions. Mental health professionals point to deinstitutionalization and our fragmented mental health system as primary causes. Criminologists minimize the role of mental illness and contend that persons with and without mental illness are arrested for the same reasons. Meanwhile, practice guidelines offer little guidance to clinicians about how to address the problem. Drawing upon contemporary crime prevention principles as well as current knowledge of psychotic disorders and their treatment, this article presents a conceptual framework for understanding and preventing criminal recidivism. The framework highlights the importance of individual and service-system risk variables and emphasizes the central role of treatment nonadherence as a mediator between modifiable risk variables and recidivism. On the basis of the conceptual framework described in this article, three necessary elements of intervention are presented for preventing recidivism among adults with psychotic disorders: competent care, access to services, and legal leverage. Research is needed to further define and test these intervention elements as foundations for future service delivery efforts. (*Psychiatric Services* 58: 773–781, 2007)

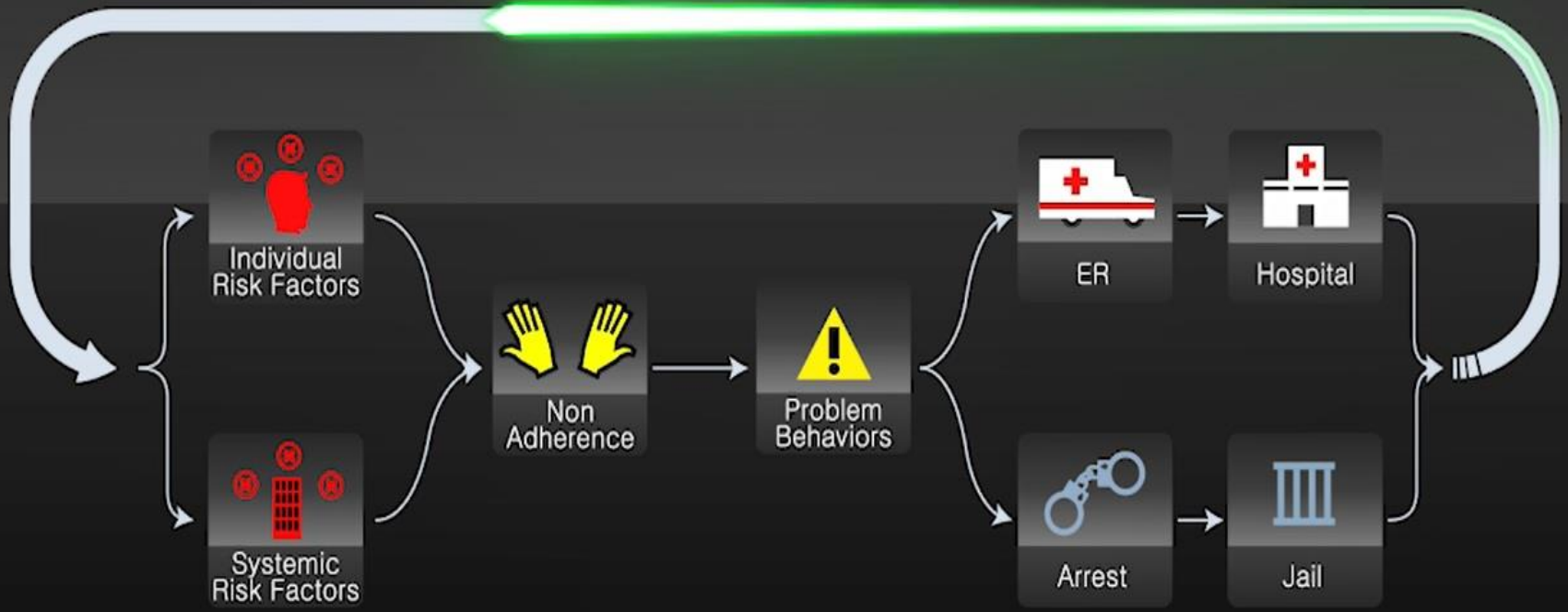
On March 5, 1998, the *New York Times* published a front-page headline stating "Prisons Replace Hospitals for the Nation's Mentally Ill" (1). Five years later a Human Rights Watch report noted that more people with severe men-

disorders as well as the current literature in the field of criminology. On the basis of this review and synthesis, a conceptual framework for understanding and preventing criminal recidivism is proposed and necessary elements of intervention are identified

other psychotic disorders from more rigorous studies are also concerning. Using data from the Epidemiologic Catchment Area program, Robins and Regier (6) found that 6.7% of prisoners had experienced symptoms of schizophrenia at some point in their lives. A Correctional Service of Canada study using the Diagnostic Interview Schedule and the American Psychiatric Association's (APA's) *DSM-III-R* criteria found a 7.7% prevalence of psychotic disorders in a sample of 9,801 inmates (7). Also, a large study comparing the weighted prevalence of psychotic disorders between the national household survey and prisons in Great Britain found a tenfold higher prevalence of psychotic disorders among prisoners (8). These findings are consistent with reports that individuals with psychotic disorders are arrested more frequently and have higher rates of criminal conviction for both nonviolent and violent offenses, compared with the public (9,10).

Most persons with schizophrenia are arrested for minor crimes, such as disturbing the peace and public intox-

The Cycle of Recidivism

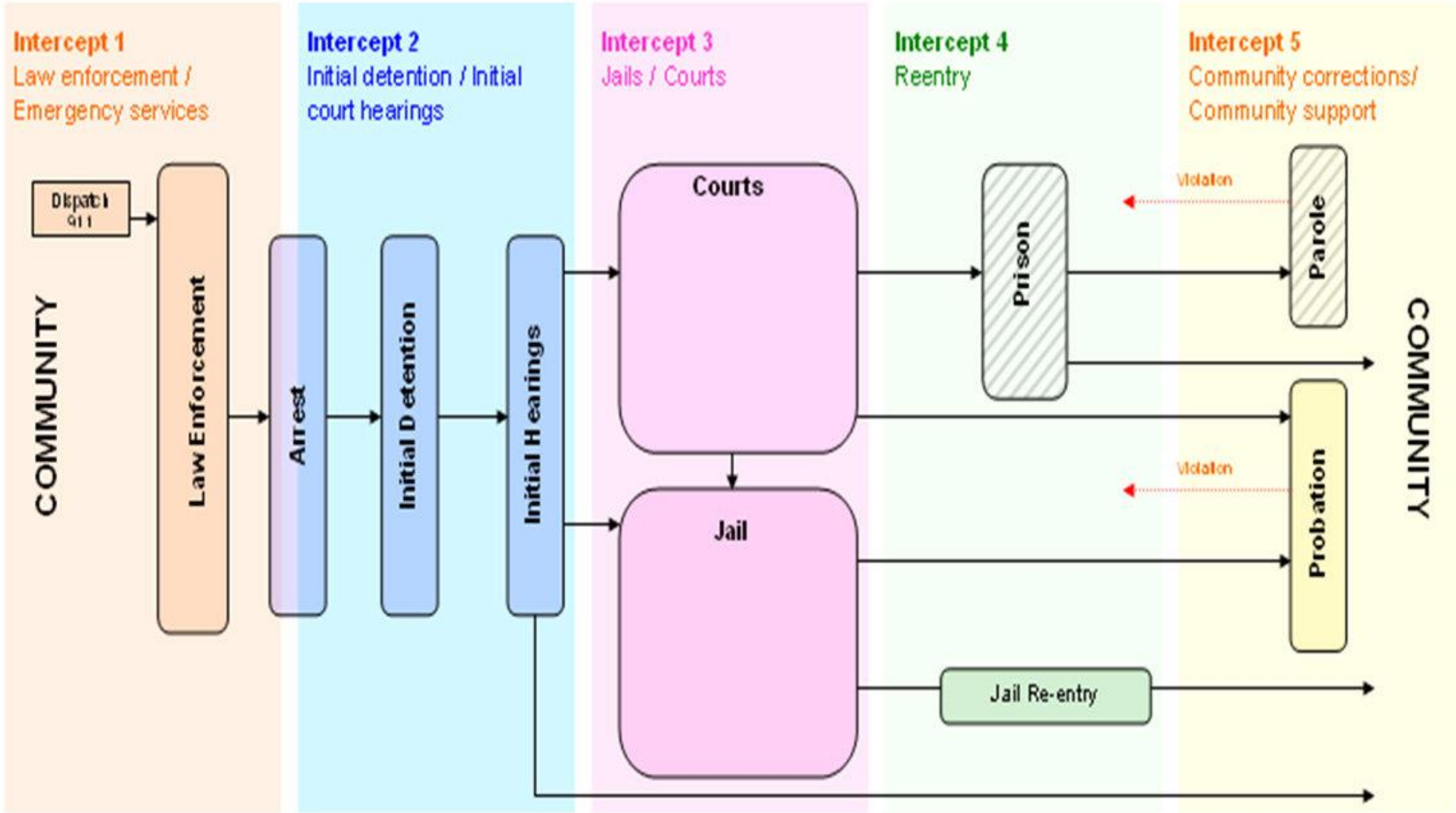


Current Best Practices

Sequential Intercept Model

- Highlights where to intercept individuals as they move through the criminal justice system

Griffin and Munetz, Psychiatric Services 2006


Intercept 1
Law enforcement / Emergency services
Intercept 2
Initial detention / Initial court hearings
Intercept 3
Jails / Courts
Intercept 4
Reentry
Intercept 5
Community corrections/ Community support
COMMUNITY
Dispatch 911
Law Enforcement
Arrest
Initial Detention
Initial Hearings
Courts
Jail
Prison
Parole
Violation
Probation
Violation
Jail Re-entry
COMMUNITY

Five Phases or *Intercepts*

1. Law enforcement / Emergency Services
2. Booking / Initial Court Hearings
3. Courts / Jails
4. Re-entry from Jails / Prisons
5. Community Corrections / Community Interventions

Best Practice:

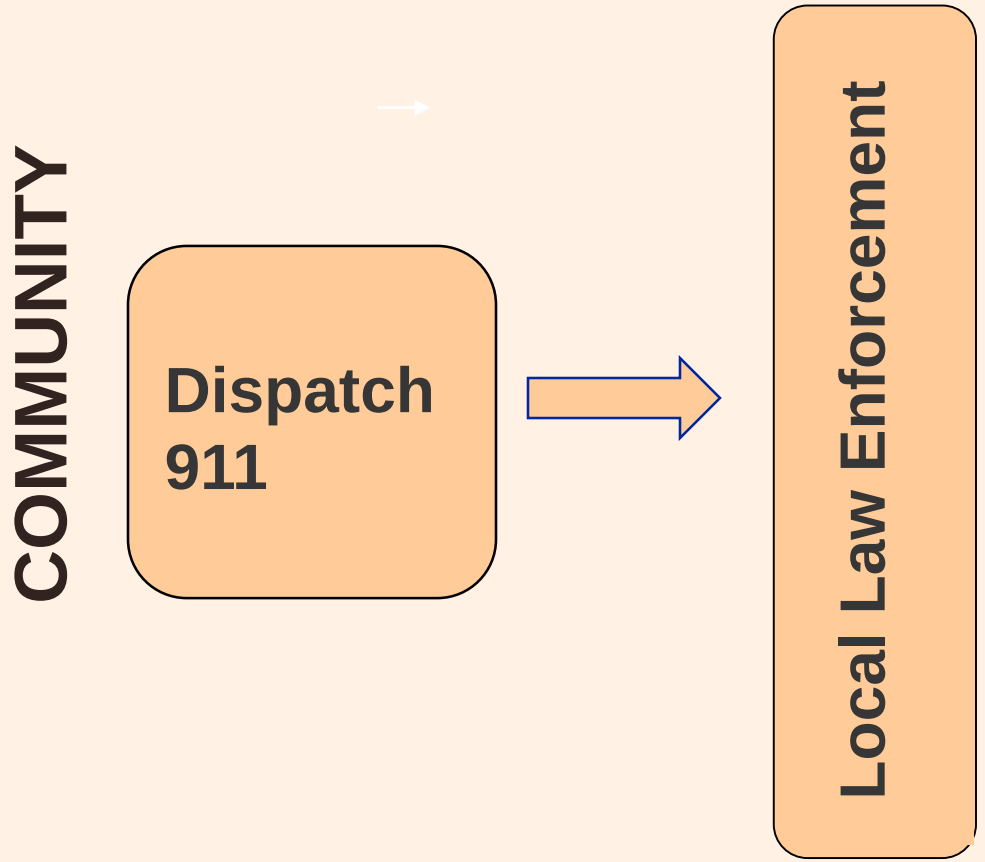
Crisis Intervention Teams

"CIT"

40 Hours Training for Police

Intercept 1

Law enforcement / Emergency services



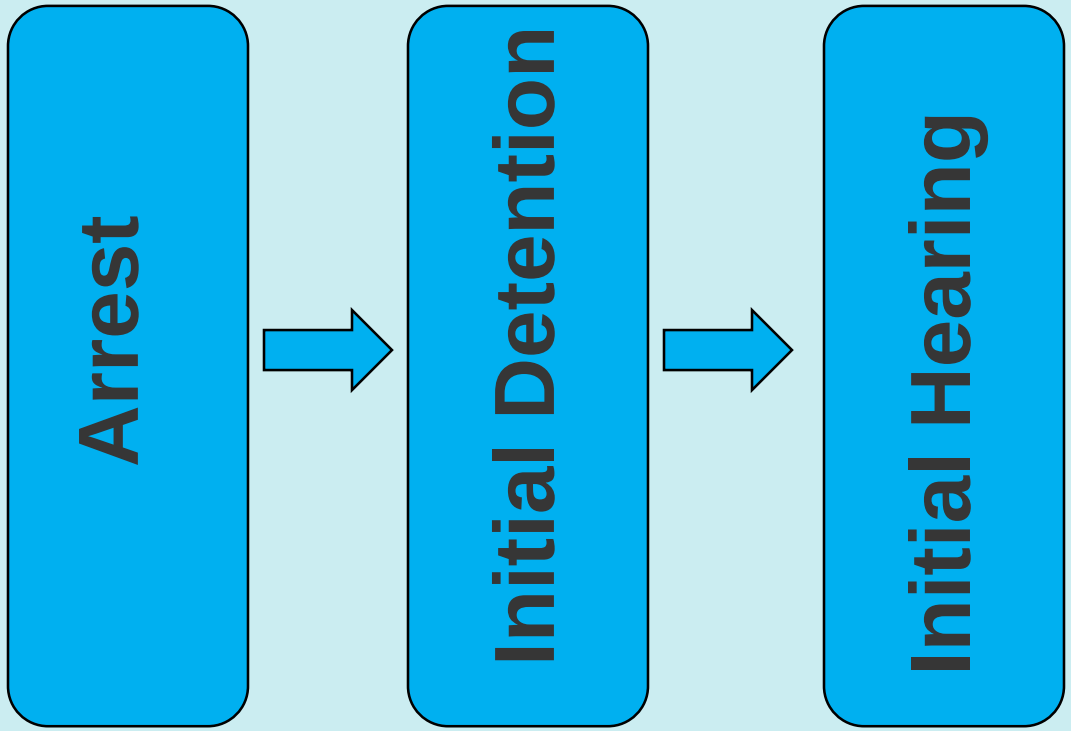
Best Practice:

Pretrial Services Programs (Pretrial Diversion)

Early identification and disposition of mentally ill detainees

Intercept 2

Initial detention / Initial court



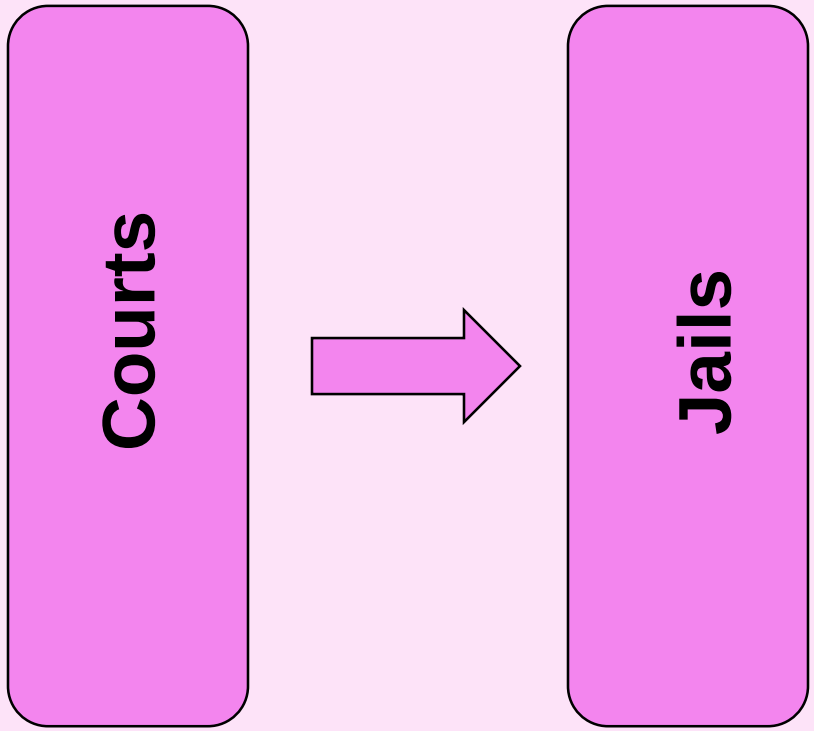
Best Practice:

Mental Health Courts

Specialized dockets where a judge oversees treatment in partnership with treatment providers

Intercept 3

Courts / Jail



Best Practices:

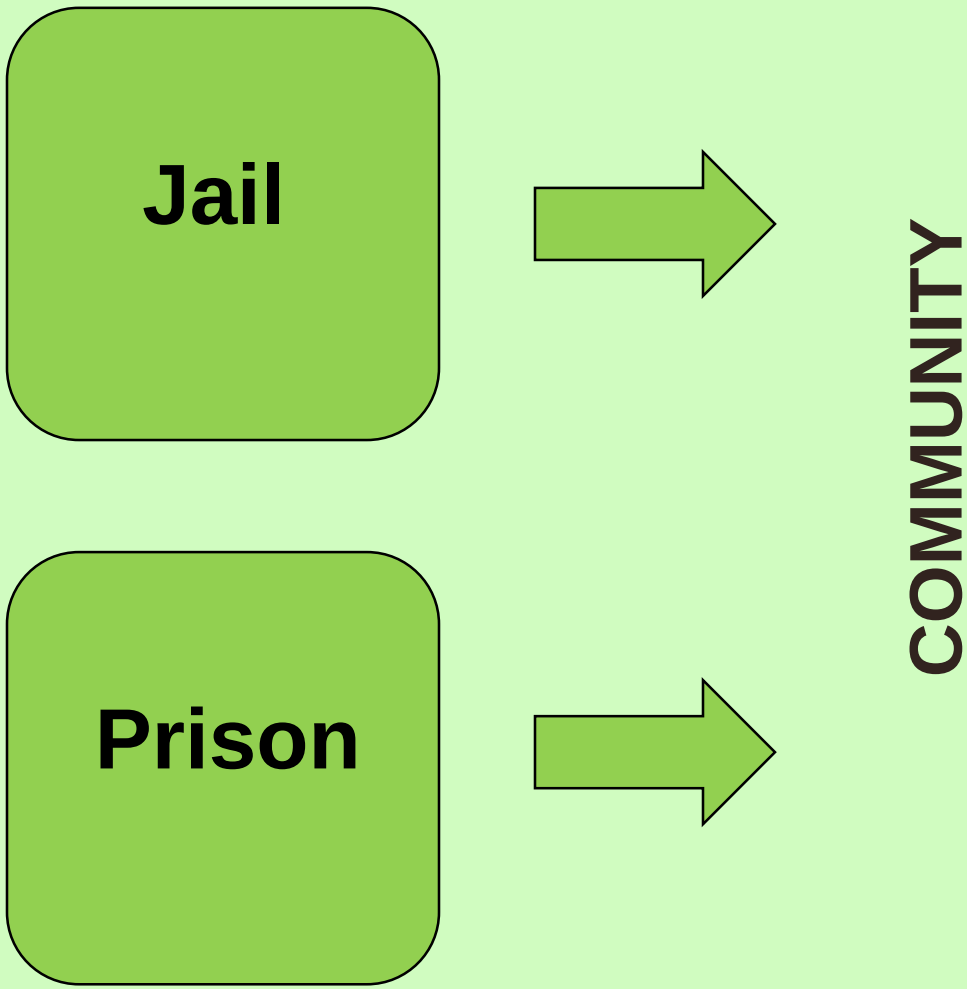
Reentry Planning

Transitional Case Management

Critical Time Intervention

Prepare inmates for release by arranging insurance, medications, housing, follow-up appointments, and providing transitional support

Intercept 4 Re-Entry



Best Practices:

Assisted Outpatient Treatment

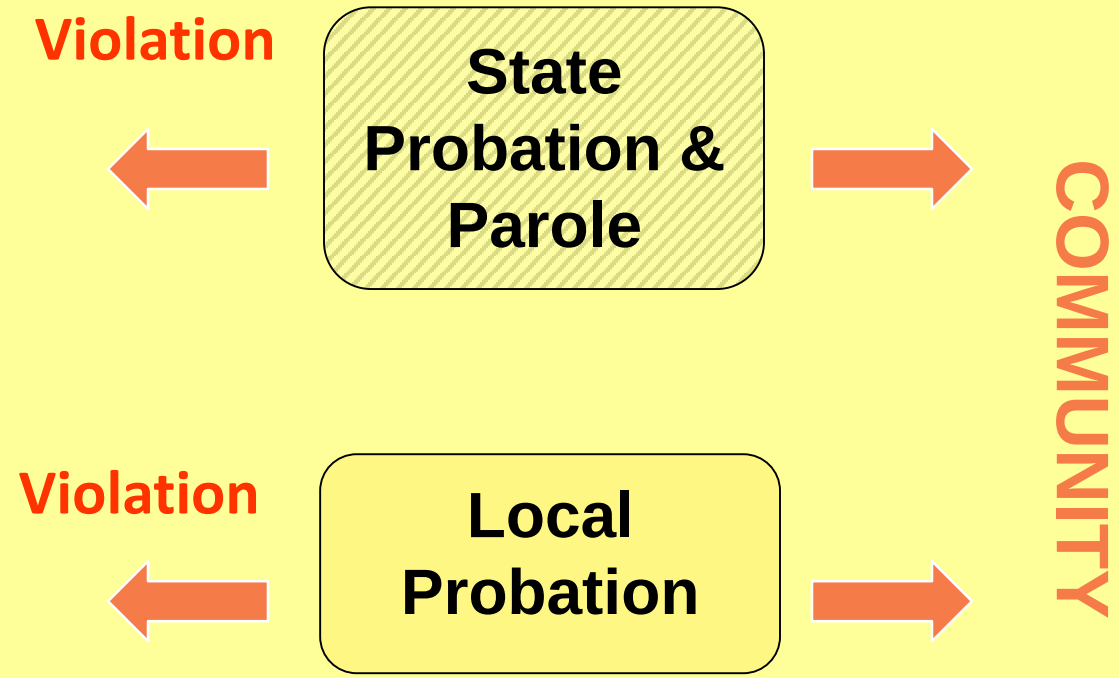
Specialty Probation and Parole

Forensic Peer Specialists

FACT

Intercept 5

Community Corrections / Community Interventions



Sequential Intercept *Mapping*

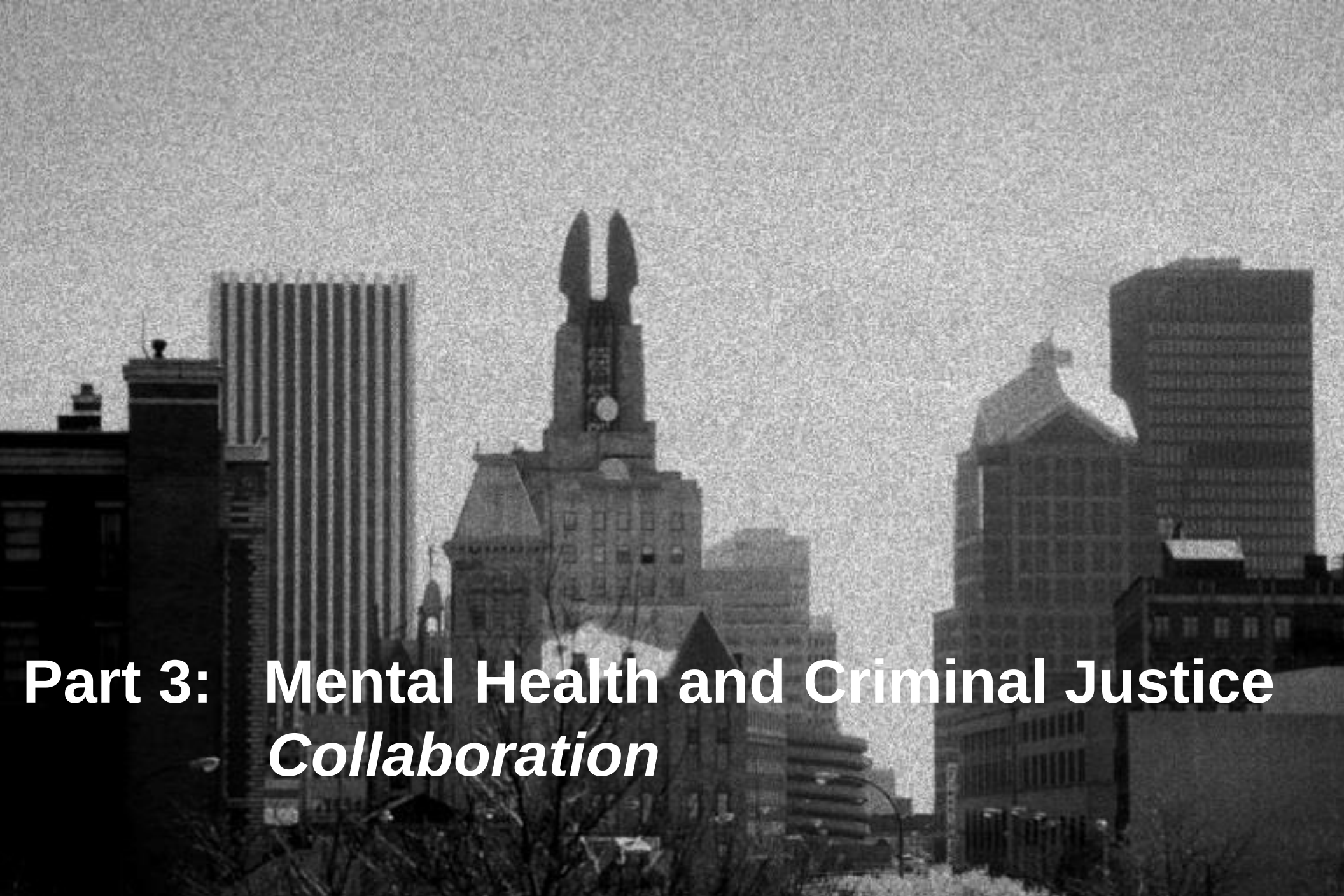
- Oregon Center on Behavioral Health and Justice Integration: www.ocbhji.org
- Stepping Up Initiative: www.stepuptogether.org
- Northeastern Ohio Medical University: www.neomed.edu
- Council of State Governments: www.csgjusticecenter.org

Best Practice Interventions
For Justice-Involved Patients

- CIT Police Teams
- Mental Health Courts
- Drug Courts
- Veterans Courts
- Specialty Probation
- Specialty Parole
- Pre-Trial Services Programs
- Forensic Assertive Community Treatment

What Do Most of These Best Practices Have In Common?

Mental health – Criminal Justice Collaboration



Part 3: Mental Health and Criminal Justice
Collaboration

Preventing Criminal Recidivism Through Mental Health and Criminal Justice Collaboration

J. Steven Lamberti, M.D.

Criminal justice system involvement is common among persons with serious mental illness in community treatment settings. Various intervention strategies are used to prevent criminal recidivism among justice-involved individuals, including mental health courts, specialty probation, and conditional release programs. Despite differences in these approaches, most involve the use of legal leverage to promote treatment adherence. Evidence supporting the effectiveness of leverage-based interventions at preventing criminal recidivism is mixed, however, with some studies suggesting that involving criminal justice authorities in mental health treatment can increase recidivism rates. The effectiveness of interventions that utilize legal leverage is likely to depend on several factors, including the ability of mental health and criminal justice staff to work together. Collaboration is widely acknowledged as essential in managing justice-involved individuals, yet fundamental differences in goals, values, and methods exist between mental health and criminal justice professionals. This article presents a six-step conceptual framework for optimal mental health–criminal justice collaboration to prevent criminal recidivism among individuals with serious mental illness who are under criminal justice supervision in the community. Combining best practices from each field, the stepwise process includes engagement, assessment, planning and treatment, monitoring, problem solving, and transition. Rationale and opportunities for collaboration at each step are discussed.

Psychiatric Services 2016; 67:1206–1212; doi: 10.1176/appi.ps.201500384

Various intervention strategies are commonly used to prevent criminal recidivism among justice-involved individuals with serious mental illness in community treatment settings. Broadly

The effectiveness of leverage-based interventions at preventing criminal recidivism is likely to depend on several factors, including the ability of mental health and criminal

Mental Health and Criminal Justice Professionals
Similarities

Engagement	Both must form a working relationship with client
Assessment	Both must assess each client
Planning	Both must plan how to manage each client
Intervention	Both must intervene to help the client
Monitoring	Both must monitor clients' progress
Problem Solving	Both must respond when problem behaviors occur

Six Opportunities for Collaboration

1. Engagement
2. Assessment
3. Service Planning
4. Intervention
5. Progress Monitoring
6. Problem Solving

- Why is it sometimes difficult to engage people with serious mental illness in treatment?

SYSTEMIC CAUSES	INDIVIDUAL CAUSES
• Lack of outreach	• Lack of motivation
• Financial barriers	• Attitudes toward medications
• Clinician inexperience	• Family Influences
• Treatment ineffectiveness	• Homelessness
• Cultural and language barriers	• Cognitive impairment
• Treatment side effects	• Fear of stigmatization
• Lack of public transportation	• Substance use
• Limited hours of availability	• Unawareness of illness

- Most clients can be engaged by addressing barriers using trauma-informed, culturally competent, and motivationally based strategies.

However . . .

- Sometimes optimizing care is not enough.

Engagement Strategies
Legal Leverage

- Appropriate use of legal authority to engage people with serious mental illness in treatment

- Examples:
  - Judicial supervision
  - Probationary supervision
  - Parole supervision
  - Assisted outpatient treatment

What Legal Leverage Is Not

- Use of legal authority to force patients to comply
- Making threats of punishment to enforce compliance

What Legal Leverage Is

- Respectful guidance toward compliance
- Requires mental health and criminal justice collaboration to be effective

Latessa, Listwan and Koetzle 2014, Lamberti 2016

Six Opportunities for Collaboration

1. Engagement
2. Assessment
3. Service Planning
4. Intervention
5. Progress Monitoring
6. Problem Solving

Clinical Assessment

The Intake Process

- Focuses on psychosocial assessment: Social history, family history, substance use, history of illness, and mental status exam.

Criminogenic Risk Factors

Among Adults with Severe Mental Illness

1. History of Antisocial Behavior
2. Antisocial Personality
3. Antisocial Cognition
4. Social Support for Crime
5. Family/Marital Problems
6. Work/School Problems
7. Lack of Healthy Recreation
8. Substance Use
9. Psychosis and Mania

Typically Not Covered In Psychosocial Assessment

Typically Covered In Psychosocial Assessment

Criminogenic Risk Factors

Among Adults with Severe Mental Illness

1. History of Antisocial Behavior
2. Antisocial Personality
3. Antisocial Cognition
4. Social Support for Crime
5. Family/Marital Problems
6. Work/School Problems
7. Lack of Healthy Recreation
8. Substance Use
9. Psychosis and Mania

"THE BIG FOUR"

Typically Covered in Psychosocial Assessment

Collaborative Intake Process

- Conducted by mental health professionals in conjunction with criminal justice professionals

- Focuses on clinical assessment and *risk/needs assessment*

Standardized Risk/Needs Assessment Tools

- Level of Service Inventory – Revised (LSI-R)
- Level of Service/Case Management Inventory (LS/CMI)
- Ohio Risk Assessment System (ORAS)
- Correctional Assessment and Intervention System (CAIS)
- Correctional Offender Management Profile for Alternative Sanctions (COMPAS)

Toward Collaborative Assessment
Three Questions

- Do your clients' mental health court, probation or parole supervisors conduct or have access to risk/needs assessments?
- If so, can risk/needs assessment results be shared?
- If not, can risk/needs assessment be implemented within your program?

Risk/Needs Assessment
Training Providers

- University of Cincinnati Corrections Institute
- National Council on Crime and Delinquency
- Justice System Assessment and Training
- Multi-Health Systems, Inc. / Global Institute of Forensic Research, Inc.

Six Opportunities for Collaboration

1. Engagement
2. Assessment
3. Service Planning
4. Intervention
5. Progress Monitoring
6. Problem Solving

Traditional Service Planning

- Courts, Probation, Parole: Focus on planning supervision method and frequency

- Clinicians: Focus on planning mental health treatment and support services

The Service Planning Process

a. What are the client's strengths?
b. What are the client's problems?
c. What are the client's goals?
d. What are the service providers' goals?
e. What treatments, services and supports are needed to achieve these goals?
f. How will progress toward each goal be measured?

Collaborative Service Planning

- Shared focus on planning interventions to address clinical *and* criminogenic needs

Collaborative Service Planning
Two Things

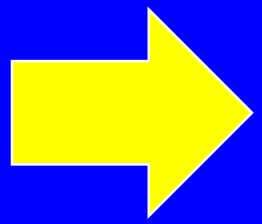
- THING 1: Ask *"Why is the client getting into legal trouble?"*
- THING 2: *Add one or more criminogenic needs to the client's treatment plan.*

Six Opportunities for Collaboration

1. Engagement
2. Assessment
3. Service Planning
4. Intervention
5. Progress Monitoring
6. Problem Solving

Criminogenic Risk Factors
Best Practice Interventions

1. History of Antisocial Behavior
2. Antisocial Cognition
3. Antisocial Personality



Cognitive-Behavioral Therapies

4. Social Support for Crime → *Legal Stipulations*
5. Family/Marital Problems → *Family Therapy*
6. Work/School Problems → *Vocational Rehabilitation*
7. Lack of Healthy Recreation → *Recreation Therapy*
8. Substance Use → *Addiction Treatment*
9. Psychosis and Mania → *Pharmacotherapy*

Cognitive-Behavior Therapy

Antisocial Behaviors and Cognitions

- Thinking for a Change
- Moral Reconation Therapy
- Reasoning and Rehabilitation

The most well researched

- Lifestyle Change
- Aggression Replacement Training
- Interactive Journaling
- Relapse Prevention Therapy
- Moving On (for female offenders)

CBT Interventions
What Do They Have in Common?

- All are manualized, highly structured, and group based
- All are evidence based with **general** offender populations
- No research on comparative effectiveness with **severely mentally ill** offenders

CBT Interventions

Modifications for Severely Mentally Ill Clients

Strategy	Rationale
Go slow	Impaired comprehension
Use repetition	Impaired memory
Use visual aids	Low literacy rates
Be brief	Limited attention span
Be engaging	Amotivation

Six Opportunities for Collaboration

1. Engagement
2. Assessment
3. Service Planning
4. Intervention
5. Progress Monitoring
6. Problem Solving

Progress Monitoring Principles

- Look for progress, not just problems
- Encourage client self-monitoring
- Focus on the facts
- Review regularly

Progress Monitoring Principles

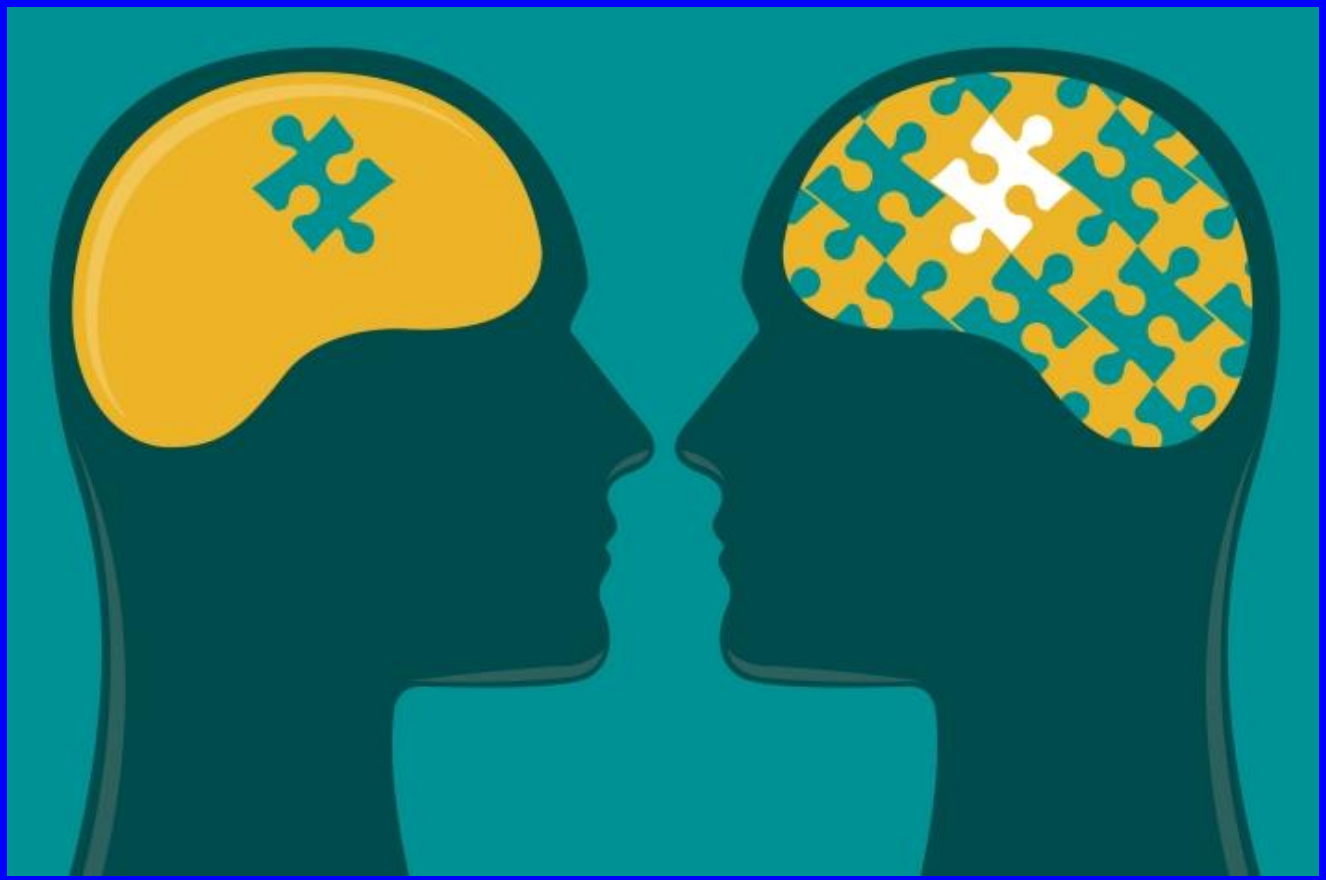
- Communication is the key to effective progress monitoring

Six Opportunities for Collaboration

1. Engagement
2. Assessment
3. Service Planning
4. Intervention
5. Progress Monitoring
6. Problem Solving

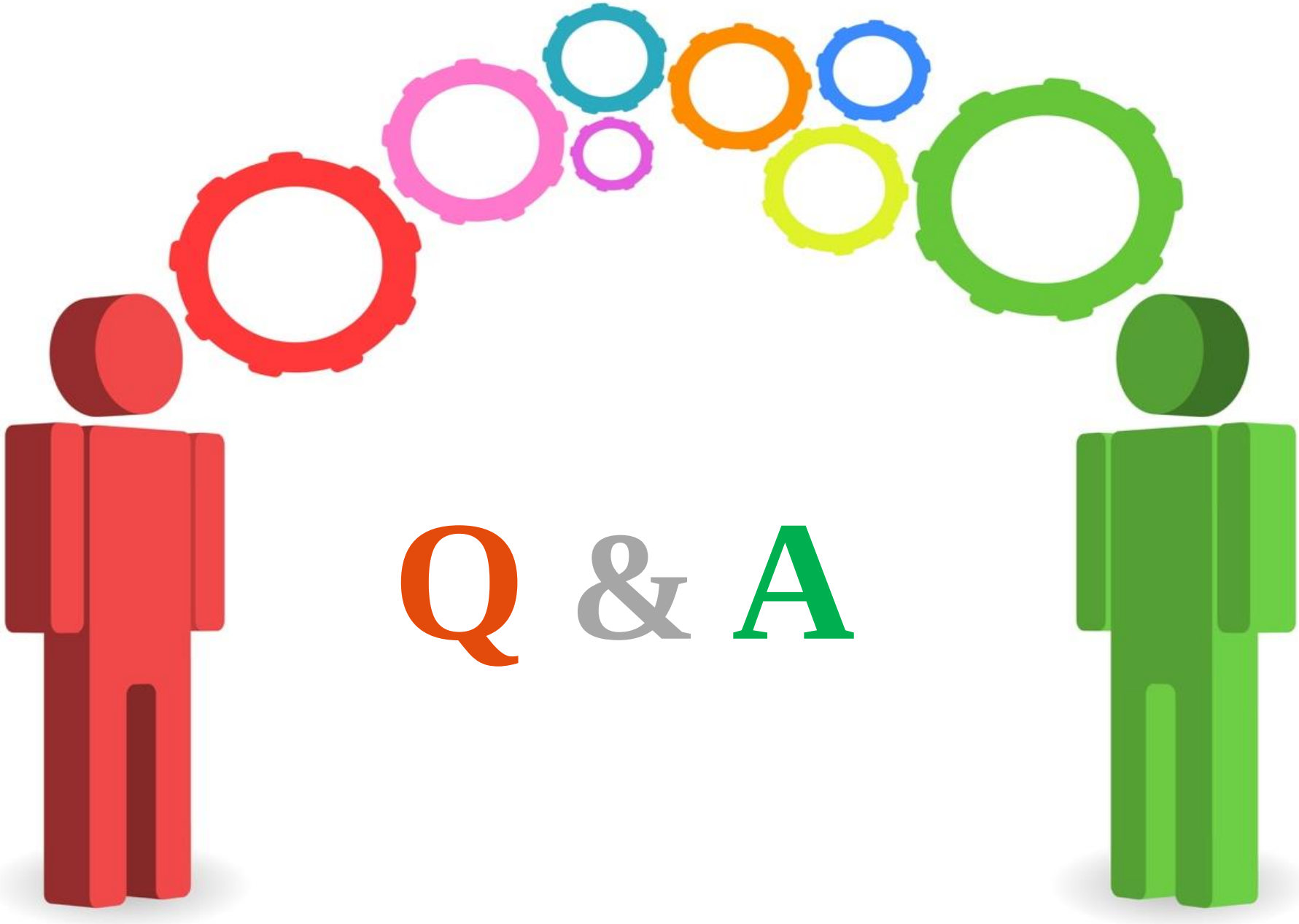
PROBLEM SOLVING

- Two heads are better than one



Problem Solving Strategies

1. Shared Problem Solving
2. Therapeutic Alternatives to Punishment
3. Rewards and Graduated Sanctions


Q & A

J. Steven Lamberti, MD

- Slamberti@commfit.org
- Steve_Lamberti@URMC.Rochester.edu