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Mental Illness and Involvement with the Justice System: Effective Clinical Interventions and Programmatic Approaches

The first brief of this series emphasized opportunities to divert individuals with serious mental illness (SMI) at various points of contact with the criminal justice system and explored the complexities that contribute to the difficulties these individuals face. This brief introduces effective approaches to meeting the needs of individuals with SMI as they move further through the stages of criminal justice system processing.

Diversion from arrest and incarceration to appropriate treatment for individuals with SMI is increasingly becoming an option. However, when police-assisted diversion is not a possible alternative to arrest, individuals with SMI may be charged and booked into jails. At arraignment, a judge decides whether to remand individuals to custody to await trial (if they pose a flight risk or threat to public safety), set an amount of cash bail to secure their release until they return to stand trial, or release individuals on their own recognizance.

Many individuals with SMI who come before the court (1) are detained in jails awaiting trial because they cannot afford to post bail, (2) have a co-occurring substance use disorder (COD), and (3) face charges for offenses unrelated to their mental illness. A recent study found that nearly two-thirds of the charges brought against people with SMI were for offenses completely unrelated to their mental condition (Figure A).[i] Research has shown assessments that predict risk of reoffending are equally accurate for individuals with and without SMI.[ii] Halting the flow of individuals with SMI through the revolving jail door requires appropriate behavioral health (i.e., mental illness and substance use disorder [SUD]) support and rehabilitative interventions that reduce criminal behavior.

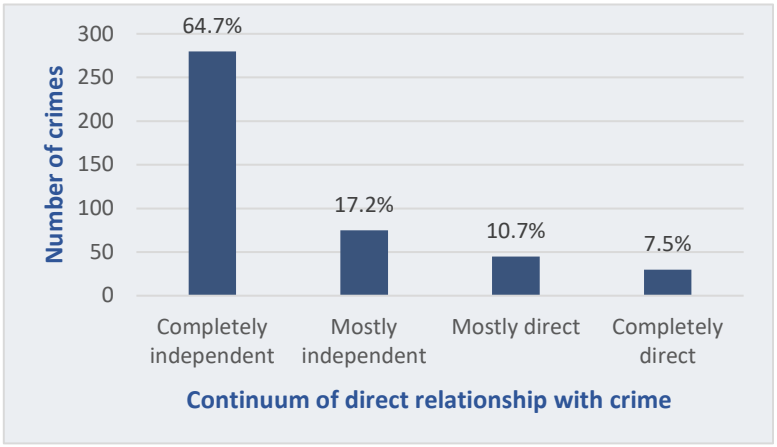

Figure A: Association between crime and mental condition

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Risk/Needs Assessment vs. Clinical Assessment

The criminal justice system uses validated risk/needs assessments to determine the level of security risk individuals pose and their potential for institutional infractions. These assessments also help determine the likelihood an individual will reoffend upon release and the types of rehabilitative programming needed to reduce the risk of recidivism. Clinical assessments, on the other hand, diagnose and determine the severity of mental illnesses and/or SUDs.

It is helpful for behavioral health professionals providing services for individuals in criminal justice settings to understand this distinction and to become familiar with key criminal risk factors (Figure B).[iii] For example, top predictors of recidivism include criminal thinking/values and having criminal associates. Therefore, even individuals whose mental illness has been successfully managed in custody may be at high risk for reoffending upon release if they continue to surround themselves with peers involved in criminal activity and to believe their criminal behaviors are justified.

Figure B: Top Predictors of Recidivism

Criminal Thinking/Values	Criminal Associates	Antisocial Personality Traits	Substance Use	Criminal History	Active Psychosis
Examples include feeling entitled to have things your way; hostility toward authority and believing criminal behavior is justified; dodging responsibility for actions; valuing street smarts and "getting over."	Difficulty separating from criminal associates can mean absence of pro-social contacts. Family, faith-based and recovery networks, pro-social activities, and avoiding criminal contacts are vital.	While not a clinical personality disorder diagnosis, this includes traits like impulsivity, restless aggressive energy, thrill seeking, poor problem solving and self-regulation skills, and low tolerance for frustration.	A history of substance use is associated with reoffending. A clinical assessment is needed to determine SUD severity, levels of care, and type and intensity of recovery supports required.	The biggest predictor of future behavior is past behavior. Criminal history is a static risk factor that cannot be changed, but it is a powerful predictor of reoffending and recidivism.	Reoffending is less likely if symptoms of psychotic disorders are controlled with anti-psychotic medications and therapeutic supports that promote continued treatment adherence.

Effective Interventions and Approaches

The following interventions and integrated approaches have proven effective in promoting rehabilitation and behavioral health among individuals across all levels of criminal justice involvement: diversion programs, problem-solving courts, in-custody treatment programs, reentry support, and post-release supervision.

Cognitive Behavioral Therapy (CBT)

Cognitive approaches target attitudes and thought processes, teaching individuals to recognize thinking errors and replace them with rational, pro-social thoughts. Behavioral approaches focus on reinforcing new pro-social behaviors. Research on CBT has demonstrated effectiveness in treating mental illness and SUDs, as well as its use in rehabilitative programming. A meta-analysis found that in-custody CBT programs that target criminal thinking and behavior had the potential to reduce recidivism by an average of 35 percent.[iv]

The most effective interventions with criminal justice populations have strong behavioral components that engage participants in *practicing* new behaviors through role-playing, skill rehearsing, and positively reinforcing target behaviors. Effective CBT targeting a variety of behavioral disorders, such as anxiety disorders and antisocial or aggressive behavior, is also available.[v]

- For more information: Does Cognitive Behavioral Therapy Work in Criminal Justice? A New Analysis from CrimeSolutions.gov

Psychiatric Medication Management and Medication-Assisted Treatment

The appropriate use of treatments involving medication, such as those described below, is known to effectively treat behavioral health conditions.

Psychiatric Medications

A variety of antidepressant, antianxiety, anticonvulsant, antipsychotic, and mood-stabilizing medications are used to treat mental disorders, often in combination with behavioral treatments and psychotherapy. Prescribed medications are the most common form of mental health treatment available in custody settings. According to the Bureau of Justice Statistics, 27 percent of individuals in state prison with mental health conditions have taken psychiatric medications since intake.[vi]

Medications can be especially important for individuals whose mental health conditions went undiagnosed prior to criminal justice involvement. Yet, continuation of medications once individuals reenter the community is often a challenge. Collaboration between community behavioral health service providers, correctional facilities, and parole/probation is critical to continuity of care during these transitions.

It is within the constitutional rights of an individual who is incarcerated to refuse medication for a health condition. Individuals in custody maintain the right to make healthcare decisions. Mechanisms are in place to override this right for people in custody with SMI, but their use is not common practice.[vii]

- For more information, see American Academy of Psychiatry and the Law Practice Resource for Prescribing in Correction

Medication-Assisted Treatment (MAT)

More individuals with opioid use disorder are accessing medications approved for treatment (buprenorphine formulations, methadone, and long-acting naltrexone) while in custody or upon release.[viii] MAT can help stabilize and manage withdrawal symptoms, reduce cravings, and decrease relapses. Research shows that MAT can reduce high overdose fatally rates among individuals recently released from custody by as much as 80 percent.[ix] A prescribing physician experienced in addiction medicine must monitor individuals who are also taking psychiatric

medications (or medications for any health condition), preferably and psychiatric medication management, to avoid medication interactions and to adjust dosages of one or both medications as needed.

- For more information, see Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field

Motivational Approaches

The three practices that follow have been found effective in increasing motivation for treatment and recovery among justice-involved individuals.

Motivational Interviewing (MI)

MI is a brief, directive counseling approach for exploring and resolving ambivalence. It employs a consistent set of principles and techniques, such as asking open-ended questions, practicing supportive listening, and soliciting client commitments to change. Studies on MI use with individuals who are incarcerated have demonstrated effectiveness in mental health and drug court programs and for individuals on probation or parole.[x]

Motivational Enhancement Therapy (MET)

MET is a counseling approach that incorporates MI into individual sessions to review assessment results, build motivation, and prepare clients for CBT group sessions that follow the individual sessions. The central manualized intervention, MET/CBT, is considered one of the most cost-effective evidence-based SUD treatments for juvenile justice populations.[xi]

- For more information, go to Motivational Enhancement/Motivational Interviewing

Contingency Management (CM)

CM is a system of predetermined rewards used to acknowledge and reinforce target behaviors. It has long been considered an evidence-based approach for treating justice-involved individuals with SUD, but research that is recent suggests its effectiveness for individuals with SMI, as well.[xii] Incentivizing entire units has been effective in correctional treatment settings serving people with SMI (e.g., any unit with no disciplinary reports for 90 days receives a DVD player).[xiii] Reinforcing positive behavior among individuals on probation or parole can involve nonmonetary, social reinforcers such as recognition for progress or transitions to advanced phases of treatment.[xiv]

- For more information, see Contingency Management: Foundations and Principles

Strength-Based Recovery Self-Management Approaches

The following practices empower people with mental illness or CODs to achieve and sustain recovery. They are often self-directed or peer-led, affording people in recovery greater control over their care and their lives. Outcomes include increased family and community recovery support, improved ability to communicate and work collaboratively with providers, and more effective coping strategies for setbacks or distressing symptoms.[xv]

Illness Management and Recovery (IMR)

IMR is an evidence-based practice that helps individuals manage their mental illness while maintaining and achieving goals in their recovery. Incorporating psychoeducation, behavioral tailoring, relapse prevention training, and coping skills training, IMR has been shown to reduce the number and length of psychiatric hospitalizations and increase social functioning.[xvi]

- For more information, see Illness Management and Recovery (IMR)

Wellness Recovery Action Plan (WRAP)

This evidence-based approach helps individuals develop a personal plan to prevent relapse by identifying triggers and early warning signs and establishing an action plan to deal with them before things get worse. WRAP is widely available in many communities and has been adapted specifically for use in criminal justice settings.

- For more information, go to the WRAP website.

Peer Reentry Support

Reentry peer support specialists promote linkages to community resources. Individuals with CODs may greatly benefit from both mental health and addiction recovery peer support, or they may have a decided preference for one or the other.

- For more information, go to the National Reentry Resource Center

Integrated Trauma and SUD Interventions

Dual diagnosis of mental health issues, such as post-traumatic stress disorder (PTSD) and SUD, is common among women, people in custody, veterans, and justice-involved juveniles. Integrated interventions help address these issues concurrently, which can be particularly important in custody environments rife with unavoidable trauma triggers.[xvii] Evaluation studies suggest that integrated trauma and SUD interventions improve treatment engagement and emotional stability.[xviii] Such interventions do not delve into traumatic histories and can be delivered without extensive specialized training. Examples include the following:

Trauma Recovery and Empowerment Model (TREM) and *Men's Trauma Recovery and Empowerment Model (M-TREM)*

TREM is a manualized, group-based, gender-specific intervention that draws on cognitive–behavioral, skills training, and psychoeducational techniques. It has been implemented in many settings, including correctional institutions and both residential and nonresidential mental illness and SUD programs.[xix]

- For more information on TREM, see Trauma Recovery and Empowerment Model (TREM)
- For more information on M-TREM, see Addressing the Specific Behavioral Health Needs of Men

Seeking Safety

The 25 sessions of Seeking Safety, a blend of psychoeducation and building coping skills, can be delivered in any order, in-group or individual sessions, in a variety of settings. One of the many studies of the intervention revealed improvement in general mental health symptoms and psychological functioning of men who participated in the intervention while incarcerated.[xx]

- For more information, go to Seeking Safety

Trauma Affect Regulation: Guide for Education and Therapy (TARGET)

This manualized, trauma-focused psychotherapy has been used with adolescents in the juvenile justice system who have PTSD. TARGET can be delivered as group or individual sessions. Sessions feature steps for regulating intense emotions and solving social problems.

- For more information, see TARGET

Assertive Community Treatment (ACT)/Intensive Case Management (ICM) Models

With ACT, teams of social workers, nurses, psychiatrists, SUD counselors, case managers, and peer recovery specialists are available to help in all areas of life. Collaborative teams deliver this approach to individuals, typically those with longer histories of SMI and CODs. Admission criteria for ACT services may focus on specific populations and individuals with complex needs—for example, those transitioning from incarceration. Studies have shown significant drops in jail time for people with SMI and in the length of hospital stays in states that have implemented ACT programs.[xxi] Forensic Assertive Community Treatment (FACT) teams often include probation and parole officers to support justice-involved individuals in co-occurring recovery.

ICM evolved from ACT and is generally most appropriate for individuals with complex behavioral health needs who could benefit from reentry support. Compared with standard care, people receiving ICM are significantly more likely to stay in contact with providers and have lower rates of hospitalization, higher rates of stable housing, and better overall functioning.[xxii] Both ACT and ICM include frequent service contact, mobile outreach, and low staff-to-client ratios.

- For more information, see Forensic Assertive Community Treatment: Updating the Evidence

Pre-Release Planning for Transitions to Community-Based Care

Specialized pre-release planning and case management that begins well in advance of release dates helps reentering individuals with SMI secure benefits for which they may be eligible. Effective person-centered planning helps ensure continuity of care and avoids interruption of beneficial medication regimens.

Housing First models, supported employment programs, and reentry peer support are all non-clinical recovery supports that have proven critical to success in the community.

- Housing First offers safe, stable, supportive housing that is not conditional on treatment adherence or abstinence.
- Supported employment programs offer reentering individuals with SMI opportunities for meaningful work activities in supportive agencies, such as Goodwill Industries, Easterseals, and other nonprofit community-based agencies.
- Transitional mental health case management (pre-release in-reach into facilities by case managers who continue to support clients upon release) leads to reentry success. This can include pre-release arrangement of intake appointments with warm handoffs to community prescribers and providers.

  - For more information, see Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide

Special Consideration: Disparities

Racial and economic disparities affect individuals with SMI involved with the criminal justice system. People of color are overrepresented in prisons and jails; Black Americans, for example, comprise only 13 percent of the nation's general population but make up 40 percent of its incarcerated population.[xxiii] Women, whose incarceration rates have risen faster than men's for decades, are often behind bars due to their inability to pay bail or retain legal representation.[xxiv] The same is true of many other economically disadvantaged people who are jailed while awaiting trial. Health disparities are also a key consideration in pre-release planning since a disproportionate number of individuals released from incarceration return to poor, urban communities where access to quality behavioral health care is limited.[xxv]

It is important for behavioral health professionals working with both adult and youth minority clients with SMI to be proactive in avoiding unnecessary incarceration. Diversion programs, mental health and drug courts have not always been inclusive of minorities, especially minority youth. To help remedy these disparities, the Office of Juvenile Justice and Delinquency Prevention requires states to report disproportionate minority contact and to act when the proportion of contacts with minority youth exceeds the proportion of minority youth in the general population.[xxvi]

Moreover, professionals who work with justice-involved individuals with SMI and CODS must stay current on drug use and overdose trends that affect minority clients. For example, drug overdose deaths increased among Black individuals in urban settings by 41 percent in 2016, which outpaced any other racial or ethnic group. Fatalities are continuing to rise, especially those involving cocaine or illicit opioids.[xxvii]

Reentry planning for individuals returning to underserved communities must realistically account for the limited availability of and associated wait lists for services; the high number of people in need of care returning to these communities and the extent of that care; and other barriers to treatment, such as lack of transportation or healthcare coverage.[xxviii, xxix] Linkages with trusted community-based providers should be well established before release.

Special Consideration: COVID-19

Vulnerability to the spread of communicable disease among individuals housed in correctional facilities and the risk of fatality for older inmates due to COVID-19 has prompted some local and state officials to order early releases from both jails and prisons—at a time when fewer reentry supports and safety net services are operating at full capacity. History has demonstrated that when community-based support for people with SMI is scarce, rates of arrest and incarceration increase.[xxx]

Fortunately, behavioral health professionals are not without options for delivering vital services and supports. For example, telehealth (via videoconferencing and other technologies) has been demonstrated to be effective across a range of psychiatric treatments, populations, and settings.[xxxi] Research on its cost-effectiveness has shown decreases in missed appointments and increased patient engagement and retention.[xxxii] Medicaid, Medicare, and private insurers all reimburse for telehealth services to some extent and may temporarily offer expanded coverage.[xxxiii] Additionally, rules governing prescribing and medication refills, including those used to treat opioid use disorders, have been temporarily relaxed during periods when a public health emergency has been declared and remains in effect.

Tips for Facilitating Reentry During a Public Health Emergency

- ✓ Ensure that agencies to which clients are referred are open and operative.
- ✓ Stay informed about emergency services, such as transitional housing, that may be available.
- ✓ Understand permanent and temporary rules pertaining to Medicare and Medicaid coverage for telehealth services.
- ✓ Connect clients with online and distance peer support services available in the community, such as telephone recovery coaching and online support groups.

➢ For more information, go to the Medicare Telemedicine Health Care Provider Fact Sheet and the Coronavirus (COVID-19) Partner Toolkit.

Conclusion

The clinical interventions and programmatic approaches highlighted in this brief are but a sample of programs and practices that have demonstrated effectiveness in meeting the complex recovery support needs of individuals with SMI who are involved with the criminal justice system. These individuals benefit from behavioral health services delivered by professionals who are committed to finding common ground and establishing common goals with law enforcement, the courts, corrections, and probation/parole. Access to vital behavioral health services can increase the chances that individuals with SMI remain in the community and avoid unnecessary periods of incarceration and the complex problems that often result.

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