Merging Mental Health Services & Correctional Treatment

LACDMH Multicultural Mental Health Conference: Health Integration

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June 18, 2019

About me:

- LCSW: Mental Health 1986-1999
- U. S. Probation 1999 to April 2019 – Retired
- Cal State L. A., School of Social Work, Lecturer, 2006 to now
- Forensic Mental Health Association of California
- My interest right now: the integration of the recovery model with evidence-based practices
- “To teach is to learn”, Japanese proverb

Mental Health & Criminal Justice

- About you? mental health? substance use treatment; medical? who else?
- Of the mental health: how many clinicians? managers or mid-managers? (directors; program heads; supervisors)

RNR? On a 1-5 scale:

- 1 = "RNR"?! – I'm in the wrong place – I thought this was R&R – rest & relaxation
- 2 = I've heard of it
- 3 = I have had some training but need help knowing how to integrate it into my daily work with clients
- 4 = I have had some training; I'm ready to integrate into my practice, but I don't have the agency support I need, i.e., ongoing training, coaching & supervision
- 5 = I should be doing the training instead of this guy

Today's workshop

- Definitions of evidence based practice in correctional treatment
- Symptom reduction does not equal recidivism reduction
- Practice vignette #1
- RNR theory (how to think about it) and in practice (how to do it)
- RNR and cultural competence
- Back to vignette #1 with (hopefully) new knowledge

- Best practices for immediate reentry needs
- Integration of the recovery model with correctional EBPs – Challenge of the dual role
- Organizational implementation
- Back to clinical, 1 more vignette
- Closing – questions/discussion

- *Did I miss anything you came expecting or wanting to hear?*

Forensic Mental Health?

- Dictionary definition of forensic: “pertaining to, connected with, or used in courts of law …”

“Forensic social work is the application of social work to questions and issues relating to law and legal systems … A broader definition includes social work practice which in any way is related to legal issues and litigation, both criminal and civil. “(NOFSW)

“Forensic psychology is the application of clinical specialties to the legal arena. The broad definition of forensic psychology emphasizes the application of research and experimentation in other areas of psychology … to the legal arena.”(APA)

What is evidence-based practice (EBP)?

- "…simply … the use of research findings as a primary source of knowledge for practice" (Trotter, 2006)

- National Institute of Corrections (NIC)
  - Best practices = based on collective professional experience, not scientifically tested
  - "What works" = general outcomes
  - EBP = definable, measurable outcomes of practical realities, e.g., recidivism

Washington State Institute for Public Policy (WSIPP)

- Evidence-based: tested in heterogeneous or intended populations; multiple randomized and/or statistically-controlled evaluations or one large multiple-site randomized and/or statistically controlled evaluation; weight of systematic review demonstrates sustained improvements; can be implemented with a set of procedures for successful replication; cost-beneficial

- Washington State Institute for Public Policy (WSIPP) continued

- Research-based: tested with one randomized and/or statistically-controlled evaluation demonstrating sustained desirable outcomes; or weight of evidence from a systematic review supports sustained outcomes

- Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP)
  - http://nrepp.samhsa.gov/01_landing.aspx
  - Evidence-based practice: “A practice that is based on rigorous research that has demonstrated effectiveness in achieving the outcomes that it is designed to achieve.”
  - Promising: “Outcomes based on an evidence base which produced sufficient evidence of a favorable effect.”
  - Ineffective or Inconclusive

- Office of Justice Programs (OJP), National Institute of Justice (NIJ)
- http://www.crimesolutions.gov/
- Effective: “Programs have strong evidence to indicate they achieve their intended outcomes when implemented with fidelity.”
- Promising: “Programs have some evidence to indicate their intended outcomes.”
- No Effects

How do we really know?

- Excited over data?
- “There are 3 kinds of lies: lies, damned lies, and statistics” (Benjamin Disraeli)
- Best we have.
- RNR works – reduces recidivism 25-50% = win-win-win: truly “ex”-offenders, their families, and prevention of real victims!

The personal & organizational why

- Take a minute to remember why we chose this work: sounds cliché, but it's not – to help people, to make a difference
- High caseloads, paperwork, agency rules, politics takes the humanity out of us and our clients?
- Are you still passionate about your work?

What client population are we talking about today?

- 35 yo female. Single, divorced. Has 2 latency-age sons. Diagnosed with Bipolar Disorder. Non-compliant with treatment. She is camping in a national park with her boyfriend when she believes he is Satan and attempts to kill him by stabbing him in the back with a large knife. He survives. She has no prior criminal history. No significant alcohol/drug use. She is found NGRI in federal court. After being confined to a federal medical center for about 4 years, she is conditionally released.

- Success: After about 5 years of supervision in the community, she is compliant with mental health treatment, including a mood stabilizer; she is raising her 2 boys on her own with the help of her mother (who cared for them when she was incarcerated), and she is attending nursing school. Her conditional release is terminated.

- This is a client with severe mental illness who was psychotic at the time of the assault. She had no prior history of violence or behavioral issues.
- Post-script: She later completes nursing school and is employed at a major hospital.
- This is NOT the population we are focused on today.

Symptom reduction alone does not decrease recidivism

- 1 in 10 direct connection between mental illness and crime
- At most, there is a 4 – 12% incidence of individuals committing crimes while in the midst of severe mental health symptoms
- Of these, 2/3 also commit crimes independent of symptoms

Symptom reduction alone does not decrease recidivism

- Risk factors the same across mentally ill & non-mentally ill offenders (or higher for mentally ill offenders)

(Peterson et al. 2014; Bonta et al. 2014; Morgan et al. 2010; Skeem et al. 2009; Bonta et al. 1998; Gendreau 1996)

- This is the potential problem with diversion programs

Q&A – discussion

Practice with feedback

Treatment Planning

- Develop a brief prioritized treatment plan for this client (5 – 8 bullet points)

“I have this guy …” Vignette 1

- 30 yo male. Single, gang affiliated. Multiple convictions since age 14 including drug possession/sales, assault and armed robbery. 1 strike. Current charge ADW has served 6 years in prison, paroled 2 weeks ago. History of methamphetamine, cocaine and alcohol dependence from age 13. Diagnosed with PTSD and Major Depression. Client is homeless, estranged from his biological family, no employment history and no high school diploma or GED.

- Keep your treatment plan handy – we will come back to it …

What are the EBPs in forensic or correctional treatment?

- RNR first published in 1990s
- I first heard it in 2004
- Mental health clinicians don't read correctional literature
- Corrections practitioners don't read academic corrections literature
- Federal probation – strategic plan in 2008; actual implementation in 2011 – had to wait for dynamic risk assessment tool

The Risk–Need–Responsivity (RNR) Model
(Andrews & Bonta 2010)

- How to think about it …

Individual vs. actuarial risk

Of recidivism. How is it defined?

RNR

- Risk Principle – focus resources on moderate & high risk offenders
- Interventions with low risk offenders can be harmful

RNR

- Need Principle – target criminogenic needs/dynamic risk factors

Dynamic Risk Factors
Criminogenic Needs

- History of Antisocial Behavior (static)
- Antisocial Personality Pattern
- Antisocial Cognition
- Antisocial Associates
- Family/Marital Circumstances
- School/Work
- Leisure/Recreation
- Substance Abuse

RNR

- Responsivity Principle
  - General responsivity – use CBT; based on cognitive-behavioral & social learning theory
  - Specific responsivity – offender characteristics; not direct risk factors but potential obstacles to delivery of interventions that will decrease risk;

Specific responsivity factors

- Transportation; trauma history; homelessness; mental illness (remember the 1 in 10); language; gender; motivation; learning style; literacy; child care; medical problems; cultural factors
- This is where strengths based fits into the model

RNR – how to do it …

RISK-N-R

- Use a validated risk assessment tool, e.g., COMPAS, LSI-R, LS-CMI, LS-RNR, ORAS, PCRA
- Actuarial risk assessment more accurate than professional judgment
- Clinical/professional judgment comes in on overrides

The tool gives a risk level

RISK continued

- Most risk assessment tools do not have to be given by clinical staff
- Challenges and realities of risk assessment: time; obtaining the score
- Challenges and realities of risk assessment: are they racially biased?

R-Need-R

- The risk assessment tool will also provide the dynamic risk factors to target for the individual

Need continued

- Interventions can be “brand name”, off the shelf:
  - Moral Reconation Therapy (MRT)®
  - Interactive Journaling®
  - Thinking For A Change; Reasoning & Rehabilitation; Aggression Replacement Therapy (ART)
- Or generic/local programs based on EBP principles

Need continued

- Measure cognitions/criminal thinking:

- Psychological Inventory of Criminal Thinking Styles (PICTS); Glenn D. Walters
- Texas Christian University Criminal Thinking Scales (CTU CTS)

R-N-Responsivity

- Describes how treatment should be provided
  - CBT with social learning approach – "prosocial model" includes problem solving and prosocial modeling (Trotter, 2006)
  - Assess and adjust for obstacles
    - Consider that "resistance" may be a responsivity factor

- Gender responsive
- Focus on abilities and strengths
- Cultural issues

Q&A – discussion

- “Cultural competence is, generally, referred to, as having the knowledge, the skills, and the attitudes to work effectively in cross-cultural situations.”
- Awareness vs. competence vs. humility
- Disproportionate incarceration rates

Implicit Bias – Institutional racism?

- Incarceration rates: black males 5x the rate, and Hispanic males 2.5x the rate, of white males
- 1.5% of black men, 0.8% of Hispanic men vs. 0.3% of white men
- Black women 4x the rate of white women and 2x the rate of Hispanic women
- Black men ages 18–19: 12x more likely than white men
- Some good news: overall incarceration rates down 13% from 2007; down 14% for white; 31% for black, & 25% for Hispanic
- (Bronson & Carson, 2019)

- Implicit bias
- https://implicit.harvard.edu/implicit/takeatest.html
- A couple of case examples

Q&A – discussion

Back to the vignette: how did you do?

Is there anything you would change given the information we've talked about so far?

Let's look at him again …

- 30 yo male. Single, never married. Multiple convictions since age 14 including drug possession/sales, assault and armed robbery. 1 strike. Current charge ADW has served 6 years in prison, paroled 2 weeks ago. Gang affiliated. History of methamphetamine, cocaine and alcohol dependence from age 13. Diagnosed with PTSD and Major Depression. Client is homeless, estranged from his biological family, no employment history and no high school diploma or GED.

Did your treatment plan address …

Evidence Based Practices in Mental Health

- The Relationship
- Illness Management & Recovery
  - May include medication
- Assertive Community Treatment
- Integrated Co-Occurring Disorders Treatment
  - May include Medication Assisted Treatment (MAT) for addiction recovery
- Trauma Interventions
- Supported housing and supported employment

Using the RNR model, what more information do you need?

- Risk level – Low, Moderate, High?

Dynamic Risk Factors

- Extensive criminal history starting before age 15 = Antisocial personality pattern = Cognitions
- Single, gang-affiliated, estranged from family = Social Networks
- No HS diploma nor GED & no employment history = Education/Employment
- Meth, cocaine, alcohol dependence = Substance Abuse
- Leisure/recreation activities?

- Responsivity factors:
  - Mental illness – Major Depression and PTSD – unknown trauma history
  - Homelessness
  - Transportation
  - More? Literacy? Motivation? Learning style?

This changes the treatment plan …

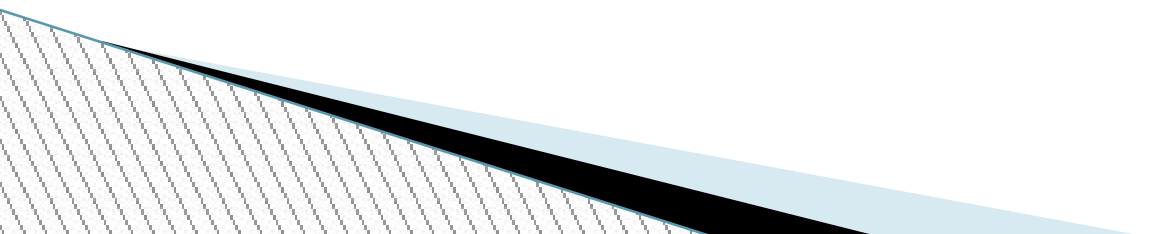
- In addition to traditional mental health treatment – cognitive behavioral, social learning, and motivational interviewing approaches to address dynamic risk factors

Quality forensic treatment = individualized and comprehensive =

- EBPs in mental health + RNR + best practices in corrections
  - Highlights:
    - Reentry planning
    - Housing first
    - Employment assistance
    - Integrated health & behavioral health care
    - FACT
    - Trauma Informed
  - Family support/involvement
  - Court/Criminal Justice advocacy and liaison
  - Partnership between probation/parole and clinical service providers
  - Problem solving approaches to behavior challenges

- A word about immediate reentry planning:
- The Federal model – Residential Reentry Centers (RRCs) = halfway houses
- In-reach and warm handoffs
  - Checklist:
    - Housing; employment/education/reinstatement of benefits; identification; family/prosocial supports; appointment with probation/parole officer; mental health and/or substance use treatment appointments
- (Shaffer, et al. 2019; Travis, 2005)

- That’s a lot of layers!
- Anyone actually doing all of this?



Q&A – discussion

- Substance Abuse and Mental Health Services Administration: *Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide.* HHS Publication No. SMA- 19-5097. Rockville, MD: Office of Policy, Planning, and Innovation. Substance Abuse and Mental Health Services Administration, 2019

How do we integrate recovery and public safety?

The challenge of the dual role

- Probation/parole: Monitoring and helping
- Treatment: Recovery and public safety

10 SAMHSA Recovery Principles

- Self-direction
- Individualized and person centered
- Empowerment
- Holistic
- Non-linear
- Strengths based
- Peer support
- Respect
- Responsibility
- Hope

The recovery part – therapeutic relationship

- I think CBT & social learning needs relationship first
- The power of empathy and story
- Not us vs. them – human beings

- The Relationship – Engagement = Respect, empathy, genuine caring, active listening & motivational interviewing (this is more than just advice giving) (genuineness of the therapist and self-disclosure?)

The recovery part

- “Don’t ask what’s wrong with me, ask what happened to me” (medical model vs. recovery model)
  - Eleanor Longdon TED Talk https://www.youtube.com/watch?v=syjEN3peCJw
- “Do you really want to know?”
- We all have a story – narrative therapy

- Hope & self-efficacy
  - Can the client visualize a changed, better future?
- Control – empowerment in a mandated/involuntary situation?

- “I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel”
  - Maya Angelou

Responsivity and trauma

- My thinking is still evolving on this one, not my expertise, but:
- Brain research:
  - ACEs – developmental trauma
  - TBI – 65–87% (30–97%) of inmates report traumatic brain injury (Williams, Mewse, Tonks, Mills, Burgess,& Cordan, 2010; Slaughter, Fann, & Ehde, 2003); Glover, et al., 2018)
  - Drug and alcohol use
  - Effects of poverty

- Lead to:
- Damage to the prefrontal cortex = cognitive impairment – short attention span; decreased concentration; difficulty integrating information verbally; difficulty in organization; emotional regulation; impulsivity
- All the things we are asking our clients to do

- Responsivity factor of learning style and coping skills
- Talk therapy and written curriculums vs. experiential learning (e.g., rehearsal, role play, drawing)?
- Trauma informed CBT treatment – Seeking Safety
- Resiliency: mindfulness; self-talk; breathing; self-compassion; gratitude; humor; journaling (Brene Brown 2015; Sandburg & Grant 2017)

Q&A

The public safety part: traditional mental health treatment vs. forensic treatment

- Criminal justice money for mental health treatment, the focus is on public safety
- Symptom reduction alone does not reduce recidivism
- Focus on high need, high risk
- On mild to moderate need and low risk, if criminal justice is paying for it, then brief, goal targeted interventions are expected (Clement et al. 2011)

Challenges of the dual role: consistent and balanced vision & mission

- Back to organizational & personal why
- "… since we are in their house (probation), we use their language, 'public safety", 'reduce recidivism', but we all know we just want the client to get better"
  - unnamed LCSW at conference presentation on integration of mental health & criminal justice

Challenges of the Dual Relationship: Client Centered?

- "If we report every positive drug screen … this compels the client to be secretive and lie about continued use or lapses. To be honest would be self-defeating to get what they want (to get off probation). But, in fact, it would be us as treatment providers who created an environment of conning and dishonesty. Our job is to focus on assessment and treatment rather than sanctioning a person for recurrence of their addiction illness."
  - written by unnamed M.D. in 2009

Challenges of the Dual Relationship: Nonjudgmental and empowering and directive?

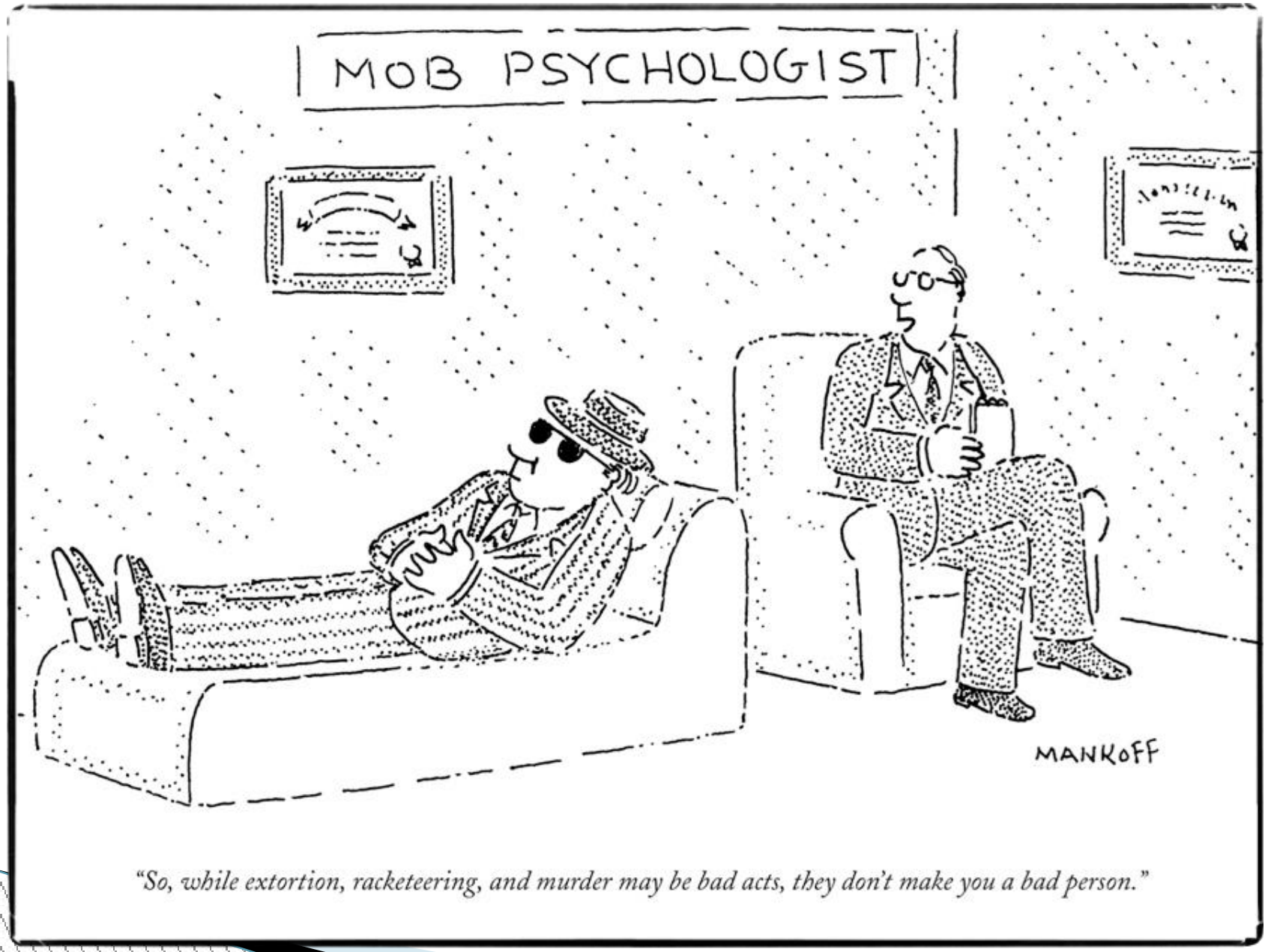
- “Workers with involuntary clients are employed by the state to work with people who have been judged to have transgressed social mores. On a day-to-day basis, they make judgments about unacceptable standards of parenting or acceptable levels of drug use or violence. Direct practice workers make these judgments, they communicate them to clients, and they in turn influence the behaviour of these clients.” (Trotter 2006)

- Balance of empathy and accountability

Q&A – discussion

What doesn't work

- Blaming and/or punitive
- Insight alone
  - ✕"To know and not to act is not to know" African proverb
- Relationship alone (without prosocial modeling and problem solving)
- Targeting self-esteem



"So, while extortion, racketeering, and murder may be bad acts, they don't make you a bad person."

How to implement RNR?
Organizational Change

Definitions

- Implementation: "A specified set of activities designed to put into practice an activity or program of known dimensions"
- “Implementation Science is the study of factors that influence the full and effective use of innovations in practice. The goal is not to answer factual questions about what is, but rather to determine what is required.”
- National Implementation Research Network (NIRN) http://nirn.fpg.unc.edu
- Fixsen et al. 2015 & 2005

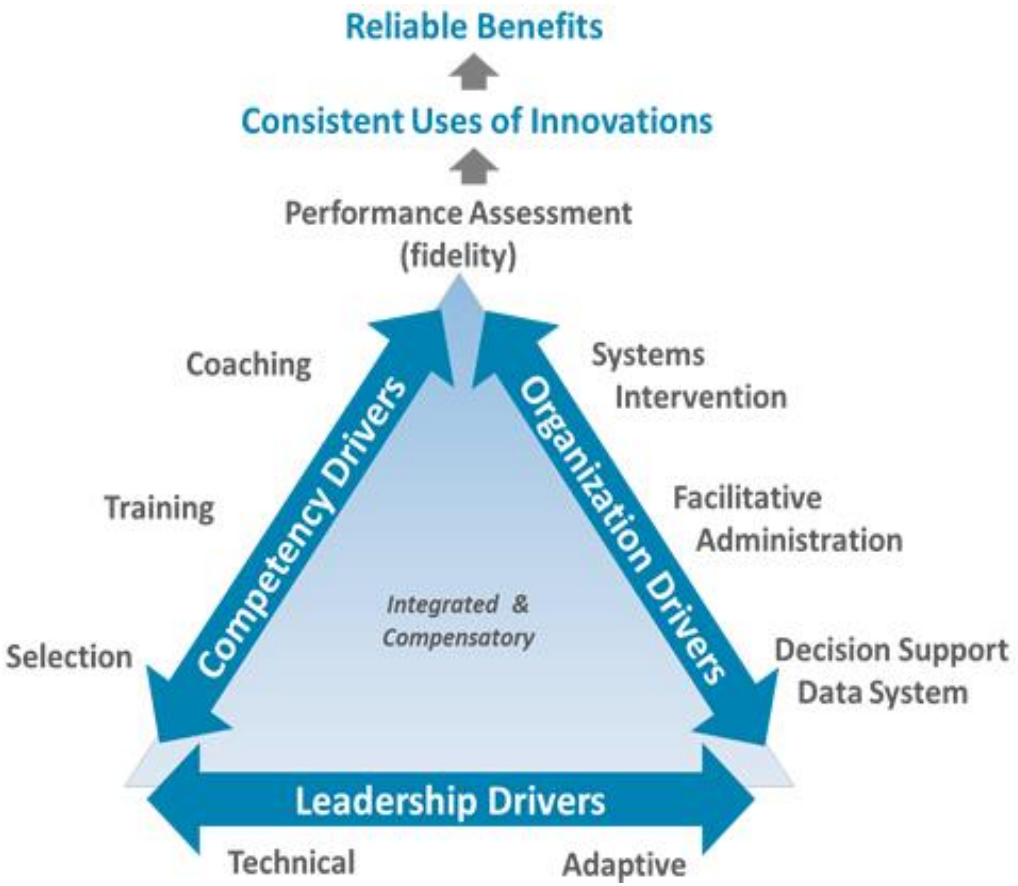
- RNR programs and practices are well-researched and effective
- More CBT research is a good thing but does not lead to successful implementation

Clinical staff – don't check out here; why this is important to talk about

- Will you go and actually change your practice after this training? The research says you won't
- Positional leadership vs. everyday leadership
  - Drew Dudley TED Talk https://www.youtube.com/watch?v=uAy6EawKKME&sns=em

- A study with teachers in education:
  - ✕ Theory & discussion in training – 0 use in the classroom
  - ✕ Demonstration in training – 0 use in the classroom
  - ✕ Practice & feedback in training – 5% use in the classroom
  - ✕ Coaching in the classroom – 95% use
    - Joyce & Showers, 2002

Drivers of Successful Implementation



- Competent workforce
- Hospitable environment
- Engaging leaders

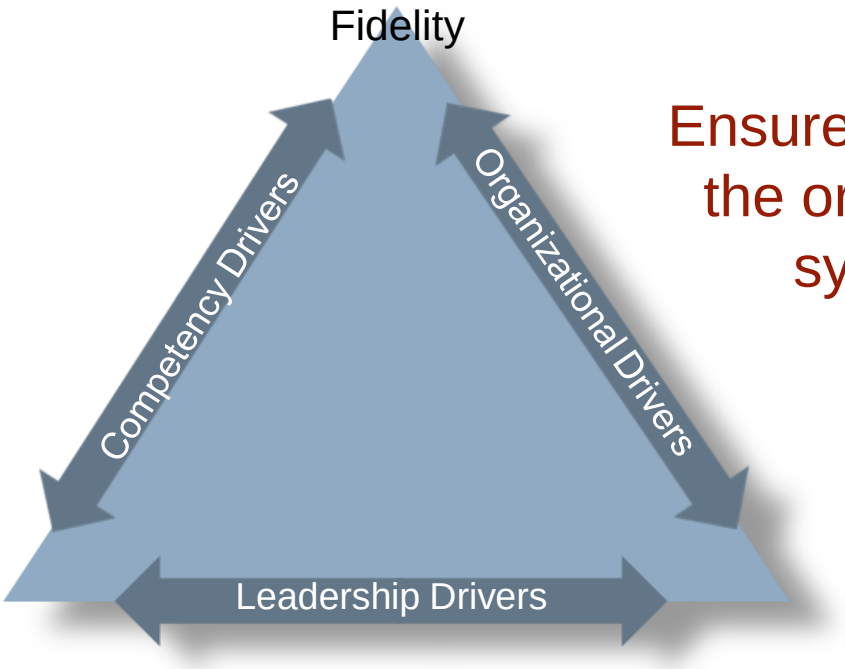
Implementation Drivers

Reliable Benefits

Consistent Use of Innovation

Fidelity

Develop practitioners' competence and confidence to implement



Ensure sustainability at the organization and system levels

Use the right leadership strategies for the situation

- We are asking our clients to change their behavior
- EBP implementation requires behavioral change by practitioner, supervisor, & administrators. Training & coaching are the #1 way behavior change brought about.

Q&A – discussion

Back to implementation at the clinical level …

“I have another guy …” Vignette 2

- Don is a 50 year old male court-ordered to psychotherapy. He says that although he does not think he has any problems that he needs counseling for, he will come to therapy because he does not want to go back to prison. Don has a lengthy criminal history starting with multiple car thefts and burglaries as an adolescent. As an adult, he has been convicted of crimes ranging in seriousness from driving with a suspended license to attempted rape. He has been convicted of multiple forgeries, credit card fraud violations and drug possession. He also has multiple arrests for forgery that he was not convicted of.

- At age 25, he was less than honorably discharged from the Army. He has an 11th grade education and has been unable to keep jobs between his incarcerations. He has a history of methamphetamine addiction. He has no medical problems. He says he is through with his criminal lifestyle because he is too old to go to prison again, but he shows no remorse for his actions. He was recently released after 5 years in prison. He is currently living with his elderly father and he has a girlfriend, but he has no other friends. He is currently unemployed. He denies any symptoms of depression, anxiety, or psychosis.

vignette 2 – what more information do you need from the RNR perspective?

- Risk level is High
- Top dynamic risk factors are Antisocial Personality Pattern, Cognitions, Social Networks, Substance Abuse
- Responsivity factor – motivation?

Discussion of treatment plan for Don

- Clinically or diagnostically:
  - No clinical mental health disorder present(old Axis I)
  - Severe Methamphetamine Use Disorder
  - Antisocial Personality Disorder

In conclusion: Implementation

- Not rocket science, but you have to implement training in the intervention(s), ongoing coaching, fidelity, and process and outcomes measurement
- Effective implementation strategies are essential to successful outcomes
  - 2-4 year process with implementation support vs. 17 years without!

In conclusion:
“Correctional Quackery”

- Quackery = common sense or tradition over scientific evidence
- Unscientific services -- no change or can increase antisocial behavior (Flores et al. 2005)

My encouragement and challenge for you…

- Don't practice correctional quackery
- A personal action plan… tell the person next to you one change you are going to make when you return to your office as a result of attending this workshop?

My contact info

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