Addressing a National Crisis: Too Many Individuals with Mental Illnesses in our Jails

Florida’s CJMHSA Reinvestment Grantees

Fred C. Osher, M.D.
Quarterly Technical Assistance Call
November 24, 2015
An Expanding Population under Correctional Supervision

7 MILLION AND COUNTING

Led by probation, the correctional population has tripled in 25 years.

PROBATION
4,293,163
PAROLE
824,365
PRISON
1,512,576
JAIL
780,581

NOTE: Due to offenders with dual status, the sum of these four correctional categories slightly overstates the total correctional population.

….. Jails Are Where the Volume Is

Number of National Admissions in a Week and a Year for Jails and Prisons, 2012

- Jail Admissions: 11,605,175 annually, 222,565 weekly
- Prison Admissions: 553,843 annually, 10,621 weekly

Council of State Governments Justice Center
Jail Population Declining Nationally

Inmates Confined in Local Jails at Midyear and Percent Change in the Jail Population, 2000-2013

Number of Inmates at Midyear

Annual Percent Change
But Jail Population Changes Are Uneven: Individuals with Mental Illnesses


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

- 2005:
  - M Group: 3,319 (24%)
  - Non-M Group: 10,257 (76%)
- 2012:
  - M Group: 4,391 (37%)
  - Non-M Group: 7,557 (63%)

Total:
- 2005: 13,576
- 2012: 11,948

Council of State Governments Justice Center | 5
Mental Illnesses: Overrepresented in Our Jails

<table>
<thead>
<tr>
<th>General Population</th>
<th>Jail Population</th>
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<tr>
<td>5% Serious Mental Illness</td>
<td>17% Serious Mental Illness</td>
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<tr>
<td>72% Co-Occurring Substance Use Disorder</td>
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Serious Mental Illnesses (SMI) vs. Less Serious Mental Illnesses

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)
Factors driving this crisis

- Disproportionately higher rates of arrest
- Longer stays in jail and prison
- Limited access to health care
- Disproportionality higher recidivism rates
- Low utilization of EBPs
- More criminogenic risk factors
What Accounts for the Problem?

Low utilization of EBPs

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

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

Source: NSDUH (2008)
Average length of stay in jails

Source: The City of New York Department of Correction, 2008 Department of Correction Admission Cohort with Length of Stay > 3 Days (First 2008 Admission)
Percentage of People with Behavioral Health Disorders Rebooked into Franklin County Jail within Three Years of Release*

- **Non-SMI**: 51%
  - N = 20,412
- **SMI**: 60%
  - N = 1,554

*Analysis of 2010 Franklin County jail bookings
SMI identified using match to behavioral health service utilization data
Incarceration is Not Always Directly Related to Mental Illness

Source: Peterson, Skeem, Kennealy, Bray, and Zvonkovic (2014)
Criminogenic Risk

**Risk:**

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

**Risk** = How likely is a person to commit a crime or violate the conditions of supervision?
Individuals with Mental Illnesses Have *Many* of the “Central 8” Dynamic Risk Factors

...and these predict recidivism more strongly than mental illness

Source: Skeem, Nicholson, & Kregg (2008)
History of Addressing Criminogenic Risk Factors as Part of Behavioral Health Services

Dynamic risk factors and associated needs

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<th>Dynamic Risk Factor</th>
<th>Need</th>
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<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>
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<tr>
<td>Antisocial cognition</td>
<td>Develop less risky thinking</td>
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<tr>
<td>Antisocial associates</td>
<td>Reduce association with criminal others</td>
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<tr>
<td>Family and/or marital discord</td>
<td>Reduce conflict, build positive relationships</td>
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<tr>
<td>Poor school and/or work performance</td>
<td>Enhance performance, rewards</td>
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<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>
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*Source: Andrews (2006)*
Risk-Need-Responsivity (RNR) Model as a Guide to Best Practices

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Importance of Risk Principle

Failing to adhere to the risk principle can increase recidivism

Average Difference in Recidivism by Risk for Individuals in Ohio Halfway House

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

Source: Presentation by Dr. Edward Latessa, “What Works and What Doesn’t in Reducing Recidivism: Applying the Principles of Effective Intervention to Offender Reentry”

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Reduce Recidivism by Targeting Multiple Criminogenic Needs

Recidivism Reductions as a Function of Targeting Multiple Criminogenic vs. Non-Criminogenic Needs

(Andrews, Dowden, & Gendreau, 1999; Dowden, 1998)

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Responsivity Principle

- **Responsivity**: general and specific factors that will impact the effectiveness of treatment.

Use methods which are effective for justice involved individuals

Adapt treatment to individual limits (length of service, intensity)

Consider those factors that may serve as barriers to program or supervision compliance (language barrier, illiteracy, etc.)
ADULTS WITH BEHAVIORAL HEALTH NEEDS UNDER CORRECTIONAL SUPERVISION:
A Shared Framework for Reducing Recidivism and Promoting Recovery

Substance Abuse and Mental Health Services Administration

CSG Justice Center
A Framework for Prioritizing Target Population

Low Criminogenic Risk (low)

Low Severity of Substance Abuse (low)

Group 1
I – L
CR: low
SA: low
MI: low

Group 2
II – L
CR: low
SA: low
MI: med/high

Group 3
III – L
CR: low
SA: low
MI: med/high

Group 4
IV – L
CR: low
SA: med/high
MI: med/high

Low Severity of Mental Illness (low)

Serious Mental Illness (med/high)

Group 5
I – H
CR: med/high
SA: med/high
MI: low

Group 6
II – H
CR: med/high
SA: med/high
MI: low

Group 7
III – H
CR: med/high
SA: med/high
MI: low

Group 8
IV – H
CR: med/high
SA: med/high
MI: med/high

Medium to High Criminogenic Risk (med/high)

Low Severity of Substance Abuse (low)

Group 9
I – H
CR: med/high
SA: med/high
MI: med/high

Group 10
II – H
CR: med/high
SA: med/high
MI: med/high

Group 11
III – H
CR: med/high
SA: med/high
MI: med/high

Group 12
IV – H
CR: med/high
SA: med/high
MI: med/high

Substance Dependence (med/high)

Low Severity of Mental Illness (low)

Serious Mental Illness (med/high)

Group 13
I – H
CR: med/high
SA: med/high
MI: low

Group 14
II – H
CR: med/high
SA: med/high
MI: low

Group 15
III – H
CR: med/high
SA: med/high
MI: low

Group 16
IV – H
CR: med/high
SA: med/high
MI: low

Serious Mental Illness (med/high)
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
Two Critical Components

Target Population

Comprehensive Effective Community-based Services
Comprehensive, Effective Community-Based Services

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<th>Data for J I</th>
<th>Impact</th>
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<tr>
<td>Housing</td>
<td>++</td>
<td>++++++</td>
</tr>
<tr>
<td>Integrated Tx</td>
<td>+++</td>
<td>+++++</td>
</tr>
<tr>
<td>ACT/ICM</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Supported Emp.</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Illness Mgmt.</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Trauma Inter./Inf.</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>CBT</td>
<td>+++++</td>
<td>+++++</td>
</tr>
<tr>
<td>Medications</td>
<td>+++++</td>
<td>+++++</td>
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Resource: A Checklist for Implementing EBP’s for Justice-involved with Behavioral Health Disorders

GOAL: Be comprehensive and bring efforts to scale

- **Law Enforcement**: 911, Local Law Enforcement
- **Initial Detention**: Initial Detention, First Appearance Court
- **Jails/Courts**: Specialty Court, Jail, Dispositional Court
- **Reentry**: Prison/Reentry, Jail/Reentry, Evidence Based Practices to Reduce Likelihood of Return to Jail
- **Community Corrections**: Parole, Probation

### Community-Based Responses
- Specialized Police Based Responses
- Alternatives to Incarceration: Crisis Centers

### Alternatives to Detention
- Universal Screening and Assessment
- Alternatives to Detention
- Specialized Pretrial Supervision and Treatment

### Expedited Processing
- Mental Health Courts

### Reentry Planning
- Specialized Probation
County leaders are being asked to focus on system-level outcomes

1. **Reduce**
   the number of people with mental illness booked into jail

   You need trained law enforcement officers and alternatives to incarceration before they are booked into jail

2. **Shorten**
   the length of stay for people with mental illnesses in jails

   You need early identification, pretrial release to treatment with conditions

3. **Increase**
   the percentage of people with mental illnesses in jail connected to the right services and supports upon release

   You need well developed “warm hand-offs”, quality treatment, and sufficient capacity

4. **Lower**
   rates of recidivism

   You need effective connection to treatment with supervision conditions and dedicated program funding
Achieving these outcomes requires major changes to policy and practice

1. Maximize opportunities to connect people to treatment upon first contact with law enforcement

2. Conduct universal risk, substance use, and mental health screens at booking, and full assessments as appropriate

3. Get relevant information into hands of decision-makers in time to inform pre-trial release decisions

4. Use assessment information to connect people to appropriate jail-based services and post-release services and supervision

5. Ensure services and supervision are evidence-based and hold system accountable by measuring outcomes
Easier Said than Done: Challenges

• Difficult to pinpoint target population and understand the scope of the problems; BH definitions need to align

• Must understand what services are funded, for whom, under current billing options

• Must know capacity of existing services and the gap

• Workforce development has to happen in parallel

• Tracking and measuring results is a priority for sustainability
County officials are speaking up...

“Jails should not be de facto mental health treatment facilities, and using them this way does not improve public safety. There are better ways to address this national issue to ultimately reduce costs, improve lives and provide hope.”

-- Sheriff Susan Pamerleau, Bexar County, TX

“[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 Sheriff Terri McDonald, Los Angeles, CA

“The costs are high—to public safety, to the budget and to the lives of our residents—and we are committed to connecting people with mental illness to care and treatment instead of needless incarceration.”

-- Commissioner Marilyn Brown, Franklin County, OH

“We’ve known for some time that we needed better data on where the gaps are in how we identify, assess, track and treat those folks who wind up in jail as the facility of last resort.”

-- County Mayor Ben McAdams, Salt Lake County, UT

Jails are the wrong place to treat mental illnesses
A national initiative to reduce the number of people with mental illnesses in jails
Major partners rally around a common goal

**County elected officials**
- National Association of Counties (NACo)

**Behavioral health**
- National Council on Behavioral Health
- American Psychiatric Association Foundation

**Law enforcement**
- National Sheriffs' Association
- Sheriff's Association

**Other experts**
- Policy Research Associates

**Individuals and families**
- National Alliance on Mental Illness (NAMI)
Counties and individuals join call to action

Over 50 million people reside in Stepping Up counties
The six-step approach

A Call to Action (6 steps)

1. Convene or draw on a diverse team
2. Collect and review prevalence number and assess individuals’ needs
3. Examine treatment and service capacity
4. Develop a plan with measurable outcomes
5. Implement research-based approaches
6. Create a process to track progress

Stepping Up Toolkit
https://stepuptogether.org/toolkit

- Planning guides keyed to 6 action steps
- Six webinars featuring experts and examples from the field
- Curated resource library
- New tools and resources (e.g., health policy guide)
Approximately 50 county teams, composed of representatives from law enforcement, corrections, behavioral health, and public officials, will come together to:

- **Interact** with national experts
- **Learn** from experiences of other counties
- **Build** upon their county plan
- **Identify** opportunities for technical assistance
Thank You

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