Assessing Risk for Persons with Behavioral Health Needs Involved in the Criminal Justice System

Hillsborough County Strategic Planning Department & Court Administration for the 13th Judicial Circuit

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Goals of this Presentation

Review

• The importance of risk level, treatment needs, and responsivity in designing interventions for substance-involved offenders
• The relationship between mental disorders and crime
• The process of matching supervision and treatment to offenders’ level of risk and needs
• Proximal and distal goals for different levels of risk and treatment needs
Dispositions for Drug Offenders and Policy Implications

Adapted from Marlowe, 2013
Using Offender Risk and Needs to Guide Sentencing and Disposition

- Focus resources on **Moderate to High Risk** cases (*risk for criminal recidivism*)

- Interventions should target **Dynamic Risk Factors** for criminal recidivism (e.g., antisocial attitudes, criminal peers, substance abuse)

- Focus on those who have **High Needs** for substance abuse treatment

- **Responsivity** – Tailor services to enhance engagement in evidence-based interventions that address dynamic risk factors
Screening and Assessment of Criminal Risk Level

- Goal is to **match level of services** to risk level

- **Improved outcomes** if focus on moderate to high risk offenders
  - Providing intensive treatment and supervision for low risk offenders can **increase recidivism**
  - Mixing risk levels is contraindicated

- Higher risk offenders require greater structure, and **more intensive treatment and supervision**
How is Level of Risk Determined?

- **Risk for criminal recidivism**
- **Use of risk assessment**
  - ‘Static’ factors (e.g., criminal history)
  - ‘Dynamic’ or changeable factors that are targets of interventions in the criminal justice system
Interventions should Target Dynamic Risk Factors

“People involved in the justice system have many needs deserving treatment, but not all of these needs are associated with criminal behavior”

Dynamic Risk Factors for Criminal Recidivism

1. Antisocial attitudes
2. Antisocial friends and peers
3. Antisocial personality pattern
4. Substance abuse
5. Family and/or marital problems
6. Lack of education
7. Poor employment history
8. Lack of prosocial leisure activities
9. Post-Traumatic Stress Disorder (?)
Recidivism outcomes in targeting criminogenic vs. non-criminogenic needs

(Andrews et al., 1999; Carey, 2011; Dowden, 1998)
Risk Assessment Instruments

- Historical-Clinical-Risk Management - 20 (HCR-20)
- Level of Service Inventory - Revised – Screening Version (LSI-R-SV)
- Ohio Risk Assessment System (ORAS)
- Psychopathy Checklist - Screening Version (PCL-SV)
- Risk and Needs Triage (RANT)
- Short-Term Assessment of Risk and Treatability (START)
- Violence Risk Scale (VRS): Screening Version
Translating Risk Assessment to Service Planning

- Target areas of **high need** related to dynamic risk factors
- **Treatment and supervision plans** should be aligned to focus on areas of high needs
- **Readminister risk assessment**
  - Frequency depends on setting and opportunity for change
  - Revise service goals, incentives and sanctions
Focus on High Needs for Substance Abuse Treatment

- The **higher the severity** of substance use problems, the higher the level of treatment services needed
- Offenders with low severity substance use problems **may not require treatment**
- Mixing persons with high and low levels of substance use treatment needs is **contraindicated**
- Structured interventions **compete with other prosocial activities** for low need offenders
How do you Determine High Needs for SA Treatment?

• Use of **screening and assessment**
  - Screening to flag severe substance use problems
  - Assessment to determine level of services needed
  - Usually involves used of formal instruments

• Identify a “**problematic pattern of use**, leading to significant impairment or distress” (DSM-V)
  - Formerly - drug or alcohol “**dependence**”
  - New severity ratings: “mild”, “moderate”, “severe”, based on number of symptoms related to substance use
Neglected “Needs” Related to Recidivism Reduction

- Criminal attitudes and beliefs
- Criminal peer networks
- Family/social relationships
- Education
- Employment
- Developing leisure skills
- What about mental health treatment?
What’s the Connection between Mental Disorders and Crime?
Prevalence of Mental Illness in Jails and Prisons

Serious Mental Disorders among Offenders and the General Population

Percentage of Population

Sources: General Population (Kessler et al., 1996), Jail (Steadman et al., 2009), Prison (Ditton 1999)
Co-Occurring Substance Use Disorders

74% of state prisoners with mental problems also have substance abuse or dependence problems

Source: U.S. Department of Justice, 2006
For Persons with Mental Illness, only 8% of Arrests are Attributable to Mental Illness

Junginger, Claypoole, Laygo, & Cristina (2006); National Reentry Resource Center
Offenders with Mental Illness have High Levels of Criminogenic Risk

Key Criminogenic Risks

- Antisocial attitudes and beliefs
- Antisocial peers
- Antisocial personality features
- Substance use disorders
- Family/marital problems
- Lack of education
- Poor employment history
- Few prosocial/leisure skills

Skeem, Nicholson, & Kregg (2008), National Reentry Resource Center, 2012
What’s the Connection Between Mental Disorders and Criminal Behavior?

- Persons with mental disorders have similar risk for recidivism as other offenders
- Treating mental disorders is insufficient to reduce recidivism – not an independent risk factor for recidivism
- However, mental health services enhance participants’ responsivity to evidence-based treatments that can reduce recidivism
- Thus, court-based programs should address both mental disorders and criminal risk factors
Integrating Treatment and Supervision Reduces Risk

Change in Recidivism Rates for Adult Offenders

- Intensive Supervision: Surveillance Oriented
  - 0%

- Employment Training & Assistance
  - -4.8%

- Drug Treatment
  - -12.4%

- Intensive Supervision: Treatment Oriented
  - -21.9%

Responsivity – Key Areas

Strategies to **tailor treatment and supervision** to help offenders engage in evidence-based interventions that address dynamic risk factors

- Mental health treatment/specialized COD services
- Trauma/PTSD services
- Gender-specific treatment
- Motivational enhancement techniques
- Address language and literacy issues
- Use of cognitive-behavioral approaches
Considerations in Implementing Risk Reduction Interventions

- **Staff training** in RNR model, use of incentives and sanctions, and evidence-based practices
- **Integrated screening and assessment** approach - focused on offender risk/needs
- **Monitoring fidelity** of treatment and supervision
- **Individualizing service plans** to address areas of high needs, reassessing risk, and updating plans
Screening and Assessment for Risk, Needs, and Responsivity

What’s the difference between:

- Risk screening and assessment
- Screening for high substance use needs
- Screening/assessment related to responsivity issues
- Clinical assessment
Addressing Different Levels of Substance Use Severity

**Moderate - Severe SU**
- Cravings and compulsive use
- Major consequences of use
- Tolerance and withdrawal

**Abstinence is distal goal**

(** Engagement in services is proximal goal**)

**Mild SU**

**Abstinence is proximal goal**

**Special Needs**
- Mental health
- Criminal thinking

**Engagement in services is proximal goal**
Addressing Different Levels of Criminal Risk

High Risk } Abstinence and major changes in antisocial behavior are distal goals

(Moderate Risk } Abstinence can be proximal goal

Low Risk } Abstinence can be proximal goal
<table>
<thead>
<tr>
<th>High Risk</th>
<th>Low Risk</th>
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<tbody>
<tr>
<td><strong>High SA Needs</strong></td>
<td><strong>Low SA Needs</strong></td>
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<tr>
<td>(moderate – severe)</td>
<td>(mild)</td>
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<tr>
<td>Accountability,</td>
<td>Treatment</td>
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Adapted from Marlowe, 2013
## Practice Implications

### High Risk

- Status calendar
- Drug Treatment
- Prosocial and life skills
- Abstinence is distal
- Positive reinforcement
- Self-help/alumni groups
- ~ 18-24 mos. (~200 hrs.)

### Low Risk

- Noncompliance calendar
- Treatment (separate milieu)
- Life skills
- Abstinence is distal
- Positive reinforcement
- Self-help/alumni groups
- ~ 12-18 mos. (~150 hrs.)

### High SA Needs

- Status calendar
- Drug Treatment
- Prosocial and life skills
- Abstinence is distal
- Positive reinforcement
- Self-help/alumni groups
- ~ 18-24 mos. (~200 hrs.)

### Low SA Needs (mild)

- Status calendar
- Prosocial habilitation
- Abstinence is proximal
- Negative reinforcement
- ~ 12-18 mos. (~100 hrs.)

- Noncompliance calendar
- Psychoeducation
- Abstinence is proximal
- Individual/stratified groups
- ~ 3-6 mos. (~12-26 hrs.)

Adapted from Marlowe, 2013
Adjusting Services for High Risk and High Need Offenders

- **Intensive outpatient treatment** (4-5x week)
- **Longer duration** of treatment and supervision
- ‘Criminal thinking’ groups
- **More frequent supervision** (status hearings, home visits, etc.)
- **More frequent drug testing**
- **Proximal goals**: Engage in SA treatment and other services to address criminal risk factors
Dispositional Continuum

- Low risk
  - Low needs
  - Low risk
  - High needs
  - High risk
  - High needs
  - High risk
  - Low needs

Risk of Dangerousness

Pre-Plea Diversion
- Post-Plea Diversion
  - Probation
  - Drug Courts
  - Intermediate Sanctions
  - Incarceration

Adapted from Marlowe, 2013