Policy and interventions for adults with serious mental illness and criminal justice involvement

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Overview

• Scope and history of the CJ-MH problem

• Risk factors for CJ involvement among adults with SMI

• CT cost studies: a look at the CJ-MH link in one population

• Sequential Intercept Model: the landscape of opportunities for program and policy intervention
Scope of the problem of criminal justice involvement among persons with serious mental illness (SMI)

- **11 million adults** in the U.S. (5%) **with SMI**
  - SMI almost twice as prevalent among impoverished adults (9%)
  - Women twice as likely as men to have SMI (6.4% v. 2.8%)

- **25%** have a co-occurring **substance use disorder**

- Nearly **37% uninsured, 40% receive no treatment**

Kessler et al, 2005; SAMHSA, 2011
Scope of the problem of criminal justice involvement among persons with serious mental illness (SMI)

- Approximately 2 million persons with SMI in U.S. jails
  - Many continue to cycle repeatedly through the criminal justice system

- About 1 in 5 incarcerated individuals suffer from a serious mental illness
  - 15% of male inmates; 30% of female inmates
  - Once incarcerated, persons with SMI stay far longer

- Each year, hundreds of thousands of adults in the U.S. are released from incarceration
  - Ex-prisoners with SMI face extraordinary challenges in successfully reentering the community and avoiding recidivism
  - 5 million probationers; approximately 27% have SMI

Scope of the problem of criminal justice involvement among persons with serious mental illness (SMI)

• Michael Kerr’s death while in NC prison in March 2014
  – 54 years old, schizoaffective disorder, isolation for 30+ days, no treatment, died of dehydration

• 2011 internal review of conditions for SMI inmates inside Central Prison in Raleigh

• A more typical case...
  – Homeless, mentally ill, arrested for minor offense, can’t afford bail, revolves in and out of the system
Macro trends affecting criminal justice and mental health system capacity, utilization, and cost

• Number of state and county psychiatric hospital beds declined 63% between 1980 and 2000

• Number of persons incarcerated in state correctional facilities increased almost 500% during the same period

• Jails/prisons described as today’s de facto psychiatric institutions

• Declining budgets for behavioral healthcare in state systems
MHSA Expenditures as a Percent of Total Health Care Expenditures

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenditures as a Percent of Total Health Care Expenditures</th>
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<tbody>
<tr>
<td>1986</td>
<td>9.7%</td>
</tr>
<tr>
<td>2003</td>
<td>7.5%</td>
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<tr>
<td>2013</td>
<td>6.9%</td>
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Rapid rise in state spending on corrections: Fivefold increase over two decades

Growth in U.S. inmate population

U.S. prison population

State inmates

Federal inmates

Source: Bureau of Justice Statistics
Prison population growth by crime type

Federal inmates
- Violent: +6K
- Other: +65K
- Drug: +89K

State inmates
- Violent: +461K
- Property: +107K
- Drug: +171K
- Public order/other: +124K

Source: Bureau of Justice Statistics
Coincidental trends?

Source: Bureau of Justice Statistics & SAMHSA
Criminalization v. criminogenesis

• Early consensus centered around criminalization hypothesis
  – Attributes justice involvement problem to untreated mental illness
  – Assumes that offending would stop with access to appropriate MH treatment

• More recently, greater focus on addressing MH treatment needs and criminogenic risks in this population
  – Many treatment interventions for CJ-involved adults with SMI show improvements in MH functioning, but no reductions in recidivism
  – Newer research indicates offenders with SMI share same risk factors for offending as non-MI counterparts

Morrissey, 2007; Case, 2009; Skeem, 2009; Epperson, 2011; Skeem et al., 2014
Criminalization v. criminogenesis

• Important roles of social, environmental, and political contexts
  – Poverty, inadequate social insurance for disabled
  – Loss of low-cost housing options
  – 3-strikes laws and harsher sentencing for drug crimes
  – Generally, very high rates of incarceration in the U.S.
“Central 8” criminogenic risks

1. Anti-social Attitudes
2. Anti-social Peers
3. Anti-social Personality Pattern
4. History of Anti-Social Behavior
5. Family / Marital Factors
6. Lack of Achievement in Education / Employment
7. Lack of Pro-social Leisure Activities
8. Substance Abuse

“The Big 4” criminogenic risks

1. Anti-social Attitudes
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Clinical risk factors for CJ involvement in SMI population

• Among SMI adults who are involved in the CJ system, substance abuse is highly prevalent: **approx 75% have co-occurring SUDs**

• Histories of **trauma** are **nearly universal**; PTSD is highly prevalent

• **Personality disorders** – especially ASPD – also highly prevalent

• **Social-environmental problems** compound the risk and vulnerabilities
  – Intimate partner violence, dependent children, underemployment among women
  – Homelessness, antisocial behavior and associations, violent victimization among men
Connecticut CJ-SMI Study

• Aim: To describe CJ involvement in SMI population, estimate utilization and costs for treatment services and justice involvement

• Multi-agency service records for 25,133 adult clients of Connecticut’s Department of Mental Health and Addiction Services who met the following criteria:
  – chart diagnosis of schizophrenia spectrum disorder or bipolar disorder
  – served in the publicly-operated or funded system of care
  – 2-year window of observation (SFYs 06-07)

• Matched to CJ-related data: arrests, incarceration, probation, parole, jail diversion program, forensic evaluations and hospitalizations
Connecticut CJ-SMI Study: Proportion of SMI sample with any criminal justice system involvement in 2 years

Total sample N=25,133

Not CJ-involved n=18,229 (73%)

CJ-involved n=6,904 (27%)
Connecticut CJ-SMI Study:
Proportion with any involvement by category, entire sample (N=25,133)

72.5%: no CJ involvement

27.5% with any CJ involvement

- No CJ (n=18,229)
- Arrest (n=4,250)
- Incarceration (n=3,968)
- Probation (n=3,299)
- Jail diversion (n=1,973)
- Parole (n=230)
- Forensic evals (n=508)
- Forensic hosp (n=231)
Connecticut CJ-SMI Study: Types of arrests by category (total arrests n=7,157)

- Miscellaneous minor offenses: 3,074 (43%)
- Property: 1,527 (21%)
- Drugs: 1,070 (15%)
- Violent offenses: 738 (10%)
- Other crimes against person: 610 (9%)
- Weapons: 68 (1%)
- Miscellaneous felonies: 70 (1%)

(Includes trespassing, breach of peace, criminal mischief, prostitution, false statements, technical violations of probation/parole, failure to appear, and others.)
Connecticut CJ-SMI Study: Clinical risk factors for CJ involvement in SMI population

• Men with bipolar disorder and substance use disorder had the highest **absolute** risk of offending across several categories of justice involvement.

• But bipolar disorder and substance abuse had especially strong **relative** influences in women, increasing their offending risk much more dramatically.

• Substance abuse appeared to have strongest influence on offending risk.
  – especially among women
  – especially among women with schizophrenia.

Robertson et al. 2014
Clinical risk factors for CJ involvement in CT SMI population

Robertson et al. 2014
Clinical risk factors for CJ involvement in CT SMI population—by primary psych diagnosis

Robertson et al. 2014
Clinical risk factors for CJ involvement in CT SMI population – by SA diagnosis

Robertson et al. 2014
Predicted mean treatment costs by combined risk factors – CJ involvement and psychiatric diagnosis

- Model 1: No risk factor combinations
- Model 2: Combinations by CJ involvement and SUD diagnosis
- Model 3: Combinations by CJ involvement and primary diagnosis

Robertson et al., 2015
Predicted mean treatment costs by combined risk factors – CJ involvement and psychiatric diagnosis

CJ group = 27% higher costs than no CJ group

Model 1: No risk factor combinations

Model 2: Combinations by CJI and SUD diagnosis

Model 3: Combinations by CJI and primary diagnosis

Robertson et al., 2015
Predicted mean treatment costs by combined risk factors – CJ involvement and psychiatric diagnosis

Robertson et al., 2015
Among those with no CJ, having a SUD raised treatment costs nearly 50%.
Predicted mean treatment costs by combined risk factors – CJ involvement and psychiatric diagnosis

Model 1: No risk factor combinations

Model 2: Combinations by CJI and SUD diagnosis

Model 3: Combinations by CJI and primary diagnosis

But among those with CJ, having a SUD had almost no effect on costs

Robertson et al., 2015
Predicted mean treatment costs by combined risk factors – CJ involvement and psychiatric diagnosis

Model 1: No risk factor combinations

Model 2: Combinations by CJ and SUD diagnosis

Model 3: Combinations by CJ and primary diagnosis

Robertson et al., 2015
Predicted mean treatment costs by combined risk factors – CJ involvement and psychiatric diagnosis

Model 1: No risk factor combinations

Model 2: Combinations by CJI and SUD diagnosis

Model 3: Combinations by CJI and primary diagnosis

Costs for CJ-involved adults with schiz were 70% higher than for those with schiz and no CJ involvement.

Robertson et al., 2015
Among those without CJ, adults with schiz had costs that were 3.3 times higher than those with bipolar.

Robertson et al., 2015
Predicted mean treatment costs by combined risk factors – CJ involvement and psychiatric diagnosis

Model 1: No risk factor combinations

Model 2: Combinations by CJI and SUD diagnosis

Model 3: Combinations by CJI and primary diagnosis

CJ-involved with schiz had costs that were 5 times higher than CJ-involved with bipolar

Robertson et al., 2015
Robertson et al., 2015
Policy implications for treatment cost differences by CJ and clinical characteristics

- Competency evaluations described as a “back door” into psychiatric hospitals

- Systems story: Differential treatment costs represent patterns of movement through the public treatment and CJ systems and how those systems yield different access to needed care

- Mental illness life-course story: Differences in costs between those with and w/o justice involvement also a story of illness severity, higher degrees of disability and use of high-cost care among persons with schizophrenia

- More focus needed on how the public treatment and justice systems can coordinate to reduce risk and costs for justice-involved adults with schizophrenia
  - possible alternatives to high-cost, often lengthy forensic hospitalizations (e.g., outpatient programs for competency restoration)
Sequential Intercept Model

- **Intercept 1**
  - Law enforcement

- **Intercept 2**
  - Initial detention / Initial court hearings

- **Intercept 3**
  - Jails / Courts
    - Initial Detention
    - First Appearance Court
    - Specialty Court
    - Dispositional Court

- **Intercept 4**
  - Reentry
    - Prison / Reentry
    - Re-entry

- **Intercept 5**
  - Community corrections
    - Parole
    - Probation

**Community Corrections** by Munetz MR & Griffin PA, 2006
Sequential Intercept Model

Intercept 1
Law enforcement

Intercept 2
Initial detention / initial court hearings

Intercept 3
Jails / Courts

Intercept 4
Reentry

Intercept 5
Community corrections

- Crisis Intervention Training (CIT)
- MH First Aid

Munetz MR & Griffin PA, 2006
Sequential Intercept Model

Intercept 1
Law enforcement

Intercept 2
Initial detention / Initial court hearings

Intercept 3
Jails / Courts

Intercept 4
Reentry

Intercept 5
Community corrections

- Post-booking Jail Diversion Programs

Munetz MR & Griffin PA, 2006
Sequential Intercept Model

Intercept 1
Law enforcement

Intercept 2
Initial detention / Initial court hearings

Intercept 3
Jails / Courts

Intercept 4
Reentry

Mental Health Courts

Intercept 5
Community corrections

- Parole
- Probation

Munetz MR & Griffin PA, 2006
Sequential Intercept Model

- Prison Re-entry Programs
- Medicaid reinstatement
- Outpatient Commitment
Sequential Intercept Model

Intercept 1
Law enforcement

- Specialized Probation & Parole
- Outpatient Commitment

Intercept 2
Initial detention / Initial court hearings

Intercept 3
Jails / Courts

Intercept 4
Reentry

Intercept 5
Community corrections

911

Law Enforcement

Arrest

Initial Detention

First Appearance Court

Specialty

Dispositional Court

Jail

Prison/Reentry

Reentry

Parole

Violation

Probation

Community corrections

Munetz MR & Griffin PA, 2006
Interventions at the CJ-MI interface: the state of the evidence

• While evidence for **effectiveness is promising**, overall **impact has been modest**
  – Often demonstrate reductions in recidivism without improvements in MH symptoms, or *vice versa*

• **Co-occurring SUDs** are a consistent **predictor of program failure**

• **Cost implications** are largely unclear, but some suggest **interventions are not a magic bullet**
Key components for intervention success

• **Systematic screening and assessment** using well validated instruments
  – Including MI, SUD, trauma, gender-specific, and criminogenic needs

• **Strong coordination** between CJ and treatment agencies
  – Big challenges, including philosophical divides, HIPPA privacy constraints

• Trauma-informed, evidence-based **integrated treatment** paired with other social services
Current Status of State Medicaid Expansion Decisions

NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. *AR, IA, IN, MI, and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect on January 1, 2015, but the newly-elected governor may opt for a state plan amendment. Coverage under the IN waiver is set to begin February 1, 2015. NH has submitted a waiver to continue their expansion via premium assistance. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

Thank you