

## Primary Prevention of Criminal Justice Involvement

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If we conceptualize criminal justice system involvement (CJSI) as an adverse condition for which individuals with serious mental illness (SMI) in the community are at some risk, then we can think of primary, secondary and tertiary preventive measures for CJSI among clients of public mental health care systems.

Tertiary prevention aims to reduce the negative impact of established conditions by restoring function and reducing condition-related complications. Secondary prevention aims to diagnose and treat an existing condition in its early stages before it results in significant morbidity. Primary prevention aims to avoid the development of an adverse condition.

The Sequential Intercept Model<sup>1</sup> was developed as a way to conceptualize efforts to move people with SMI out of the cycle of CJSI by means of stages of interventions described as “filters” or intercepts. The five intercepts are: 1) law enforcement and emergency services; 2) post-arrest detention, initial hearings and pretrial services; 3) post-initial hearings: jail, courts, forensic evaluations and forensic commitments; 4) reentry from jails, state prisons, and forensic hospitalization; and 5) community corrections and community support services. An excellent review by Heilbrun and colleagues describes the literature on community alternatives at these various intercepts.<sup>2</sup> Many jurisdictions in the United States have utilized this model in designing interventions within partnerships between public mental health and judicial systems. A quick internet search on “sequential intercept mapping” will produce examples from all over the country of jurisdictions that have engaged this process.

The last four of the five intercepts all describe tertiary prevention; they include programs such as jail diversion; drug, mental health and community courts; assertive community treatment (ACT), intensive case management, and correctional re-entry; and special mental health probation or parole. The first intercept, which primarily involves the crisis intervention team (CIT) approach, can be considered secondary prevention.

The most important public health technology is, however, primary prevention. Munetz and Griffin referred to this as “the ultimate intercept” and described it as involving “best clinical practices” (Ref 1, p 545). It is also now referred to as Intercept Zero.<sup>3</sup> Munetz and Griffin thought that few people would be intercepted early because few communities are able to make these services available and easily accessible to those who need them.

My experience tells me that even with willing, well-intended, and active collaboration between mental health and criminal justice systems, and even with a well-developed public mental health system, too many people continue to experience most of the intercept stages. Nearly every week, people with SMI are admitted to our forensic hospital for restoration of competence to stand trial (CST) with low level misdemeanor charges on low bonds or a promise to appear. My colleagues in other states report that they have been seeing increases in CST evaluations and restoration admissions as well. Waiting lists and lawsuits are common struggles for forensic system directors. In response, more than a dozen states have already developed programs for CST restoration in jails, because they do not have the capacity in their hospitals to accommodate the influx of such individuals (including the Los Angeles program described in the January Newsletter<sup>4</sup>).

These individuals are often as frustrating to community clinicians as they are to the courts. Services are offered, medications supplied, substance treatment available and people continue to get arrested for manifestations of their mental illness and/or substance use disorders. Clinicians might be relieved that their patient was arrested, and at least relatively safe and abstinent for a while. Courts are relieved to send people to the forensic hospital for 60-90 days for restoration, so that the communities will have some respite from their troublesome behavior.

But this is not how we ought to spell relief.

We need to develop and teach different and better skills to our frontline community clinicians to equip them to be more successful at primary prevention. At the very least this will require 1) proper assessment of risk; 2) risk management to the extent that this is possible in a system of care; 3) effective treatment to reduce risk; and 4) ongoing training, supervision and consultation by forensic psychiatrists and psychologists.

Even these interventions, though, are not enough because they tend to assume that criminal behavior by individuals with SMI is a direct result of psychiatric symptoms and, if symptoms are well managed and basic needs are met, these individuals are unlikely to commit a criminal offense. However, extensive research has found that the same criminogenic factors that predict arrest for the average adult criminal also predict arrest for SMI adults.<sup>5</sup> Criminogenic factors refer to those personal factors that increase risk of criminal behavior, including antisocial behavior, personality, cognitions and associates.

Many offenders, SMI or otherwise, often have deficits in interpersonal skills and in cognitive skills (like problem solving, planning, and future thinking) that need to be addressed to promote prosocial behaviors. Thus, criminogenic needs are targets for intervention to prevent involvement (or further involvement) in criminal activity and can be employed in com-

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munity forensic mental health.<sup>6</sup> A recent encouraging development has been the creation of a forensic hospital version of START NOW (available in the public domain<sup>7</sup>) from Robert Trestman and colleagues at the University of Connecticut Health Center, in collaboration with members of the Forensic Division of the National Association of State Mental Health Program Directors (NASMHPD). START NOW uses a cognitive-behavioral and motivation interview-focused treatment approach to offenders with behavioral disorders and has demonstrated positive outcomes in several correctional studies.<sup>8</sup> The hope is that forensic clinicians in hospital settings will be interested in employing the program and conducting evaluation or research on its effectiveness with that population. START NOW has already been used with good effectiveness in Connecticut in a community program at the fifth intercept, involving specialty probation/parole, case management and clinical supports.<sup>9</sup>

What we need next is to develop the capacity to utilize the programs cited by Rotter & Carr and by Trestman with clients in the community who are not yet (or at least not currently) involved in the criminal justice system. I am encouraged by the current enthusiasm for collaboration among the AAPL committees devoted to community, hospital and correctional forensic practice. I am also encouraged at the potential for development of a forensic recovery committee within AAPL, under the leadership of Sandy Simpson.<sup>10</sup> I am particularly intrigued at the notion Simpson cites of the "moral agenda" of recovery for forensic patients – learning to live better so as not to re-offend.<sup>11</sup>

Perhaps members of these committees can continue to help develop programs and training for public mental health systems to encourage primary prevention of CJSI. This is an area ripe for AAPL members' leadership in education and implementation, with

the potential for tremendous public health advances in the mental health and justice systems. ☪

### References:

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11. Dorkins E, Adshead G: Working with offenders: challenges to the recovery agenda. *Advances in Psychiatric Treatment* 17: 178-187, 2011

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to point out that many of the words I used in this article, not the highlighted ones, were once new and different.

Finally, many thanks to the printer of the Newsletter, whom I know is going crazy with all my quotes and ellipses. ☪

## The Tarasoff Pendulum

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to third parties under very limited circumstances, gave explicit instructions on how to discharge that duty, and created immunity for mental health professionals who act in good faith.<sup>8</sup> California<sup>9</sup> and Nebraska<sup>10</sup> have adopted similar limiting statutes and Washington State could do the same. ☪

### References:

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