Primary Prevention of Criminal Justice Involvement for People with SMI

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Public Health Concepts

- **Tertiary prevention** aims to reduce the negative impact of established conditions by restoring function and reducing condition-related complications (e.g., diabetes management & stroke rehabilitation programs).

- **Secondary prevention** aims to diagnose and treat an existing condition in its early stages before it results in significant morbidity (e.g., daily aspirin to prevent further heart attack, Pap tests or other screening).

- **Primary prevention** aims to avoid the development of an adverse condition (e.g., immunizations, bike helmets).
Sequential Intercept Model (Munetz & Griffin 2006)

I. Law Enforcement/ Emergency Services

II. Post Arrest: Initial Detention/Initial Hearings

III. Post-Initial Hearings: Jail/Prison, Courts, Forensic Evaluations and Commitments

IV. Re-Entry From Jails, State Prisons and Forensic Hospitalization

V. Community Correction and Community Support

Jail Diversion

Specialty Courts

Tertiary Prevention

Re-entry programs

Mental Health Probation & Parole
I. Law Enforcement/ Emergency Services

II. Post Arrest: Initial Detention/Initial Hearings

III. Post-Initial Hearings: Jail/Prison, Courts, Forensic Evaluations and Commitments

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Secondary Prevention

Crisis Intervention Team

Tertiary Prevention
“Best Clinical Practices – The Ultimate Intercept”

Primary Prevention  
(aka “Intercept Zero” - GAINS Center)

Secondary Prevention

Tertiary Prevention
Policy Research Associates (GAINS Center): Framework for Intercept Zero*

**Crisis Response**
- Certified Community Behavioral Health Clinics
- Crisis Care Teams
- Crisis Response Centers
- Mobile Crisis Teams

**Police Strategies**
- Crisis Intervention Teams
- Homeless Outreach Teams
- Serial Inebriate Programs
- Systemwide Mental Assessment Response Teams

Problems with Primary Prevention

• Every week individuals with SMI are hospitalized for competency restoration on misdemeanor charges and low/no bond

• Best clinical practices work when clients are collaborating with treatment and not abusing substances
  • Even when services are accessible, available and well-delivered & coordinated, individuals get arrested for nuisance crimes
  • Clinicians and courts get frustrated
  • Arrest and competency evaluations and restoration relieve the frustration (temporarily)

• Usual Motivational Interviewing is not enough for many clients

• Clinical staff are not equipped to provide primary prevention
  • Why not? Often, they have the wrong tool box
Problem with traditional clinical responses*

• Best practices reduce symptoms, but may not decrease criminal recidivism

• Arrest for individuals with SMI predicted by same criminogenic factors as average adult criminal population
  • antisocial personality, cognition, and associates; family/marital; school/work; leisure/recreation

• Special Cognitive Behavioral programs designed for offenders can reduce recidivism in individuals with SMI

Available Cognitive Behavioral Programs

• Thinking for a Change (T4C)
• Moral Reconciliation Therapy (MRT)
• Interactive Journaling
• Reasoning & Rehabilitation (R&R)
• Options
• START NOW
Robert Trestman PhD, MD: START NOW Presentation to NASHMPD Forensic Division (2016)

• An integrative skills training model informed by a number of theoretical approaches & models-
  • Primarily a cognitive behavior therapy (CBT) model
  • Includes motivational interviewing principles & practices to enhance motivation for change
  • Infused with elements of cognitive neuro-rehabilitation, in consultation with correctional neuro-cognitive researcher, D. Fishbein (Fishbein et al., 2009).
  • Theories of criminal behavior, including relevant examples in participant workbooks.

Overall Principles

• Reinforce personal responsibility for behavior
• Identify strengths & build on them
• Appreciate & respect individual differences, capabilities, & limitations
• Look for multiple opportunities to teach the connections between thoughts, feelings, & behavior:
  • “Your feelings don’t make you act a certain way- you choose how you respond to situations.”

Structure & Design

• 32 Skills training group sessions
  • twice weekly, for 16 weeks (or can be provided weekly)
  • 75 minutes in length

• Potential for rolling admissions

• Clinical tools:
  • Participant workbook
  • Facilitator manual
  • Checklists to be used for fidelity monitoring & supervision

• Freely available, public domain materials
Specifically for offenders with behavioral disorders

• Concepts & language are simplified given potential cognitive limitations

• Numerous icons included in the participant workbook- especially useful with TBI or verbally limited participants

• Illustrative examples & coping behaviors relevant to correctional situations

• Facilitator manual supports engaging difficult-to-engage participants: shaping by reinforcing any movement toward the desired behavioral change
Units

1. My Foundation: Starting with Me (10 sessions)
   • Focuses on developing increased self-control & ability to cope with stressors

2. My Emotions: Dealing with Upset Feelings (8 sessions)
   • Recognizing, understanding, coping with emotions

3. My Relationships: Connecting with Others (8 sessions)
   • Focuses on developing positive relationship skills

4. My Future: Setting & Meeting My Goals (6 sessions)
   • Preparing for a positive future by developing hope, realistic goals, problem solving skills
Mixed Gender Group Participant Workbook

FORENSIC EDITION

UConn Health

Susan Sampl, Ph.D.
Robert L. Trestman, Ph.D., M.D.
Julie Wright, Psy.D.

With Cognitive Rehabilitation Enhancements by
Diana Fishbein, Ph.D.

RTI International

Version F 1.0, July 2016
Discussion

• Can we train/augment clinical staff with START NOW and other cognitive behavioral approaches to criminogenic needs?

• Can we implement these approaches with individuals at high risk for justice involvement or re-involvement?

• What steps can we take to explore this option and assess results?