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Envisioning the next generation of behavioral health and criminal justice interventions

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ABSTRACT

The purpose of this paper is to cast a vision for the next generation of behavioral health and criminal justice interventions for persons with serious mental illnesses in the criminal justice system. The limitations of first generation interventions, including their primary focus on mental health treatment connection, are discussed. A person–place framework for understanding the complex factors that contribute to criminal justice involvement for this population is presented. We discuss practice and research recommendations for building more effective interventions to address both criminal justice and mental health outcomes.

1. Introduction

Over the past two decades in the United States, there has been a systematic effort to develop and implement interventions to address the needs of persons with serious mental illnesses (SMI)[1] who are involved in the criminal justice system. The need for these interventions was driven in part by the overrepresentation of adults with mental illnesses in the criminal justice system and in part by the pervasive belief that it is socially and clinically inappropriate for most people with SMI to be enmeshed in that system. These factors motivated both federal legislation and state and local policies and mandates to develop targeted responses to reduce the prevalence of justice-involved persons with SMI. These interventions included jail diversion programs, mental health courts, specialized probation and parole caseloads, and forensic mental health services emphasizing psychiatric rehabilitation.

We refer to this collection of interventions by the term "first generation" for two reasons. The first is to acknowledge that these interventions are united by a common philosophy and theme: criminal justice involvement of people with SMI is reduced primarily by providing mental health treatment to these individuals. Correspondingly, the principal objective of first generation interventions was to create or strengthen linkages to effective mental health services. The treatment emphasis of first generation interventions, while laudable, has overshadowed a growing body of research suggesting that people with SMI have encounters with the criminal justice system for many of the same reasons as people without SMI (Fisher, Silver, & Wolff, 2006). Limiting the focus of intervention to treatment engagement may account for the weak performance of first generation interventions. To date, empirical research on first generation interventions has demonstrated limited effectiveness in terms of improving both criminal justice and clinical outcomes for justice-involved persons with SMI (Martin, Dorken, Wamboldt, & Wootten, 2011). Practice confirms this research: over the past 20 years that these interventions have proliferated, there has been no meaningful decrease in the prevalence of persons with SMI in the criminal justice system (Fazel & Danesh, 2002; Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, 1990; Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010).

The second reason, then, for classifying these interventions collectively as "first generation" is to draw attention to the need for a more nuanced and evidence-based foundation for the next generation of interventions. To be effective, research is suggesting that these interventions need to be reframed to more directly account for the multitude of factors contributing to the criminal justice involvement of persons with SMI. These factors are supported by research showing that people with SMI, in general, display many of the same risk factors for criminal involvement as the broader offender population. Effective mental health treatment will be an important response to their unique needs, but focusing primarily on treatment is likely to be insufficient for most persons with SMI in the criminal justice system.

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[1] We use the term "serious mental illnesses" (SMI) to describe major Axis I diagnoses, including schizophrenia spectrum disorders, bipolar spectrum disorders, and major depressive disorders. We also use the term "mental illnesses" to refer to a broader category of any diagnosed mental health condition.

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The purpose of this paper is to cast a vision for the next generation of behavioral health and criminal justice interventions by presenting a set of empirically informed individual and environmental factors that directly and indirectly contribute to criminal justice involvement for individuals with SMI and are, therefore, critical targets for intervention. Although justice-involved persons with SMI bear unique stressors attributable to their mental illness, they also have many "normal" risk factors for criminal behavior. Attending to these shared risk factors, when combined with those associated directly with mental illness, provides a richer, more nuanced foundation for the next generation of interventions, which will likely improve their performance in reducing recidivism and psychiatric relapse. Finally, we present practice recommendations for developing the next generation of interventions and suggest a research agenda for the future.

2. First generation mental health and criminal justice interventions

The first generation of mental health and criminal justice interventions emerged over growing concern regarding the overrepresentation of persons with SMI involved in the criminal justice system. The first rigorous study to measure the prevalence of SMI in the criminal justice system was conducted by Teplin and colleagues in Chicago's Cook County Jail (Teplin, 1990; Teplin, Abram, & McClelland, 1996). Using then state-of-the art field epidemiologic techniques, they estimated a prevalence of SMI of 6.4% for men and 15% for women (Teplin, 1990; Teplin et al., 1996). These rates of SMI and co-occurring substance abuse substantially exceeded the general population rates obtained in the Epidemiologic Catchment Area study (Robins & Regier, 1991). Although prevalence estimates in subsequent studies have varied, a meta-analysis of 62 surveys from 12 countries indicates that roughly 14% of persons in the criminal justice system suffer from one or more SMI (Fazel & Danesh, 2002). Some of the most recent research in U.S. jails estimates the rate of SMI to be approximately 14% and as high as 31% for female inmates (Parsons & Sandwick, 2012; Steadman et al., 2009). Based on this body of research, it is estimated that over one million adults with SMI in the U.S. are under correctional supervision, with most living in the community while being supervised (Ditton, 1999; Glaze & Parks, 2012).

In response to the overrepresentation of persons with SMI in the criminal justice system, numerous first generation interventions were planned, developed, and implemented. These interventions have been situated in a variety of mental health and criminal justice settings, and were predicated on the "criminalization" hypothesis. Psychiatrist David Abramson first used this term in 1972 to describe the "criminalization of mentally disordered behavior," by which he was referring to the increasing numbers of former state hospital patients who were now found in jails and prisons (Abramson, 1972). It was reasoned, at the time, that the solution to the problem of criminalization resided within the mental health system. That is, it was assumed that untreated symptoms of mental illness caused criminal justice involvement. As a result, the first generation of interventions was grounded in two related beliefs. The first was that the justice system entanglement of persons with SMI was caused either by ineffective access to mental health services or disconnection from services. The second was that developing mechanisms for connecting or reconnecting persons with SMI to mental health treatment would prevent further criminal justice involvement (Fisher et al., 2006).

Federal legislation and state and local policies responded to the growing concern about the criminalization of persons with SMI. In 1997, the Jail Diversion Knowledge Development Application initiative was launched by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (Case, Steadman, Dupuis, & Morris, 2009). The Center for Mental Health Services later supported jail diversion programs through several Targeted Capacity Expansion funding projects. America's Law Enforcement and Mental Health Project was signed into law by President Bill Clinton in 2000, which established the Mental Health Courts Program within the U.S. Department of Justice, and provided grants to develop continuing judicial supervision and the coordinated delivery of services to persons with SMI in the criminal justice system (Litschge & Vaughn, 2009). Even more influential was a second piece of federal legislation: the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA), signed by President George W. Bush in 2004, which has authorized over $50 million in grants to promote the development of first generation interventions (Council of State Governments Justice Center, 2012). The MIOTCRA, informed by President Bush's New Freedom Commission's 2004 report, recommended diversion from jails and prisons to mental health treatment programs for persons with SMI as an emerging best practice and cost-saving measure (Litschge & Vaughn, 2009). The MIOTCRA offered incentives for state and local governments to create policies and programs that would foster an environment that was supportive of and hospitable to interventions focusing on mental health service linkage for justice-involved persons with SMI. For example, both California and Florida have developed formal grant programs geared toward crime reduction and reinvestment for persons with SMI (Case et al., 2009).

Guided by the belief about the criminalization of persons with SMI and the effectiveness of existing treatment and services, the first generation of interventions was designed and implemented primarily to divert justice-involved people with SMI to the mental health system, with the goal of establishing an enduring treatment connection between people with SMI and mental health providers. First generation "connecting" interventions were implemented at various intercept points in the justice system, beginning with police, proceeding through the courts, and ending at the point of reentry to the community following a spell of incarceration and/or supervision (Munetz & Griffin, 2006) (for a detailed review of these intervention types, see Epperson et al., 2011; Skeem, Manchak, & Peterson, 2011). These interventions may be situated within criminal justice or mental health settings. Criminal justice interventions generally expand police, court-based, and mandatory supervision practices in ways that use legal means at their disposal to divert persons with SMI to the mental health system. Mental health interventions, on the other hand, are traditionally case management-based services that have been altered to enhance mental health treatment access and adherence for persons with SMI entangled in the criminal justice system.

2.1. Criminal justice interventions

Energized by federal funding and cooperative state and local policies, a range of first generation interventions flourished. Focusing primarily on diversion of non-dangerous offenders with SMI from jails and, to a lesser extent, prisons to mental health treatment, these interventions are classified as either "pre-booking" or "post-booking." Pre-booking diversion refers generally to training police officers to recognize symptoms of SMI and, if possible, transport of persons with SMI to a designated mental health portal in lieu of criminal arrest. In the U.S., the most common pre-booking diversion model is the Crisis Intervention Team (CIT), with over 1000 police departments nationwide indicating that they are implementing this model or have already done so. CIT entails a cadre of specially trained officers who are designated first responders to any call involving a person known or suspected to have a serious mental illness, with the goal of diverting persons with SMI to mental health services (Cochran, Deane, & Borum, 2000; Dupont & Cochran, 2000; Watson, Morabito, Draine, & Ottati, 2008). Post-booking diversion programs divert persons with SMI to mental health treatment after the individual has undergone processing within the justice system. This type of diversion typically takes place at the point of a court hearing. Mental health courts are the most widely implemented form of post-booking diversion; there were over 250 mental health courts in operation or development as of 2010 (Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011). Like drug courts, mental health