"'What works' for justice-involved people with mental illness"

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Summary:

In this presentation, Skeem highlights specific challenges faced by people in the justice system with mental illness and explores why these individuals are more likely to *"fail"* when incarcerated and on community supervision. Does the evidence suggest that it might be time to question what experts have always thought was the best method to reduce recidivism among offenders with mental illness?

People with mental illness are overrepresented in the criminal justice system with the majority having a substance abuse disorder. When incarcerated they have longer stays because they are more likely to have behavioral problems and therefore are not engaging in programs to earn credits or are placed in administrative segregation – both resulting in reduced likeliness to be paroled. Once in community supervision they also *"fail,"* having much higher rates of recidivism.

Skeem investigates the implicit model we have of "what works" – sentence to treatment or a special program, control psychiatric symptoms, and then see reduced recidivism. Yet there are some problems with this model according to the data and research. Symptoms rarely cause crime and psychiatric services rarely reduce crime.

Skeem emphasizes the importance of taking a broader look at offenders who face mental health and/or substance use challenges in order to successfully provide treatment and reduce recidivism. Using risk assessments to test for various risk factors (much more than just mental health and/or substance use challenges) for recidivism has proven to produce much more accurate predictions and plans for this population. Therefore, targeting risk factors, targeting criminogenic needs, and implementing cognitive behavioral programs for criminal offenders demonstrate the best outcomes. Having justice system employees establish a dual role - a balanced combination of control and care rather than authoritarian and punitive roles with offenders, especially those facing mental health and/or substance use challenges, can also have a positive impact based on Skeem's research. Specialty supervision as opposed to traditional supervision has proven cost-effective when examining total mental health and criminal justice costs.

Questions/Answers:

1. **Q: How do offending risk factors for those who face mental health and/or substance use challenges differ from the rest of the population?**
   A: The relationship between mental illness and violence or criminal behavior is largely indirect. Mental illness relates to other variables (e.g., substance abuse, neighborhood disadvantage) that are, in turn, the foundation for general risk factors like antisocial peers/attitudes that can establish and maintain criminal behavior. The strongest risk factors for recidivism between offenders with mental illness and general offenders are shared. Those offenders with mental illness just tend to have a longer list of risk factors.

2. **Q: What is cognitive-behavioral treatment (CBT) and how does it impact offenders who face mental health challenges?**
   A: CBT is based on the assumption that offenders' cognitive distortions are learned rather than inherent. CBT involves structured, often group-based techniques that focus on building prosocial problem-solving skills and changing offenders' patterns of thinking and feeling. Meta-analyses consistently indicate that these are among the most effective forms of treatment for those with mental illness. Additionally we have seen a mean recidivism reduction of 25% with the implementation of CBTs.

3. **Q: Why should there be a significant focus on psychiatric treatment if there are so many other factors besides mental health that can increase a person's risk for offending?**
   A: If we cannot accurately identify people who will commit a crime that is directly caused by mental illness symptoms, the best approach would be to provide psychiatric treatment preventatively to large groups regardless of their status. This strategy also addresses public health problems. Additionally, psychiatric treatment proves to be cost effective, as research has proven that specialty programs have not been as expensive as traditional programs. This cost effectiveness unfortunately is not attributable to criminal justice savings.

4. **Q: Did you find any specific training or skill set for specialty staff that led to better outcomes?**
   A: Better outcomes come from a mixture of selection and training. Training is important because it probably will make a change for a core subset of people, but selection is just as important because you need to have people with good values focused on behavioral change rather than just traditional correctional values.
5. **Q: How does the officer-offender relationship impact recidivism?**
   A: Officers who balance roles are more effective in reducing recidivism than those oriented only toward rehabilitation or law enforcement**.** A good dual role relationship has a therapeutic and surveillance role and is ultimately defined as firm, fair, and caring.

6. **Q: Do you have recommendations about good tools that are easy to use in jails and prisons to figure out who is suffering from mental health challenges?**
   A: Yes. The Brief Jail Mental Health Screen (BJMHS) is one example of a screening tool that is eight items long. There are others like the Kessler 6 (K6), which only contain 6 items. These are

self-report screens and they are not going to catch everybody, especially if people don't want to disclose symptoms, but having them is definitely a good starting place.

7. **Q: Looking forward, what strategies would be the most important to implement to positively impact the justice involved population that faces mental health and/or substance use challenges but also to reduce recidivism?**
   A: Targeting the robust risk factors such as antisocial behavior rather than just mental illness, reevaluating correctional practices to advocate more balanced relationships between inmates and correctional officers, and continuing psychiatric services would all be valuable steps in this process.

8. **Q: Do you have a suggestion for a council like COMIO regarding where we should focus our efforts?**
   A. First, it is important to let go of mental illness as the "master status" that defines justice-involved people with mental illness. The problem of justice involvement cannot be reduced to mental illness; so services meant to solve the problem must reach beyond psychiatric treatment. Second, work hard to reduce stigma- based decision-making. People with mental illness are often perceived as much more dangerous (and incompetent) than they are—by supervision officers, judges, and other members of the public. This can translate into overly conservative decisions about levels of supervision, revocation, and incarceration. We ask professionals to consider, "would I be making this decision if not for the mental illness?" If the answer to that question is "no," then consider alternative courses of action. Anybody making critical decisions about those with mental health and/or substance use challenges should be targeted. Bringing successful people with mental health challenges in, to interact with critical decision makers seems to have a lot of promise for loosening stigma. In short, many gains could be made by loosening stigma from key decisions we make about these individuals.