Retention and Risk Reduction …

Or Let's Bake Bread

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From Basic to State-of-the-Art

- For students or professionals new to forensic mental health – most up-to-date assessment & treatment research in forensic mental health
- For intermediate or advanced practitioners – compare your treatment program to the state-of-the-art in evidence-based practices (EBPs) and a roadmap for implementation

Or Let's Bake Bread…

Huh?

Now you know us… Who are you?

- LMFTs? Social Workers? Psychologists? Psychiatrists? Probation/Parole? Attorneys? Judges?

What client population are we talking about?

- 35 yo female. Single, divorced. Has 2 latency-age sons. Diagnosed with Bipolar Disorder. Non-compliant with treatment. She is camping in a national park with her boyfriend when she believes he is Satan and attempts to kill him by stabbing him in the back with a large knife. He survives. She has no prior criminal history. No significant alcohol/drug use. She is found NGRI in federal court. After being confined to a federal medical center for about 4 years, she is conditionally released.

Severe, chronic mental illness – *not* our focus population

- Success: After about 5 years of supervision in the community, she is compliant with mental health treatment, including a mood stabilizer; she is raising her 2 boys on her own with the help of her mother (who cared for them when she was incarcerated), and she is attending nursing school. Her conditional release is terminated.
- This is a client with severe mental illness who was psychotic at the time of the assault. She had no prior history of violence or behavioral issues. This is NOT the population we are focused on today.
- Post-script: She later completes nursing school and is employed at a major hospital.

Forensic Treatment vs Mental Health Treatment

- At most, there is a 4 – 12% incidence of individuals committing crimes while in the midst of severe mental health symptoms
- Of these, 2/3 also commit crimes independent of symptoms
- Symptom reduction models alone do not decrease recidivism
- Risk factors the same across mentally ill & non-mentally ill offenders

(Peterson et al. 2014; Skeem et al. 2009; Bonta et al. 1998)

Our focus population

- 30 yo male. Single, gang affiliated. Multiple convictions since age 14 including drug possession/sales, assault and armed robbery. 1 strike. Current charge ADW has served 6 years in prison, paroled 2 weeks ago. History of methamphetamine, cocaine and alcohol dependence from age 13. Diagnosed with PTSD and Major Depression. Client is homeless, estranged from his biological family, no employment history and no high school diploma or GED.

It's your turn!

Treatment Planning

- Based on your agency practices:
  - What issues or concerns are primary for this client
  - Develop a brief treatment plan (5 – 8 bullet points of the order of and treatment needs)

Forensic Treatment vs Mental Health Treatment

How is Forensic Treatment (or Behavioral Health) different than traditional Mental Health Treatment?

Forensic Treatment vs Mental Health Treatment

- When working with a criminal justice population, why is it important that treatment design and delivery be specified for offenders?
  - Standard outpatient programs that don't address criminogenic need (1% INCREASE in recidivism)
  - Programs addressing criminogenic need (19% decrease in recidivism)
  - Programs with criminogenic and CBT/RNR approaches (32% decrease in recidivism)

The Risk-Need-Responsivity Model

- Risk-Need-Responsivity (RNR) Model developed in the 1980s and operationalized in the 1990s; designed for treatment of a criminal justice population
- Risk
  - Must be assessed; focus of resources on moderate & high risk offenders (Andrews & Bonta 2010)
- Need
  - Must be targeted to level of risk, criminogenic needs and dynamic risk factors
- Responsivity
  - Must be provided in a format that makes sense for this population

Dynamic Risk Factors Criminogenic Needs

- History of Antisocial Behavior (static)
- Antisocial Personality Pattern
- Antisocial Cognition
- Antisocial Associates
- Family/Marital Circumstances
- School/Work
- Leisure/Recreation
- Substance Abuse

RISK-N-R

- Must be assessed – risk (in addition to functional impairment, mental health, substance use disorders, life needs)
- Criminal behaviors can be reliably predicted
- Widely used validated risk assessment tools: COMPAS, LSI-R, LS-CMI, LS-RNR, ORAS

RISK continued

- The good news… most risk assessment tools do not have to be given by clinical staff
- Challenges and realities of risk assessment
- Validated Brief Assessment Tools, e.g. SAQ

R-Need-R

- Treatment design and delivery must be specified for offenders using “brand name” EBP/PP programs or generic/local programs based on EBP principles
- Treatment must target criminogenic needs/dynamic risk factors

Purpose of forensic mental health treatment

- Criminal justice money for mental health treatment focus on public safety
- Focus on high need, high risk
- On mild to moderate need and low risk, we expect brief, goal targeted interventions (Clement et al. 2011)

R-N-Responsivity

- Quantity and design of services must correlate to level of risk
- Describes how treatment should be provided
  - Cognitive Behavioral Therapy with Cognitive Social learning approach (practicing pro-social behaviors, problem solving tools and experience)
  - Focus on client’s learning style
  - Focus on motivation and stage of change (pre-contemplation, contemplation, preparation, action, maintenance)
  - Focus on abilities and strengths

Responsivity, continued

- What's still missing?
- Impacts of socioeconomic factors on brain development and the correlation to adult learning
- Individuals from lower socioeconomic backgrounds more commonly have significant impacts to their allostatic load (*"wear and tear" on the body from the neuroendocrine, nervous, cardiovascular, metabolic and immune systems*)
- The greater the allostatic load, the greater the impairment to other brain functions

Responsivity, continued

- Impacts on brain development:
  - Decreased Executive Functioning
    - Behavioral self regulation
    - Adult intelligence
    - Problem solving
  - Decreased Working Memory Functioning
    - Giving/receiving multiple directions at once
    - Planning
    - Task completion
    - Ability to identify options

Responsivity, continued

- Challenges with most EBP and PP curriculums – even those designed for offender treatment – don't take into account these impacts on brain development in their learning format
  - Curriculums are primarily reading/writing intensive
  - Demand independent problem solving
  - Depend on memory without repetition or role play
  - Require planning and task completion
  - Often use language that is set in a more formal register (rather than the casual register that clients use)

Responsivity, continued

- What parts of the brain are NOT commonly impacted?

  Visual and spatial abilities - suggesting that visual teaching and learning techniques are the most effective

- How can materials be modified to become more responsive to learner needs?
  - **Sensory/Experiential learning format**
  - **Sight, sound, smell, taste, visual, tactile experiences**
  - **Repetition and role play are vital**

Forensic Evidence Based Practices

- The Relationship
- Cognitive Behavioral Interventions
- Integrated Treatment
  - Co-Occurring Disorders
  - Trauma Treatment
  - Medication (as needed, psychotropic and Medication Assisted Treatment (MAT) for addiction recovery)

Forensic Evidence Based Practices, continued

- Intensive case management - supported housing and supported employment
- Forensic/Behavioral Treatment

Promising and Best Practices

- Forensic Assertive Community Treatment (FACT)
  - RNR
  - Basic necessity care and goal-planning
  - Community based support including medical/dental
  - Family and vocational support
  - Court/Criminal Justice advocacy and liaison
  - Transition and step down planning
  - Adherence monitoring
  - Problem solving approaches to behavior challenges
- Partnership between Criminal Justice and Clinical Service Providers

How Did You Do?

If you look at your vignette… how did you do?

Is there anything you would change given the information we've talked about so far?

Trauma Informed Care

- 90% of all clients receiving MH support have been exposed to or experienced trauma (Mueser et al., 1998)
- Adults with trauma histories are frequently traumatized further in incarcerated settings and in the community by supervising and social service agencies
  - Unsafe environments
  - Coercive interventions

Trauma Informed Care, continued

- Trauma Informed Interventions
  - Incorporate knowledge about trauma – prevalence, impact and recovery – in all aspects of service delivery
  - Create environments that are hospitable and engaging for survivors
  - Consider factors of gender and culture
  - Minimize re-victimization
  - Facilitate recovery and empowerment
  - Symptoms are not understood as pathology but primarily as attempts to cope and survive
  - Survivors are survivors – their strengths need to be recognized

Challenges of the Dual Relationship

- Buy in from both sides – social service providers question consequences and openness about criminal justice issues; supervising agencies question "hug a thug" position

Challenges of the Dual Relationship: Client Centered?

- "If we report every positive drug screen ... this compels the client to be secretive and lie about continued use or lapses. To be honest would be self-defeating to get what they want (to get off probation). But, in fact, it would be us as treatment providers who created an environment of conning and dishonesty. Our job is to focus on assessment and treatment rather than sanctioning a person for recurrence of their addiction illness." written by unnamed M.D. in 2009

Challenges of the Dual Relationship: Public Safety?

- "Workers with involuntary clients are employed by the state to work with people who have been judged to have transgressed social mores. On a day-to-day basis, they make judgments about unacceptable standards of parenting or acceptable levels of drug use or violence. Direct practice workers make these judgments, they communicate them to clients, and they in turn influence the behaviour of these clients." (Trotter 2006)

Impact of Community and Environment

How is a discussion about the community and environment of a treatment agency relevant to a training on the treatment of offenders?

The Impact of Community

- What makes people stay connected? Retention is driven by emotional factors.
- The Power of Habit by Charles Duhigg
  - 2000 YMCA Study on Club Retention
  - "Retention, the data said, was driven by emotional factors, such as whether employees knew members' names or said hello when they walked in." *(p. 211)*
  - This is most likely the same reason that community based organizations are the ONLY treatment providers to invert the retention numbers (70% retention vs. the 30% that is typically seen)
  - Underlines the importance of feeling 'connected' at an agency or program

The Impact of Environment

- A Welcoming Environment
  - This is as simple as good customer service
  - Why do social service agencies think they work in an industry where the idea of "customer service" doesn't apply?
  - Basic customer service skills that don't seem to be expected in the social service world:
    - Either answer your phone or return your calls
    - Don't make promises unless you can keep them
    - Listen to your customers
    - Deal with complaints
    - Be helpful – even if there is no immediate profit in it
    - Train your staff to be helpful, courteous and knowledgeable
    - Take the extra step
    - Think outside the box

How to implement and integrate RNR?

Integration and Implementation… the macro steps

- National Implementation Research Network (NIRN) http://nirn.fpg.unc.edu
- Implementation drivers:
  - Leadership – change has to start from the top but middle management are the key to driving change
  - Organizational – is your message consistent with your mission
  - Competency – takes a lot of training to help staff overcome judgement, understand trauma, embrace a collaborative approach, learn RNR and use EBPs

Organizational

- "… since we are in their house (probation), we use their language, 'public safety", 'reduce recidivism', but we all know we just want the client to get better" unnamed LCSW at conference presentation on integration of mental health & criminal justice

Competency

- "Train and hope" vs. "train and expect" vs. train, coach, booster
- Retention of training in education study: Theory & discussion - 0; Demonstration - 0; Practice & Feedback - 5%; peer coaching & collegial support 95%

(Joyce, B. & Showers, B. (2002). Student achievement through staff development, 3rd ed. Alexandria, VA: ASCD, p. 78)

Integration and Implementation… the micro steps

- RNR
- EBPs for the offender population
- Integrated care (wherever possible)
- FACT
- Trauma treatment and trauma informed care
- Criminal justice and social service collaboration

How do we really know?

- Excited over data? “There are 3 kinds of lies: lies, damned lies, and statistics” Best we have.
- RNR works - reduces recidivism 25-50% = win-win: truly “ex”-offenders and prevention of real victims!
- Quackery = common sense or tradition over scientific evidence
- Unscientific services -- no change or can increase antisocial behavior (Flores et al. 2005)

Our encouragement and challenge for you…

- A personal action plan… one change, for when you return to your agency next week
- Communication… we don’t know about what your agencies or programs are doing!
  - Have you integrated RNR into your program?
  - Do you want to talk to other agencies making these changes?
  - Do you want input, assistance, suggestions?
  - Please let us know – and please reach out to each other!

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