Understanding and Preventing Criminal Behavior among People with Serious Mental Illness

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Part 1: The Problem
Prisons Replace Hospitals for the Nation's Mentally Ill

By FOX BUTTERFIELD

LOS ANGELES — Michael H. had not had a shave or haircut in months when he was found one recent morning sleeping on the floor of St. Paul's Episcopal Church in suburban Lancaster, next to empty cans of tuna and soup from the church pantry.

There was little to suggest that he had once been a prosperous college graduate with a wife and two children — until he developed schizophrenia, lost his job and, without insurance, could no longer afford the drugs needed to control his mental illness.

Charged with illegal entry and burglary, Michael H. was taken to the Los Angeles County Jail. The jail, by default, is the nation's largest mental institution. On an average day, it holds 1,500 to 1,700 inmates who are severely mentally ill, most of them detained on minor charges, essentially for being public nuisances.

The situation in the jail, scathing...
Incarceration in the USA
Psychiatric Hospitalization in the USA

Illustration based on *From The Asylum To The Prison*
Bernard E. Harcourt, March 2007
Transinstitutionalization?

Illustration based on From The Asylum To The Prison
Bernard E. Harcourt, March 2007

Rate per 100,000
A leading explanation for why people with mental illness enter the criminal justice system suggests that the answer to this problem is simply more psychiatric hospitals.
Two Problems

1. We are not going to build more psychiatric hospitals.

2. Evidence suggests that mental illness is not the only cause of crime.
Part 2: Understanding the Problem
Why are people with mental illness over-represented in the criminal justice system?
Risk – Needs – Responsivity

“RNR”
Criminogenic Risk Factors

*The “Central Eight”*

1. History of Antisocial Behavior
2. Antisocial Personality
3. Antisocial Cognition
4. Social Support for Crime
5. Family/Marital Problems
6. Work/School Problems
7. Lack of Healthy Recreation
8. Substance Use
Standardized Risk/Needs Assessment Tools

- Level of Service/Case Management Inventory (LS/CMI)
- Level of Service Inventory – Revised (LSI-R)
- Ohio Risk Assessment System (ORAS)
- Correctional Assessment and Intervention System (CAIS)
- Correctional Offender Management Profile for Alternative Sanctions (COMPAS)
“Tom T”

LS/CMI Item Scores

- Criminal History (8)
- Education/Employment (9)
- Family/Marital (4)
- Leisure/Recreation (2)
- Companions (4)
- Alcohol/Drug Problem (8)
- Pro-Criminal Attitude (4)
- Antisocial Pattern (4)
“Tom Z”

LS/CMI Item Scores

- Antisocial Pattern (4)
- Pro-Criminal Attitude (4)
- Alcohol/Drug Problem (8)
- Companions (4)
- Leisure/Recreation (2)
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- Criminal History (8)
Criminogenic Risk Factors

The “Central Eight”

1. History of Antisocial Behavior
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True or False:

- Mental illness is a risk factor for crime.
Psychosis and Mania

Increasingly Recognized as Risk Factors

- McNiel et al 2000
- Hodgins et al 2003
- Joyal et al 2004
- Swanson et al 2006
- Christopher et al 2012
- Peterson et al 2014
Psychotic Symptoms:
- Command Auditory Hallucinations
- Persecutory Delusions
- Agitation and Violence

Manic Symptoms:
- Speeding
- Impulsivity
- Agitation and Violence
Most serious mental Illnesses are “Relapsing and Remitting”

Shepard et al. 1989
Criminogenic Risk Factors
In People with Serious Mental Illness

1. History of Antisocial Behavior
2. Antisocial Personality
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4. Social Support for Crime
5. Family/Marital Problems
6. Work/School Problems
7. Lack of Healthy Recreation
8. Substance Use
9. Psychosis and Mania
People with Serious Mental Illness Have An Increased Prevalence of Other Risk Factors

<table>
<thead>
<tr>
<th></th>
<th>Schizophrenia</th>
<th>General Public</th>
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<tbody>
<tr>
<td>Substance Use</td>
<td>40%</td>
<td>10%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>73%</td>
<td>4%</td>
</tr>
<tr>
<td>Less than HS degree</td>
<td>50%</td>
<td>25%</td>
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</tbody>
</table>

BLS 2013; Rosenheck et al. 2006; Moran & Hodgins 2004; SAMHSA 2011; NAMI 2013
Adults with Serious Mental Illness Also Have Responsivity Factors

- Paranoia
- History of Trauma
- Disorganized Thoughts
- Lack of Energy and Motivation
Why are people with mental illness over-represented in the criminal justice system?
Three Reasons

- They have an extra risk factor
- They have more of the other risk factors
- They also have responsivity factors
How do we prevent criminal recidivism among people with serious mental illness?
Part 3: Mental Health and Criminal Justice Collaboration
collaboration

/kəˈlæbərəˈʃən/ (noun)

- The action of working with someone to achieve a goal
- Traitorous cooperation with an enemy
## Mental Health and Criminal Justice: Basic Differences

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<thead>
<tr>
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<th>Mental Health</th>
<th>Criminal Justice</th>
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<tbody>
<tr>
<td><strong>Traditional Attire</strong></td>
<td>White</td>
<td>Black</td>
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<td><strong>Core Values</strong></td>
<td>Wellness</td>
<td>Justice</td>
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<tr>
<td><strong>Priorities</strong></td>
<td>Patient Health</td>
<td>Public Safety</td>
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<td><strong>Daily Focus</strong></td>
<td>Fighting Disease</td>
<td>Fighting Crime</td>
</tr>
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<td><strong>Communication Style</strong></td>
<td>Relational</td>
<td>Authoritarian</td>
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<tr>
<td><strong>Key Environments</strong></td>
<td>Clinics and Hospitals</td>
<td>Courts and Jails</td>
</tr>
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Lamberti and Weisman, 2017
6.5 Million Adults In Corrections

10 Million Adults With Serious Mental Illness
1,000,000 people with serious mental illness are in the criminal justice system at any given time

*More cycle through the system each year*
Why Collaborate?

- MH – CJ collaboration enables shared problem solving
- MH – CJ collaboration enables therapeutic alternatives to punishment
- MH – CJ collaboration brings together different skill sets
Criminogenic Risk Factors
Among Adults with Serious Mental Illness

1. History of Antisocial Behavior
2. Antisocial Personality
3. Antisocial Cognition
4. Social Support for Crime
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6. Work/School Problems
7. Lack of Healthy Recreation
8. Substance Use
9. Psychosis and Mania

Addressed by mental health professionals
Addressed by criminal justice professionals
Understanding and Preventing Criminal Recidivism Among Adults With Psychotic Disorders

J. Steven Lamberti, M.D.

The high prevalence of adults with psychotic disorders in the criminal justice system has received much attention recently, but our understanding of this problem is marked by diverging opinions. Mental health professionals point to deinstitutionalization and our fragmented mental health system as primary causes. Criminologists minimize the role of mental illness and contend that persons with and without mental illness are arrested for the same reasons. Meanwhile, practice guidelines offer little guidance to clinicians about how to address the problem. Drawing upon contemporary crime prevention principles as well as current knowledge of psychotic disorders and their treatment, this article presents a conceptual framework for understanding and preventing criminal recidivism. The framework highlights the importance of individual and service-system risk variables and emphasizes the central role of treatment nonadherence as a mediator between modifiable risk variables and recidivism. On the basis of the conceptual framework described in this article, three necessary elements of intervention are presented for preventing recidivism among adults with psychotic disorders: competent care, access to services, and legal leverage. Research is needed to further define and test these intervention elements as foundations for future service delivery efforts. (Psychiatric Services 58: 773–781, 2007)

On March 5, 1995, the New York Times published a front-page headline stating “Prisons Replace Hospitals for the Nation’s Mentally Ill” (1). Five years later a Human Rights Watch report noted that more people with severe mental disorders as well as the current literature in the field of criminology. On the basis of this review and synthesis, a conceptual framework for understanding and preventing criminal recidivism is proposed and necessary elements of intervention are identified.

Other psychotic disorders from more rigorous studies are also concerning. Using data from the Epidemiologic Catchment Area program, Robins and Regier (6) found that 6.7% of prisoners had experienced symptoms of schizophrenia at some point in their lives. A Correctional Service of Canada study using the Diagnostic Interview Schedule and the American Psychiatric Association’s (APA’s) DSM-III-R criteria found a 7.7% prevalence of psychotic disorders in a sample of 9,801 inmates (7). Also, a large study comparing the weighted prevalence of psychotic disorders between the national household survey and prisons in Great Britain found a tenfold higher prevalence of psychotic disorders among prisoners (8). These findings are consistent with reports that individuals with psychotic disorders are arrested more frequently and have higher rates of criminal conviction for both nonviolent and violent offenses, compared with the public (9,10).

Most persons with schizophrenia are arrested for minor crimes, such as disturbing the peace and public intoxication, and high percentages of these persons have histories of service use before their arrest. This suggests a lack of community mental health services and the presence of barriers to accessing services. Moreover, research indicates that a high percentage of persons with schizophrenia experience homelessness, are unemployed, and have histories of substance abuse. This may reflect the effect of chronic illness on the social functioning of an individual.
A patient is determined to harm himself to self or others. If hospitalized, patients are typically treated for seven days with sedative-hypnotic medications and discharged with a follow-up appointment at a local community mental health center. In the absence of appropriate intervention after discharge, patients with multiple risk factors are likely to stop their medications, resume their use of illegal substances, alcohol, and return to living on the streets. Such patients are continuing the cycle of non-adherence, arrest or emergency room intervention, and readmission.

A patient is arrested instead of going to an emergency room, several days or weeks after being discharged from a hospital. In the current crisis, the patient is a prime candidate for incarceration. Yet, hospitalization provided no opportunity to address the symptoms that precipitated the patient's admission. Clinical observation lends support to the idea that incarcerated patients who are psychotic and non-adherent are very likely to have significant risk factors. It is unlikely that these risk factors will be identified or addressed in the correctional environment.
The Key to Prevention

The key to preventing criminal recidivism among people with serious mental illness is to engage them in interventions that target the risk factors driving the cycle.

Engagement

◆ Easier said than done

◆ Half of people with serious mental illness don’t know that they’re ill.
Engagement Strategies

Relationship Building

- Being respectful and non-judgmental
- Being empathic
- Providing clear explanations
- Offering choices when possible
- Providing hope

Core CIT Communication Techniques
Engagement Strategies

Legal Leverage

◆ Appropriate use of legal authority to engage people with serious mental illness in treatment

◆ Individuals who pose a danger to self or others as a result of mental illness, and who are unable or unwilling to accept treatment
What Legal Leverage Is Not

- Use of legal authority to **force** patients to comply
- Making **threats** of punishment to enforce compliance
What Legal Leverage Is

- Respectful guidance toward compliance
- Use of legal authority to promote engagement in care
- A process that requires mental health and criminal justice collaboration
Models of Mental Health and Criminal Justice Collaboration

- Mental Health Courts
- Mental Health Probation and Parole
- Forensic Assertive Community Treatment
A Randomized Controlled Trial of the Rochester Forensic Assertive Community Treatment Model

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Objective: Forensic assertive community treatment (FACT) is an adaptation of the assertive community treatment model and is designed to serve justice-involved adults with serious mental illness. This study compared the effectiveness of a standardized FACT model and enhanced treatment as usual in reducing jail and hospital use and in promoting engagement in outpatient mental health services.

Methods: Seventy adults with psychotic disorders who were arrested for misdemeanor crimes and who were eligible for conditional discharge were recruited from the Monroe County, New York, court system. Participants were randomly assigned to receive either FACT (N=35) or enhanced treatment as usual (N=35) for one year. Criminal justice and mental health service utilization outcomes were measured by using state and county databases.

Results: Forty-nine participants (70%) completed the full one-year intervention period. Nineteen (27%) were removed early by judicial order, one was removed by county health authorities, and one died of a medical illness. Intent-to-treat analysis for all 70 participants showed that those receiving the FACT intervention had fewer mean±SD convictions (4±7 versus 9±13, p=0.025), fewer mean days in jail (21.5±25.9 versus 43.5±59.2, p=0.025), fewer mean days in the hospital (4.4±15.1 versus 23.8±64.2, p=0.025), and more mean days in outpatient mental health treatment (30.5±92.1 versus 369.4±139.6, p<0.001) compared with participants who received treatment as usual.

Conclusions: The Rochester FACT model was associated with fewer convictions for new crimes, less time in jail and hospitals, and more time in outpatient treatment among justice-involved adults with psychotic disorders compared with treatment as usual.

Providing treatment for justice-involved adults with serious mental illness in outpatient mental health settings is challenging. Patients with histories of arrest and incarceration are often enrolled in assertive community treatment (ACT) programs (1), which are generally effective in preventing psychiatric hospitalization and promoting housing stability. However, ACT has not been found to be effective in reducing criminal justice system involvement (2–4). Consequently, outcomes for these programs have been mixed. Some studies of ACT interventions have reported significantly reduced criminal justice system involvement (5–9), others have failed to find consistently positive outcomes (10,11), and others have found evidence of increased jail recidivism (12). To address these disparate findings, a standardized FACT model was developed on the basis of a conceptual framework for pre-preparation and adapted to the context of forensic treatment.
Study Details

- 70 adults with psychotic disorders and substantial criminal histories*.

- Randomly assigned to “R-FACT” or standard treatment*.

- R-FACT involved collaboration* between a mobile treatment team and a criminal court judge.
Study Results

R-FACT was associated with significantly:

- Fewer convictions for new crimes
- Fewer days in jail
- Fewer days in hospital
- Greater engagement in outpatient treatment
Models of Mental Health and Criminal Justice Collaboration

- Mental Health Courts
- Mental Health Probation and Parole
- Forensic Assertive Community Treatment
- CIT
CIT: A Challenge and Opportunities

- CIT has the *briefest* contact
- CIT is on *the front lines*
*Additional Opportunities*

- Identifying and communicating about the highest service utilizers
- Collaborating mental health courts, probation and parole
- Collaborating with unique local programs
Q & A