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Reducing Criminal Recidivism for Justice-Involved Persons with Mental Illness: Risk/Needs/Responsivity and Cognitive-Behavioral Interventions

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Introduction

Decreased criminal recidivism, particularly resulting from new crimes with new victims, is the measure most consistently desired by programs, policymakers, and funding agencies for justice-involved individuals with mental illness. This one measure captures both improved client stability and public safety, while providing support for the promised decreased jail-day cost savings required to sustain continued financial resources (Almquist, 2009; Milkman, 2007).

Evidence-based practices (EBP) with track records of effectiveness in treating serious mental illness, co-occurring substance abuse, trauma, and motivational challenges have been utilized with some success in forensic populations (CMHS National GAINS Center, n.d.). However, recent reviews of offender-focused and jail diversion programs found that many EBPs, such as **Assertive Community Treatment**, may achieve symptom reduction but not decrease criminal recidivism (Morrissey, 2007; Case, 2009; Skeem, 2009). In fact, studies indicate that offenders with mental illness share diagnoses and treatment needs similar to those of individuals with mental illness who do not commit crimes. However, with reference to recurrent criminal behavior, offenders with mental illness share the same risk factors for offending as their non-mentally ill counterparts (Epperson, 2011).

In this document, we review the leading offender recidivism–targeted intervention paradigm: Risk/Needs/Responsivity (RNR). RNR proposes that to address the community behavior of offenders:

- the intensity of treatment and supervision should match the *"Risk"* level for re-offense
- the treatment provided should match the individual *"Needs"* most clearly associated with criminality
- and the intervention modalities should match those to which the individual is most *"Responsive"* (Andrews, 2010).

In particular, we focus on criminal thinking, one of the identified "needs," and structured cognitive-behavioral interventions from the worlds of criminal justice and mental health that were created or adapted to specifically target the thoughts, feelings, and behaviors associated with criminal recidivism.

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Risk

Varying treatment intensity and supervision as a clinical tool is familiar to most providers and is consistent with the risk principle. Risk-focused options include residential vs. outpatient treatment; clinic vs. day programming; outreach services, such as intensive case management or assertive community treatment; and use of outpatient civil commitment or other forms of community leverage to improve patient compliance (Douglas, 2001; Monahan, 2005). Underlying these options is the clinical algorithm that the greater the concern, the greater the need for structure. This parallels the algorithm in the criminal justice world of increasing supervision intensity with increasing risk of criminality. The documented successes of court-based mental health diversion programs and specialized probation may be

the result of the intense supervision provided by the criminal justice system, even though the programs may not have included specific attention to all the offender needs discussed below.

The risk principle demands a purposeful, evidence-based assessment of criminogenic risk, and for a population with mental illness, integration of that assessment with an evaluation of their additional clinical needs (Osher, 2012). Several standardized tools are in use, such as COMPAS, LSI-R, and LS-CMI. These tools also standardize the assessment of criminogenic needs.

Reductions in recidivism among R&R recipients similar to those in a general offending population were found in a forensically hospitalized cohort that received R&R (Robinson, 1995).

Needs

The hallmark of the needs principle—individualized treatment—is also familiar to mental health practitioners. In the context of addressing so-called criminogenic needs, this principle suggests that treatment providers should avoid grouping individuals based solely on the offenses they have committed (e.g., sex offenders, drunk drivers); rather, consideration must also be given to ensuring that offenders receive interventions that target needs directly associated with criminal recidivism: antisocial behavior and personality, antisocial cognitions, antisocial associates, family support, leisure activities, education/employment, and substance abuse. Offenders with mental illness have been found to have high scores on measures of these so-called "criminogenic needs" (Skeem, 2009). Many of the above needs and associated evidence-based interventions (e.g., substance abuse and integrated treatment) are familiar to providers of mental health services. Therefore, we turn our attention to the less familiar antisocial cognitions to which offenders with mental illness have at least as much predisposition as offenders without mental illness (Lamberti, 2007; Carr, 2009; Morgan, 2010; Wolff, 2011; Gross, 2013).

Cognitive-Behavioral Therapy and Adaptations for Justice-Involved Populations

Cognitive-Behavioral Therapy (CBT) is an accepted evidence-based intervention for ameliorating distressing feelings, disturbing behavior, and the dysfunctional thoughts from which they spring. Improvements in target symptoms, such as anxiety and depression, are mediated through identifying and disputing the automatic thoughts that generate those feelings. The targets of recidivism-focused CBT are interpersonal skills and acceptance of community standards for responsible behavior (Milkman, 2007).

An exhaustive survey of programs is beyond the scope of this document; however, the following represent typical CBT interventions used in correctional settings. These programs include **Thinking for a Change (T4C)** (Golden, 2002), **Moral Reconation Therapy (MRT)** (Little, 1988), **Interactive Journaling** (Walters, 1999), **Reasoning & Rehabilitation (R&R)** (Ross, 1988), and **Options** (Bush, 1993). Each of these programs has demonstrated statistically significant reductions in criminal recidivism in non-mentally ill populations (Golden, 2002; Robinson, 1995; Walters, 2005; Ross, 1988; Little, 1994).

A 2006 meta-analysis found an 8.2 percent reduction in felony re-convictions for general offenders who complete CBT interventions, although specific reductions vary by category of offender (Aos, 2006). Outcomes are also affected by differences in measures of success (rearrest vs. reconviction, vs. reincarceration); target population (high or low risk); and in the content, intensity, and length of the interventions, not to mention variable levels of research rigor.

While these interventions were originally developed for a general offender population, the structured, skills-focused clinical modalities they represent also match the learning style of the individuals with mental illness, even those with severe mental illness (Grant, 2012). Not surprisingly then, for offenders with mental illnesses, there is positive data as well. Reductions in recidivism among **R&R** recipients similar to those in a general offending population were found in a forensically hospitalized cohort that received R&R (Robinson, 1995). The R&R protocol has been modified specifically to accommodate the learning abilities of offenders with mental illness (termed R&R2M). A preliminary study demonstrated positive results. However the cohort was detained forensic patients; the outcome measure was disruptive behavior (Young, 2010); and there was significant dropout of individuals who were diagnosed with antisocial personality disorder or psychopathy and had recent violence (Cullen, 2011).

Participation of offenders with mental illness in **Options** (intent-to-treat and completed cohorts) was associated with reduced arrests, including violent arrests, compared to a mentally ill offender control group. The Options groups tended to receive more technical probation violations compared to the control, but this may be related to the increased oversight that such offenders receive relative to the control group, as opposed to an index of program ineffectiveness (Ashford, 2008).

Structured mental health interventions have also been adapted for an offending population. These interventions emphasize clinical features associated with criminality such as frustration intolerance, social skills deficits, and misperceptions of the environment (Galietta, 2009).

MRT and **Interactive Journaling** have been integrated into programs serving justice-involved individuals with mental illness, including mental health courts in Idaho and New York, respectively. Anecdotal feedback from staff is that there were no implementation issues and clients feel they benefit (Rotter, 2010). A recent, unpublished prospective design Bureau of Justice Assistance–funded grant evaluation report of a New York City–based mental health diversion program that included both Interactive Journaling and T4C found statistically significant decreases in criminal thinking among participants (from baseline to 6 months), with no significant differences in change over time between those clients assigned to either intervention. However, the research design of this study precludes attributing causation to Interactive Journaling or T4C, given that clients also received a myriad of other interventions, including case management, mental health treatment, court monitoring, and substance abuse treatment (A. Garcia-Mansilla, personal communication, September 24, 2013). (It is also notable that this sample of offenders with co-occurring disorders had baseline scores in the high range on a criminal thinking scale normed on a general offender population.)

Structured mental health interventions have also been adapted for an offending population. These interventions emphasize clinical features associated with criminality, such as frustration intolerance, social skills deficits, and misperceptions of the environment (Galietta, 2009). **Dialectical Behavioral Therapy (DBT)**, which was originally created to address self-cutting behavior in patients with borderline personality disorder (BPD), has been implemented in forensic settings for offenders with BPD, resulting in fewer violent incidents and reduced self-reported anger (Evershed, 2003; Berzins, 2004). In a program more specifically targeting community-based criminal behavior, DBT has also been used with stalking offenders, who are disproportionately likely to suffer from narcissistic, antisocial, and/or borderline personality disorders. Completion of the 6-month program resulted in significantly fewer rearrests for stalking compared to treatment dropouts or published rates of recidivism for stalking (Rosenfeld, 2007). Finally, **Schema Focused Therapy (SFT)** has been utilized with offenders diagnosed with psychopathy (Bernstein, 2007) and individuals with personality disorders and substance abuse (Ball, 2011), with many of the latter under criminal justice supervision. SFT with these groups has not been assessed with regard to criminal justice outcomes.

Responsivity

Thinking about what intervention modality is most effective and engaging for a particular patient is standard practice in mental health treatment. It is the hallmark of individualized treatment and consistent with the responsivity principle. Both external and internal factors create the climate for maximizing responsivity. External factors include staff characteristics and training, community versus institutional settings, and the application of legal or other social leverage. Internal factors are client characteristics, background, and learning style (Kennedy, 2000).The choice of the types of interventions discussed above is premised on the recognition that a cognitive behavioral approach is more effective for offenders, including those with mental illness (Andrews, 2010).

Individual motivation for and engagement in treatment must be also considered (Bonta, 1995). Where motivation is poor or lacking, a more direct intervention may be required as a precursor to the program. **Motivational Interviewing** is one well-established approach that has also been used with justice-involved populations (McMurran, 2009). The SPECTRM Project (Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management) addresses both sides of the responsivity approach: staff readiness and client engagement. The SPECTRM staff training, "Clinical Impact of Doing Time," provides

staff with a cultural competence framework within which to understand and engage clients. (Rotter, 2005). The client-focused Reentry After Prison (RAP) group focuses on the behaviors that are considered adaptive in jail and prison but get in the way of community treatment engagement (Rotter, 2011; Morgan, 2007).

While mental illness is not an identified "criminogenic need," it has been incorporated into the RNR model as a responsivity factor. The foundation of integrated treatment for co-occurring mental illness and substance abuse is the need to adapt traditional substance abuse intervention to accommodate the unique characteristics of individuals with mental illness. So too, assessments and interventions that target criminogenic needs must be implemented in a manner to which individuals with mental illness can be maximally responsive (Osher, 2012).

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Summary

Although connecting individuals with mental illness to appropriate and effective community care is clearly good in and of itself, the failure of traditional case management and clinical services to fully address criminal justice recidivism in the mentally ill offender population challenges providers to adopt and adapt best practices that may be ultimately more effective in decriminalizing persons with mental illness. These practices include RNR-based recidivism-focused assessment; clinically sensitive mandated community case management, such as probation officers with specialized caseloads and mental health courts; criminal-thinking and behavior-focused structured clinical interventions; and an awareness of how to maximize the likelihood that an offender will take advantage of these interventions. Integrating these approaches with existing assessments and interventions for individuals with mental illness is also necessary and is beginning to receive attention in research, clinical, and policy forums (Osher, 2012).

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