SYSTEMS, STRUGGLES AND STRATEGIES: OPPORTUNITIES AT THE JUSTICE AND BEHAVIORAL HEALTH INTERFACE

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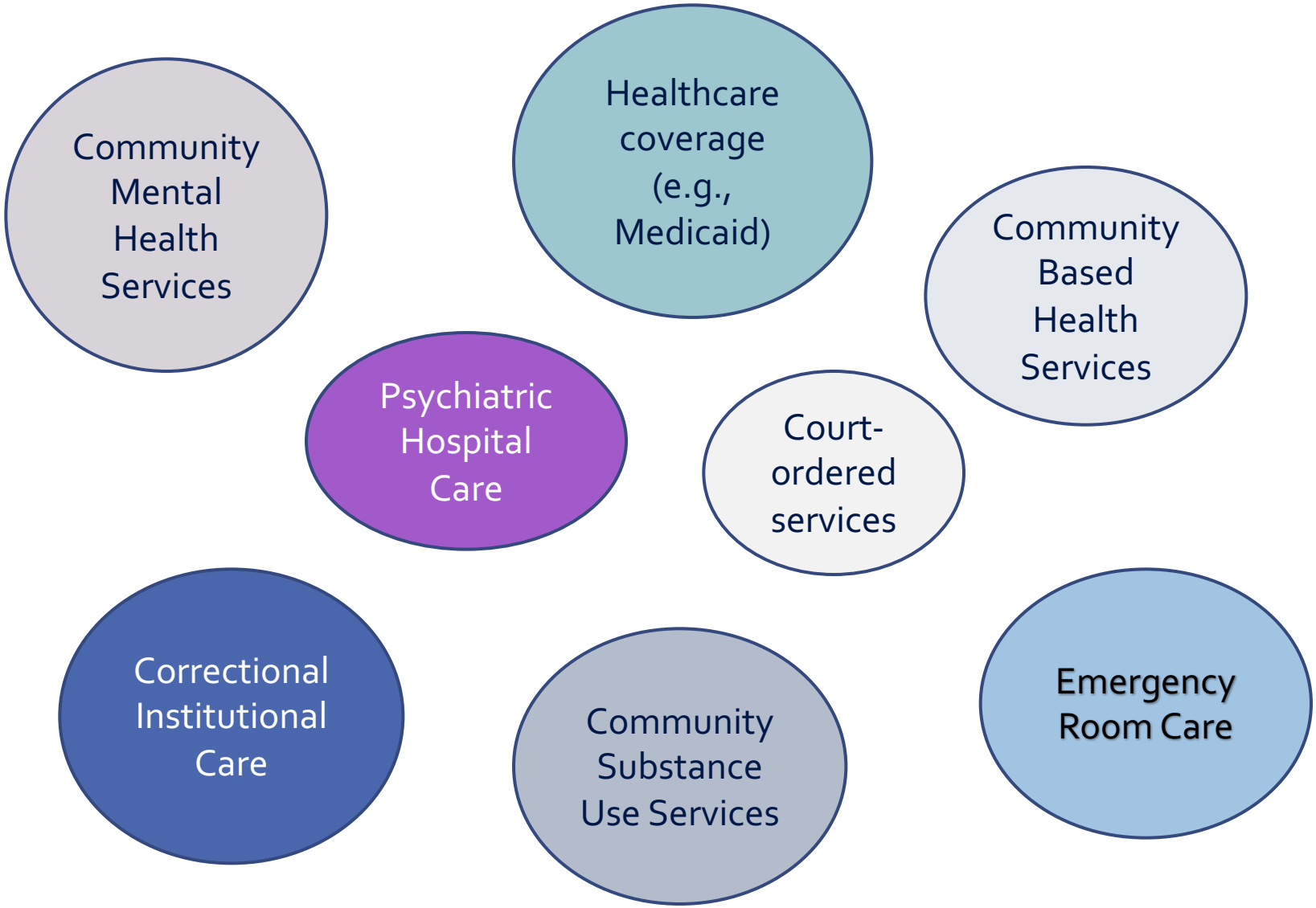
SYSTEMS


Community Mental Health Services
Healthcare coverage (e.g., Medicaid)
Community Based Health Services
Psychiatric Hospital Care
Court-ordered services
Correctional Institutional Care
Community Substance Use Services
Emergency Room Care

RECIDIVISM: A MEASURE OF RETURN TO THE CRIMINAL SYSTEM THAT MAY INCLUDE REARREST, REINCARCERATION, TECHNICAL AND NON-TECHNICAL VIOLATIONS

RECOVERY:
A PROCESS OF CHANGE THROUGH WHICH INDIVIDUALS IMPROVE THEIR HEALTH AND WELLNESS, LIVE A SELF-DIRECTED LIFE, AND STRIVE TO REACH THEIR FULL POTENTIAL (SAMHSA 2014)

E.G., Symptom Resolution, Sobriety, Reduced Recidivism, Social Connectedness, Employment, Education, Independent Living, Self-Reliance

Regulatory/Statutory Definitions of Mental Illness

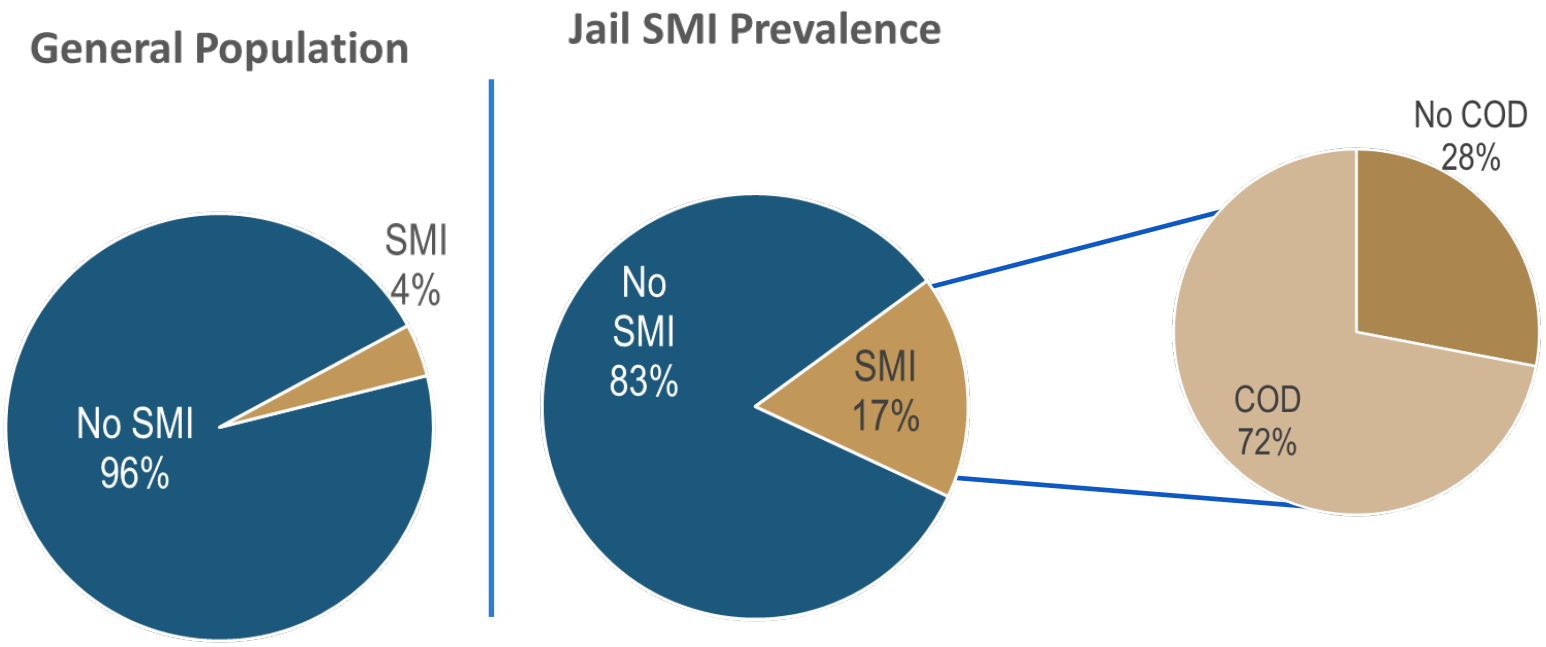
- Michigan: MCL 330.1400(g) "Mental illness" means a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
- Illinois: (405 ILCS 5/1-129)
  Sec. 1-129. Mental illness. "Mental illness" means a mental, or emotional disorder that substantially impairs a person's thought, perception of reality, emotional process, judgment, behavior, or ability to cope with the ordinary demands of life, but does not include a developmental disability, dementia or Alzheimer's disease absent psychosis, a substance use disorder, or an abnormality manifested only by repeated criminal or otherwise antisocial conduct.
  (Source: P.A. 100-759, eff. 1-1-19.

System Intersections

- Community "civil" systems
  - Crisis system, emergency services
  - Psychiatric services
  - State Hospitals
- Criminal systems
  - Courts
  - Jails
  - Prisons
  - Forensic beds at state hospitals

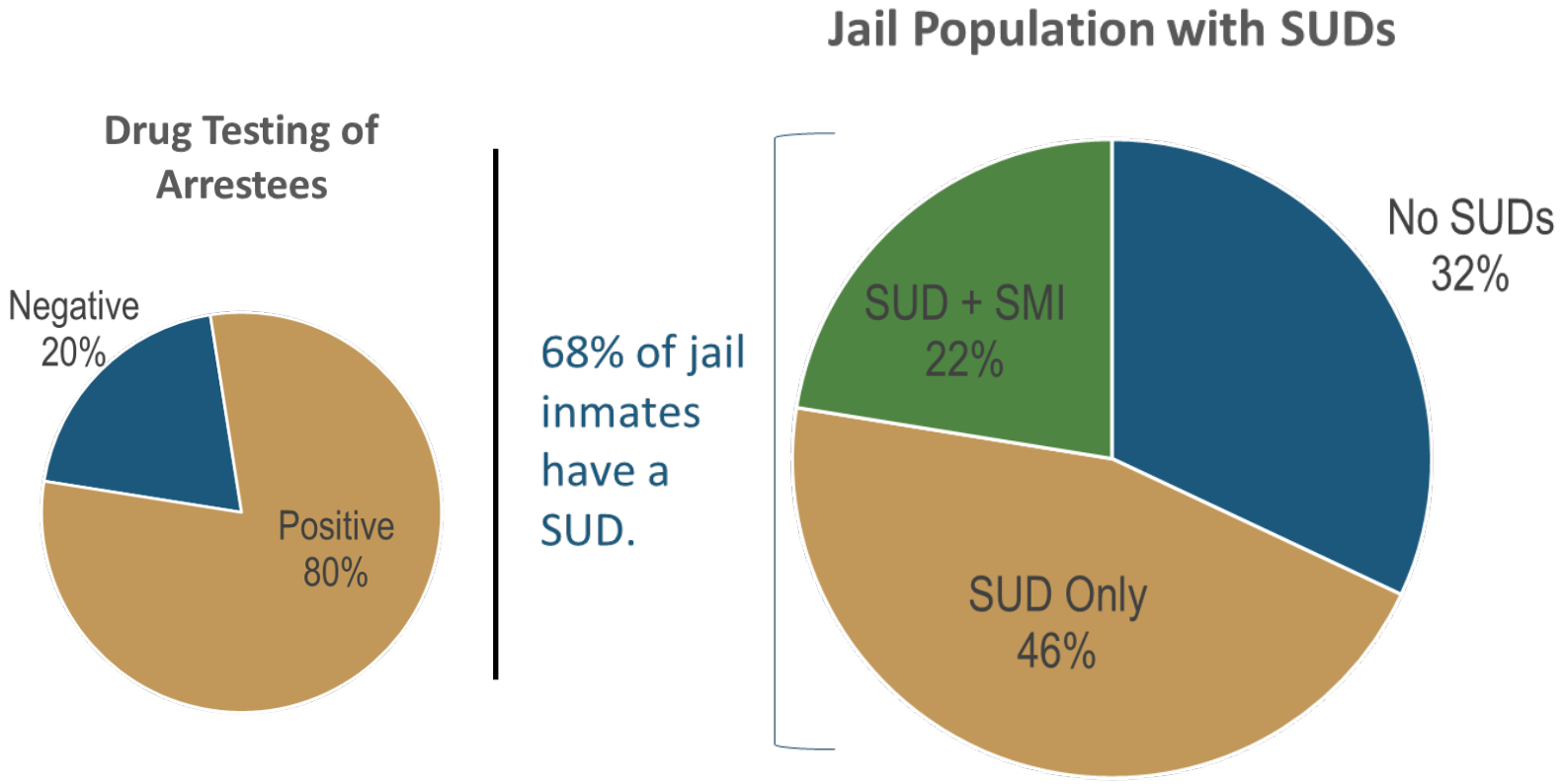
STRUGGLES

Jails and Mental Disorders



SAMHSA's GAINS CENTER

Jails and Substance Use Disorders



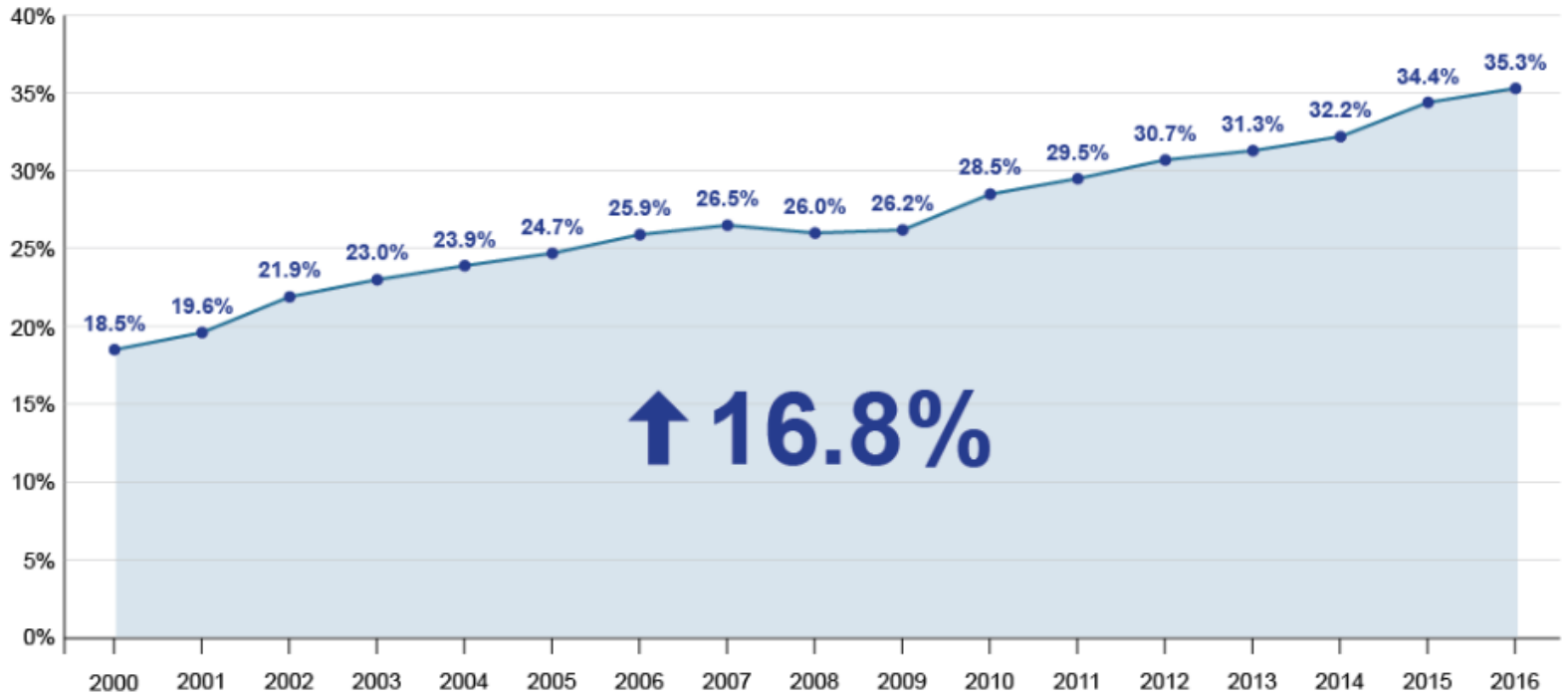
SAMHSA's GAINS CENTER

Negative Consequences Related to Child Welfare Systems

- From 2009 to 2016, the percentage of entries submitted to foster care, for which parental substance use was a contributing factor, rose from 26% to 34%, representing the largest percentage increase among reasons for home removal.
- State child welfare directors attributed a significant portion of the rise in foster placement rates to parental substance use, particularly the rise in opioid and methamphetamine use
- Source:https://www.ajmc.com/journals/supplement/2019/deaths-dollars-diverted-resources-opioid-epidemic/considering-child-welfare-system-burden-opioid-misuse-research-priorities-estimating-public-costs

Child Welfare Impacts

Prevalence of Parental Alcohol or Other Drug Use as a Contributing Factor for Reason for Removal in the United States, 2000 to 2016



https://ncsacw.samhsa.gov/resources/child-welfare-and-treatment-statistics.aspx

Negative Consequences: Opioid Use and Reentry After Incarceration, and Risk of Death

(Ranapurwala et al 2018)

RELAPSE: Within 3 months of release, 75% of formerly incarcerated individuals with an OUD relapse to opioid use.[5]

RECIDIVISM: Within 1 year, 40 to 50% are arrested for a new crime.[19]

OPIOID OVERDOSE DEATH: OOD for former prison inmates was 40x higher at 2 weeks post-release and 11x higher at 1-year post-release compared to general population in one study out of North Carolina.[23]

RISK FACTORS: Inmates at greatest risk were within 2 weeks of release, 26-50 years old, male, white and with more than two prior prison terms and had received in-prison mental health and substance use treatment. [23]

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Opioid Overdose Mortality Among Former North Carolina Inmates: 2000–2015

Shabbar I. Ranapurwala PhD, MPH, Meghan E. Shanahan PhD, Apostolos A. Alexandridis MPH, Scott K. Proescholdbell MPH, Rebecca B. Naumann PhD, MPH, Daniel Edwards Jr MRP, and Stephen W. Marshall PhD, MPH

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Accepted: April 27, 2018 Published Online: August 08, 2018

Abstract Full Text References Supplements PDF PDF Plus

Objectives. To examine differences in rates of opioid overdose death (OOD) between former North Carolina (NC) inmates and NC residents and evaluate factors associated with postrelease OOD.

Methods. We linked NC inmate release data to NC death records, calculated OOD standardized mortality ratios to compare former inmates with NC residents, and calculated hazard ratios to identify predictors of time to OOD.

Results. Of the 229 274 former inmates released during 2000 to 2015, 1329 died from OOD after release. At 2-weeks, 1-year, and complete follow-up after release, the respective OOD risk among former inmates was 40 (95% confidence interval [CI] = 30, 51), 11 (95% CI = 9.5, 12), and 8.3 (95% CI = 7.8, 8.7) times as high as general NC residents; the corresponding heroin overdose death risk among former inmates was 74 (95% CI = 43, 106), 18 (95% CI = 15, 21), and 14 (95% CI = 13, 16) times as high as general NC residents, respectively. Former inmates at greatest OOD risk were those within the first 2 weeks after release, aged 26 to 50 years, male, White, with more than 2 previous prison terms, and who received in-prison mental health and substance abuse treatment.

Conclusions. Former inmates are highly vulnerable to opioids and need urgent prevention measures.

Relationship between crime and Symptoms (Peterson et al 2014)

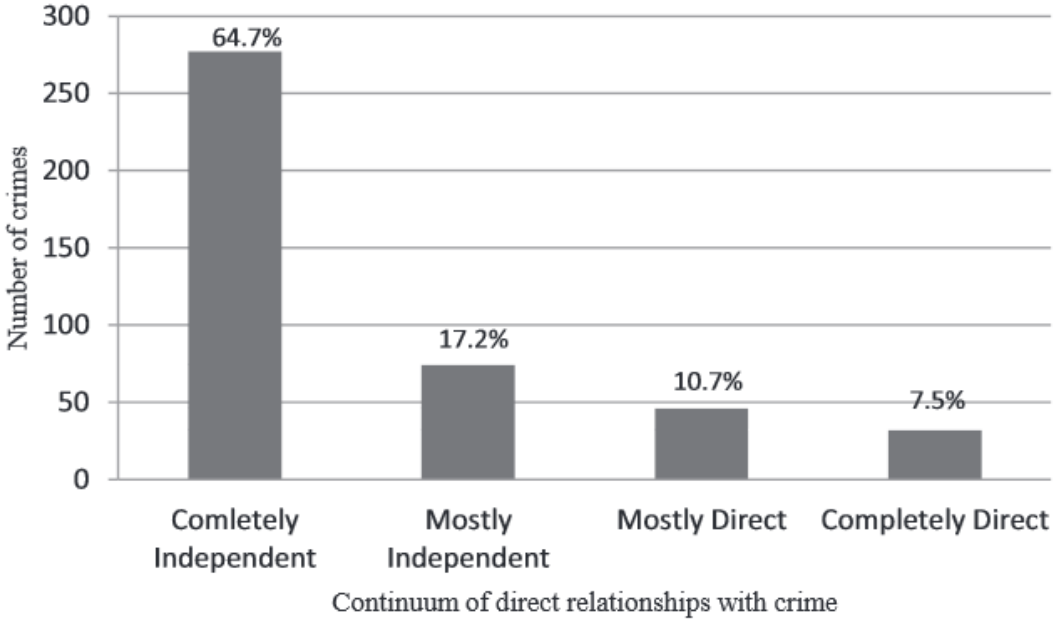


Figure 3. Distribution of crimes along the direct continuum from independent to direct.

Race/Ethnicity and Mental Illness

- Healthcare disparities
- Criminal justice disparities
- Social determinants of health
  - Poverty
  - Environmental factors
  - Social context

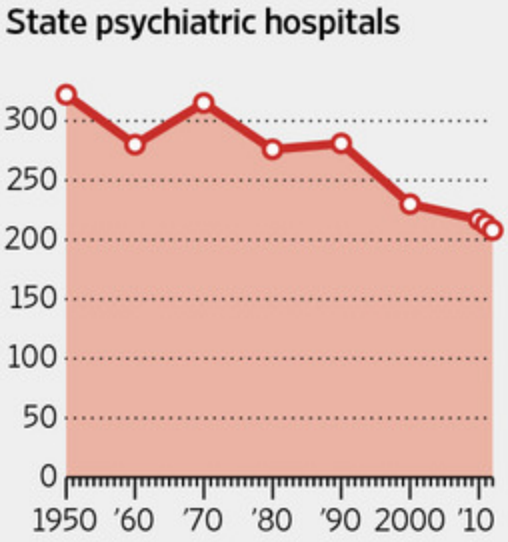
Model	OR	CI
Model 1 (N=11,446)[b]		
Defendants referred for an inpatient evaluation, both genders		
White	1	—
Black	1.26	1.136–1.397***
Hispanic	.806	.713–.912
Model 2 (N=9,255)[b]		
Defendants referred for an inpatient evaluation, males only		
White	1	—
Black	1.247	1.113–1.398***
Hispanic	.819	.717–.935**
Model 3 (N=9,255)[b]		
Defendants referred for an inpatient evaluation in a strict-security facility, males only		
White	1	—
Black	1.87	1.609–2.175***
Hispanic	1.374	1.153–1.638**

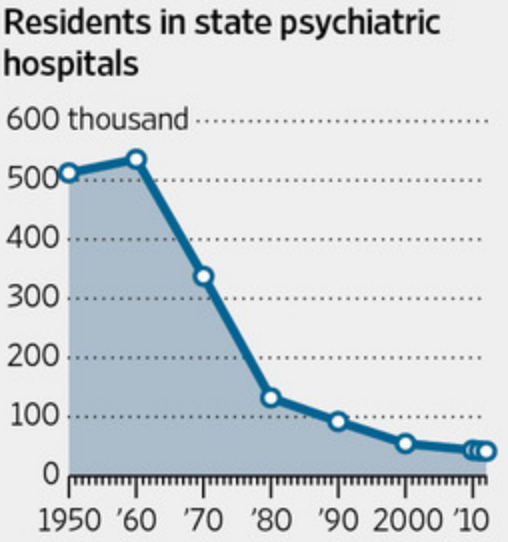
DIFFERENCES IN CRIMINAL FORENSIC CASE ROUTING BY RACE/ETHNICITY

Pinals, Packer, et al. 2004

Shifting Burdens

Since 1950, a third of state psychiatric hospitals have closed and others have cut patient capacity. Many in need of treatment eventually wind up in the prison system.



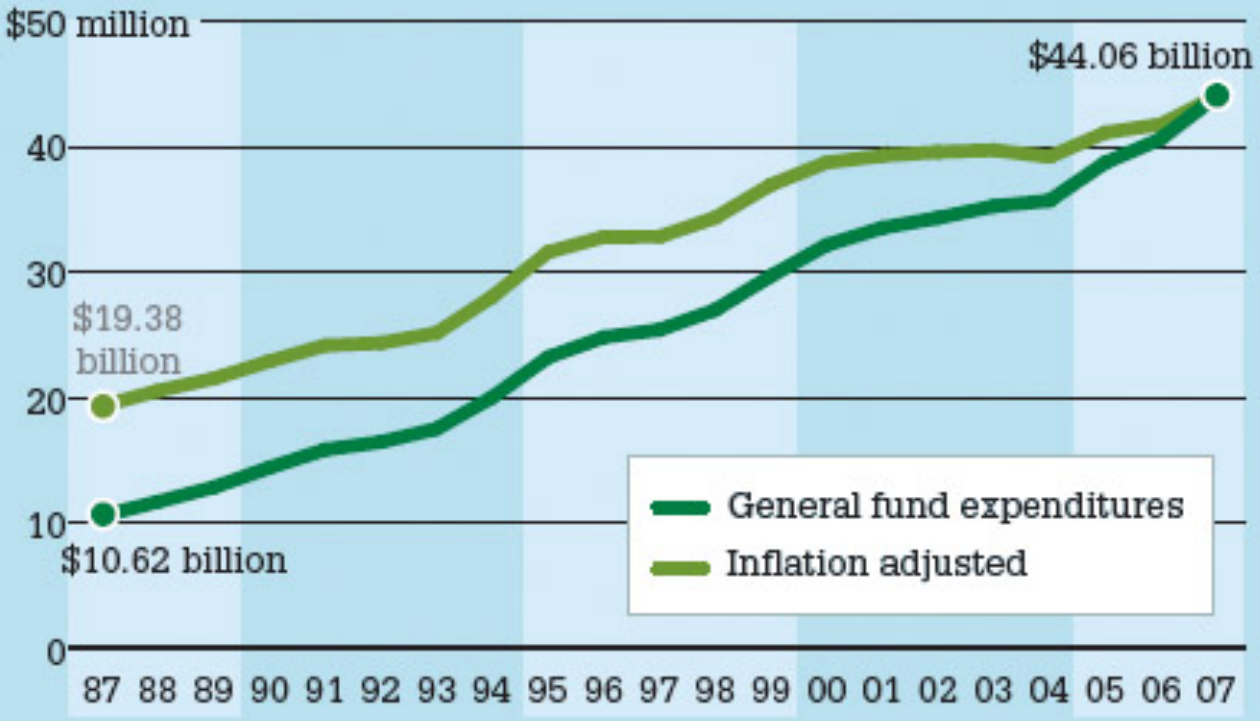


Source: NASMHPD Research Institute

The Wall Street Journal

TWENTY YEARS OF RISING COSTS

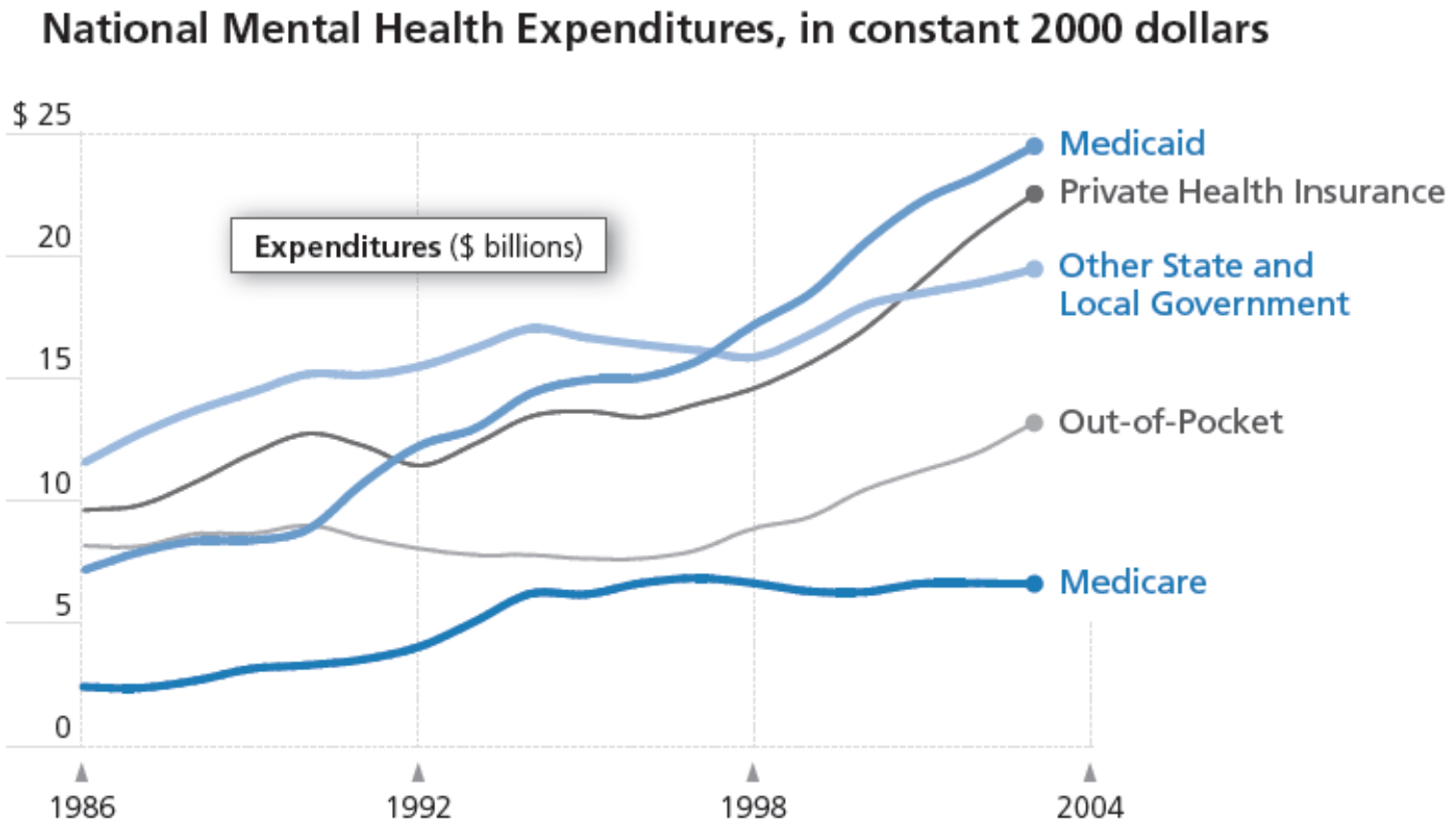
Between fiscal years 1987 and 2007, total state general fund expenditures on corrections rose 315 percent.



SOURCE: National Association of State Budget Officers, "State Expenditure Report" series; Inflation adjusted figures are based on a reanalysis of data in this series.

NOTE: These figures represent state general funds. They do not include federal or local government corrections expenditures and typically do not include funding from other state sources.

Coordinating services over the next generation



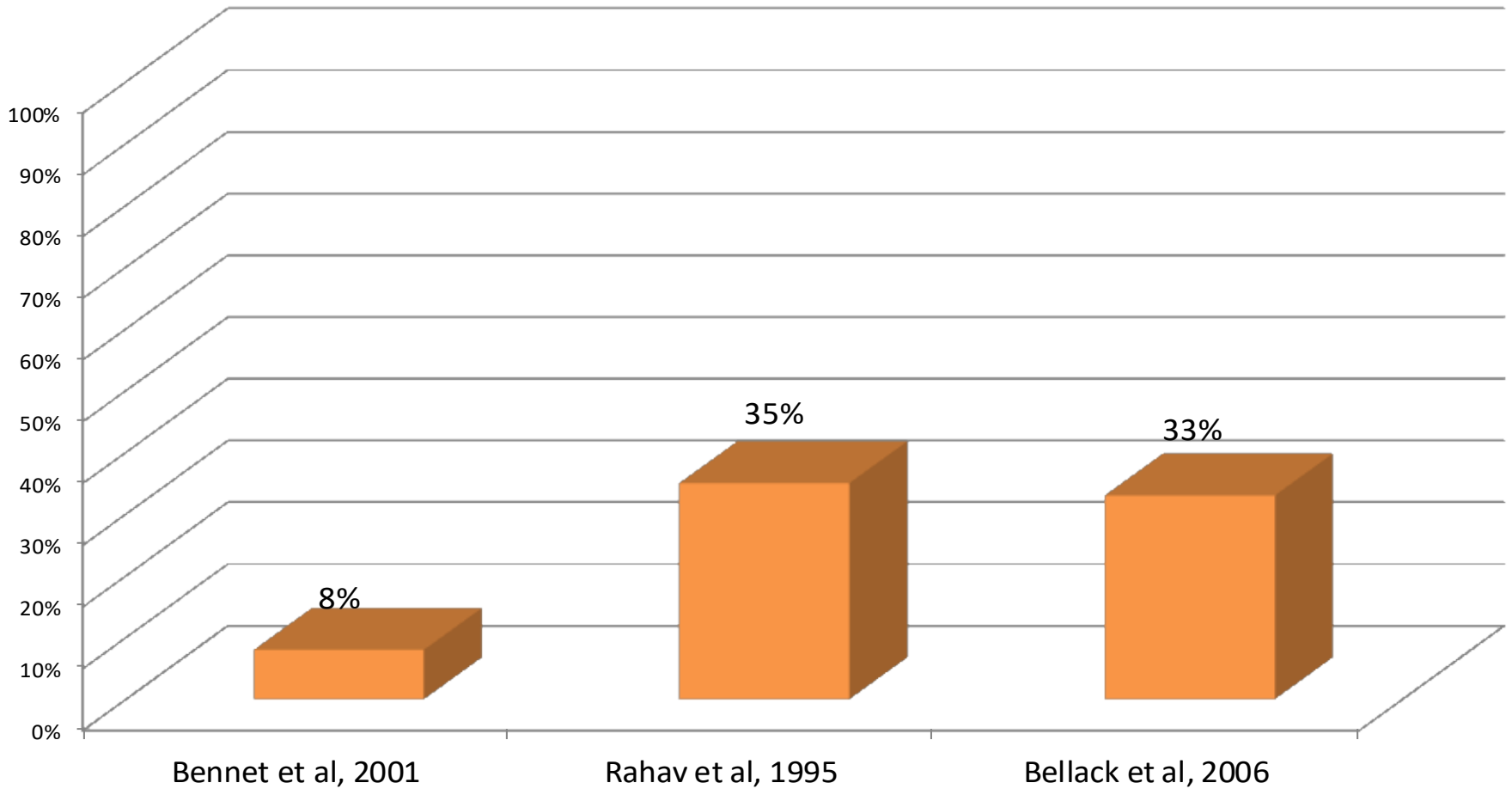
Source: Shirk, Cynthia, National Health Policy Forum; available at http://www.nhpf.org/library/background-papers/BP66_MedicaidMentalHealth_10-23-08.pdf

Mental Health Court Cost Factors

- Drivers of cost were related to
  - More days in jail prior to enrollment
  - Co-occurring mental health and substance use disorders
- Conclusions seem to suggest a targeted group for enrollment, and interventions that target CODs and criminogenic risks

(Steadman, Callahan, Robbins, et al. *Psych Svcs* 65:1100-1104, 2014)

Poor Treatment Engagement



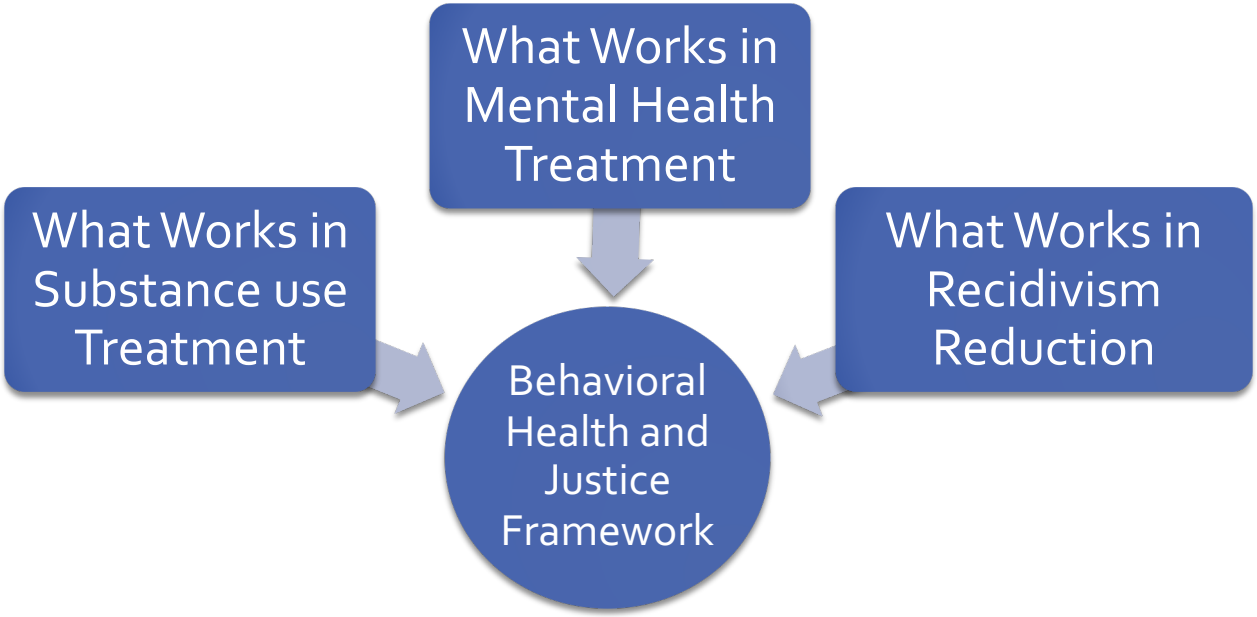
8% referred from residential care to day treatment remained engaged at 6 months

35% of individuals enrolled in outpatient treatment complete the program

33% of individuals randomized to behavioral therapy did not receive any treatment

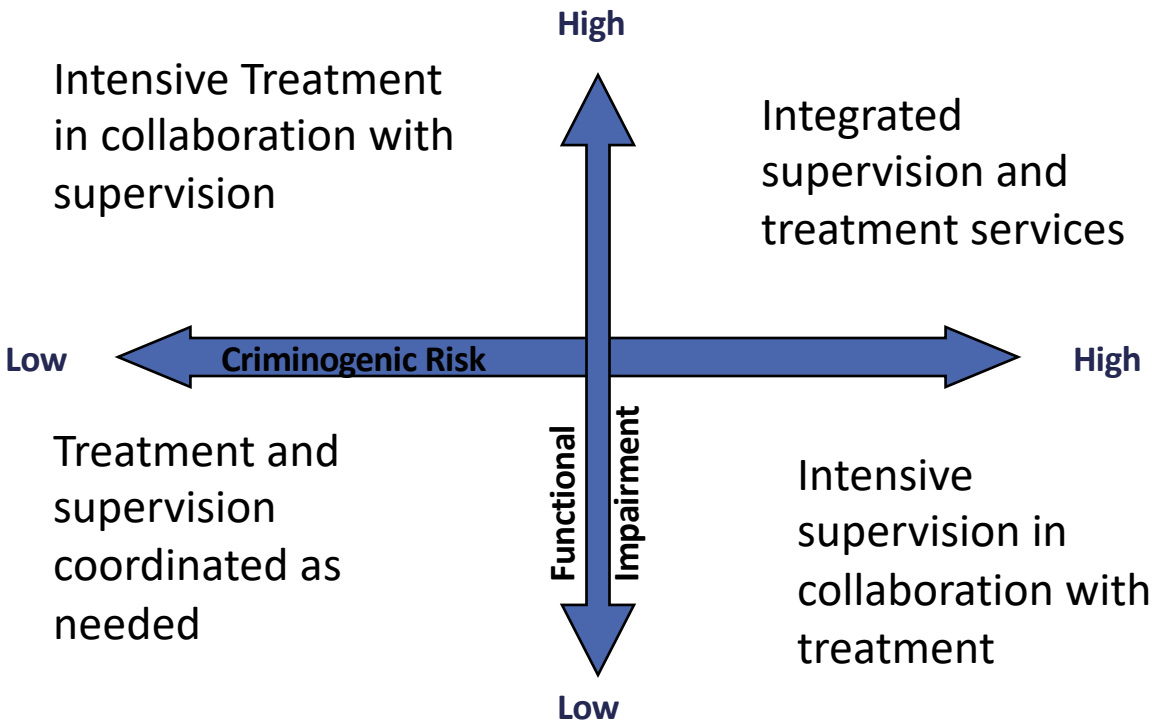
STRATEGIES

Creating Cross-System Collaboration



Council of State Governments Justice Center; Osher 2013

Identifying Strategies to Work with Target Population by Criminogenic Need and Functional Impairment

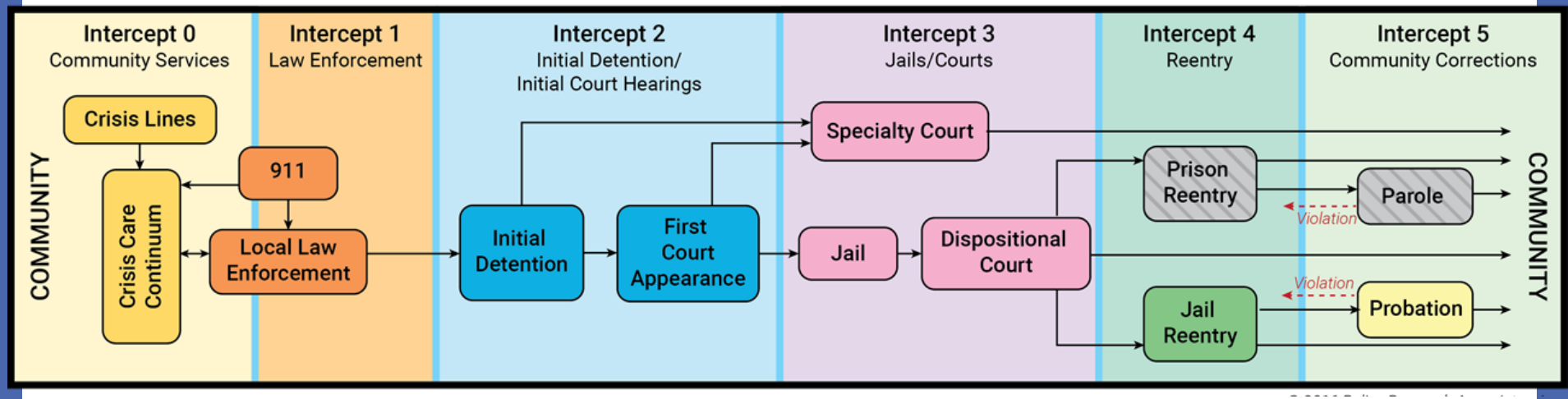


Adapted from Prins and Osher, Council of State Governments Justice Center, 2009

Building Safety Networks

- Individual
- Family/Friends
- Peer supports
- Community at Large
- Spiritual connections/faith-based partners
- Criminal justice partners

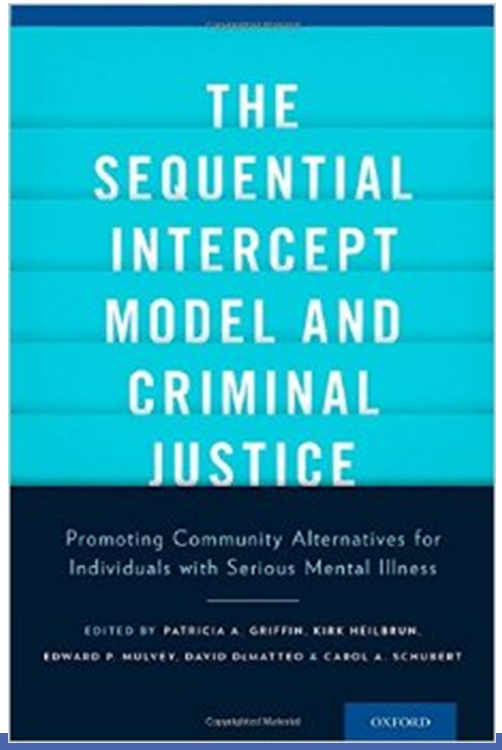
Sequential Intercept Model



SAMHSA's National GAINS Center, Delmar, NY 2017; Adapted from Munetz MR, Griffin PA. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57(4): 544-549.*

The Sequential Intercept Model (Munetz and Griffin 2006)

- Simple premise- criminal justice process take place along a continuum
- Robust policy targets multiple intercept points where an intervention might reduce the penetration of persons with mental illness in the criminal justice system
- Initially focused on mental illness, but now focuses on co-occurring substance use as another challenge



Stepping Up: A National Initiative to Reduce the Number of People with Mental Illnesses in Jails

Take Action Now

Six questions county leaders need to ask:

- Question 1: Is your leadership committed?
- Question 2: Do you have timely screening and assessment?
- Question 3: Do you have baseline data?
- Question 4: Have you conducted a comprehensive process analysis and service inventory?
- Question 5: Have you prioritized policy, practice, and funding?
- Question 6: Do you track progress?

BEHAVIORAL HEALTH AND JUSTICE PRACTICE REFORMS

Examples of Policy Reforms

- Screening at various intercept points
- Reclassifying drug offenses
- Revise sentencing practices
- Improve pre-trial systems
- Enhance parole practices (e.g., medical parole, earned good time)
- Performance incentives for community corrections
- EBPs in community corrections- specialized probation, specialized parole (focus on mental illness)
- Enhance efficiencies

Improving outcomes of Justice-Involved Individuals with Mental Illness

- Screening and early intervention
- Innovative coverage beyond routine healthcare costs
- Minimized breaks in entitlements
- Integrated and collaborative models of care delivery across healthcare and justice systems
- Cross Trainings

EVOLVING TRENDS IN TREATMENTS TO ADDRESS THE JUSTICE-INVOLVED POPULATIONS

Co-Occurring Substance Use Disorders and Mental Illness: General Lifetime Prevalence Rates

- About 50% of people with an SUD will develop a mental illness
- About 50% of people with a mental illness will develop an SUD
- Rates are not as clear in children, but about as many youth with an SUD will have a mental health condition such as depression and anxiety

https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses

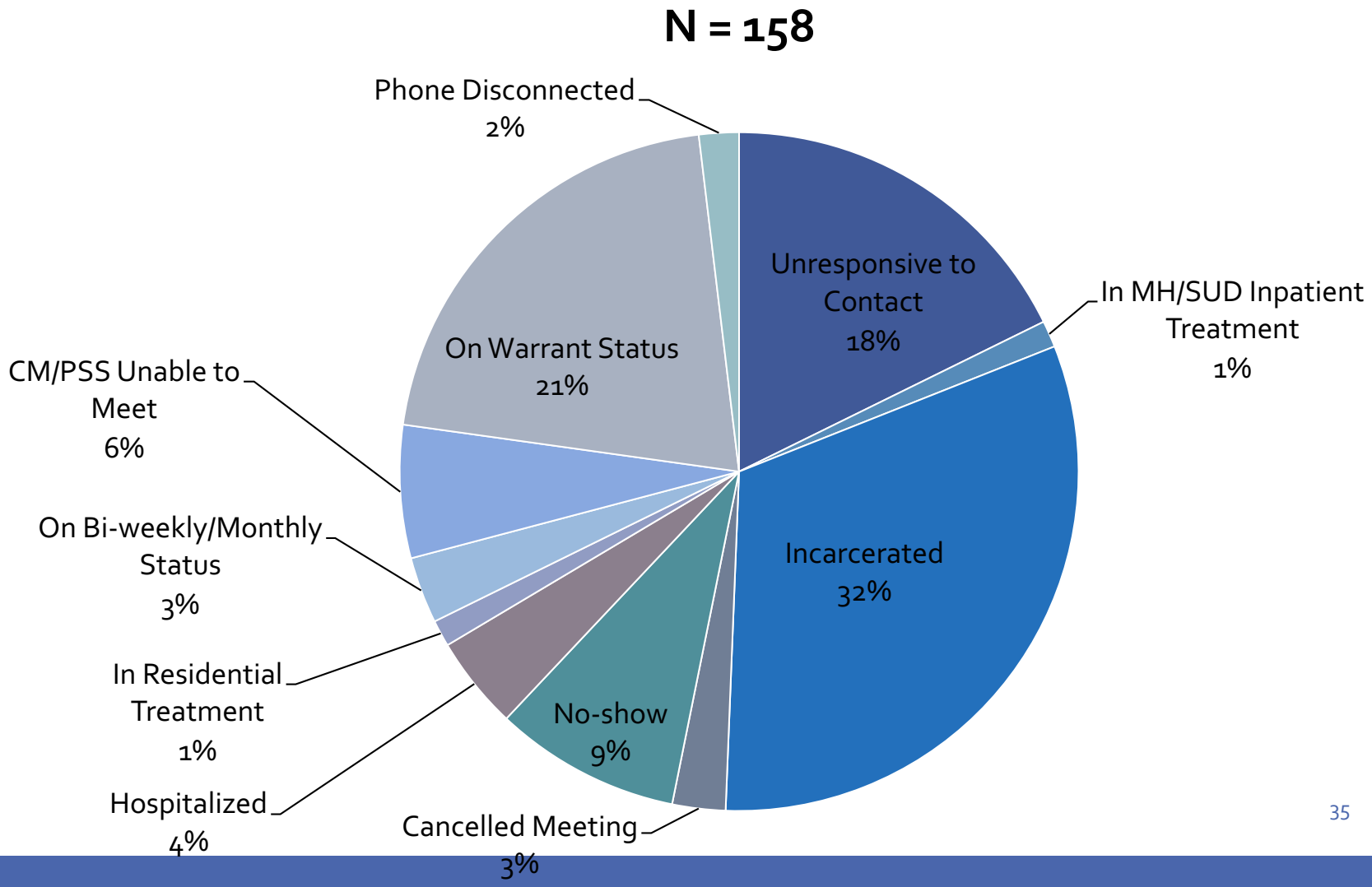
Co-Occurring Disorders in Specialty Courts

- Drug Courts: 30%–40% have diagnosable mental illnesses in addition to their SUD
- Mental Health Courts: 75%–80% have substance use disorders

(Steadman et al 2013, Blenko, 2001; Almquist & Dodd, 2009)

SAMHSA's GAINS CENTER

Examining Data Such as Reasons for not meeting with client- Leading to Quality Improvement



FDA-Approved Medications for Substance Abuse Treatment and Tobacco Cessation

Medications for Alcohol Dependence	Naltrexone (ReVia®, Vivitrol®, Depade®) Disulfiram (Antabuse®) Acamprosate Calcium (Campral®)
Medications for Opioid Dependence	Methadone Buprenorphine (Suboxone®, Subutex®, and Zubsolv®) Naltrexone (ReVia®, Vivitrol®, Depade®)
Medications for Smoking Cessation	Varenicline(Chantix®) Bupropion (Zyban® and Wellbutrin®) Nicotine Replacement Therapy (NRT)

SAMHSA
Substance Abuse and Mental Health Services Administration

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BRSS TACS

Recovery Support Tools and Resources

Peers

- Core Competencies for Peer Workers
- FAQs: Core Competencies

Shared Decision-Making Tools
Share Your Story
Parents and Families
Youth and Young Adults

Peers

BRSS TACS
Bringing Recovery Supports to Scale
TECHNICAL ASSISTANCE CENTER STRATEGY

Learn about the role of peer workers and access recovery-related resources about peer supports and services.

Who Are Peer Workers?

the CMHS National GAINS CENTER

Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists

Larry Davidson, Ph.D.[1], and Michael Rowe, Ph.D.[2]

The CMHS National GAINS Center May, 2008

The past decade has witnessed a virtual explosion in the provision of peer support to people with serious mental illness, including those with criminal justice system involvement. Acting on one of the key recommendations of the President's New Freedom Commission on Mental Health, 30 states have developed criteria for the training and deployment of "peer specialists," while at least 13 states have initiated a Medicaid waiver option that provides reimbursement for peer-delivered mental health services.

What Is Peer Support?

While people in recovery can provide conventional services, peer support *per se* is made possible by the

in that the experience of having "been there" and having made progress in one's own personal recovery comprises a major part of the support provided.

Forensic peer support involves trained peer specialists with histories of mental illness and criminal justice involvement helping those with similar histories. This type of support requires special attention to the needs of justice-involved people with mental illness, including an understanding of the impact of the culture of incarceration on behavior. Recognition of trauma and posttraumatic stress disorder, prevalent among this population, is critical.

What Do Forensic Peer Specialists Do?

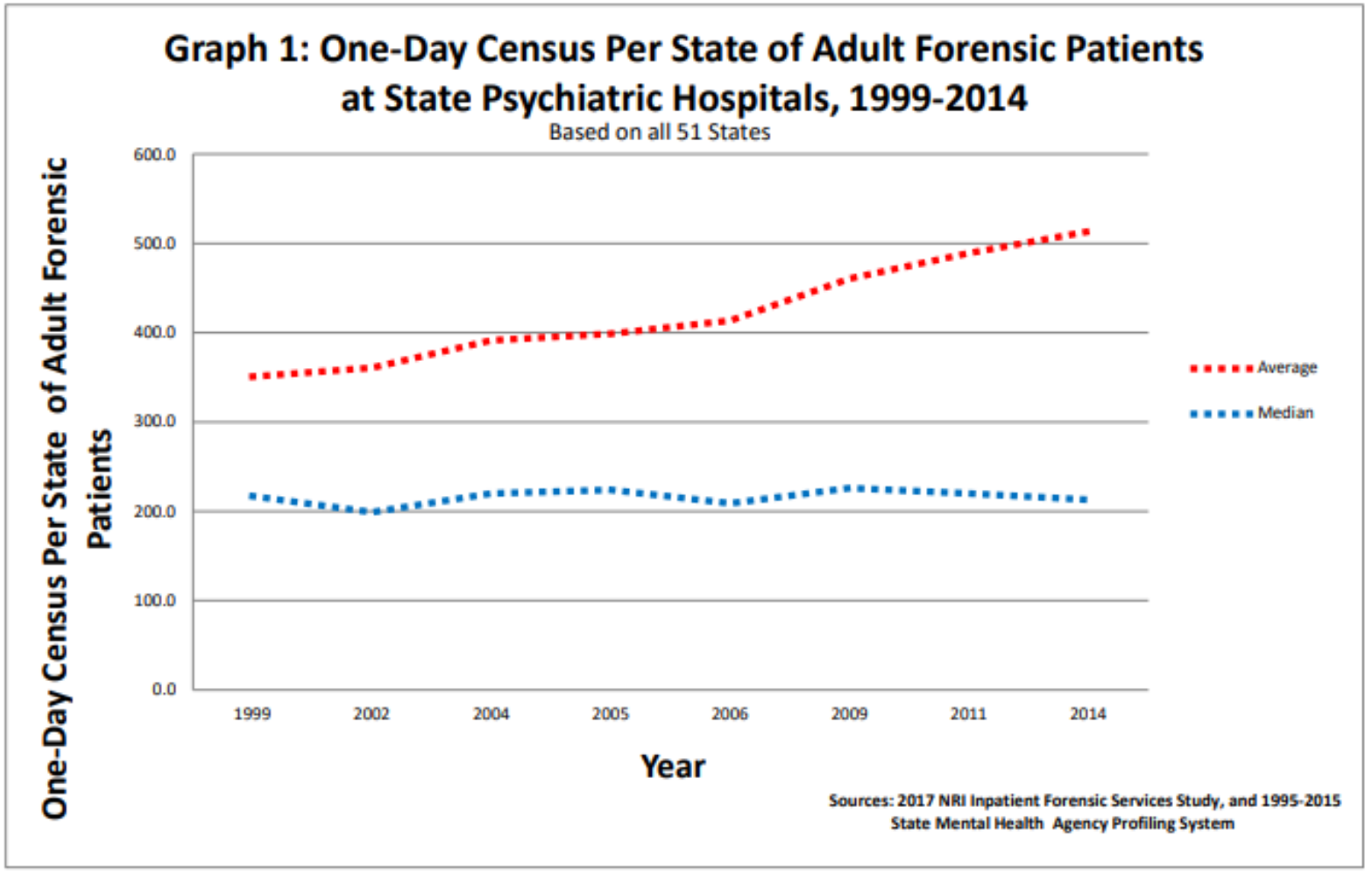
Forensic Peer Specialists assist people through a

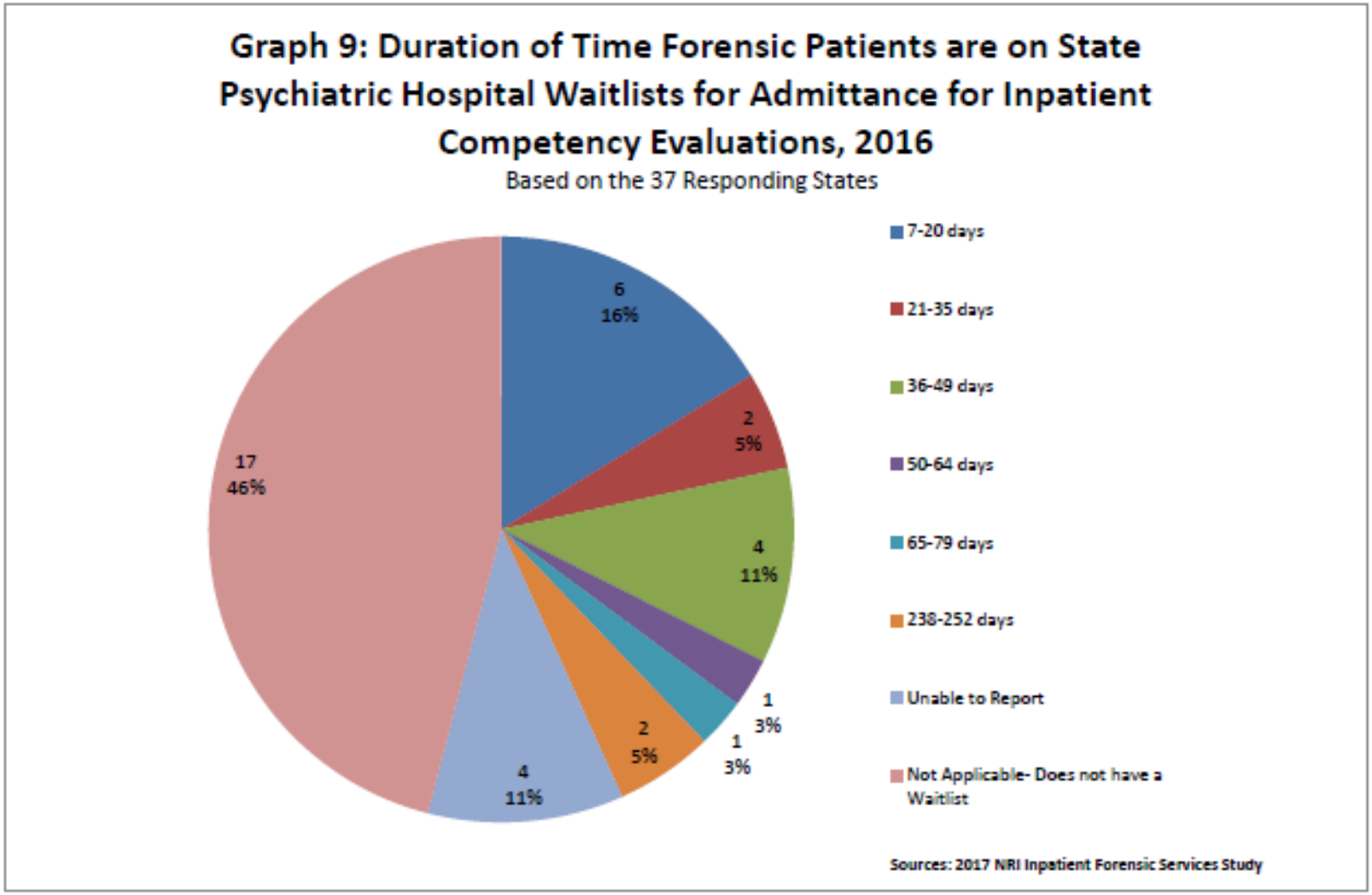
THE ROLE OF PEERS AT THE BEHAVIORAL HEALTH AND JUSTICE INTERFACE

Trauma and wellness as a Key Area of Focus

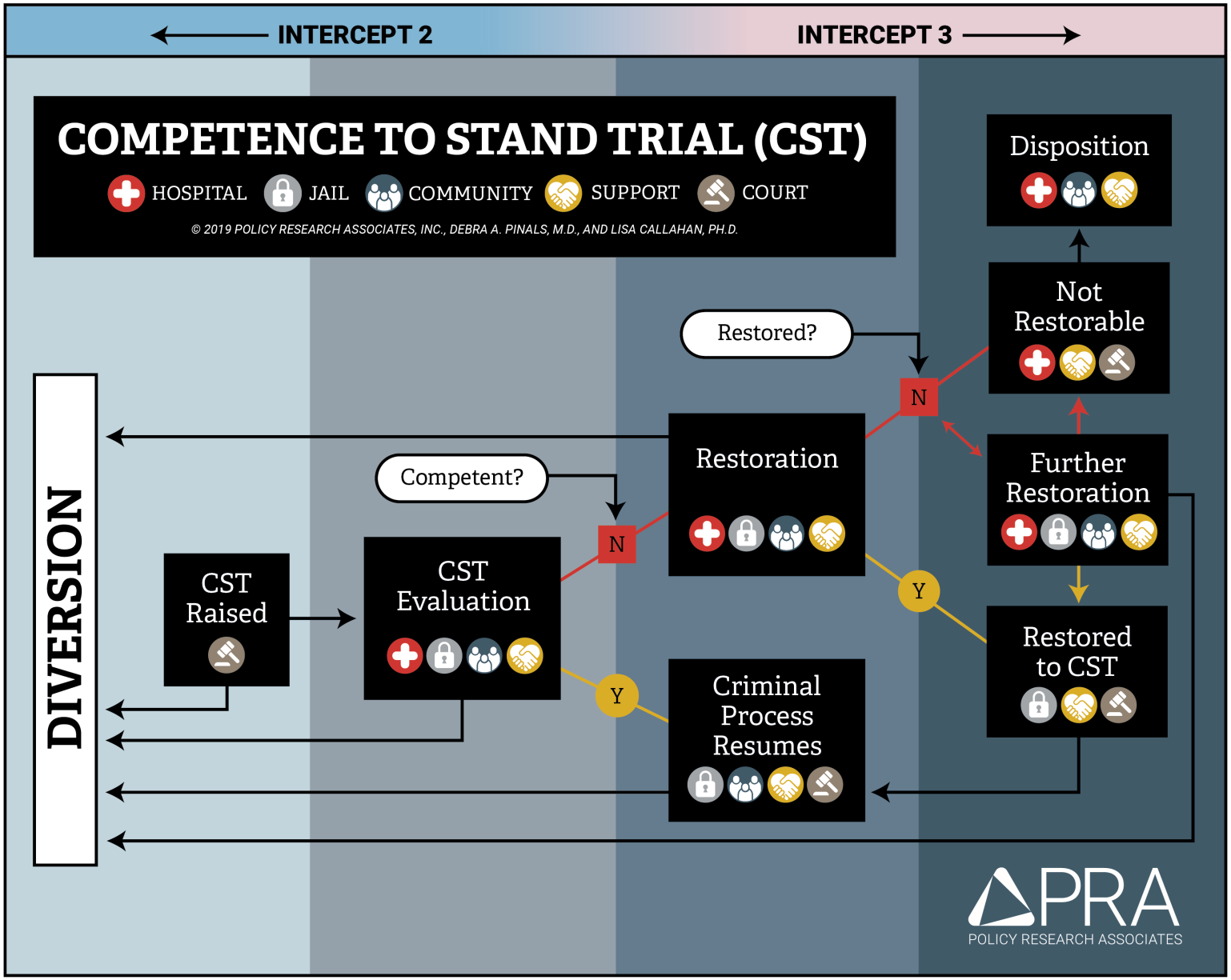
- Understanding trauma of justice-involved individuals
- Understanding trauma-related responses of systems

EVOLVING TRENDS IN FORENSIC SYSTEM RESPONSES


Graph 1: One-Day Census Per State of Adult Forensic Patients at State Psychiatric Hospitals, 1999-2014
Based on all 51 States
One-Day Census Per State of Adult Forensic Patients
600.0
500.0
400.0
300.0
200.0
100.0
0.0
1999
2002
2004
2005
2006
2009
2011
2014
Year
Average
Median
Sources: 2017 NRI Inpatient Forensic Services Study, and 1995-2015 State Mental Health Agency Profiling System



Wik, et al 2017, NASMHPD; Ava at https://www.nasmhpd.org/


INTERCEPT 2
INTERCEPT 3
COMPETENCE TO STAND TRIAL (CST)
HOSPITAL
JAIL
COMMUNITY
SUPPORT
COURT
© 2019 POLICY RESEARCH ASSOCIATES, INC., DEBRA A. PINALS, M.D., AND LISA CALLAHAN, PH.D.
DIVERSION
CST Raised
Competent?
CST Evaluation
N
Y
Restoration
Restored?
N
Y
Not Restorable
Disposition
Further Restoration
Restored to CST
Criminal Process Resumes
PRA
POLICY RESEARCH ASSOCIATES

EVOLVING TRENDS IN BEHAVIORAL HEALTH CRISIS RESPONSE

Strategies to Assist Law Enforcement in their Work with Persons with Mental Illness

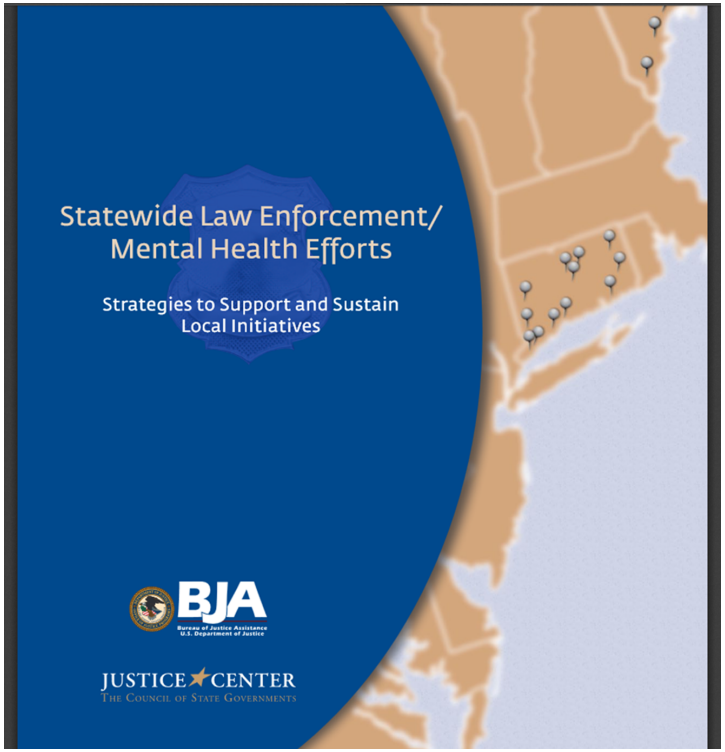
- Local
- State
- National

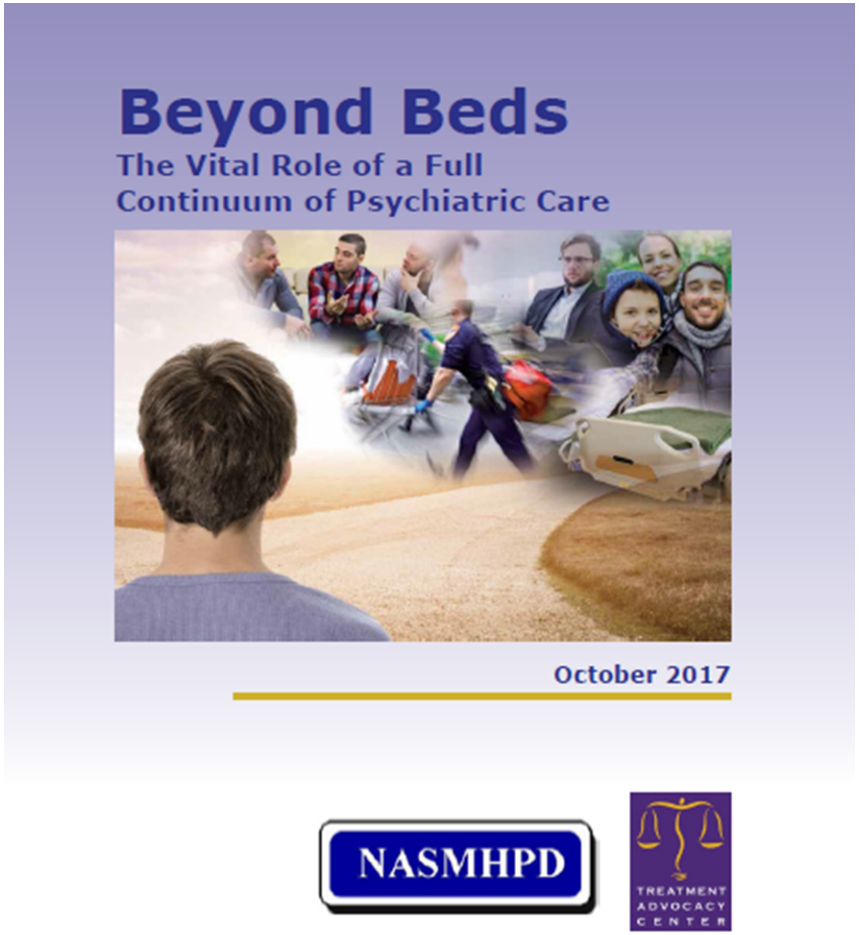
Intercept 0
Specialized Crisis Responses

- Central drop off
  - Co-location with SUD services
- Police-friendly policies
  - No refusal policy
  - Streamlined intake
- Legal foundation
  - Criminal code
  - Civil code
- Cross-training
  - Ride-along
- Community linkages
  - Case management
  - Care coordination
  - Co-response or warm hand-off

Intercept 1 Pre-Booking Jail Diversion and Response Types:

- Police-based police response
  - e.g., CIT
- Police-based mental health response
  - e.g., co-response
- Mental health-based mental health response
  - e.g., behavioral health mobile crisis teams



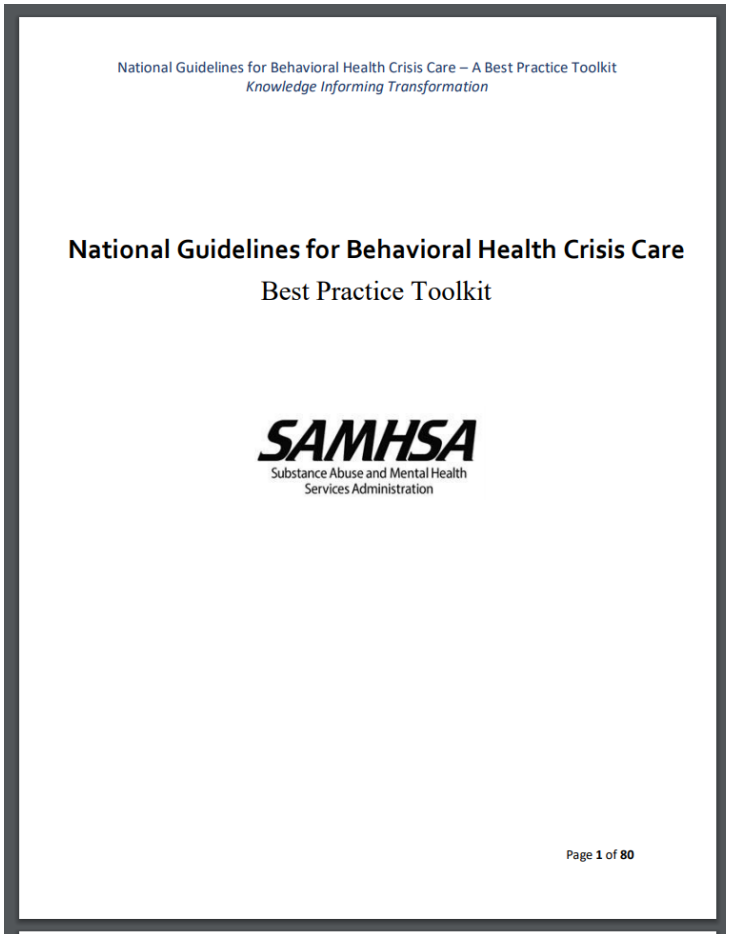


2017 Recommendations:

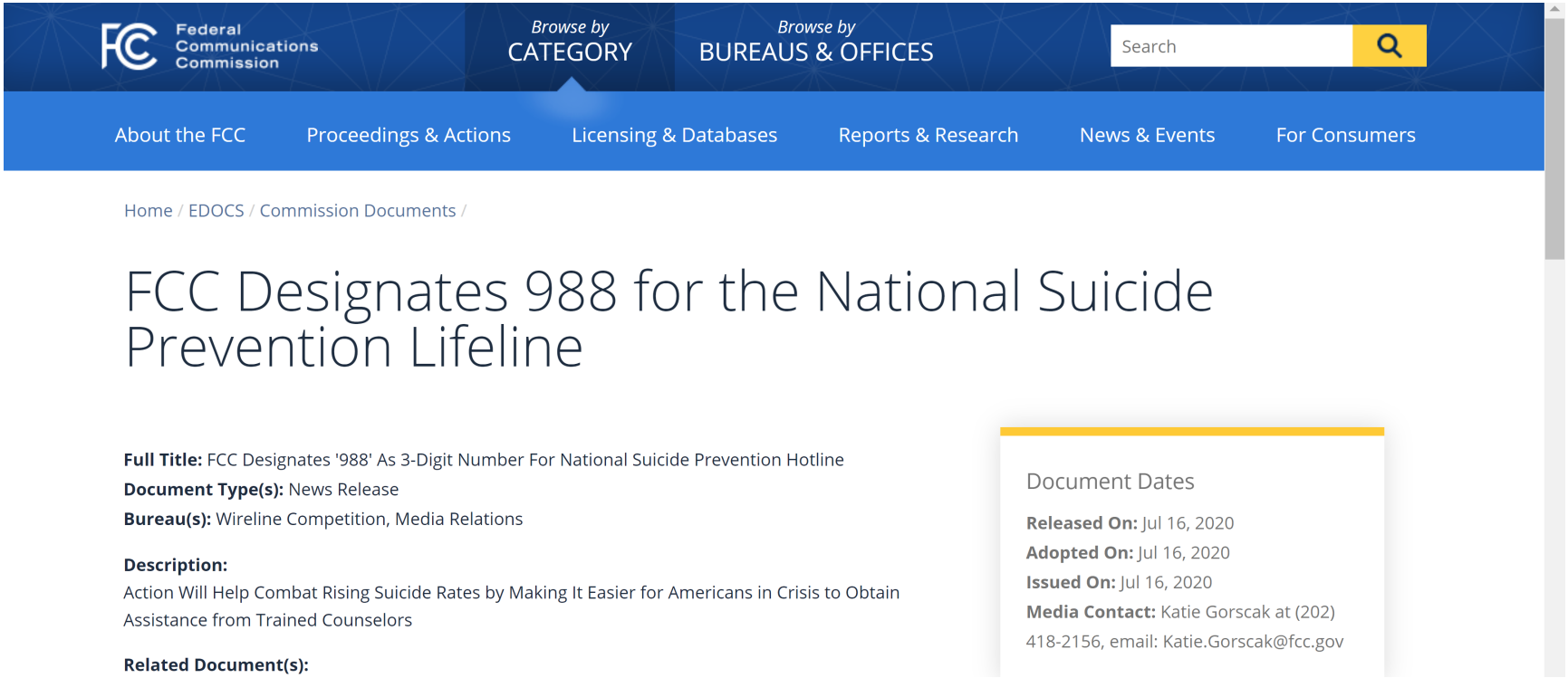
1. The vital continuum
2. Terminology
3. Criminal and juvenile justice diversion
4. Emergency treatment practices
5. Psychiatric beds
6. Data-driven solutions
7. Linkages
8. Technology
9. Workforce
10. Partnerships

Before COVID-19

- Release of the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit by SAMHSA Feb 2020



Planning for the Future



NASMHPD Crisis Services Papers

- SAMHSA's Crisis Services Best Practices Toolkit
- Future-
  - 988 or 911
  - Warm lines
  - Mobile crisis
  - Crisis stabilization
  - Crisis residential
  - Living room services
  - Urgent Care
  - Bridge clinics
  - Etc.

EVOLVING TRENDS IN BALANCING STRATEGIES FOR JUSTICE-INVOLVED POPULATIONS

Balancing Approaches

SMIAdviser
A Clinical Support System for Serious Mental Illness

An APA and SAMHSA Initiative

CLINICIANS | INDIVIDUALS & FAMILIES | ABOUT US | CALENDAR | CONTACT

/ Knowledge Base (Clinicians) / Psychiatric Advance Directives: Taking Charge Of Your Care

Psychiatric Advance Directives: Taking Charge Of Your Care

SMIAdviser
A Clinical Support System for Serious Mental Illness

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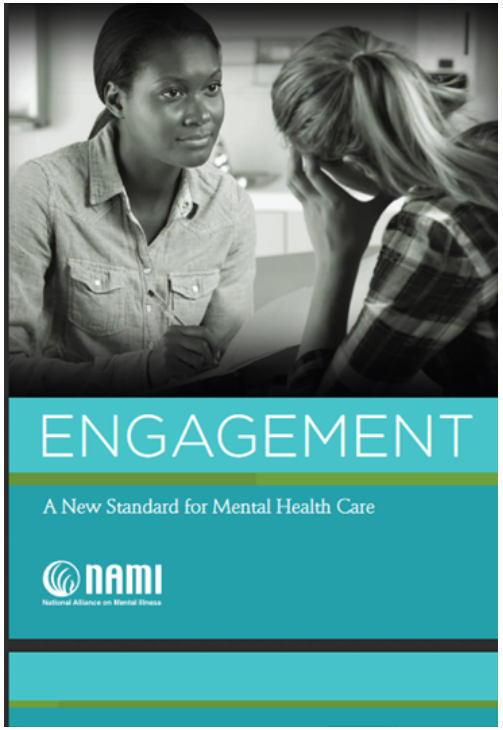
Partnership to Advance Assisted Outpatient Treatment

SMI Adviser and Treatment Advocacy Center (TAC) are partners in facilitating the national expansion of assisted outpatient treatment

Building Engagement into All Strategies

- "Many people with mental illness are handcuffed during psychiatric crises, discharged to parking lots, jailed, turned away from services and left to live on the streets. Many never experience what should be the most basic standard of care in the mental health system: a healing connection with a mental health professional, dignity, respect and a sense of hope."
  - -NAMI's "Engagement: A New Standard for Mental Health Care", July 2016



Need to Include Evidence Based Practices and Engagement Strategies

- An emerging field….
- Psychopharmacology
- Substance use treatments (SBIRT, MAT, etc)
- Supportive services with focused models (e.g., Critical Time Intervention, MISSION-CJ)
- Cognitive behavioral type practices and other therapies
  - Treatments that address criminal thinking patterns
  - Treatments that address behavioral challenges
  - Treatments that address chronic psychoses
- Trauma specific practices
- Motivational Interviewing
- Psychiatric Advance Directives

Conclusions

- Evolving strategies at the behavioral health and justice interface
- Partnerships matter
  - Case level
  - Local level
  - State system level
- Understanding communities
- …Continuous network development and problem-solving feedback loops