assessment & treatment of offenders with co-occurring disorders
for the 37th Annual conference of the forensic mental health association of california

today’s workshop: goals
• Forensic assessment & treatment are not the same as for the general mh population
• Assessment must include risk of recidivism (public safety) and mental health/substance abuse needs (public health)
• Treatment must be integrated for co-occurring disorders and address risk factors for criminal behavior (Clement et al 2011; Skeem 2009; Scott 2008)

• Idea behind this presentation - FMHAC conference archives back to 2005
• Qualification - non-forensic vs. forensic audience
  • From basic to state of the art
• Who’s my audience - RNR?

today’s workshop
• Current data on the offender population, recidivism, & prevalence of co-occurring disorders
• The realignment
• Health care reform & the CJ population

today’s workshop
• Assessment
• Screening Instruments
• Risk Assessment
• Needs vs. risk factors
• Characteristics of the forensic population
• Common diagnoses
• Assessment of criminality and remorse
today's workshop

• Treatment
• What works in mental health treatment, substance abuse treatment, & co-occurring disorders treatment
• Evidence-based practices in forensic treatment
• Effective collaboration with probation/parole
• Q&A

statistics

• “There are three kinds of lies: lies, damned lies, and statistics” Benjamin Disraeli
  (Best 2001)

the offender population
the numbers

• As of January 1, 2008:
  • One in every 100 (99.1) adult U. S. residents in prison or jail
• As of March 1, 2009:
  • 1 in 31 under correctional supervision: 3.2%
  (The Pew Center on the States, 2008 & 2009)
are we any safer?

- incarceration & crime
  (Stemen 2007; King, Mauer, Young 2005)
  - No consistent relationship between the rate at which incarceration increased and rate at which crime decreased
  - 10% increase in imprisonment correlated with 2-4% decrease in crime rate; 1992-1997: imprisonment responsible for 25% of decrease in crime
• Other factors: growing economy; policing strategies; higher high school graduation rates; changes in drug markets; community responses; fewer younger persons; smaller urban populations

• Tipping point - higher incarceration destabilizing to communities/neighborhoods - family bonds; employment (Stemen 2007; King, Mauer; Young 2005)

• Other criminogenic effects

• Over-punish non-violent drug offenders & under-punish violent offenders?

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**reentry**
(petersilia 2011; travis 2005; travis et al. 2001)

• "But They All Come Back"

• From 150K in 1970 to 630K in 2002 to 750K in 2011; 2000 state and federal prisoners released per day

• Checklist: contact w/ family; housing; health care appointments (including mental health & substance); work or educational program; safety plan

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**recidivism**

• 50-70% Recidivism within 3 years; 70% in California (OJJ BJS 2002)

• 44% Nationally; 60% in California (Pew Center on the States 2011)
mentally ill offenders: The Numbers

- DOJ BJS 1999 - 7% of Federal inmates; 16% in state prisons, local jails, and on probation
- Fazel & Danesh 2002 – 14%
- BJS 2006 – 56% state prison; 45% federal; 64% local jails; Change in methodology issue
- Steadman, et al. 2009 - 14% of males; 31% of females

co-occurring disorders forensic numbers

- Across studies: 56% - 87% (85% for alcohol) compared to:
  - General MH Population: 20-80% of severely mentally ill abusing substances
  - Substance abuse treatment: 30-75% of addicts have a mental disorder
the realignment- ab 109
(Report of the Los Angeles County Countywide Criminal Justice Coordination committee, December 15, 2011)

• Latest Data: October & November 2011, L.A. Co. DMH assessed 30% (515) of 1,710 PSPs at hubs
  • 20% did not need treatment
  • 28% refused treatment
  • 4% substance abuse treatment only
  • 48% referred for mental health treatment

• Of the 48% referred for mental health treatment
  • 83% referred to contract providers (9 specialty providers)
  • 16% referred to DMH directly operated clinics

Health care reform

• From “dual diagnosis” to “co-occurring disorders” to “integrated care”
Health Care Reform & the CJ population

- Health reform expands eligibility for Medicaid
- Individuals in cj system have high rates of chronic disease & behavioral disorders
- Inclusion of mh & substance abuse services as essential health benefit
- Partner w/ FQHCs (DiPietro, 2011)

forensic MH: shortage of qualified providers

- Qualified:
  - Integrated Co-Occurring Disorders Treatment and Forensic Treatment

assessment & diagnosis
screening & assessment instruments

- Recommended screening, assessment, and diagnostic instruments
- TCUDS-II

needs vs. criminogenic needs/dynamic risk factors

- Risk assessment - individualized & actuarial
  - The "Central 8": History of Antisocial Behavior; Antisocial Personality Pattern; Antisocial Cognition; Antisocial Associates; Family/Marital Circumstances; School/Work; Leisure/Recreation; Substance Abuse
- Instruments better predictor than individual professional judgement (Andrews & Bonta, 2010; Solomon et al. 2008)

- Reliable, valid & normed for specific population
- LSI-R or CMI; COMPAS; RMS; PCRA
characteristics of the forensic mh population vs. the general mh population

- Mandated/Involuntary = Unmotivated?
- Deceptive?
- Dangerousness?
- Substance Abuse
- Criminal Lifestyle?

most common diagnoses in the forensic population

- Psychotic Disorders and Major Depression 2-4x more common than in the general population (Fazel & Danesh 2002)

most common diagnoses in the forensic population

- Personality disorders: 65%
- Antisocial Personality Disorder: 47%
  - 10x more common than in the general population
antisocial personality

- DSM IV-TR - A pervasive pattern of disregard for & violation of the rights of others since age 15

DSM criteria

- Three or more of the following:
  - failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
  - deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  - impulsivity or failure to plan ahead
  - reckless disregard for safety of self or others
  - consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
  - lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
identification of antisocial personality

- Power in daily life - OK to use others - exploitive, intimidation, deviousness
- Power in crime - excitement is the goal
- Sexuality - youthful, multiple partners, multiple children; control is the goal
- Lying under control (Samenow 2004)

personality disorders

- Cluster A -- odd or eccentric
  - Paranoid, schizoid, schizotypal
- Cluster B -- dramatic, emotional or erratic
  - Antisocial, borderline, histrionic, narcissistic
- Cluster C -- anxious or fearful
  - Avoidant, dependent, obsessive-compulsive

assessment of criminality

- Antisocials: 33-49%
- Dependent: 16-29%
- Situational: 17-25%
- Neurotic: 13-18% (Lidman et al. 2004)
SUBSTANCE ABUSE AND CRIMINALITY

- Criminal vs. criminal to support habit

psychopathy/sociopathy
(Hare 1999; Hart et al. 1995; Lykken 1998)

- The Mask of Sanity (Cleckley 1941)
- PCL-R or SV
  - Factor 1: Selfish, callous, & remorseless use of others
  - Factor 2: Chronically unstable & antisocial lifestyle or social deviance
- DSM equivalent: antisocial, narcissistic, histrionic, & borderline

ASPD vs. psychopathy

- ASPD = 3-5% of general male population and 50-80% of prison population vs. Psychopathy = 1% of general male population & 15-20% of prison population
- "It’s like having pneumonia vs. having a cold. They share some common symptoms, but one is much more virulent" Robert Hare
responsibility and remorse

• 26 yo female convicted of conspiracy to commit bank fraud (identity theft)
• "very remorseful"; the offense took her "away from family and life ... there is no greater crime than to be taken away from life"

responsibility and remorse

• 50 yo male convicted of impersonation of a federal employee
• "Subject to my court hearing; I am mollified by the verdict rendered. It is ostensibly clear that I am irrefutably the blame. My jurisprudence was fair and just. I wish to interject my remorse for my actions of injustice. I wasn’t really attempting to deceive you. You have my sincerest apology."

treatment
### what works in mental health treatment

- The Relationship
- Cognitive Behavioral
- Medication
- Assertive Community Treatment (ACT) Models
- Illness management & recovery
- Supported employment - Supported housing
- Family Psychoeducation

### what works in substance abuse treatment

- Motivational Interviewing
- Cognitive-behavioral treatment: relapse prevention
- Contingency Management
- Trauma-focused treatment
- Medication-assisted
- 90 days minimum effective dose

### motivational interviewing & stages of change

(Prochaska & DiClemente 1986; Prochaska & Prochaska 1999)

- Precontemplation
- Contemplation
- Preparation (determination)
- Action
- Maintenance
- Relapse
• Motivation is not dichotomous - motivated vs. unmotivated
• Motivation is an interpersonal process

Treatment: what works for co-occurring disorders

• IDDT (Mueser, et al. 2003)
• Integrated Treatment =
  • Co-located; Cross trained staff
  • Adequate staffing: low staff to client ratios for intensive case management (ACT model)
  • Individualized screening; Flexible
  • Peer support
  • Comprehensive services: housing, employment, HIV/AIDS, Hepatitis
samhsa

- National Registry of Evidence-based Programs and Practices
- [www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov)

forensic treatment: approach

- Balance of Empathy and Accountability
  - Relationship
  - Directive & Confrontive
  - Victim-Centered

forensic: treatment readiness

- Street values vs. treatment values
- Respect
- Self-disclosure
- Snitching vs. accountability
rnr approach
(Andrews & Bonta 2010)

- Risk
- Needs
- Responsivity

dynamic risk factors/criminogenic needs

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

dynamic risk factors
AO U.S. Courts Data 12/2011, 60K PCRAs

- 20% substance abuse
- 30% cognitions (most predictive)
- 65% education/employment
- 80% social networks (2nd most predictive)
ebp for treating offenders

- Cognitive-Behavioral Curriculum-Based Group Therapy
- Examples: Thinking For a Change (T4C) [www.nicic.org](http://www.nicic.org) and Moral Reconciliation Therapy (MRT) [www.moral-reconciliation-therapy.com](http://www.moral-reconciliation-therapy.com)

rnr treatment

(Andrews & Bonta 2010)

- Encourage self-examination by the offender - think before acting, consider consequences, weigh merits of alternative ways of behaving; cognitive self-change
- Model/demonstrate anticriminal expressions
- Reinforcement & approval of anticriminal expressions
- Disapprove of procriminal expressions and demonstrate alternatives

research informed treatment of criminality

- Address Instant Offense and Criminal History
- Confront Anti-social Attitudes
- Eliminate/reduce Anti-social Associations
- Encourage Pro-social thinking and behavior
- Abstinence from alcohol and drugs
- Develop/increase empathy
- Eliminate/decrease impulsive behavior
- Develop/improve life skills
• Abstinence vs. harm reduction
• Recovery in abstinence-based culture maintains cognitive dissonance that offenders need to remain motivated to change (Scott 2008)
• AA designed for pro-socials

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criminal thinking
Samenow 2004; Yochelson & Samenow 2000

• Techniques of neutralization - rationalizations & excuses
  • Denial of responsibility
  • Denial of injury (minimization)
  • Denial of the victim (rationalization/projection)
  • Condemnation of condemners (projection)

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• Appeal to higher loyalties
• Identification w/ criminal others I’m tough, I’m trouble, stuff happens
• Rejection of convention – work & education devalued
• I’m the victim
• No empathy - I’m too important; I’m the victim
• Failure to assume obligation; obligation = weakness
• Failure to assume responsibility
• Lack of trust; trust = weakness
• Narcissism: I’m too slick, too cool to be caught
• Celebration - flashing money; impressing others

• Premeditation - crime rarely impulsive
• Criminal equivalents – recklessness, drugs
• Anti-authority
• Know right from wrong but choose wrong
• Demanding - anger, rage, violence

denial

• Denies vs. Denial vs. Lying
• “Denied” ... implies the client was lying about her past history, and that the clinician knows the real truth. Even if the clinician is not documenting this history with that attitude and is merely saying that the client said she had not been in previous treatment, why is it necessary to use the word “deny”?

David Mee-Lee, M.D. TIPS & TOPICS Volume 6, No. 3 June 2008
Minimization

• “...there is nothing for a client to shave the truth about if you are open to whatever the client is doing. When you approach the client with an attitude that you assume they are lying, it comes across whether you say it directly or not.”  David Mee-Lee, M.D.  TIPS & TOPICS Volume 6, No. 3  June 2008
identification & Intervention of criminal attitudes

• Psychological Inventory of Criminal Thinking Styles (Walters 2002)

• General Criminal Thinking (GCT)
  • Proactive - goal directed; expect positive things to come from criminal behavior - money, status, power; described by others as devious, callous, scheming
  • Reactive - crime more reactive than planned; view the world suspiciously and misinterpret others as hostile; described by others as impulsive & emotional
proactive criminal thinking case example

- PO: “Do you have any special occupational skills?”
- Offender: “Yes, thieving and thugging”

thinking styles

- Mollification/Making Excuses - blame others; use rationalizations & self-justifications; talk about inequity & unfairness in life
  - Intervention: cognitive restructuring - injustices do not excuse or justify their behavior; accept responsibility for negative consequences of their behavior

- Cutoff/Ignoring Responsible Action: “screw it” to eliminate fear, anxiety, or other deterrents
  - Intervention: cognitive restructuring & “stop & think” - develop skills such as patience, tolerance, & emotional control
• Entitlement/Feeling Above the Law - personally exempt from the rules that govern everyone else; “owed” whatever they want; mislabel wants as needs; justify whatever means to meet their “needs”

• Intervention: cognitive restructuring - distinguish wants from needs; develop personal inventory of values/expectancies; point out discrepancies values & behaviors

• Power Orientation/Asserting Power over Others - simplistic view of the world, strong & weak; weak easy to intimidate & use; control surroundings by domination

• Intervention - cognitive restructuring & problem solving; develop personal control & self-discipline

• Sentimentality/Self-Serving Acts of Kindness - try to present selves in as favorable a light as possible; express feelings & interests in self-serving manner; justify behavior by pointing to their positive qualities or good things they have done

• Intervention: cognitive restructuring - good deeds do not erase harmful actions; raise awareness of harm to others
• Super Optimism/Getting Away With Anything - unrealistic assessments of themselves and chances of avoiding consequences of antisocial behavior; undetected crimes reinforce their thinking
  • Intervention: cognitive restructuring - point out how offender has been unable to escape negative consequences of behavior

• Cognitive Indolence/Lazy Thinking - lazy in both thought & behavior; take the path of least resistance; easily bored, may pursue excitement to compensate for shallow & under-stimulating inner world
  • Intervention: cognitive restructuring & problem solving - develop & reinforce critical reasoning skills

• Discontinuity/Getting Sidetracked - fail to follow through on commitments; lose focus on goals; easily distracted; quickly give up; leave tasks uncompleted; difficulty maintaining any commitment to change
  • Intervention: the most difficult to confront; regular feedback & goal-setting
peers & leisure/recreation

• Encourage prosocial associations & avoidance of high risk situations; ask offender what s/he is doing on Friday & Saturday nights & with who?
• Use of free time?
• Encourage prosocial hobbies/leisure/recreational activities (Andrews & Bonta, 2010)

where is treatment going next?

• Family therapy?
• Offenders cite family as most influential in staying out of prison (Solomon et al. 2008)

• Gender specific?
• Gendered pathways (Rettinger & Andrews 2010)
• RNR + target female risk factors: child abuse, drugs, poverty, relationships, trauma, mental illness, parenting (Ney, Van Voorhis, & Lerner 2011)
• DBT & Seeking Safety (Bast 2008)
• Treatment works, even if mandated.
  • (Scott 2008; NIDA 2006)

What does not work with offenders

• Non-Directive
• Targeting Self-Esteem
  • (Latessa & Lowenkamp 2005; Latessa 1999; Gendreau 1996)
collaboration with probation & parole: treatment & public safety

- Confidentiality/Release of Information
  - Details? (Scott 2008)
  - No Shows
    - "If a client does not show up for even a second appointment, the treatment provider should consider (italics added) informing the Probation Officer that the client may be out of compliance with agreement to do treatment"
    - David Mee-Lee, M.D.
    - TIPS & TOPICS Volume 7, No. 1, April 2009

- Positive Tests
  - "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."
    - David Mee-Lee, M.D.
    - TIPS & TOPICS Volume 7, No. 1, April 2009

- Reliance on self report vs. collaterals?
  - Persons on disability in Los Angeles: 49% of income to drugs and alcohol
    - (Shaner et al., 1995)
  - Don’t minimize cost of property crimes - each incarcerated person results in prevention of 15 crimes
    - (King, Mauer, & Young 2005)
  - Serious crime -- bank robbery & heroin addiction
collaboration

- Multiple clients - the client/offender, the community, the probation officer (Scott 2008)
- our Charter For Excellence: Effective stewards of public resources

summary & conclusion
(Clement et al. 2011)

- “Screening and assessment strategies that incorporate both of these two key dimensions - risk of recidivism and needs based on functional impairment - do not exist in most communities”

- “Even if dynamic risk factors have been identified, most behavioral health treatment options for people with mental illnesses or co-occurring substance use disorders who are under community supervision do not address these risk factors for criminal behavior” (Clement et al. 2011)
• "From a strictly public safety perspective, criminal justice treatment dollars should be prioritized for people with high functional impairment who present a high risk of recidivating ... For individuals who either present less criminogenic risk or have lower functional impairments, interventions should be time-limited and targeted to specific goals" (Clement et al. 2011)

• “correctional quackery” (Flores et al. 2005)
  • Quackery = common sense or tradition over scientific evidence
  • Unscientific services -- no change or can increase antisocial behavior

the pendulum?

• Punishment vs. rehabilitation
q&a

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