American Psychological Association

Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment


NOTE: There are two Forensics modules. They are designed to be used together and are not intended to be used separately or as stand alone modules

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Overview

This is the second of two modules that consider issues related to people with serious mental illnesses in the forensic/criminal justice system. The two modules are designed to be used together; they cannot stand alone as the content of any one is not sufficient to understand the issues or provide recovery oriented psychosocial rehabilitation (PSR) interventions.

In the first Forensics module, information was presented about the prevalence of people with serious mental illnesses who are in contact with the forensic/criminal justice system and about the many co-occurring factors that impact on the lives of the people involved. These factors include homelessness, co-occurring substance abuse, trauma and physical ill health.

This second module in the Forensics series presents information about the interventions recommended to help people avoid re-incarceration and achieve a stable and satisfying life in the community. Given the complexity of the issues involved, release planning and intervention efforts must also be complex and information about this critical component is also presented.

In both of the Forensic/Criminal Justice System modules, the terms forensic and criminal justice system are frequently used interchangeably. In some jurisdictions, the forensic system refers to inpatient settings while in others, it refers to the totality of the criminal justice system. In some settings, jails, prisons, mental health courts, jail diversion programs are considered to be part of the forensic system, while in others, they are called by a different system name. For clarity, in both of the Forensics modules, the terms are used interchangeably, although it is recognized that there are often critical distinctions within these systems.

It is important to note however, that forensic psychiatric hospitals and jails/prisons are very different. For the most part, forensic psychiatric hospitals provide at least minimal levels of treatment, i.e., psychotropic medications (sometimes over medicating individuals), traditional assessment, and varying kinds and levels of interventions. For the most part, jails and prisons, despite their status as the largest “warehouser” of individuals with mental health disorders, provide little to no treatment (although in rare cases, some jails/prisons have become designated mental health providers) and sometimes keep individuals (particularly those with disabilities of all kinds) in isolation, padded cells, etc., with no access to toilet facilities, fresh air, exercise, medication, or other essentials of human life, except for food passed through a small opening in the door.

While the deplorable conditions of jails and prisons may make forensic psychiatric hospitals appear to be stellar institutions, for the majority of U.S. jails, prisons, and forensic psychiatric hospitals, there are not adequate or appropriate services for people with serious mental illnesses in any setting. Though they are distinct, the Forensics modules in this curriculum treat them similarly because of the paucity of literature on either category and
because both have major hurdles to overcome in order to provide the services needed by people with serious mental health conditions.

**Learning Objectives**

At the end of this module you will be able to:

- Identify four confounding factors most often experienced by people with serious mental illnesses who are in the forensic/criminal justice system
- State the two overarching findings for achieving community citizenship, e.g., chosen social and community roles, community tenure, economic self-sufficiency, etc.
- List the six interventions for people with serious mental illnesses in the forensic/criminal justice system that currently have good research support
- Describe four reasons why transition planning and follow up are essential
- Discuss nine of the essential elements critical to transition planning and follow up

**Resources**

- Lecture Notes
- Required Readings
- Lecture Notes Citations
- Sample Learning Activity
- Sample Evaluation Questions
- Additional Resources

**Required Readings**


Substance Abuse and Mental Health Services Administration GAINS Center for Behavioral Health and Justice Transformation. (undated-a). *Treatment of People with Co-occurring Disorders in the Justice System*. Available at: gainscenter.samhsa.gov/html


**Activities**

Complete the following activities:

- Read the lecture notes
- Read the required readings
- Engage in a learning activity related to this module
- Evaluate students’ understanding of this module.
Lecture Notes

People with lived experience of serious mental illness are strongly encouraged to be part of the delivery of the curriculum including being active participants in the delivery of the lecture. Refer to the curriculum Instruction module for additional information.

Introduction

In the U.S. it is often said that jails and prisons have become the largest mental health treatment venue (McNiel, Binder & Robinson, 2005; Steadman, Osher, Robbins, Case & Samuels, 2009). However, little real treatment is provided in these settings and where any treatment is provided, it is most often psychotropic medication and little else. Moreover, when medication is provided, the prescribed dosage can be more than what might be prescribed in a non-criminal justice setting due to the focus on managing risk in these settings.

The reasons for the paucity of treatment are complex and relate to the double stigma of the illnesses and criminality, dwindling resources, and a corrections mentality that is often at odds with a treatment mentality. All of these make provision of effective services, especially those that are recovery oriented, challenging.

As discussed in the first Forensics module, forensic and criminal justice settings are antithetical to the concept of recovery for people with serious mental illness. Individuals who are in these systems have little free choice and often have serious threats to their own safety. Thus, in most, although not all, forensic/criminal justice settings, there is little recognition of, or ability to provide services consistent with the recovery paradigm and to offer services designed to help people learn the skills they need to achieve their life goals (Simpson & Penney, 2011). This is not always the case, and in many settings, mental health professionals are desirous of offering recovery oriented rehabilitation services. Due to the emphasis on risk management that is prevalent in most justice related systems, this is frequently not possible however.

Despite the fact that respect, autonomy, person centered care, hope, evidence based practices, etc. are currently not typically conceptualized as part of the forensic system/criminal justice system, there are some examples of forensic systems that have implemented recovery oriented services. Fulton State Hospital in Missouri has been a leader in these efforts (Newbill, Paul, Menditto, Springer & Mehta, 2011), and there are others where individual mental health professionals are desirous of doing so (Tapp, Warren, Fife-Schaw, Perkins & Moore, 2013).

Most mental health practitioners who work in forensic/criminal justice settings do not understand the adaptive behaviors that must be learned if one is to blend in, avoid abuse, and survive in an environment where coercion can come at the hand of other inmates and or at the hands of guards and officials – this is particularly true in jails and prisons. Mental health practitioners need to understand the complex dynamics of forensics/criminal justice...
settings and assist the people they work with to learn healthy behaviors that will help them adapt in the community and avoid re-incarceration (Rotter, McQuistion, Broner & Steinbacher, 2005). Given the increasing census of correctional systems and the decreasing budgets allocated to these systems, implementing recovery oriented best practices remains a desirable but elusive goal for most.

Research on clinical interventions for people with serious mental illness in forensic settings has been limited, with much of that research aimed principally at reducing re-arrest, although some attention has been given to symptom improvement. In the forensic/criminal justice arena, there are several reasons for the limited research and the emphasis on reducing re-arrest, chief among them is the fact that those who have committed a crime have not been viewed as candidates for clinical services, largely due to the emphasis on risk management in these settings. This approach has been questioned more frequently in recent years due to the high cost of maintaining increasing numbers of individuals in expensive institutional settings, and because of the social implications of failing to help mentally ill offenders achieve a satisfying and productive life in the community. Research is also resource intensive and it can be difficult if not impossible for forensic systems that are continually facing budget cuts to choose between continuing to house people versus conducting research on the best ways to achieve long term solutions even though such long term solutions will ultimately benefit the systems and the people in them. Some have suggested a more collaborative approach, which includes asking the affected individuals what would best help them (Tapp, Warren, Fife-Schaw, Perkins & Moore, 2013); this collaborative approach is not normative however in the forensic/criminal justice system.

Among the more prominent endeavors has been research aimed at improving adaptive behavior deficits to help individuals learn more pro-social behaviors in order to integrate more successfully into the community. Social learning programs based on the work of Paul and Lentz (1977) are the basis for these efforts which have achieved success in multiple residential settings, including forensic psychiatric hospitals (Beck, Menditto, Baldwin, Angelone & Maddox, 1991; Lyskowski, Menditto & Csernansky, 2009; Newbill, Paul, Menditto, Springer & Mehta, 2011; Silverstein, Spaulding, Menditto, Savitz, Liberman, et al., 2009). Social learning programs aim to teach skill development, including communication and other social skills, increase an individual’s capacity for self-care, and improve cognitive skills such as attentional capacity, problem-solving skills, etc., and help people learn more appropriate leisure skills (Newbill, Paul, Menditto, Springer & Mehta, 2011). While not common in forensic psychiatric hospitals, where provided, these programs have achieved remarkable success.

Like research, providing complex planning and intervention strategies is resource intensive. Unfortunately the forensic/criminal justice system is significantly under resourced and becoming ever more challenged by the growing census of people who are mentally ill, homeless, have co-occurring substance abuse disorders, are physically ill, and have been severely abused and traumatized. Thus, it is important to recognize that simply providing
one or more interventions will not solve the multitude of problems faced by individuals within this population. Rather, a set of services designed for, and with, the individual and tailored to his or her complex needs must be provided if we are to help people break the cycle of incarceration, release, symptom exacerbation, and re-incarceration (Epperson, Wolff, Morgan, Fisher, Frueh & Huening, 2011).

Driven often by intervention from the U.S. Department of Justice, but also by the independent recognition of a need to improve the quality of services provided, many state-run forensic psychiatric hospitals are further along in incorporation of recovery approaches and inclusion of a range of services than are prisons and jails. The kinds of treatments that can be found in modern, well-run forensic psychiatric hospitals (such as Fulton State Hospital in Missouri) include a range of treatments identified as effective, promising, and supporting, and are described in the Interventions modules of this curriculum.

Recently forensic and criminal justice mental health professionals have begun to think about using interventions already shown to be effective with non-forensic populations with those in forensic and criminal justice settings. A few of the evidence based practices (EBPs) discussed in the second interventions module of this curriculum (Interventions II) have been adapted and tested for this population as have some of the promising practices and supporting services discussed in Interventions III. Initial results indicate some success with some individuals. Results are not clear cut however, as there are several different settings within the overall forensic/criminal justice system, and because of the diversity of the population which ranges from people who have committed petty crimes to those who have committed capital offenses and also ranges from people with less serious mental health disorders to those with very severe mental illnesses. It can also be difficult to recruit subjects who are willing to participate in research studies; further there is a high drop out rate from such studies and from treatment. All of these factors make drawing consistent conclusions about the effectiveness of an intervention with varied populations difficult.

Not withstanding the above, two overarching findings that have emerged consistently across settings and populations are the following:

1. Combining mental health interventions with forensic supervision is necessary to achieve success; often multiple interventions are needed.

2. The intensity of both the clinical intervention and the forensic supervision must be matched to the level of risk or recidivism of the individual with greater intensity afforded to those at higher risk. In the forensic/criminal justice literature, this is called the Risk-Needs-Responsivity principle (Andrews, Zinger, Hoge, Bonta, Gendreau & Cullen, 1990; Blackburn, 2004; Prins & Draper, 2009).

The Risk-Needs-Responsivity principle is widely accepted as the premier model for guiding assessment and treatment in forensic settings. A recent adaptation is the Good Lives Model which places greater emphasis on a strengths based approach (Barnao, 2013), but which does not differ substantially in content from the Risk-Needs-Responsivity principle
according to recent reviews (Andrews, Bonta, & Wormith, 2011). However, from the perspective of providing services that are oriented toward helping people recover and achieve a satisfying and productive life in the community, some have called into question the ethics of following these models because of their reliance on controlling risk as the basis for providing services instead of focusing on establishing a true therapeutic partnership and providing the best services available (Gannon & Ward, 2014). Given the current emphasis on controlling real or perceived risk, the debate about what is most appropriate is likely to continue.

Interventions for People in Contact with the Forensic/Criminal Justice System

Although intervention research related to these settings is limited, three clinical EBPs (assertive community treatment, cognitive behavioral therapy, concurrent disorders treatment (also known as integrated dual diagnosis treatment) and some promising/supporting practices (trauma informed care, supported housing) have been studied in forensic/criminal justice settings. Additionally, an intervention that includes mental health interventions and that was developed specifically to address individuals in the justice system (the mental health court) has been tested. These interventions are discussed below.

In addition, other interventions, most often based on cognitive behavioral approaches, are often offered in various justice related settings and some of these have begun to show positive results (Haddock, Barowclough, Shaw, Dunn, Novaco & Tarrier, 2009; Tew, Dixon, Harkins & Benett, 2012). Systematic reviews of published studies have also begun to provide evidence that interventions to help people with serious mental illnesses in forensic systems can be beneficial (Duncan, Nicol, Ager & Dalgleish, 2006; Mancini, Linhorst, Menditto & Coleman, 2013; Martin, Dorken, Wamboldt & Wootten, 2012). For the most part, research on these efforts is in early stages. Consequently, the following discussion is limited to what is currently known about using the existing EBPs, promising and supporting services, and mental health courts, in forensic settings.

Forensic Assertive Community Treatment (FACT)

FACT is a version of the EBP Assertive Community Treatment (ACT), modified for use in the forensic system. FACT combines mental health and criminal justice involvement through collaboration between the two systems and is described as follows:

Forensic Assertive Community Treatment (FACT) is distinguished from ACT in four ways: participants have criminal justice histories, preventing arrest and incarceration are explicit outcome goals, the majority of referrals come from criminal justice agencies, and supervised residential treatment is incorporated into the program (Prins & Draper, 2009, p. 27).
People with serious mental illnesses in the varied parts of the criminal justice/forensic system are very diverse. Because of this, FACT and other interventions are typically provided in a wide array of settings. In addition to use in community settings for individuals with serious mental illnesses released from the criminal justice system, FACT has been used in jail diversion programs and in prison re-entry programs. Recently, characteristics of individuals in these two settings have been found to be very different. Prison re-entry consumers are more likely to be older, male, have schizophrenia, and be in assisted living, while jail diversion consumers are more likely to be female, have mood and substance use disorders, be living independently, and have been physically and sexually abused. Given these differences, FACT and other intervention programs need to be tailored to meet the needs of the group they are to be serving. Services for older and more ill individuals likely need to focus on providing help with independent living skills while services for younger, less severely ill persons may need to be aimed at helping people achieve successful and stable transition to more normalized community life (Cuddeback, Wright & Bisig, 2013).

Outcome studies for FACT in a variety of settings have yielded mixed results but several have shown decreased recidivism, improved community treatment engagement, and reductions in overall spending (Cusack, Morrissey, Cuddeback, Prins & Williams, 2010; Lamberti, Deem, Weisman & LaDuke, 2011; Prins & Draper, 2009). FACT is currently considered to be a promising practice for helping people in the forensic system who serious mental illnesses avoid re-incarceration and remain in the community. The services and the intensity of those services need continued study to determine which combination works best for consumers with varying needs and in different settings.

**Cognitive Behavioral Therapy (CBT)**

The research literature is replete with recommendations for use of interventions based on CBT with incarcerated individuals with mental illness and particularly for those with conduct disorders and antisocial personality disorder, principally aimed at controlling anger and reducing aggression (Novaco, 2013; Wilson, Gandolfi, Dudley, Thomas, Tapp & Moore, 2013). Recent research has also shown promise for helping individuals with schizophrenia achieve better interpersonal functioning (Williams, Ferrito & Tapp, 2014), and helping individuals reduce the impact of substance misuse (Morris & Moore, 2009). Additionally, medication and psychoeducation combined with CBT have been found to be beneficial (Tapp, Perkins, Warren, Fife-Schaw & Moore, 2013). A recent meta-analysis of the effectiveness of CBT for corrections populations concluded that its use can substantially decrease recidivism (Lipsey, Landenberger & Wilson, 2007). This review found that several factors were related to increased success including adequate training for the clinician providing the intervention, skills training targeted at specific problem behaviors, the risk level of the participants, the quality of the treatment implementation, and the presence of anger management strategies and interpersonal problem solving components.
One CBT program that was designed specifically for forensic populations has been extensively evaluated, the Reasoning and Rehabilitation CBT intervention program (Fabiano, Porporino & Robinson, 1990; Porporino & Fabiano, 2000). The program has been implemented in several countries including the United States, Canada, England, Wales, Scotland, each of the Scandinavian countries, Spain, the Canary Islands, Germany, Australia and New Zealand. The program has consistently demonstrated good results (Tong & Farrington, 2006; Young, Chick & Gudjonsson, 2010). Cognitive-behavioral programs for this population typically address attributes most related to criminal behavior and that may be most amenable to change. These include such factors as impulsivity, inability to control anger, violent behavior, maladaptive patterns of thinking, antisocial behaviors and attitudes, associations with pro-drug and antisocial peers, poor social skills, and drug use.

**Concurrent Disorders Treatment (Integrated Dual Diagnosis Treatment)**

The rate of co-occurring substance abuse and mental health disorders among forensic/criminal justice populations is extremely high, estimated to be 72% of both males and females in the corrections system (Abram & Teplin, 1991) and it is widely acknowledged that integrated treatment must be a cornerstone of efforts to assist persons to remain out of prison and achieve success in the community (Osher & Steadman, 2007; Prins & Draper, 2009). Unfortunately, needed treatments are not readily available; this is also widely acknowledged.

The components of a concurrent treatment approach include psychotropic medication, Motivational Interviewing, and CBT interventions.

The U.S. National Institute on Drug Abuse (NIDA) recently issued a revised report based on the latest research entitled Principles of Drug Abuse Treatment for Criminal Justice Populations. Due to the very high rates of co-morbid mental health and substance abuse disorder in forensic psychiatric populations, these principles could guide the provision of services for this population. The principles articulated by NIDA include:

1. Drug addiction is a brain disease that affects behavior.
2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
3. Treatment must last long enough to produce stable behavioral changes.
4. Assessment is the first step in treatment.
5. Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.
6. Drug use during treatment should be carefully monitored.
7. Treatment should target factors that are associated with criminal behavior.
8. Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.

9. Continuity of care is essential for drug abusers in re-entering the community.

10. A balance of rewards and sanctions encourages prosocial behavior and treatment participation.

11. Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.

12. Medications are an important part of treatment for many drug abusing offenders.

13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis (U.S. Department of Health and Human Services, 2012).

The SAMHSA GAINS Center’s publication entitled Treatment of People with Co-occurring Disorders in the Justice System (undated-a) is an excellent document that succinctly outlines what providers need to do to help people with co-occurring disorders. These are:

- Engage the person and encourage commitment
- Take steps to ensure continuity of care from one setting to another
- Provide comprehensive services
- Provide on-going assessment and services tailored to the needs of each individual.

The document also outlines the key strategies needed:

- Provide integrated treatment for both the mental health disorder and the substance abuse disorder; both should be considered primary disorders and treated as such
- Design individual psychosocial and skills building interventions that are tailored to the needs and goals of each person
- Review all medications and ensure that appropriate ones are used. Inform each person about the complications that can be caused by use of alcohol and other drugs
- Ensure community connections that follow through with release planning for continuity
- Integrate therapy with self help groups and support (p. 3).

**Trauma Informed Care**

The prevalence of exposure to trauma is so high for individuals in the criminal justice system that it should be considered the norm (Osher & Steadman, 2007). For both men and women who are under probation supervision, 39 percent of those with mental illnesses,
compared with 12 percent of people without mental illnesses, reported being abused before their arrest (Prins & Draper, 2009). This figure does not include individuals in jails, prisons, or forensic psychiatric hospitals. If all those in the forensic system were included, the figures would likely be much higher. As described by Jennings, (2008, p. 2):

Many of the individuals ... have developed extreme coping strategies, in childhood, adolescence and as adults, to manage the impacts of overwhelming traumatic stress, including suicidality, substance abuse and addictions, self-harming behaviors such as cutting and burning, hallucinations, emotional numbing and dissociation, hypervigilance, somatization, aggression and rage, re-enactments such as abusive relationships, and serious health risk behaviors (Saakvitne et al., 2000; Dube et al., 2001; Felitti et al., 2002; Felitti, 1998; Hammersley, 2004; Sareen, 2005; CDC, 2005)...For the most part these individuals have never received screening, assessment or treatment for trauma. (Cusack, Frueh, & Brady, 2004; Frueh et al., 2002; Mueser et al., 1998). The situation is similar for children in the mental health service system. Although many have histories of severe interpersonal violence and multiple adverse childhood experiences, recognition of the trauma underlying their behaviors and diagnoses typically does not occur (Hodas, 2006; Perrin et al, 2000).

And from Herman:

The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants. Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992, p. 22).

According to SAMHSA:

Trauma-specific treatment services are “interventions designed to address the specific behavioral, intrapsychic, and interpersonal consequences of exposure to sexual, physical, and prolonged emotional abuse” (Substance Abuse and Mental Health Services Administration, 2000).

Harris and Fallot, 2001 described a trauma informed system as:

A “trauma-informed” system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of adults, children and adolescents and families or caregivers seeking mental health and addictions services (Harris & Fallot, 2001). A “trauma informed” system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely
knit collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical expertise in “traumatology”.

In contrast, trauma specific services are described as:

“Trauma-specific” services are designed to treat the actual sequelae of sexual or physical abuse trauma. Examples of trauma-specific services include grounding techniques which help trauma survivors manage dissociative symptoms, desensitization therapies which help to render painful images more tolerable, and behavioral therapies which teach skills for the modulation of powerful emotions (Harris & Fallot, 2001). Treatment programs designed specifically for survivors of childhood trauma are consistent on several points: the need for respect, information, connection, and hope for clients; the importance of recognizing the adaptive function of “symptoms;” and the need to work in a collaborative empowering way with survivors of abuse (Saakvitne, 2000).

Though interventions designed to assist people who have experienced trauma are not yet an EBP, there has been research to support the efficacy of some specially developed interventions in the justice system (Prins & Draper, 2009; Substance Abuse and Mental Health Services Administration GAINS Center for Behavioral Health and Justice Transformation, 2011).

A recent review of interventions for people with serious mental illness and severe trauma found that both cognitive behavioral treatment (combined with psycho-education about traumatic reactions most often referred to as PTSD, breathing retraining, and cognitive restructuring) (Mueser, Rosenberg, Xie, Jankowski, Bolton, Lu, et al., 2008) and exposure therapy (combined with group therapy focused on education, relaxation training and social skills building) (Frueh, Grubaugh, Cusack, Kimble, Elhai & Knapp, 2009) were found to be effective, with the cognitive behavioral treatment program evaluated in the largest clinical trial conducted to date. This comprehensive review notes that continuing research is needed to address the extremely important but often overlooked issue of addressing trauma experienced by people with serious mental illnesses (Grubaugh, Zinzow, Paul, Egede & Frueh, 2011).

Elements common to many treatment modalities for PTSD include education, exposure, exploration of feelings and beliefs, and coping-skills training. CBT is common to many of the treatment paradigms. Components of these paradigms are listed in the excerpt below, taken from the website of the U.S. National Center for PTSD:

Cognitive-behavioral therapy (CBT) involves working with cognitions to change emotions, thoughts, and behaviors. Exposure therapy is one form of CBT that is unique to trauma treatment. It uses careful, repeated, detailed imagining of the trauma (exposure) in a safe, controlled context to help the survivor face and gain control of the fear and distress that was overwhelming during the trauma. In some
cases, trauma memories or reminders can be confronted all at once ("flooding"). For other individuals or traumas, it is preferable to work up to the most severe trauma gradually by using relaxation techniques and by starting with less upsetting life stresses or by taking the trauma one piece at a time ("desensitization") (www.ncptsd.va.gov).

Along with exposure, CBT for trauma includes:

- Learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts (cognitive restructuring)
- Managing anger
- Preparing for stress reactions (stress inoculation)
- Handling future trauma symptoms
- Addressing urges to use alcohol or drugs when trauma symptoms occur (relapse prevention), and
- Communicating and relating effectively with people (social skills or marital therapy).

One program that has several versions and has been tested with various populations including individuals in the forensic system with good initial results is Seeking Safety (Najavits, 2009). For more in-depth information about trauma interventions see the module in this curriculum entitled Interventions III.

**Trauma Informed Care for Women**

Several studies have reported the extremely high rates of abuse for women in the forensic/criminal justice system. The traumatic experiences of women put them at heightened risk for PTSD and other anxiety disorders with 34 percent meeting criteria for PTSD (Alvorado, 2002). The U.S. Bureau of Justice Statistics found that 73% of the women in state prisons and 75% of women in local jails have symptoms of mental disorders, compared to 12% of women in the general population. Three-quarters of the women who had a mental health problem also met criteria for substance abuse or dependence (James & Glaze, 2006).

The issue of services for women in the forensic system deserves special attention. It has been estimated that the likelihood of a woman entering the criminal justice system with a substance use disorder is 9 times the rate for women in the community and up to 48 times the rate for non-Hispanic white women aged 26 – 50 in the community (Teplin, Abram & McClelland, 1996.) While these data are not specific to women with serious mental illnesses, it may be that the extraordinarily high rate of substance abuse among women in the forensic/criminal justice system is the result of their attempt to erase the memories and pain of physical and sexual abuse.
Women with mental health problems who do not receive appropriate mental health treatment while in the forensic/criminal justice system are highly vulnerable and at high risk for homelessness, violence, further abuse and trauma, and repeated involvement in the criminal justice system when they are released (Smith, Simonian & Yarussi, 2006).

Because most of the trauma experienced by women has been at the hands of men, women with a history of abuse by men will be unable to work through those issues in a mixed group; a mixed trauma group can actually exacerbate their trauma making gender specific interventions developed for women essential. Trauma treatment should be designed to provide a safe and secure environment where trust can be developed. Interventions designed to help women deal with the effects of trauma should be offered by trained women clinicians and in women-only groups. The Seeking Safety program mentioned above has been adapted for women in prison settings and has demonstrated sustained benefits for this population (Lynch, Heath, Matthews & Cepeda, 2012; Zlotnick, Johnson & Najavits, 2009).

**Supported Housing**

Many of those with serious mental health disorders often have no place to live when they are discharged. These individuals, most of whom have also experienced trauma and may have been re-traumatized by the criminal justice experience, find themselves living on the streets and at risk of being re-traumatized, continued abuse of alcohol and other drugs, and re-incarceration. Supported housing, which is typically offered in conjunction with FACT, has been suggested as an approach that may be beneficial for helping these individuals to become connected with the treatment system and remain out of the forensic/criminal justice system.

Some studies have found that supported housing can improve outcomes for this population by helping people connect with treatment services that can lead to reduced incarceration rates (Culhane, Metreaux & Hadley, 2002; Osher & Steadman, 2007; Prins & Draper, 2009). Clearly, individuals need stable housing and having a safe and secure place to live coupled with help to remain connected with treatment services makes sense. All too often, resources to provide supported housing, FACT and other needed services are limited, making it difficult for people with serious mental illnesses who have been in the forensic/criminal justice system to achieve stability and a satisfying life in the community (Prins & Osher, 2009).

**Mental Health Courts**

Mental health courts have been introduced in several jurisdictions throughout the U.S. and in Canada. Mental health courts are specialized court dockets that deal exclusively with people with mental health disorders in the criminal justice system. These courts combine community treatment services for people with serious mental illness with criminal justice supervision and have the following goals:
...to improve public safety by reducing criminal recidivism; to improve the quality of life of people with mental illnesses and increase their participation in effective treatment; and to reduce court- and corrections-related costs through administrative efficiencies and often by providing an alternative to incarceration (Almquist & Dodd, 2009, p. v).

Mental health courts are used for individuals who can be adjudicated to community supervision. The combination of criminal justice supervision with community treatment holds promise of helping individuals with serious mental illnesses avoid incarceration, increase community tenure and achieve stability. Almquist & Dodd, 2009, offered the following related to mental health courts:

Research has found that participants in some mental health courts have lower rates of recidivism than individuals with mental illnesses processed through the traditional criminal court system. Some research findings indicate that this trend continues after individuals are no longer under court supervision. Mental health courts have also been found to connect participants with mental health treatment services more effectively than do the traditional court system and jails. In addition, mental health courts have the potential to save money through reduced recidivism and associated savings in jail and court costs. Also, treatment costs are reduced by avoiding expensive inpatient care (p. vi).

Although chiefly a criminal justice intervention for individuals who are not incarcerated, the principle of coordinated care that mental health courts embody is one that the mental health service delivery system has been advocating for years. Combined with a range of interventions provided at the intensity needed by this population, and when implemented with competent and knowledgeable court outreach personnel who assist individuals to access needed health mental health, and legal services, it may be that mental health courts hold promise of helping individuals remain out of the forensic/criminal justice system and achieve a stable and satisfying life in the community (Sylvestre, Aubry, Smith & Bridger, 2010).

It must be noted however, that factors such as community isolation, social disadvantage, poverty and stigmatization will impede the success of interventions aimed at helping individuals achieve successful re-integration into the community. A wide range of interventions aimed at ensuring proper housing, successful employment if the person is able to work, help with medical and mental health follow up, and community integration that diminishes stigmatization are all necessary to help individuals in this population succeed (Barrenger & Draine, 2013).
Transition Planning and Follow-up for Incarcerated People with Serious Mental Health Disorders

For people who are being discharged from forensic and criminal justice settings, providing adequate and appropriate transition planning and follow up are crucial (Cuddeback, Wright & Bisig, 2013). The failure to provide the needed planning and follow up is a major reason for the revolving door of release, illness, substance use, homelessness, trauma, and re-incarceration that afflicts this population.

Almost all jail inmates with co-occurring mental illness and substance use disorders will leave correctional settings and return to the community. Inadequate transition planning puts people with co-occurring disorders who enter jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness, and re-arrest (Osher, Steadman & Barr, 2002, p. 1). Inadequate transition planning puts people with co-occurring disorders who entered the jail in a state of crisis back on the streets in the middle of the same crisis (p. 3).

A comprehensive model to address the problem and provide guidance for how to ensure that coordinated and integrated planning and follow up services are delivered has been developed and is called the APIC model (Osher, Steadman & Barr, 2002). The model consists of the following components:

- Assessment of the person’s clinical and social needs, and public safety risks
- Planning for the treatment and services required to address the person’s needs
- Identifying required community and correctional programs responsible for post-release services
- Coordinating the transition plan to ensure implementation and avoid gaps in care with community-based services.

The authors stress that planning must take the following into account:

- The period immediately after release is critical – the first hour, day or week can determine success or failure and high intensity interventions that support the person during this time are essential;
- The person him or herself must be engaged and asked what helped or hindered success following previous incarcerations – this is considered the most important part of the assessment and planning process;
- Seeking input from family members;
- Addressing housing and the other multiple needs of the person;
• Naming specific community referrals that are appropriate for the person’s medical, mental health, social and economic needs and forwarding a copy of the person’s discharge summary to the community provider;

• Connecting the person with appropriate medical resources and making needed appointments;

• Ensuring that the person has an adequate supply of appropriate medication that will last until the first follow up appointment;

• Initiating applications for needed benefits (Medicaid, SSDI/SSI, veterans benefits, food stamps, Temporary Assistance for Needy Families (TANF), etc.

• Ensuring that the person has:
  ○ Adequate clothing
  ○ Resources to obtain adequate nutrition
  ○ Transportation from jail to place of residence and from residence to appointments
  ○ A plan for childcare if needed that will allow him or her to keep appointments (Osher, Steadman & Barr, 2002, p. 8–9).

Transition planning must attend to the cultural, racial, gender and age related factors that are important to ensure the person is linked to services that are accepting and compatible (Hicks, 2004; Osher, Steadman & Barr, 2002; Rotter, Mcquistion, Broner & Steinbacher, 2005).

To ensure the person has as much support as needed to follow through with services, it is crucial to explicitly inform the person him or herself, the family, those in the releasing facility and the treatment providers in the community of the names and contact information for the person(s) responsible for following up between the time of release and the first follow-up appointment. On-going support is essential, as is a mechanism to stay in touch with the individual and reach those who miss the first follow-up appointment to reschedule and get the person back on track with the transition (Osher, Steadman & Bar, 2002). Connecting people with their communities and ensuring that follow-up and help with all needed aspects (housing, employment, medical and mental health services, normalized leisure and socialization to diminish stigma, etc.) is essential (Barrenger & Draine, 2013).

Challenges

The challenges facing psychologists and others desirous of finding and implementing interventions that help people with serious mental illnesses in the forensic/criminal justice system achieve their goals and live a satisfying life in the community include little research to guide decisions, few resources to undertake the studies needed and to implement recommended interventions, stigma and resistance to the concept of recovery and
rehabilitation for this population, an over emphasis on controlling risk, and the complexity of the problems individuals face.

In order to overcome these challenges, psychologists must be willing to partner with colleagues in the justice system to leverage resources and establish joint working relationships in order to provide the coordinated supervision and clinical interventions that are crucial to help people with serious mental illnesses overcome the multiple issues they face and achieve stability in the community. Leveraged resources and joint working partnerships can also help psychologists develop and carry out needed research to identify which interventions can be of most benefit for individuals in this population and under which conditions the greatest success can be achieved. Factors such as severity of trauma experienced, differential diagnoses, degree of symptomatology, degree of behavioral adaptation to the corrections environment, motivation for change, etc., are all factors that may impact on outcomes for this population – a group that is greatly in need of effective interventions to assist them to live well in the community and avoid re-incarceration.

Due to the deplorable conditions that people with mental health disorders (and disabilities of all kinds) find themselves in when it comes to jails, prisons, and to a much lesser extent forensic psychiatric hospitals, psychologists have an ethical responsibility to advocate for fundamental attitudinal change on the part of authorities who subscribe to a containment and risk management approach and to bring their knowledge of mental health recovery to forensic and criminal justice settings. Psychologists excel at finding research opportunities, obtaining funding to test promising practices in new settings, and translating the results of research into clinical practice. There are few populations more in need of this expertise than people in forensic and criminal justice settings and few institutions more worthy of utilizing this expertise of psychologists than those of the justice system.

**Summary**

Despite the overwhelming numbers of people with serious mental illnesses in forensic and criminal justice settings, little real treatment is too often the norm, especially in jails and prisons. There are some noteworthy exceptions and mental health professionals are often desirous of providing recovery oriented rehabilitation services. In some institutions important research and clinical work is underway. However, lack of resources and a prevailing emphasis on risk management typically make this difficult to achieve in many settings.

Despite these challenges, some interventions have shown promise and several are recommended for people with serious mental illnesses in forensic/criminal justice settings including forensic assertive community treatment, cognitive behavioral therapy, concurrent disorders treatment, trauma informed care, and supported housing. Mental health courts, a specialized court docket dedicated to cases involving people with mental health disorders, combines forensic supervision with mental health interventions and has shown good results. Two principles have emerged from the forensic and clinical literature: combined
forensic supervision and mental health treatment are necessary, and the intensity of both the supervision and clinical interventions must be matched to the needs of the individual. For individuals who are in the justice system, transition planning and follow up are crucial to avoid the revolving door that so many people with serious mental illnesses face. If released without a solid transition plan for stable housing, medical care, community intervention, establishing support and friendships, skills training tailored to each person’s needs and wishes, and without intense supervision and continued follow-up, most will end up on the streets, abusing drugs, the victims of abuse, and ultimately re-incarcerated.
Sample Learning Activity

For this activity, the large group can remain together as one group unless it is a very large group, in which case it can be divided into two groups. The activity has two parts. Each part has a discussion component following the activity.

Part 1. The first part is a round robin where everyone is to finish the sentence by filling in the blank following each word. The sentence with each word to be completed is:

Someone with serious mental illness who has been physically or sexually abused is picked up by the police and:

feels_______

is__________

wants_______

wishes_______

After each person in the group has taken a turn at filling in the remainder of the sentence after each word, the group is to ask each other questions about why the person gave each response, and discuss what alternate responses might be. The discussion should be based on what was learned from the content of this module.

Part 2. The second part of the activity consists of a group discussion about what each person thinks is the most important thing he or she could do for an individual with serious mental illness in the forensic system. Each person is to give one response. When all have given one response, the group is to discuss the responses and individuals should indicate why they agree or disagree with others’ responses.
Sample Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Correct Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The two overarching findings from forensic and mental health research are:</td>
<td></td>
</tr>
<tr>
<td>a) the population is extremely varied and results are inclusive</td>
<td></td>
</tr>
<tr>
<td>b) subjects are difficult to recruit and drop out frequently</td>
<td></td>
</tr>
<tr>
<td>c) forensic supervision and mental health treatment are essential and both must be matched to the individual level of risk and need</td>
<td></td>
</tr>
<tr>
<td>d) a and b above</td>
<td></td>
</tr>
<tr>
<td>e) c above</td>
<td>e is correct</td>
</tr>
<tr>
<td>f) none of the above</td>
<td></td>
</tr>
<tr>
<td>2. Thus far, three evidence based practices and some promising and supporting practices have been studied with this population and initial results are promising. These practices are:</td>
<td></td>
</tr>
<tr>
<td>a) forensic assertive community treatment, cognitive behavioral therapy, illness management and support, supported education, trauma informed care, and supported housing</td>
<td></td>
</tr>
<tr>
<td>b) integrated dual diagnosis treatment, cognitive behavioral therapy, forensic assertive community treatment, trauma informed care, supported housing, and mental health courts</td>
<td>b is correct</td>
</tr>
<tr>
<td>c) integrated dual diagnosis treatment, cognitive behavioral therapy, forensic assertive community treatment, family psychoeducation, supported employment, and mental health courts</td>
<td></td>
</tr>
<tr>
<td>d) none of the above</td>
<td></td>
</tr>
<tr>
<td>3. The single most important thing that can be done in transition planning is:</td>
<td></td>
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<tr>
<td>a) working with the person to be released and asking him or her what he or she believes is most important to ensure success and if released previously, what did and did not work the last time</td>
<td>a is correct</td>
</tr>
<tr>
<td>b) engaging the support of family and friends so that help and support are available and to be sure that a support system is in place</td>
<td></td>
</tr>
<tr>
<td>c) ensuring that the person has an adequate supply of medication</td>
<td></td>
</tr>
<tr>
<td>d) connecting the person with community resources who will provide the services needed to avoid re-incarceration</td>
<td></td>
</tr>
<tr>
<td>e) all of the above</td>
<td></td>
</tr>
</tbody>
</table>
4. If transition planning is done correctly, following up with those who have been released from incarceration is not needed because community service agencies take charge of people once they are in the community. 

5. Transition planning must take into account the culture, gender, and race of those who are being released in order to ensure that the services the person is to be connected with are compatible, accepting of the person, and willing to work with the individual from his or her frame of reference.
Lecture Notes Citations


**Additional Resources**


Citing the Curriculum

Citation for this Module:

Citation for the full Curriculum:

For additional information, contact:
Recovery to Practice initiative at the American Psychological Association, 
[www.apa.org/pi/rtp](http://www.apa.org/pi/rtp)

or

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