# *READINESS FOR RECOVERY: BRINGING COMMUNITY PRINCIPLES TO CORRECTIONAL SETTINGS*

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# CONFLICTS OF INTEREST

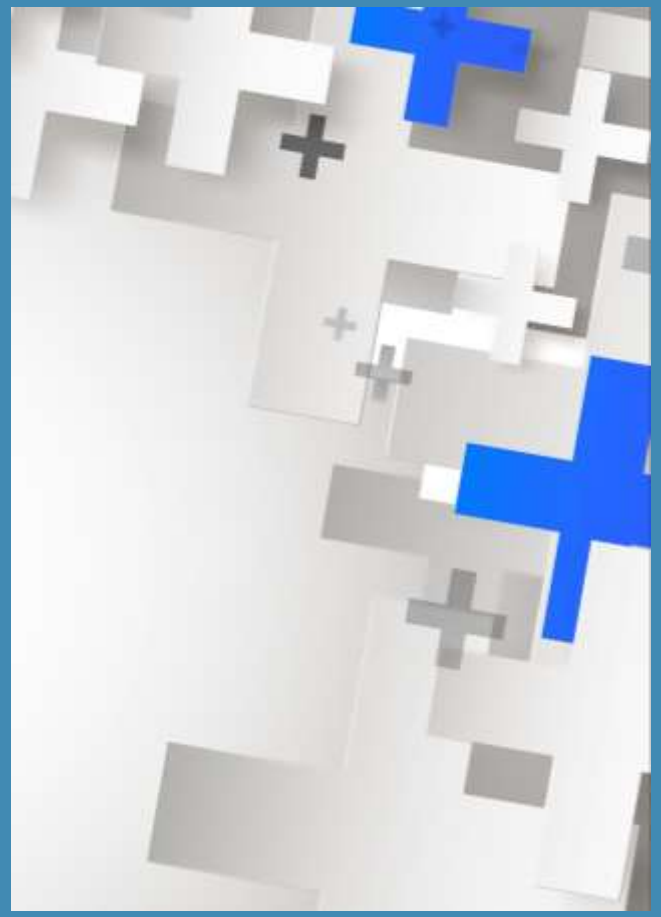
- Dr. Pinals consults on forensic cases and provides system level consultation. She has no conflicts of interest relevant to this presentation.

# ABSTRACT


- Individuals with behavioral health challenges are frequently found in correctional settings or under correctional supervision in the community, yet there is often a sense of feeling ill equipped and inadequately trained for correctional staff to work with these individuals. Further, the goals of public safety and reducing recidivism are often framed outside of the recovery-oriented systems of care upon which behavioral health systems rest. It's increasingly important to bring recovery principles into the correctional conversation and frame lessons to be learned around these principles. Recovery, centered on hope and community inclusion, trauma awareness, and managing challenges with health and wellness as a framework, can fit neatly into correctional system approaches. Dr. Pinals will review experiences across the country in correctional, forensic, and behavioral health services to draw upon as she covers these principles and speaks to the importance of being responsive to the populations' needs, the various systems issues that can present barriers and opportunities, and the ability of each part of the correctional and behavioral health system to lean in and achieve positive results and inspiration for ongoing improvement in service delivery and attention to public safety while improving outcomes for people with mental health, intellectual and developmental disabilities and substance use challenges in the criminal justice system.

# PRESENTATION OBJECTIVES

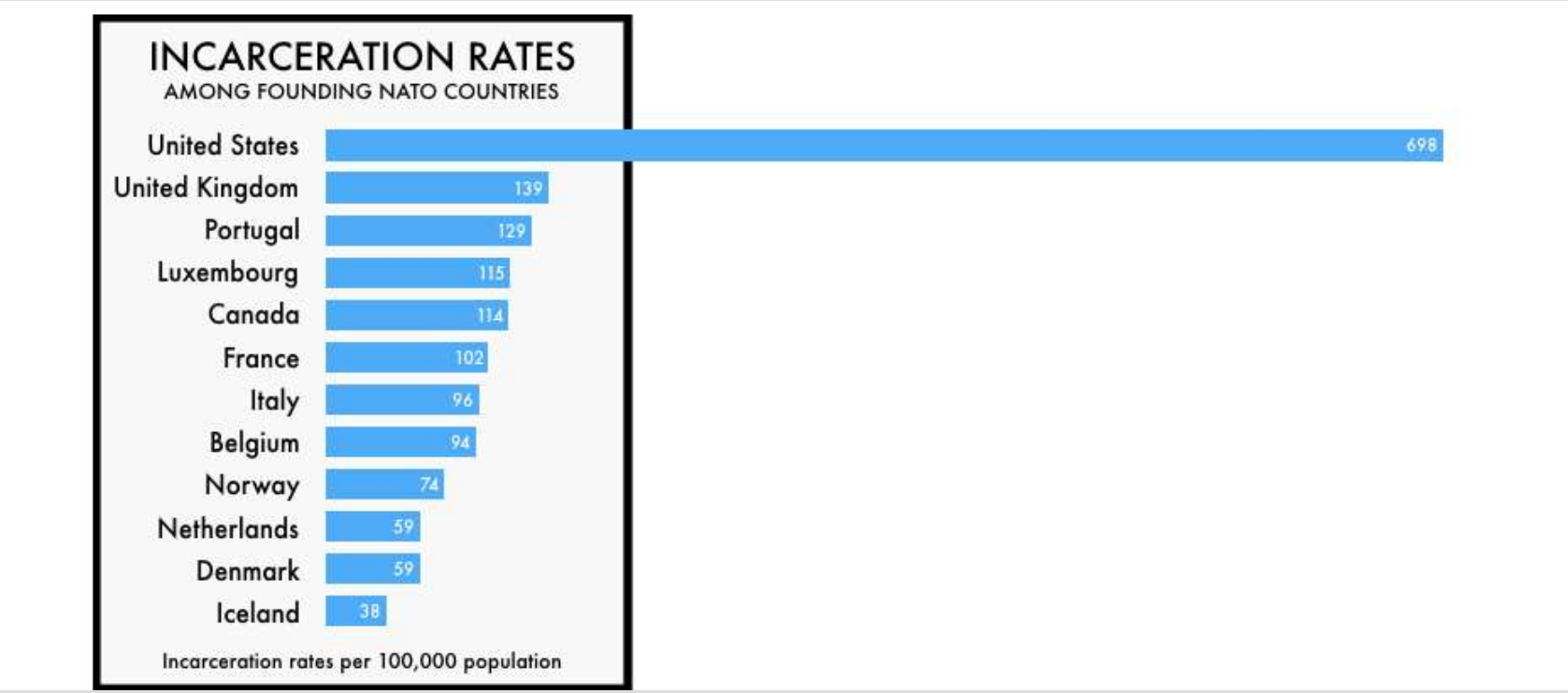
1. Discuss populations served between corrections and communities
2. Describe paradigms for recidivism reduction and recovery to bring recovery into corrections
3. Discuss approaches to increase recovery orientation within correctional settings and among individuals in the community under correctional supervision



# LEARNING OBJECTIVE

1. Discuss populations served between corrections and communities

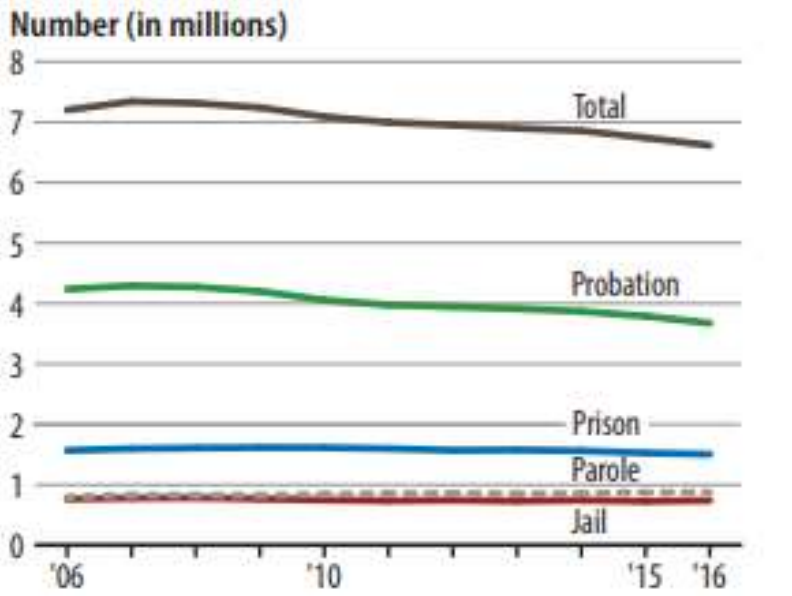
# INCARCERATION IN THE UNITED STATES




- https://www.prisonpolicy.org/global/2018.html

# CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2016

(KAEBLE D, COWHIG M, BJS, APRIL 2018, NCJ 251211)




Note: Estimates may not be comparable to previously published BJS reports because of updated information or rounding. See *Methodology* for details.

Source: Bureau of Justice Statistics, Annual Probation Survey, Annual Parole Survey, Annual Survey of Jails, and National Prisoner Statistics program, 2006–2016.

"The incarceration rate has declined since 2009 and is currently at its lowest rate since 1996."

"All of the decrease in the incarcerated population was due to a decline in the prison population (down 21,200), while the jail population remained relatively stable."

"All of the decrease in the community supervision population in 2016 was due to a decline in the probation population (down 52,500)"

-COVID-19 as a game changer

# TOTAL CORRECTIONAL POPULATION IN THE U.S. AS OF DECEMBER 31, 2016

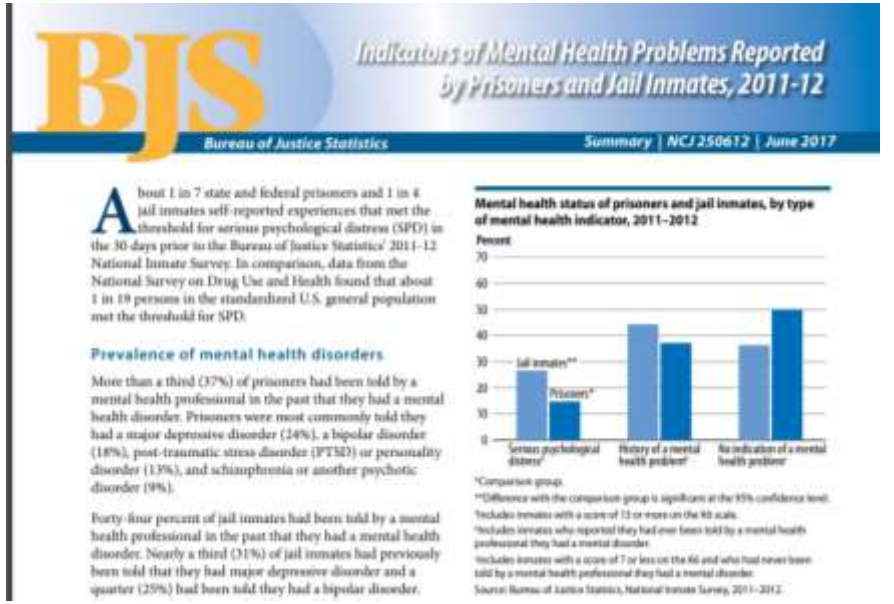
| | Population Numbers |
|---|---|
| Total under correctional supervision | 6,613,500 |
| Total Incarcerated | 2,162,400 |
| Jail | 740,000 |
| Prison | 1,505,400 |
| Community Supervision | 4,537,100 |
| Probation | 3,673,100 |
| Parole | 874,800 |

Source: Correctional Populations in the United States, 2016
(Kaeble D, Cowhig M, BJS, April 2018, NCJ 251211)

# INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONER AND JAIL INMATES, 2011-12 (BRONSON ET AL, BJS, NCJ 250612, JUNE 2017)

About 1 in 7 prisoners and 1 in 4 jail inmates reported serious psychological distress in the past 30 days, in comparison to 1 in 19 of the general population.

About 75% of those that reported serious psychological distress had also said they received prior mental health treatment.



BJS

Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12

Bureau of Justice Statistics | Summary | NCJ 250612 | June 2017

About 1 in 7 state and federal prisoners and 1 in 4 jail inmates self-reported experiences that met the threshold for serious psychological distress (SPD) in the 30 days prior to the Bureau of Justice Statistics' 2011–12 National Inmate Survey. In comparison, data from the National Survey on Drug Use and Health found that about 1 in 19 persons in the standardized U.S. general population met the threshold for SPD.

## Prevalence of mental health disorders

More than a third (37%) of prisoners had been told by a mental health professional in the past that they had a mental health disorder. Prisoners were most commonly told they had a major depressive disorder (24%), a bipolar disorder (18%), post-traumatic stress disorder (PTSD) or personality disorder (13%), and schizophrenia or another psychotic disorder (9%).

Forty-four percent of jail inmates had been told by a mental health professional in the past that they had a mental health disorder. Nearly a third (31%) of jail inmates had previously been told that they had major depressive disorder and a quarter (25%) had been told they had a bipolar disorder.

**Mental health status of prisoners and jail inmates, by type of mental health indicator, 2011–2012**

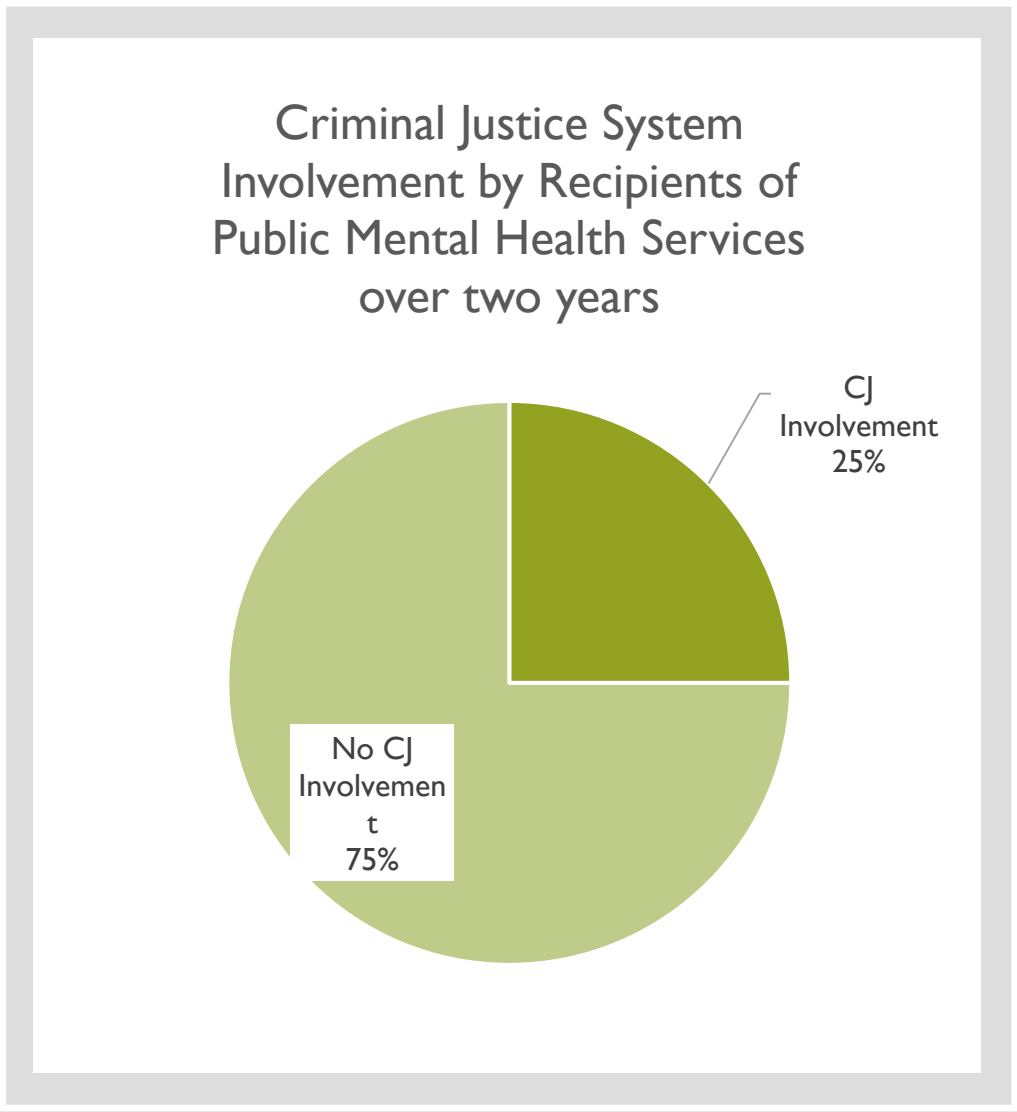
Percent

70
60
50
40
30
20
10
0

Jail inmates**
Prisoners*

Serious psychological distress†
History of a mental health problem‡
No indication of a mental health problem§

*Comparison group.
**Difference with the comparison group is significant at the 95% confidence level.
†Includes inmates with a score of 13 or more on the K6 scale.
‡Includes inmates who reported they had ever been told by a mental health professional they had a mental disorder.
§Includes inmates with a score of 7 or less on the K6 and who had never been told by a mental health professional they had a mental disorder.
Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.




# EXAMINING PREVALENCE FROM THE LENS OF THE PUBLIC MENTAL HEALTH SYSTEM

Higher risk of arrest among public mental health service recipients (OR=1.62) (Fisher et al., Psych Serv 2011)

- Highest risk for arrest on misdemeanor charges

Approximately 25% of individuals with either schizophrenia or bipolar disorder served by one public mental health system was involved in the criminal justice system during a two-year data review (Swanson et al, Psych Serv 2013)

- Costs per person were approximately double to those without criminal justice involvement

# 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]


AJPH

Home Articles Authors Subscript

Home > American Journal of Public Health (AJPH) > September 2018

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 MSP, and Stephen W. Marshall PhD, MPH

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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.

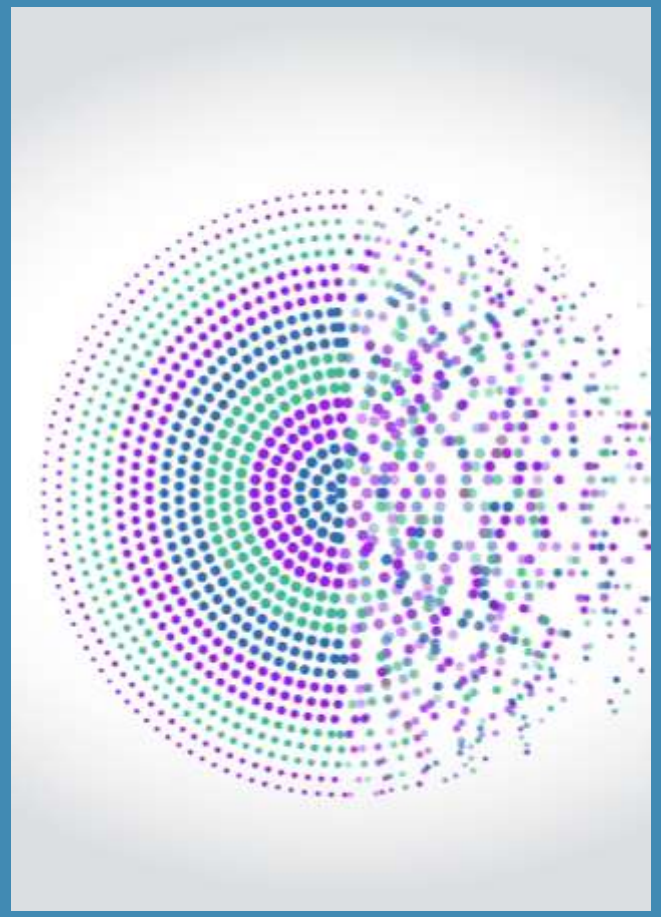
Results. Of the 229 274 former inmates released during 2000 to 2015, 1329 died from OOD after release. At 2 weeks, 1 year, and complete follow-up after release, the respective OOD risk among former inmates was 40 (95% confidence interval [CI] = 30, 51), 11 (95% CI = 9.5, 12), and 8.3 (95% CI = 7.8, 8.7) 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.

# COMORBID SUBSTANCE USE DISORDERS IN ADULTS

| Among individuals with: | Percentage of individuals who also have: | | | | | |
|---|---|---|---|---|---|---|
| | Alcohol Use Disorder | Nicotine Dependence | Marijuana Use Disorder | Cocaine Use Disorder | Prescription Opioid Use Disorder | Heroin Use Disorder |
| Alcohol Use Disorder | - | 23.8 | 9.5 | 3.3 | 3.9 | 0.9 |
| Nicotine Dependence | 12.9 | - | 4.3 | 1.4 | 2.7 | 1.3 |
| Marijuana Use Disorder | 38.7 | 32.6 | - | 4.8 | 7.9 | 1.8 |
| Cocaine Use Disorder | 59.8 | 47.7 | 21.3 | - | 16.4 | 13.4 |
| Prescription Opioid Use Disorder | 35.2 | 45.4 | 17.6 | 8.2 | - | 11.2 |
| Heroin Use Disorder | 24.5 | 66.3 | 12.3 | 20.9 | 34.9 | - |

NIDA: Ava at: https://www.drugabuse.gov/longdesc/table-1-comorbid-substance-use-disorders



# LEARNING OBJECTIVE

2. Describe paradigms for recidivism and recovery to bring recovery into correctional settings

# What is recovery?

## 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*

Recidivism reduction focuses on
"Criminogenic Risk Factors"
and
The Risk-Need-Responsivity (RNR) Paradigm

| Risk Factor |
| --- |
| History of antisocial behavior |
| Antisocial personality pattern |
| Antisocial cognition |
| Antisocial attitudes |
| Family and/or marital discord |
| Poor school and/or work performance |
| Few leisure or recreation activities |
| Substance misuse |

Source: Andrews (2006)

# "RESPONSIVITY FACTORS"

- Mental Illness
- Trauma
- Culture
- Housing
- Etc.

# ADDRESSING CRIMINOGENIC NEEDS

- Risk assessment Tools (e.g., LS/CMI, ORAS, COMPAS, etc)
- CBT treatments for correctional populations
  - Focuses on behavior
  - Focuses on thoughts
  - Focuses on societal responsibility
- Goal includes reduced recidivism
- General tenet of separating programming by level of risk/need

Milkman & Wanberg 2007

# LEARNING OBJECTIVE

3. Discuss approaches to increase recovery orientation within correctional settings and among individuals in the community under correctional supervision

# MENTAL ILLNESS AND CRIME: WHAT IS THE RELATIONSHIP?

- Symptoms of mental illness are variably, but often infrequently the driving feature of criminal conduct.
  - Bipolar symptoms more frequently associated with criminal behavior than psychosis (Peterson, Skeem, et al 2014)
- Co-morbid antisocial personality disorder, substance use and PTSD are more likely associated with arrest for violent crime than psychosis (McCabe, Christopher et al 2012)
- Decreasing symptoms of mental illness alone therefore will only have a modest effect on criminal behavior
- Because mental illness can be a driver for some behaviors, traditional treatments must not be ignored, but they will not reduce most crime

# CHALLENGES FOR MENTAL HEALTH SERVICES PROVIDERS WORKING WITH PEOPLE WITH SMI IN THE CJ SYSTEM

- Lack of understanding of the CJ System
- Lack of comfort and training with some patient personality styles
- Concerns for safety even if based on stigma due to label of "criminal" attaching to patients
- Trainings like this can help improve comfort with a "foreign" system

# CHALLENGES FOR STAFF IN CORRECTIONAL SETTINGS IN WORKING WITH COMMUNITY RECOVERY PRINCIPLES

- Lack of understanding of the recovery principles
- Lack of comfort and training with the approaches
- System cultural differences
- Concerns for safety even if based on stigma due to label of "criminal" attaching to patients
- Trainings like this can help improve comfort with a "foreign" system

# BRINGING RECOVERY TO CORRECTIONAL SETTINGS

Can it reduce risk?

Is it a growing imperative?

## Recovery Themes

Self-determinism

Full community integration

Maximal civil rights

Nothing about me without me

Persons not diagnoses

Empowerment

Strength-based

## Correctional Themes

Mandates

Accountability

Structure

Rules

Institutional and public safety

Monitoring

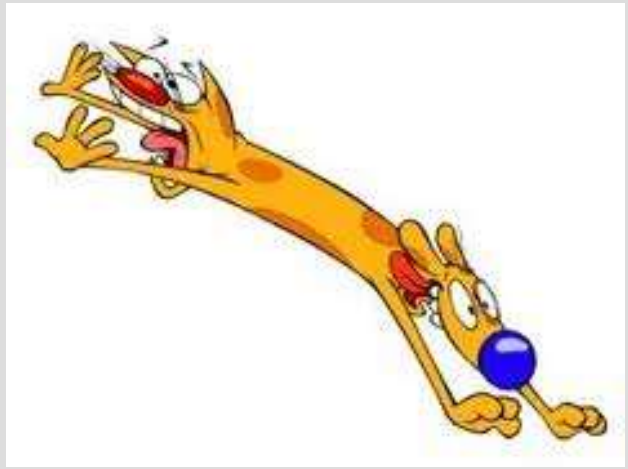
Risk of recidivism

Discipline for infractions

Hardened environments

# THE PUSH ME - PULL YOU DILEMMA

Bad outcomes →
Increased public safety concerns →
Tighter oversight laws →
Limiting community autonomy



Advocate focused→
Person Centered →
Maximized autonomy →
Increased community access

Breaking Siloes

Aiming for continuity

Community-minded

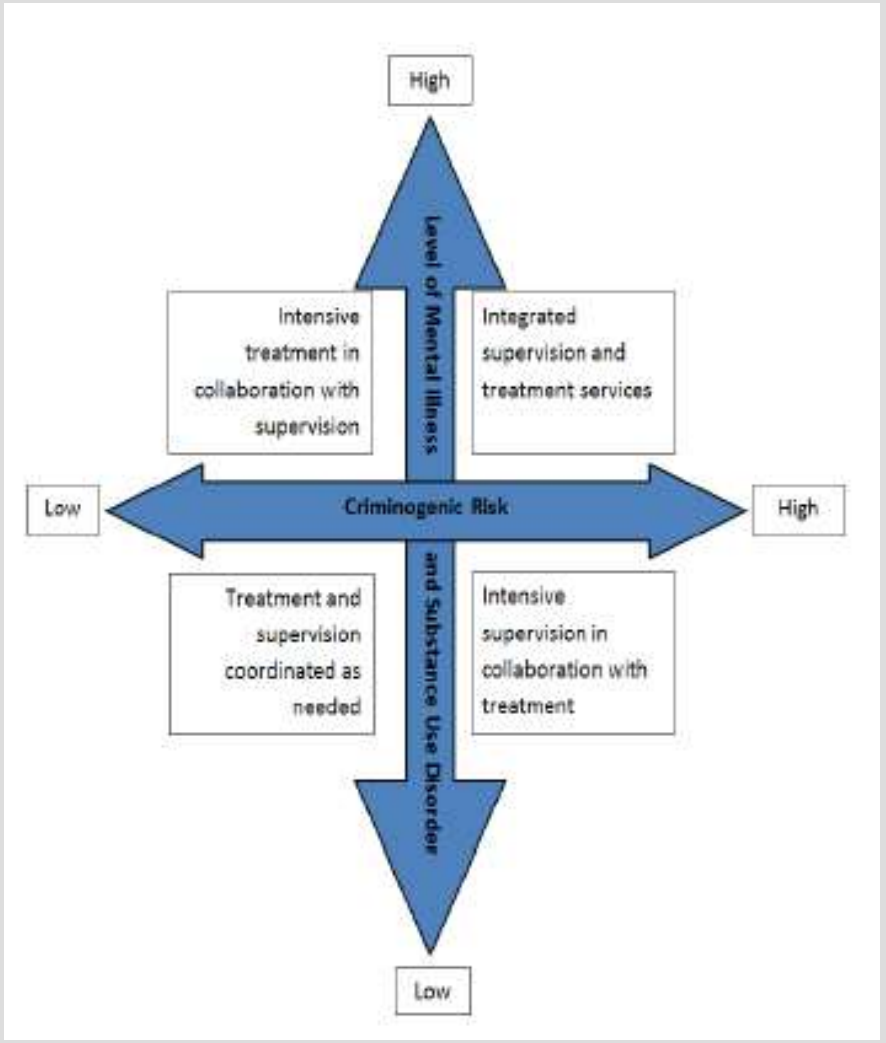
Peer-focused

# RECOVERY ORIENTED SYSTEMS OF CARE (ROSC)

# UNDERSTANDING ROLES AND RESPONSIBILITIES

# SUPERVISION AND TREATMENT COLLABORATIONS FOR JUSTICE INVOLVED PERSONS WITH SMI

- Understanding the risks of criminal recidivism and type of supervision
- Understanding the mental health supports needed
- "Intentional" coordination between treatment professionals and supervising entities




Prins and Osher, CSG Justice Center 2009
Pinals, Gaba, Cleary 2019

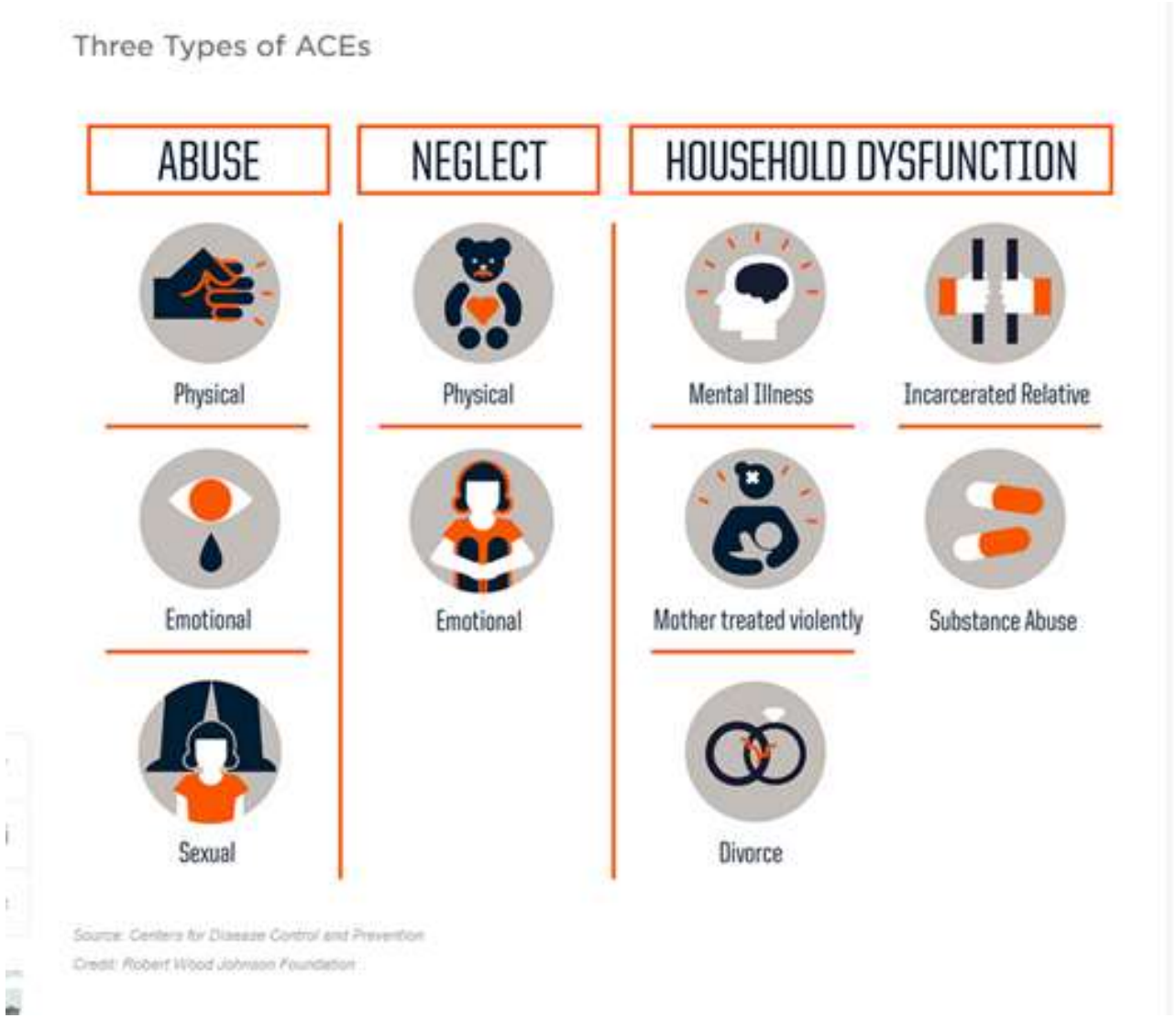
# UNDERSTANDING THE ROLE OF TRAUMA

# TRAUMA, BEHAVIORAL HEALTH AND JUSTICE POPULATIONS

- High level of trauma exposure in juvenile justice involved youth
- High levels of trauma for those receiving care in psychiatric settings
- High levels of trauma among individuals in jails and prisons
- High levels of trauma, victimization, and offending, along with substance use, seem to interplay
- Earlier and more prolonged trauma leads to greater biological/developmental disruption

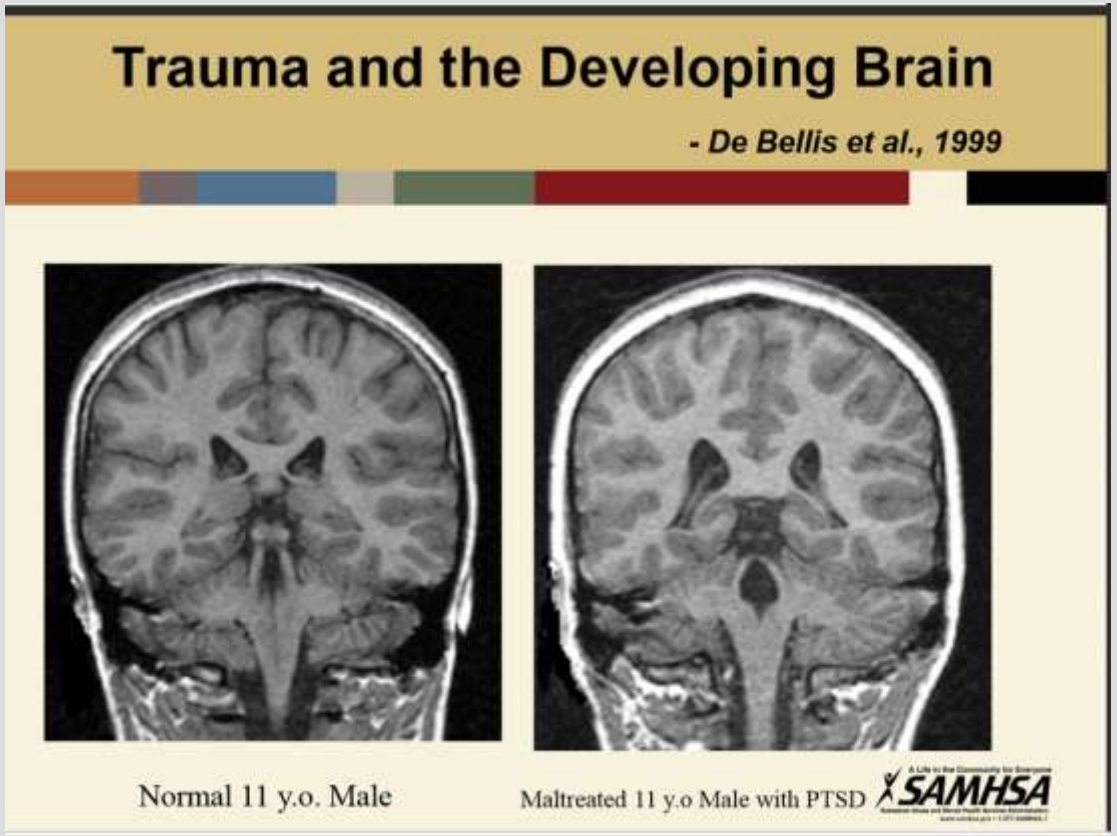
- Hodas 2004; Muesar et al., 1998, Lipschitz et al., 1999, NASMHPD, 1998, SAMHSA 2015

# ACES

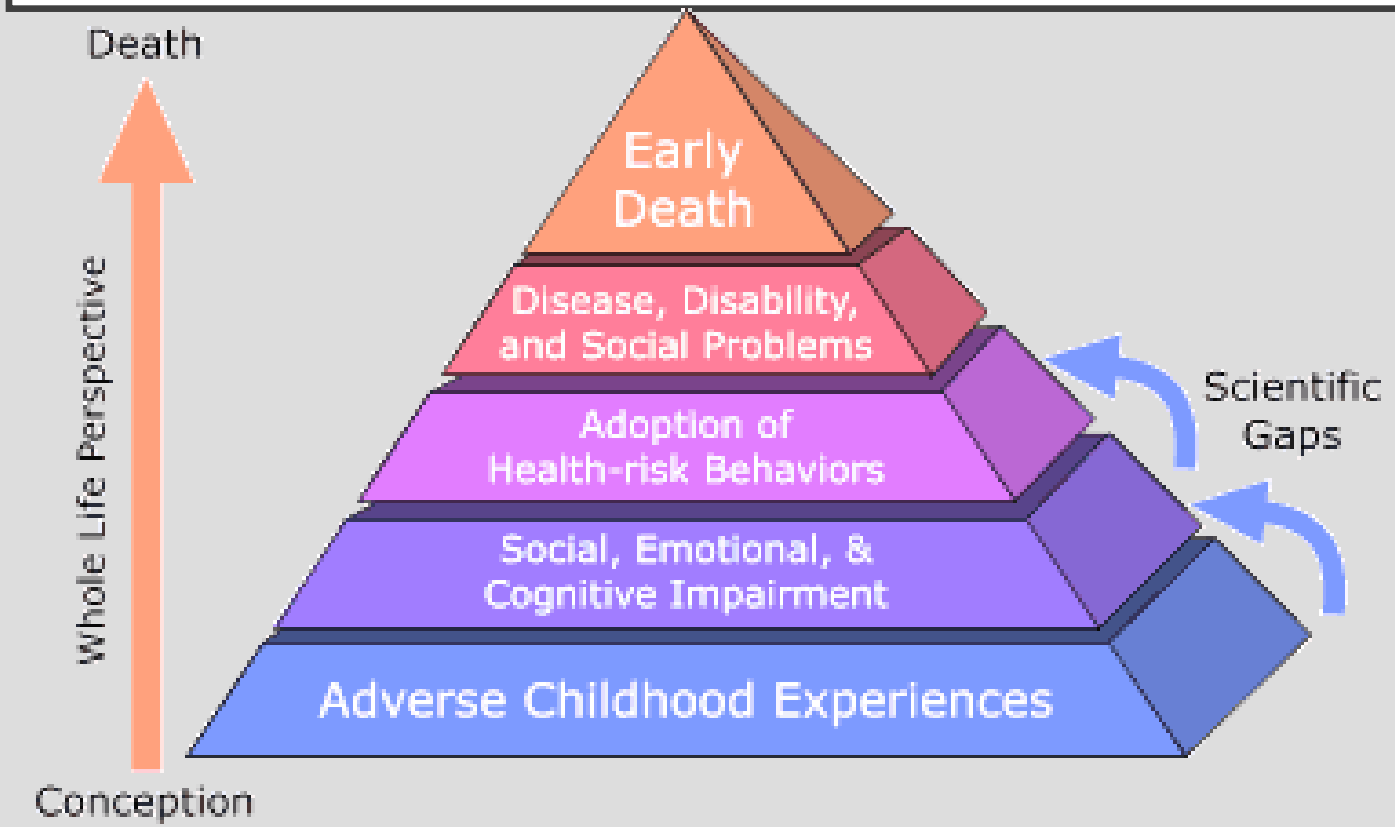

Three Types of ACEs
ABUSE
NEGLECT
HOUSEHOLD DYSFUNCTION
Physical
Emotional
Sexual
Physical
Emotional
Mental Illness
Mother treated violently
Divorce
Incarcerated Relative
Substance Abuse
Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation

# TRAUMA AND NEUROCIRCUITS

Trauma exposure
and
Overactivity
Numbing



# ACE STUDY CONCEPTUAL FRAMEWORK RELATED TO OUTCOMES




http://www.cdc.gov/ace/pyramid.htm

# RACE AND SOCIAL DETERMINANTS, TRAUMA, AND VIOLENCE AND DISPARITIES

- Environment, Social Determinants play a large role
- Victimization can increase risk of subsequent aggression
- Cultural biases must be attended to while structural issues are addressed
- Attend to Safety Needs as a top priority

Jones-Webb and Wall 2008; Carter et al. 2017

# CRIMINAL JUSTICE AND INSTITUTIONS AS TRAUMATIZING

- Pre-arrest circumstances
- Arrest circumstances
- Disruptions in social networks
- Exposure to high noise level
- Exposure to individuals with traumatic and tragic life circumstances
- Exposure to individuals with antisocial and violent propensities
- Loss of control
- Humiliation
- Public exposure
- Fear of unknown

Pinals 2015; Miller and Najavits 2012

# SAMHSA'S CHARACTERISTICS OF A TRAUMA-INFORMED APPROACH: THE FOUR "R"S

- 1. Realization
  - People within an organization realize the impact of trauma
- 2. Recognition
  - Of the signs and symptoms and manifestations of trauma

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

# SAMHSA'S CHARACTERISTICS OF A TRAUMA-INFORMED APPROACH: THE FOUR "R"S

- 3. Responds
  - The organization/system responds by applying trauma-informed approaches to all aspects of the system
- 4. Resist Re-traumatization
  - The system makes efforts to resist re-traumatization of individuals in the system that can interfere with recovery

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

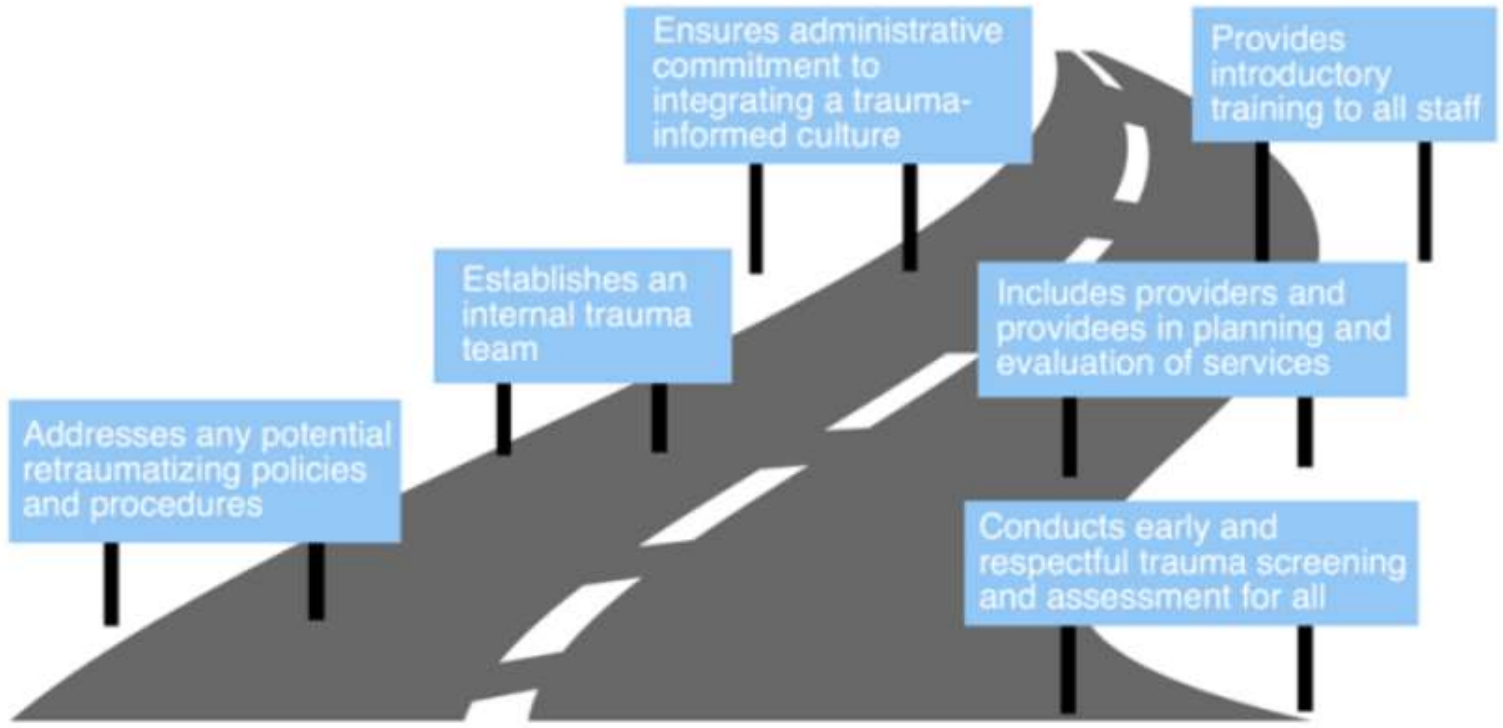
# WORKING WITH JUSTICE INVOLVED PERSONS: BEING TRAUMA-INFORMED

- Universal Precautions
- Procedural justice
- Safety and community
- Holding hope
- Peer support

# The Road to Trauma-Informed Care (TIC)

*Trauma-Informed Care calls for a change in organizational culture, where an emphasis is placed on understanding, respecting and appropriately responding to the effects trauma at all levels.*

(Bloom, 2010)




(Fallot & Harris, 2001)

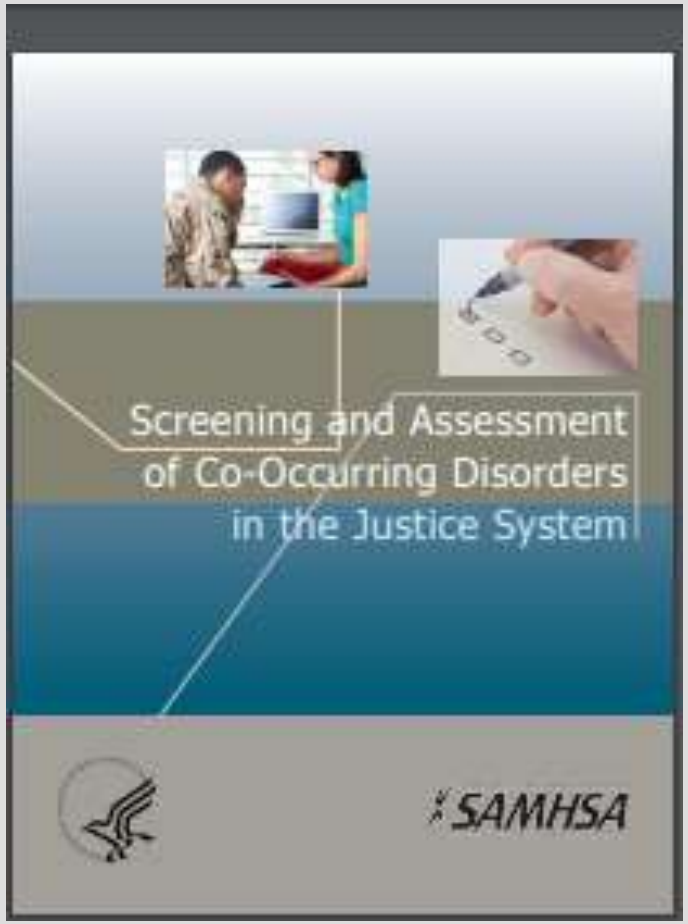
The Road to Trauma-Informed Care Infographic Transcript (71 KB)

http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

# SPECIALIZED APPROACHES FOR BEHAVIORAL HEALTH AND JUSTICE POPULATIONS

# SCREENING FOR CODS

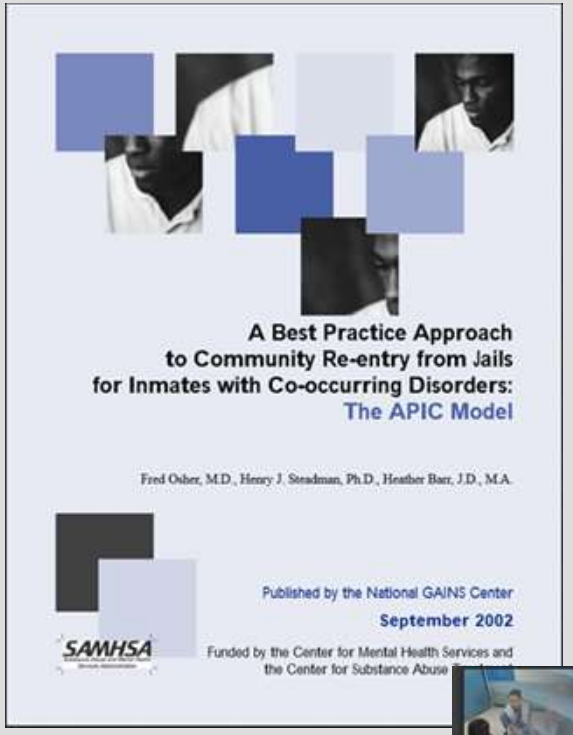
- Screening for both Mental Illness and Substance Use Disorders
- Assessments following positive screens
- Linkage to Appropriate Treatment

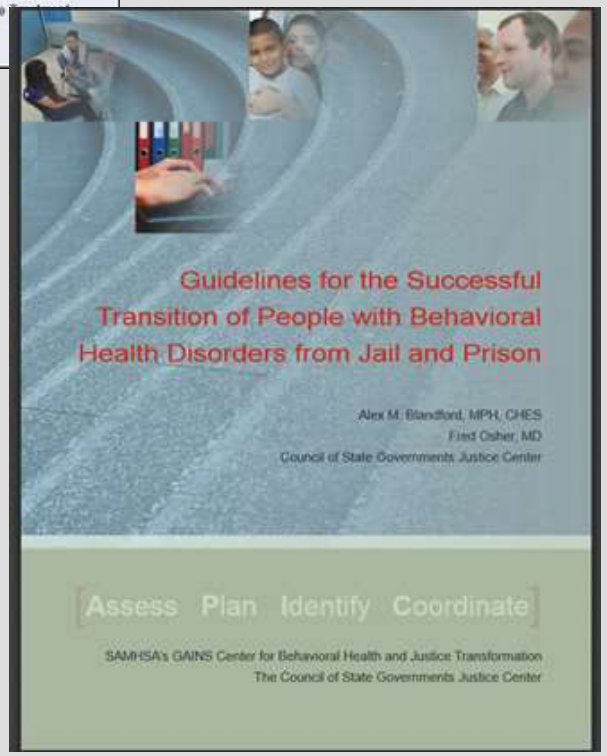


# LESSONS FROM PERCEIVED COERCION RESEARCH

- Perceptions of coercion have been associated with:
  - Greater sense of stigma
  - Decreased sense of fairness
  - Decreased acceptance of treatment
  - Negative perceptions of one's recovery

Even with legally mandated treatment, care can be delivered to minimize feelings of negative pressure and perceptions of coercion…




**10 Guidelines following the APIC framework including:**

Assess
- Screening for behavioral health needs and risk
- Assessments after positive screenings

Plan
- Individualized treatment planning with appropriate treatment levels and dosing to match risk in collaborative programs
- Collaborative responses between behavioral health and justice systems

Identify
- Anticipate critical periods especially time surrounding release
- Policies and practices that enhance continuity of care

Coordinate
- Support "firm but fair" adherence to treatment and supervision conditions
- Develop Information sharing mechanisms
- Support cross training
- Support data analysis

# HARM REDUCTION: BUILDING SAFETY NETWORKS

Individual

Family/Friends

Peer supports

Community at Large

Spiritual connections

Criminal justice partners

# SYSTEM ADAPTATIONS

- Changes in environments
- Balance task demand with capabilities
- Workforce development
- Procedural modifications

# BUILD RESILIENCE FOR INDIVIDUALS SERVED

- Build self esteem
- Model behavior desired
- Stress-busters
- Self-reflection
- Mindfulness

# CONSIDER WHOLE HEALTH

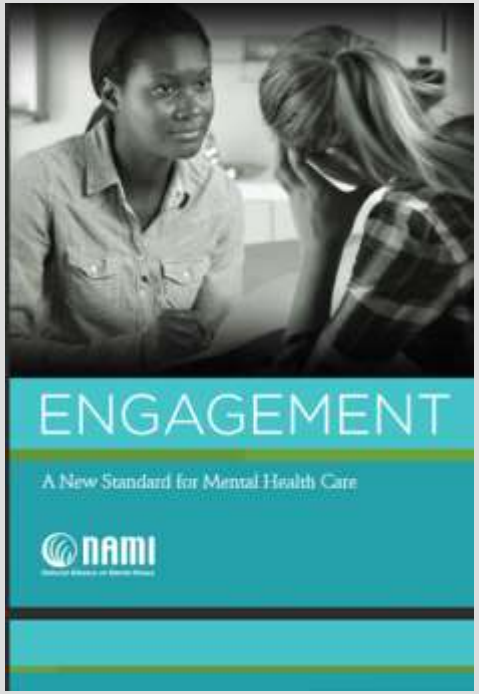
Frequent occurrence of co-occurring substance use disorders

Health conditions that might be unattended

# ENGAGEMENT

- "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



# RECOGNIZING THE IMPACT OF STIGMA

- Reduced access care
- Reduced access to housing, employment, etc
- Discrimination, isolation
- Lack of parity in healthcare coverage
- Belief that persons with mental illness and substance use are not sufficiently held responsible for their actions
- Belief that persons with MI are less competent and more dangerous

# I/DD: PERSON-CENTERED PLANNING AND SELF-DETERMINATION (LOTAN & ELLS 2010)

- Autonomy
- Empowerment
- Participation in Decision-Making
  - Desire for information may or may not mean desire to make decision without support
  - Critical importance of mindfulness about placing our own values in the middle of another's decision-making
- Asymmetrical Relationships
- Respect for persons

# USE DATA TO DRIVE DECISIONS

And Enhance Engagement Strategically

# BUILDING ON FRAMEWORKS OF CARE TO FACILITATE POSITIVE OUTCOMES

# ACCESS TO EFFECTIVE MEDICATION AND PROMISING THERAPIES

US Examples

- SMI-Advisor
- Early studies on Open Dialogue

Lessons from the International Community

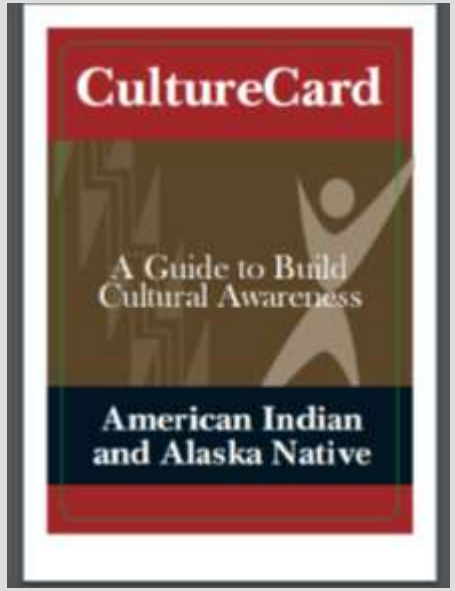
- Medication access differences
  - Clozapine access
  - Long acting medications
  - Medications to treat SUD
- Therapies (non-medication) access differences
  - CBTp- CBT for Psychosis
  - Open Dialogue

BEYOND THE BORDERS

Pinals, NASMHPD 2019

# CULTURE AND SPIRITUALITY INTO MENTAL HEALTH CARE

- Learning from native populations
- Moving beyond "cultural competence" to national CLAS standards (Culturally and Linguistically Appropriate Services in health care)

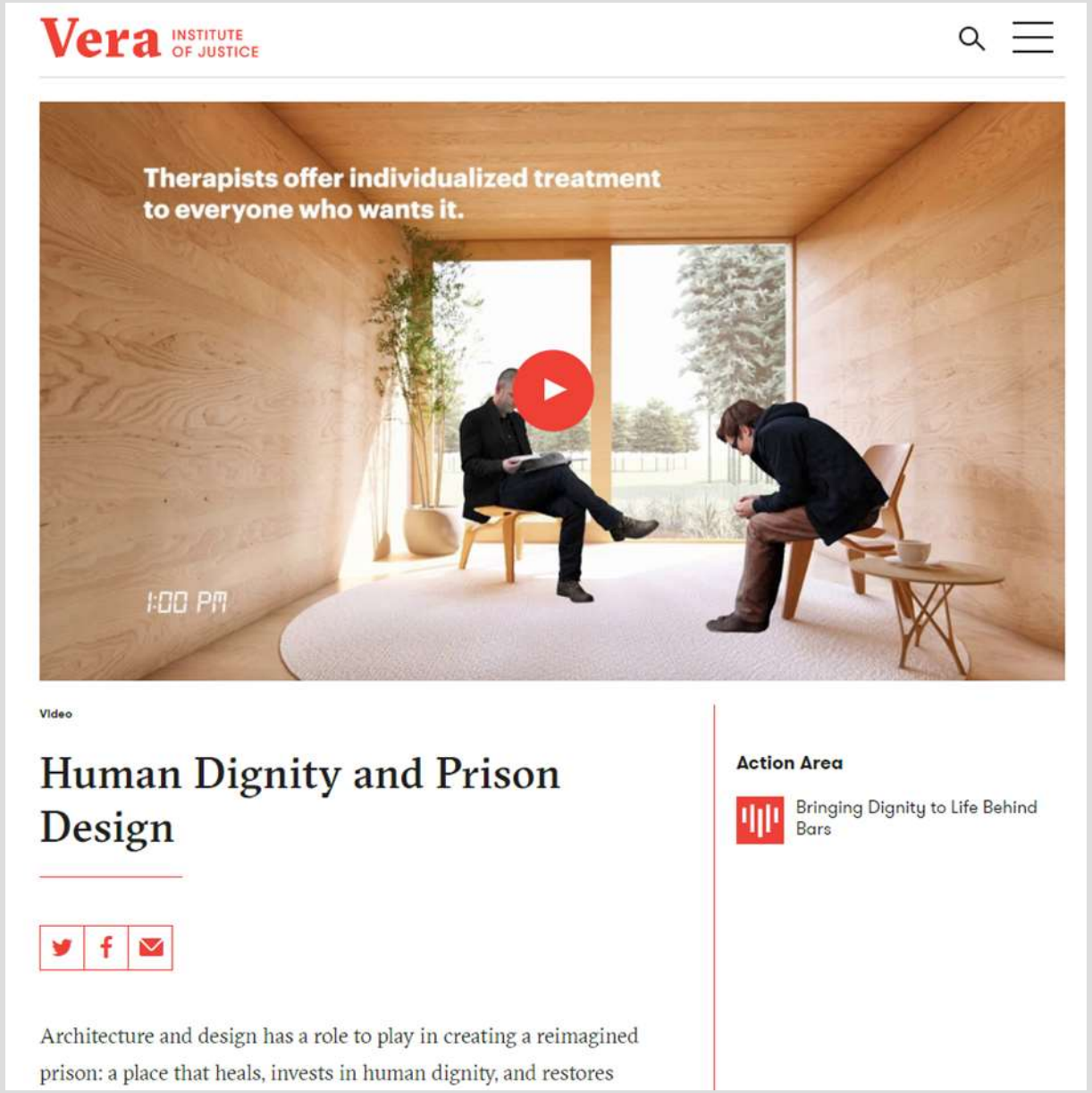



Pinals, NASMHPD 2019

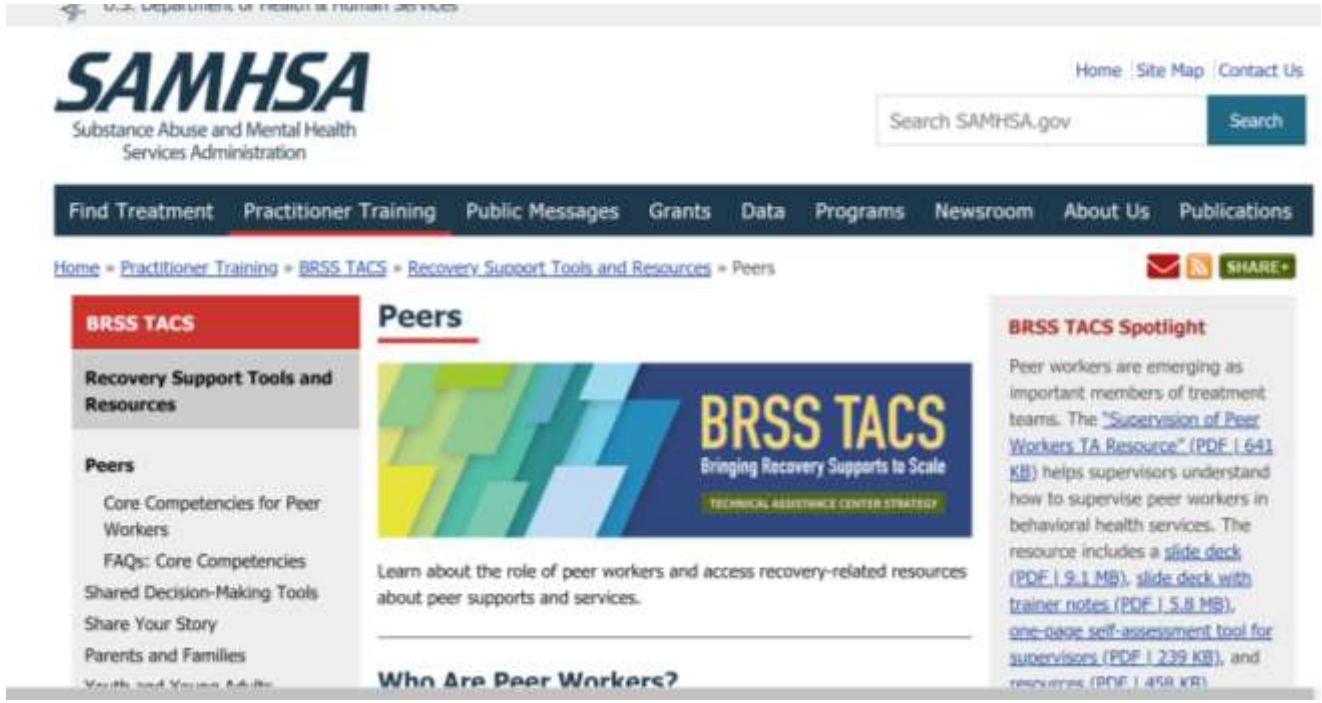
# EVOLVING CONDITIONS OF CONFINEMENT THROUGH DESIGN, PROGRAMS, AND LINKAGES

**Today**

Vera Institute Re-imagining Prison Report 2018



# IMPORTANCE OF PEERS



# DISASTER RESPONSE AND OPPORTUNITY FOR SUSTAINED IMPROVEMENT

- SAMHSA technical assistance with disaster relief
- Expanded knowledge about trauma informed systems
- COVID-19 and its aftermath

BEYOND THE BORDERS

# CDC AND SOCIAL DETERMINANTS OF HEALTH

- Conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.
- Five Key Areas:
  - Healthcare access and quality
  - Education access and quality
  - Social community context
  - Economic stability
  - Neighborhood and built environment

https://www.cdc.gov/socialdeterminants/about.html


YOU!

Everyone counts!

# CONCLUSIONS

Progress not perfection

Importance of responsivity to the populations' needs

Various systems issues that can present barriers and opportunities

Correctional and behavioral health systems can lean in together to achieve positive results

Shared goals include improving outcomes, fiscal responsibility, attention to public safety

Evolving collaborative strategies at the behavioral health and justice interface

Partnerships matter

…Continuous network development and problem-solving feedback loops

# CONTACT INFORMATION

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