The intersection of mental illness and the criminal justice system

Amy C Watson, PhD
Overview

- Introduction
- Sequential Intercept Model
- Overrepresentation of persons with mental illnesses in the criminal justice system
- Approaches to reduce contact, penetration & re-entry
- Police Response, CIT and Chicago
- Discussion
Points of Contact with the Criminal Justice System

Sequential Intercept Model

SAMHSA GAINS CENTER, 2013
Initial Contact

• ~10% of police encounters involve persons with serious mental illnesses, smaller percentage involve mental health crises
  – Mental Health Crisis
  – Domestic Disturbance
  – Non-domestic Law Violation (nuisance to felonies)
  – Victim, Request for Assistance
  – Street Stop/Id Check

• Over 1 million arrests of persons with mental illnesses a year in the United States
  – Evidence regarding whether mental illness increases likelihood of arrest is equivocal.
Extent of Penetration

- Persons with serious mental illnesses are over represented in jails and prisons (~17% compared to 5-7% general population)
  - 72% of this group have co-occurring SUD
- Los Angeles County and Cook County jails are the two largest psychiatric hospitals
- Recent report indicated 2 million of 13 million jail admissions each year involve persons with serious mental illnesses
- Once they get in the system, they stay longer than individuals without mental illnesses
Why are people with mental illnesses over-represented in the criminal justice system?

• **Criminalization?**

  Process by which behaviors once considered legal become illegal...............whereby behaviors in one era had been managed by involuntary hospitalization are now handled by the criminal justice system

• **Trans-institutionalization?**

  Large numbers of individuals who previously would have been in state psychiatric hospitals now in the community>> end up in other institutional settings
Trans-institutionalization?
POLL: Link between mental illness and crime

• Roughly, what percentage of persons with mental illnesses in the CJ system were arrested from crimes directly related to their mental illness symptoms?
  a) 75-100%
  b) 50-74%
  c) 25-49%
  d) 10-24%
  e) <10%
So-why do people with mental illnesses commit crimes?

Useful heuristic: three categories of offenders with mental illnesses (Hiday, 1999)

1. persons with mental illnesses, maybe homeless, with COD, commit survival crimes (substance related, theft, etc..)
2. Independent anti-social and mental illness disorders co-occur but not related
3. Those who crimes directly related to psychiatric symptoms (5%-8%)
Link Between Mental Illness and Incarceration

Peterson, Skeem, Kennealy, Bray, and Zvonkovic (2014)

<table>
<thead>
<tr>
<th>Relationship to Mental Illness</th>
<th>Percent of Crimes</th>
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<tbody>
<tr>
<td>Completely Direct</td>
<td>7.5</td>
</tr>
<tr>
<td>Mostly Direct</td>
<td>10.7</td>
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<tr>
<td>Mostly Independent</td>
<td>17.2</td>
</tr>
<tr>
<td>Completely Independent</td>
<td>64.7</td>
</tr>
</tbody>
</table>
So why do people with mental illnesses commit crimes?

Most offenders with mental illnesses commit crimes for the same reasons people without MI commit crimes:

- because they are poor (and thus exposed to conditions, risk factors, opportunities)
- antisocial cognitions
- criminal associates
- substance use

Mental illness may impact exposure to risk factors for criminal behavior
So-why do people with mental illnesses commit crimes?

Mental illness may impact exposure to risk factors for criminal behavior via:

- Impact on life transitions and opportunities for prosocial activities and networks and normative pressures
- Impact on stability of life circumstances
- Impact on lifestyle and routine activities
POLICE RESPONSE TO PERSONS WITH MENTAL ILLNESS/EXPERIENCING MENTAL HEALTH CRISIS
Strategies at the front end

Sequential Intercept Model

Sequential Intercepts for Change: Criminal Justice - Mental Health Partnerships

SAMHSA GAINS CENTER, 2013
Pre-arrest diversion

- **Mental-health-based specialized mental health response.** Interagency agreements with agency based mobile mental health teams

- **Police-based specialized mental health response.** Mental health clinicians embedded in police agency that provide consultation to officers in the field

- **Police-based specialized police response (CIT).** Specially trained police officers who provide initial crisis response in the field and liaise with mental health providers to resolve calls
The Crisis Intervention Team Model

CIT Core Elements

– Police-based specialized police response

  • Specialized Training for volunteers (15-20% patrol)
  • Single point of entry to emergency psychiatric services
  • Partnerships with community providers
  • Changes in policies and procedures

  • Some jurisdictions implementing clinician/officer teams for secondary response to improve linkage and address high intensity utilizers

  • Some evidence supporting CIT as effective for improving safety and linkage. Evidence related to impact on arrest varies.
  • “CIT – It’s more than just training” - Major Sam Cochran
Layered Models

- Houston Police Department Mental Health Division
  - 40 Hours CI-Training for all Officers
  - Crisis Intervention Response Teams (secondary crisis response and follow-up)
  - Homeless Outreach Team
  - Chronic Consumer Stabilization Initiative

- Los Angeles Police Department Mental Evaluation Unit
  - 40 hours CI-training for all officers
  - Crisis Triage Desk
  - SMART Teams-secondary crisis response
  - Case Assessment Management Team (CAMP)
Courts and Corrections

Sequential Intercept Model
Post – arrest

• Screening & Pretrial Diversion

• In-custody services

• CIT for corrections staff
Mental Health Courts

- Dedicated Court Call
- Non-adversarial team approach
- Judically-centered program
- Variation in
  - Target population
  - Mechanism of supervision
  - The intervention itself
  - Community context
  - Resources

Some evidence of decreased criminal justice involvement and increased community treatment involvement
Services on the back end
Treatment should address mental health and criminogenic needs

- Accurate assessment at all levels
- Integrated MH/SUD treatment
- Case management
- Supported employment, housing, family psycho-education, trauma interventions
- Structured cognitive-behavioral and skill building interventions
CHICAGO POLICE DEPARTMENT’S CIT PROGRAM
CIT in Chicago-History

Late 1990s-Mental Health Task Force began meeting and talking about the need to improve CPD training related to mental health crisis response

- Increase Academy Content on MH
- This CIT Model people are talking about....

Chicago Police Department assigned Lt. Jeff Murphy to work with this group
CIT in Chicago

• Began in 2 pilot districts in 2005-
  – 30-40 officers/supervisors per district

• Training developed in collaboration with community providers & stakeholders

• Citywide (all 225 districts) implementation began 2006

• 2300 CIT officers trained-~1500 in districts currently
Involving people in recovery in the training process
Crisis Intervention Team – BASIC – Course Evaluation

Date of Training: Friday, 26 SEPTEMBER 2014

YOUR FEEDBACK IS VERY IMPORTANT
PLEASE GIVE US YOUR HONEST OPINIONS ON THIS CIT TRAINING COURSE

STRENGTHS OF THIS COURSE:

Consumers! Best training I have had in over 19 years in CPD. Utilizing actual consumers to share their experiences & role playing is totally genius !!! Awesome course! Proud to be a CIT member !!!!
CIT in Chicago: Evidence to date

Testing a systems level intervention to improve police response to persons with mental illness: CIT in Chicago

♦ 2008 NIMH funded Study of CIT in 4 Chicago police districts

- CIT trained officers directed 18% more call subjects to MH services than non CIT peers
- Linkage more likely in districts with more MH services
- CIT officers used less force at higher levels of resistance
CIT and Mental Health Service Accessibility in Police Encounters: Impact on Outcomes for Persons with Serious Mental Illnesses

Credit where credit is due

- Co-investigators
  - Michael Compton, MD, MPH, Lenox Hill Hospital
  - Jeff Draine, PhD, Temple University
  - Jen Wood, PhD, Temple University
  - Joel Caplan, PhD, Rutgers University
  - Don Hedeker, PhD University of Illinois at Chicago
  - Linda Owens, PhD, University of Illinois at Chicago

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Specific Aims:
Examine CIT in all Chicago Police Districts in order to:

1. Estimate the impact of CIT training on immediate outcomes of mental health-related calls

2. Determine how immediate call outcomes, CIT response, access arrangements, & availability of mental health services affect longer-term outcomes and utilization of services over a period of 12 months

3. Describe process by which officers connect individuals with psychiatric services through both experiences that officers, consumers, and other key individuals have had and the perceptions they hold

4. To explore the geographic associations between MH service accessibility, community characteristics, characteristics of calls and call subjects, call outcomes, and longer-term MH and CJ system outcomes
• Chicago Police Districts, Designated ER drop offs & MH Service Providers
Some Ride Along Findings

♦ Variation by district

♦ Procedural Justice Themes

♦ Difference between CIT & non CIT officers
  o Patience vs. when it is “on”
  o What police should be involved in
  o Problem solving to make sure person is linked

♦ Where the service gaps are
  o Need for Urgent rather than Emergency care
  o More outreach and engagement from MH side

♦ Need for more CIT officers to ensure availability, continued attention to coordinate CIT officers to the right calls

♦ Many “gray zone” encounters

♦ Officers find creative solutions
When the system fails
Momentum for change -

Meeting with Mayor’s staff and the formation of the Mayor’s Mental Health Steering Committee - it takes a crisis and a billionaire
And a DOJ Investigation

Training for Emergency Communications staff

Multi-disciplinary training – Fire, Police, OEMC, and EMS

Targeted community outreach and training

Rebuilding the Infrastructure
DISCUSSION & QUESTIONS
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