DOWNLOAD PDF CLINICAL TREATMENT OF THE CRIMINAL OFFENDER IN OUTPATIENT MENTAL HEALTH SETTINGS

Chapter 1 : Criminals Need Mental Health Care - Scientific American

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This fact sheet discusses research findings on effective treatment approaches for drug abuse and addiction. What is drug addiction? Drug addiction is a chronic disease characterized by compulsive, or uncontrollable, drug seeking and use despite harmful consequences and changes in the brain, which can be long lasting. These changes in the brain can lead to the harmful behaviors seen in people who use drugs. Drug addiction is also a relapsing disease. Relapse is the return to drug use after an attempt to stop. Seeking and taking the drug becomes compulsive. This is mostly due to the effects of long-term drug exposure on brain function. Addiction affects parts of the brain involved in reward and motivation, learning and memory, and control over behavior. Addiction is a disease that affects both the brain and behavior. Can drug addiction be treated? Most patients need long-term or repeated care to stop using completely and recover their lives. Addiction treatment must help the person do the following: Addiction is a complex but treatable disease that affects brain function and behavior. No single treatment is right for everyone. People need to have quick access to treatment. Staying in treatment long enough is critical. Counseling and other behavioral therapies are the most commonly used forms of treatment. Medications are often an important part of treatment, especially when combined with behavioral therapies. Treatment should address other possible mental disorders. Medically assisted detoxification is only the first stage of treatment. Drug use during treatment must be monitored continuously. What are treatments for drug addiction? There are many options that have been successful in treating drug addiction, including: Treatment should include both medical and mental health services as needed. Follow-up care may include community- or family-based recovery support systems. How are medications and devices used in drug addiction treatment? Medications and devices can be used to manage withdrawal symptoms, prevent relapse, and treat co-occurring conditions. Medications and devices can help suppress withdrawal symptoms during detoxification. Detoxification is not in itself "treatment," but only the first step in the process. Patients who do not receive any further treatment after detoxification usually resume their drug use. One study of treatment facilities found that medications were used in almost 80 percent of detoxifications SAMHSA, This device is placed behind the ear and sends electrical pulses to stimulate certain brain nerves. Patients can use medications to help re-establish normal brain function and decrease cravings. Medications are available for treatment of opioid heroin, prescription pain relievers , tobacco nicotine , and alcohol addiction. Scientists are developing other medications to treat stimulant cocaine, methamphetamine and cannabis marijuana addiction. People who use more than one drug, which is very common, need treatment for all of the substances they use. Acting on the same targets in the brain as heroin and morphine, methadone and buprenorphine suppress withdrawal symptoms and relieve cravings. Naltrexone blocks the effects of opioids at their receptor sites in the brain and should be used only in patients who have already been detoxified. All medications help patients reduce drug seeking and related criminal behavior and help them become more open to behavioral treatments. Because full detoxification is necessary for treatment with naloxone, initiating treatment among active users was difficult, but once detoxification was complete, both medications had similar effectiveness. Nicotine replacement therapies have several forms, including the patch, spray, gum, and lozenges. These products are available over the counter. They work differently in the brain, but both help prevent relapse in people trying to quit. The medications are more effective when combined with behavioral treatments, such as group and individual therapy as well as telephone quitlines. Three medications have been FDA-approved for treating alcohol addiction and a fourth, topiramate, has shown promise in clinical trials large-scale studies with people. The three approved medications are as follows: Naltrexone blocks opioid

receptors that are involved in the rewarding effects of drinking and in the craving for alcohol. It reduces relapse to heavy drinking and is highly effective in some patients. Genetic differences may affect how well the drug works in certain patients. It may be more effective in patients with severe addiction. Acetaldehyde builds up in the body, leading to unpleasant reactions that include flushing warmth and redness in the face , nausea, and irregular heartbeat if the patient drinks alcohol. Compliance taking the drug as prescribed can be a problem, but it may help patients who are highly motivated to quit drinking. How are behavioral therapies used to treat drug addiction? Behavioral therapies help patients: Most of the programs involve individual or group drug counseling, or both. These programs typically offer forms of behavioral therapy such as: After completing intensive treatment, patients transition to regular outpatient treatment, which meets less often and for fewer hours per week to help sustain their recovery. This application is intended to be used with outpatient treatment to treat alcohol, cocaine, marijuana, and stimulant substance use disorders. Licensed residential treatment facilities offer hour structured and intensive care, including safe housing and medical attention. Residential treatment facilities may use a variety of therapeutic approaches, and they are generally aimed at helping the patient live a drug-free, crime-free lifestyle after treatment. Examples of residential treatment settings include: Therapeutic communities, which are highly structured programs in which patients remain at a residence, typically for 6 to 12 months. Read more about therapeutic communities in the Therapeutic Communities Research Report at https: Shorter-term residential treatment, which typically focuses on detoxification as well as providing initial intensive counseling and preparation for treatment in a community-based setting. Recovery housing, which provides supervised, short-term housing for patients, often following other types of inpatient or residential treatment. Recovery housing can help people make the transition to an independent lifeâ€”for example, helping them learn how to manage finances or seek employment, as well as connecting them to support services in the community. Is treatment different for criminal justice populations? Scientific research since the mids shows that drug abuse treatment can help many drug-using offenders change their attitudes, beliefs, and behaviors towards drug abuse; avoid relapse; and successfully remove themselves from a life of substance abuse and crime. Many of the principles of treating drug addiction are similar for people within the criminal justice system as for those in the general population. Treatment that is of poor quality or is not well suited to the needs of offenders may not be effective at reducing drug use and criminal behavior. In addition to the general principles of treatment, some considerations specific to offenders include the following: This includes skills related to thinking, understanding, learning, and remembering. Treatment planning should include tailored services within the correctional facility as well as transition to community-based treatment after release. Ongoing coordination between treatment providers and courts or parole and probation officers is important in addressing the complex needs of offenders re-entering society. Challenges of Re-entry Drug abuse changes the function of the brain, and many things can "trigger" drug cravings within the brain. How many people get treatment for drug addiction? Of these, about 2.

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Chapter 2 : DrugFacts: Treatment Approaches for Drug Addiction | National Institute on Drug Abuse (NIDA

This volume brings together in a single source a set of perspectives by leaders in the clinical treatment of criminal offenders in outpatient settings, particularly those whose crimes have involved domestic violence and/or substance abuse.

Treatment Admission into a state hospital requires a court order. Each patient in state hospitals is admitted by order of a California court. More than 90 percent of our patients are forensic psychiatric patients, which means they are mental health patients who also have some involvement with the criminal justice system. The rest of our patients are admitted through a civil court process because they pose a danger to themselves or others and the mental health services of the county are insufficient to care for the individual. Here is a list of all county program phone numbers. Different types of treatment for are required for state hospital patients. All patients in state hospitals have an individualized treatment plan developed with them. Each patient is assigned to a treatment team, consisting of a psychiatrist, psychologist, social worker, rehabilitation therapist, and nursing staff. Daily interventions are provided by team members and other trained staff to support progress. The overall goal of treatment is preparing each one of our patients for discharge and to be successful in what comes next. For some, that next step may be life back in a community, for others it may be a criminal trial or a return to prison. Regardless, the Department of State Hospitals is committed to providing treatment that meets the highest therapeutic standards in a safe environment for staff and patients, while maintaining responsible stewardship, excellence in forensic evaluation, and excellence in treatment. What follows is information that provides a closer look at different treatment program that occur within our hospital as well as programs that continue for some after discharge. There is also information on the clinical team behind these programs. Civil Commitment Program People who come to a state hospital in California through a civil commitment require physically secure hour care that is not available through community programs. They have been found by the court to be a danger to themselves or others, or unable to provide for their own basic needs, such as health and safety, because of a mental disorder. Through this division, clinical staff has a voice in setting priorities, planning and decisions. The division works with statewide clinical leadership, to identify best practices and improve training. See more about Clinical Operations Conditional Release Some forensic patients are allowed to transition from being a patient in our hospitals to living in a California community by participating in an outpatient treatment system known as Conditional Release CONREP. Individuals must agree to follow a treatment plan designed by specialists and approved by the committing court. In order to protect the public, individuals who do not comply with treatment are reported to the court and can be returned to the state hospital. Some are referred by a criminal court for treatment that will help them to understand the criminal charges against them and to assist in their own defense. Others are admitted after they have been found not guilty by reason of insanity. A third group of forensic commitments are individuals who a state prisoners in need of mental health treatment. See more about Forensic Commitments and Treatment Sex Offender Commitment Program Concerns about violent, mentally disordered sex offenders being released from prison resulted in the Legislature creating a new category of civil commitment for individuals. Upon release from prison, a person determined by a court to be a sexually violent predator SVP may be placed in a state hospital facility. The initial term of commitment is indeterminate and the individuals are evaluated annually. If a judge later determines that the individual is no longer likely to commit an act of sexual violence, that person can be unconditionally released. Some civilly committed SVPs are allowed to transition from being a patient in our hospitals to living in a California community by participating in an outpatient treatment system.

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Chapter 3 : About TASC: Behavioral Health Clinic | TASC

Perspectives on clinical treatment in outpatient settings of criminal offenders, particularly those whose crimes have involved domestic violence or substance abuse.

This section provides a brief description of treatment levels that may be available in criminal justice settings. The continuum of treatment levels includes three major treatment categories: Several types of program services often are available within each treatment level. As the text box below indicates, research suggests that all major treatment levels are effective. Nonetheless, the consensus panel believes that clients should be matched not only on the intensity of services they need, but also on the particular components that are responsive to their individual needs. For example, reductions in weekly cocaine use from pretreatment to 1 year posttreatment followup ranged from 46 percent among short-term residential clients to 20 percent among outpatient methadone clients. Reductions in criminal activity from pretreatment to 1 year posttreatment followup ranged from 25 percent among long-term residential clients to 8 percent among outpatient clients. These factors, when routinely assessed by criminal justice programs, may be useful in targeting offenders who need more intensive services e. When routinely assessed, these predictors can help identify clients who require specialized interventions e. Clients are more likely to engage in ongoing peer support groups if they begin these activities during treatment. Pretreatment Services Pretreatment services, which are not part of primary treatment, include primary prevention, early intervention, and detoxification. Primary prevention and early intervention are not typically used in criminal justice settings. These are services for people who have not used substances. Most primary prevention programs are in schools or the community. This includes psychoeducational programs for those who have used substances and are considered to be at high risk for substance-related problems or have a history of substance abuse. Other interventions include screening and assessment to identify substance abuse problems. Brief interventions also are appropriate for offenders who use substances but who do not meet the diagnosis of having a substance use disorder. For example, ongoing evaluation can help determine if referral to a more intensive level of care is needed. In some instances, early intervention can be used as short-term treatment for individuals with low-severity substance abuse problems. Medically supervised detoxification services are required for offenders whose alcohol or drug abuse has caused severe and life-threatening symptoms e. Although detoxification typically is conducted prior to the onset of substance abuse treatment, it is important to provide a thorough assessment during detoxification and to provide orientation to the recovery and treatment process. Outpatient Treatment Also referred to as ambulatory care, outpatient treatment provides a broad range of services without overnight accommodation and includes nonintensive and intensive outpatient treatment, methadone treatment, and day treatment or partial hospitalization. Some of these services can be provided following inpatient or residential treatment, or as followup care after involvement in a residential program. This is substance abuse treatment that includes professional assessment and treatment involving less than 9 hours per week in regularly scheduled sessions. Nonintensive outpatient treatment often addresses related psychiatric, emotional, and social issues, and offers a forum to explore issues such as the relationship between violence and mental disorders. Nonintensive outpatient treatment also can accommodate clients with job or family responsibilities, as treatment services may be offered on weekends or evenings. This is substance abuse treatment with professional assessment and treatment from 9 to 20 hours per week in a structured program. These programs can be held on evenings or weekends. This is a medically supervised outpatient treatment that provides counseling while maintaining the client on the drug methadone. This regimen is used primarily for heroin or other opioid addiction and provides a legitimate, closely monitored substitute for illicit drugs. The client must be able to document at least a 2-year history of addiction to qualify for a methadone treatment program. It is rarely used with those who are incarcerated. Day treatment or partial hospitalization. This is substance abuse treatment with professional assessment and treatment of more than 20 hours per week in a structured program. This is the most intensive

of the outpatient treatment options and can be used for treating clients who demonstrate the greatest degree of dysfunction but who do not require inpatient or residential treatment. Evening and weekend programming often is included. Inpatient Treatment and Residential Care Inpatient treatment options include intensive medical, psychiatric, and psychosocial treatment provided on a hour basis. The continuum of residential care includes psychosocial care at the most intensive end and group living with no professional supervision at the least intensive end. It is unlikely that the full range of services will be available in any one community. This long-term treatment can be directed by a substance abuse treatment professional or could be medically directed. Intensive residential treatment is appropriate for people with multiple problems, especially those with co-occurring mental and substance use disorders COD. Psychosocial rehabilitation is always a goal of treatment. The duration of treatment in this setting varies considerably, from 3 months to as long as 2 years. The traditional TC is a long-term 15 to 24 months rehabilitative model that is often staffed by recovering professionals, treatment and mental health professionals, and vocational and educational counselors. Therapeutic help from the residential community paves the way for residents to recover from their substance abuse problems and to develop the vocational, educational, and social skills they need to become productive members of society. Most TC residents have been involved with the criminal justice system. The theory and practice of the TC have been detailed in the literature De Leon , and the effectiveness of these programs has been documented both in prisons and in community-based settings Melnick et al. This course consists of lectures, small groups, and instructional materials on the TC model and how it works. For more information go to www. This long-term 6 to 24 months psychosocial care model has elements similar to the therapeutic community model in that it relies heavily on peer pressure as well as formal treatment to shape behavior. It is appropriate for people with substance abuse problems and concomitant disorders that do not require acute medical or psychiatric intervention. People compliant with psychiatric and other prescription medications are appropriate for this level of care. The focus of care is on psychosocial rehabilitation. Medically monitored intensive inpatient treatment. This level of care involves around-the-clock medical monitoring, assessment, and treatment in an inpatient setting, usually by a nurse or nurse practitioner. It is used for clients who have acute and severe substance use disorders and who may also have a coexisting medical or psychiatric disorder. Such treatment generally involves a short to intermediate length of stay 7 to 45 days and may include nonmedical or social model programs with variable lengths of stay. Medically managed intensive inpatient treatment. This level of care involves around-the-clock, medically directed evaluation and treatment in an acute-care inpatient setting, usually by a medical doctor. This level of care is appropriate for the treatment of medical and psychiatric problems that may require biomedical treatment such as life support or secure services such as locked units. Such treatment generally involves a short to intermediate length of stay 7 to 45 days. Short-term nonhospital intensive residential treatment. This treatment is generally 21 to 45 days in length and is designed to teach the client how to live a substance-free life and to provide motivation for the maintenance of such a lifestyle. Follow-up care on an outpatient basis and continued participation in peer support groups is recommended to maintain the recovery process begun in the residential setting. Residents are expected to follow house rules and share house responsibilities in a residential setting under staff supervision. Residents generally find their own way to outside activities e. The house sometimes offers treatment services. Length of stay is limited or unlimited depending on the attainment of specific progress goals. This refers to a residential, transitional living situation without any specific treatment plan and minimal staff supervision. It is sometimes known as a three-quarter-way house. Residents may work and receive education, training, or treatment in the community. House residents generally decide on admission of new residents. House responsibilities are shared, and the house is governed and run by its residents. The length of stay is generally unlimited as long as abstinence from substances is maintained; the Oxford House model includes complete resident self-governance and self-sufficiency. The key to success in all such models is that the living situation is substance free, which supports abstinence among residents. Potential Barriers to Triage and Placement Inadequate Screening and Assessment Accurate screening and assessment are necessary for effective

placement. However, resources, adequate time to conduct comprehensive assessments, and trained staff are not always available in criminal justice settings. As a result, substance abuse treatment in criminal justice settings often is based on sparse and inadequate information Knight et al. Or, inmates could be assigned to institutional education programs. In addition, there are also competing demands for treatment. Treatment service options often are limited and waiting lists exist for most services in community-based programs. The community-based system of care across the country largely is funded to provide services to a nonoffender population. In some cases, prioritization of community treatment services for offenders has placed a strain on the limited number of available treatment slots. Information Flow Issues regarding the transfer of information across different settings in the criminal justice system present a major barrier to effective placement in offender treatment services. For example, this might include a need for a centralized database that can be accessed by various providers as offenders move through the system. Coordination of treatment matching within the criminal justice system can reduce the long-term costs of incarceration and other criminal justice functions only if adequate personnel and funding are available for case management. Ongoing planning and coordination among criminal justice staff, substance abuse treatment staff, and policymakers and other stakeholders is important to establish an effective treatment matching system. Once the triage and placement system has been developed, the team can review cases referred to treatment, transfers, and placement in high intensity or specialized treatment programs e. This coordinated approach also can ensure that ongoing troubleshooting occurs to adjust eligibility criteria, to check admission and transfer procedures, and to monitor reentry to the community. Scoring criteria for assigning offenders to different levels of treatment often are developed by clinical staff with significant involvement and review by criminal justice staff e. Use of scoring criteria and development of a triage and placement database are useful for document standardization and treatment provision across different groups of offenders. Following are key triage and placement activities that the consensus panel believes can be jointly undertaken by a team of correctional and clinical staff: Developing a treatment placement database of treatment resources available in the community or correctional facility Defining key characteristics of existing treatment programs and the types of offenders and associated levels of treatment needs with whom the programs are most successful Documenting the referral process with appropriate timeframes and communication requirements for each system Outlining the information to be shared between agencies and developing procedures for transfer of key information without breaching confidentiality for more information on confidentiality, go to www. In some criminal justice settings e. In these settings, elaborate triage and referral systems are unnecessary, and placement decisions are often based on a brief substance abuse screening and a brief risk screening e. This often is accomplished by a single staff member and through a combination of self-administered tests, brief interview, and records review. In settings that feature a range of treatment services, triage and placement are usually lengthier, often involving multiple staff and compilation of multiple sources of information. Research indicates that treatment programs targeting offenders with moderate to high risk for recidivism produce the greatest posttreatment reductions in recidivism and are more cost-effective Andrews et al. However, research does not support placement of moderate- to high-risk offenders in minimally intensive treatment services e.

Chapter 4 : Behavioral Health Services - SHIELDS for Families

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Consultations at BPC provide many opportunities for court testimony. Statewide work at BPC is focused on: Forensic evaluations of insanity acquitees both immediately past -acquittal and at critical treatment junctures Risk assessments at state hospitals and correctional settings Forensic program and policy development for New York State Office of Mental Health. These referrals involve include fitness to stand trial, health care law, domestic violence, immigration proceedings, veteran status hearings and child custody evaluations. Fellows are generally actively involved in consultations at any given time, including both Bronx PC and State-wide work. Faculty at BPC includes the Program Director and one of the Associate Program Directors, who share overall responsibility for education and training on-site and throughout the program and directly train fellows for a total of three to four hours a week. The faculty also supervises the state-wide and non-state cases that are referred to the program for evaluation and consultation. The program offers mental health evaluations for both adults and children who are involved in ongoing custody-visitation proceedings, as well as for children and adolescents engaged in delinquency proceedings. Fellows are required to spend one day a week for a six month period dedicated to this service. A child under the age of 18 who does not attend school, or behaves in a way that is dangerous or out of control--or often disobeys his or her parents, guardians or other authorities--may be found to be a Person In Need of Supervision or "PINS". After an initial period of observing evaluations, fellows will conduct evaluations and complete a report under the guidance of the site supervisor. Reports will be presented to the court and fellows will have opportunities for expert testimony. Fellows attend a series of lectures regarding issues relevant to the forensic assessments they are performing. Faculty consists of a forensic psychologist with extensive experience in both performing family court cases and training fellows to do same. The faculty provides both direct service and ongoing supervision. In addition, fellows have at least one hour of individual supervision with a forensic faculty member each week. It offers an alternative to incarceration by evaluating, placing and monitoring defendants who are referred for possible diversion from jail and prison into residential and outpatient mental health settings. Working with the diversion service provides the residents with active exposure to this increasingly important area of forensic psychiatry. This group of patients comprise an ethnically, racially, socioeconomically, culturally and diagnostically diverse population. They have usually been charged with a felony and are facing prison time, if not diverted into treatment under court supervision. Each defendant referred is evaluated comprehensively for history of mental illness, current clinical condition and risk assessment. The majority of cases in which pleas are taken and diversion approved are transferred to a specially-created mental health court for monitoring. The forensic fellows are required to spend one full day a week for six months on this service. Knowledge of what what kinds of defendants are referred, how the mental health system views them Understanding the particular challenges of running a diversion service. Opportunities to participate in ongoing multi-system collaboration and research in diversion. Forensic faculty at Bronx TASC consists of a forensic psychiatrist who is also an Associate Fellowship Program Director and a forensic psychologist, who provide direct and ongoing supervision. Fellows receive at least one hour of individual supervision each week with a forensic faculty member. Sing Sing is a Maximum Security Prison with: A general population census of about active patients, most on psychotropic medication. Their diagnoses include Axis I and Axis II disorders, ranging from active psychosis to persistent character pathology An Outpatient Satellite Unit with a bed crisis Unit with six mental observation cells An Intermediate Care Unit a Day Hospital model with 62 beds The fellow functions as part of the mental health team and attends morning rounds and participates in evaluating admissions to the residential unit. Caseloads average 12 patients. Our fellows spend two full days a week for six months at Sing Sing. The Clinical Director of the mental health unit and Unit Chief coordinate the program and provide

clinical on-site guidance and supervision. Other teachers include social workers and psychology and administration staff with significant experience in correctional psychiatry. Outpatient responsibilities include initial psychiatric evaluations, as well as continuing medication cases. The fellow functions as part of the mental health team and attends morning rounds and participates in evaluating admissions to the residential crisis unit. Four hours on site are devoted to these duties. Caseloads average patients. Six hours will be devoted to these duties. Fellows also have opportunities to visit related facilities, including: Depending on your individual interest, you may spend up to four hours a week at Downstate or Bedford Hills. Mental health services are provided for the detection, diagnosis and treatment of mental illness. Currently, mental health services are provided at eleven sites, nine of which are on Rikers Island. In addition to mental health staff e. Our Forensic psychiatry fellows who participate in this program will be given: Training in conducting mental health assessments and continuing mental health treatment within the context of the correctional setting An orientation to all services, policies and procedures An orientation to general Correctional Health rules and regulations Exposure to clinical administrative decision making within a correctional setting Research Opportunities Our fellows enjoy many research opportunities. We expect them to participate either in ongoing division work or to develop an independent project of their own with the anticipated goal of giving a year-end presentations of their individual work. In addition, we encourage fellows to submit abstracts for annual meeting presentations. These have covered a wide range of topics, including: Evaluations objectively inform the court with regard to the parental capacity of adult parties involvedâ€”as well as the emotional, educational and social adjustment of children who are either subjects in custody proceedings or respondents in delinquency cases. Evaluations are intended to assist judges in making dispositions in these cases. Expert testimony is provided if deemed necessary by the court.

Chapter 5 : Outpatient Clinics for Behavioral Health

www.nxgvision.com: The Clinical Treatment of the Criminal Offender in Outpatient Mental Health Settings: New and Emerging Perspectives (Journal of Offender Counseling, Services & Rehabilitation) (): Letitia C Pallone: Books.

Criminal thinking assessment and treatment HIV education sexual health Assistance in accessing State or Federal entitlements such as Medicaid; Temporary Assistance for Needy Families; Women, Infants, and Children Program; Food Stamps; and housing programs available for clients willing to enter treatment These additional services are integral to fostering long-term recovery but they do add cost, more service and supervision layers, and the need for case management. In the long run, however, treatment can save greater costs to the criminal justice, medical, and foster care systems. Use of Sanctions Judges and prosecutors have seen that sanctions encourage participation in treatment and are necessary to gain public acceptance of treatment in lieu of punishment. Sanctions include a range of measures that focus on holding offenders accountable for their actions. When a system of sanctions is implemented in concert with a sound treatment plan, offenders swiftly experience real consequences of their actions. This accountability is achieved through graduated sanctions. For example, an offender in an outpatient program requires drug testing three times per week. After a first positive drug test, the offender may be required to participate in treatment exercises to address reasons for relapse and may be required to submit to more frequent testing. If the offender continues to test positive, he or she may be required to enroll in more intensive services e. Further, if an offender, who pleaded guilty and received a deferred jail or prison sentence so that he could enter treatment, continues to fail to comply with his treatment program, despite the imposition of intermediate sanctions, the ultimate sanction of a sentence of incarceration will be imposed. It is important, from a motivational standpoint, that other program participants see what will happen to them i. Other sanctions such as victim impact meetings encourage the offender to recognize how drug-related activities affect the community. If the offender fails to complete the required treatment activities, victim restitution may be imposed as the next level of sanctions. By holding offenders accountable, graduated sanctions can be effective in redirecting individuals away from substance abuse and toward recovery. In general, the availability and use of sanctions tends to strengthen the impact of treatment, just as involvement in treatment tends to strengthen adherence to community supervision arrangements. The total amount of these fines is calibrated to both the severity of the crime and the discretionary income of the offender, with the calibration and calculation established by the court as a whole for all cases in which this type of fine is to be imposed. This type of fine contrasts with traditional fines that are imposed at the discretion of the judge according to ranges set by the legislature for particular offenses. This approach to setting the fine amount is typically coupled with expanded payment options and collection procedures that are tighter than usual. This is the performance by offenders of services or manual labor for government, private, or nonprofit organizations for a set number of hours with no payment. Community service can be arranged for individuals, case-by-case, or organized by corrections agencies as programs. For example, a group of offenders can serve as a work crew to clean highways or paint buildings. In some cases, payment is made to a general victim compensation fund; in others, especially where there is no identifiable victim, payment is made to the community as a whole with the payment going to the municipal or State treasury. Outpatient or residential substance abuse treatment centers. Both public and private treatment centers may be contracted to provide treatment to offenders, as described in this TIP. Day reporting centers or residential centers for other types of treatment or training. These centers are established to provide services other than substance abuse treatment. The level and types of supervision that are labeled intensive vary widely but usually involve closer supervision and greater reporting requirements than regular probation for offenders. This level can range from more than five contacts per week to fewer than four per month. Supervision usually entails other obligations to attend school, have a job, participate in treatment, or the like. Intensive supervision parole has similar requirements and variations but is usually provided by parole agents to offenders who have

completed a prison term and who are serving the balance of their sentences in the community. Curfews or house arrest with or without electronic monitoring. Offenders are restricted to their homes for various durations of time, ranging from all the time to all times except for work or treatment hours, with a few hours for recreation. Frequently, the curfew or house arrest is enforced by means of an electronic device worn by the offender, which can alert corrections officials to his or her unauthorized absence from the house. Halfway houses or work release centers. Offenders are restricted to the facility but can leave for work, school, or treatment. The facility is in the community or attached to a jail or similar institution. Brief jail incarceration e. Brief incarceration is often used with offenders who have committed major program infractions in DTCs or in other diversion programs. This provides respite from temptations to use drugs and is useful in reinforcing the importance of sobriety and treatment. In some cases, incarceration can be used counterproductively for DTC or diversion participants if it is lengthy and if it prevents the offender from reengaging in treatment activities. Typically, a sentence to a boot camp also called shock incarceration is for a relatively short time 3 to 6 months. As the name implies, boot camps are characterized by intense regimentation, physical conditioning, manual labor, drill and ceremony, and military-style obedience. Because boot camps are a form of incarceration, some in the criminal justice field reject their inclusion in the category of intermediate sanctions. Others include boot camps because placement in them is intended to take the place of a longer, traditional prison term. Several research studies have shown that boot camps do not significantly reduce criminal recidivism or substance abuse. One potential explanation for these findings is that most boot camps do not provide intensive substance abuse treatment services. How to use sanctions Evidence on the usefulness of sanctions from other institutional settings demonstrates several principles. Sanctions must be of sufficient intensity so the client does not become habituated to threats and punishments, yet not so severe that the judge exhausts all options for sanctions. A sanction should be delivered for each infraction. To the extent possible, sanctions should be delivered immediately after the undesirable behavior. Undesirable behavior must be reliably detected e. Behavior does not change by punishment alone; desired behaviors should be rewarded. Rewards for positive behavior and behavior change in DTCs include public praise and recognition of achievement by the judge and other staff, reduction of fees or time in the program, small prizes such as key chains or movie tickets, and certificates of phase and program completion. Treatment Issues The counselor-client relationship in a pretrial setting raises unique challenges. For one, the role of the counselor can become blurred between therapist and gatekeeper, answerable to both the treatment and the criminal justice communities. The discussion below highlights some of the issues counselors operating in a pretrial setting are likely to face. Importance of Screening Unpredictability characterizes the hours and days immediately following arrest. The rapidly developing nature of arrest and arraignment creates a challenge for counselors in gaining access to the arrestee. Arrests can occur at odd hours, while assessment staff are unavailable. Interviewing conditions, such as in a police lockup, are less than ideal. Still, the consensus panel believes that detainees should receive screening for substance abuse during the initial intake procedure to determine whether further assessment should be recommended or whether referrals should be made. See chapter 2 , Screening and Assessment, for examples of appropriate screening instruments. Prompt screening is also important to identify offenders in need of detoxification services. Understanding this, some offenders who do not genuinely have a drug or alcohol problem will participate in treatment nonetheless. One example is a drug dealer who does not have a substance use disorder, but earns income from drug trafficking. During assessment the offender may deny using substances. To address this dilemma, the panel suggests that treatment counselors assess collateral evidence of a substance use disorder. Not every offender is appropriate for treatment. Early drug screening and the use of professional alcohol breathalizers can also be helpful in determining the need for further screening and treatment. Advice to the Counselor: For example, it is unrealistic to believe that a defendant will suddenly become a model citizen, meeting all of his or her responsibilities, simply because of an arrest. Generally, these are people who are knowledgeable about criminal justice processing and different community treatment systems and resources. Meeting Immediate

Needs The pretrial setting can create difficult scheduling problems for clients. Individuals may have lost their jobs because of an arrest, and clients who are employed may wonder how they will hold onto their job if they are required to attend treatment. This is especially true when weighed against considerations such as displacement from housing and lack of appropriate childcare. Many clients who are navigating more immediate and pressing needs are not ready to engage in the therapeutic process. Effective triage helps to build client trust and lays a foundation for successful engagement in therapy. The consensus panel recommends that counselors prioritize case management services to include the most pressing client needs, such as food, clothing, shelter, and medical treatment. Does the client need detoxification? Are there childcare issues to be resolved? Is the client in need of medication? Screen for the need for detoxification services and refer clients when appropriate. Train staff in signs and symptoms of withdrawal so that staff can detoxify clients from alcohol and drugs. Provide on-site childcare at treatment facilities. Provide bus tokens, car-service vouchers, and transportation support. Ensure that medical needs are addressed, including receipt of prescription medicines and screening for infectious diseases. Maintaining Existing Services In many U. Although Federal regulations do not require these supports to be terminated for jail detainees, misunderstandings regarding policies often result in loss of services. Upon release, these individuals must re-apply for Federal supports, a somewhat lengthy process that often creates a delay in access to community treatment services. A lapse between incarceration and treatment without benefits means that these individuals are often unable to meet their basic subsistence, health, and mental health needs and usually lose any stabilization gained while in jail, bringing them back in contact with the criminal justice system after a short period of time National GAINS Center b. In Lane County, Oregon, diverted individuals with co-occurring mental and substance use disorders experienced difficulties in maintaining uninterrupted treatment due to issues with Medicaid and Social Security Insurance benefits. The State recognized this situation as a continuum-of-care issue for those with short-term stays in the jail. In addition to this policy change, Lane County has coordinated with the local application processing agency for Medicaid and Social Security Insurance. This relationship allows detainees who did not have benefits upon booking or who have been incarcerated longer than 14 days to begin the application process while still in custody. Diversion program participants are now given priority and are able to regain or obtain benefits within a few days National GAINS Center b. The staff of the Lane County diversion program reports that the disenrollment policy has been crucial for offenders and has greatly benefited program participants. Other jail staff members, providers, and advocates are also encouraged to develop a thorough understanding of the rules regarding Federal benefits, and to maintain an open line of communication with the State Medicaid agency and local Social Security office National GAINS Center b. An MOU signed by the prosecutor will ensure that the prosecuting attorney in the case will not use information gathered during the treatment process against the client. A judicial order attached to such an MOU may carry more weight:

Chapter 6 : CA Dept of State Hospitals - Treatment

Group mental health counseling ranges from structured settings with strict objectives to flexible, process-focused group treatment - depending on the individual needs of our clients. AT TASC, all clients, even in group settings, are treated with dignity, respect and confidentiality.

Criminal Justice Research Training Program Incarceration and Mental Health The closing of state psychiatric facilities during the process of deinstitutionalization in the s was intended to improve care for people suffering from mental illness and shift treatment provision to less restrictive settings. People with mental illness left state-funded institutions to return home, to nursing homes, and other community-based residences. However, nearly half of the proposed community-based health centers that were to replace state psychiatric facilities were never built, and those that were completed ran into financial distress when federal money ran out a few years later. The lack of sufficient community-based treatment options has instead resulted in the drastic increase in the incarceration of the people with mental illness. In fact, correctional facilities in New York, Los Angeles, and Chicago currently act as the three biggest psychiatric facilities in the country. The number of hospitalized persons with serious mental illness SMI decreased from , in the s to 70, in ; concurrently, the prison population grew from , in the s to 5. The percentage of individuals with SMI in prisons increased from. The War on Drugs may account for up to two-thirds of the increase in the federal prison population and one-half of the increase in the state prison populations between and Given the comorbidity of mental illness and substance dependence, the War on Drugs has made a significant contribution to the increase the number of people with mental illness behind bar. Compared to the general population, justice-involved individuals are substantially more likely to have a history of mental illness, including psychotic illness and depression, as well as of trauma stemming from abuse. Data from shows that over half of prison and jail inmates meet criteria for mental illness. Female inmates and older inmates have higher rates of mental illness, and suicide rates in detention facilities are approximately three times greater than in the general population. People with mental illness are 4. Incarcerating people with SMI raises a number of critical ethical and security issues. Mental illness is associated with high recidivism rates and increased rates of disciplinary infractions in prisons, making incarceration for individuals suffering from mental illness challenging for staff and other inmates. Mentally ill prisoners are disproportionately placed in solitary confinement as a response to behavioral difficulties, which can cause their mental health to deteriorate further. As a vulnerable population, they are also at a higher risk for abuse by other inmates and correctional staff. The use of segregation and medical services associated with inmates that have SMI, as well as the cost of litigation associated with inmate abuse and mistreatment makes them an extremely expensive population to house in correctional facilities. More communities are now attempting to keep the people with mental illness out of the criminal justice system by using specialized police- or court-based diversion programs. The Affordable Care Act presents a unique opportunity to get more people into care for the mental health issues, and hopefully stem the tide of incarceration. As awareness grows about the problem of incarcerating people with mental illness, communities will need to once again address the need to expand local resources for treating mental illness. Public Health and the Epidemic of Incarceration. Annual Review of Public Health,33, Deaths in Custody Statistical Tables. The research articles included below are intended to provide tools for general readers as well as researchers and students who are interested in learning more about Incarceration and Mental Health. The list is neither comprehensive nor exhaustive, but is intended to help a reader dive deeper into the subject matter at hand. We will be updating articles on a monthly basis. Measuring suicidality using the personality assessment inventory: The data indicated robust validity support for both the Suicide Ideation Scale and Suicide Potential Index, which were each correlated with a broad group of validity indices representing multiple assessment modalities. Recommendations for future research to build upon these findings through replication and extension are made. A second purpose was to determine whether the effect of comorbid antisocial and substance misuse proclivity

on mental health service utilization is cumulative or interactive. In a survey of female federal prison inmates, it was noted that proclivity for both antisocial behavior and substance misuse was associated with significantly greater subsequent use of mental health services in female inmates than either proclivity alone, even after preexisting mental health diagnoses and treatment were controlled. In addition, the effect was additive rather than interactive. Testing of conditional effects Matejkowski J, Ostermann M. The current study examined whether this relationship with recidivism is mediated by criminal risk level and whether parole supervision can ameliorate the effects of SMI on recidivism. Findings indicate that SMI did exhibit a significant indirect effect with recidivism when considering its relationship with actuarially assessed risk. However, this indirect effect was not conditioned by whether the individual was released to parole; specifically release status did not moderate the relationship between risk and recidivism. The direct effects of SMI on recidivism were found to be conditioned upon release status. Specifically, we found no relationship between SMI and recidivism for parolees and a negative relationship between SMI and recidivism among nonparolees. Findings indicate a need for paroling authorities to find more effective ways of reducing criminal risk, which can decrease subsequent recidivism, among the individuals they supervise. Most female inmates have mental health, substance use, or co-occurring disorders CODs , which can create greater difficulty adjusting to incarceration and higher rates of prison misconduct. This article examined whether disciplinary actions are more severe for women with CODs. The final sample of women included those who had committed a minor misconduct during their incarceration. Disorder categories were created based on intake assessments, and multivariate models were estimated to determine the effect of disorder category on whether the prison imposed a severe or minor disciplinary response to the misconduct. The odds of receiving severe disciplinary responses to minor misconduct was significantly greater for women with CODs than those with the singular disorders of mental illness or substance abuse disorders, or those with no disorders. Conclusions and Implications for Practice: Findings suggest correctional institutions are responding in a punitive manner to the symptomatic manifestations of CODs in female inmates. These findings suggest the importance of screening instruments in correctional settings that assess for the presence of dual disorders. In addition, correctional administrators must implement training protocols for correctional officers and staff on the complexity of CODs and the ability to identify behavioral and emotional symptoms associated with this vulnerable subset of the offender population. Adm Policy Ment Health. This longitudinal study explores patterns and barriers for engaging treatment services during early reentry. Seventy-five men and 62 women in jail, prison, or community based correctional facilities CBCFs participated in pre- and post-release interviews. Findings indicate that services were engaged at a lower-than-needed rate and barriers were greater for individuals leaving jails compared to prison or CBCF. Exploratory factor analysis of the barriers instrument is presented. Implications for extending service access to this population are discussed, as are future directions for research.

Chapter 7 : Incarceration and Mental Health | The Center for Prisoner Health and Human Rights

CSO is a Certified Community Behavioral Health Clinic and provides a full range of behavioral health and substance abuse services through a network of five licensed outpatient sites. Services are provided both on-site and in homes, schools and other community settings.

Share via Print Although some prisons do have programs such as group therapy sessions that are intended to treat mental disorders, these interventions are largely unsuccessful. Most defendants with mental illnesses end up incarceratedâ€”studies reveal that fully half of all prisoners have at least one mental disorder. That is one million people in the U. As a result, the recidivism rate among released convicts is especially high for those with serious disorders. Forensic hospitals, on the other hand, which hold and treat offenders found not guilty by reason of insanity, have a very high success rate in preventing disordered individuals from returning to crime. Psychiatrist Jeremy Coid and his colleagues at St. Still, solutions are within reach. A Connecticut program, for example, allows some veterans who have committed crimes to seek psychiatric treatment instead of serving time. Public knowledge of and support for such programs are essential to breaking the cycle of crime that the current prison system perpetuates. Prisons as Mental Institutions The prison system functions in substantial part as the successor to our shuttered mental institutions. First, the invention of antipsychotic medication in the s led to a movement to close the many psychiatric hospitals then extant. These closed institutions were supposed to be replaced by community facilities, but in reality most were not. More offenders with psychiatric and substance abuse problems, often one and the same, were incarcerated for many years without treatment and then released into a community that had nothing for them: This led to drifting, homelessness, further mental decline and the chronic reoffending we see today. And their numbers are rising. Schnittker reports that for the past 40 years, the rate of incarceration has quintupled, from per , in to per , in As people go in, other people come out. Nationally, , inmates are released every year, which means, according to the National Institutes of Health, that more than , disordered offenders return untreated to society. In most accountings, most of these people will reoffend. Clearly, this system does not work. Strikingly, though, it runs in parallel with a system that does work, namely the system of forensic hospitals, which is where defendants end up who are found not guilty by reason of insanity. This outcome is difficult to achieve: A small fraction of 1 percent of all criminal defendants are acquitted by reason of insanity. Forensic hospitals confine people as prisons do but achieve radically different results. Both function by way of the criminal justice system, but prisons cause disordered offenders to break the law moreâ€”even more than offenders without a disorderâ€”whereas forensic hospitals treat offenders as patients who can and do recover and who return to society as people who can be expected, for the most part, to be law-abiding citizens. Cured of Criminality The radical difference in outcomes from these two systems is illustrated by the experience in Connecticut, where I practice law. Yet after their release, having been confined in mental hospitals, not prisons, not only are they less likely to reoffend than disordered inmates, but they are even less recidivist than offenders without a recognized mental illness. Indeed, in Connecticut they return to crime so seldom that the department of correction does not have a category for them in its annual recidivism reports. The agency with jurisdiction over acquittees, the Psychiatric Security Review Board, also does not publish data on persons discharged. In response to my inquiry, however, it reported that between and , four acquittees were arrested while on temporary leave, and one acquittee was arrested while on conditional release. Forensic hospitals provide one effective alternative to incarceration for disordered offenders. Mental health courts offer another. McNeil, a clinical psychologist at the Langley Porter Psychiatric Institute, part of the University of California, San Francisco, reported in that 34 states have such courts and that they are effective in reducing recidivism and violent reoffending. Typically these courts provide a separate docket for defendants with disorders, with designated judges and counsel, and they offer defendants the option of entering a nonadversarial process in which they follow a treatment plan in return for reduced sanctions. His results showed that mental health court

participants went longer without reoffending than those who did not participate. Further, the risk of violent offense was halved. Should Society Bear the Costs? We know treatment works. Yet the barriers to treating more mentally ill offenders are huge. For one, treatment is not cheap. Outpatient treatment for insanity acquittees is cheaper, although I could find no specific data on how much less. One advantage for states in classifying an offender as a patient is that he or she becomes eligible for Medicaid reimbursement, which means that the federal government covers half the cost of confinement and treatment. Still, that is a cost ultimately borne by society. The cost to society of treating mentally ill criminals is hard for some people to swallow. If offenders, disordered or not, are morally responsible for their offenses, why not just keep them in prison? It is so much cheaper. I believe the answer to this dilemma becomes apparent if one considers the etiology of mental disorder, which suggests that circumstances and experiences, rather than innate character flaws, give rise to symptoms. More than a million soldiers in World War II suffered enough mental symptoms to be deemed unfit for combat. At the time, doctors had no system of describing most of those symptoms. These symptoms and disorders were caused by conditions and circumstances, not moral defects; the more combat a soldier saw, the more likely he was to suffer symptoms. We can conclude that those who develop disorders, then, whether by circumstances or genetics, are not responsible for their dysfunction. Early Solutions Given the difficulty of successfully pleading not guilty by reason of insanityâ€”as well as the inherent problems in mixing disordered inmates, whose disorders tend to make them vulnerable, with nondisordered inmates, who are often predatorsâ€”early attempts at solving this problem have been workarounds. Mental health courts, which are designed to funnel mentally ill offenders who cannot make a legal case for insanity away from prisons and toward treatment, fall into this category. One successful program in Connecticut intervenes on behalf of veterans when they find themselves in criminal court, offering reduced or eliminated sentences in return for closely monitored psychiatric treatment. This policy of intervention speaks to a growing recognition that society is better served by treating mentally ill offenders than by incarcerating them. We are learning not to hold veterans responsible for how they react to the cauldrons they are thrust into. War, however, is not the only aspect of modern life that can produce disorder. Schnittker notes that in , 7. Work used to be how many of us redeemed ourselves from early disadvantages. We might hope the reigning powers will, as they did in another era, come to recognize the need people have for productive enterprise and the vital part work has in our individual and national psyches. Some may debate the connection between disorder and usefulness, but it is beyond contention that the rise in the number of persons incarcerated has been yoked to the rise of disordered persons incarcerated. We should recognize that unfortunate conditions produce unfortunate effects. We do not criminalize people who get sick from polluted waters nor those wounded and maimed in wars. We do not call them defective and make of them a pariah class. We treat them, and so should we do with the mentally disordered, however they exhibit that affliction. Choice, Guilt, Punishment, and Other Perspectives. Psychiatric Disorders and Repeat Incarceration: The Revolving Prison Door. Jacques Baillargeon, Ingrid A. Williams and Owen J. Incarceration and Psychiatric Disorder.

Chapter 8 : Clinical Services: Counseling & Treatment | TASC

Clinical Treatment Of The Criminal Off- Ender In Outpatient Mental Health Settings: Chaneles: Books - www.nxgvision.com

Chapter 9 : Sex Offender Archives - Affiliated Clinical Services

Levels of treatment services specified within the ASAM criteria would also need to be tailored to specific types of criminal justice settings (e.g., drug courts, restitution or day treatment centers, in-jail and in-prison settings), with additional client-offender dimensional criteria developed for each of these new settings.