Establishing mental health as a cornerstone of overall health.

Forensic Focus

Ohio | Department of Mental Health

Office of Forensic Services • December 2011

Above, Anita Lieser, Chief of ODMH's Office of Licensure and Certification, asks a question during the Trauma-Informed Care presentation by Lisa Drogosz, Ph.D., (photo above, right) during the 2011 Forensic Conference on November 17.

Chief's Corner

Highlights of Fall

By Tereasa Moorman-Jamison, LISW-S, CPM, Chief, Office of Forensic Services

We've passed from a busy autumn – full of yard work, back-to-school shopping and football games – into the hectic holiday season. In the Office of Forensic Services, fall included many conferences (including ours on Nov. 17) and grant reports due by the end of the federal fiscal year. This all requires staff to balance work and family while addressing our goal of improving the lives of people with mental illness who are involved in the criminal justice system. Following are some of the highlights from the last three months.

Community Linkage Updates

Under the leadership of Kathy Coate-Ortiz, the community linkage program continues to be a positive force in helping individuals with mental illness smoothly transition from prison to the community. We continue to make great strides in the processing of Supplemental Security Income (SSI) applications. We have also improved our linkage compliance rate (those offenders who agree to meet with a Community Linkage Social Worker) from about 64 percent to around 90 percent.

Our social workers are building great relationships with colleagues at the Ohio Department of Rehabilitation and Correction (ODRC) and other community stakeholders. We are taking our "show on the road" by meeting with boards, providers and other local entities to market the community linkage program and to gain valuable insight on how we can improve it.

At this time, one social worker vacancy exists for our northeast Ohio position.

Project VETS Grant

Our work with veterans who are involved in the criminal justice system is moving forward. Our original pilot site in Hamilton County now has a fully operational veteran's court and data collection from participating veterans continues.

The ODMH Office of Research and Evaluation (ORE), began data collection for the project in December 2010. ORE staff members have successfully collected baseline data on 61 individuals and six-month reassessment data on 17 of 24 eligible participants (a 70.8 percent success rate).

Some interesting information is that more than 66 percent graduated from college or attended some college and another 21 percent were high school graduates. However, in spite of the high level of education, only 20 percent are employed full time and over 50 percent are unemployed (including the disabled unemployed). We will continue to follow the participants in this program and have high hopes that the interventions that are being provided via the grant will lead to positive

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outcomes for the individual participants.

In addition, we are exploring two other potential Project VETS pilot sites in Mansfield and Chillicothe. Although we're still in the planning stages, we expect to enter into agreements with Mansfield in the very near future and will be conducting focus groups in the Chillicothe area to identify gaps and needs.

Good News on Forensic Funding

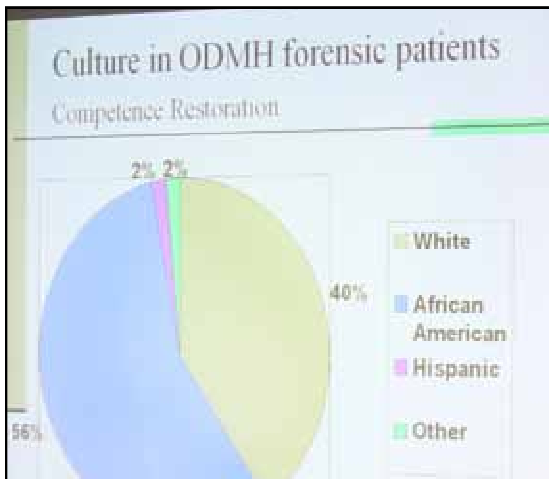
The General Revenue Funds for Forensic Services (line item 401) was kept whole for this State Fiscal Year 2012 (July 1, 2011- June 30, 2012). This line funds forensic evaluations for common pleas courts and partially funds the forensic monitoring activity, so this is good news both at the state and local levels. Both of these services are very valuable to the overall mental health system and to the individuals with mental illness who are involved in the criminal justice system.

New this year is a $400,000 block grant allocation to our office to assist with the reentry of individuals with mental illness from prison back to the community. We have selected to fund 14 grant applications from ADAMH boards interested in expanding services to offenders with mental illness leaving an ODRC prison. Grants range from $16,000 in Ashtabula to $80,000 in Franklin County. A complete list is available under "Numbered Advisories" on the ODMH website.

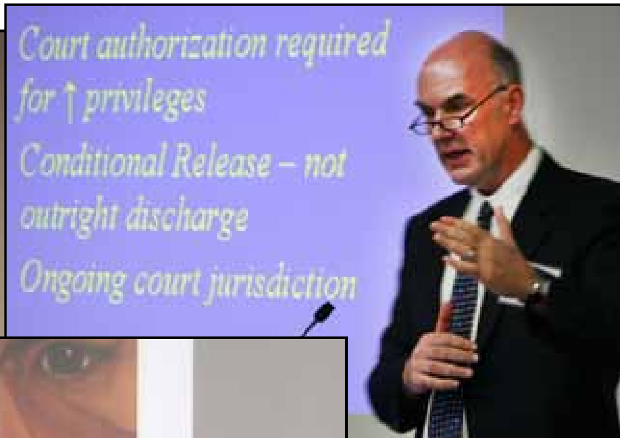
Forensic Strategies

Progress on the 2010 Forensic Strategies Workgroup recommendations continues. Most notably, Manager of Community Forensic Programs Bob Baker, Ph.D., is collaborating with others to decrease the number of people charged with misdemeanors who are admitted to our hospitals for competency restoration purposes. This change results in shorter lengths of stay for those who need stabilization and makes the most efficient use of our resources. He is educating various stakeholders (judges, court personnel, forensic monitors, etc.) about the forensic system and working with other state departments, community agencies and our state hospitals to improve collaboration and efficiency of forensic processes.

Our office is committed to ongoing program and performance improvement. Enjoy the photos from our 2011 Forensic Conference held Nov. 17 at Mount Carmel Hospital, West in Columbus. PowerPoint slides from various presentations are available on the Forensic Services page of the ODMH website. See you next year!



ODMH Psychiatrist Delaney Smith, MD, (right) discussed the importance of cultural competence when delivering services.



Left, Forensic Psychiatrist and Lecturer Steve Noffsinger, M.D., of northeast Ohio presented on recent court decisions.

Above, ODMH Director Tracy Plouck welcomes the crowd of 273 attendees, followed by Community Forensic Manager Bob Baker, Ph.D., (left) who provided updates on new initiatives.

Ex-offenders Face Tough Odds, Success is Based in FACT

By Nikki Bisig, PCC-S, LICDC, ACT Services Director, Greater Cincinnati Behavioral Health Services

Ex-offenders have tough odds to face as they leave the prison system; add on a severe mental illness and the chances of success can seem pretty bleak. **Forensic Assertive Community Treatment** utilizes the ACT model of case management and incorporates the collaborative efforts of the corrections and mental health systems.

In 2002, the Ohio Department of Rehabilitation and Correction (ODRC) in collaboration with the Ohio Department of Mental Health (ODMH) decided to try a new approach for individuals with severe mental illness who were being released from Ohio's prisons on parole or post release control. Hamilton County was fortunate to be chosen as a site for this innovative project that has shaped our understanding of how successful reintegration can be approached for individuals with severe mental illness. Nine years later, the Hamilton County FACT Team remains a thriving program that has served more than 277 individuals.

Greater Cincinnati Behavioral Health Services (GCB) has been administering Hamilton County's FACT Team since its inception. The collaborative efforts of GCB, ODMH, the Hamilton County Adult Parole Authority (APA), the Hamilton County Mental Health and Recovery Services Board, Mental Health Access Point and ongoing grant funding through ODRC has made this program possible. These agencies have consistently worked together to provide oversight to the project through all stages of its development, identify and address system barriers for offenders returning to the community, and keep the program focused on fulfilling its mission.

The FACT Team is unlike traditional case management approaches in that it implements the evidence-based practice of ACT and applies it to a forensic population. ACT is designed to serve those individuals with severe mental illness who have the most intensive needs and are difficult to engage through traditional mental health models. It is a multi-disciplinary approach that uses assertive engagement and a team-based approach to treat the client in the community and flexibly respond to client needs.

A cornerstone of the ACT Model is the daily team meeting where the entire caseload is reviewed so that the resources of the team can be matched with the treatment needs of the clients in a constantly evolving and adaptable manner. The FACT team is made up of a full-time team leader, three full-time case managers, one full-time substance abuse specialist, a part-time psychiatrist, a part-time nurse and a full-time parole officer. The team is designed to serve 55 to 60 clients at a time.

Assertive Community Treatment (ACT) is a team approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation and support to people with serious and persistent mental illness such as schizophrenia.

A team of professionals whose backgrounds and training include social work, rehabilitation, counseling, nursing and psychiatry provide ACT services. These services include case management; initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services and other supports critical to an individual's ability to live successfully in the community. ACT services are available 24 hours per day, 365 days per year. Clients served by ACT have serious and persistent mental illness or personality disorders with severe functional impairments. They have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services. They often have co-existing problems, such as homelessness, substance abuse or involvement with the judicial system.

From Assertive Community Treatment Association website

The FACT Team has found that pairing the ACT Model with a forensic population is an excellent match. ACT lends itself extremely well to this population of clients who present with serious mental illness, functional impairments related to institutionalization, and often have significant risk and safety issues.

Another element that makes the FACT Team different than "treatment as usual" is the integration of a full-time parole officer (PO) who serves all of the clients on the FACT team. He is employed by the APA but he is a fully integrated member of the client's treatment team. He attends treatment team meetings and has daily contact with FACT case managers. His role as a "boundary spanner" between corrections and treatment is integral to the success of this team and the clients it serves.

The commitment from ODRC and the APA to devote a full time PO to a specific mental health team was a new initiative for them. Prior to the initiation of FACT, case managers had little access to a client's criminal history and/or potential for violence, limited knowledge of the client's legal issues, and few resources for managing high risk situations. Similarly, POs knew little about parolees' mental health symptoms and medications, had limited contact with parolees due to large caseloads, and little access or knowledge of community and mental health resources available to these individuals.

Continued next page »

Under the FACT model, the PO has all of the powers of arrest for parole violations, the ability to write psychiatric holds and is an active member of the treatment team. The mental health treatment team in return has input in parole matters such as sanctions and the time when someone is released from supervision. The team is also frequently involved in parole board hearings.

This unique, integrated relationship is critical to the success of the program. Individuals with specialized needs require a specialized approach to service. We have found that approach in FACT.

Outcomes:

From June 2002 to September 2011, FACT served 277 clients. Over the course of the project, 75 percent of these clients successfully completed parole or are still on parole at this time. The majority of these individuals had been in prison more than one time and had failed on community supervision in the past. Some of FACT's most astounding success stories have been individuals who had failed on parole multiple times in the past and have successfully completed supervision with the help of FACT services.

Client Demographics:

Gender: 86% Male; 14% Female

Race: 71% African-American; 29% Caucasian

Axis I Diagnoses:

Schizophrenia: 36%

Schizoaffective Disorder: 24%

Bipolar Disorder: 23%

Major Depression or other Mood Disorders: 17%

89% of these individuals also had a co-occurring substance abuse disorder.

Offenses:

The offenses of these individuals include, but are not limited to, aggravated burglary, aggravated assault, aggravated manslaughter, aggravated vehicular homicide, involuntary manslaughter, voluntary manslaughter, murder, aggravated robbery, aggravated arson, escape, gross sexual imposition, attempted rape, rape, carrying concealed weapons, aggravated menacing and drug trafficking.

The population served by the FACT team is not a handpicked, most-likely-to-succeed group of ex-offenders. Prison terms of these individuals range from six months for a parole violation to 27 years for aggravated robbery and murder.

The team strives to find creative ways to serve this very high-risk population. The question that the team asks when reviewing referrals is not, "Can we serve this person?" but, rather, "How can we safely serve this person?" Very few referrals have been denied due to risk concerns over the course of the program.

Housing and Employment:

Seventy-two percent of FACT clients ultimately secure permanent housing while on the FACT team and 27 percent percent of FACT clients worked in tax-paying jobs while in services.

Just One of Many FACT Success Stories

At the time of release from prison in 2006, Jim was a 47-year-old, single, African-American male who had been incarcerated for 10 years for involuntary manslaughter and aggravated robbery. Prior to his most recent incarceration, he had been to prison at least three times for charges such as domestic violence and assault. His extensive criminal history began in his early adult years. He is a registered sex offender.

He is diagnosed with paranoid schizophrenia, antisocial personality disorder, and substance abuse issues -- cocaine, alcohol and marijuana. He had a great deal of anger and experienced mental health symptoms such as severe paranoia and command auditory hallucinations of a violent nature. His history included multiple hospitalizations when in the community and several suicide attempts.

That was the man before FACT. Today, Jim is 52 years old and has successfully completed his five years on parole. He has indicated that this is the first time he has ever successfully completed supervision through the criminal justice system.

Early in his treatment with the FACT Team he faced several parole violations and had one hospitalization. Over time, as he built trust with the FACT Team, he began to take his medications more consistently and to deal with his feelings of anger. He gained insight into his mental illness and developed coping skills to manage his symptoms.

Now, he is employed in two 30-hour-per-week jobs at two different fast food restaurants and is paying back child support. He is successfully maintaining his own apartment. There have been no new charges in the last five years and no hospitalizations for more than three years. He has also been clean and sober for three years.

Jim is now preparing to transition to services at a lower level of care within Greater Cincinnati Behavioral Health Services.

Spotlight on Community Linkage

Recent graduate, Babka wants to be part of the bigger picture

By Kathy Coate-Ortiz, Manager of ODMH's Community Linkage Program

Licensed Social Worker Elizabeth Babka joined the ODMH Office of Forensic Services in June of 2010 just after receiving a Master of Social Work degree from The Ohio State University. She previously graduated from Ohio University in 2009 with a bachelor's in social work.

During her undergraduate years, Elizabeth worked as a mental health technician at Fox Run, a child/adolescent residential treatment facility in St. Clairsville. She interned with the Athens County Court Appointed Special Advocates/ Guardian Ad Litem Program, helping abused or neglected dependent children of Athens County to advocate for their best interests in the court system. She later interned at Reynoldsburg High School and Trailblazers Alternative School providing crisis intervention, behavior modification, and other services for at-risk high school youth.

Elizabeth Babka

Through her studies and work experiences, Elizabeth saw the impact of mental illness on individuals, families, groups of people and society. She chose to join ODMH because she wanted to be a part of the bigger picture in advocating for those affected by mental illness, and to have the opportunity to be involved in program and policy changes that support the needs of consumers, communities and agencies. Elizabeth also wanted to expand her skills from working with children, adolescents and their families to include adults. She truly believes that Community Linkage Social Worker position chose her, rather than the other way around, because she was also interested in working in collaboration with the criminal justice system.

Born and raised in Belmont County, Elizabeth has friends and family in Noble County, and her school experiences in Athens and Franklin Counties. All of these connections help her to understand the communities where she is assigned. Elizabeth provides linkage services to these Ohio Department of Rehabilitation and Correction institutions: Belmont Correctional, Noble Correctional, Southeast Correctional, and Hocking Treatment Facility. Familiarity with the region helps her to provide the best possible linkage and reentry services for individuals with Severe and Persistent Mental Illness (SPMI).

Assisting individuals with SPMI in their reentry from institution to community, specifically securing their continuity of mental health treatment, is something that Elizabeth enjoys. She appreciates that individuals feel comfortable sharing their stories with her, regardless of what that story may be. Gaining knowledge about many different systems and agencies across the state is a benefit in her job, Elizabeth said. The opportunity to collaborate with community providers to provide continuity of mental health treatment is something that is rewarding both personally and professionally.

To further develop professionally, Elizabeth engages in continuing education courses and trainings. She is preparing for the LISW exam, including obtaining necessary supervision hours. In 10 years, she hopes to obtain her LISW-S and CDCA, hold the position as a department head or administrator, be actively involved in volunteering or moonlighting as an individual and family therapist, and starting a family of her own.

Family, friends and faith are three things that she holds close to her heart and from where she draws her ability to be patient, to empathize with individuals and to advocate for others. Elizabeth has a large family, including five siblings, 30+ aunts and uncles, two sets of parents, eight living grandparents, and 30+cousins and second cousins. She attended Catholic Schools for 14 years and through her freshman year in college. In her free time, she enjoys reading, spending time around campfires with family and friends, and playing tennis or hiking with co-workers.

Quotes from Elizabeth's ODRC peers:

From Social Worker James Yevincy, Belmont Correctional Institution: *"The addition of Elizabeth Babka to the Mental Health Department at BeCI has been nothing but positive. Her work is an essential component to our mission of reducing recidivism. Elizabeth's work ethic and professionalism are superb. On a more personal note, Elizabeth is great colleague and a positive person to work with. She is an essential and valued member of our Treatment Team."*

From Psychologist Supervisor/Mental Health Manager Dr. Janet Bowers, Southeast Correctional Institution: *"Elizabeth has the character, competence and work ethic that make her exceptional. She has a vivacious and focused way of interacting with both SCI staff and inmates. I respect her judgment and know the big picture is always in sight. Her personal talents and professional skills are consistently tempered with a sense of teamwork. She allows her experience and humor to surface at such times. She has the unique ability to express sensitivity along with a no-nonsense focus to the task at hand. When challenged, she clearly decides to 'try smarter' instead of 'try harder.' Elizabeth is a delight to work with and deserving of recognition."*

The Application of Risk-Need-Responsivity to Risk Assessment and Intervention-Planning: Opportunities, Current Limitations, and Relevant Research Needs

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Authors: Stephanie Brooks-Holliday, Kento Yasuhara, Sanjay Shah, Anne Bingham, Chris King, Danielle Hamilton, Anna Danylyuk, David DeMatteo & Kirk Heilbrun, Drexel University

The theory of risk-need-responsivity (RNR) has been widely recognized as an empirically-supported model of effective correctional assessment and programming. Developed by Andrews, Bonta, and Hoge (1990), the RNR model advocates matching intervention type and intensity with a particular offender's risk level and criminogenic needs. Rather than providing one-size fits all rehabilitation, this model promotes tailoring an individual's treatment to his or her individual, risk-relevant deficits. Accordingly, it is one of the best examples of the interface between assessment and intervention with offender populations.

Relevant Context

RNR in correctional settings. A series of studies has examined RNR on a meta-analytic level with a number of populations, including general and youthful offenders (Andrews, Zinger, Hoge, Bonta, Gendreau, et al., 1990), violent offenders (Dowden & Andrews, 2000), and females (Dowden & Andrews, 1999). In addition, a number of empirical studies have attempted to examine the implementation of RNR for specific correctional programs. These studies have provided support for the use of this model in correctional settings. For instance, a recent study in New Zealand found that medium- and high-risk offenders who received intensive cognitive-behavioral rehabilitation had 10-12% fewer reconvictions for violence compared to an untreated sample matched for risk level (Polaschek, 2011). Another study compared the recidivism of offenders in 5-, 10-, or 15-week interventions, and found that the match between risk level and service intensity did have important effects (Bourgon & Armstrong, 2005). High risk offenders who received longer interventions had lower recidivism than those in the shorter-term programs, whereas low-risk offenders participating in the longer-term intervention had higher recidivism than those who participated in the short-term intervention.

RNR and offenders with SMI. In addition, there is increasing evidence that RNR is an effective model for offenders with serious mental illness (SMI). Research has demonstrated that most offenders with mental illness share risk/need factors with offenders without mental illness, and that a small proportion of SMI offenders need primarily mental health treatment to curb offending behavior. Similarly, there is evidence that increasing mental health services does not necessarily reduce recidivism, and that instead the focus should be on high risk individuals, targeting criminogenic needs, and consideration of responsivity factors (Skeem, Manchak, & Peterson, 2011). This evidence suggests that RNR may have a role in treatment programming at forensic hospitals.

Research Gaps and Needs

Though RNR has been widely recognized as an effective model for intervention with justice-involved populations, there are some gaps and inconsistencies in the literature. For instance, meta-analyses have focused on RNR at a programmatic level, helping investigators determine whether a program *generally* served high- versus low-risk offenders, or if services were available to target criminogenic needs. Although other empirical studies have examined the risk level of individual program participants, relatively little research has focused on the effects of targeting an individual's specific criminogenic needs (Heilbrun et al., 2011). Other inconsistencies, such as lack of support for RNR in certain programs or with certain populations (e.g., Hall et al., 2010), suggest that something may be missing from the previous research. To better address these gaps, there should be an increased focus on the use of RNR for individual case planning.

This omission raises the question: how effective is RNR when implemented on an individual level? According to the RNR model, in addition to matching service intensity to an individual's risk level, two other considerations are important to individualized case planning. First, an offender should be matched to programs or services based on his specific criminogenic needs. For instance, an offender with deficits in education or unsupportive family relationships may be appropriate for GED courses and family service programs, whereas an offender with longstanding substance use and strong antisocial attitudes may be best served by substance use treatment and cognitive behavioral therapy designed to reduce thinking errors related to offending behaviors. Frequently, treatment programs are applied in a one-size-fits all manner due to a lack of financial resources or a shortage of staff. However, it seems a much better use of limited resources to provide only those services that an individual needs, thereby individualizing the risk-reduction impact, than to provide a generalized intervention to all offenders that may not target the necessary deficits.

The second consideration is specific responsivity. Whereas *general responsivity* dictates that effective programs follow a cognitive-behavioral or social-learning orientation, *specific responsivity* relates to the individual characteristics of offenders that should be considered in the delivery of interventions (Andrews & Bonta, 2010). These include a client's individual strengths, ability, motivation, personality, and bio-demographic characteristics. General responsivity

considerations have been widely studied and examined meta-analytically, and cognitive-behavioral interventions have been associated with a 15% reduction in recidivism over control groups (Smith, Gendreau, & Swartz, 2009). However, there is a noteworthy absence of empirical evidence regarding specific responsivity. This is true even though some risk/needs tools, such as the Level of Service/Case Management Inventory (LS/CMI; Andrews, Bonta, & Wormith, 2004), contain a section devoted to specific responsivity factors such as gender-specific issues, mental disorder, and interpersonal anxiety. Other interview-based and questionnaire-based classification approaches also exist. Andrews, Bonta, and Wormith (2006) noted the limited evaluations of responsivity systems in the context of risk and need, and emphasized the need for attention to specific responsivity domains--but this has yet to be accomplished in a systematic manner[1].

Other research has attempted to gauge the adherence to RNR at a number of correctional programs using a standardized assessment (Matthews, Hubbard, & Latessa, 2001). The results indicated that correctional programs typically do not follow the principles of effective intervention. For instance, the majority of programs received unsatisfactory scores with respect to pre-treatment assessment and program characteristics, and few had objective methods for assessing risk, need, and responsivity. Approximately 27% of programs assessed specific responsivity (though in a non-standardized manner); 16% varied intensity of treatment in accordance with risk level; and when risks or needs were assessed, this was done in a subjective manner guided largely by clinical judgment. However, even these studies focus more on the programmatic level than individual aspects of RNR implementation. To determine if RNR is truly an effective intervention, we believe it is important for correctional providers to begin considering the principles of risk, need, and specific responsivity when developing treatment plans for their clients.

Identification of Treatment Targets

Specialized risk assessment instruments. The third-generation of specialized risk assessment tools assess both static and dynamic risk factors, and the fourth-generation of instruments incorporates case management variables, thereby facilitating the implementation of a more individualized RNR approach. By providing information about an individual's specific needs, these results may be used to determine the services necessary to target and improve upon those needs. The fourth generation instruments also facilitate the consideration of specific responsivity factors, which is useful information for a treatment provider to consider when determining if an individual is more appropriate for group versus individual treatment, for example, or whether any intellectual deficits may interfere with treatment. A strong example of a fourth-generation instrument for use with adults is the LS/CMI (Andrews et al., 2004). There are also options for justice-involved juveniles and sexual offenders.

Linking Assessment and Intervention. Even when using a third- or fourth-generation specialized risk assessment tool, there are several steps that should be taken to ensure the appropriate assessment-intervention linkage is made in light of specific criminogenic needs and responsivity factors. These steps can be summarized as follows

1. *Supplement formal RNR assessment with behavioral analysis, record review, and collateral interviews.* In most cases, the domain of strong criminogenic needs for an individual will be covered by a specialized risk-need measure. Occasionally, however, a review of the individual's history of offending and violence obtained through records, collateral interviews, and behavioral analysis will reveal an unusual risk factor, or relevant strengths that may serve as protective factors. This information can be used to complement the measurement of risk and need using a specialized tool, more fully individualizing the assessment and providing a check on the comprehensiveness and accuracy of the information obtained with a specialized tool.
2. *Identifying appropriate interventions for risk-relevant needs.* Once a clinician has identified the needs, he or she must determine the approach to target these needs. For many criminogenic needs, a correctional or forensic facility may already have programming available, as with common deficits such as substance use, anger problems, educational deficits, or limited vocational skills. However, if an intervention does not exist for an identified deficit, then treatment staff must devise an individualized approach using an existing modality, using evidence-based interventions whenever possible.
3. *Avoiding the assignment of individuals to all available programs.* The literature related to the risk factor has demonstrated that providing intensive interventions to lower-risk individuals may have iatrogenic effects. In addition, some forms of treatment begin with the expectation that the individual will openly and honestly acknowledge a problem. Those without such a problem to honestly acknowledge may risk being seen as "in denial"—or may inadvertently promote genuine denial among those in a group with a problem. For these reasons, it is im-

[1] Vieira and colleagues (2009) evaluated the matching of services to criminogenic needs and responsivity factors among a sample of juvenile offenders who were referred for a court-ordered assessment at a mental health agency. They began by calculating a "matching variable" to reflect the match between number of present needs and services provided to address those needs, as well as the match between responsivity factors and services provided to address those factors. Individuals who had a greater proportion of their need and responsivity factors targeted had a significantly lower number of recidivism events, and a lower probability of reoffense. This study is an important example of the manner in which RNR may be operationalized on an individualized level. However, this area remains understudied. (Note: This footnote did not appear in the original AP-LS News article.)

portant to be deliberate in matching an individual to interventions based on a thorough consideration of risk level and clear criminogenic needs.

4. *Tailoring interventions in light of specific responsivity considerations.* Information regarding specific responsivity is often obtained from both self-report and past records. Such information may affect the way an intervention is delivered, giving the treatment-provider valuable information about the need for alterations that range from minor adjustments to major changes. If an individual is cognitively limited, for example, then interventions that rely on verbal facility or abstractions might be profitably adjusted to include a greater emphasis on modeling, role playing, and behavioral tracking. Similarly, treatment for males and females may have a somewhat different focus, particularly when addressing topics related to trauma and adverse events (Covington & Bloom, 2006).

The RNR model has promoted substantial empirical gains in the area of risk-need assessment and intervention-planning for justice-involved populations. Through an increased focus on individualized implementation of the RNR model, these gains can be more fully implemented on an individual level, complementing the programmatic advances that have been made.

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Bath Salts:

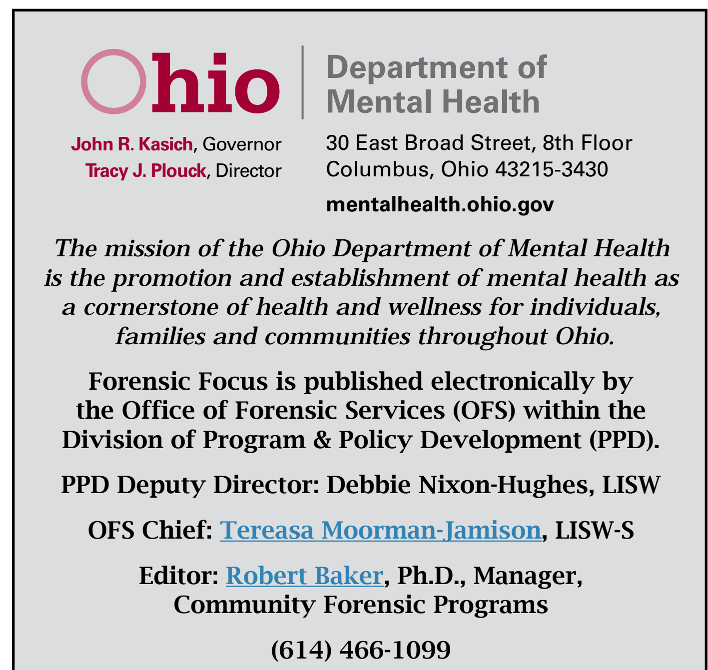
A Dangerous Designer Drug

By James Raia, Ph.D., Psychology Director, Twin Valley Behavioral Healthcare (TVBH), Columbus

In recent years, a new class of dangerous drugs is finding its way into the hands of curious people who are trying to get high but avoid legal consequences. These drugs are called "designer drugs," since they are synthetically developed to cause a high similar to illegal drugs but are chemically manipulated so that none of their active ingredients are illegal.

Often, designer drugs are more powerful than the drugs they mimic. They are also more unpredictable. For example, "bath salts" are more potent than cocaine, methamphetamine or ecstacy. Bath salts have been linked to extreme paranoia, agitation and horrifying hallucinations that can last for days. A review of TVBH patient admission records a few months ago showed that approximately 20 percent of the patients admitted had been exposed to the use of bath salts. Clinicians and others should become knowledgeable about the dangers of bath salts.

Editor's Note: Recently passed legislation made "bath salts" illegal in Ohio.



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The mission of the Ohio Department of Mental Health is the promotion and establishment of mental health as a cornerstone of health and wellness for individuals, families and communities throughout Ohio.

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