“What works” for justice-involved people with mental illness

Jennifer Skeem
Mental illness cases swamp criminal justice system
People with mental illness overrepresented in the criminal justice system

Steadman, Osher, et al. (2009): 14% men 31% women

Source: Teplin, 1990; Teplin, Abram, & McClelland, 1996
Most have co-occurring substance abuse disorders

Source: The National GAINS Center, 2004
Most supervised in the community… and often “fail” supervision

Sources: Bureau of Justice Statistics (2007); Skeem, Manchak & Peterson (2013)
“The current situation not only exacts a significant toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system.”

-Council of State Governments Criminal Justice/Mental Health Consensus Project (2002; see also 2014)
Perceived root of the problem

“People on the front lines every day believe too many people with mental illness become involved in the criminal justice system because the mental health system has somehow failed. They believe that if many of the people with mental illness received the services they needed, they would not end up under arrest, in jail, or facing charges in court”
The implicit model of “what works”

Sentence to treatment and/or specialty program

Psychiatric services → Symptom control

Reduced recidivism
Roadmap

• Problems with the implicit model
  • Symptoms rarely cause crime
  • Psychiatric services rarely reduce crime

• Refining the model

• Promising directions
  • Target robust risk factors
  • Use core correctional practices
  • Continue psychiatric services
Mental illness – alone – weakly predicts violence

- **Participants**
  - 1,136 psychiatric inpatients
  - 519 “neighbors”
- **Interviews**
  - Hospital baseline & five community follow-ups
  - One-time assessment
- **Violence (3 sources)**
  - Violence BR= 27.5%
  - OAA BR= 33.0%
- **Focus on first 10 week period**

Steadman et al. (1998); Monahan et al. (2001)
Among high risk people, symptom change predicts violence weakly – or not at all

Symptoms uncommonly cause arrest

Table 3

Mean of three raters’ probability estimates of effects of serious mental illness and substance abuse on committing a criminal offense and number of criminal offenses assigned a mean estimate of 75 ("probably") or higher

<table>
<thead>
<tr>
<th>Effect</th>
<th>Mean</th>
<th>CI</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct effect of serious mental illness</td>
<td>6.4</td>
<td>3.0–9.9</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Indirect effect of serious mental illness</td>
<td>14.3</td>
<td>10.2–18.4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Direct effect of substance abuse</td>
<td>22.5</td>
<td>15.7–29.3</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>Indirect effect of substance abuse</td>
<td>8.6</td>
<td>4.0–13.2</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

* The probability that offenses were the result of serious mental illness or substance abuse was rated as follows: 0, definitely not; 25, probably not; 50, possibly; 75, probably; and 100, definitely.

Junginger, Claypoole, Laygo, & Cristina (2006); see also Peterson, Skeem, et al. (2009, 2014)
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Psychiatric services not lynchpin

• “State of the art” psychiatric services rarely reduce recidivism
  • ACT - Clark, Ricketts, & McHugo, 1999
• Forensic adaptations sometimes reduce recidivism
  • FACT – Cusack, Morrissey, et al., 2010; cf. Morrissey, Meyer & Cudeback 2009
• But not for the assumed reasons
  • Specialty probation illustration…
MacArthur probation outcome study

- 360 methodologically- and statistically-matched probationers with mental disorder

- General officers
  - General caseloads
  - Standard/large size
  - Surveillance emphasis

- Specialty officers
  - Mental health caseloads
  - Reduced/small size
  - Rehabilitation emphasis (psychiatric)

Manchak et al., (2013); Skeem et al. (2014)
Specialty probationers less likely to be re-arrested than traditional counterparts

***$p < .001$, OR$= 1.94$ propensity weighted
But not because of symptom reduction

Site unrelated to i or s: $X^2 (5) = 6.12, \text{ns}; \text{CFI} = 1.0, \text{RMSEA} = .03$

Conditional model with site as covariate, propensity weighted
...or substance abuse reduction

• Baseline & twelve months
• Latent change score
  • Whole sample: “no change” model fits best
  • Subgroups: estimated slope not significant for either specialty or traditional (alcohol problems shown below)

![Diagram showing latent variable model]

- Alcohol problems

\[50.27^{***}\]

\[-1.33, \text{ns}\]

\[0.00, \text{ns}\]
…but not because of symptom reduction

Skeem et al. (2009; & in prep)

Similar findings in multi-site jail diversion & mental health court evaluations

Steadman & Naples (2005); Steadman et al. (2009)
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Integrating alternative views

• Some people with serious mental illness may “engage in offending and other forms of deviant behavior not because they have a mental disorder, but because they are poor. Their poverty situates them socially and geographically, and places them at risk of engaging in many of the same behaviors displayed by persons without mental illness who are similarly situated”
• Fisher et al. (2006), p. 553
General alternative model

Mental illness → Third variable → General risk factors → Criminal behavior

Skeem, Manchak, & Peterson (2012)
Offenders with mental illness have more general risk factors than their counterparts. 

...and these predict recidivism more strongly than risk factors unique to mental illness.

Source: Skeem, Nicholson, et al. (2014)
## Robust general risk factors
*(Andrews, 2006)*

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of criminal behavior</td>
<td>Build alternative behaviors</td>
</tr>
<tr>
<td>Antisocial personality pattern***</td>
<td>Problem solving skills, anger management</td>
</tr>
<tr>
<td>Antisocial cognition*</td>
<td>Develop less risky thinking</td>
</tr>
<tr>
<td>Antisocial peers</td>
<td>Reduce association with criminal others</td>
</tr>
<tr>
<td>Family and/or marital discord**</td>
<td>Reduce conflict, build positive relationships</td>
</tr>
<tr>
<td>Poor school and/or work performance*</td>
<td>Enhance performance, rewards</td>
</tr>
<tr>
<td>Few leisure or recreation activities</td>
<td>Enhance outside involvement</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Reduce use</td>
</tr>
</tbody>
</table>

***$p < .001$, **$p < .01$, *$p < .05$, PMI > Non-PMI, Skeem et al. (2014)***
Strongest risk factors for recidivism are shared
Refining the model of “what works”

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Reduced recidivism
Refining the model of “what works”

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- Psychiatric services
- Correctional services

Reduced recidivism
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Promise of explicitly targeting antisocial features

Effects of Cognitive-Behavioral Programs for Criminal Offenders

Mark W. Lipsey, Nana A. Landenberger, Sandra J. Wilson

Effect on recidivism not yet known

Sacks et al. (2004)
Robust risk factors occasionally targeted in specialty probation

Eno Louden, Skeem, et al. (2010)
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Officer-offender relationship quality explains effect of specialty probation.
Consistent with early, qualitative work

Process colors every interaction and affects outcomes

**Authoritarian**

- “The first time I met this particular probation officer, he let me know that he owns me…”
- “The first time I met him, he threatened to put me in prison…I got so damned scared, okay? And I didn’t do anything”
- “He is chuckling to the other one… and nods his head over towards me and says, ‘You can tell when he’s lying cause his lips are moving.’”

**Relational**

- “Actually the first question he asks when I step into his office is, ‘How are you doing?’ And he really wants to know…”
- “For me, we all need encouragement sometimes to do the right thing – and it’s okay with me as long as it’s done in the right way…talk to me first of all…if you think that I’m going in a direction that you feel is going to be harmful to me”
- “She talks to me the right way”
Dual role relationships

• Two roles
  • Therapeutic role ("social work")
  • Surveillance role ("police work")

• Hybrid orientations provide a broader base of power and are most effective in achieving change (Klockars, 1972)

## Dual Role Relationship Inventory

<table>
<thead>
<tr>
<th>Toughness</th>
<th>Caring, Fairness &amp; Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I feel that ____ is looking to punish me…</td>
<td>• I know that ____ truly wants to help me.</td>
</tr>
<tr>
<td>• …puts me down when I’ve done something wrong</td>
<td>• …treats me fairly.</td>
</tr>
<tr>
<td>• …makes unreasonable demands of me.</td>
<td>• …considers my views.</td>
</tr>
<tr>
<td>• …expects me to do all the work alone and doesn’t…</td>
<td>• …takes my needs into account.</td>
</tr>
<tr>
<td>• …talks down to me.</td>
<td>• …encourages me to work with him/her.</td>
</tr>
<tr>
<td>• If I’m going in a bad direction, ____ will talk with me…</td>
<td>• If I’m going in a bad direction, ____ will talk with me…</td>
</tr>
<tr>
<td>• …is someone I trust.</td>
<td>• …is someone I trust.</td>
</tr>
</tbody>
</table>

Dual role relationship quality

• Not the therapeutic alliance or “liking”
• Relates to within-meeting behavior (e.g., confrontation & resistance)
• Captures officer-offender & provider-offender relationships
• Protects against recidivism…
  • across risk levels
  • across mental health status

Skeem, Eno Louden, Polaschek, & Camp (2007); Skeem & Manchak (2008); Kennealy, Skeem, et al. (2009); Manchak, Skeem et al. (in press)
Reduce reliance on punitive strategies

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Not Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bark at him…chew him up on one side and down the other…you basically lie to them, “You’re looking at prison”</td>
<td>…talk with him to identify any obstacles to compliance (like transportation problems), remove those obstacles, and agree on a compliance plan.</td>
</tr>
<tr>
<td>The “big bluff”- threats and reminders</td>
<td>Problem-solving strategies</td>
</tr>
</tbody>
</table>

Problem-solving strategies help explain the effect of specialty probation on recidivism
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Symptom-based crimes occur almost randomly across people

- 112 offenders with mental illness, repeated crimes
  - ICC = .00 (no cluster.)
- 100 MacRisk patients with repeated violence
  - 89% incidents not preceded by delusions or hallucinations
  - ICC = .42 (fair cluster.)

Peterson, Skeem, & Kennealy (2014); Skeem, Kennealy, Monahan & Appelbaum (under review)
Occur almost randomly?

NOT...

- People with exclusively non-symptom based violence (90%)
- People with exclusively symptom-based violence (10%)

BUT INSTEAD...

• People with mostly non-symptom-based violence peppered with symptom-based violence

Skeem, Kennealy, Monahan & Appelbaum (under review)
Specialty probation is cost effective…

* p < .05, ** p < .01, propensity controlled
But cost effectiveness is not attributable to CJ savings
Instead, cost effectiveness is based on treatment savings

** p<.01, *** p<.001, propensity controlled
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RNR model as answer?

“The field must avoid rushing to the next ‘evidence base’ too rapidly and with too little data.”

-Skeem, Steadman, & Manchak (in press)
Thank you!

- MacArthur Research Network on Mandated Community Treatment
- California Policy Research Center
- UC Irvine Center for Evidence-Based Corrections
- Risk-resilience lab
- Web: http://risk-resilience.berkeley.edu
- Contact: jenskeem@berkeley.edu
Reduce stigma-driven decision-making

Reduced Thresholds/ Stigma

“If there’s a nutso on my caseload and he’s just taking up too much of my time, when there’s an opportunity to transfer him to another officer, I’ll transfer him.”

(from Skeem, Encandela, & Eno Louden (2003))

Mental Illness

“Recidivism” with no new crime

Reduced thresholds: Eno Louden & Skeem (in press); Porporino & Motiuk (1995); Skeem, Nicholson et al. (2009)
There’s more than one way to return to custody…

* $p < .05$, $+ p < .10$. Skeem, Nicholson et al., 2009
In sum: Help to ex-novate ineffective practices

• High thresholds for release & low thresholds for revocation
  • think “equity”

• Reliance on punitive strategies & programs
  • think “problem solving” and “step down”

• Exclusive focus on mental health
  • think “criminogenic needs”
Propensity Scores

- Likelihood of traditional supervision, given 40+ criminal, psychiatric, substance use, & personality features
- Nagelkerke $R^2 = .38$; Classification accuracy $= 74$

<table>
<thead>
<tr>
<th>Most serious lifetime offense</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>2.83</td>
<td>1.15</td>
<td>6.04</td>
<td>1.00</td>
<td>.01</td>
<td>17.00</td>
</tr>
<tr>
<td>Drug</td>
<td>1.23</td>
<td>1.19</td>
<td>1.07</td>
<td>1.00</td>
<td>.30</td>
<td>3.41</td>
</tr>
<tr>
<td>Property</td>
<td>1.75</td>
<td>1.16</td>
<td>2.27</td>
<td>1.00</td>
<td>.13</td>
<td>5.77</td>
</tr>
<tr>
<td>Number lifetime arrests</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three+</td>
<td>10.84</td>
<td>2.00</td>
<td></td>
<td></td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>-1.62</td>
<td>.51</td>
<td>10.06</td>
<td>1.00</td>
<td>.00</td>
<td>.20</td>
</tr>
<tr>
<td>One</td>
<td>.22</td>
<td>.44</td>
<td>.26</td>
<td>1.00</td>
<td>.61</td>
<td>1.25</td>
</tr>
<tr>
<td>Time on probation</td>
<td>-.45</td>
<td>.13</td>
<td>11.67</td>
<td>1.00</td>
<td>.00</td>
<td>.64</td>
</tr>
<tr>
<td>GAF score, interviewer</td>
<td>.06</td>
<td>.01</td>
<td>26.67</td>
<td>1.00</td>
<td>.00</td>
<td>1.06</td>
</tr>
<tr>
<td>Symptoms, CSI Total</td>
<td>-.03</td>
<td>.02</td>
<td>4.44</td>
<td>1.00</td>
<td>.04</td>
<td>.97</td>
</tr>
<tr>
<td>PAI, Anxiety scale</td>
<td>-.05</td>
<td>.01</td>
<td>13.83</td>
<td>1.00</td>
<td>.00</td>
<td>.95</td>
</tr>
</tbody>
</table>