Probationers and parolees with mental illness: What works!

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Overview

What is the problem?

How can we improve supervision success for offenders with mental illness?

An existing package: Specialty caseloads

Implications for practice…now
Statement of the problem

- Persons with mental disorder grossly overrepresented in the criminal justice system
- 55-75% have co-occurring substance abuse disorder
- CJS essential component of de facto mental health system
  - Los Angeles County Jail
  - Riker’s Island Jail

Source: Teplin, 1990; Teplin, Abram, & McClelland, 1996

+ Corrections population now over 7.2 million

3.2% of all adults in the United States

Source: Bureau of Justice Statistics (2007)
Most are supervised in the community

![Graph showing the number of people in Probation, Prison, Parole, and Jail from 1980 to 2000. The graph shows a steady increase in the number of people in Probation over the years.]

Source: Bureau of Justice Statistics (2007)

Statement of the problem

- Probationers and parolees with mental illnesses (PMIs) are at double the risk of failing supervision.
- ...and are more likely than their counterparts to fail because of technical violation.
- N= 105,430 CA parolees followed one year (Eno Louden, Dickinger, & Skeem, 2008)

See also: Dauphinot, 1999; Porporino & Motiuk, 1985
“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.”


Statement of the problem

- A staggering number of individuals with serious mental illness are placed on probation and parole each year. Many fail.

- Probation and parole represent unrealized opportunities to:
  - engage and work with high risk individuals who otherwise might be inaccessible;
  - facilitate these individuals’ exit from the criminal justice system and re-entry to the community

- How do we get there?
Overview
What is the problem?

How can we improve supervision success for offenders with mental illness?
1. The unvalidated model
2. A more promising model

An existing program: Specialty caseloads
Implications for practice...now

Is the cause mental illness itself?
The unvalidated model of “what works”

Assumption #1: Involved in crime solely because of mental illness

Good Outcomes
Symptoms & Functioning
Recidivism Risk
Arrest rarely is a direct product of mental illness; even for mentally ill

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>4.3</td>
<td>10.2-15.4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Direct effect of substance abuse</td>
<td>22.5</td>
<td>15.7-20.3</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.


Mental illness is a modest risk factor for recidivism

- Leading risk factors (e.g., criminal history, young age, substance abuse, personality traits) for violence and other crime are shared by those with and without mental illness

Table 5
Predictors of Violent Recidivism Within Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Zr</th>
<th>Lower</th>
<th>Upper</th>
<th>z</th>
<th>Q</th>
<th>N</th>
<th>No. of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal demographic</td>
<td>.12</td>
<td>.08</td>
<td>.16</td>
<td>5.36***</td>
<td>7.65</td>
<td>2,140</td>
<td>8</td>
</tr>
<tr>
<td>Criminal history</td>
<td>.15</td>
<td>.12</td>
<td>.18</td>
<td>8.42***</td>
<td>9.63</td>
<td>3,230</td>
<td>13</td>
</tr>
<tr>
<td>Deviant behavior</td>
<td>.08</td>
<td>.05</td>
<td>.11</td>
<td>4.40***</td>
<td>13.63</td>
<td>1,709</td>
<td>9</td>
</tr>
<tr>
<td>Clinical</td>
<td>-.03</td>
<td>-.03</td>
<td>-.01</td>
<td>2.69**</td>
<td>88.29***</td>
<td>7,532</td>
<td>22</td>
</tr>
</tbody>
</table>

Note.  Zr = mean effect size; z = significance of Zr; Q = test of homogeneity.
*** p < .001. ** p < .01.

Bonta, Law, & Hanson (1998)
Offenders with mental illness have significantly more of “The Big 8” risk factors for recidivism

<table>
<thead>
<tr>
<th>LS/CMI Total Scores</th>
<th>MD</th>
<th>Non-MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>General risk/need (Section 1)***</td>
<td>27.5 (5)</td>
<td>24.8 (5)</td>
</tr>
<tr>
<td>Specific risk/need (Section 2)***</td>
<td>6.5 (3)</td>
<td>4.7 (3)</td>
</tr>
</tbody>
</table>

...and these predict recidivism more strongly than risk factors unique to mental illness (i.e., HCR-20 total scores)

Source: Skeem, Nicholson, & Kregg (2008)

The “Big Eight” Risk Factors
A Closer Look: …particularly antisocial pattern

<table>
<thead>
<tr>
<th>General Risk/Need Factor Scores</th>
<th>MD</th>
<th>Non-MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal History</td>
<td>17.3 (7)</td>
<td>15.8 (7)</td>
</tr>
<tr>
<td>Education/Employment</td>
<td>4.1 (2)</td>
<td>3.7 (2)</td>
</tr>
<tr>
<td>Family/Marital**</td>
<td>4.2 (2)</td>
<td>5.0 (2)</td>
</tr>
<tr>
<td>Leisure/Recreation</td>
<td>1.7 (1)</td>
<td>1.9 (1)</td>
</tr>
<tr>
<td>Procriminal Attitudes</td>
<td>3.1 (1)</td>
<td>3.3 (1)</td>
</tr>
<tr>
<td><strong>Antisocial Pattern</strong>*</td>
<td>2.5 (1)</td>
<td>1.8 (1)</td>
</tr>
<tr>
<td>Alcohol/Drug Problems</td>
<td>8.6 (1)</td>
<td>8.5 (1)</td>
</tr>
<tr>
<td>Criminogenic Companions</td>
<td>3.2 (1)</td>
<td>3.1 (1)</td>
</tr>
</tbody>
</table>

**Antisocial Pattern***

<table>
<thead>
<tr>
<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>Antisocial Pattern</td>
<td>.72</td>
<td>.16</td>
<td>21.15</td>
<td>1</td>
<td>.000</td>
</tr>
<tr>
<td>Constant</td>
<td>-1.53</td>
<td>.37</td>
<td>17.25</td>
<td>1</td>
<td>.000</td>
</tr>
</tbody>
</table>
Is the cause mental illness itself?

The unvalidated model of “what works”

Probation or Parole
Treatment mandate

Mental Health Treatment
Access
Amount

Assumption #2: Providing usual mental health services will end involvement

Good Outcomes
Symptoms & Functioning
Recidivism Risk

Increased services often do not translate into reduced recidivism

Even for those “enrolled in state of the art treatment programs, arrests and other encounters with the legal system are regular occurrences for persons with dual disorders”


Clark, Ricketts, & McHugo, 1999; Skeem & Eno Louden, 2006; Steadman & Naples, 2006
Is the cause mental illness itself?
The unvalidated model of “what works”

Probation or Parole
Treatment mandate

Mental Health Treatment
Access
Amount

Assumption #3: The way we implement the mandate doesn’t matter

Good Outcomes
Symptoms & Functioning
Recidivism Risk

Supervision style matters

Officer’s reaction to mentally ill offenders

Mental illness → sensitivity to bad practices

“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.”

Beware the “treater turned monitor” phenomenon

Skeem, Encandela, & Eno Louden (2003)
Compliance strategies
Consider “Mike”

Traditional
- Bark at him... chew him up one side and down the other... you basically lie to them, “You’re looking at prison”
- The “big bluff”- threats and reminders

Not Traditional
- ...talk with him to identify any obstacles to compliance (like transportation problems), remove those obstacles, and agree on a compliance plan.
- Problem-solving strategies

---

Compliance Strategies

<table>
<thead>
<tr>
<th></th>
<th>Prob Solv</th>
<th>Sanction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Told you that if you followed the rules...</td>
<td>.41</td>
<td>.25</td>
</tr>
<tr>
<td>Met with you and your therapist or case manager to try to solve...</td>
<td>.32</td>
<td></td>
</tr>
<tr>
<td>Told you that you would feel better if you stayed out of trouble...</td>
<td>.76</td>
<td></td>
</tr>
<tr>
<td>Talked with you to help find a solution to a problem that you agreed on...</td>
<td>.75</td>
<td></td>
</tr>
<tr>
<td>Reminded you of the conditions of probation or...</td>
<td>.54</td>
<td>.34</td>
</tr>
<tr>
<td>Praised or rewarded you when you’ve followed the rules</td>
<td>.52</td>
<td></td>
</tr>
<tr>
<td>Talked with you to figure out the reasons for any problems...listened</td>
<td>.77</td>
<td></td>
</tr>
</tbody>
</table>
**Negative pressure predicting failure at 6 months**

...bad is stronger than good

![Bar chart](image)

**p < .01, ***p < .001. Source: Manchak, Skeem, et al., 2008**

**Relationship quality**

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”
A closer look at dual role relationship quality

- Relationship quality in mandated treatment
  - Therapeutic role
  - Surveillance role

Skeem, Louden, et al. (2007)
DRI-R correspond to what happens in meetings

<table>
<thead>
<tr>
<th>PMI</th>
<th>PO DRI-R</th>
<th>PO DRI-R</th>
<th>Observer DRI-R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflect</td>
<td>-0.04</td>
<td>-0.04</td>
<td>0.24*</td>
</tr>
<tr>
<td>Affirm</td>
<td>0.03</td>
<td>0.09</td>
<td>0.42**</td>
</tr>
<tr>
<td>Support</td>
<td>0.16</td>
<td>0.12</td>
<td>0.36**</td>
</tr>
<tr>
<td>Advise</td>
<td>-0.02</td>
<td>0.00</td>
<td>0.21</td>
</tr>
<tr>
<td>Direct</td>
<td>0.02</td>
<td>-0.25*</td>
<td>-0.26*</td>
</tr>
<tr>
<td>Confront</td>
<td>-0.25**</td>
<td>-0.32**</td>
<td>-0.56**</td>
</tr>
<tr>
<td>Change talk</td>
<td>-0.07</td>
<td>-0.04</td>
<td>0.10</td>
</tr>
<tr>
<td>Resist</td>
<td>-0.29**</td>
<td>-0.28*</td>
<td>0.38**</td>
</tr>
</tbody>
</table>

DRI-R predicts failure at 6 months (better relationships, less failure)

* * p<.05; ** * p<.01
Consistency with other work:
Hybrid models work better than surveillance or treatment alone


Consistency with other research:
officers as the focus

- Dowden & Andrews (2004): How an officer applies a model determines its effectiveness
- Paparozzi & Gendreau (2005): Within ISP parole
**Consistency with other research: programs as the focus**

- Aos, Miller, & Drake (2006): meta-analysis of Intensive Supervision Programs (ISPs)
- Paparozzi & Gendreau (2005): ISP vs. traditional

**Assumptions of the unvalidated model for “what works”**

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involved in crime solely because of mental illness</td>
<td>Strongest risk factors are shared with non-mentally ill</td>
</tr>
<tr>
<td>Providing usual mental health services will end involvement in crime</td>
<td>Mental health services (meds. &amp; case management) often do not prevent recidivism</td>
</tr>
<tr>
<td>The way we implement the mandate doesn’t matter</td>
<td>Thresholds for revocation matter. Process of supervision matters.</td>
</tr>
<tr>
<td>One size fits all</td>
<td>Offenders with mental illness have diverse features</td>
</tr>
</tbody>
</table>
Overview

What is the problem?

How can we improve supervision success for offenders with mental illness?
1. The unvalidated model
2. A more promising model
An existing program: Specialty caseloads

Implications for practice...now

A less simplistic model of "what works"

Causes extend beyond mental illness; Solutions must, too

Conditional Release
Treatment mandate

Mental
Access/Amount
Quality

Correctional Treatment
Access/Amount
Quality

Good Outcomes
Symptoms & Functioning
Recidivism Risk

Supervision
Relationship quality
Compliance strategies

+/-
Evidence-based practice in mental health

The Sacred Six
- Integrated substance abuse and mental health services
- Supported employment
- Psychopharmacology
- Illness self-management and recovery
- Family psychoeducation
- Assertive Community Treatment (BUT…Morrissey, 2005)

Plus Two
- Trauma Intervention
- Pathways to housing

http://consensusproject.org/updates/features/GAINS-EBP-factsheets

A less simplistic model of “what works”

Conditional Release
Treatment mandate

Mental Health Treatment
Access/Amount
Quality

Correctional Treatment
Access/Amount
Quality

Good Outcomes
Symptoms & Functioning
Recidivism Risk

Supervision
Relationship quality
Compliance strategies

+/-
The strongest risk factors for recidivism are shared by those with, and without mental illness.

Evidence-based principles of correctional rehabilitation

- Target criminogenic needs like anger, substance abuse, antisocial attitudes, and criminogenic peers (Andrews et al., 1990)

- Use cognitive behavioral techniques like relapse prevention (Pearson, Lipton, Cleland, & Yee, 2002)

- Ensure implementation (Gendreau, Goggin, & Smith, 2001)

- Focus resources on high risk cases (Andrews & Dowden, 2006)
  - Including those with problematic traits
    - YES…even those with high PCL-R scores
    - Skeem, Polaschek & Manchak, in press
Fitting supervision to the offender to improve outcomes

- EBP in mental health
- EBP in corrections & EBP in mental health
- Treatment as usual
- EBP in corrections & treatment as usual

Coordinated supervision & treatment

Best supervision practices essential to all

Integrated supervision & treatment

Specialty mental health caseloads
Best supervision practices + integration of supervision and treatment

AZ S001 S002 CA S004 S006 S007 S022 S031 S032 S067 S083 CO S033 CT S094 FL S035 IL S081 IA S071 S008 MD S009 MO S010 S037 S068 NJ S068 NM S057 NY S011 OH S012 S082 S059 S013 S014 S060 S025 S026 OR S040 S027 PA S069 S073 S028 S078 S041 S084 S042 S043 S017 S061 S044 S019 S029 S062 S051 S052 S020 S030 S064 UT S02 WA S065 WI S070 S054
National survey: The prototypic specialty mental health agency

- Exclusive mental health caseload
- Substantially reduced caseload size ($M = 48$)
- Sustained officer training
- Active integration of internal and external resources
- Problem-solving strategies to prevent or address noncompliance

Skeem, Emke-Francis, & Louden, 2006; Louden et al., in press

Outcome study: better practices and outcomes found in specialty than traditional agencies

Ongoing two-year prospective matched trial: 360 PMIs and officers in prototypic specialty and traditional agencies
**Baseline Compliance Strategies**

- Differences, $p < .001$; remain so after controlling for propensity scores

**Baseline Relationship Quality**

- All differences, $p < .001$, remain significant after controlling for propensity scores
Relative to traditional supervision, specialty supervision predicts:

- Better supervision practices
- Greater
  - Medication adherence
  - Mental health treatment sessions
- But not greater
  - Improvement in symptoms and functioning over time
- What about criminal justice outcomes?

Recorded violations at 12 months:

***p<.001; **p<.01, controlling for propensity scores
Self reported violations at 12 months

**p < .01; controlling for propensity scores

Recorded arrests and revocation at 12 months

***p < .001, ** p < .05; controlling for propensity scores; no diff in violation type by revocation
Active ingredients of specialty supervision?

- Risk reduction is not based on receiving more mental health services
- More a function of what officers do
  - Avoidance of negative pressures
  - Positive dual role relationship quality

Relationship quality partially mediates relation between specialty supervision and arrests and revocation (shown)

Repeated measures ANCOVA, with site and propensity controlled
BS relationship main effect, p < .01; WS relationship x revocation effect, p < .05
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What to do...

Screen and assess

- Identify offenders with mental illnesses, using a validated tool like the K-6 or BJMHS
  - http://www.hcp.med.harvard.edu/ncs/k6_scales.php
  - Eno Louden, Skeem et al. (2008)
- Assess risk of recidivism, using a validated tool like the LSI-R or LS/CMI

Target criminogenic risk & clinical needs with EBPs

E出自83 in corrections & EBP in mental health

- EBP in mental health
- Treatment as usual
- EBP in corrections & treatment as usual

Criminogenic Risk
What to do…

**Coordinate or Integrate**
- Depending on risk and need
- For high risk, high need cases, consider specialty caseloads
  - But…target RISK

**Above all**
- Avoid bad supervision practices
- Low thresholds for revocation
- Threats
- Authoritarian relationships
- Apply good practices
  - Same threshold for revocation
  - Problem solving
  - Firm but fair relationships

---

**Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision**
A Guide to Research-Informed Policy and Practice

Forthcoming, 2008

http://consensusproject.org/issue-areas/corrections/
How do we know?
Research behind the principles

- Focus group study (Skeem, Encandela, & Louden, 2003)
  - Three states, 6 focus groups with officers and PMIs

- National survey (Skeem, Emke-Francis, & Louden, 2006; Louden et al., in press)
  - All multi-caseload specialty agencies (n=66) and matched traditional agencies (n=25); Participation =93% supervisors

- Relationship quality study (Skeem, Louden, Polaschek, & Camp, 2007)
  - 90 PMIs and their officers in a specialty agency; interviews, recorded meetings, and 1-year recidivism followup
How do we know?

Ongoing outcome study
- Prospective design (2 years)
  - Interviews: Baseline, 6 mo, 12 mo (retention ≥ 85%)
  - Record downloads: 12 mo (services) & 24 mo (justice)
- Matched trial: 360 probationers and their officers
  - Specialty (Dallas) & Traditional (Los Angeles)
- Matched probationers
  - Recruitment: age, gender, ethnicity, offense, and time on probation
  - Propensity scores: any remaining differences

Consistency with other research
- ISPs: Aos, Miller & Drake (2006)
- PMIs: Solomon & Draine (1995)
- Application: Dowden & Andrews (2004); Paparozzi & Gendreau (2005)