

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

Jennifer Skeem, PhD
Professor & Associate Dean of Research

SCHOOL OF SOCIAL WELFARE | GOLDMAN SCHOOL OF PUBLIC POLICY
UNIVERSITY OF CALIFORNIA, BERKELEY

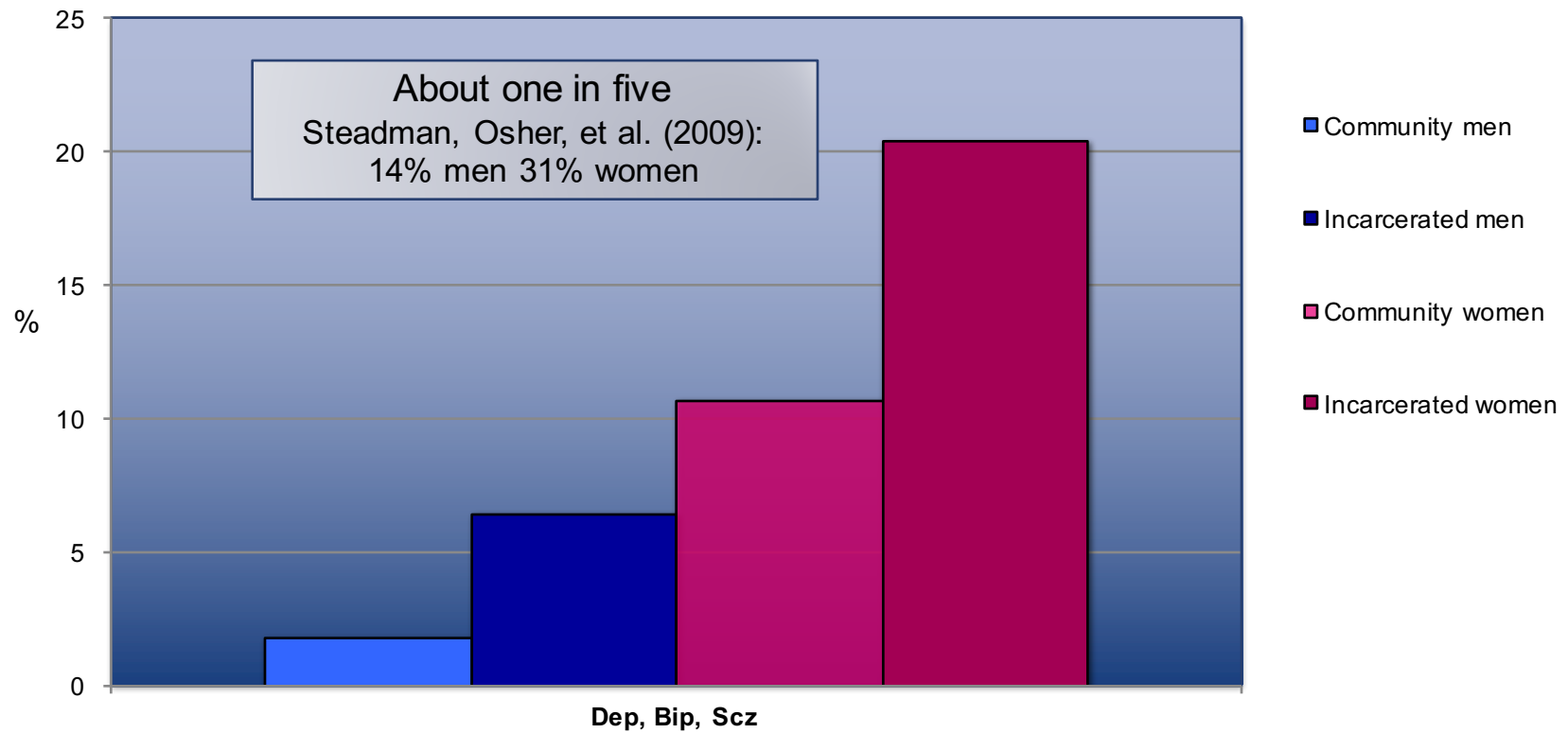




**Mental illness cases swamp
criminal justice system**

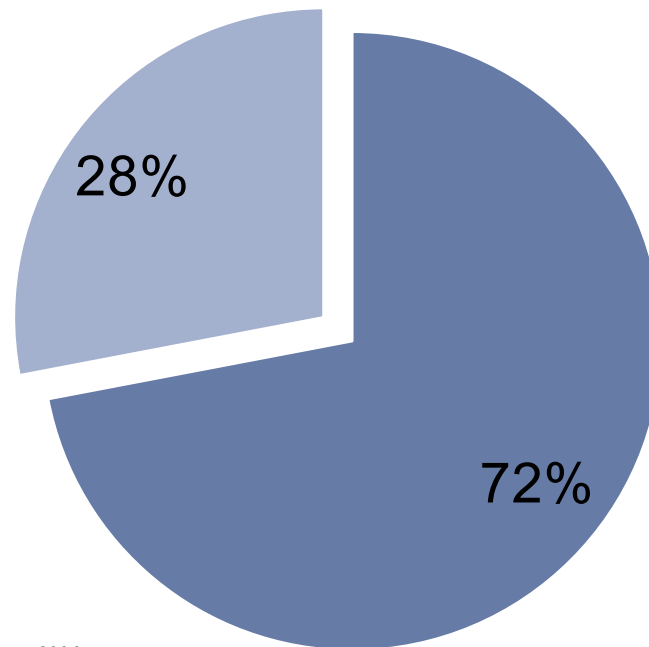
Rikers. Where mental illness meets brutality in jail

People with mental illness overrepresented in the justice system



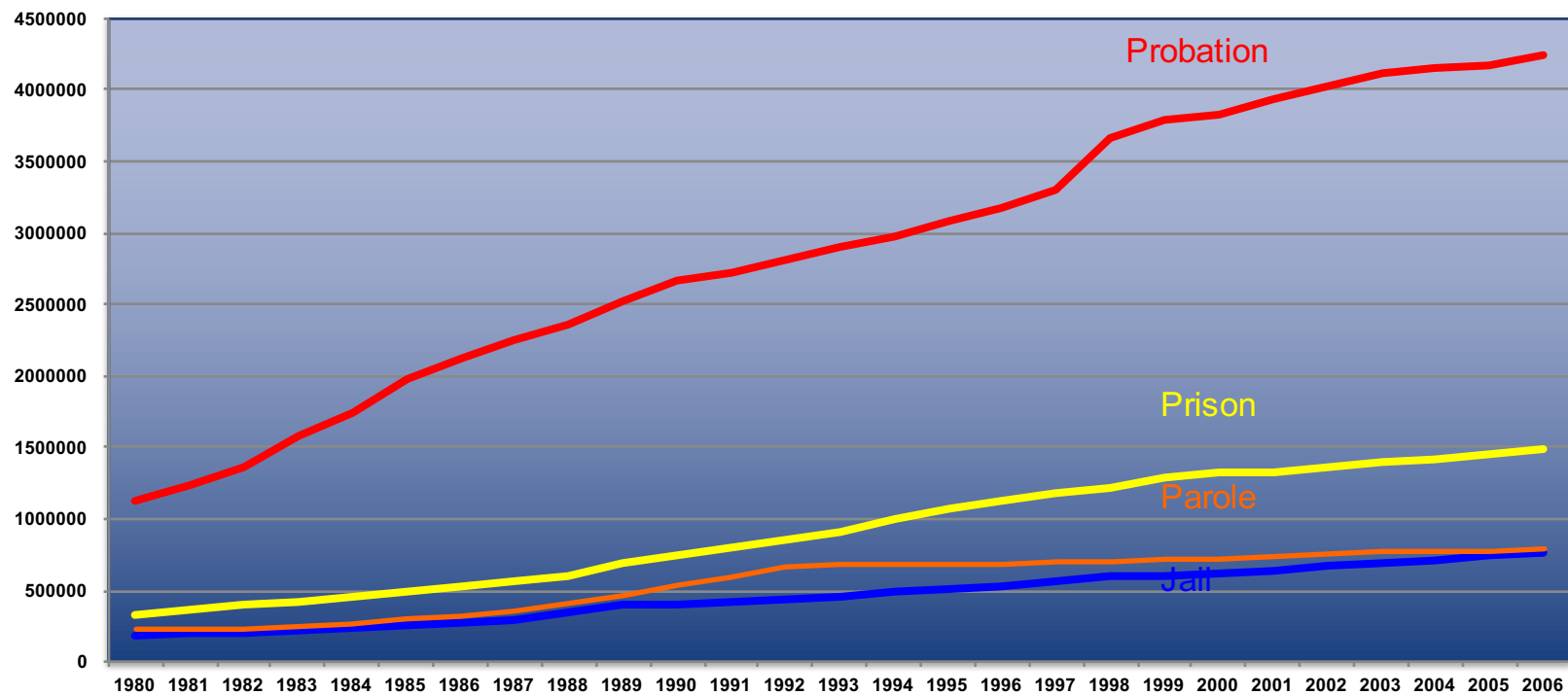
Source: Teplin, 1990; Teplin, Abram, & McClelland, 1996

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 or special 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

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

Effect	Mean	CI	Rating $\geq 75^a$	
			N	%
Direct effect of serious mental illness	6.4	3.0–9.9	4	4
Indirect effect of serious mental illness	14.3	10.2–18.4	4	4
Direct effect of substance abuse	22.5	15.7–29.3	21	19
Indirect effect of substance abuse	8.6	4.0–13.2	8	7

^a 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.

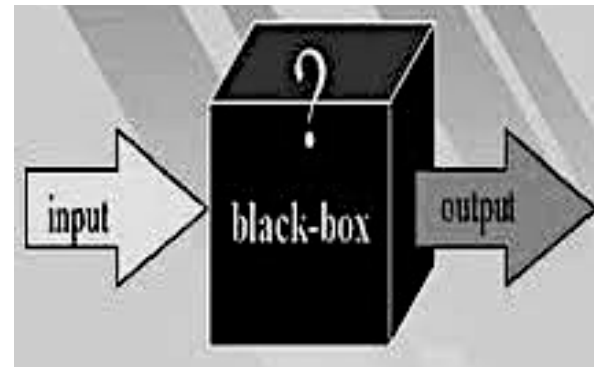


Roadmap

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

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...

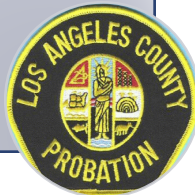


MacArthur probation outcome study

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

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

Traditional



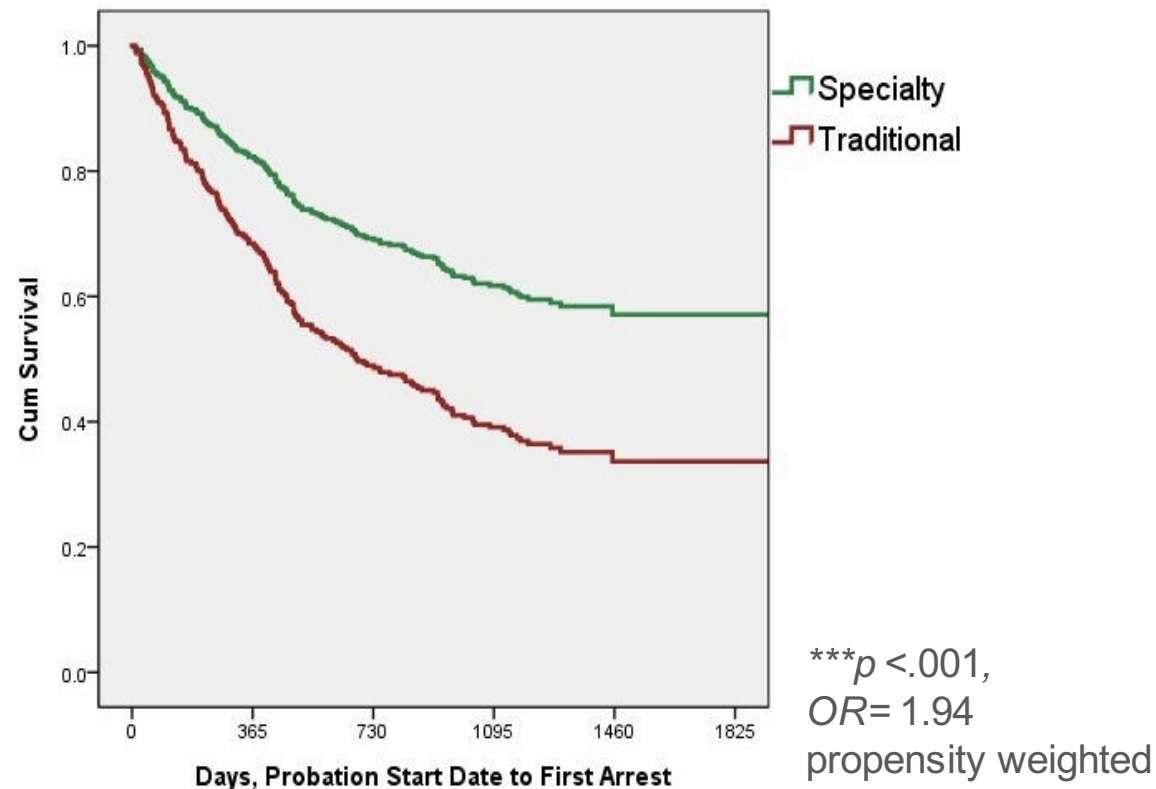
- Specialty officers
- Mental health caseloads
- Reduced/small size
- Rehabilitation emphasis (psychiatric)

Specialty



Manchak et al., (2013); Skeem et al. (2014)

Specialty probationers less likely to be re-arrested than traditional counterparts



...but not because of symptom reduction





Roadmap

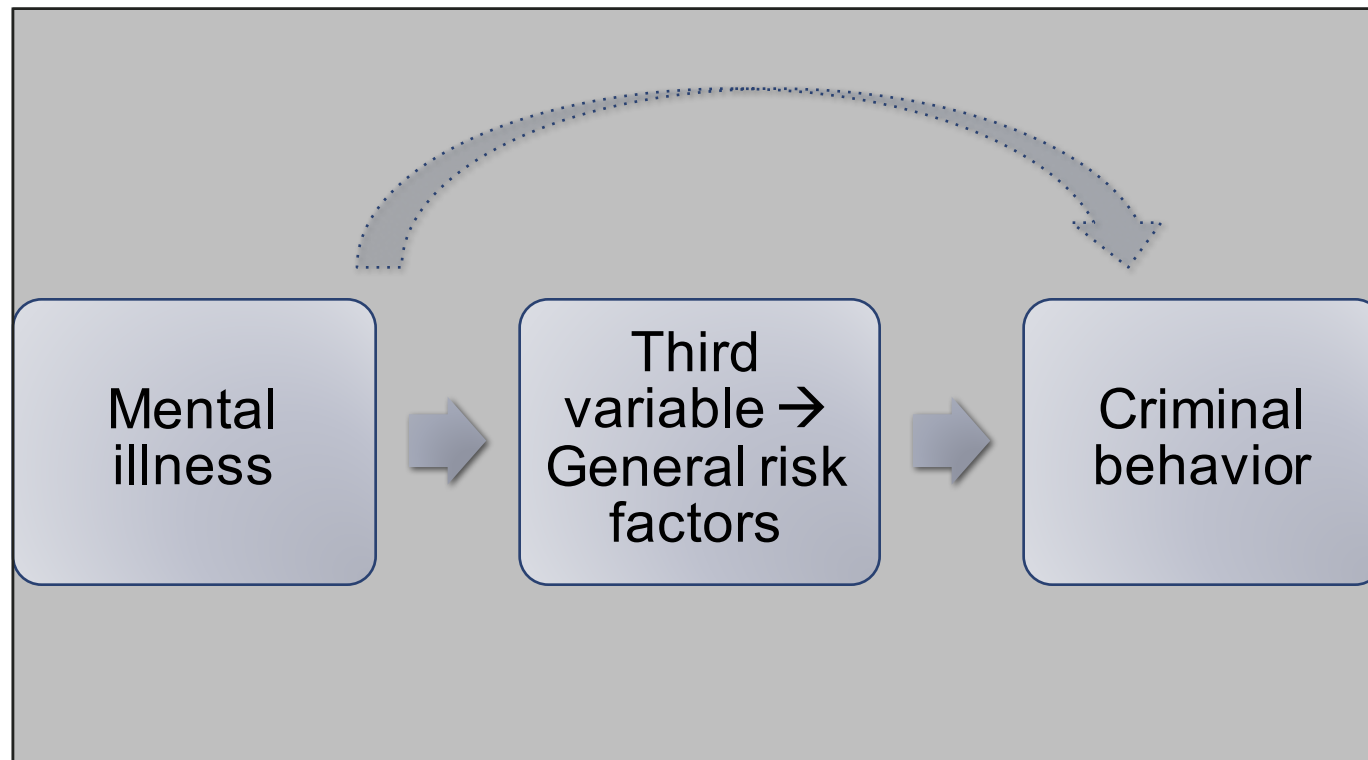
- Problems with the implicit model
 - Symptoms rarely cause crime
 - Psychiatric services rarely reduce crime
- **Refining the model**



Consider alternative views

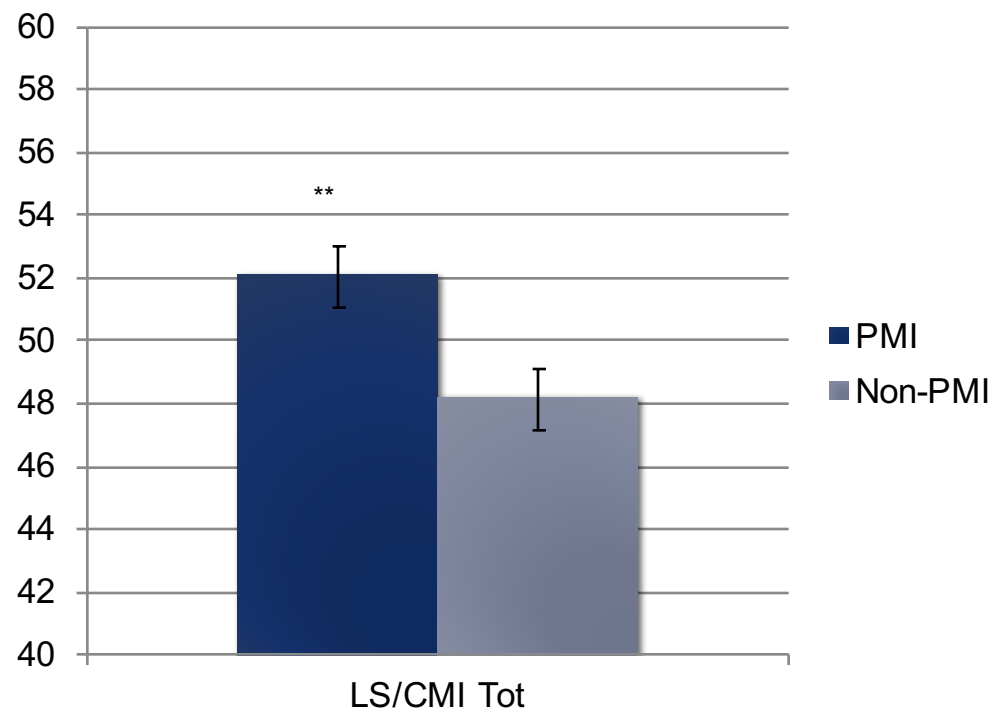
- Some people with serious mental illness may “engage in offending and other forms of deviant behavior not because they have a mental disorder, but because they are poor.”
- Their poverty situates them socially and geographically, and places them at risk of engaging in many of the same behaviors displayed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

General alternative model



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)

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

*** $p < .001$, ** $p < .01$, * $p < .05$, PMI > Non-PMI, Skeem et al. (2014)

← General offenders

Offenders with mental illness→



Strongest risk factors for recidivism are shared

Refining the model of “what works”

Sentence to treatment or special program

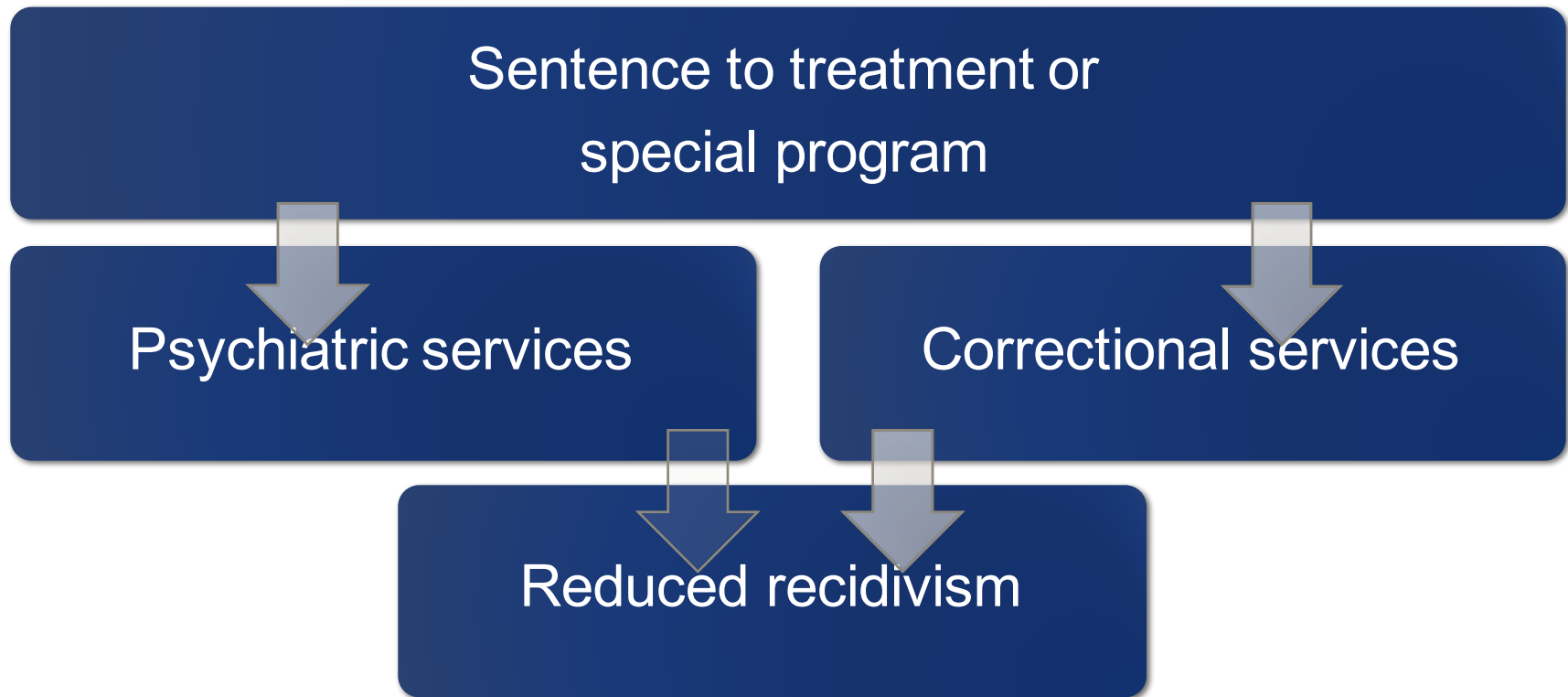


Psychiatric services → Symptom control



Reduced recidivism

Refining the model of “what works”



Roadmap

- Problems with the implicit model
 - Symptoms rarely cause crime
 - Psychiatric services rarely reduce crime
- Refining the model
- **Promising directions**
 - **Target robust risk factors**



Promise of explicitly targeting antisocial features



Effects of Cognitive-Behavioral Programs for Criminal Offenders

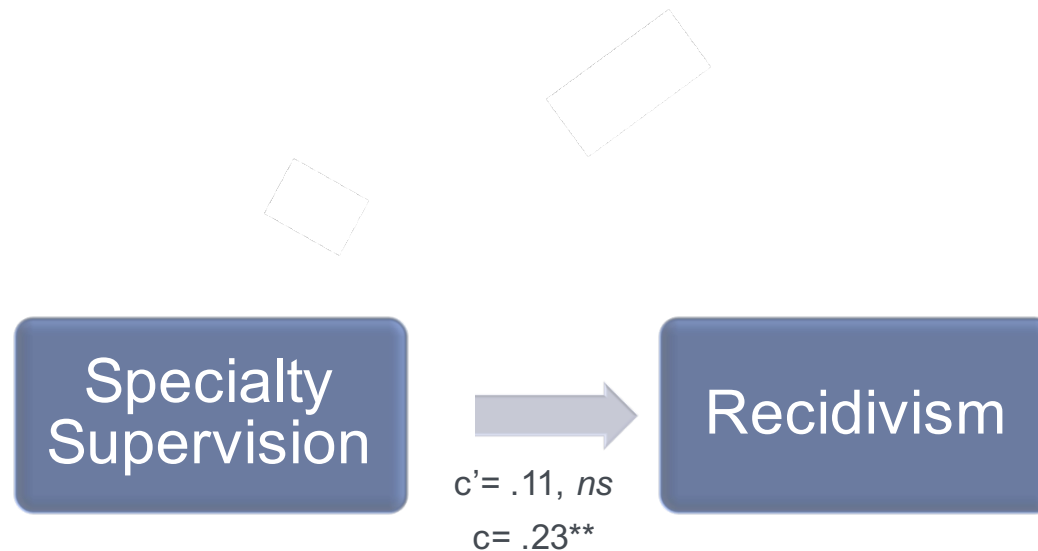
Mark W. Lipsey, Nana A. Landenberger, Sandra J. Wilson

Sacks et al. (2004)

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**

Officer-offender relationship quality explains effect of specialty probation



Consistent with early, qualitative work

Process colors every interaction and affects outcomes

Authoritarian

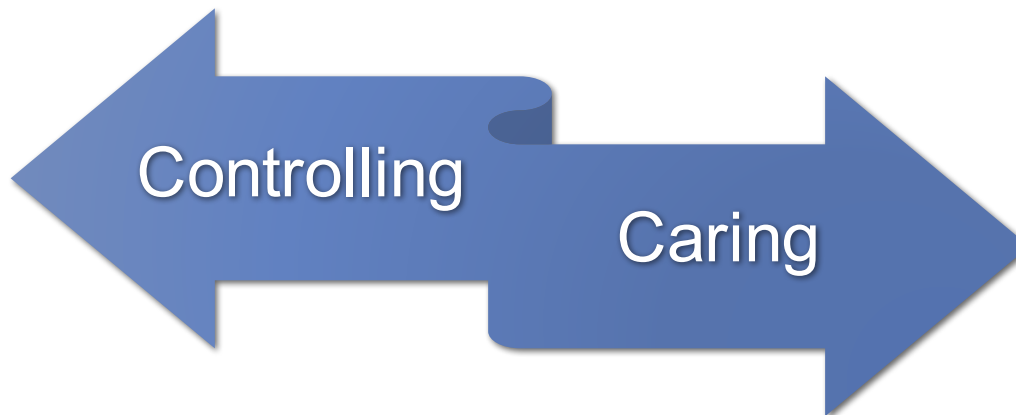
- *“The first time I met this particular probation officer, he let me know that he owns me...”*
- *“The first time I met him, he threatened to put me in prison...I got so damned scared, okay? And I didn’t do anything”*
- *“He is chuckling to the other one...and nods his head over towards me and says,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



Skeem, Eno Louden, Polaschek, & Camp (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment*, 19, 397-410.

Dual role relationship quality

- Not the therapeutic alliance or “liking”
- Conveys what is happening in officer-offender meetings
- Also describes provider-offender relationships
- Protects against recidivism...
 - across risk levels
 - across mental health status



Skeem & Manchak (2008); Kennealy, Skeem, et al. (2009); Manchak, Skeem et al. (2015)

Reduce reliance on punitive strategies

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

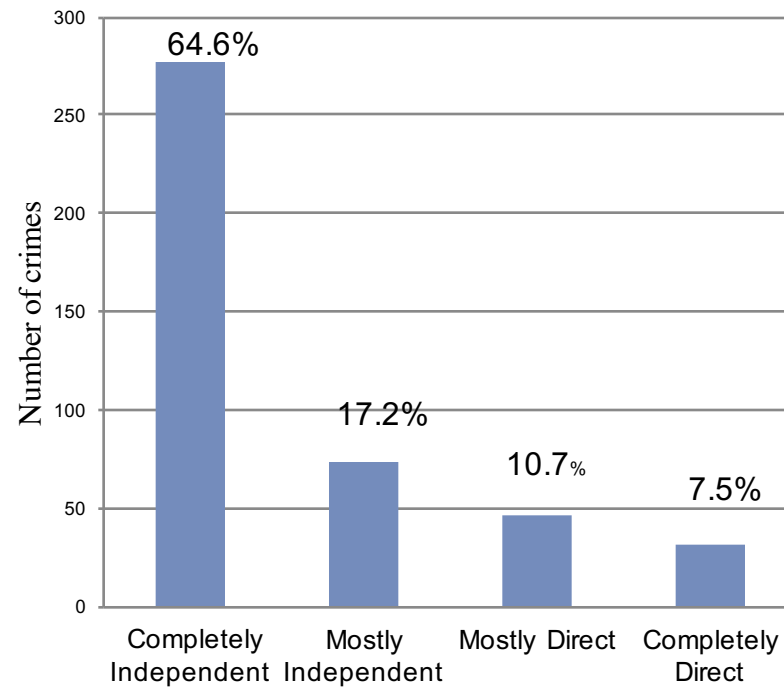
Problem-solving strategies help explain protective effect of specialty probation

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**

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.)



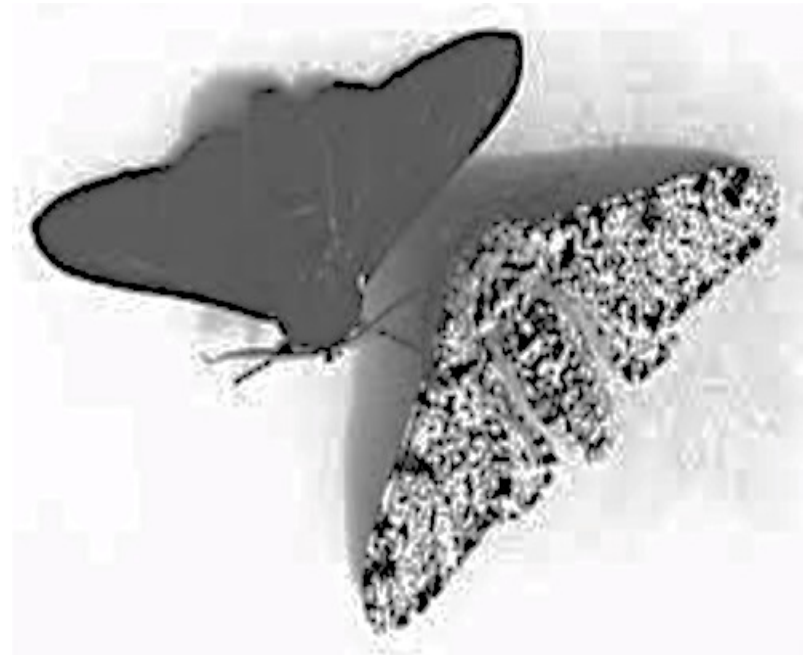
Peterson, Skeem, & Kennealy (2014); Skeem, Kennealy, Monahan & Appelbaum (2015)

Occur almost randomly?

NOT...

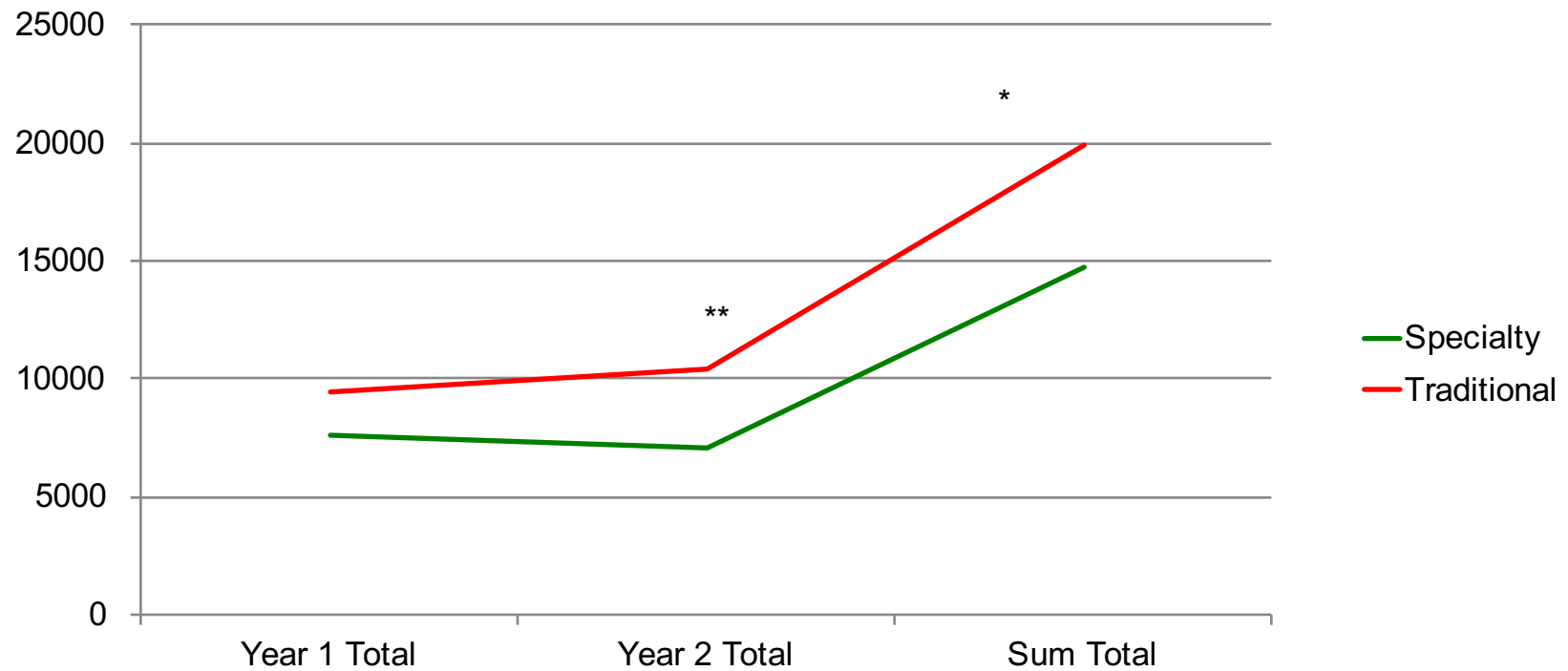
- People with exclusively non-symptom based violence (90%)
- People with exclusively symptom-based violence (10%)

BUT INSTEAD...



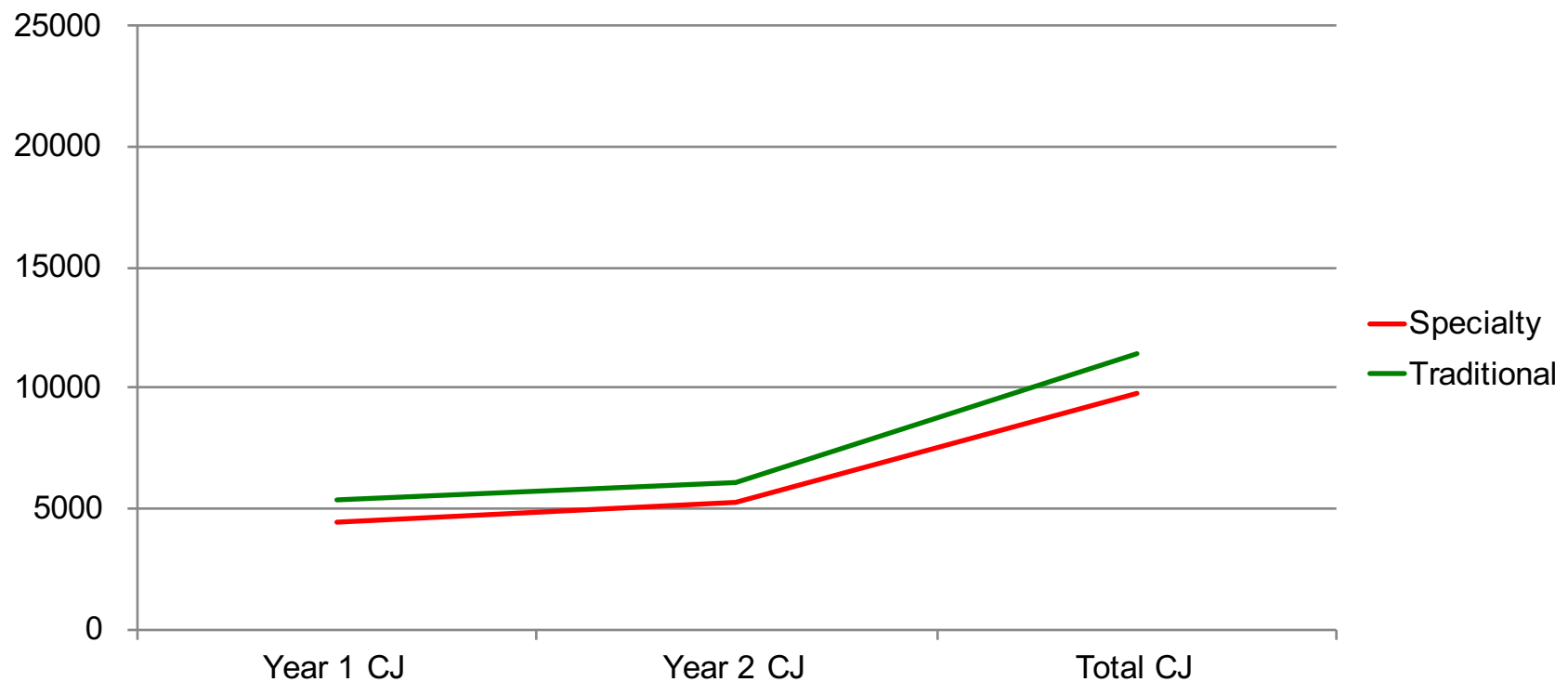
Skeem, Kennealy, Monahan & Appelbaum (2015)

Specialty probation is cost effective...

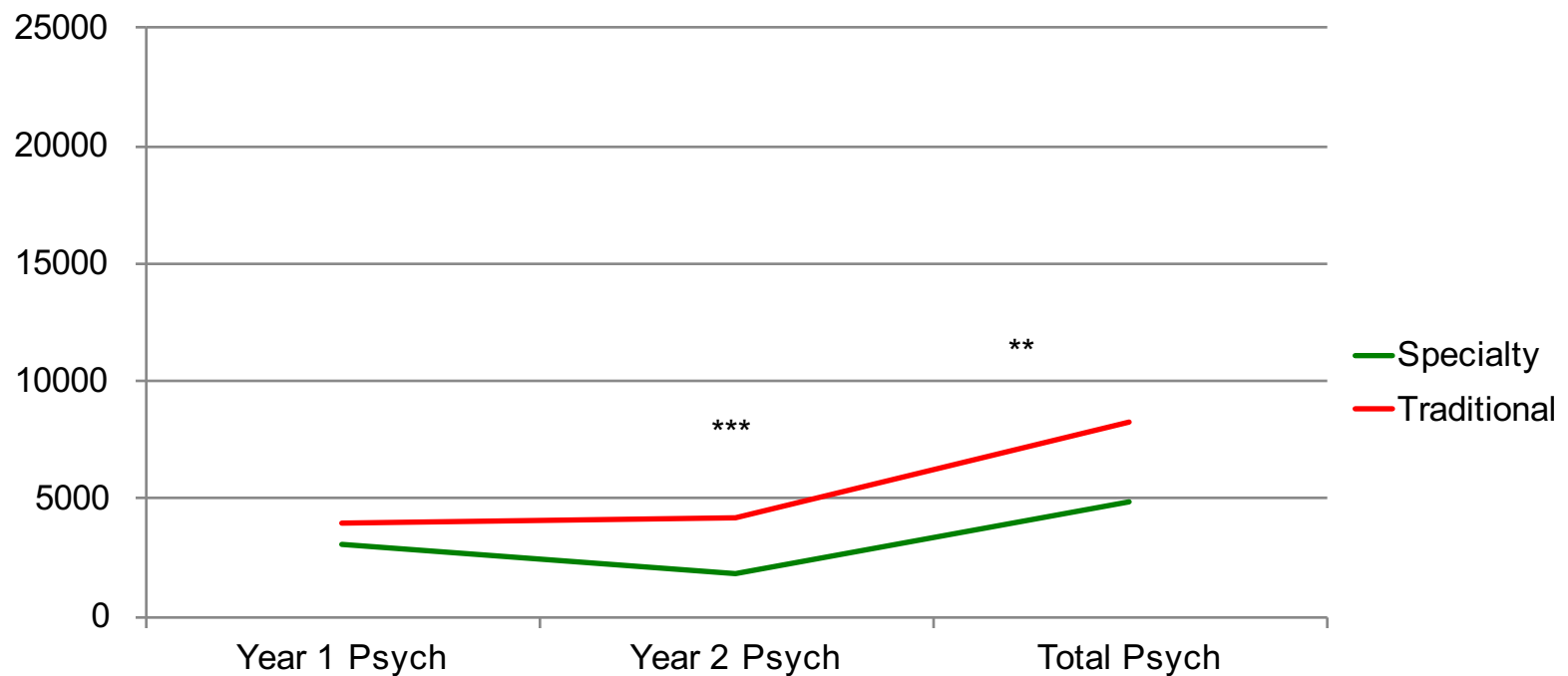


* p < .05, ** p < .01, propensity controlled

But cost effectiveness is not attributable to CJ savings



Instead, cost effectiveness is based on treatment savings



** $p < .01$, *** $p < .001$, propensity controlled

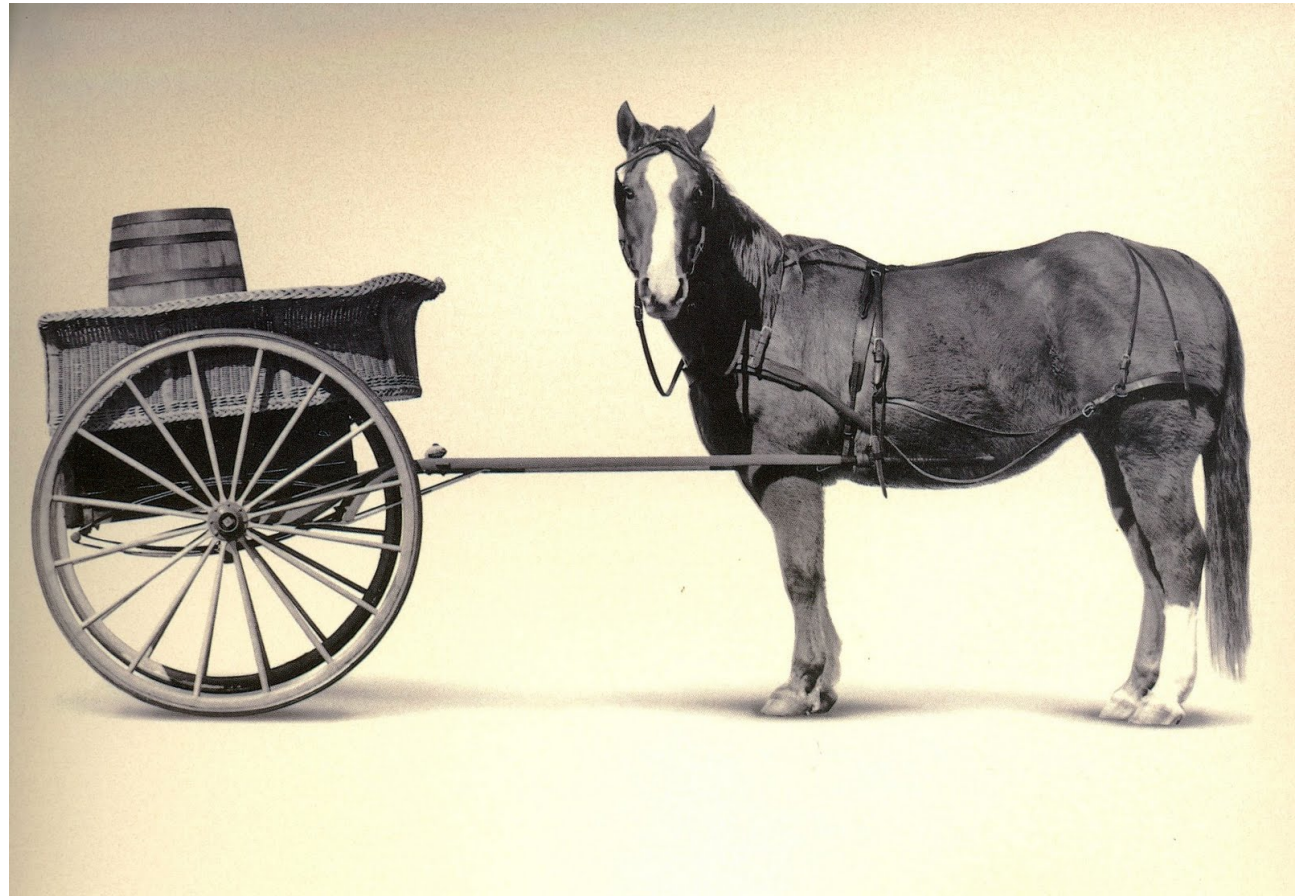
Roadmap


- 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

Is RNR the answer?

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

-Skeem, Steadman, & Manchak (2015)





Thank you!

- Risk-resilience lab: <http://risk-resilience.berkeley.edu>
- Contact: jenskeem@berkeley.edu