Reducing recidivism risk for offenders with mental disorder

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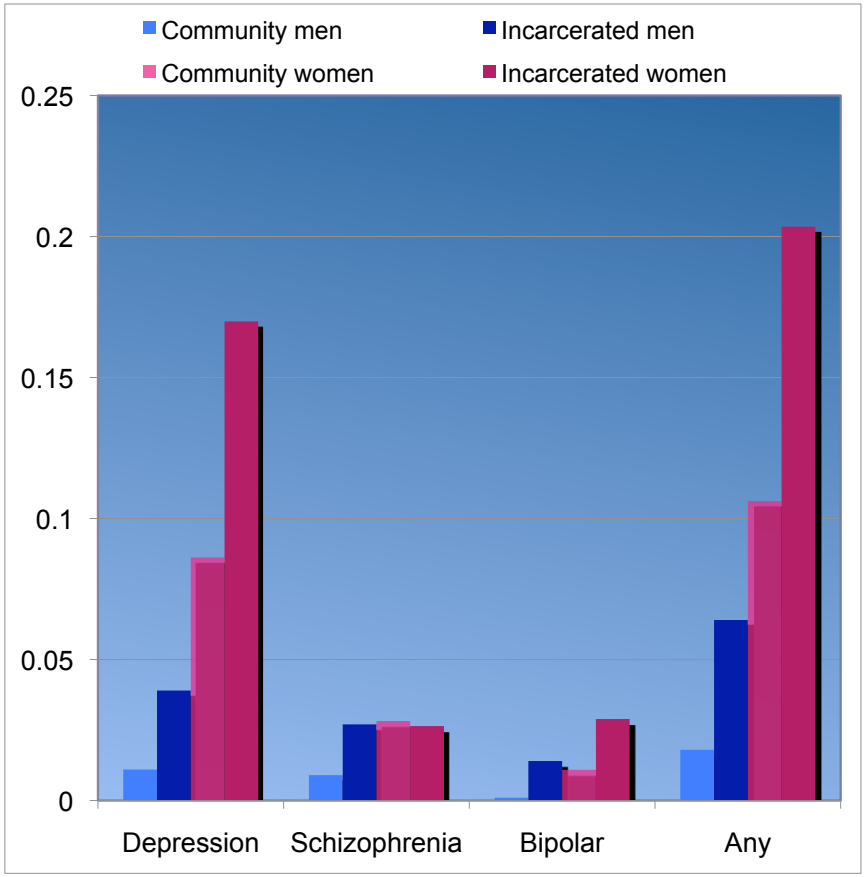
Overview

- Statement of the problem
- The current response
- Evaluating the current response
- Alternative approaches

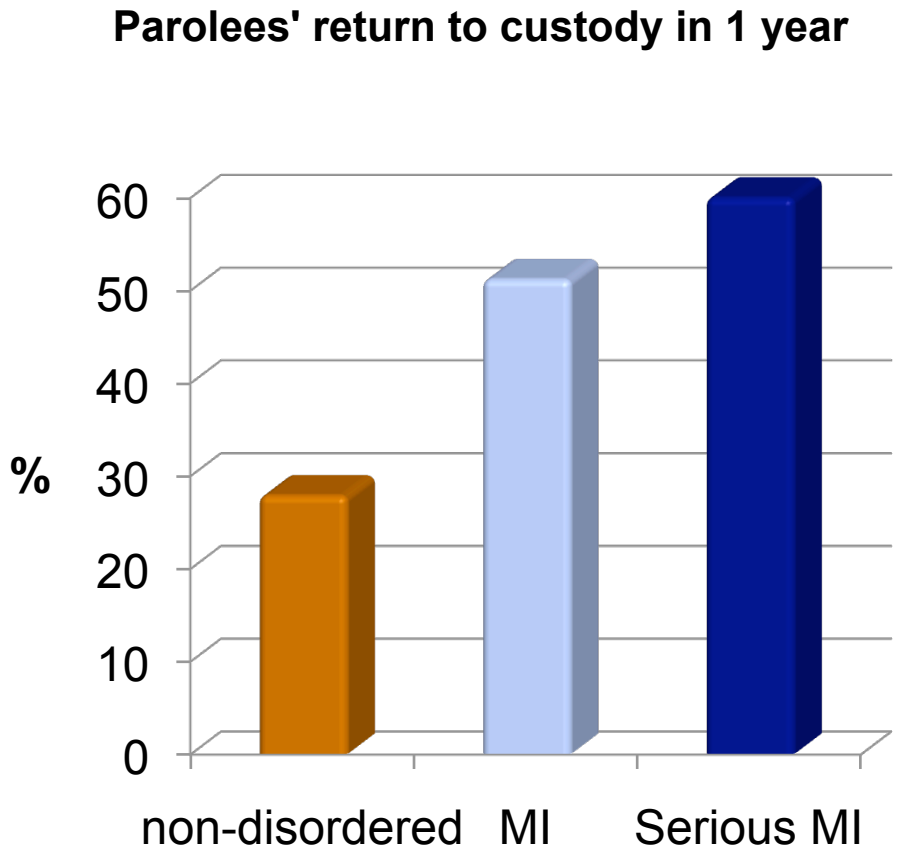
Overrepresentation of persons with mental disorder in criminal justice system

- Offenders are 2 to 3 times more likely to have a mental disorder than the general population
- Offenders with mental disorder are highly likely (75%) to have alcohol and drug abuse (Abram & Teplin, 1991; Hartwell, 2004)



Source: Teplin, 1990; Teplin et al., 1996

Increased risk of failure



- Offenders with mental disorder more likely to commit technical violations than non-disordered offenders
- Mixed evidence of increased risk of new offense

Source: Eno Louden & Skeem, in press; see also Dauphinot, 1997; Porporino & Motiuk, 1995

Scope of the problem

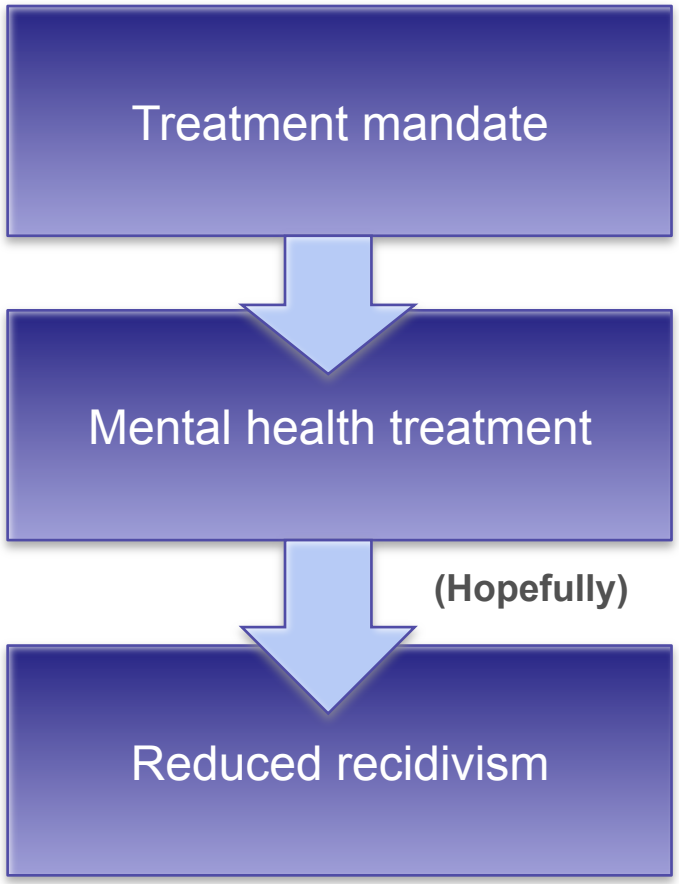
"The current system not only exacts a significant toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system."

Council of State Governments Criminal Justice/Mental Health Consensus Project (2002)

The current response

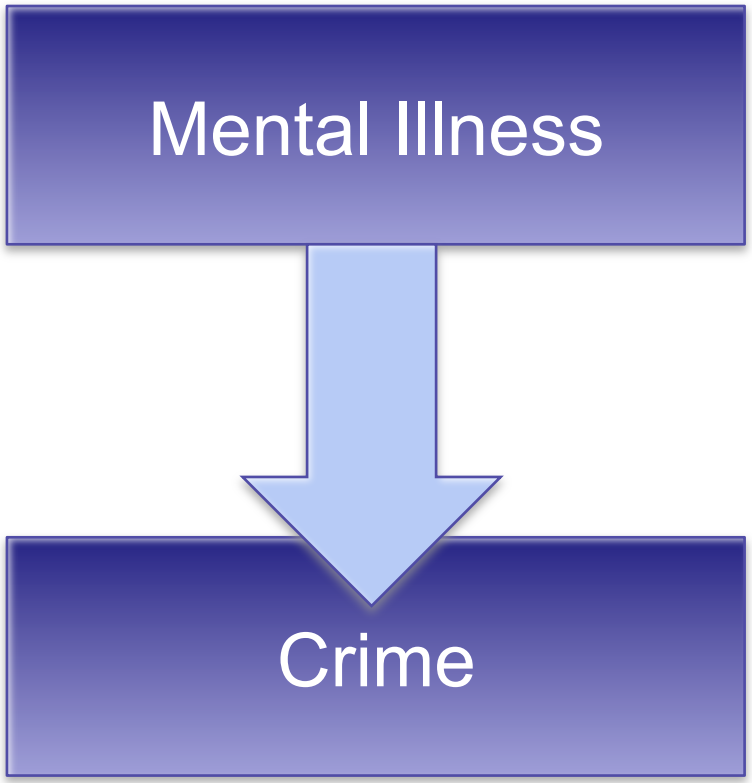
The current response

- Specialty programs:
  - Jail diversion
  - Mental health courts
  - Specialized community supervision caseloads
  - Forensic Assertive Community Treatment (FACT)
- Emphasis on mental illness and treatment: based on the **one-dimensional model**



Source: Skeem, Manchak, & Peterson, under review

The one-dimensional model



- Assumptions of this model:
  1. Symptoms of mental illness cause most criminal offenses
  2. Mental health treatment will reduce re-offense for offenders with mental disorder

Source: Skeem, Manchak, & Peterson, under review

How accurate is the one-dimensional model?

Evaluating the assumptions

Assumption 1: Symptoms cause offenses

- Evidence?
  - Most offenses committed by offenders with mental disorder are not the direct result of symptoms

Table 2.
Frequency Totals

	N	Gang/drug Involved	Socially Disadvantaged	Emotionally Reactive	Emotionally Detached	Psychotic
Total Cases	220	19 (8.6%)	6 (2.7%)	174 (79.1%)	15 (6.8%)	6 (2.7%)
With Mental Disorder	111	0 (0%)	2 (1.8%)	100 (90.0%)	3 (2.7%)	6 (5.4%)
Without Mental Disorder	109	19 (17.4%)	4 (3.7%)	74 (67.9%)	12 (11.0%)	0 (0%)

Source: Peterson, Skeem, Hart, Keith, & Vidal, 2009; see also Junginger, Claypoole, Laygo, & Crisanti, 2006

Assumption 1: Symptoms cause offenses

- Evidence?
  - Mental disorder is only weakly predictive of recidivism—other characteristics are more predictive

Table 3
Predictors of General Recidivism Within Domains

Domain	*Zr*	95% confidence interval		*z*	*Q*	*N*	No. of studies
		Lower	Upper				
Personal demographic	.12	.09	.15	7.63*	27.80	4,277	23
Criminal history	.08	.05	.11	6.48***	89.32***	6,099	29
Deviant lifestyle	.07	.04	.10	5.45***	25.96	3,860	17
Clinical	−.02	−.04	.00	2.51*	283.79***	11,156	44

Note. *Zr* = mean effect size; *z* = significance of *Zr*; *Q* = test of homogeneity.
* $p < .05$. *** $p < .001$.

Source: Bonta, Law, & Hanson, 1998; see also Douglas, Guy, & Hart, 2009

Assumption 2: Mental health treatment will reduce recidivism

- Evidence?
  - Support for the effect of mental health treatment on recidivism is mixed…however, the most rigorous studies generally find no effect
  - Studies of California parolees:
    - Comparing outcomes for PMDs after release to parole finds modest effect of mental health treatment
    - BUT…controlling for differences in PMDs who did and did not receive treatment, the effect of treatment is minimal

Source: Dillman, Eno Louden, et al., 2009; see also Calsyn et al., 2005, Clark, Ricketts, & McHugo, 1999

Assumption 2: Mental health treatment will reduce recidivism

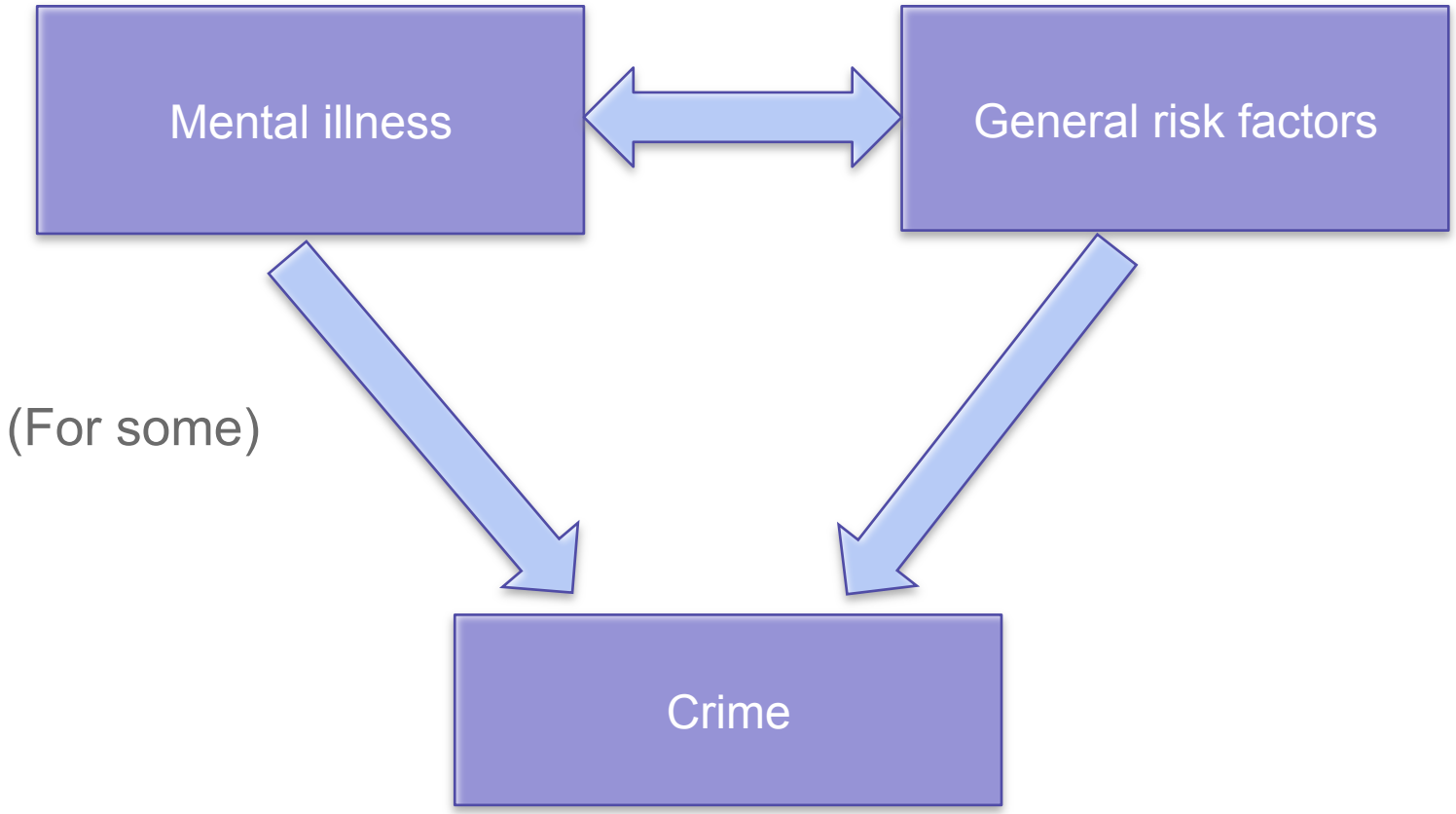
- Evidence?
  - Specialty mental health programs that have shown improved outcomes for offenders are not effective *because* of metal health treatment those offenders received
- Example: Multisite longitudinal study comparing probationers with mental disorder (PMDs) at a specialty mental heath agency (*n* = 183) to PMDs at a traditional agency (*n* = 176)
- Findings:
  - PMDs in the specialty agency received more mental health treatment, and had fewer arrests and probation revocations BUT they did not experience greater reduction in symptoms than PMDs in the traditional agnecy
  - Symptom reduction did not mediate criminal justice outcomes

Source: Skeem et al., 2009; see also Steadman et al., 2009

Reconsidering the one-dimensional model

Alternative approaches

An alternative model



Adapted from: Skeem, Manchak, & Peterson, under review

Predicting risk

The best predictors of re-offense:

the “Central 8”

TABLE 1 Major Risk and/or Need Factors and Promising Intermediate Targets for Reduced Recidivism

Factor	*Risk*	*Dynamic Need*
History of antisocial behavior	Early and continuing involvement in a number and variety of antisocial acts in a variety of settings	Build noncriminal alternative behavior in risky situations
Antisocial personality pattern	Adventurous pleasure seeking, weak self-control, restlessly aggressive	Build problem-solving skills, self-management skills, anger management and coping skills
Antisocial cognition	Attitudes, values, beliefs, and rationalizations supportive of crime; cognitive emotional states of anger, resentment, and defiance; criminal versus reformed identity; criminal versus anticriminal identity	Reduce antisocial cognition, recognize risky thinking and feeling, build up alternative less risky thinking and feeling, adopt a reform and/or anticriminal identity
Antisocial associates	Close association with criminal others and relative isolation from anticriminal others; immediate social support for crime	Reduce association with criminal others, enhance association with anticriminal others
Family and/or marital	Two key elements are nurturance and/or caring and monitoring and/or supervision	Reduce conflict, build positive relationships, enhance monitoring and supervision
School and/or work	Low levels of performance and satisfactions in school and/or work	Enhance performance, rewards, and satisfactions
Leisure and/or recreation	Low levels of involvement and satisfactions in anticriminal leisure pursuits	Enhance involvement, rewards, and satisfactions
Substance Abuse	Abuse of alcohol and/or other drugs	Reduce substance abuse, reduce the personal and interpersonal supports for substance-oriented behavior, enhance alternatives to drug abuse

Source: Andrews, Bonta, & Wormith, 2006

Offenders with mental disorder are "riskier"

- Comparison of risk factors in 112 parolees with mental disorder matched with 109 non-disordered parolees
  - PMDs scored higher on general risk factors (LS/CMI) than non-disordered, and this score was more predictive for recidivism than clinical factors (HCR-20)
  - Specific risk factors where PMDs are particularly risky: family/marital and antisocial pattern

Source: Skeem, Nicholson, & Kregg, 2008; Skeem, Eno Louden, et al., in prep.

Evidence-based corrections: focus on general risk factors

- The most effective corrections programs are those that target changeable risk factors

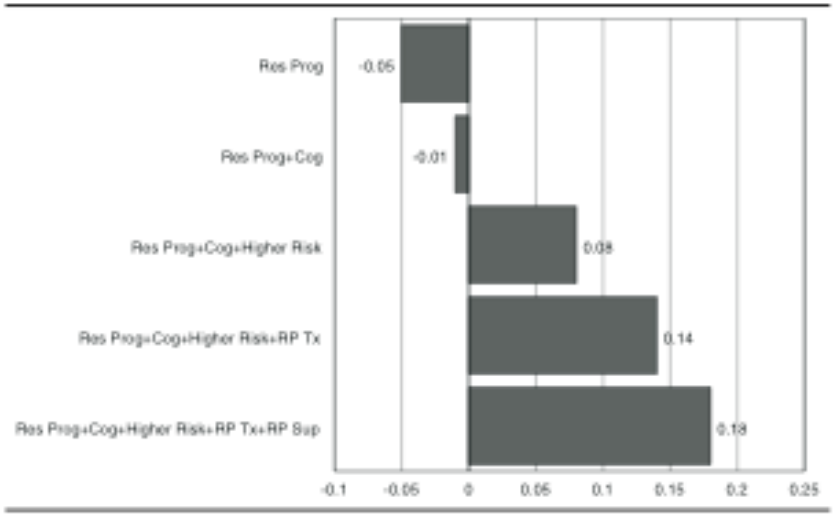
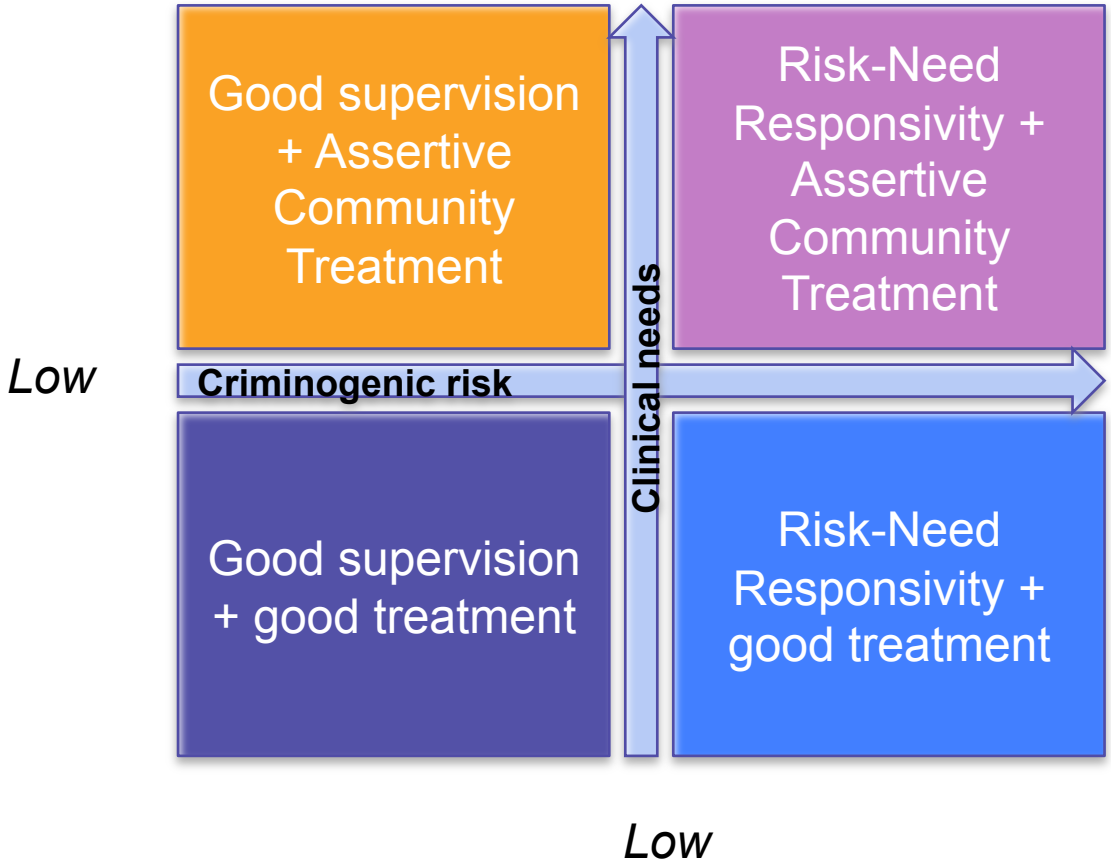


FIGURE 1 Predicted *r* Value Based on Adherence to Risk Principle and Treatment Type for Residential Programs

NOTE: Res Prog = Residential Program, Cog = Cognitive Behavioral or Behavioral Program, Higher risk = 66% or more of sample higher risk, RP Tx = more services for offenders who were higher risk, RP Sup = Longer or equal length of stay (LOS) for offenders who were higher risk.

Source: Lowenkamp, Latessa, & Holsinger, 2006

Risk-Needs Responsivity: matching offender needs to supervision approach



Source: Skeem et al., under review; Skeem, 2009

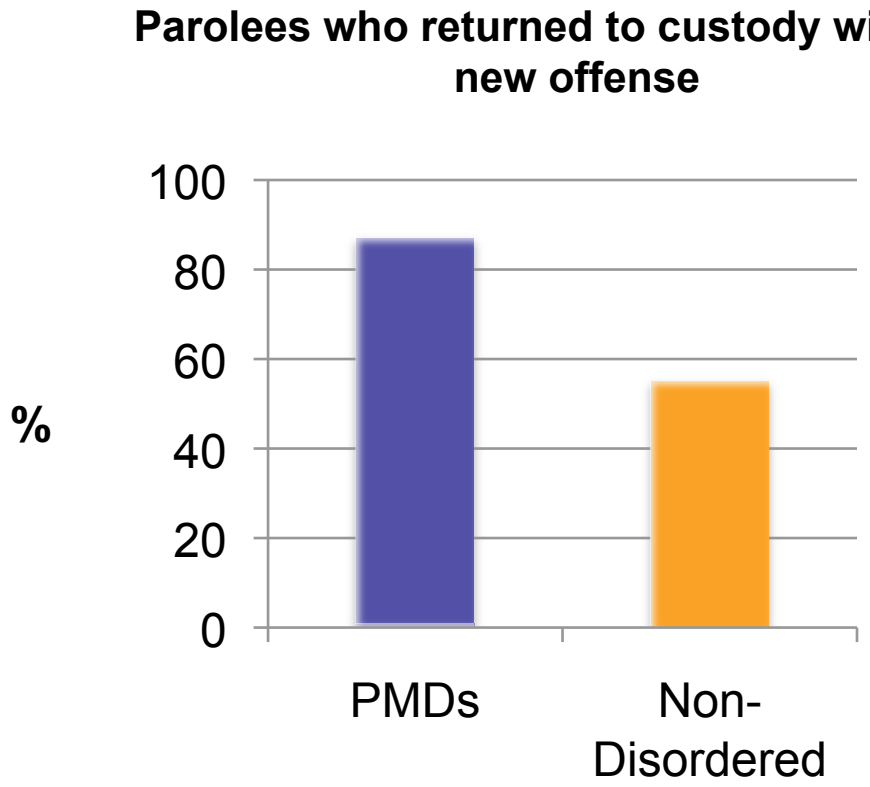
Other considerations

- Practice of individual officers just as important as program design (Dowden & Andrews, 2004)
- Offenders with mental disorder may be particularly sensitive to bad correctional practice (Skeem et al., 2008)

> "My mental condition is something of a severe emotional turbulence . . . and anything that causes me an additional bit of unease or anything, you know, additionally bad in my life, contributes to the strain of a situation that is already teetering on the brink of suicide. So. . it seems like it would make sense for my probation officer…to be very decent in his treatment of me…" (Skeem et al., 2003, pp. 454-455)

The role of officers: the good and the bad

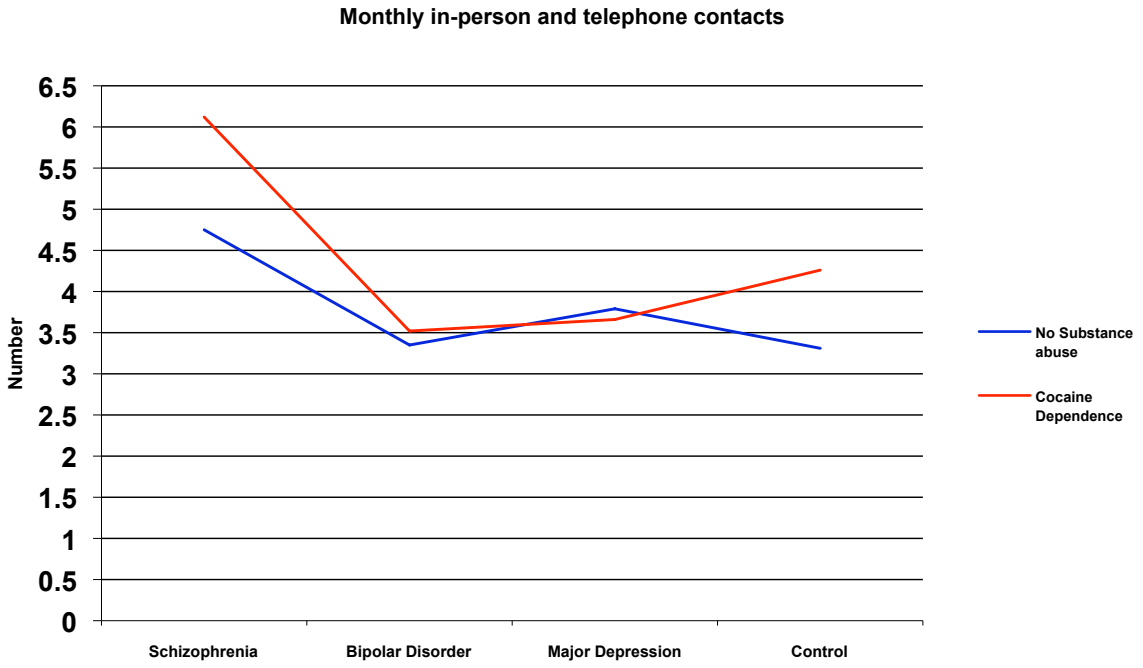
- Officers' use of discretion may result in more revocations for offenders with mental disorder



Source: Porporino & Motiuk, 1995

The role of officers: the good and the bad

- Officers judge offenders with mental disorder as more likely to be violent than offenders with no disorder or only substance abuse
- Officers want to watch these offenders more closely



Source: Eno Louden, 2009

The role of officers: the good and the bad

- Officers can foster better outcomes through a “firm but fair” approach to supervision

Table 4

Relation Between Informants' DRI-R Scores and Recent Recorded Rule Compliance

	Probationer DRI-R scores		Officer DRI-R scores	
Recent violations	Total	C-F/Trust/Tough	Total	C-F/Trust/Tough
Number	−.15	−.09/−.10/.34***	−.26**	−.12/−.36***/.11
Treatment noncompliance	.02	.04/.04/.07	−.17	−.08/−.22*/.09
Substance abuse	−.13	−.09/−.11/.23*	−.26*	−.14/−.24*/.24*
Failure to report	−.26*	−.20/−.22*/.40***	−.16	−.09/−.19/.08
Other technical	−.08	−.04/−.12/.19	−.23*	−.18/−.23*/.07
Violence/new offense	−.19*	−.23*/−.11/.04	.19	.19/.07/−.12

Source: Skeem, Eno Louden, Polaschek, & Camp, 2007

Key recommendations

What to avoid:

- Singular focus on mental illness and treatment
- One-size fits all approach to supervision
- Bad correctional practice (use of threats, intensive monitoring)

What to do:

- Assess for risk and focus on changeable risk factors
- Apply principles of evidence-based practice:
  - Firm but fair supervision
  - Discussion of criminogenic needs
  - Problem-solving supervision approach
- Match offenders' needs and risk level to approach

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Thank you!