Supervising and Treating Probationers and Parolees with Mental Illness: What You Need to Know

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Overview

• Statement of the Problem

• The link between mental illness and crime

• Effectiveness of current interventions for offenders with mental illness

• New directions in supervising and treating offenders with mental illness
Over-representation in the CJ system

Fazel & Danesh (2002); Steadman et al.(2009); Teplin, (1990), Teplin et al.(1996)
Varied and serious psycho-social needs

- Co-occurring substance disorder
  - (~75% have James & Glaze, 2006)

- Poor living situation
  - (~50% unemployed; ~25% on disability, welfare; Ditton, 1999)

- Chronic physical health concerns
  - (see Odgers, 2008, 2010)
Most are supervised in the community

Bureau of Justice Statistics (2013)
Increased risk for supervision failure

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

Eno Louden & Skeem (2011); see also Porporino & Motiuk (1995)
Concerns about incarceration

- Victimization
- Self-harm
- Acting out

“Stigmatized, isolated, and misunderstood”
(Lord, 2008, p. 930)
A call to action

“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.”

Mental illness and crime
Public perceptions

Public Perceptions (n=1444)
Link et al (1999)

Probation Officers (n=234)
Eno Louden et al (2012)

% indicating violence likely

How risky for violence?
A direct link: Some background

Deinstitutionalization & Criminalization

“Thousands of mentally ill are left untreated and un-helped until they have deteriorated so greatly that they windup arrested and prosecuted for crimes they might have never committed had they been able to access therapy, medication, and assisted living facilities in the community”

-Human Rights Watch, 2003
A direct link: The evidence

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>

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.
A direct link: The evidence (cont.)

Distribution of Crimes Along Independent-Direct Continuum

N = 143; 450 crimes; ~3/person (Range = 1-7); Peterson et al. (in press)
A direct link: The evidence (cont.)

Percentage of Direct Crimes

Number of Participants

<table>
<thead>
<tr>
<th>Percentage Range</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>60</td>
</tr>
<tr>
<td>1-25%</td>
<td>10</td>
</tr>
<tr>
<td>26-75%</td>
<td>30</td>
</tr>
<tr>
<td>76-100%</td>
<td>5</td>
</tr>
</tbody>
</table>

Peterson et al. (in press)
A direct link: The evidence (cont.)

<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>.09</td>
<td>.15</td>
<td>7.63*</td>
<td>27.80</td>
<td>4,277</td>
<td>23</td>
</tr>
<tr>
<td>Criminal history</td>
<td>.08</td>
<td>.05</td>
<td>.11</td>
<td>6.48***</td>
<td>89.32***</td>
<td>6,099</td>
<td>29</td>
</tr>
<tr>
<td>Deviant lifestyle</td>
<td>.07</td>
<td>.04</td>
<td>.10</td>
<td>5.45***</td>
<td>25.96</td>
<td>3,860</td>
<td>17</td>
</tr>
<tr>
<td>Clinical</td>
<td>-.02</td>
<td>-.04</td>
<td>.00</td>
<td>2.51*</td>
<td>283.79***</td>
<td>11,156</td>
<td>44</td>
</tr>
</tbody>
</table>

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

Bonta, Law, & Hanson (1998)
Mental illness-violence link: The Evidence

- 1,136 patients vs. 519 “neighbors”
- Assessments every 10 weeks post hospital discharge
- Multiple violence indicators

“The MacArthur Studies”  
Steadman et al. (1998)
More on the mental illness-violence link

• N = 132; 26 weekly assessments
  – Symptoms (BSI)
    • Depression
    • Anxiety
    • Hostility
    • Somatization
    • TCO
  – Violence

Skeem et al. (2006)
Current interventions

• Jail diversion
  – Divert from jail into treatment pre or post booking

• Specialty probation or parole
  – Sustained officer training in mental illness, coordination with treatment

• Mental health courts
  – Collaboration between judge, probation, treatment, prosecutor, & defense

• Jail aftercare or prison reentry
  – Timely access / linkage to treatment
Implicit model of existing interventions

Skeem, Manchak, & Peterson (2010)
## Effectiveness of interventions

|                     | Arrest                                                                 | Symptoms                                                            |
|---------------------|------------------------------------------------------------------------|                                                                    |
| Jail Diversion      | Diverted = Comparison (1 yr)                                            | Comparison = Control on Sx Δ                                         |
|                     | Diverted > Longer (TTA)                                                |                                                                    |
| Specialty Supervision | Specialty < Traditional (1 yr)                                          | Comparison = Control on Sx Δ                                         |
|                     | 36% vs. 64%                                                            |                                                                    |
| Mental Health Courts | MHC < Traditional (18 mo.)                                             | Not assessed                                                        |
|                     | 42% vs. 57%                                                            |                                                                    |
| Jail/Prison Aftercare | Aftercare < None                                                        | Not assessed                                                        |
|                     | 5% vs. 16% (re-incarceration 1 yr) Experimental                        |                                                                    |

Skeem et al. (2010)
Effects of psychiatric treatment on outcomes

• 25 studies
• 15,678 participants
  – CJ outcomes: $d = .19$
  – Fewer symptoms $d = .12$
  – Higher functioning $d = .20$
  – When accounting for study quality
    • Randomized $d = .09$, ns
    • Well-controlled for bias $d = .05$, ns

Martin et al. (2012)
To recap...

• Mental health symptoms do not predict violence
  – Substance abuse & hostility do
• Clinical factors may lead to crime for ~1 in 10
  – ...but only some of the time
• Clinical factors do not typically predict recidivism
  – ...there is a negative relationship
• Addressing clinical factors does not reduce recidivism

If symptoms are not causing crime why are we targeting them to reduce recidivism???
Revisiting the policy model

Intervention

Recidivism

What do we need to target?
# Criminogenic risk factors

<table>
<thead>
<tr>
<th>LS/CMI Total Scores</th>
<th>OMIs</th>
<th>Non-OMIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>General risk/need (Section 1)</td>
<td>27.0</td>
<td>24.6</td>
</tr>
</tbody>
</table>

## General Risk/Need Factor Scores

<table>
<thead>
<tr>
<th>Factor</th>
<th>OMIs</th>
<th>Non-OMIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal History</td>
<td>6.1</td>
<td>5.9</td>
</tr>
<tr>
<td>Education/Employment</td>
<td>6.1</td>
<td>5.4</td>
</tr>
<tr>
<td>Family/Marital</td>
<td>2.6</td>
<td>2.1</td>
</tr>
<tr>
<td>Leisure/Recreation</td>
<td>1.4</td>
<td>1.3</td>
</tr>
<tr>
<td>Procriminal Attitudes</td>
<td>2.2</td>
<td>1.9</td>
</tr>
<tr>
<td>Antisocial Pattern</td>
<td>2.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Alcohol/Drug Problems</td>
<td>3.4</td>
<td>3.1</td>
</tr>
<tr>
<td>Criminogenic Companions</td>
<td>3.4</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Skeem et al. (2013); see also Morgan et al. (2010)
“What Works”: The RNR Principles

Risk Principle
• Refers to risk for recidivism, not seriousness of offense
• Use a validated assessment (ORAS; LS/CMI) to classify risk
• Match the intensity of services to the level of risk
  – Do not mix offenders of low and high risk
  – Leave low risk offenders alone

Needs Principle
• Focus on dynamic (changeable) risk factors that are linked to recidivism
• Target the “Central Eight”
• Emphasis on the “Big Four”
Risk is directly linked to recidivism

Latessa et al. (2010)
The Risk Principle & correctional intervention results from meta-analysis

Dowden & Andrews (1999)
EBP in mental health

High

Low

Clinical Needs/Risk

Criminogenic Risk

EBP in corrections & EBP in mental health

EBP in corrections & treatment as usual

Treatment as usual

Prins & Draper (2009) (Council of State Governments)
Targeting criminogenic need

Reduced Recidivism

Increased Recidivism

Target 1-3 more non-criminogenic needs

Target at least 4-6 more criminogenic needs

Revisiting the policy model

Intervention → Criminogenic Need

How do we need to do it?

“Within Person” Effects

Recidivism

“Systemic” Effects
What else “works”?

General Responsivity

• Delivering services conducive to offenders’ learning styles
  – cognitive and behavioral strategies
  – Reinforcement, modeling, practice
• The Cognitive- behavioral model
  – SCIENTIFIC
  – ACTION ORIENTED
  – PRESENT-FOCUSED
  – BASED ON THEORIES OF LEARNING
  – STEPWISE PROGRESSION
  – BRIEF

Core Correctional Practices

• Appropriate use of authority
• Modeling and behavioral reinforcement
• Service brokerage
• Problem-solving strategies for compliance
• Good working relationship
Supervision strategies

Negative Compliance Strategies
• Closer monitoring
• Threats / sanctions
  – Violations, jail etc.
• Stronger effects than positive compliance in predicting new offense and violation reports

Positive Compliance Strategies
• Problem solving
• Positive reinforcement
• Pro-social modeling

Skeem et al. (2006); Eno Louden et al. (2012); Manchak et al. (under review)
Dual role relationship quality

• Components:
  – Firm-but-fair
    • Procedural justice
    • Authoritative not authoritarian
  – Caring
  – Trusting
  – NOT Tough
    • Out to get me
    • Makes me figure it out on my own

• Predicts:
  – In session behavior
  – Violations
  – Fully mediates the effectiveness of specialty probation

• Same components in mandated mental health treatment

Skeem et al. (2007); Skeem & Manchak (2010); Manchak et al. (in press)
Boundary spanning

• Going beyond service “brokerage”
  – Communication and coordination with outside agencies
  – Knowledge to navigate other systems
  – Breaking through red tape
• Predicts access to better, evidence-based treatment

Skeem et al. (2007); Manchak et al. (under review)
Conclusion

• Move away from mental illness as “master status”
  – How we view cause of behavior is how we treat it
  – OMIs have many of the same criminogenic risk factors as non-OMIs... so target those!

• Secure mental health treatment for those with the highest need for it
  – This will improve responsivity
  – May help with rule noncompliance
  – If criminality is linked to symptoms
Questions?
Requests for more information?

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