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

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Mental illness cases swamp criminal justice system

The N ly Ill

Rikers: Where Mental Illness Meets Brutality in Jail

The involvement of people with mental illness in the justice system has captured a substantial amount of attention over recent years. This recent USA Today headline read…

If USA Today feels like a gimmicky and insubstantial outlet, similar headlines can be found in recent months in both the WSJ and NYT

These stories typically portray part of the problem correctly – beginning with one fundamental fact.

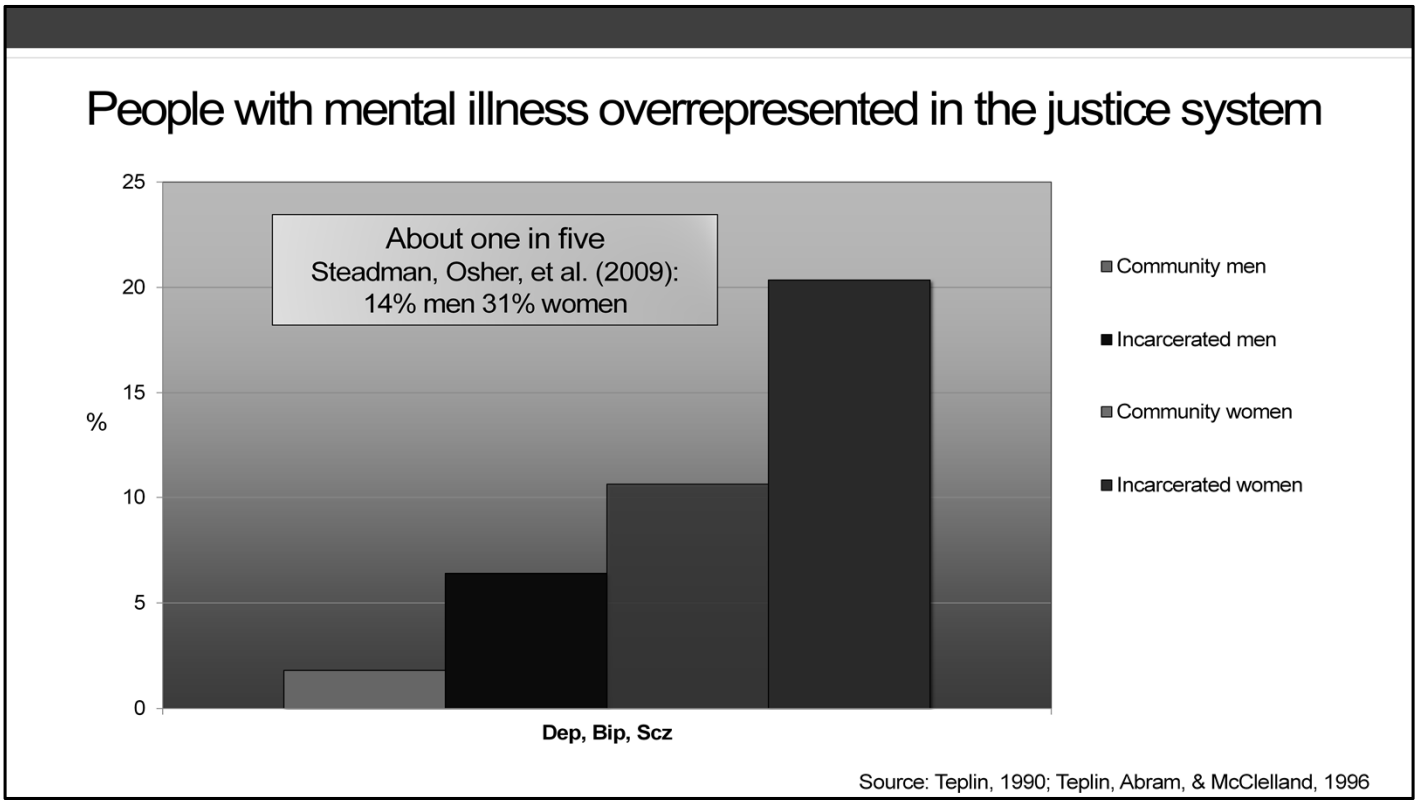
No event has sparked more policy debate about guns and mental illness than this tragedy at Sandy Hook elementary school in 2012.

Hindsight is often 20/20 (in these cases)…but if these individuals had been effectively linked with psychiatric treatment, would that have prevented the shootings? I hope that, by the end of my talk today, you are not certain. I'm not. First, there is varying evidence that each of these individuals was seriously mentally ill. Second, and more importantly, the issue is the extent to which that illness led directly and strongly to these specific criminal acts. Maybe. Maybe not.

Three things are important to say for the bigger picture.

First, thankfully, mass shootings are incredibly rare. So rare that science can't help us predict them (threat assessment is a much better approach than profiling or zero tolerance).
Second, mental illness per se is not strongly linked with violence. The vast majority of people with serious mental illness are never violent. And, according to Swanson's epidemiological study, only 4% of violent incidents in the US can be attributed to the mentally ill. In his words, even if we could cure these terrible illnesses today, it would do little to solve the nation's violence problem. 96% would continue.
Third, the brightest lights in my field are unanimous in saying that keeping guns out of the hands of dangerous people (not necessarily mentally ill people) will go further in preventing these events than anything else. That's an uphill battle with congress.

But…that's not the problem I'm here to talk with you about today. It merely provides context for discussing evidence-based practice for offenders with serious mental illness.



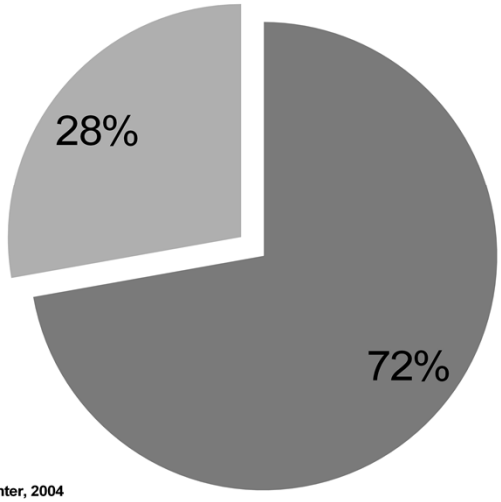
CDCR estimate: 23%

People with mental illness are disproportionately represented in the criminal justice system. Although prevalence estimates vary widely, the best were produced by Linda Teplin, who administered comprehensive diagnostic interviews to community residents and probability samples of people in jail. We will focus on aggregate numbers for three disorders – depression, bipolar disorder, and schizophrenia.

This graph shows the prevalence rates of those disorders, as a function of gender and population. As you can see here, the prevalence of SMI in JAIL is three times higher than in COMMUNITY for men….and two times higher for women.

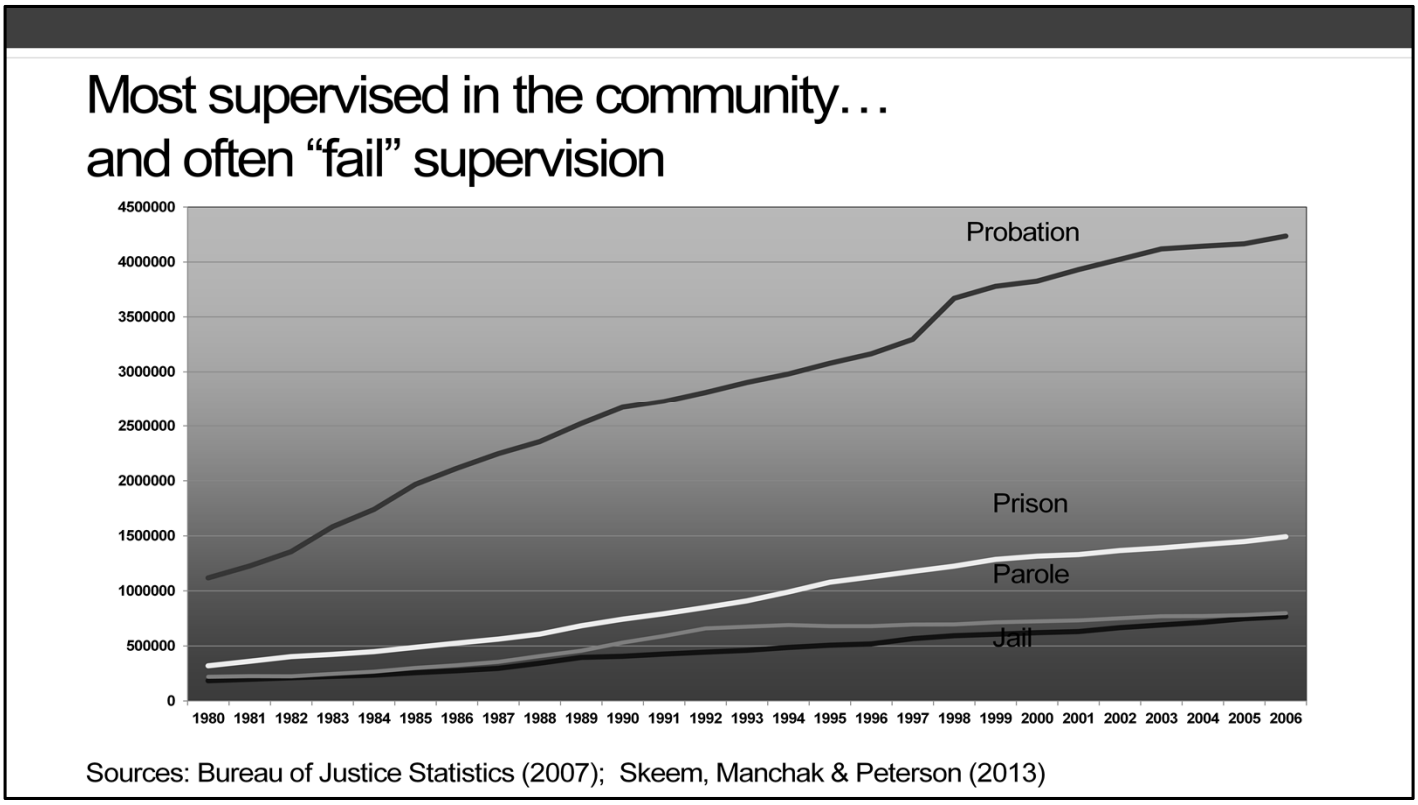
Recent updates suggest that 1 in 5 offenders has a serious mental illness. And…anecdotally, the largest providers of inpatient psychiatric services in the nation are not hospitals, but jails. Specifically, jails in LA, NYC, and Chicago. Some have called the CJ system the de facto mental health system.

Most have co-occurring substance abuse disorders



Source: The National GAINS Center, 2004

About three quarters of the target population has co-occurring substance abuse disorder



Much of my research focuses on probation and parole – community supervision – because it is where most of this population is found. It also represents an unrealized opportunity. Twice the likelihood of RTC

When incarcerated, they also "fail," in the sense that they are more likely to have behavioral problems and be placed in SHUs/admin seg…and less likely to be paroled. A lot of attention recently (jails).

"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)

Disproportionate representation in the CJ system; poor outcomes.

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.

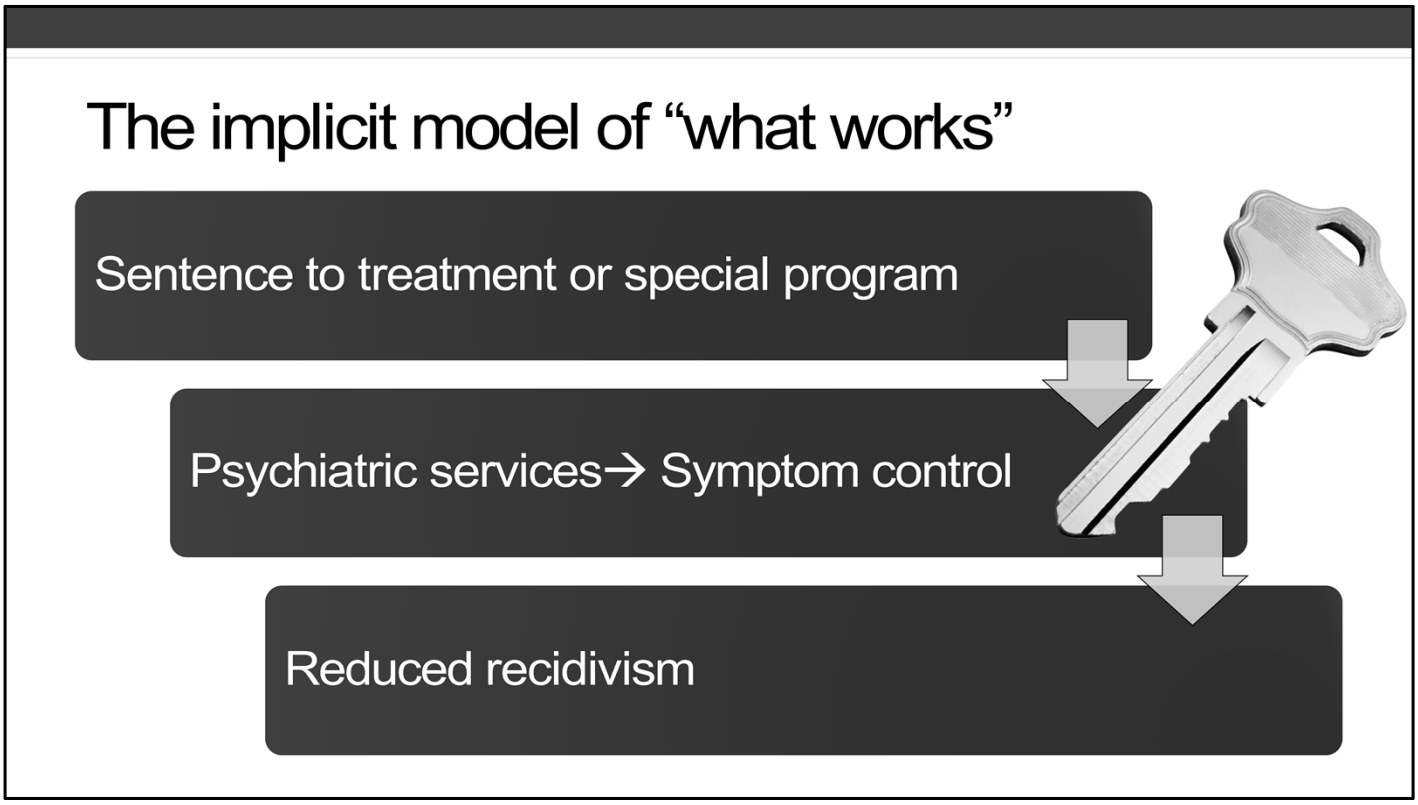
They believe that if many of the people with mental illness received the services they needed, they would not end up under arrest, in jail, or facing charges in court"

Criminal Justice Mental Health

CONSENSUS PROJECT

Why are so many people with mental illness in correctional system?

The "direct cause" or "criminalization" model. Readily apparent in the recent news stories I mentioned, which typically blame deinstitutionalization…or the emptyping of psychiatric hospitals without adequate community-based care.



If criminal justice involvement is the direct product of mental illness, what is the key to solving it? Linkage with mental health treatment.

A number of CJ programs are now available for JIPMIs. They are diverse – they include mental health courts (which have spread like wildfire), specialty mental health probation, and a variety of jail diversion programs including police-based Crisis Intervention Teams. They are united, however, by this basic model.

In essence, they seek to replace involvement in the criminal justice system with (greater) involvement in the mental health system.

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

Of course, research suggests that the problem – and needed solutions—are more complex than the criminalization model suggests.

The rest of this talk is organized into three parts. HIT at BROADEST LEVEL.

FOCUS = CRIMINAL BEHAVIOR (FEWER NEW CRIMES AND NEW VICTIMS). There are certainly important public health goals too – but policy discourses mainly focuses on recidivism.

Let's start with unsupported assumptions of this model…

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

			Rating ≥75[a]	
Effect	Mean	CI	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.

Junginger, Claypoole, Laygo, & Cristina (2006); see also Peterson, Skeem, et al. (2009, 2014)

Here, reliable raters coded 113 post-booking jail diversion cases to indicate the probability that inmates' offenses were the result of serious mental illness or substance abuse. Relied on brief interviews about the offense and police reports.

Direct= delusions or hallucinations directly led to crime (vs. other symptoms) OR being intoxicated or high at time (vs. doing crime to get drugs). "

Peterson et al. – sample of about 200 parolees with- and without- mental illness. Only 10% of those with mental illness classified as having a pattern that fit criminalization (e.g., survival crimes; mercy bookings; psychosis→arrest)

Conclusion: Persons with serious mental illness may be overrepresented in jails and prisons, but we can offer little evidence…that it was their illness that got them there.

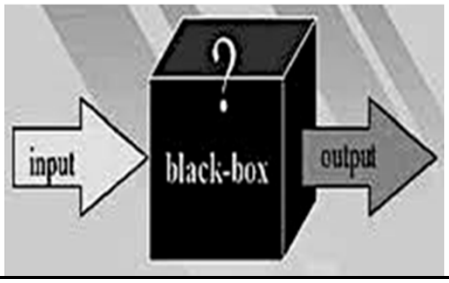
Roadmap

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

13 min

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…



ACT uses a multidisciplinary team, which typically includes a psychiatrist, a nurse, and at least two case managers. ACT is characterized by (1) low client to staff ratios; (2) providing services in the community rather than in the office; (3) shared caseloads among team members; (4) 24-hour staff availability, (5) direct provision of all services by the team (rather than referring consumers to other agencies); and (6) time-unlimited services.

Specialty MH probation (assigned to officer with interest/training in mental health who manages a much smaller caseload than traditional)– it worked – one of largest effect sizes of these types of programs. But we looked into the black box to assess the logic model of the program, which didn't not pan out

MacArthur probation outcome study

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

Traditional	Specialty
• 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 VS. TRADITIONAL – Defined prototypic features based on national survey (about 200 agencies).

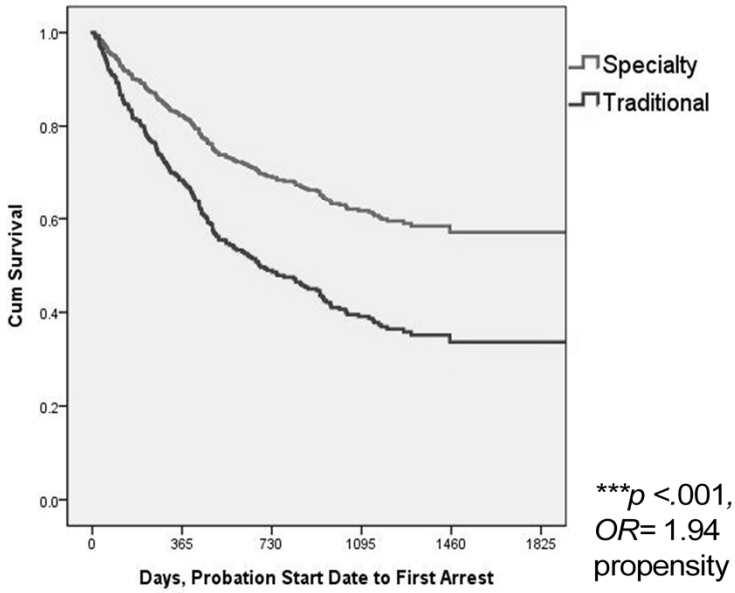
Selected specialty site that matched the prototype (Dallas); used traditional site that was similar in jurisdiction size, ethnic distribution and MH expenditures (Los Angeles)

Method matching variables: Age, gender, ethnicity, offense (person vs. other), and total time on probation (over/under 1 year)

Propensity score weighting: rich measures of covariates produced excellent model of treatment assignment; traditional/specialty groups had good overlap in scores across distribution.

Longitudinal study. Followed intensively for one year (baseline; 6 month; 12 month interviews of probationers and their officers) with 90% retention rate. Followed through records for five years (admin databases: probation; mH billing; prison/jail) + FBI arrest records

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



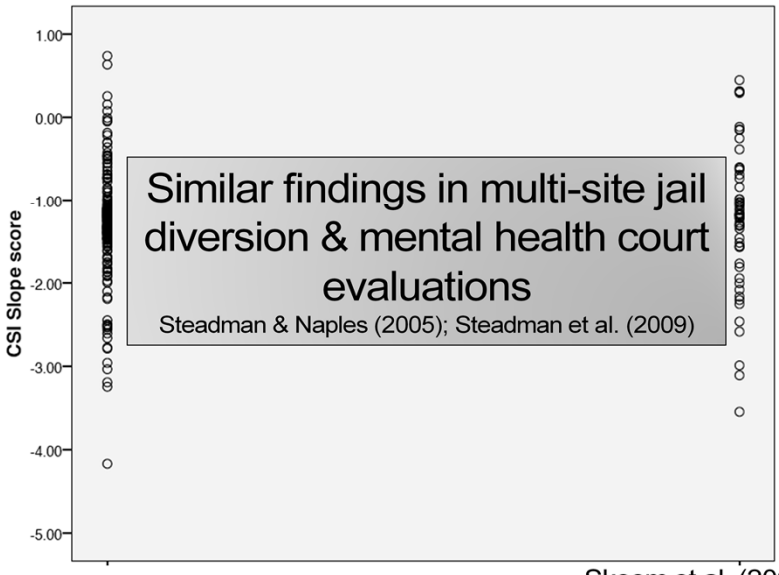
****p* <.001,
OR= 1.94
propensity weighted

Those on specialty probation survive longer in the community without reoffending over five years. By that time, about 60% of specialty vs. 35% of traditional are in the community without a re-arrest

Context: FBI/UCR arrest rates *higher* at specialty (6.6%) than traditional (3.4%) site (specifically same for violent crime, higher for property crime, drug crimes unknown?)

Similar results for violation reports to the court

…but not because of symptom reduction



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

Steadman & Naples (2005); Steadman et al. (2009)

Skeem et al. (2009; & in prep)

Take out of mediation context and address directly. Some had lots of symptom improvement. Others had none, or even worsened. So we examined individuals' change in symptoms as a function of arrest. There were no differences (either across- or within sites).

Roadmap

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

SHOULD BE AT 20-22 MINUTES

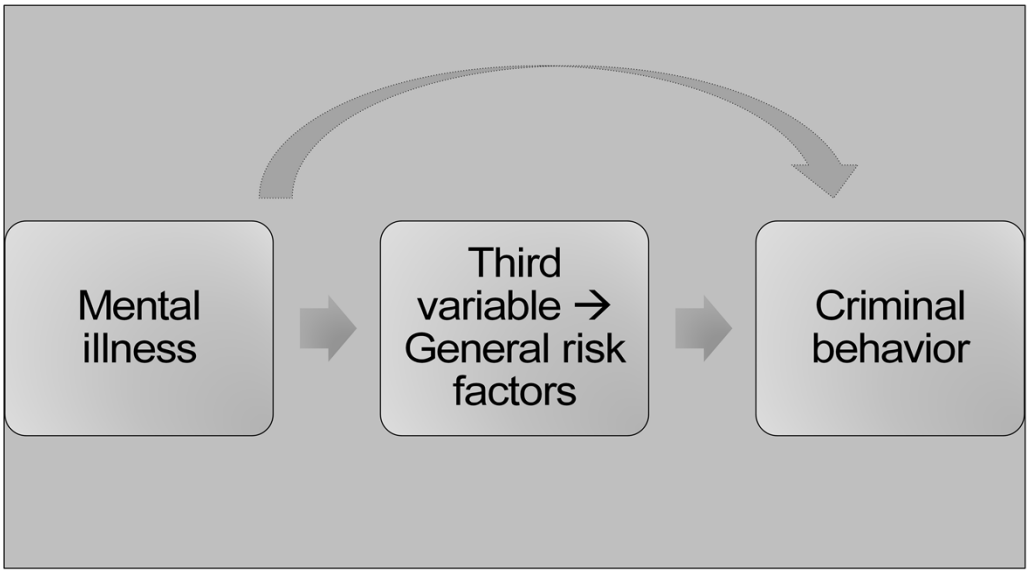
Consider alternative views

- 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

"[T]he predictive validity of mental disorders most likely reflects antisocial cognition, antisocial personality pattern, and substance abuse."

Andrews et al. (2006)

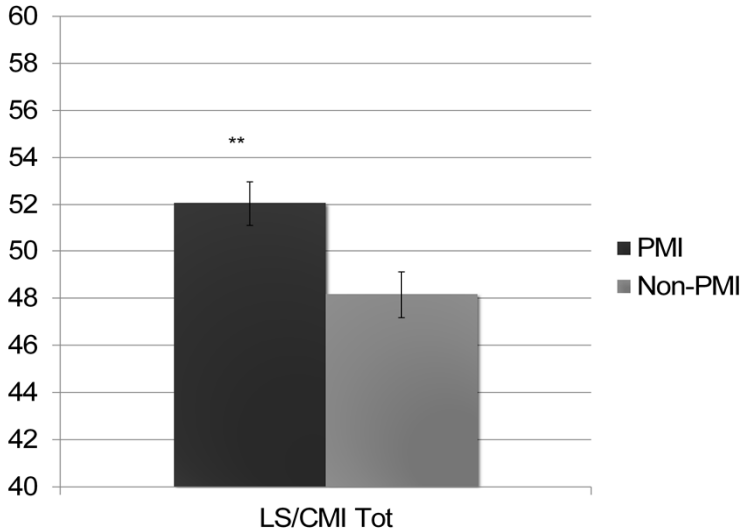
General alternative model



Skeem, Manchak, & Peterson (2012)

The relationship between mental illness and violence/criminal behavior is largely indirect. Mental illness relates to other variables (e.g., substance abuse, neighborhood disadvantage) that are, in turn, the foundation for general risk factors like antisocial peers/attitudes that can establish and maintain criminal behavior. Although I don't have time to go into it, this model is developmental (accounts for fact that serious mental illness onsets during adolescence; can disrupt prosocial relationships, employment, etc. that can buffer against CJ involvement)

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)

Consistent with findings of Baldry- based on sample of over 2K OMIs in NSW.
http://www.afao.org.au/library/hiv-australia/volume-9/Number-1/mental-health-and-the-criminal-justice-system-in-nsw
Specialized assessment for antisocial pattern.
Early and diverse antisocial behavior (Item A plus at least one of B, C, or D)
Severe problems of adjustment in childhood, as indicated by school and social welfare records, or arrested and charged under age 16
Official record of assault/violence
Escape history from a correctional facility, unlawfully-at-large
Charge laid, probation breached, or parole suspended during prior community supervision
Criminal attitude (At least one of A, B, or C)
Supportive of crime (1.7.36)
Unfavorable toward convention (1.7.37)
Poor, toward supervision/treatment (1.7.39)
Pattern of generalized trouble (At least four of letters A. through H.)
Financial problems (Yes if rated as "0" or "1")
3 or more address changes last year
Never employed for a full year (1.2.11)
Less than a regular grade 10 or equivalent (1.2.12)
Suspended or expelled at least once (1.2.14)
Nonrewarding, parental (1.3.19)
Could make better use of time (1.4.23)
Few anticriminal friends (1.5.27)

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)

Early onset of behavior problems, impulsive behavior, anger control problems, antisocial attitudes

Antisocial cognition (3-4 studies now) – self justificatory thinking, displacement of blame, schemas of dominance and entitlement, and the like. Tend to misperceive benign situations as threats (e.g., be predisposed to perceive harmless
remarks as disrespectful or deliberately provocative), demand instant gratification, and confuse wants with needs. LEARNED; not inherent.

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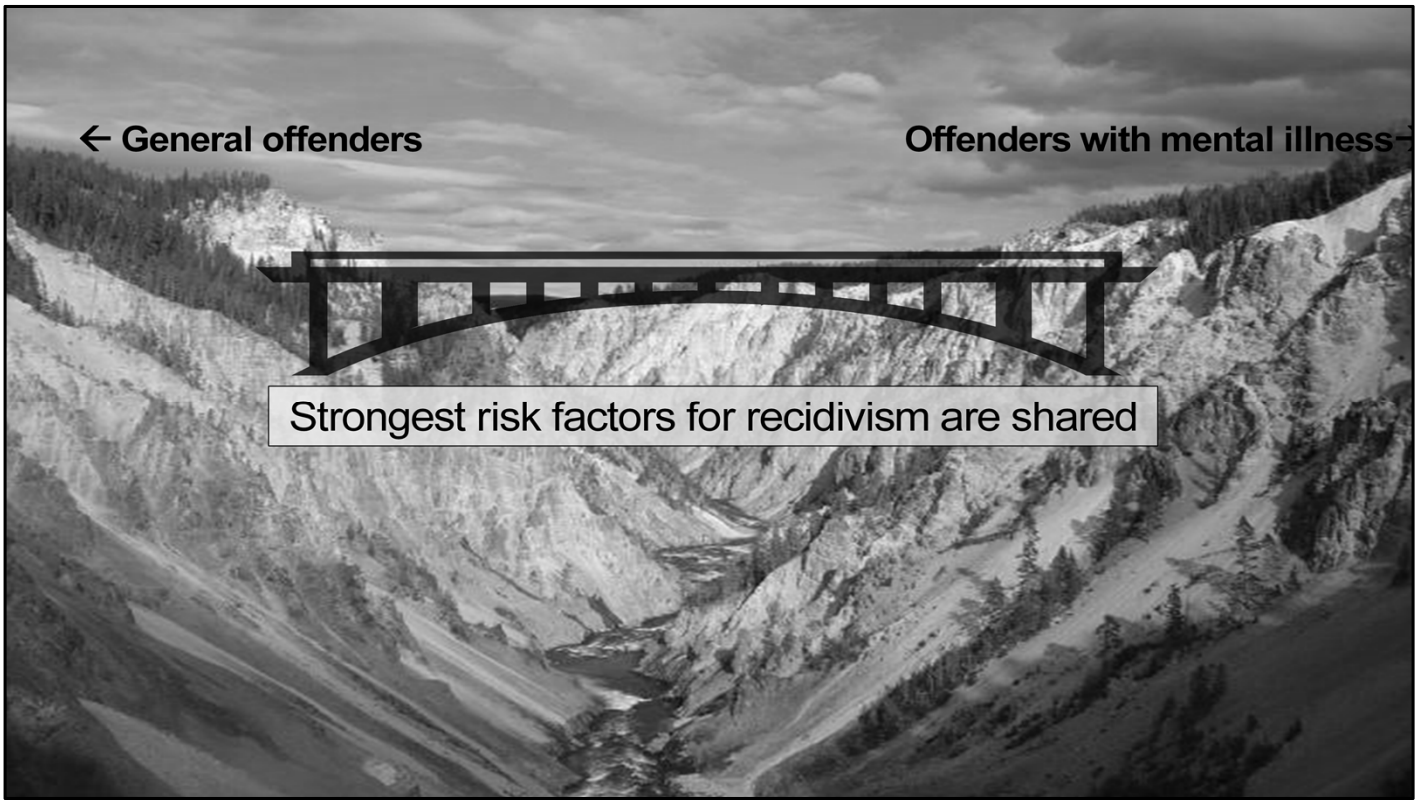
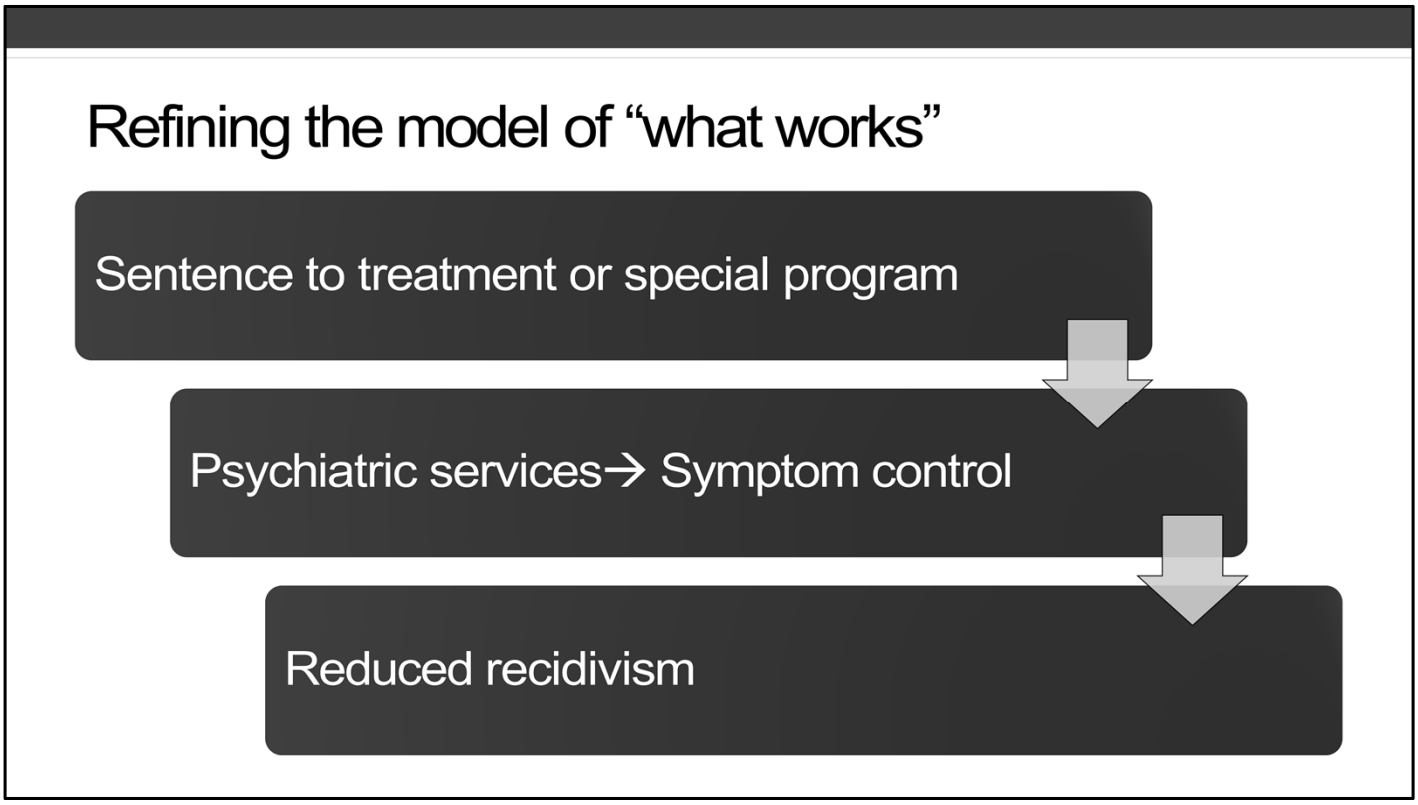
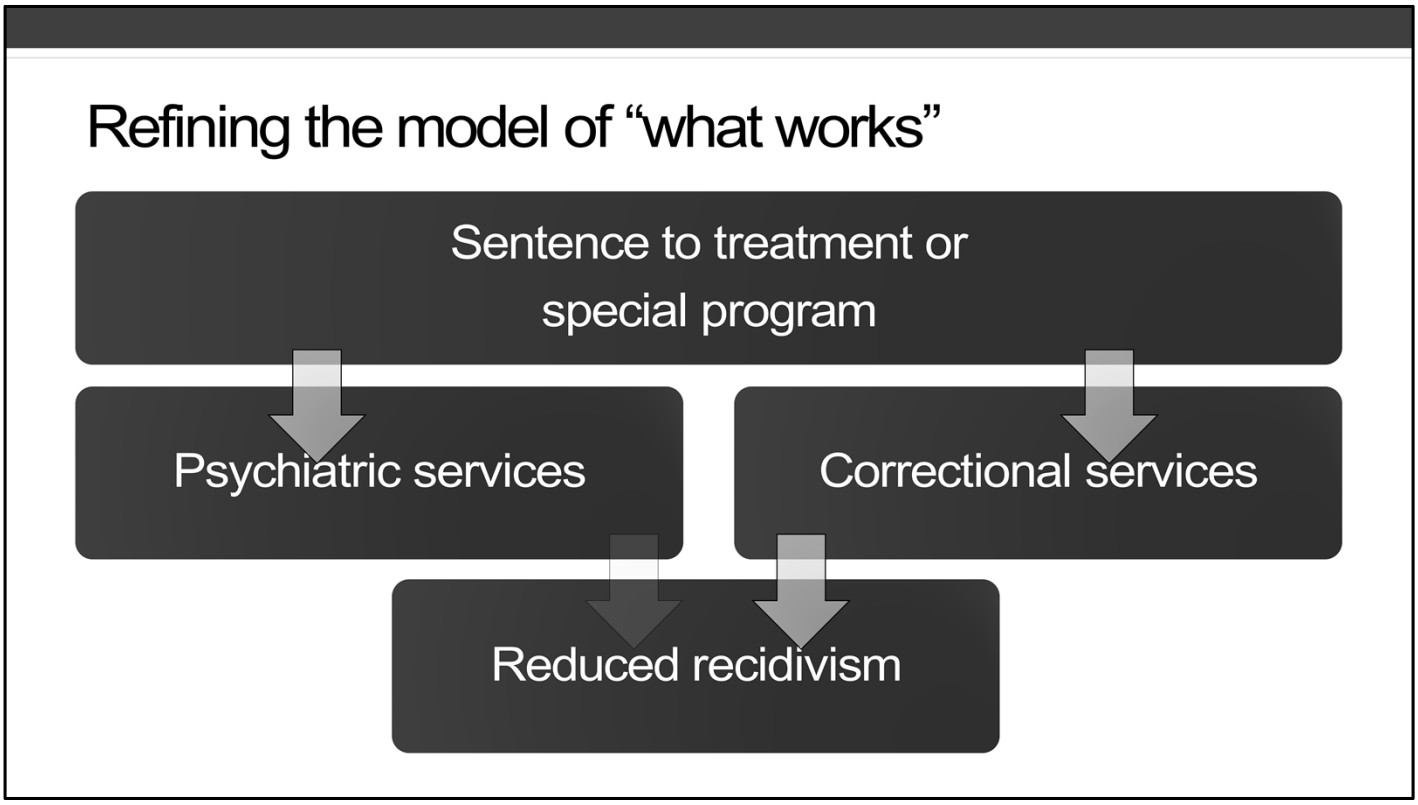

← General offenders
Offenders with mental illness→
Strongest risk factors for recidivism are shared

A visual aid



These efforts are diverse, both across- and within- countries. Nevertheless, they are united by the belief that these individuals wind up arrested and under correctional supervision because they do not receive the mental health services they need. They view criminal justice involvement as the direct product of mental illness, and linkage with mental health treatment as the solution. Contemporary policy underlying these efforts relies heavily on the notion of diversion, seeking to replace involvement in the criminal justice system with (greater) involvement in the mental health system. Mental health courts have spread prolifically in the U.S. over recent years (BJA, 2009), with some recent uptake in Australasia but little or none in the UK.

esearch indicates that the problem – and needed solutions – are more complex
Unsupported assumption #1: Symptoms frequently and directly lead to justice system involvement
Unsupported assumption #2: Symptom control will reduce justice system involvement (i.e., symptoms are causal risk factors)



Some of the principles we've found to work with this group overlap heavily with those identified in meta-analyses of effective corectional treatment. (Disappointing…nothing new under the sun!)

Roadmap

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

Should be at 30 MIN

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)

A “bread and butter” intervention for offenders is CBT. CBT is based on the assumption that offenders’ cognitive distortions
are learned rather than inherent. CBT involves structured, often group-based techniques that focus on building
Pprosocial problem-solving skills and changing offenders’ patterns of thinking/feeling.

Meta-analyses of RCTS consistently indicate that these are among the most effective forms of treatment- Lipsey et al. found mean recidivism reduction of 25% in RCTs.

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Focus: In an effort to improve the criminal justice's response to people with mental illness, policymakers and practitioners in the U.S. have launched numerous federal initiatives and local programs for this population (see Skeem, Peterson, & Manchak, in press). Similar movements inspired by large populations of offenders with mental illness are apparent across the U.K. and Australiasia (e.g., Beyond Bars Alliance, 2007; Mullen, 2001; Rethink & Sainsbury Centre for Mental Health, 2010).
The term "evidence-based practice" and "what works" have come to be used very loosely…so I'll define what I mean by those here, before we proceed.
EBP: Apply the best research to inform practice that improves outcomes

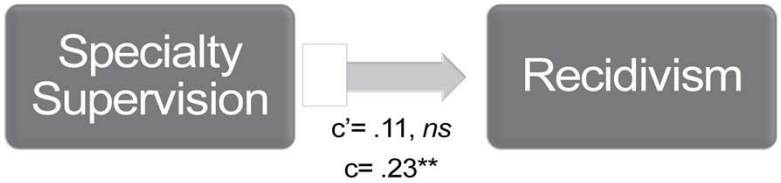
Fewer new crimes & new victims

The real world ($$)

"optimal intervention. . . the least extensive, intensive, intrusive, and costly intervention capable of successfully addressing the presenting problem" TRY to identify MECHANISMS of CHANGE

TWO PARTS

Officer-offender relationship quality explains effect of specialty probation



Content (*what)*: Identify and target causal risk factors for recidivism

Process (*how)*: Reduce reliance on surveillance relationships and heavily punitive strategies.

STRONGEST finding that threaded through MacArthur series of probation studies (focus groups; national survey; outcome study)

Consistent with early, qualitative work

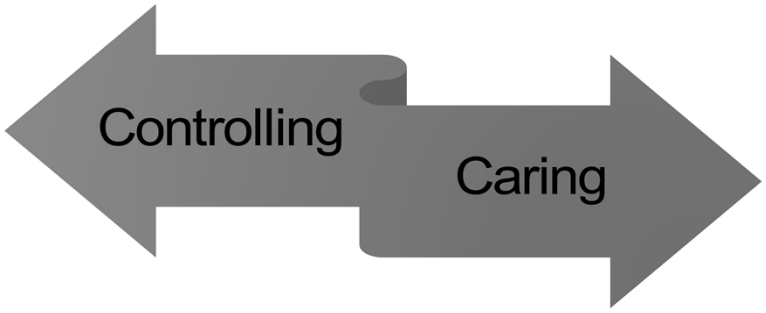
Process colors every interaction and affects outcomes

Authoritarian	Relational
• *"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.'"*	• *"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"*

CONSIDER HIGHLIGHTS ONLY (TIME)

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.

What defines a good officer-offender relationship?
Not an easy questino to answer. Why? When you work with a non-voluntary client, you have two roles. Probation has long recognized this – despite the surveillance orientation now, it grew out of a casework model.

POWER: sucessfully address the dual role dilemma (i.e., real behavior change requires disclosure of real problems…even when those disclosures risk getting the offender in serious trouble).

Klockars showed that officers who balance these roles are more effective in reducing recidivism than those oriented only toward rehabilitation OR law enforcement.. His work, our qualitative work, and research on procedural justice led us to develop a measure of relatonship quality that ultimately defines good dual role relatinoshisp as firm, fair and caring.

succe

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	Not Traditional
• *Bark at him…chew him up one side and down the other...you basically lie to them, "You're looking at prison"*	• *…talk with him to identify any obstacles to compliance (like transportation problems), remove those obstacles, and agree on a compliance plan.*
• The "big bluff"- threats and reminders	• Problem-solving strategies

Problem-solving strategies help explain protective effect of specialty probation

"Mike," a 29-year old probationer who was convicted of a drug offense and is required to participate in mental health treatment. For the past two weeks, Mike hasn't been taking his prescribed medication to control his false, suspicious beliefs and the voices that he hears. He has also missed three appointments at the mental health center recently. <IF QUESTIONED: INDICATE THAT THIS IS NOT MIKE'S 1ST OFFENCE. IF PRESSURED FURTHER SAY IT IS HIS 2ND OF 3RD>

What would a typical officer in your agency do to encourage or enforce Mike's compliance with treatment?

Roadmap

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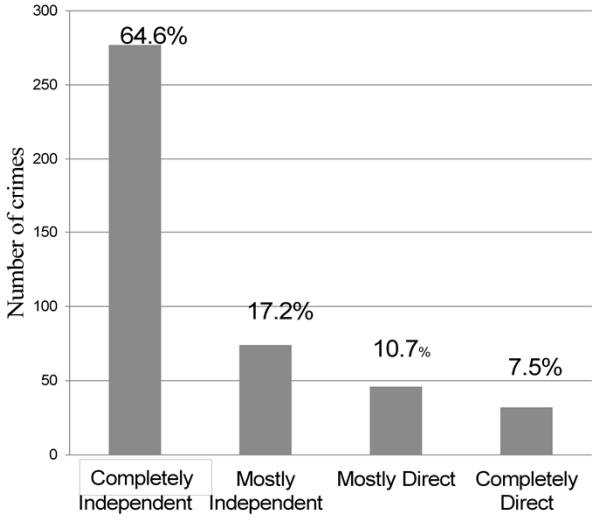
- Promising directions
  - Target robust risk factors
  - Use core correctional practices
  - **Continue psychiatric services**

Should be at 40 min

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)

Our original theoretical model included two groups of people – one for whom the relation between mental illness and crime was direct (10%) and the vast majority for whom this was not true (crime indirectly related to, or independent of, criminal behavior; 90%).

The great part about research is that you learn when you're (mostly) wrong.

In two quite different studies, we've found that symptom-preceded crimes mostly do not "cluster" by person. Peterson et al. Model with clustering fit no better than model wihtout clustering and ICC= 0.

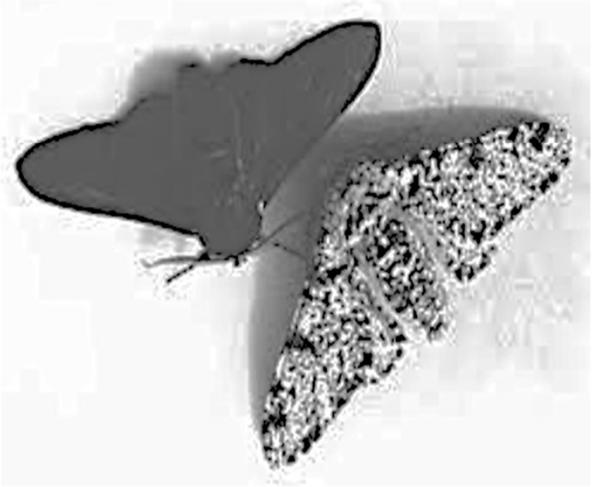
MacRisk – better/more precise data. Cluster model fit better than no cluster model, but clustering was only fair. AND mostly applied to the exclusively "not-preceded" group.

Occur almost randomly?

NOT…

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

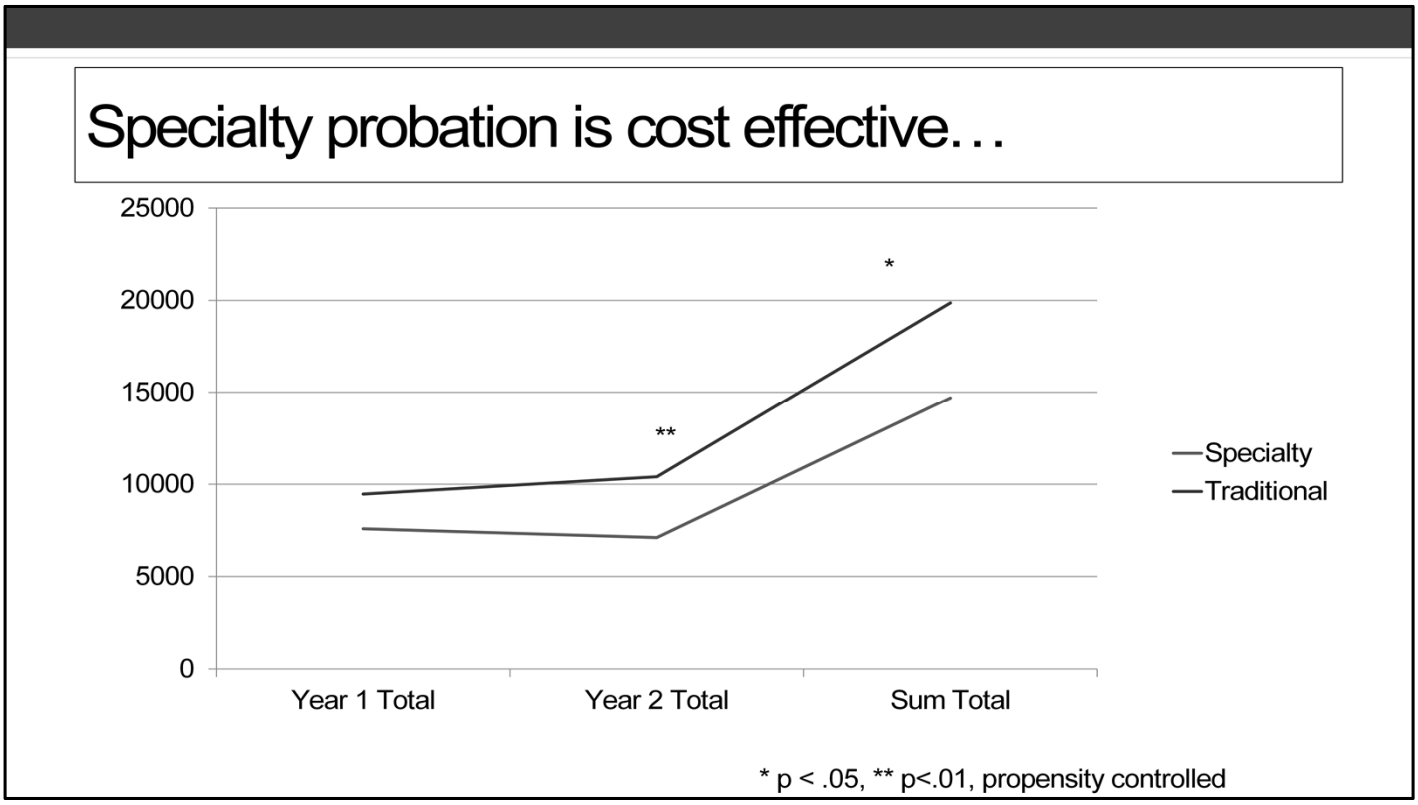
BUT INSTEAD…



Skeem, Kennealy, Monahan & Appelbaum (2015)

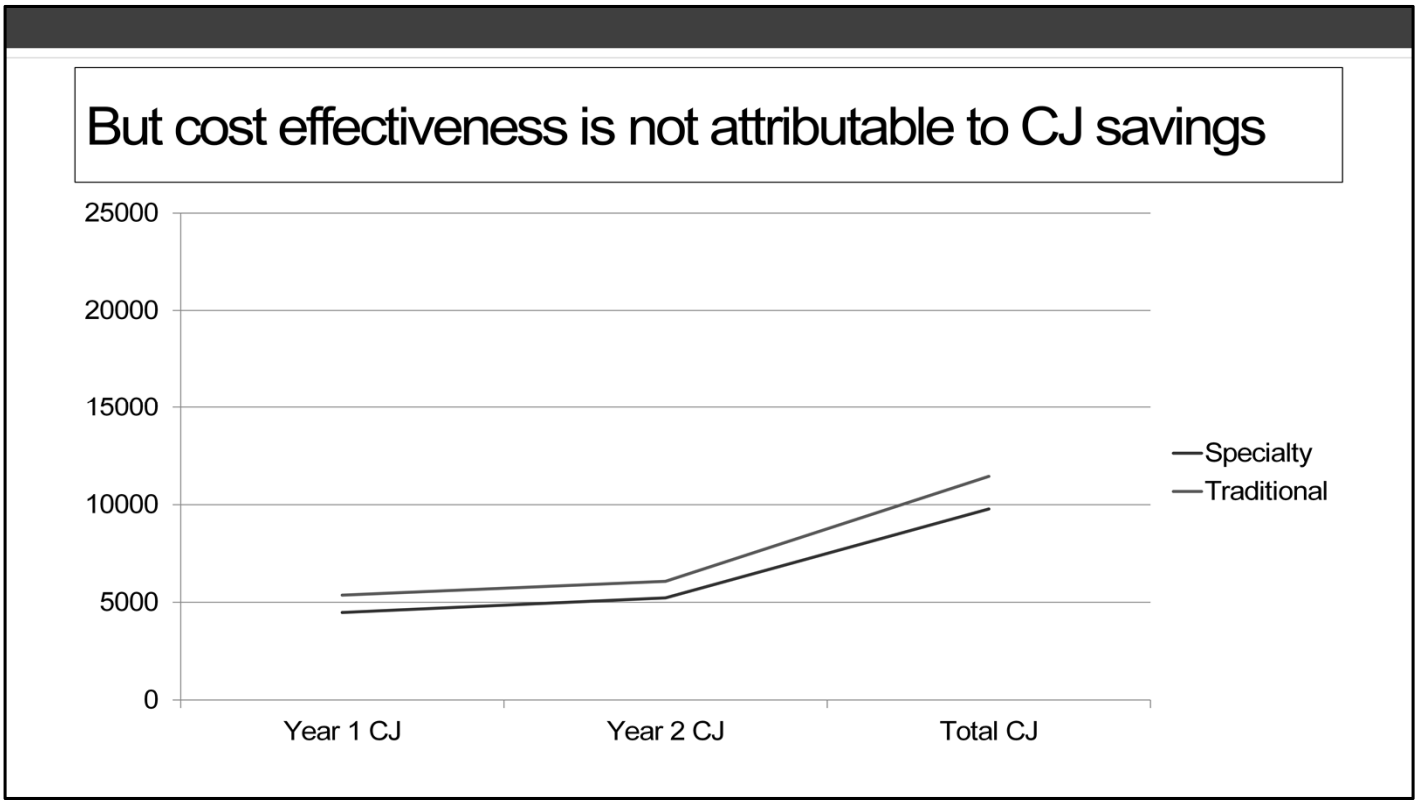
Offenders – completely random, according to Peterson et al.
Patients – some clustering, according to Skeem et al.

UPSHOT – cannot accurately identify people who will have a crime that is directly caused by symptoms. Needle in a haystack problem. Best approach is to provide psychiatric treatment preventively to the whole group . Besides…doing so addresses a public health problem.

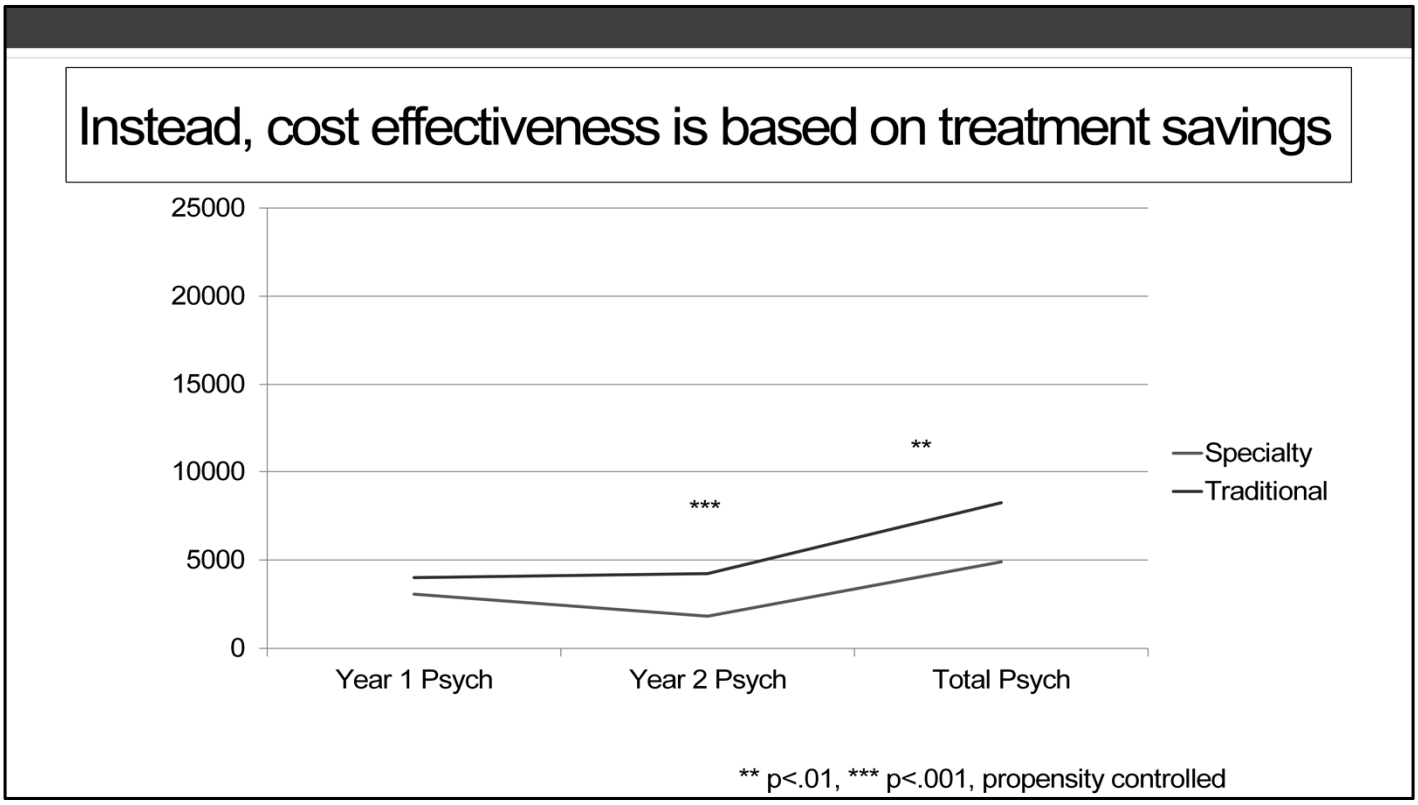


SECOND REASON TO INCLUDE PSYCHIATRIC TREATMENT (beyond crime prevention): may underpin cost effectiveness of programs.

Time period: baseline to two years
System cost sources: Criminal justice & Psychiatric treatment
Strategy: Assign cost = (CPI adjusted cost per unit * units)
- Aggregate cost (Year 1, Year 2, Total)
  - subcategory (e.g., arrest costs, case management costs)
  - general category (CJ costs, treatment costs)
  - total (CJ + treatment costs)
- Test difference in means, propensity weighted



Greater supervision cost (45 per caseload vs. 110+) offset by reduced likelihood of arrest/jail



greater outpatient cost more than offset by reduced inpatient/ER cost

Specialty probation works for different reasons, for different outcomes

Policy Goal #1: Reduce re-arrest

- Achieved more often through better correctional practices than psychiatric treatment

Policy Goal #2: Be cost-effective (avoid hospitalization)

- Achieved more through psychiatric treatment than correctional practices(avoid hospitalization)

Roadmap

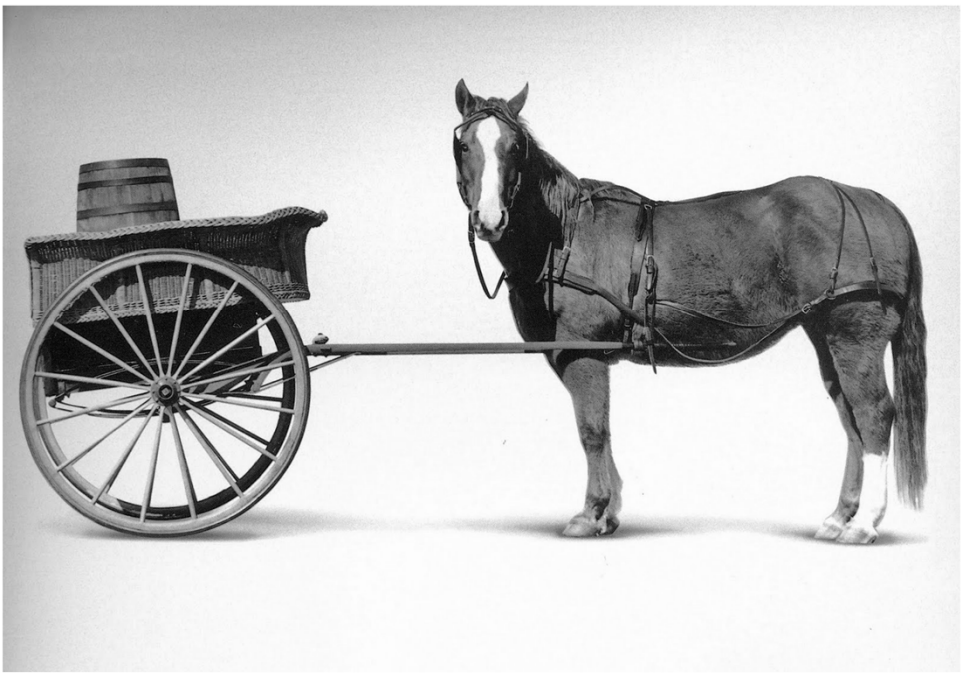
- Problems with the implicit model
  - Symptoms rarely cause crime
  - Psychiatric services rarely reduce crime
- Refining the model
- Promising directions
  - Target robust risk factors
  - Use core correctional practices
  - Continue psychiatric services

My last point – continue psychiatric services – is there for a reason.
Having been involved in policy discussions about this population for over a decade, I have witnessed a strange “swing effect”

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)



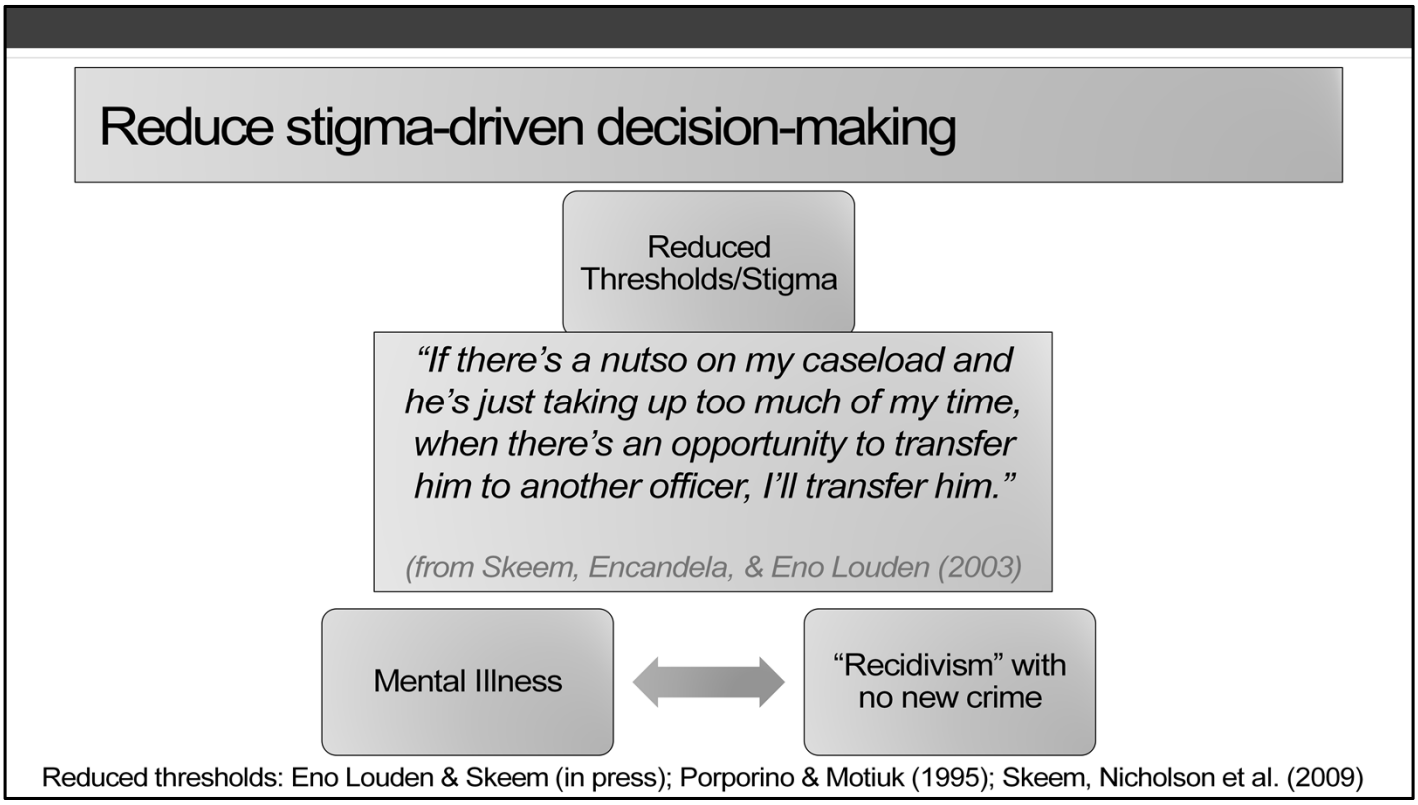
This recent publication by CSG represents a new policy emphasis—one that focuses on providing correctional treatment services consistent with the Risk-Need-Responsivity (RNR) model to reduce recidivism.

Somewhat awkwardly, I've now written a paper that calls for moderation. QUOTE Swapping prioritization of psychiatric services for emphasis on correctional services may not represent much of an advance.

These services are being applied to a new population with unique characteristics (i.e., mental illness *combined* with justice-system involvement). In this paper, we pose some major questions the field needs to address, to improve outcomes for this population. I'm addressing some of them, with Ed Latessa from Ucinn and Citywide psych. Services in SF.

But this underscores the problem of having to do 'something' while you refine understanding of what works. CLICK. How do we avoid this cart before the horse problem? Advice welcome.
MONEY and SUPPORT welcome – Ed Latessa's CBT model; working with San Francisco to do RCT to see if adding this criminogenic focus reduces recidivism, compared to psychiatric TAU

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

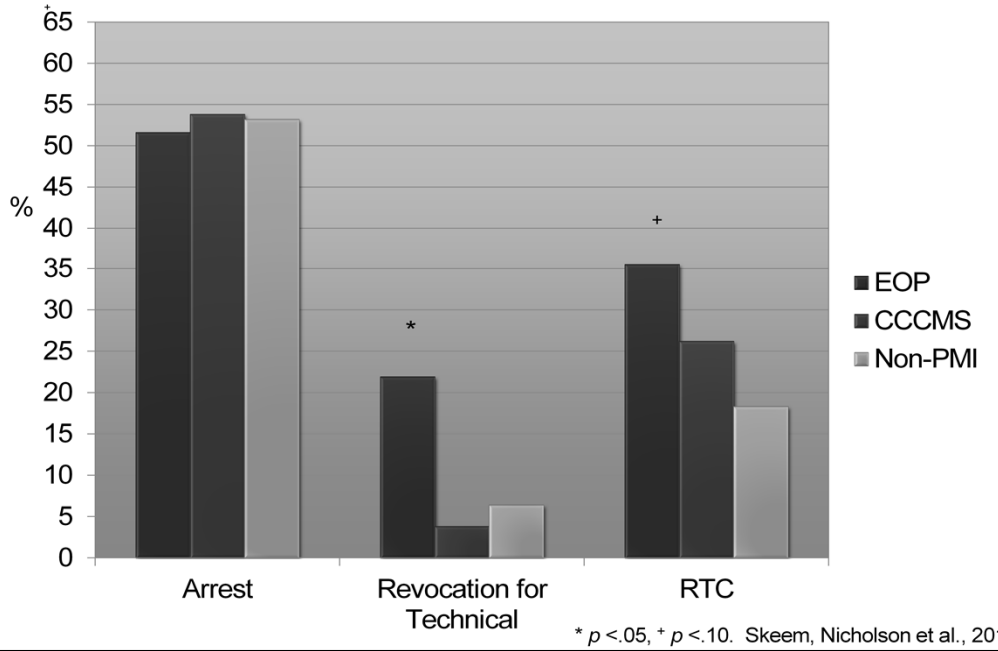


Many OMIs don't get any kind of step-down from prison…because they max out and are not granted parole. Many move from full supervision in prison to no supervision in the community (see Matejkowski, Caplan & Cullen, in press). Parole boards need to guard against stigma-based decisions about this group – it is difficult, given a wealth of research, to believe that these offenders are categorically higher risk than those without mental illness.

Not only do decision-makers set the bar uncommonly high for OMIs to get out of prison…they also set it very low for OMIs to return to prison. Here is the model we've arrived at for community corrections – where a lot of OMIs return to jail or prison without having committed a new crime.

Clearly, this has to be addressed. If we reduce OMIs' risk of recidivism with CBT/other strategies, they will still fail if our decisions about them are biased.

There's more than one way to return to custody…



* $p < .05$, + $p < .10$. Skeem, Nicholson et al., 2013