Probationers with mental disorder: What (really) works?
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People with serious mental illness are overrepresented in criminal justice system

Source: Teplin, 1990; Teplin, Abram, & McClelland, 1996
The 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” for offenders with mental disorder

- Specialty program-
  Treatment mandate

- Psychiatric treatment-
  Symptom reduction

- Reduced recidivism
Probation:
Specialty Mental Health Caseloads

Sources: Bureau of Justice Statistics (2007); Skeem, Emke-Francis, et al. (2006)
**Probationers**

- N=359 (~180 per site)
- Matched
  - Age (~36), Male (~50%), AA ethnicity (~50%), person charge (~40%), total time on probation
- Eligibility
  - 18-65 years old, English-speaking, pass consent test
  - On active supervision, completed >1 initial meeting with officer, >1 year remaining on term
  - Serious mental disorder
    - Specialty: placement on MIMR caseload
    - Traditional: Screened in or officer referral

Modal primary chart diagnosis: Traditional: schiz/aff (40%), Specialty: bipolar (48%)

**Baseline Symptoms/Personality (PAI)**
Approximating an Experiment: Propensity Scores

- Condense covariates into one propensity score that predicts probability of high intensity treatment
- Determine that treatment assignment process is ignorable, given propensity score
- Condition treatment estimate on propensity scores

Propensity Scores

- Probability of traditional supervision, given 40+ criminal and clinical characteristics
- Nagelkerke R² = .38; Classification accuracy = 74%

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The implicit model of “what works” for offenders with mental disorder

Specialty program-Treatment mandate

Psychiatric treatment-Symptom reduction

Reduced recidivism

Provisional: probation-recorded arrest or revocation, over 12 months

* $p = .05$, ns, controlling for propensity scores

** $p < .001$, <.01; controlling for propensity scores
The implicit model of “what works” for offenders with mental disorder

- Specialty program
  - Treatment mandate
- Psychiatric treatment
  - Symptom reduction
- Reduced recidivism

Number mental health sessions, over 12 mo

![Bar chart showing number of mental health sessions over 12 mo for Traditional and Specialty programs.]

- Traditional:
  - None
  - 14-25 (bimonthly)
  - 1-12 (monthly)
  - 26-89 (biweekly)

- Specialty:
  - None
  - 14-25 (bimonthly)
  - 1-12 (monthly)
  - 26-89 (biweekly)

Raw # sessions: Traditional M=18 (38) Specialty M=25 (24)
***K-S Z= 2.5, p<.001; remains significant after controlling in regression for propensity scores and jail time
Propensity-controlled estimated mean services over time

Week (12-25)

Bimonthly (6-11)

Monthly (1-5)

None

Baseline Six months Twelve Months

Range: 0-5; M= 1.5 (1.5)

Specialty

Traditional

ANOVA, Site * Time F (248, 2) = 8.61, p < .001

MH Session Trajectories

Week (12-25)

Bimonthly (6-11)

Monthly (1-5)

None

Baseline Six months Twelve Months

Range: 0-5; M= 1.5 (1.5)

Specialty

Traditional

Slopes invariant across site: $\chi^2 (8) = 16.47, p<.05$; CFI = .90, RMSEA = .06 Unconditional model
The implicit model of “what works” for offenders with mental disorder

Specialty program - Treatment mandate

Psychiatric treatment ✓
Symptom change ?

Reduced recidivism

CSI Symptom Trajectories

Range: 14-70;
M= 32 (12)

Slopes invariant across site: $\chi^2 (8) = 7.45, ns; CFI = 1.0, RMSEA=.00$
Unconditional model
CSI Symptom Trajectory Propensity Controlled

Range: 14-70; M=32 (12)

Both Sites

Baseline Six months Twelve Months

Site unrelated to i or s: X² (5) = 6.12, ns; CFI =1.0, RMSEA=.03
Conditional model, with site and propensity as covariates

PAI Latent Difference Scores

• Internalizing & Externalizing
• Baseline & 12 months
  – Zero change model fits better than free overall
  – Specialty= 0; Traditional= 1-2 point change
GAF Functioning Trajectories

Range: 23-85;
M= 50 (14)

In conditional model, site → s,*** not i

Slopes not invariant across site: \( X^2 (7) = 77.06, p<.05; \) CFI =.94, RMSEA=.06
Unconditional model

The implicit model of “what works” for offenders with mental disorder

Specialty program-
Treatment mandate

Psychiatric treatment ✔
Symptom change ✗

Reduced recidivism
Stripped down: Is it about symptoms?

Symptom change

Reduced recidivism

Symptom & Functioning Change vs. Recidivism

Not revoked
$M = -1.29, sd = .60$

Revoked
$M = -1.23, sd = .80$
Provisional Conclusions

• Specialty probation
  – Significantly increases mental health sessions
  – Significantly reduces risk of revocation and perhaps arrest
  – ...but not because of symptom reduction or improvement in functioning

• Elsewhere, we have shown that specialty probation involves better core correctional practices...and those protect against recidivism

Toward a more evidence-based model of “what works”
Towards “smarter sentencing” for offenders with mental illness

- Small subgroup have offenses that can be directly attributed to mental illness per se
  - Juninger et al., 2006; Peterson, Skeem et al., 2009
- Strongest risk factors for crime and recidivism are shared by those with- and without- disorder
  - Bonta, Law & Hanson, 1998; Skeem, Nicholson et al., in prep.
- Increased mental health services do not always translate into reduced recidivism
  - Clark et al., 1999; Steadman & Naples, 2005
- So...discontinue “carving out” this group from evidence-based corrections

Skeem, J., Manchak, S., & Peterson, J. (in press), Special Issue: Chapman Journal of Criminal Justice

Frank & Glied (2006)

- “it would be a mistake to attribute the increase in homelessness and incarceration among people with SPMI directly to the experience of deinstitutionalization.
- Increases in homelessness and incarceration are, for the most part, associated with increases in the proportion of the entire population (most of whom do not have SPMI) who experience these undesirable circumstances” (p. 128).
Thanks
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Council of State Governments
Criminal Justice and Mental Health Lab
Probationers, officers, and supervisor participants

Program Questions

• Does specialty supervision produce better outcomes than traditional supervision?
  – Survival (arrests/revocation)
  – Symptom change (latent difference scores)

• If so, to what extent is this explained by increased psychiatric services or core correctional practices?
Non-Program Questions

- Do increased services decrease symptoms (PARALLEL PROCESS MODEL) and recidivism risk (POUR SERVICE SCORES OUT)?
- Do better correctional practices decrease symptoms and recidivism risk?

- Are the above effects (and program effects) moderated by psychosis or cd/antisocial traits?