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.”

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

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

<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.

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 Calsynet 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 mental health treatment those offenders received

- Example: Multisite longitudinal study comparing probationers with mental disorder (PMDs) at a specialty mental health 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 agency
  - 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

Mental illness ↔ General risk factors

(For some)

Crime

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

The best predictors of re-offense:

the “Central 8”

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

Source: Lowenkamp, Latessa, & Holsinger, 2006
Risk-Needs Responsivity: matching offender needs to supervision approach

Good supervision + Assertive Community Treatment

Low Criminogenic risk

Low Clinical needs

Good supervision + good treatment

Risk-Need Responsivity + Assertive Community Treatment

Risk-Need Responsivity + good treatment

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

![Bar chart showing Parolees who returned to custody without a new offense]

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.

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
Thank you!