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High-Fidelity Specialty Mental Health Probation Improves Officer Practices, Treatment Access, and Rule Compliance

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Many probation agencies in the United States assign offenders with mental illness to relatively small specialty caseloads supervised by officers with relevant training, rather than to large general caseloads. Specialty caseloads are designed to improve the process and outcomes of probation, largely by linking these probationers with psychiatric treatment and avoiding unnecessary violations. In this multimethod, longitudinal matched trial, we tested whether a prototypical specialty agency ($n = 183$) differed from a traditional agency ($n = 176$) in officers' practices, probationers' treatment access, and probationers' rule violations. The specialty agency yielded significantly (a) better officer practices (e.g., problem solving rather than sanction threats; higher quality relationships with probationers; more boundary spanning), (b) greater rates of treatment involvement, and (c) lower rates of violation reports than the traditional agency. Additionally, officers' use of sanctions and threats increased probationers' risk of incurring a probation violation, whereas high-quality officer–probationer relationships protected against this outcome. When implemented with fidelity, specialty mental health caseloads improved the supervision process for this high-need group.

Keywords: offenders with mental illness, specialty mental health probation, evidence-based corrections, community supervision

Specialty mental health probation is a community-based criminal justice program for offenders with mental illness that has been implemented in over 100 jurisdictions nationwide (Skeem, Emke-Francis, & Eno Louden, 2006). This program was developed to reduce the disproportionately high rate of community supervision

failures among offenders with mental illness (Dauphinot, 1997; Gagliardi, Lovell, Peterson, & Jemelka, 2004; Messina, Burdon, Hagopian, & Prendergast, 2004). Specialty mental health probation has been heralded as a promising practice (Skeem & Eno Louden, 2006), partly because it has been shown to reduce recidivism in at least one controlled study (Burke & Keaton, 2004).

Specialty Mental Health Probation: What Do We Know?

To date, two studies have provided information about how specialty mental health probation differs from traditional probation. The first study, a series of focus groups with specialty and traditional probation officers, demonstrated that specialty officers place greater emphasis on rehabilitation, establish better relationships with supervisees, and have a more versatile “toolkit” of supervision strategies than traditional officers (Skeem, Encandela, & Eno Louden, 2003). The second study, a national survey of specialty ($n = 66$) and traditional ($n = 25$) agencies, helped to identify the features that maximally distinguish the two supervision models (Skeem et al., 2006). We turn to these features now.

Organizational Features and Officer Practices

According to the national survey, five key features distinguish specialty mental health supervision from traditional supervision (Skeem et al., 2006). First, specialty officers supervise relatively small caseloads ($M < 50$) comprised solely of offenders with

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mental illness, whereas traditional officers' caseloads tend to be large ($M > 100$) and comprised of general offenders (see also Kinsella & Fuller, 2003). Second, specialty officers are trained in issues relevant to mental illness (e.g., what diagnoses mean, treatment options available in their communities). Third, specialty officers actively coordinate and integrate internal (i.e., probation) and external (i.e., treatment) resources, often working quite closely with the treatment provider and sometimes even serving as part of a treatment team. In contrast, traditional officers typically broker services; they refer probationers to community providers and resources but are not typically involved in treatment decisions. Fourth, traditional officers tend to rely on threats and sanctions to obtain compliance, whereas specialty officers emphasize problem solving in their supervision approach in an effort to "make the absolute last resort, jail, an infrequent event" (Skeem et al., 2006, p. 175; see also Eno Louden, Skeem, Camp, Vidal, & Peterson, 2012; Eno Louden, Skeem, Camp, & Christensen, 2008). Finally, specialty officers strive to establish firm, fair, and caring relationships with their supervisees (i.e., authoritative, not authoritarian; see Skeem et al., 2003).

Underlying Philosophy

When programs are evaluated, researchers often employ a "logic model," which is a "schematic of the basic activities undertaken" in a program and how they may impact specific outcomes (see Case, Steadman, Dupius, & Morris, 2009, p. 665). The key components that set prototypical specialty agencies apart from traditional agencies—and how these components relate to offenders' outcomes—comprise the underlying philosophy, or logic model, of specialty mental health probation.

First, prototypical specialty agencies balance "care" (social work) with "control" (police work) in the process of supervision, whereas traditional agencies emphasize control more exclusively. Specialty officers may emphasize problem solving over sanctions, because they are aware that offenders with mental illness have functional impairments that contribute to unnecessary probation violations and (ultimately) to revocation (Skeem et al., 2003; see also Skeem & Eno Louden, 2006; Skeem & Petrila, 2004). Similarly, specialty officers may strive to establish firm, fair, and caring relationships, because they are aware that a purely control-oriented interaction style promotes such poor criminal justice outcomes as violations and arrests (see Skeem, Eno Louden, Polaschek, & Camp, 2007; Kennealy, Skeem, Manchak, & Eno Louden, 2012). These relatively progressive supervision approaches may help promote better criminal justice outcomes, including fewer probation violations.

Second, unlike traditional agencies, specialty mental health agencies place a premium on linkage with psychiatric treatment, largely because symptom control is viewed as the route to recidivism reduction (see Skeem, Manchak, & Peterson, 2011). Specialty officers spend considerable time discussing mental health issues with their probationers (Eno Louden et al., 2012). They also work very closely with treatment providers; sometimes functioning as part of the treatment team (Skeem et al., 2003), and occasionally "fighting" with beleaguered mental health systems to access appropriate care for these probationers" (Skeem et al., 2003, p. 15). In a sense, specialty officers serve as "boundary spanners" (see Dvoskin & Steadman, 1994; Steadman, 1992). They step

outside their traditional role and work with outside agencies to coordinate care and services on their supervisees' behalf. To do so, they must have a specialized set of skills that allows them to understand, navigate, communicate, and coordinate with outside agencies to address probationers' needs. These boundary spanning skills may help promote better clinical outcomes, including greater access to psychiatric care and other community services.

The philosophical and structural features of specialty probation work together. Organizational features, such as reduced caseload size and sustained officer training, provide a foundation for specialty officers to supervise offenders in a manner that balances control with care and emphasizes linkage with psychiatric treatment.

Unanswered Questions About Specialty Mental Health Probation

Understanding of specialty supervision has grown substantially over recent years (see Eno Louden et al., 2008; Eno Louden et al., 2012; Epperson et al., 2011; Lurigio, Epperson, Canada, & Babchuk, 2012; Skeem et al., 2003; Skeem et al., 2006; Skeem et al., 2007; Wolff et al., 2012). Nevertheless, we could not locate any methodologically rigorous studies (e.g., randomized controlled trials, matched comparisons) of practices in prototypical specialty—and traditional—agencies. Such comparisons are needed to address two important questions about specialty probation.

First, can specialty mental health probation be successfully implemented? Research on correctional intervention has robustly indicated that (a) there is a chasm between theory and practice (Magaletta & Verdeyen, 2005; Nathan & Gorman, 2002), and (b) "fidelity matters"—as practices stray from the theoretical model, their effect on recidivism is diluted (see Andrews & Dowden, 2005). These findings seem to generalize to specialty mental health probation. Specifically, in the national survey described earlier, (a) only one in five "specialty" mental health agencies manifested all of the specialty model's distinguishing features, and (b) departures from some of the model's features (e.g., small caseload size) were associated with traditional practices (e.g., use of threats/sanctions to manage noncompliance; Skeem et al., 2006). In the present study, we sought to examine whether a prototypical specialty mental health agency could implement with fidelity the key components of the model. To do so, we rigorously tested the extent to which practices in this specialty mental health agency differ meaningfully from those in a traditional agency across theoretically relevant dimensions of distinction (e.g., officer–probationer relationship quality, boundary spanning, compliance strategies).

Second, does specialty probation "work" because of its core features? It is important to determine whether the officer practices that are central to the specialty mental health probation model (e.g., boundary spanning, problem solving, high quality officer–probationer relationships) actually help achieve the philosophical goals of specialty probation—chiefly to increase mental health service access and to improve offenders' criminal justice outcomes vis-à-vis reducing violations. Although some essential ingredients like officer–probationer relationship quality have been shown to affect recidivism (Kennealy et al., 2012), evidence for the effectiveness of other ingredients is indirect and/or based on stakeholders' perceptions.

As with any intervention, it is necessary to get inside the “black box” and test whether the ingredients that are perceived to be essential to the model do, in fact, explain its effect on probationers’ progress and outcomes. Demonstrating that specialty mental health probation “works” provides very little guidance to practitioners about *why* it works. “By understanding the processes that account for . . . change, one ought to better be able to optimize . . . change” (Kazdin, 2007, p. 4). In our study, we were specifically interested in exploring whether officer boundary spanning would help achieve the philosophical principle of linking probationers with psychiatric and related services, and whether officers’ use of problem solving and high-quality relationships with probationers would help protect against probation violations.

Study Aims

The present study had three specific aims. First, to test whether key features of specialty mental health probation were implemented in a prototypical agency, we examined the extent to which specialty officers manifested better boundary-spanning skills, more problem solving, fewer sanction threats, and higher quality relationships than traditional officers. Second, to test the logic model and underlying philosophy of specialty probation, we examined the intermediate goals of specialty probation, namely, to determine whether specialty probationers would achieve greater access to mental health services and decreased violations compared with traditional probationers. Third, to explore the effectiveness of “essential ingredients” of specialty probation, we tested the extent to which boundary spanning would predict greater service access, and compliance strategies and relationship quality would protect against violation reports to the court.

Method

The present study employed a longitudinal multimethod and multimeasure matched design in which 176 probationers on traditional probation supervision were compared with 183 probationers on prototypical specialty probation supervision. Probationers were interviewed at three time points over the course of 1 year, and their supervising officers completed a brief survey on the same time schedule. Additionally, researchers coded probation and court records for information about violations.

Site Selection

Sites were identified through the national survey mentioned earlier (see Skeem et al., 2006). We first selected a prototypical specialty agency and then selected a traditional agency (i.e., probation as usual) based on its match to the specialty agency on (a) jurisdiction size, (b) urban location, (c) demographic characteristics (e.g., gender, age, race) of the probation population served, and (d) county mental health expenditures. Of note, at the mid-point of data collection, average caseload sizes for specialty and traditional officers were approximately 50 and 100 probationers, respectively.

Participants

To be eligible, participants had to be (a) age 18–65 years, (b) English speaking, (c) capable of providing informed consent for research (five failed the study consent test and were not enrolled), (d) identified as having an Axis I mental illness (see identification process in the next section), and (e) no comorbid intellectual disability. Probationers had to be on active probation supervision with at least one year remaining on their term and have met with their supervising officer at least once since starting probation.

Identification of mental illness. Because the two sites differed in whether they systematically identified probationers with mental illness, details of the identification processes used for this study are parsed in the next two sections. The flow from recruitment to enrollment at each site is depicted in Figures 1 and 2.

Specialty site recruitment. Individuals at the specialty site were eligible because they were supervised on specialty caseload supervision. Individuals with a mental illness were referred to specialty caseload supervision primarily because they were on traditional probation to begin with, and then the supervising probation officer determined presence of mental illness and referred them to mental illness/mental retardation (MIMR) probation supervision (about 96%); the other 4% were referred directly from the court. Researchers recruited individuals newly assigned to MIMR caseloads. As seen in Figure 1, 183 individuals were eventually enrolled in the study at the specialty site. There were no significant differences in age between those enrolled ($M = 36$ years, $SD = 10$) and those eligible but not enrolled (refusal or nonresponse; $M = 35$ years, $SD = 10$), $t(245) = .90$, ns , 95% confidence interval (CI) $[-1.6, 4.2]$, $d = .10$, gender (54% and 65% male, respectively), $\chi^2(1) = 1.6$, Cramer’s $V = .08$, ns , or race (62% and 59% nonwhite, respectively), $\chi^2(1) = 0.3$, Cramer’s $V = .04$, ns .

Traditional site recruitment. The traditional site did not have a systematic process for identifying probationers with mental illness. We used two approaches to identify these probationers: (a) an officer identification approach similar to that used at the specialty site, wherein officers were asked to “refer” clients who had a known psychiatric diagnosis or were currently taking psychotropic medications, had been hospitalized in an inpatient psychiatric facility during the course of their supervision, and/or showed signs of serious symptoms (e.g., delusional beliefs, pressured speech, depression); and (b) implementation of a self-report mental health screen during part of the regular intake process. The screen inte-

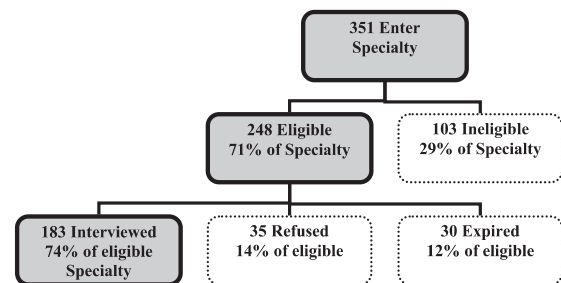


Figure 1. Specialty site recruitment.

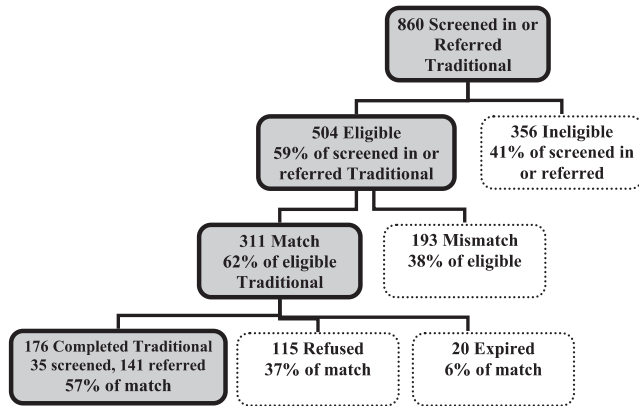


Figure 2. Traditional site recruitment.

grated the K-6 (Kessler et al., 2002) and the Brief Jail Mental Health Screen (Steadman, Scott, Osher, Agnese, & Robbins, 2005), both of which have been validated for use with probationers (Eno Louden, Skeem, & Blevins, 2013). The officer referral process identified 80% ($n = 141$) of traditional probationers with mental

illness; these probationers were pooled with the remaining 20% identified using the screening process because the two groups did not differ in their clinical characteristics (e.g., functioning and symptoms).

Of the 860 total potential participants identified across the 1.6-year enrollment period at the traditional site, 176 probationers enrolled. As seen in Figure 2, most potential participants were ineligible or did not match participants at the specialty site. There were no significant differences between enrolled probationers and those who refused or failed to respond to invitations in age ($M_{\text{Enrolled}} = 38$ years, $SD = 11$; $M_{\text{Lost/Refused}} = 37.5$ years, $SD = 10$), $t(303) = .09$, 95% CI $[-2.3, 2.5]$, ns , $d = .01$, gender (60% and 69%, respectively), $\chi^2(1) = 2.79$, Cramer's $V = .10$, ns , and race (61% and 57% non-White, respectively), $\chi^2(1) = 0.7$, Cramer's $V = .05$, ns .

Probationer demographics. Participants at the two sites were matched on gender, age, ethnicity, length of time on probation (under/over 1 year), and index offense (person/violent vs. other). As shown in Table 1, these efforts were generally successful. On average, our full sample was approximately 37 years old ($SD = 11$), generally either White (about 38%) or African American (about 50%), and approximately equally representative of both genders (57% male). Differences between sites were con-

Table 1
Comparison of Specialty and Traditional Probationers with Mental Disorder

Sample characteristics	Specialty ($n = 183$)	Traditional ($n = 176$)	t or χ^2 (df)	95% CI	Cohen's d or Cramer's V
Age (years)	36 (10)	38 (11)	-1.3 (356)	$[-3.7, 0.7]$	.14
Percent male	54	60	1.4 (1)		.06
Percent White (vs. other)	38	39	0.0 (1)		.01
Percent Hispanic	12	12	1.0 (2)		.05
Criminal indicators					
Age at first arrest, M (SD)	22 (9)	20 (9)	1.6 (350)	$[-0.3, 3.3]$	.17
Prior arrests, M (SD)*	3 (0.7)	3 (0.6)	-2.4 (310)	$[-0.3, -0.0]$	.27
Violence prior 6 months					
Any	38	31	3.4 (2)		.10
Serious	12	18	3.7 (1)		.09
Most serious index offense (%)			3.6 (3)		.10
Person	34	38			
Property	30	23			
Drug	26	32			
Minor	11	8			
>One or more years on probation (%)	21	14	2.9 (2)		.09
Mental health indicators					
Past psychiatric hospitalizations (%)	52	68	2.4 (1)		.12
Baseline GAF score, M (SD)*	45 (12)	55 (15)	-6.6 (347)	$[-12.5, -6.8]$	.71
CSI Total Score, M (SD)*	45 (12)	49 (13)	-3.2 (356)	$[-6.9, -1.7]$	.34
PAI subscale scores, M (SD)					
Somatization**	30 (14)	26 (14)	3.1 (352)	$[1.7, 7.5]$	.33
Anxiety-Physiological***	38 (14)	30 (13)	5.6 (352)	$[5.2, 10.9]$	.60
Anxiety-Related Disorder***	37 (12)	31 (11)	4.7 (352)	$[3.4, 8.2]$	.50
Depression***	35 (14)	28 (12)	5.3 (352)	$[4.6, 10.0]$	.57
Mania	33 (13)	32 (11)	0.6 (352)	$[-1.7, 3.3]$	.06
Paranoia	34 (11)	33 (12)	0.9 (352)	$[-1.2, 3.4]$	.10
Schizophrenia**	31 (13)	26 (12)	3.4 (352)	$[2.0, 7.4]$	.36
Borderline**	29 (10)	25 (9)	3.4 (351)	$[1.4, 5.4]$	.36
Antisocial	27 (12)	27 (11)	0.0 (352)	$[-2.4, 2.4]$	.00
Aggression	25 (12)	24 (10)	0.7 (352)	$[-1.5, 3.3]$	.07
Alcohol	9 (8)	11 (8)	-1.6 (350)	$[-3.1, 0.3]$	.17
Drug	14 (8)	15 (9)	-1.3 (350)	$[-2.9, 0.6]$	.14

Note. CI = confidence interval; GAF = Global Assessment of Functioning (American Psychiatric Association, 1994); PAI = Personality Assessment Inventory (Morey, 1991); CSI = Colorado Symptom Index (Shern et al., 1994).

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 2
Probation Officer Demographic Characteristics

Demographic characteristic	Specialty (<i>n</i> = 15)	Traditional (<i>n</i> = 87)	<i>t</i> or χ^2 (<i>df</i>)	95% CI	Cohen's <i>d</i> or Cramer's <i>V</i>
Age, <i>M</i> (<i>SD</i>) (years)	42 (10)	46 (10)	-1.2 (72)	[-9.4, 2.4]	.28
Years as a PO, <i>M</i> (<i>SD</i>)**	9 (6)	15 (8)	-2.8 (92)	[-10.4, -1.8]	.58
Percent male*	20	48	4.0 (1)		.20
Percent White (vs. other)***	53	10	17.0 (1)		.41
Percent Hispanic	7	14	0.6 (1)		.08
Education/training					
Percent higher than bachelor's degree*	33	11	4.9 (1)		.23
Percent criminal justice degree	40	43	0.1 (1)		.03
Percent social work or psychology degree*	40	17	4.0 (1)		.21

Note. CI = confidence interval; PO = probation officer.

* $p < .05$. ** $p < .01$. *** $p < .001$.

trolled for using propensity scores (see Rubin, 1997) (see Preliminary Analytic Procedures section below).

Probation officer demographics. In total, 102 officers who supervised the 359 probationers at baseline (specialty $n = 15$; traditional $n = 87$) were also enrolled. As shown in Table 2, officers at the specialty site were significantly more likely to be female, White, and have more education, but fewer years on the job as probation officers, than officers at the traditional site.

Measures

In this study, there were typically two or more measures for each construct of interest. For each measure, we provide relevant psychometric properties in the section below.

Officer practices. We assessed officer practices across three domains: (1) officer boundary spanning, (2) officer compliance strategies, and (3) the officer-probationer relationship quality.

Boundary spanning. An 11-item probationer-rated measure of Boundary Spanning was developed for this study to assess a hypothesized three-factor hierarchical model of the construct: General Features (three items; e.g., "My PO [probation officer] is good at explaining my needs to people in other agencies"), Knowledge of Other Systems (five items; e.g., "How knowledgeable is your PO about mental health symptoms and local treatment programs?"), and Securing Needed Help (three items; probationers' reports of whether their officers helped them get needed services across several domains). Confirmatory factor analysis indicated adequate fit for this three-factor model, $\chi^2(41, 359) = 125.13$; comparative fit index (CFI) = .94; root mean square error of approximation (RMSEA) = .08; standardized root mean square residual (SRMR) = .04. Scores on each factor were summed and converted to *z* scores, and the sum of *z* scores was used in all analyses.

Compliance strategies. Based on measures used in past research (Skeem et al., 2007), a probationer- and officer-rated measure of compliance strategies was developed for this study to assess two hypothesized scales: Positive Compliance Strategies (e.g., problem solving) and Negative Compliance Strategies (e.g., threats/sanctions). Given the possibility of impression management among officers, analyses reported below focus on probationer-rated compliance strategies. Probationer-rated Positive Compliance Strategies (seven items; e.g., "In the past six months, how often has your PO talked with you to help you find

a solution to a problem that you both agreed on?") and Negative Compliance Strategies (five items; e.g., "In the past six months, how often has your PO asked or got the judge to put you in jail for a short time?") indicated adequate fit (Positive Compliance: CFI = .94, RMSEA = .09, SRMR = .04; Negative Compliance: CFI = .96, RMSEA = .10, SRMR = .04).

Probationer officer - probationer relationship quality. To assess overall relationship quality between the probationers and their supervising officers at baseline, probationers and their supervising officers each completed the Dual-Role Relationship Inventory - Revised (DRI-R; Skeem et al., 2007). Developed and validated on two large samples ($n = 90$, $n = 322$) of probationers with mental disorder in prototypical specialty agencies, this measure assesses the extent to which officer-probationer relationships are firm, fair, caring, and trusting (i.e., authoritative, rather than authoritarian). Respondents rated the relationship across 30 items with 7-point scales (1 = *never* and 7 = *always*). The DRI-R has a three-factor structure (Fairness/Caring, Trust, and [low] Toughness) that demonstrated adequate fit in the present sample (CFI \geq .90; RMSEA \leq .10; see Skeem et al., 2007, for additional psychometric properties). Previous studies of the DRI-R have demonstrated its internal consistency, construct validity (e.g., DRI-R scores relate in a theoretically coherent manner to within-session observational codes of process), and predictive utility for arrests and revocation (Skeem et al., 2007; Kennealy et al., 2012). In the current study, internal consistency was generally good (officer-rated $\alpha = .92, .86, .54, .88$; probationer-rated $\alpha = .98, .90, .90, .94$ for Fairness/Caring, Trust, Toughness, and total score, respectively). Because the DRI-R tends to predict outcomes more strongly when rated by probationers than officers (see Skeem et al., 2007), we use probationer-rated DRI-R scores (focusing on total scores) in the analyses below.

Philosophical and intermediate goals of specialty probation: site differences in service receipt and violation reports. To examine whether specialty agencies are better at achieving their philosophical goals than traditional agencies, we assessed probationers' receipt of treatment services and of formal court violation reports.

Service receipt. Receipt of services was assessed based both on probationer self-report and public billing databases. First, at each of the three interviews (baseline, 6 months, 12 months), probationers were asked a series of questions about their receipt of

mental health treatment, substance abuse treatment, or integrated dual-diagnosis treatment. Self-reported indices of service receipt (yes/no) were combined from each interview to form 1-year service receipt variables. Second, county billing databases for public mental health services also provided information on mental health treatment only. We chose to integrate the public billing database and self-reported mental health treatment as one index, because preliminary analyses indicated that only 64% of those who received mental health treatment, as reported in either database, were recorded in both databases. Additionally, mental health treatment could have been provided by private providers and would, thus, not be recorded in public mental health services billing databases. As such, we wanted to provide a more accurate and complete picture of mental health treatment access. Because a secondary source of substance abuse treatment and integrated dual-diagnosis treatment was not available, analyses using these variables reflect self-report only.

Violation reports. Violation reports are official reports of a probation violation that are filed with the court. Formal violation reports were coded by a doctoral-level student at the traditional site and probation administrative staff person at the specialty site. Presence and number of formal violations were recorded after carefully reading of each probationer's electronic and hard copy record, as well as from reading court appearance transcriptions and summaries.

General Procedures

Research assistants (RAs) invited eligible probationers to participate in the study by letter, telephone, and (if necessary) personal visit. RAs enrolled probationers who were interested in the study and were able to provide written informed consent. RAs completed a baseline interview with these probationers (about 3 hr), as well as follow-up interviews 6 and 12 months later (about 2 hr each). At each assessment period, RAs also obtained surveys from the probationers' supervising officer (who also provided written consent to participate). Participants were paid or provided with gift cards for their time.

The study had excellent retention; of probationers enrolled at baseline, approximately 85–90% were retained at each of the two follow-up interviews. High retention rates were maintained by implementing an intensive recruitment and tracking protocol, and by conducting interviews in the community or jails or prisons, as necessary (see Schubert, Mulvey, Lidz, Gardner, & Skeem, 2005). Participation rates for officers were 99% (specialty site) and 84% (traditional site); on the rare occasion that officers did not complete a survey, researchers coded probation files for necessary information.

Preliminary Analytic Procedures

To accurately test our study aims, it was necessary first to control for two potential confounds: officer effects and probationer effects. Before presenting our study results, we report the analytical steps we took to control for these issues, and then detail the main analytical procedures and corresponding results for each study aim.

Controlling for probationer effects: Propensity score matching. As noted earlier, traditional probationers were matched by design to specialty probationers on age, gender, race, index of

fense, and time on probation (under vs. over 1 year). To approximate a randomized controlled trial as closely as possible, propensity scores (Rubin, 1997) were used to statistically control for any remaining observed differences between traditional and specialty probationers at baseline. Three steps were involved. First, covariates of the treatment assignment process were condensed into a single propensity score. Specifically, 42 theoretically relevant criminal, psychiatric, substance abuse, and personality characteristics were entered into a binary logistic regression to predict probationers' likelihood of assignment to traditional (rather than to specialty) supervision. This included all variables assessed at baseline that represented individual characteristics relevant to criminality and mental illness. As shown in Table 3, a weighted combination of six baseline variables significantly predicted traditional supervision (e.g., more serious lifetime offenses, less anxiety). A propensity score was created for each probationer, based on this formula, to distill his or her probability of assignment to traditional probation at baseline, given the set of covariates.

Second, we determined that the treatment process was ignorable, given the propensity score. Specifically, we cross-tabulated actual treatment assignment by propensity score quintiles to determine that there was sufficient overlap between the two conditions at each level (e.g., a significant minority of specialty probationers had upper quintile propensity scores, indicating high probability of traditional assignment). We also determined that the logistic formula produced a classification accuracy of 74% and moderately distinguished the two groups (Nagelkerke $R^2 = .38$). A comparison of specialty and traditional probationers' propensity scores yielded a large and significant difference, $t(327) = -11.9$, Cohen's $d = -1.3$, $p < .001$. Third, we conditioned the treatment estimates below on propensity scores. That is, we controlled participant's propensity scores in relevant outcome analyses.

Controlling for officer effects: Officer nesting. Because a small number ($n = 15$) of officers supervised all probationers at the specialty site, and some officers ($n = 38$) supervised more than one probationer at the traditional site, there was potential "nesting" of effects within officer. That is, observed differences between specialty and traditional sites may be partially a function of dif-

Table 3
Propensity Scores

Variables	<i>B</i>	<i>SE</i>	<i>Wald</i>	<i>df</i>	<i>Exp(b)</i>
Most serious lifetime offense					
Minor ^{***}			25.82	3	
Drug ^{**}	2.83	1.15	6.04	1	17.00
Property	1.23	1.19	1.07	1	3.41
Person	1.75	1.16	2.27	1	5.77
Number of lifetime arrests					
Three plus ^{***}			10.84	2	
Two ^{***}	-1.62	0.51	10.06	1	0.20
One	0.22	0.44	0.26	1	1.25
Time on probation ^{***}	-0.45	0.13	11.67	1	0.64
Baseline GAF score ^{***}	0.06	0.01	26.67	1	1.06
CSI total score [*]	-0.03	0.02	4.44	1	0.97
PAI Anxiety subscale score ^{***}	-0.05	0.01	13.83	1	0.95

Note. Nagelkerke $R^2 = .38$; classification accuracy = 74%. GAF = Global Assessment of Functioning (American Psychiatric Association, 1994); PAI = Personality Assessment Inventory (Morey, 1991); CSI = Colorado Symptom Index (Shern et al., 1994).

^{*} $p < .05$. ^{**} $p < .01$. ^{***} $p < .001$.

ferences between select officers within those sites who are consistent in their practices across multiple cases. To avoid overestimating differences between specialty and traditional probation, we first tested for nesting effects by using a mixed multilevel modeling strategy in Stata, Version 12, where DRI-R total scores, Positive and Negative Compliance Strategies, and Boundary Spanning scores were predicted from site in two separate models—one with and one without a unique officer identifier. For each variable, model fit was significantly improved by adding officer effects. Intraclass correlation coefficients computed for each variable suggested that 35% of the variance in officer–probationer relationship quality; 31% and 8% of the variance in Negative and Positive Compliance Strategy scores, respectively; and 22% of the variance in officer Boundary Spanning was attributable to officers. As such, to address study aims that reference officer practices, we controlled for officer nesting effects using the “, Cluster (Nest ID)” command in Stata, Version 12 (Rabe-Hesketh & Skrondal, 2008).

Results

This study sought to determine whether (a) specialty officers exhibit better boundary-spanning skills, more problem solving, less sanctioning and threats, and better officer–probationer relationship quality than traditional probationers (Aim 1), (b) specialty probationers have greater access to psychiatric care and fewer violations than traditional probationers (Aim 2), and (c) officer boundary spanning predicts greater service access, and officer problem solving and establishment of high-quality dual-role relationships predicts fewer probation violations (Aim 3). Analytical steps and results for each aim are reported below.

Aim 1: Do Specialty Officers Practice Different Compliance Strategies, Exhibit Better Boundary Spanning Skills, and Establish Better Relationships Than Traditional Officers?

The study’s first aim was to test whether specialty officers differ from traditional officers in theoretically relevant practices and processes. Because officer practices and processes may be constrained (or potentiated by) the intensity of supervision, we began by comparing traditional and specialty sites in the frequency and duration of officer–probationer meetings (as reported by probationers). Compared with traditional probationers, specialty probationers met almost twice as often with their officers ($M = 1.9$ visits/month, $SD = 0.9$, vs. 1.1 visits/month, $SD = 0.8$), $t(319) = 8.1$, 95% CI [0.58, 0.95], $p < .001$, and spent more time with their officers in each meeting ($M = 25.8$ min/visit, $SD = 12.4$, vs. $M = 18.4$ min/visit, $SD = 14.3$), $t(335) = 5.5$, 95% CI [3.3, 9.6], $p < .001$. These results held even after controlling for propensity scores. As context for differences in supervision practices, specialty supervision clearly is more intensive than traditional supervision.

To test whether specialty officers use different compliance strategies, exhibit better boundary spanning, and establish better officer–probationer relationship quality than traditional officers, we performed a linear regression to predict each process/practice (continuous scores) from probation site (0 = *specialty*, 1 = *traditional*) controlling for propensity scores and officer nesting. Basic descriptive statistics comparing sites on officer practices are reported in Table 4, which includes both officer and probationer-rated items. The results reported below, however, reflect analyses that control for participants’ propensity scores and officer nesting effects. As shown

Table 4
Mean Differences Between Sites in Officer Practices

Variables	Specialty <i>M</i> (<i>SD</i>)	Traditional <i>M</i> (<i>SD</i>)	<i>t</i> (<i>df</i>)	Cohen’s <i>d</i>
Probationer ratings				
Compliance strategies				
Positive**	1.1 (0.7)	0.7 (0.6)	5.6 (357)	.61
Negative**	0.2 (0.3)	0.4 (0.5)	−3.0 (357)	−.49
Officer–probationer relationship				
DRI-R Fairness/Caring**	6.0 (1.2)	4.7 (2.0)	7.9 (356)	.79
DRI-R Trust**	5.5 (1.5)	4.5 (2.0)	5.4 (356)	.57
DRI-R Toughness**	1.6 (1.1)	2.6 (1.8)	−5.9 (356)	−.67
DRI-R total score**	6.0 (1.1)	4.8 (1.9)	7.5 (356)	.77
Boundary spanning				
General features**	4.5 (2.0)	3.4 (2.3)	4.5 (341)	.51
Knowledge**	5.0 (1.4)	4.0 (1.9)	5.7 (339)	.60
Help**	0.3 (0.5)	0.0 (0.4)	6.9 (356)	.66
Total (standardized)**	0.8 (2.0)	−0.9 (2.5)	7.1 (357)	.75
Officer ratings				
Compliance strategies				
Positive*	1.0 (0.6)	0.9 (0.5)	−6.0 (325)	.18
Negative**	0.1 (0.2)	0.3 (0.4)	−5.1 (325)	−.63
Officer–probationer relationship				
DRI-R Fairness/Caring**	6.0 (0.6)	5.5 (0.9)	5.7 (328)	.65
DRI-R Trust	4.5 (1.0)	4.3 (1.2)	1.4 (328)	.18
DRI-R Toughness	2.5 (0.8)	2.7 (0.8)	−1.7 (328)	−.25
DRI-R total score**	5.7 (0.6)	5.3 (0.7)	5.3 (328)	.61

Note. DRI-R = Dual-Role Relationship Inventory.
* $p < .01$. ** $p < .001$.

Table 5
Unstandardized Regression Coefficients for Officer Practices, Controlling for Propensity Scores and Officer Nesting

Officer Practices	<i>B</i>	Robust <i>SE</i> (<i>b</i>)	95% CI	<i>t</i> (<i>df</i>)	Cohen's <i>d</i>
Boundary spanning**	-1.5	0.4	[-2.3, -0.8]	-4.0 (329)	-0.44
DRI-R total score**	-1.2	0.3	[-1.8, -0.6]	-4.3 (329)	-0.47
Positive compliance*	-0.4	0.1	[-0.6, -0.1]	-2.9 (329)	-0.32
Negative compliance*	0.2	0.1	[0.1, 0.4]	3.1 (329)	0.34

Note. Specialty probation is coded as 0 and traditional probation is coded as 1. CI = confidence interval; DRI-R = Dual-Role Relationship Inventory.

* $p < .01$. ** $p < .001$.

in Table 5, results indicate a small effects for probation type on officer practices (Cohen's d range: .32–.44). After controlling for propensity scores and accounting for officer nesting effects, specialtyofficers manifested higher (i.e., better) Boundary Spanning, Positive Compliance Strategy, and DRI-R scores, and lower Negative Compliance Strategy scores than traditional officers.

Aim 2: Do Specialty Probationers Receive More Services and Have Fewer Violations Than Traditional Probationers?

The study's second aim was to examine the logic model of specialty supervision by testing whether specialty probationers achieve greater access to mental health services and decreased violations, compared with traditional probationers. To address this aim, we performed a series of binary logistic regressions in which (a) the criterion variable was either treatment involvement (yes/no for one of three types of treatment: mental health, substance use, or dual diagnosis) or receipt of a formal violation report (yes/no), (b) the predictor was probation site (specialty/traditional), and (c) propensity scores were covariates.

Service access. Table 6 reports basic site differences in service access and violation reports filed. Table 7 reports the effects after controlling for propensity scores. Small effects were observed favoring specialty probation in mental health-related service access. Probationers at the specialty site were significantly more likely to receive mental health treatment, $B = -1.47$, $SE(b) = .36$, odds ratio [OR] = .23, $p < .001$, and integrated dual-diagnosis

treatment, $B = -1.03$, $SE(b) = .33$, $OR = .36$, $p < .01$, than those at the traditional site, but there were no differences between sites on access to substance use treatment.

Probation violations. Also shown in Table 7, a large effect ($OR = 2.19$) was observed favoring specialty probation in probation violations. Probationers on specialty probation were approximately two times *less* likely than those on traditional probation to have a formal violation report filed against them.

This finding is particularly noteworthy when placed in context. Our supplemental analyses indicated that specialty officers were more often aware that their probationers had violated supervision than traditional officers. Table 8 portrays the proportion of probationers who self-reported and the proportion of officers who were aware of (according to the probation file or officer survey) any treatment violation, any technical violation, any aggression or violence, and any new offense. There is visibly more correspondence between specialty officers' and probationers' reports of violations than there is between traditional officers' and probationers'. Indeed, kappa values for specialty probationers and specialty officers ranged from .22–.61 across these four violation categories, whereas traditional officers ranged from .07–.25 across the same violation categories. Outside of truly serious violations (e.g., violence and new offenses), specialty officers are more often aware of violations than traditional officers. Notably, specialty probationers reported significantly greater violations than traditional probationers in only one category—"any technical" violation, $\chi^2(1) = 6.6$, $p < .01$, Cramer's $V = .14$.

Table 6
Differences in Service Access and Violations (Yes/No) Between Sites

Variables	Specialty %	Traditional %	χ^2 ($df = 1$)	Cramer's <i>V</i>
Clinical outcomes				
Mental health treatment ^{a,***}	91	60	48.8	.37
Substance use treatment	28	31	.22	.03
Dual diagnosis treatment**	34	15	15.6	.22
Probationer violations				
Treatment noncompliance**	77	54	25.9	.27
Any technical violation	85	81	2.0	.08
Fighting or new offense*	37	50	6.4	.13
Official violation report filed ^{a,***}	24	45	18.3	.23

^a Integrated self-report and public billing database data.

* $p < .05$. ** $p < .001$.

Table 7
Unstandardized Regression Coefficients for Service Access and Violations Reports, Controlling for Propensity Scores

Philosophical Goals	<i>B</i>	Robust <i>SE</i> (<i>b</i>)	95% CI	<i>z</i> (<i>df</i>)	<i>OR</i>
Service receipt (yes/no)					
Mental health treatment***	-1.47	0.36	[-2.18, 0.76]	-4.07 (329)	0.23
Substance use treatment	0.37	0.29	[-0.21, 0.94]	1.25 (329)	1.44
Dual-diagnosis treatment*	-1.03	0.33	[-1.67, -0.38]	-3.13 (304)	0.36
Violation report (yes/no)*	0.78	0.28	[-2.16, -1.09]	2.75 (329)	2.19

Note. Specialty probation is coded as 0 and traditional probation is coded as 1. CI = confidence interval.
* $p < .01$. ** $p < .001$.

Aim 3: Do Specialty Officer Practices/Processes Promote Service Access and Protect Against Violations?

Our third aim was to explore whether these intermediate outcomes—reduced violations and increased service access—were a function of specialty probation practices (e.g., Boundary Spanning, Positive Compliance Strategies, high-quality dual-role relationships). First, we examined whether officer Boundary Spanning predicted improved access to services by conducting a series of three binary logistic regressions in which service access was the criterion (yes/no) to mental health, substance use, and dual-diagnosis treatment over 1 year, total Boundary Spanning scores were the predictor, and propensity scores and officer nesting effects were covariates. Results indicated that Boundary Spanning does not predict mental health, $B = 0.07$, $SE(b) = 0.05$, $OR = 1.07$, *ns*, substance use service access, $B = -0.02$, $SE(b) = 0.05$, $OR = 0.99$, *ns*, or access to integrated dual-diagnosis treatment, $B = 0.04$, $SE(b) = 0.07$, $OR = 1.00$, *ns*.

Second, we examined whether officer supervision strategies predicted violation reports by conducting a binary logistic regression in which a violation report (yes/no) was the criterion, Positive and Negative Compliance Strategy scores ($r = .16$, *ns*) were the predictors, and propensity scores and officer nesting effects were covariates. A significant and medium effect was observed for Negative Compliance Strategy scores, $B = -0.11$, $SE(b) = 0.19$, $OR = 3.09$, $p < .01$. Specifically, for every 1-point increase on the Negative Compliance Strategies scale, the odds of receiving a violation report increased by 300%. The effects of Positive Compliance Strategy scores were not significant, $B = 1.13$, $SE(b) = 0.42$, $OR = 1.07$, *ns*.

Last, we tested whether officer–probationer relationship quality protected against violation reports. The logistic regression model

was the same as above, but replaced compliance strategies with DRI-R total scores as predictors. Results indicated a small effect for officer–probationer relationship quality on formal violation reports, $B = -0.20$, $SE(b) = 0.07$, $OR = 0.82$, $p < .01$. Specifically, for every 1-point increase in DRI-R total scores (range: 30–210), the odds of receiving a formal violation report decreased by 18%.

Discussion

In this quasi-experimental study, we tested for theoretically relevant differences in practices and intermediate outcomes between specialty mental health probation and traditional probation. Our findings provide partial support for the logic of the specialty model, as implemented in a prototypical agency. First, we found that specialty officers manifest greater boundary spanning, more positive compliance strategies, and higher quality dual-role relationships with their supervisees than traditional officers. Second, relative to traditional supervision, specialty supervision was more effective in achieving the intermediate goals of accessing psychiatric and dual-diagnosis (but not substance abuse) services; and of reducing violation reports to the court. Third, although boundary spanning did not predict somewhat rough indices of service access (yes/no), compliance strategies and relationship quality helped protect against violation reports. The latter officer practices may be regarded as “essential ingredients” of the specialty model.

Before discussing each of these results, we note two limitations that must be borne in mind while doing so. First, although specialty and traditional probationers were matched statistically and by design, this study was not a true experiment. Because group differences could reflect the influence of unobserved variables, they cannot be attributed with confidence to probation type. Sec-

Table 8
Violations of Probation

Violations	Probationer self-report		Officer report (interview)		Officer report (file review)	
	Specialty	Traditional	Specialty	Traditional	Specialty	Traditional
Treatment noncompliance	68%	54%	68%	25%	64%	15%
Any technical	93%	85%	76%	59%	87%	67%
Aggression or violence	35%	29%	7%	5%	4%	3%
New offense	16%	25%	17%	24%	19%	23%

ond, the generalizability of these results to agencies that are less prototypical of the specialty mental health model is limited. For example, as shown in a national survey (Skeem et al., 2006; see above in the Introduction), as caseload size increases, reported practices in “specialty” mental health agencies become indistinguishable from those in traditional agencies. The specialty agency studied here had meaningfully reduced caseload sizes, in addition to the other “essential” ingredients listed earlier (e.g., sustained officer training, integration of probation and mental health services). When officers do not have the necessary time and training to supervise offenders with mental illness differently, effective practices are unlikely to be implemented.

Practices and Processes in Prototypical Specialty Probation Are Different

This study provides sound evidence that practices and processes perceived as essential to specialty mental health probation are actually implemented in prototypical agencies. Specifically, specialty officers have better boundary spanning skills, make use of more positive compliance strategies and less use of negative compliance strategies, and form higher quality dual-role relationships with their supervisees. These findings significantly buttress prior results. Indeed, a focus group study of practicing specialty and traditional officers (Skeem et al., 2003), a national survey comparing the reports of common practices in traditional and specialty agencies (Skeem et al., 2006), observations of specialty supervision (Eno Loudon et al., 2008, 2012), and surveys of general correctional practitioners (Epperson et al., 2011) all highlight these “essential ingredients” to supervising offenders with mental illness.

Establishing that the specialty model actually is implemented in a prototypical agency is critical. All too often, well-designed correctional programs fail to be implemented effectively due a host of administrative (e.g., ineffective support and oversight), organizational (e.g., lack of resources to support sustained change), and staff (e.g., turnover, nonparticipation) issues (see Gendreau, Goggin, & Smith, 1999; Alexander, 2011). If a program cannot be implemented effectively, it will not reduce recidivism (see Andrews, 2006). Implementation success is a necessary (but not sufficient) step toward reducing supervision failure among offenders with mental illness. Particularly in the current correctional climate, in which agencies are strapped for resources, it is crucial to identify the specific components officers must be sure to implement to achieve improved outcomes and philosophical goals. In turn, this can help free up officers’ time and agency resources that previously were allocated to practices with little or no evidence base.

Specialty Probation Improves Treatment Access and Protects Against Violations

The specialty probation model places a premium on access to psychiatric services. Compared with traditional probation, specialty probation significantly improved access to mental health and integrated dual-diagnosis services in this study. This finding is encouraging, because (a) it indicates that specialty probation can be true to its logic model, (b) service receipt and symptom control may help probationers avoid technical violations (see Skeem & Eno Loudon, 2006), and (c) offenders with serious mental illnesses (by definition) need such services, from a public health perspective.

Nevertheless, casting service access as the “lynchpin” of specialty probation may be a mistake, given that symptom control rarely translates into reduced recidivism (see Skeem et al., 2011). For example, Case et al. (2009) found that a jail diversion program reduced the risk of rearrest for offenders with mental illness, but not through the avenue of symptom reduction. For this reason, mental health services are best viewed as an element of specialty probation that improves responsivity to other correctional interventions for offenders with mental illness (see Andrews & Bonta, 2010). These services may act synergistically with components of supervision that more directly impact recidivism (see Skeem et al., 2011, for examples). Recent policy statements have emphasized a shift in thinking about the role of psychiatric services from having a direct effect on recidivism to having, at best, an indirect effect (e.g., Osher, D’Amora, Plotkin, Jarrett, & Eggleston, 2012).

In addition to improving service access, this study provides particularly compelling evidence that specialty probation reduces the risk of violation reports. Because offenders with mental illness are at a particular risk for failing community supervision due to technical violations (Baillargeon et al., 2009; Cloyes et al., 2010; Eno Loudon & Skeem, 2011; Ostermann & Matejkowski, 2012), it is essential to understand how officers exercise their discretion in responding to violations. Compared with traditional probationers in this study, specialty probationers (a) met twice as often with their officers; (b) were required to obey more special conditions of probation (and perhaps for that reason, were modestly more likely to have technical violations), and (c) had greater rates of agreement with their officers on reported violations. In short, specialty probationers were on intensive supervision and their officers were uncommonly aware of their (mis)behavior. In contrast, traditional probationers often violated the rules well outside of their officers’ awareness. And still, traditional officers were significantly more likely to file violation reports on their supervisees than specialty officers.

In some ways, this is the antithesis of the “surveillance effect,” or the finding that increased monitoring during community supervision promotes unnecessary violations and revocation (e.g., Petersilia & Turner, 1990). Although specialty probation is a form of intensive supervision, the “antisurveillance effect” is in operation, in that specialty officers were *less* likely to file violation reports even though they were more aware of rule violations and their supervisees had higher rates of technical violations. The antisurveillance effect is consistent with the results of past qualitative (Skeem et al., 2003) and quantitative (Skeem et al., 2006) research, which suggested that traditional officers use violation reports quite liberally, as a means toward removing high-need individuals from their caseload, whereas specialty officers use violation reports (and revocation) as a last resort.

Some “Specialty Practices”—Avoiding Negative Compliance Strategies and Establishing Firm, Fair, Caring Relationships—Enhance Intermediate Outcomes

Of the three officer practices studied in this study, two predicted important intermediate outcomes. Specifically, officers’ avoidance of negative compliance strategies and high-quality officer—probationer relationships protected against later violation reports. The latter finding is consistent with past demonstrations that high-

quality dual-role relationships protect against violations (Skeem et al., 2007) and arrests (Kennealy et al., 2012).

Notably, high-quality dual-role relationships (DRI-R total scores) were moderately associated with Positive ($r = .48, p < .01$) and Negative ($r = -.39, p < .001$) Compliance strategies in this study. But among compliance strategies, only negative strategies predicted violation reports. In other words, “bad” practices like sanction threats (which can be appropriate, at times) appear to be stronger than “good” practices like problem-solving strategies (see also Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001). This suggests that “ex-novating” (Frank & Glied, 2006) heavy reliance on negative compliance strategies (e.g., reserving threats of incarceration only for serious misbehavior) in community corrections could be a low-cost route to reducing violations for offenders with mental illness.

Unexpectedly, officer boundary spanning did not predict enhanced service access in this study. Even though specialty officers exhibited better boundary spanning skills than traditional officers, and specialty probationers got more access to mental health and integrated dual-diagnosis treatment than traditional probationers, the former did not “predict” the latter. This is surprising, particularly because others have observed the hierarchical importance of officer- over program-level effects (Dowden & Andrews, 2004; Klockars, 1972; Paparozzi & Gendreau, 2005). It may be that total boundary spanning alone do not predict service access, but rather some index of interagency communication and collaboration does. It may also be quite likely that the findings are a function of an impoverished dichotomous operationalization of services. Nevertheless, boundary spanning is likely to be an important skill set for those who work with clients who require care and supervision across multiple systems (Dvoskin & Steadman, 1994; J. J. Steadman, 1992).

Implications

The results of this study indicate that the specialty mental health probation model can be actualized in a real-world setting; improves service access and reduces violation reports for probationers when it is actualized; and does so partially through improved officer practices and processes. Those practices include establishing firm, fair, and caring relationships with probationers; and avoiding heavy reliance on negative compliance strategies.

These results may inform the development of guidelines for specialty mental health probation that help the field move away from heterogeneous implementation across jurisdictions (see Skeem et al., 2006). The success of correctional and mental health treatment programs often hinges on whether they are adherent to a particular “model” with demonstrated effectiveness. Before those guidelines are solidified, the effect of compliance strategies, relationship quality, and other theoretically relevant practices/processes on recidivism must be tested. Programs for offenders with mental illness (rightly) target a variety of intermediate and ultimate outcomes, but improving public safety by preventing new arrests arguably is the most important for this population (see Skeem et al., 2011). It will also be important to determine whether the relatively high cost of specialty probation is offset by reductions in public safety costs.

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