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Life After Adjudication: A Comparison of Three Forensic Inpatient Treatment Modalities as a Predictor of Community Reintegration Success

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Pacific University

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Life After Adjudication: A Comparison of Three Forensic Inpatient Treatment Modalities as a Predictor of Community Reintegration Success

Abstract
Oregon's Psychiatric Security Review Board (PSRB) was created in 1978 for the purpose of providing post-adjudication management to Oregon's insanity acquittees, supplying both community protection and individual treatment (Bloom, Rogers, & Manson, 1986). Most of these individuals (approximately 75%) are initially placed at the Oregon State Hospital (OSH). This study compared the effectiveness of three different treatment groups (i.e., milieu therapy, 41A Community Re-Entry and the Transitional Living Center) within OSH in an effort to determine the individuals' level of success within the community, after hospital release. The variables evaluated in determining their success within the community included length of time in the community, number of revocations (i.e., hospital readmissions), and recidivism. The findings suggest that those subjects who participated in the TLC treatment program resided in the community for a significantly longer period of time and had a reduced rate of hospital revocation than did those who participated in the Milieu or 41A program. There was no significant difference between those who participated in the Milieu program and those who participated in the 41A program. Implications and limitations are discussed.

Degree Type
Dissertation

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LIFE AFTER ADJUDICATION: A COMPARISON OF THREE FORENSIC
INPATIENT TREATMENT MODALITIES AS A PREDICTOR OF COMMUNITY
REINTEGRATION SUCCESS

A DISSERTATION
SUBMITTED TO THE FACULTY
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BY
GENEVIEVE MOORE GRADY
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY

16 APRIL 2009

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ABSTRACT

Oregon’s Psychiatric Security Review Board (PSRB) was created in 1978 for the purpose of providing post-adjudication management to Oregon’s insanity acquittees, supplying both community protection and individual treatment (Bloom, Rogers, & Manson, 1986). Most of these individuals (approximately 75%) are initially placed at the Oregon State Hospital (OSH). This study compared the effectiveness of three different treatment groups (i.e., milieu therapy, 41A Community Re-Entry and the Transitional Living Center) within OSH in an effort to determine the individuals’ level of success within the community, after hospital release. The variables evaluated in determining their success within the community included length of time in the community, number of revocations (i.e., hospital readmissions), and recidivism. The findings suggest that those subjects who participated in the TLC treatment program resided in the community for a significantly longer period of time and had a reduced rate of hospital revocation than did those who participated in the Milieu or 41A program. There was no significant difference between those who participated in the Milieu program and those who participated in the 41A program. Implications and limitations are discussed.
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INTRODUCTION

The number of patients in state mental hospitals reached its highest point in 1955 when a total of 559,000 persons out of a national population of 165 million were institutionalized (Lamb & Bachrach, 2001). Until that time, treatment planning for the mentally ill was relatively simple in that the majority of people demonstrating signs of chronic mental illness were admitted to a state mental hospital, where their tenure was often for life (Bachrach & Lamb, 1989). Since the mid-1960s, the process of deinstitutionalization has progressed throughout the country (Easton, 1978). The principle behind this movement was that long-stay psychiatric inpatients could leave the hospital if adequate facilities were available in the community, resulting in a decreased need for inpatient beds (Grinschpoon, Zilber, Lerner, & Ponizovsky, 2006).

The deinstitutionalization of individuals with mental illness has had three components: the release of such individuals from state mental hospitals and into the community, their diversion from future hospital admissions, and the establishment and maintenance of alternative community support services (Easton, 1978; Lamb & Bachrach, 2001; Rothbard, Schinnar, Hadley, Foley, & Kuno, 1998).

Although the damaging effects of long-term hospitalization prompted deinstitutionalization, the harmful effect of discharging individuals without proper community support was unanticipated (Blomberg, Yeisley, & Lucken, 1998). The local level support necessary to successfully sustain such individuals in the community was not adequate (Blomberg, Yeisley, & Lucken, 1998). As a result,
many previously hospitalized psychiatric patients were moved into the community only to suffer from homelessness and inappropriate incarceration (Lamb & Bachrach, 2001). Such incarceration has created a new population of individuals who both suffer from major mental illness and an involvement in the criminal justice system (Paul & Menditto, 1992). As such, the effect of treatment for this group is paramount because transitioning these individuals into the community raises the fundamental question of how they can be treated in the least restrictive environment while simultaneously ensuring the safety of the public (Callahan & Silver, 1998a; Lamb & Bachrach, 2001).

In this study, I sought to evaluate the effectiveness of three different inpatient treatment programs and their impact on individuals’ community success. In the following section, I review the influence of deinstitutionalization and its redirection of the mentally ill into the criminal justice system.
LITERATURE REVIEW

As a result of deinstitutionalization, in little more than 40 years the number of state hospital beds in use in the United States decreased from the high listed above of 559,000 to 21,000 (Bigelow, Bloom, Williams, & McFarland, 1999; Lamb & Bachrach, 2001). Expectations were that, with proper community treatment and support, many previous and future psychiatric inpatients would live in the community rather than in hospitals (Bigelow et al., 1999).

Since deinstitutionalization began, researchers have evaluated its impact and effectiveness in serving and maintaining the mentally ill in the community. Surprisingly, Hodgins (2001) found evidence that, among those born after the mid-1940s, those who developed a major mental illness in countries where deinstitutionalization policies have been in effect were more likely than those without major mental disorders in the same generations and societies to have been convicted of a criminal offense and, more specifically, to have been convicted of a violent offense. While in the throws of transitioning patients out of the hospital and into the community, it was expected that such populations could be effectively managed through psychotropic medication and with the assistance of new community mental health centers (Blomberg, Yeisley, & Lucken, 1998). The unintended consequence of this assumption resulted in the expansion of the mentally ill homeless population and their increased presence within the nation’s jails and prisons (Bachman & Lamb, 1989; Blomberg et al., 1998).
Chronically mentally ill individuals who formerly would have lived out their lives in a state mental hospital but who have ended up in the community frequently draw the attention of police for what is perceived to be criminal behavior (Lamb & Bachrach, 2001). Rather than receiving psychiatric treatment and hospitalization, individuals suffering from a mental illness who have committed minor legal infractions are frequently subject to inappropriate arrest and incarceration (Lamb & Bachrach, 2001). In fact, federal statistics have demonstrated that approximately 16% of inmates housed in jails and prisons have some type of mental health problem (Wolff, 2005).

Studies have suggested that mental illness is concentrated within the population of incarcerated individuals and ranges in type of disorder and pattern of comorbidity (Wolff, 2005). Both clinicians and researchers have observed that a large proportion of individuals diagnosed with mental illness who are being served by the criminal justice system resemble those who used to be served by state mental hospitals (Lamb & Bachrach, 2001). This residual consequence of deinstitutionalization has resulted in the dilemma of determining what should be done with mentally ill individuals who commit criminal acts (Lamb, Weinberger, & Gross, 1988). In the next section, I consider the development of the insanity defense, a legal defense appropriate for a subset of mentally ill offenders.

Insanity Defense

Rogers and Bloom (1985) discussed society’s long struggle to shape appropriate medical, legal, and moral responses to those individuals diagnosed with a mental illness who commit crimes. As he noted, all jurisdictions within the United
States have worked to establish various legal processes for coping with mentally ill offenders; the most specialized of these processes is the insanity defense. A typical insanity defense is determined when, as a result of a mental disorder or deficiency, an individual is found not to have had a rational understanding or ability to conform their behavior as required by the law (Melton, Petrila, Poythress & Slobogin, 1997). In most states, a successful insanity defense brings a mechanism combining elements of the civil commitment and criminal conviction procedures. Rogers and Bloom characterized the insanity defense as a separate system located within the spectrum of these two common processes for handling mentally ill offenders and further noted that a fundamental concern within this system was whether such offenders should be regarded principally as criminals or as patients.

In many states, insanity acquittees are involuntarily committed into a secure inpatient mental health hospital for the treatment of their mental illness (Monson, Gunnin, Foget, & Kyle, 2001). Although the process of deinstitutionalization began in 1955, little attention was paid to the length of confinement of insanity acquittees until 1966 (Callahan & Silver, 1998a). In fact, many of those acquitted by reason of insanity effectively received a life sentence for even minor infractions (Callahan & Silver, 1998b). This status changed in 1966 when the Supreme Court ruled in two major cases. In both Baxstrom v. Herald (1966) and Bolton v. Harris (1968), the Court of Appeals for the District of Columbia maintained that insanity acquittees must be held to the same standards for commitment as were individuals who were civilly committed (Callahan & Silver, 1998, 2001b). Such rulings produced a brief period of liberal standards related to the insanity defense until the cases of Jones v.
United States (1983) and United States v. Hinckley (1982) were ruled upon (Callahan & Silver, 1998, 2001a). In those decisions the Court held that an insanity acquittal, even for those sentenced for minor crimes, was evidence of dangerousness resulting in automatic and immediate involuntary commitment upon acquittal (Callahan & Silver, 1998, 2001b). In response to these court decisions, many states altered their insanity defense laws in an effort to make them more restrictive, especially as they related to release procedures (Callahan & Silver, 1998, 2001a).

Currently the standards for commitment and release of insanity acquittees are far from consistent or legally transparent throughout the United States (Callahan & Silver, 1998b). Prior to the rulings in Jones v. United States (1983) and United States v. Hinckley (1982) the standards for release paralleled those of the civil mental health system, with the state bearing the burden of demonstrating that the commitment was warranted (Callahan & Silver, 1998b; Monson et al., 2001). These requirements were altered, shifting the responsibility from the state to the defendant, or acquittee, to prove that he or she was no longer dangerous or no longer maintained a mental illness (Callahan & Silver, 1998a; Monson et al., 2001). If the insanity acquittee is able to demonstrate that public safety no longer requires his or her hospitalization, he or she may be released into the community on a set of conditions identified as conditional release (Callahan & Silver, 1998b, 2001; Monson et al., 2001). In the next section I will address the procedures and challenges associated with the community conditional release process.
Community Conditional Release

The conditional release of insanity acquittees is a process similar to that of parole and is a procedure that straddles both the criminal justice and mental health systems (Callahan, 1998). Consistent with public safety, legal requirements for insanity acquittees are such that they should live in the community rather than residing indefinitely in mental health institutions (Bigelow et al., 1999), as a means of providing the least restrictive and most recent model of service delivery (Heilbrun & Griffin, 1993). Such services involve the treatment and case management of insanity acquittees within the community (Heilbrun & Griffin, 1993).

The conditional release of insanity acquittees has become so widespread in the United States that it has been called the “national model” (Bloom & Williams, 1992, p. 580) for the re-entry of forensic patients from institutions into society. Through the process of conditional release, insanity acquittees are placed in the community in a manner intended to provide both community protection and individual liberty for the acquittees (Bloom & Williams, 1992). As a result of the dual relationship of having to attend to both mental health and criminal justice matters, the supervision of insanity acquittees is more intensive than for persons who were civilly committed (Callahan, 1998).

Many states have addressed issues related to forensic aftercare, and specific information about community-based forensic programs has been presented by both clinicians and researchers (Bertman-Pate et al., 2004). Research specific to the area of conditional release is sparse when considering the volume of literature related to the insanity defense (Callahan, 1998a).
Determining Conditional Release Success

Unfortunately, studies conducted on the effectiveness of conditional release programs in promoting the safe community reintegration of forensic patients are difficult to compare (Wiederanders, Bromley, & Choate, 1997). Each state has a highly technical and individualized system of managing such individuals and, adding to the complexity, are the varying legal standards. Such unique distinctions make for an imperfect and challenging scientific comparison. In this section, three main factors (i.e., recidivism, revocation and rehospitalization) associated with such programs are addressed.

Recidivism

Recidivism is frequently used as the primary outcome criterion when evaluating community success, yet the use of recidivism alone with a criminally insane population does not provide sufficient useful information (Bloom et al., 1986; Cohen, Spodak, Silver, & Williams, 1988; Steadman & Braff, 1983; Tellefson, Cohen, Silver, & Dougherty, 1992). Researchers have demonstrated that other measures of successful community reintegration should be considered, including mental health stability, general functioning, rehospitalization, as well as compliance with specifications of conditional release (Tellefson et. al, 1992). Although researchers have acknowledged the usefulness of information about recidivism for public policy makers and the public at large, they have also questioned the overall value of such studies as they relate to clinical treatment goals, given that treatment is supposed to be geared towards treating specific types of symptomatology (Bloom et
al., 1986; Steadman & Braff, 1983). Accordingly, the current discussion of recidivism will be limited.

The relationship of symptoms to criminal behavior resulting in future recidivism may be construed as incidental if present (Bloom et al., 1986; Steadman & Braff, 1983). Of chief concern is the tendency for recidivism to be equated with treatment failure, an inappropriate and far too easily made association (Bloom & Williams, 1986; Steadman & Braff, 1983). The specific variable of recidivism is often perceived to be too crude a measure to accurately describe outcome (Simpson, Jones, Evans, & McKenna, 2006), as its definition is not always consistent. It is defined by some researchers as reconviction (Simpson et al., 2006), whereas others measure it in terms of arrest rates (Spodak, Silver, & Wright, 1984). As evidence of this discrepancy and of issues surrounding recidivism, it is useful to consider the literature.

In a study conducted by Spodak et. al (1984), 86 male insanity acquitttees were conditionally released in the state of Maryland and followed post-discharge. Researchers found that, in addition to using arrest rates as a measure of recidivism, the examination of charges and convictions was useful because they provided more reliable indicators of criminality. Bloom and Williams (1986) determined that a separation existed between criminality and mental illness suggesting that, at minimum, a subgroup existed for whom psychiatric treatment was ineffective in preventing criminal behavior. Of further interest in considering recidivism and criminality was research conducted by Cohen et al. (1988), who compared 127 insanity acquitttees to groups of 127 felons and 125 mentally disordered prison
transfers. The three groups were followed for an average of 10 years after being released from hospital or prison. Although variables traditionally associated with criminality (i.e., age, race, prior employment, prior arrests as a juvenile and adult, and poor school adjustment) were significantly associated with criminality in the prison transfer cohort, the association for those in the insanity acquittee group between the traditional variables and criminality was weaker. Strong associations related to criminality within the insanity acquittee group were found for atypical variables, including prior hospitalization for mental illness, hospital adjustment (i.e., the degree to which the patient had adjusted to the hospital as evidenced by the number of rule breakings, revoked privileges, and program failures), and clinical assessment of hospital adjustment (i.e., a clinically assigned rating of their improvement as a result of treatment at the time of discharge; Cohen et. al, 1988).

In a meta-analysis conducted by Bonta, Law, and Hansen (1998), results indicated that recidivism was not highly predictive of mental illness; rather, the presence of a mental disorder was associated with lower recidivism rates. In an effort to determine whether the predictors of recidivism for mentally disordered offenders were different from those for nondisordered offenders, research was conducted using 35 predictors of general recidivism and 27 predictors of violent recidivism extracted from 64 unique samples. Results indicated that the major predictors of recidivism were similar for both the nondisordered and the mentally disordered offenders and that criminal variables (i.e., criminal history, antisocial personality, substance abuse, and family dysfunction), rather than clinical variables, were the best predictors.
The relationship between criminality as it relates to mental illness and recidivism continues to be explored; what can be agreed upon to date is that symptoms of severe mental illness often coexist with criminal behavior (Bloom & Williams, 1986; Bonta et al., 1998). Although the issue of arrest does indicate that an individual with mental illness is experiencing difficulty in the community, arrests for this patient group often do not truly reflect consistent or significant criminality (Spodak et. al, 1984). Rather, this measure is frequently utilized as a means of rehospitalization (Spodak et. al, 1984).

Revocation of Conditional Release

Within the United States, revocation of an acquittee’s conditional release typically requires that the individual simply violated his or her order of release. In general, conditional release is more easily revoked than is probation or parole (Callahan, 1998a) because it does not require the same threshold of due process, resulting in a quicker and more efficient process (Callahan, 1998b).

Previous studies of insanity acquittees conditionally released into the community have shown a typical revocation rate from 35% to 50% (Monson et. al, 2001). In a review conducted by Heilbrun and Griffin (1993), a comparison of community-based treatment and management of insanity acquittees of several states was conducted with reported results as follows:

<table>
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<tr>
<th>State</th>
<th>Illinois</th>
<th>Oregon</th>
<th>California</th>
<th>Maryland</th>
<th>New York</th>
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<tr>
<td>Revocation rate</td>
<td>25%</td>
<td>32%</td>
<td>34%</td>
<td>41%</td>
<td>5%</td>
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No reason was given as to why the State of New York experienced such a low rate of revocation.

In an evaluation of insanity acquittee conditional release programs in four states (Connecticut, Maryland, New York, and Ohio), Callahan (1998a) found the overall median length of time in the community prior to revocation was 1.7 years. The most common reason for revocation was identified as risk/dangerousness, and the second most common reason was concern about mental health status. In general, Callahan (1998a) found in four states that most persons who were conditionally released within five years from hospital discharge did not have their conditional release revoked. Regarding specific factors correlating with revocation, Monson et. al (2001) studied 125 insanity acquittees on post-hospital conditional release. Of those variables studied, Monson et. al found that minority status, substance abuse diagnosis, and prior criminal history significantly predicted conditional release revocation as well as decreased time in the community prior to revocation.

Rehospitalization

Despite an initial deinstitutionalization effort to eliminate all inpatient hospitalization (Grinschpoon et. al, 2006), researchers have reinforced the need for hospital-level care as an integral part of the continuum of care (Wilderding, 1991). Many states and countries using conditional release mechanisms employ the option of returning individuals to secure hospitals if their behavior does not adhere to the agreed-upon provisions, including medication and specified treatment requirements. Hospitalization is a valid resource for safe psychiatric treatment of the criminally mentally ill when warranted, but always in support of and toward the sustaining of a
patient’s mental illness management and skill building beyond its walls into various levels of community care (Wilberding, 1991). Given the significant investment of hope, energy, and clinical competence, it is a challenge to understand why more consistently positive outcomes in the community-based programs for insanity acquittees have not been observed (Lamb & Bachrach, 2001). In the next section, I look at the influence of treatment on the success of conditional release.

Treatment and Conditional Release Success

Researchers have suggested that adjusting to a community environment can be not only traumatic and overwhelming for patients, but also an exercise in futility and failure unless consideration is made as to what is required to make a more comfortable and complete transition (Wilberding, 1991). Insanity acquittees differ in motivation as well as in their ability to cope with pressure and stress (Lamb & Peele, 1984). Whereas some acquittees are agreeable and adaptable to social rehabilitation, others cannot handle the associated stress (Lamb & Peele, 1984). Similarly, individuals making a transition from an inpatient to community-based setting are frequently unable to manage the immediate stress and demands of such arrangements, causing them to either decompensate or recidivate (Lamb, Weinberger, & Gross, 1999).

The best defense against relapse as well as the best offense for recovery is active and continuous treatment (Davidson, O’Connell, & Tondora, 2006; Wolff, 2005). As a result, it is best to release many insanity acquittees to graduated lower levels of care and structure (Lamb, Weinberger, & Gross, 1999). The continuity of care rates from inpatient hospitals to outpatient treatment is currently 50% due to a
gap between the skills that are learned in the hospital and those that are needed in the
community (Rossotto, Wirshing, & Liberman, 2004). Research has indicated that both
the type and intensity of treatment affect the incidence of criminality among persons
with major mental illnesses (Hodgins, 2001). Consequently, it is imperative to
identify and develop effective treatment and service models in an effort to prevent all
of the various problems shown to develop in individuals suffering from a major
mental illness (Hodgins, 2001).

**Successful Treatment Components**

By better equating patient needs with specific combinations of treatment
components, the effectiveness of treatment may be enhanced (Hodgins, 2001) and the
success of conditional release heightened. Inpatient programs can help mentally ill
individuals develop the necessary social and vocational skills required for outpatient
community living (Lamb & Peele, 1984). When thousands of long-term mentally ill
patients began leaving mental hospitals and moved into the community, it quickly
became clear that many were tragically lacking in basic skills of daily living (Lamb,
1976). Intensive behavioral training, otherwise known as social skills training, is an
effective approach shown to address the issues of treatment adherence and resource
management faced by many patients in the community (Smith et. al, 1996).

Skills training programs work to promote independent functioning by
fostering the development of self-awareness and interpersonal skills (Smith et. al,
1996). In a 7.5-year retrospective study, Simpson et al. (2006) evaluated 105
discharged patient files. The researchers found that extensive broad-based inpatient
care combined with aggressive community follow-up was able to capitalize on the
rehabilitative gains made during the patient’s hospital tenure, making successful community living more probable. Patients who had made rehabilitative improvements while hospitalized were better prepared for successful community living, employment, and independent housing.

When the creation of community mental health centers began during the course of deinstitutionalization, traditional housing was mandated as one of many services required for an effective decrease in hospitalization (Wilberding, 1991). For the majority of forensic mental health patients, survival in the community has been said to depend on acquiring and maintaining an appropriately supportive and structured living situation (Lamb & Peele, 1984). Adaptive skills training is necessary to ensure an experience of competence and integration into the community environment (Nodop, 1980). Specific training in activities of daily living could and should occur during inpatient treatment if such skills are to be transferred and sustained in the community (Nodop, 1980). In the rehabilitation of hospital patients, a major focus is to include training in the area of self-care skills, and an emphasis should be placed on the patient’s development of such skills (Presly, Grubb, & Semple, 1982). Many behavioral deficits that are characteristic of mental health patients can be altered effectively through the manipulation of environmental possibilities (Shean & Zeidburg, 1971). Specific approaches to transition programs will be more fully addressed in the next section.

Purpose of the Study

The purpose of this study was to examine further the relationship between insanity acquittees’ inpatient treatment and community reintegration. Three different
inpatient treatment modalities in a psychiatric hospital (Oregon State Hospital, or OSH) located in Salem, Oregon, were compared.

As mentioned earlier, most states differ in their legal treatment of insanity acquittees. Within the State of Oregon an individual charged with a crime may proffer an insanity defense; such a plea is described as “guilty except for insanity” (GEI; Legislative Council Committee, 2006, p. 161.360). As defined by the Oregon Revised Statutes:

A person is guilty except for insanity if, as a result of mental disease or defect at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law. (Effect of Mental Disease or Defect; Guilty Except for Insanity, 1971 & Supp. 1983, ¶ 1)

In 1978 Oregon created an innovative system for both supervising and treating defendants who had successfully used a GEI defense. The focal point of this system is the Psychiatric Security Review Board (PSRB). Oregon’s PSRB has received national attention as an innovative model for the close monitoring and managing of high-risk individuals (Rogers & Bloom, 1985). The obligation of the PSRB is to provide “for care and treatment” (Legislative Council Committee, 2006, p. 161.327) of the convicted individual in addition to ensuring the protection of the public.

Treatment Modalities

The first treatment condition evaluated in this study was traditional milieu therapy, which technically means environmental treatment (Paul & Menditto, 1992). In 1953, Jones introduced a new treatment method called milieu therapy, which then spread so rapidly that by the mid-1960s almost all hospitals claimed to have such units of treatment (Jones, 1953). The milieu model is an interdisciplinary treatment
approach applied to psychiatric facilities in which the whole environment is believed to have a therapeutic potential (Duval, 1997). The treatment environment, consisting of daily events and interactions, was therapeutically designed to enhance social skills and is considered to maintain therapeutic potential (Kaltiala-Heino & Kahila, 1997). There is no universally accepted definition of milieu therapy; however, the approach is generally characterized by unit-wide procedures that work to enlist patients as the agents of change both for themselves and for their peers (Paul & Menditto, 1992). Such procedures typically include high levels of staff-to-patient interaction, such as group activities, the development of a social group pressure for improvement, conveyance by staff of the unit expectations for specifically desired behavior, and goal-directed exchanges with the purpose of indicating that patients are responsible people (Paul & Menditto, 1992). In such an environment, milieu therapy patients are generally given considerable responsibility for determining individual activities, with peer pressure applied toward prosocial interactions (Goldstein, 1979). An effort is made for activities to occur within the hospital so that patients may take on the attitudes and behaviors necessary for life after the hospital (Goldstein, 1979).

The second group evaluated in this study was a transitional care or community re-entry treatment group that is a self-contained transition unit started in 2003, called the 41A Community Re-Entry Program. Transitional care has been described as client care from the time of discharge planning through the expected recovery time. The concept of transitional care was originally developed at the University of Wisconsin Medical Center in 1977 (Forchuk et al., 1998). This form of treatment includes discharge planning to include an action plan that evolved over time with both the
patient and the staff maintaining active roles (Forchuk et al., 1998). The specialty programming in the unit included in this study included a mixture of psychoeducational activities and group programming (M. Godfrey, May 2007, personal communication). The overall goal was to orient individuals with regard to community resources and building appropriate life skills (e.g., transportation) to smoothly transition from the hospital system into less restrictive settings within the community mental health system. Unit 41A is the only self-contained forensic transition unit at OSH, meaning only 41A staff facilitate transition activities for 41A individuals. The group is operated by the ward Mental Health Specialist, Social Worker, and Mental Health Therapist (M. Godfrey, personal communication, February 3, 2007).

The third group used for comparison was a residence operated from 1983 to 2003 on OSH grounds as a simulated residential program, aptly named the Transitional Living Center (TLC). TLC was operated using a social skills training model. Social skills training is an approach that has been shown to be effective in addressing post-hospital treatment adherence and resource management problems demonstrated in the chronically mentally ill (Smith et al., 1996). Proponents of such skills training strive to cultivate the development of independent functioning by focusing on the development of patient self-awareness and interpersonal skills (Smith et al., 1996). The TLC program used modeling, shaping, prompting, and instruction, in conjunction with behavioral treatment and verbal reinforcement, with the goal of improving individual functioning in preparation for reintegration into the outside community (Hall, Deane, & Beaumont, 1996). TLC was created with the intention of
encouraging independence while providing guidance for the residents in a homelike setting. TLC was a co-ed, 26-bed residence operated out of two cottages on the hospital grounds. One cottage housed 11 residents and the other housed 15. The objective of TLC was to aid residents in achieving the following goals (OSH, 1996):

1. understand and meaningfully communicate to staff, information about their mental illness, including warning signs, their medications, and their relapse prevention plan;
2. develop constructive leisure activities of interest;
3. establish a social support network;
4. be able to identify and appropriately use resources in the community;
5. demonstrate essential living skills including: cooking, budgeting, use of public transportation, household safety and maintenance;
6. use problem-solving skills in both group and individual settings;
   and
7. seek and maintain gainful employment or be involved in an educational program should they so choose

Groups operating at the cottages included the following modules: symptom management, medication management, and basic conversation, and assertiveness. Additional Life Skills Groups included meal planning and preparation, stress management and relaxation, money management, time management, leisure and recreation, community reentry, alcohol and drug recovery group, a women’s group, interpersonal relationships, anger management, and primary groups (e.g., peer
support). Informal groups offered included recreation council, bicycle riding and
skills training, library, swimming, fitness and weight training, recycling, vocational
rehabilitation, education (through Chemeketa Community College), shopping, and
group outings (OSH, 1996).

Residents were expected to attend an 8:00 a.m meeting daily (except
weekends and holidays), maintain their medication regimen, abide by an 8:00 p.m.
curfew, complete a house chore related to cooking and cleaning, and maintain their
own bedroom cleanliness while participating in groups to assist them in adjusting to
life outside of the hospital (Snell, 2001). Residents were required to sign out of the
cottage when they left, and were required to obtain special permission to go off the
hospital grounds (Snell, 2001). Failure to complete assigned responsibilities, absence
from a group/class, or disrespectful behavior towards staff or peers, resulted in loss of
privileges (LOP) for 24 hours. The privilege lost was assigned on an individual basis
by clinical staff (OSH, May 1996). Each cottage maintained 24-hr staff providing
security and guidance to the residents. While at TLC, residents had the opportunity to
plant and maintain a garden, ride bikes, participate in daily or weekend outings, or
play with Jake (TLC’s dog and resident friend; OSH, 1996).

Though TLC was a program favored by both PSRB and OSH staff
(personal communication, M. Buckley, June 26, 2007; M. Godfrey, personal
communication, January 26, 2007), it was viewed as uneconomical and was
closed in 2003 due to a lack of state funding. In 2003, the 41A Community Re-
Entry Program was developed based on elements first used by TLC; however,
this program was designed to serve more people and is more economical in its practices (personal communication, K. Mulkey. January 15, 2007).

Historical OSH data were gathered for the three different inpatient treatment modalities just described, and subsequent community reintegration data were also collected from the PSRB for all identified subjects. The outcome data included recidivism rates and measures of community success as defined by the number of community revocations and the associated reasons for revocation, length of time in the community, and type of residential care in the community (e.g., residential, independent living).

**Hypotheses**

It was expected that the TLC group would demonstrate higher rates of community success due to the increased level of social and adaptive skills training treatment exposure. Specifically, it was predicted that individuals who participated in the TLC treatment program before being discharged into the community would evidence a longer period of conditional release, have a lower rate of revocation and a lower rate of recidivism, and transition into a higher level of independent housing. Although several researchers have evaluated the effectiveness of milieu therapy, community re-entry programs, and skills training programs individually, none have yet to compare such treatments using community outcome measures, other than recidivism, as a marker of a successful community transition. Additionally, no prior research has included all three treatments in one study.
METHOD

Subjects

This study included a total of 581 subjects, with 467 (80.4%) males and 114 (19.6%) females. All had been found guilty except for insanity (GEI) in the State of Oregon. As such, they were completing their sentence under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB). Due to confidentiality procedures in place at OSH, further demographic data were unavailable.

From the diagnostic information available, subjects had primarily been given the following primary diagnoses: 18% Schizophrenia ($n = 104$), 14.5% Bipolar Disorder ($n = 84$), and 17.4% Schizoaffective Disorder ($n = 101$). The subjects were identified through historical data and were categorized based on their past treatment participation: 251 subjects had transitioned through Milieu therapy, 44 had engaged in the 41A Community Re-Entry Program, and 286 had participated in the Transitional Living Center (TLC).

Procedure

After approval was obtained from the Pacific University Institutional Review Board and the OSH Institutional Review Board, data collection was initiated. Data for the three OSH treatment groups (i.e., Milieu, 41A, and TLC) were acquired from institutional records maintained by the unit social workers. Once subjects were identified for each treatment group, community reintegration data collection was initiated within the PSRB Portland office. PSRB staff de-identified the necessary data.
from the comprehensive PSRB database. The community reintegration outcome measures provided for each subject included date of PSRB sentencing and expiration, date of OSH admission, date of OSH discharge, criminal activity while under the PSRB (i.e., criminal arrests), number of community revocations (i.e., date revocation order was issued), and reason and type of residential housing while in the community. Residential housing data were acquired and maintained by the PSRB office beginning in 2002; thus, subsequent housing data for those in the community prior to 2002 could not be obtained.

Once data were obtained, four research assistants were each provided with one-half of each data set (i.e., OSH and PSRB) to enter into a database. These data were later cross-analyzed for accuracy. The research assistants then combined the two data sets into one comprehensive database to include both OSH treatment information and PSRB community reintegration outcome data for each subject. All data were analyzed for accuracy. For individuals who experienced multiple treatment exposures over numerous years, their first treatment exposure was used for the purposes of this study. Given that community housing records were not kept by the PSRB office until 2002, this outcome variable was eliminated from investigation. Data were analyzed using SPSS 14.0 (SPSS, Inc., 2005).
RESULTS

As described earlier, this study was designed to evaluate the effectiveness of three different inpatient treatment modalities for preparing patients for transition into the community. I hypothesized that the Transitional Living Center (TLC) group would demonstrate higher rates of community success than either the 41A Community Re-Entry or Milieu groups due to the increased level of social and adaptive skills training treatment exposure. Specifically, I predicted that individuals who participated in the TLC treatment program before being discharged into the community would evidence a longer period of conditional release, a reduced rate of revocation, and a lower rate of recidivism.

Hypothesis Testing

Three outcome variables were assessed: recidivism, revocation rate, and length of time in the community. Regarding recidivism, only 2 subjects out of the total sample \( n = 581, 0.3\% \) received criminal charges while on conditional release. Both subjects were from the Milieu group, and the criminal charges included Burglary I and Unlawful Use of a Motorized Vehicle (UUMV). Given the minimal rate of recidivism, I was unable to conduct additional analyses.

The second variable, revocation rate, included not only the frequency of revocation for each treatment group, but also the reasons for revocation. Possible reasons for revocation, as defined by the PSRB supervising body, included deterioration of mental health, violation of conditional release agreement,
escape/absconding, inability to be controlled adequately in the community, voluntary OSH admission, use of alcohol and/or drugs, recidivism, being sent to a correctional facility, and posing a danger/threat to others (personal communication, M. C. Buckley, 2007). Information for this variable was obtained for a total of 325 participants. The ranges and means for this variable are reported below in Table 2, as are the comparable statistics for total time in the community.

Table 2

*Time in community and revocations (N = 325)*

<table>
<thead>
<tr>
<th>Variables</th>
<th>TLC Group (n = 194)</th>
<th>Milieu Group (n = 121)</th>
<th>41A Group (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Time (years) in the Community</td>
<td>6.19 4.81 0 17.69 2.69 0 8 2.26 1.01 0.63 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Community Revocations</td>
<td>0.75 1.32 0 6 2.20 1.44 0 7 2.20 1.81 1 6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The second outcome variable was examined using an Analysis of Variance (ANOVA) comparing the three groups on number of community revocations. The ANOVA Levene’s test assumes equal variance (Levene, 1960); this assumption was violated. Given the inequality of the treatment groups, a Welch and Brown-Forsythe analysis was conducted. Using the median instead of the mean, the Welch and Brown-Forsythe takes the nonnormal data into account and assumes heterogeneity in variance (Welch, 1947).
A one-way between-groups ANOVA was conducted to explore the impact of treatment on the number of community revocations. There was a statistically significant difference in revocations for the three treatment groups, \( F(2, 322) = 8.60, \ p = .00 \). The effect size, calculated using an a priori alpha level, was .0167. Post-hoc comparisons using the Scheffe test indicated that the mean score for the TLC group (\( M = 0.75 \) revocations, \( SD = 1.32 \)) was significantly lower than the 41A (\( M = 2.20 \) revocations, \( SD = 0.57 \)) and Milieu groups (\( M = 1.23 \) revocations, \( SD = 1.44 \)). However, the number of revocations for the Milieu group was not significantly different from the number of revocations for the 41A group.

The revocation variable was differentiated by treatment group for both the number of revocations and reason for revocation. The TLC group demonstrated the lowest mean score of revocations with the most common reasons being a deterioration of mental health and a violation of conditional release order. The predominant reason for revocation of both the 41A and those in the Milieu program were deterioration of mental health and violation of the conditional release order. The reasons for revocation variable results are shown below in Table 3.

The third outcome variable, time in the community, was examined using an ANOVA comparing the three groups on length of time in the community. The ANOVA Levene’s test assumes equal variance (Levene, 1960); this assumption was violated. Given the inequality of the treatment groups, a Welch and Brown-Forsythe analysis was conducted. Using the median instead of the mean, the Welch and Brown-Forsythe takes the nonnormal data into account and assumes heterogeneity in variance (Welch, 1947).
Table 3

Reasons for community revocation \((N = 325)\)

<table>
<thead>
<tr>
<th>Reason for Community Revocation</th>
<th>Total Sample</th>
<th>TLC Group ((n = 194))</th>
<th>Milieu Group ((n = 121))</th>
<th>41A Group ((n = 10))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Deteriorated mental health</td>
<td>14.2</td>
<td>11.2</td>
<td>17.6</td>
<td>11.4</td>
</tr>
<tr>
<td>Violated release agreement</td>
<td>5.8</td>
<td>5.6</td>
<td>5.9</td>
<td>6.8</td>
</tr>
<tr>
<td>Escaped/absconded</td>
<td>1.9</td>
<td>2.8</td>
<td>1.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Not adequately controlled</td>
<td>1.3</td>
<td>1.7</td>
<td>1.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Voluntary hospital admission</td>
<td>1.5</td>
<td>1.7</td>
<td>1.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Used alcohol/drugs</td>
<td>1.0</td>
<td>0.7</td>
<td>1.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Recidivism</td>
<td>0.2</td>
<td>0.0</td>
<td>0.8</td>
<td>0.0</td>
</tr>
</tbody>
</table>

A one-way between-groups ANOVA was conducted to explore the impact of treatment on the length of time in the community (shown in Table 2). There was a statistically significant difference in days in the community for the three treatment groups, \(F(2, 578) = 70.3, p = .00\). The effect size, calculated using an a priori alpha level, was .0167. Post-hoc comparisons using the Games-Howell test indicated that the mean score for TLC \((M = 2261.66 \text{ days } [6.19 \text{ years}], SD = 1756.18)\) was lower than the 41A \((M = 825.77 \text{ days } [2.26 \text{ years}], SD = 371.02)\) and Milieu group \((M = 983.76 \text{ days } [2.69 \text{ years}], SD = 718.63)\). However, the time in community for the Milieu group was not significantly different from the time in community for the 41A group.
DISCUSSION

In this study, I sought to evaluate the effectiveness of three different inpatient treatment modalities in a psychiatric hospital and their influence on patients’ transition into the community. Although several researchers have evaluated the effectiveness of milieu therapy, community re-entry programs, and skills training programs individually, none have yet to compare such treatments using community outcome measures other than recidivism as a marker of a successful community transition. Additionally, current research has not compared all three treatments to each other. Given the shift toward serving this population in the community and not just in the hospital, it is important to consider factors that support these individuals in remaining in the community safely and as long as possible.

I hypothesized that the TLC group would demonstrate higher rates of community success than would the Milieu or 41A Community Re-Entry groups due to the increased level of social and adaptive skills training treatment exposure in that program. Specifically, I predicted that individuals who participated in the TLC treatment program before being discharged into the community would evidence a longer period of conditional release, a reduced rate of revocation, and a lower rate of recidivism.

Summary of Results

Regarding recidivism, only 2 subjects out of the total sample \((n = 581, 0.3\%)\) received criminal charges while on conditional release and both subjects were from
the Milieu group. Given the minimal rate of recidivism, no additional analyses were conducted.

The second variable, revocation rate, included not only the frequency of revocation for each treatment group, but also the reasons for revocation. Subjects who participated in the TLC treatment program had significantly fewer revocations than did those who participated in either the Milieu or the 41A program. There was no significant difference between those who participated in the Milieu program and those who participated in the 41A program on this variable. Thus, the hypothesis was supported for this outcome measure.

In the TLC group, the most common reasons for revocation were a violation of conditional release order and use of alcohol or drugs. The predominant reasons for revocation of the 41A group were deterioration of mental health and violation of the conditional release order, whereas individuals in the Milieu program were primarily revoked for a deterioration of mental health or a violation of the conditional release order.

The third outcome variable was length of time in the community. Subjects who participated in the TLC treatment program resided in the community for a significantly and substantially longer period of time than did those who participated in either the Milieu or the 41A program. There was no significant difference between those who participated in the Milieu program and those who participated in the 41A program. Thus, this hypothesis was also supported.
Comparison to Prior Research

These results are especially interesting when viewed in light of previous research. Researchers have noted that recidivism is frequently used as the primary outcome criterion for evaluating community success, yet the use of recidivism alone with a insanity acquittee population does not provide sufficient useful information (Bloom & Williams, 1986; Cohen, Spodak, Silver, & Williams, 1988; Steadman & Braff, 1983; Tellefson, 1992). Other authors have suggested that other measures of successful community reintegration should be considered (Tellefson, 1992).

Interestingly, supporting this concern regarding the usefulness of recidivism as an outcome measure, the results of the current study indicated a recidivism rate of 0.3%, a rate so small it did not qualify for additional analysis. For the purposes of this study, recidivism was defined as the occurrence of criminal charges. One issue that has been discussed in relevant literature is that the specific variable of recidivism is often too crude a measure to accurately describe outcome (Davies, Clarke, & Duggan, 2004; Simpson, Jones, Evans, & McKenna, 2006) because its definition is not always consistent. For example, recidivism has been defined by some researchers as reconviction (Simpson et al., 2006), whereas others have measured it in terms of arrest rates (Spodak et al., 1984). Another criticism suggested by the literature is the tendency for recidivism to be equated with treatment failure, an inappropriate and far too easily made association (Bloom & Williams, 1986; Steadman & Braff, 1983). As a result of the extremely low frequency with which recidivism appeared to occur in the current study, the information provided by the recidivism data was limited; however, based on the current results, it is fair to say that drawing a conclusion
between recidivism and treatment success or failure, or success, would be ill-advised with this sample.

Although not as widely studied, another indicator of community success is the revocation of an acquittee’s conditional release. Research by Monson et. al (2001) revealed a revocation rate of between 35% and 50% of conditionally released insanity acquittees. In research conducted by Callahan (1998), the most common reason for revocation was identified as risk/dangerousness and the second most common reason was concern regarding mental health status. In the current study, a total revocation rate of 25% was found, with the most common reason for revocation across groups being deterioration of mental health and the second most common having been a violation of the conditional release agreement. The TLC group was the least likely to experience a revocation.

The reason for the lower current total revocation rate of 25%, as compared to Monson et. al’s (2001) finding of a revocation rate between 35% and 50%, is unknown. It is possible that the rate of voluntary hospital admissions in OSH, which were an available resource until 2002, may have affected this result. Such admissions would not be considered a revocation and thus would not have been captured in these data.

Length of time in the community is an important, although overlooked, standard for success, given that the deinstitutionalization movement has caused the number of state hospital beds in use to decrease from a high of 559,000 to 21,000 in the last 40 years (Bigelo et al., 1999; Lamb & Bachrach, 2001). This movement has resulted in the conditional release of insanity acquittees who have been transferred
from institutions and into society. Given this surge in moving individuals from the hospital and into the community, thereby reducing the number of hospital beds for them to return to, knowing how long they remain in the community and the reasons associated with extending their time in the community are important criteria of success. Unfortunately, length of time in the community has not been widely investigated.

In an evaluation of insanity acquittee conditional release programs in four states (Connecticut, Maryland, New York, and Ohio), Callahan (1998a) found the overall mean length of time in the community prior to revocation was 1.7 years. In the current study, the 41A group maintained an average of 2.26 years in the community, the Milieu group maintained an average of 2.69 years, and the TLC group maintained an average of 6.19 years. These results are substantially longer than those reported by Callahan (1998a), even for the two groups with the lowest number of days in the community. Although the causes of this result are unknown, it is possible that the increased length of community time is evidence of the treatment effectiveness.

The TLC program included a comprehensive experiential component unreplicated in either the Milieu or the 41A Community Re-Entry program that replaced TLC. The opportunity to wholly simulate the community environment within the grounds of the hospital allowed those participating in TLC to immerse themselves in the community experience while maintaining the associated support and structure of the hospital. Included was a treatment plan focused on helping acquittees deal with the practical problems of daily living while simultaneously
balancing their mental health and the confines of their legal status, in preparation for similar community demands. Through the provision of the TLC program, acquittees were exposed to the realization that the basic abilities of everyday living are learned skills, and that such capabilities are not talents granted to others and not them. Such immersion ensured the development of necessary skills to successfully maintain for a greater period of time and with fewer negative consequences than other treatment groups.

The strength of the TLC program lay not only in its ability to properly simulate the community experience, but also in its ability to ease the problems associated with transition. Individuals making a transition from hospitals and into the community are frequently unable to manage the immediate stress and demands of such arrangements, causing them to either decompensate or recidivate. As a result, it is best to release many acquittees to graduated lower levels of care and structure.

Given that discharging acquittees directly from the Milieu or 41A treatment programs provided a lower rate of community success (i.e., length of time in the community, increased revocations), these programs may be better utilized as stepping stones toward discharge with a program like TLC being the last step.

Although this study did not include an investigation into the cost of the programs, financial issues are worth noting. Such programs are often discontinued due to their associated costs and limited availability when considering the number of acquittees needing to be served. The issue of cost can be considered from multiple vantage points. For the purposes of this research, it is worth considering that the costs associated with acquittees returning to the hospital as a result of revocation may
counterbalance the costs associated with the TLC program. Stated in another way, the preventative costs of the TLC program may be worth the curative costs of earlier rehospitalization.

Implications of the Results

The maintenance and treatment of insanity acquittees in the community has become a progressively urgent issue due to the increased emphasis on their transition from the hospital and into the community. Maintenance of insanity acquittees in the community must include a balance of both community safety and individual rights, a balance considered in the treatment provisions as well. Treatment focused on preparing acquittees for community living must integrate the realities of such living, including independent functioning and the creation and maintenance of internal and external controls that prevent them from behaving violently.

The current results suggest constructive implications regarding the effectiveness of the TLC program (which was discontinued in 2003, five years prior to the initiation of this study). Those who participated in the TLC program demonstrated a higher level of community success as evidenced by their reduced number of revocations and superior length of time in the community. Although it was not possible in this quasi-experimental study to identify specific causes for the TLC group’s reduced number of revocations and longer time in the community, one possibility is that the TLC program included a comprehensive experiential component unreplicated in either the Milieu or the 41A program that replaced TLC, as discussed previously.
The strength of the TLC program may have been not only its proper simulation of the community experience, but also the provision an environment that eased problems associated with transition. Individuals making a transition from hospitals into the community are frequently unable to manage the immediate stress and demands of such arrangements, causing them to either decompensate or recidivate (Lamb & Peele, 1984). As a result, it is best to release many acquittees to graduated lower levels of care and structure (Presly et. al, 1982). Although discharging acquittees directly from the Milieu or 41A treatment programs provided a lower rate of community success (i.e., length of time in the community, increased revocations), as noted earlier, such programs could be utilized as stepping stones towards discharge with TLC being the final step.

Although I did not compare the cost of such programs in the current study, it is worth noting this factor. Such programs are often discontinued due to their associated costs and limited availability when considering the number of acquittees needing to be served (Rothbard et. al, 1998). The issue of cost can be considered from multiple vantage points, however. It is worth considering that the costs associated with acquittees returning to the hospital as a result of revocation may counterbalance or exceed costs associated with a program such as TLC. The preventative costs of the program may balance the curative costs of earlier rehospitalization.

Strengths and Limitations of the Present Study

In this study I investigated an expansion of the definition of community success as it pertains to insanity acquittees. One strength of the study was the inclusion of additional factors for evaluation of community success (specifically
length of time in the community). It seems likely that the expansion of the community success standard may have facilitated the discovery of programmatic differences and strengths. An additional strength was the comparison of all three treatments against each other.

Although these results supported the hypothesis, the findings should be tempered by a few considerations. First, it is worth noting that the 41A Community Re-Entry program was not begun until 2003. Given that the data for both the Milieu and TLC group go as far back as the 1980s, the 41A group was not afforded a comparable amount of time to remain in the community, which in turn may have resulted in an unfair comparison. Data from a parallel time period might well offer a different result. In particular, the pressures associated with community release since the beginning of the 41A program may be different than those faced by individuals who transitioned previously.

Second, although all available subjects who had been exposed to at least six months of treatment and discharged into the community were included in the 41A group, only 44 subjects met the criteria for inclusion, as compared with 251 subjects in the Milieu and 286 subjects in the TLC groups. Although the differences in treatment group size did not compromise the integrity of the statistical analyses, it is worthwhile to keep this fact in mind when considering the practical aspects of the results. Future research with a larger 41A sample would be beneficial. Further, a longitudinal study that encompassed additional follow-up data for the 41A program may evidence richer results. It is quite possible that the use of a smaller group of
subjects who were matched for diagnosis and other confounding variables may provide additionally meaningful results.

Conclusions

This study was designed to evaluate the effectiveness of three different inpatient treatment modalities in a psychiatric hospital and their influence on preparing patients for transition into the community. It was found that those who participated in the TLC program demonstrated a higher level of community success as evidenced by their longer length of time in the community with fewer revocations. Thus, factors present in the TLC program, such as social skills training through the development of patient self-awareness and interpersonal skills, should be considered as potential predictors of community success.
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