California State University, San Bernardino

CSUSB ScholarWorks

1996

Indicators of delay between recommendation for community outpatient treatment and release into a conditional release program

Dennis Howard Littlefield

Eric Harley Summers

Follow this and additional works at: https://scholarworks.lib.csusb.edu/etd-project

Part of the Clinical and Medical Social Work Commons

Recommended Citation

INDICATORS OF DELAY BETWEEN RECOMMENDATION FOR

COMMUNITY OUTPATIENT TREATMENT AND RELEASE

INTO A CONDITIONAL RELEASE PROGRAM

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master

of

Social Work

by

Dennis Howard Littlefield

and

Eric Hartley Summers

June 1996

INDICATORS OF DELAY BETWEEN RECOMMENDATION FOR

COMMUNITY OUTPATIENT TREATMENT AND RELEASE

INTO A CONDITIONAL RELEASE PROGRAM

A Project

Presented to the

Faculty of

California State University,

San Bernardino

---

by

Dennis Howard Littlefield

Eric Hartley Summers

June 1996

Approved by:

_____ $6-1-96$
Dr. Morley Glicken, DSW, Project Advisor,   Date
School of Social Work

_____
Dr. Teresa Morris, PhD, Chair of Research
Sequence, School of Social Work

_____
William Summers, MSW, Executive Director,
Patton State Hospital

ABSTRACT

A closed-case review of fifty-five charts of former

Patton State Hospital patients determined to be not

guilty by reason of insanity of a crime was conducted

to determine factors which predicted a significant

delay between recommendation for and acceptance into a

conditional release program (CONREP). The variables

Instant Offense, Substance Abuse, and Previous

Hospitalization were found to be accurate predictors of

delay between recommendation and acceptance into

CONREP. Suggestions for further research were given.

TABLE OF CONTENTS

LIST OF TABLES

Introduction

The mentally ill who have been found not guilty of a crime by reason of insanity (NGRI), appear to be at risk in several areas when confronted with the judicial system. Legal ramifications of criminal activity often require involuntary commitment into a forensic psychiatric hospital setting where evaluations for release are made on the level of danger to self, others and/or the community as a result of mental illness. Once it has been determined that the individual is no longer considered to be a danger to themselves or others, it is recommended that he or she be returned to the community, generally in a conditional release program (CONREP). At this juncture, there may be several variables which hinder the individual's timely return to the community including community fear of recidivism. However, identifying these variables which lead to a delay in community placement has yet to be accomplished.

In the area of forensic psychiatry, there is minimal research to determine the predictors of re-hospitalization. Some research does describe those individuals found to have committed a crime but who

have been determined by a court of law to be not guilty

by reason of insanity (NGRI). However, no clear

patient profile has been developed that predicts, with

accuracy, those NGRI patients who will re-offend or be

re-hospitalized.

Purpose of the Study

The purpose of this study is to determine whether

the factors which predict recidivism of NGRI patients

in Community Out-patient Treatment (COT) also inhibit a

patient's release into a conditional release program

(CONREP).

Operational definitions.

Conditional Release Program (CONREP): A
county supervised program mandated at the
state level to provide aftercare services to
patients criminally committed to the State
Department of Mental Health for treatment.

Not Guilty by Reason of Insanity (NGRI): A
plea submitted to the court by a person who
has been determined to have committed a given
crime, but due to mental illness or defect,
is not responsible for his or her actions.

Community Outpatient Treatment (COT):
Recommendation made to the superior court of
the committing county that a patient be
returned to that county for continued
treatment, as the patient is no longer a
danger to the community or themselves.

Instant Offense: The crime committed by the
patient that has been determined to have been
influenced by the patient's mental disorder.

2

Mentally ill individuals face an assortment of difficulties because of cognitive and/or affective processes that may be altered because of their illnesses and which hinder their ability to adequately function in our social environment. New research using brain imaging techniques is beginning to show that biological science is close to proving empirically that thought disorders such as schizophrenia, the most commonly diagnosed mental disorder of the NGRI patient, are a neuropathological disease process which do not appear to be caused solely by environmental factors (Taylor 1980). Structural changes in the brain with other cognitive and affective disorders such as Bipolar disorder are beginning to be recognized as a substantial reason for the dysfunction as well (Taylor, 1980). These disorders can place many of the mentally ill at risk for inappropriate behavior. Often this behavior conflicts with social and legal expectations and brings them into the judicial system.

Judicial System

Once in the judicial system, a determination must be made whether the mentally ill meet the requirement of sanity, or, Mens Rea if the accused raises it as a defense. Mens Rea asks whether the individual realized that the act that he or she was committing was a crime,

and did they intend to commit a crime at the instant of offense (California Penal Code 1026). If this requirement is not met, they may be found Not Guilty by Reason of Insanity (NGRI). At this point, the assessment focus shifts from insanity to the patient's level of danger to him/herself and others as well as their capacity to manage their behavior effectively enough to rejoin society.

Some critics view the insanity defense as a loophole to escape punishment. A study by Silver, Cirincione and Steadman (1994) shows that the public overestimates both the use and the successful acquittals of NGRI. The authors further found that the public underestimates the confinement of NGRI acquittals (Silver, Cirincione and Steadman, 1994). Society expects a penalty for all criminal behavior, whether the perpetrator is found to be sane or not. Studies indicate that there are equal or longer periods of detention for insanity acquittals compared to correctional detention for similar crimes (Harris, Rice, Marnie and Cormier, 1991; Steadman, 1985; Pogrebin, Regoli and Perry, 1986). Society often places greater importance on time of confinement for a crime than the potential to re-offend at the time of release.

Hospitalization

Hospitalization is the first link between the judicial and the mental health system which an individual faces once he or she is determined to be NGRI. Once in the forensic hospital system, the focus changes from punishment to treatment. A study by Baldwin, Mendito, Beck and Smith (1992) shows that the best indicators of the length of stay, or number of days in the hospital for NGRI patients, is severity of the instant offense as defined previously. However, the authors also point out that the severity of the instant offense should be no more important than any other variables in determining length of treatment because the assessed level of danger is the determinant for community placement.

Potential to re-offend and competence in controlling one's behavior in the community are evaluated in the hospital. Treatment goals and opportunities are agreed upon with the patient. Options in treatment include group therapy, individual therapy, participation in day treatment and socialization programs that provide structure for the patient to gain insight into their illness and criminal behavior. In order to be recommended for release into the community, the treatment team must assess the patient's level of danger and therapeutic insight.

5

This level must be determined to be stable and maintainable with the support of resources provided in the patient's community.

Community Placement

A patient is recommended for Community Outpatient Treatment (COT) when the clinical treatment team assesses the patient to no longer be a danger to themselves or to others. To meet this criteria, a patient's behavior must be stable. They must have gained insight into their illness and crime and understand and recognize the need to seek therapeutic intervention when their behavior and mental processes become problematic. The decision to recommend outpatient status is a major turning point in the care of the forensic patient (Silver and Tellefsen 1991).

In general, there are two options available for community release. The first option is direct release from the hospital without required treatment. The second option is release from the hospital into a conditional release program (CONREP). These decisions ultimately made by the courts, are made with the input of both the treatment team as well as CONREP. Those who have been released from the hospital without required treatment have either completed the maximum term of confinement and have been assessed as no longer

6

dangerous, or they have had their judgement of sanity restored by the court.

There is an extensive amount of literature in support of placement in a conditional release programs (McCafferty and Dooley, 1990; Weideranders, 1992; Tellefsen, Cohen, Silver and Daughterty, 1992). These studies have determined that patients paroled through a conditional release program are up to fifty percent less likely to re-offend than are others with similar backgrounds. A restrictive environment greater than that of general parole to the community placed on participants in a conditional release program as well as the ability to revoke community placement before a violation can occur are widely attributed to these findings. Reviews of this literature indicate that conditional release programs are particularly important as a means of balancing the protection of society with the treatment of individuals in the least restrictive environment (Bloom, Williams and Bigelow 1991).

Studies by McGreevy, Steadman, Dvoskin and Dollard (1991) indicate that communities can adequately meet the needs of NGRI acquittals and that the most common condition of release is participation in a treatment program. The court evaluates the patient's ability to function in the community as well as the legal standards which address concerns for public safety and

7

community reactions to discharge. Clients may be clinically ready for discharge, according to the treating Inter-Disciplinary team, but may be required to continue in the hospital setting because of conflicting reports from the CONREP assessment as submitted to the court.

This phenomenon is observable on the hospital treating unit in many individual cases. There are those patients who have reached the therapeutic gain and insight that would allow them to function successfully in the community, according to the treating interdisciplinary team. However, despite a recommendation by the hospital for release into COT, they remain hospitalized in maximum security locked facilities. The reasons for this situation have yet to be explored in the literature.

Literature Review

There is very little information available regarding the factors which affect the length of time elapsed prior to actual release following a recommendation for community release. According to Miller (1993), forensic patients committed involuntarily in Wisconsin were subjected to different release criteria than other committed patients. An overview of difficulties are discussed by Miller,

Maier, Van-Rybeck and Weidemann (1989) which support

the need for equity in release standards. These

difficulties include counter-transference and other

objective issues on the part of those who evaluate

patients for release. While counter-transference

issues exist within all therapeutic contexts, the

hospital treating team provides team interaction to

counter act these issues, whereas many community

release programs operate from the assessment of an

individual.

Several studies indicate a particular need for

utilization of CONREP services. Bloom and Williams

(1992), recommend conditional release for schizophrenic

patients with extensive histories of crime and hospital

use. Greenberg, Shah and Seide (1993) believe that the

chronically mentally ill are becoming entrenched in a

fragmented system of treatment and incarceration. The

researchers also suggest that because of limited

ability to perform reality testing and the maintenance

of bizarre beliefs and behavior, the severely

psychiatrically ill are more likely to be recidivists.

According to Abdalian, Dabell, Polonsky, Rein and

Williams (1992), primary predictors of COT revocation

include seriousness of instant offense, severity of

substance abuse history, and number of prior

hospitalizations. The rate of those who re-offended

and fit the predictors established by Abdalian et. al.
was nearly double those who re-offended but did not
meet the predictors. Weideranders (1990), in a study
of the effectiveness of the California Department of
Mental Health Conditional Release Program, indicates
that the number of prior offenses also assists in
predicting revocation in addition to those predictors
found in Abdalian et. al. (1992). Although these
indicators of revocation predict who is most likely to
be re-hospitalized, only 25% of those predicted in
Weideranders' 1990 study actually did re-offend.
Although a majority of those patients who did re-
offend, fit the predictor categories, a greater number
of those who fit the profile of a recidivist did not
re-offend.

Findings in a study predicting success on
conditional release for insanity acquittees by
Tellefsen, Cohen, Silver, and Daugherty (1992),
concurred with the findings of Abdalian et. al. (1992).
Predictors of failure in a Maryland CONREP program
included seriousness of the instant offense, severity
of psychiatric disturbance as well as substance abuse,
specifically heroin, and the number of prior arrests
(Tellefsen, et. al., 1992). Draine, Solomon and
Meyerson (1994) also found that substance abuse and
arrest record were positive indicators of a return to

incarceration. Holcomb and Ahr (1988) found that alcohol and drug abusers were twice as likely to be arrested for crimes as were non-addicted schizophrenic patients.

Direction of the Study

With a focus on maintaining community safety from re-offense and the awareness of factors predicting revocation, CONREP may hesitate in approving the release of individuals fitting the profile of a potential re-offender. This may be the case even though Weideranders' 1990 study incorrectly predicted those who would be re-hospitalized by a factor of three out of four subjects.

The direction of this study is to determine whether the factors which predict revocation of COT and re-hospitalization also increases the length of time between recommendation for, and eventual release into a conditional release program. In order to evaluate these concerns, the following hypotheses are offered.

H1 The greater the severity of the instant offense the greater the time between recommendation for and acceptance into a COT program.

H2 The greater the presence of psychosis, the greater the time between recommendation for and acceptance into a COT program.

11

H3 The more severe the substance abuse history,
the greater the time between recommendation
for and acceptance into a COT program.

H4 The greater the number of previous psychiatric
hospitalizations, the greater the time
between recommendation for and acceptance
into a COT program.

H5 The greater the number of previous arrests, the
greater the time between recommendation for
and acceptance into a COT program.

Significance of Data

Clinicians, judicial participants and community
representatives all play a major role in the placement
and treatment of NGRI acquittals. This process is of
specific concern to social work, since social workers
are the primary clinicians involved in treatment,
discharge planning and follow up care. The findings of
this study may help to increase the awareness of risk
factors for recidivism among treatment professionals.
Another benefit of the research will be to provide data
regarding the main concerns of the CONREP program in
the care and maintenance of their patients as well as
refine access to needed resources and services. This
may aid in the development of therapeutic techniques to
increase speed in the delivery of services,

specifically discharge, and reduce recidivism.

Relevance of the Study

At present, information exists at most all levels of placement and treatment of the NGRI patient. There is information available regarding the transitional period between the judicial determination and hospital placement. Information is also available about factors affecting recidivism and revocation. However, there is very little information identifying the variables that determine the length of time between the recommendation for and the release back to the community during this transitional period. This study will attempt to determine which factors related to recidivism may contribute to the delay of timely release to the community.

Method

Subjects

Fifty-five closed case charts of Penal Code 1026 (NGRI) patients at Patton State Hospital were reviewed for this study. To ensure that charts of patients from each CONREP program were utilized, stratification of subjects was used. A frequency distribution of the population was run to determine the percentage of patients discharged to each particular program. The sample was drawn randomly from the population of each CONREP program at its given population percentage to fill the sample quota from the naturally occurring population.

Protection of Human Subjects and Informed Consent

To ensure the confidentiality of the patient charts reviewed in this study, names and identifying data of individual patients were not used. A random research number was assigned to each case file during the data collection process only. No information is available to link an individual patient to this study. No personal contact with subjects was made, to ensure that physical, psychological, and social risks to the patients would be minimal.

Due to the nature of the study and the use of closed case chart review, it was not be feasible to return to the community to ask informed consent of the

14

subjects. No personal involvement of selected participants with this study was required at any time. Personal identifying information was also not used. However, human subjects approval for this project was given by the California State University, San Bernardino; Patton State Hospital Research Committee; The Executive Director and Medical Director of Patton State Hospital; the Deputy Director of the California Department of Mental Health, Long Term Care Services; and the State of California Health and Welfare Agency Committee for the Protection of Human Subjects.

<u>Materials</u>

Five variables were analyzed for their impact on the placement process into CONREP using the following scales:

1. Severity of Instant Offense (low, moderate, high). An ordinal scale developed by Abdalian, Dabell, Polonsky, Rein and Williams (1992) was used to classify severity of instant offense. This scale was developed using numerical codes ascribed by the California Department of Justice to criminal offenses as a means of ranking severity. This scale was used in the study by the authors as a determinant and predictor for recidivism, based on the authors' findings. See Appendix A.

2. Severity of Psychosis (low, high). Brief Psychiatric Rating Scale (BPRS) was used to evaluate degree of psychotic involvement. The scale was broken down into two equally represented levels at the 50th percentile of the frequency distribution. This scale is used by the treating interdisciplinary team to aid in the treatment and discharge planning of a patient. It is used to determine specific

areas of psychotic disturbance relative to
the patient's behavior and cognition.

3. Substance Abuse (none, mild, moderate, severe)
   an ordinal scale developed by Abdalian,
   Dabell, Polonsky, Rein and Williams (1992)
   was used to determine degree of
   substance abuse history. This scale was also
   developed as a determinant and predictor of
   recidivism by Abdalian et. al. (1992). See
   Appendix B.

4. Number of Previous Hospitalizations (low,
   moderate, high). An ordinal scale was
   developed by dividing subjects into three
   groups at the 33rd and 67th percentile and
   used to classify subjects within three
   levels.

5. Number of Previous Arrests (low, moderate,
   high). An ordinal scale was developed by
   adding the number of previous arrests
   listed on rap sheet and divided with
   representation among the three levels at the
   33rd and 67th percentiles.

A data abstraction sheet was used for each subject
to collect information in these areas. See appendix C.

Procedure

This study was an non-obtrusive archival study of hospital records of NGRI (P.C. 1026) patients who have been released into a CONREP program. The records search covered the years 1989-1996. Randomly selected patient charts were reviewed and data collected for each of the five variables. For the variables with levels already established (Severity of Instant Offense, Substance Abuse), assignment corresponding with the appropriate level were made. For variables without previously calculated levels (Level of Psychosis, Previous Hospitalizations, Previous Arrest), assignment to constructed levels took place as noted in the materials section. Duration of time between recommendation and acceptance into CONREP was measured in weeks between the date of the court report sent by the treating interdisciplinary team and the date of the CONREP report which officially accepted the patient into their program.

Results

Frequency distributions of the variables Previous
Arrest and Previous Hospitalization were run to
determine cut off points for their division into levels
from raw score. The value of the 33rd percentile and
67th percentile for Previous Arrest were 1 and 5
respectively, making the values of each level: low
(0-1), moderate (2-4), and high (>4). The minimum
value was 0, the maximum value 25, and the mean value
for previous arrest was 3.7. Division into the three
levels using the 33rd and 67th percentile provided the
following distribution; low (n=22), moderate (n=16),
high (n=17).

The mean value of Previous Hospitalizations was
4.53 with a minimum value of 0, and a maximum value of
22. Grouping of the variable into the three levels
occurred at the 33rd and 67th percentile whose values
are 1 and 6 respectively. Corresponding values for
each level were: low (0-1, n=24), moderate (2-5,
n=15), and High (>5, n=16).

Oneway Analysis of Variance (ANOVA) was computed
for each of the independent variables. This test was
used to determine the probability that there is no
difference between groups divided among levels from a
sample population in relation to a dependent variable.
The scores of these tests show the probability that

they are from the same sample, and hence the chance

that an error would be made in stating that they are

not of the same sample distribution.

A 1 x 3 (Duration x Instant Offense) Oneway ANOVA

produced a significant difference between groups $F(2,$

54) = 5.1671, $p<.01$ (see **Table 1**). Post-hoc analysis

using Tukey-B showed that there was a significant

Table 1

Oneway ANOVA of Duration by Instant Offense

	DF	Sum of Squares	F
Between Groups	2	7437.2063	5.1671*
Within Groups	52	37422.5027	
Total	54	44859.7091	

    * $p<.01$

difference between the means of the moderate (17.0357)

and high (39.6923) levels of instant offense, as

predicted. Low severity of instant offense (n=1) did

not register in the findings as the count could not

produce a confidence interval.

A 1 x 4 (Duration x Substance Abuse) Oneway ANOVA

also found a significant difference between levels of

substance abusers, $F(3, 51) = 3.1523$, $p<.04$ (see **Table**

2). Further analysis showed that the severe
(mean=37.4828) substance abusers were significantly
different from the none (mean=11.30), low

Table 2

Oneway ANOVA of Duration by Substance Abuse

	DF	Sum of Squares	F
Between Groups	3	7017.0344	3.1523*
Within Groups	51	37842.6747	
Total	54	44859.7091	

  *$p < .04$

(mean=12.3333) and moderate (mean=24.00) subgroups of
substance abusers in duration of time between
recommendation and approval for release into CONREP as
predicted.

In the 1 x 3 (Duration x Previous Arrest) Oneway
ANOVA, there was no significant difference found
between groups, $F(2, 52) = 0.2912$, $p < .75$. However,
means of these subgroups (low, 24.82; moderate, 26.63;
high, 31.88) were higher in the groupings with greater
numbers of previous arrests.

In the 1 x 3 (Duration x Previous Hospitalization)
Oneway ANOVA, a significant difference was found

21

between groups, $\underline{F}(2, 52) = 3.7948$, $\underline{p}<.03$ (see **Table 3**).
However after further analysis it was determined that
those with greater numbers of previous hospitalizations

Table 3

Oneway ANOVA of Duration by Previous Hospitalization

	DF	Sum of Squares	F
Between Groups	2	5713.5049	3.7948*
Within Groups	52	39146.2042	
Total	54	44859.7091	
$\underline{p}<.03$			

had a significantly lower duration than did the low
hospitalization subgroup (high, 16.31; low, 38.92).
Although this finding was significant, it did not show
the direction as suggested in the hypothesis which
predicted that the greater the number of
hospitalizations, the greater the duration between
recommendation for release and acceptance to the CONREP
program.

Multiple regression analysis was used to determine
predictability of the value of Duration (dependent
variable) as a function of the effects of the
independent variables (Substance Abuse, Instant

22

Offense, Previous Arrest, Previous Hospitalization).

Independent variables were entered into the equation

using their strength of association or excluded from it

from a lack of association to the dependent variable.

Values were given listing strength of total association

of the combination of the independent variables

(Multiple R) and the percentage of variance explained

by the entered independent variables (R Square and

Adjusted R Square). Also given were the Beta weights

and B values which measure strength in determination of

change in the dependent variable and degree of change

in the dependent variable with a change in one unit if

the independent variable, respectively.

Multiple regression analysis with the "Forward"

method of inclusion (PIN .050) was used to determine

the strength of the relationship between the

independent variables (Instant Offense, Substance

Abuse, Previous Hospitalization, and Previous Arrest)

and the dependent variable (Duration). The variable

Previous Arrest was found not to have great enough

contribution (PIN <.05) to be included in the

regression equation. Instant Offense, Substance Abuse,

and Previous Hospitalization entered in the regression

equation showed a Multiple R value of .62157, giving an

R Square of .38635, with an adjusted R Square of .35026

explaining 35% of the variance (see **Table 4**). A

Table 4

Multiple Regression with Dependent Variable DURATION

Step	MultR	Rsq	F(Eqn)	Variable	BetaIn
1	.4045	.1637	10.371*	InstOff	.4045
2	.5784	.3346	13.072**	SubstAb	.4144
3	.6216	.3864	10.703**	PrevHos	-.2340

    * $p<.002$

    **$p<.001$

Multiple R	.62157
R Square	.38635
Adjusted R Sq.	.35026
Standard Error	23.23285

regression analysis of variance showed a linear relationship to duration, $F(3, 51)=10.70323$, $p<.0001$ (see **Table 5**).

    The Variance-Covariance matrix suggests that the independent variables are not strongly correlated with each other. Covariance values below the diagonal show small variances implying that the independent variables do not co-vary either (see **Table 6**).

24

Table 5

Regression Analysis of Variance

	DF	Sum of Squares	Mean Square	F
Regression	3	17331.68675	5777.22892	10.703*
Residual	51	27528.02234	539.76514	

*p<.0001

Instant offense had the strongest weighting with B=20.404, and a Beta coefficient of .381. Substance abuse was shown to have the second strongest weighting with B=9.679 and a Beta coefficient of .395. Previous hospitalization gave a negative regression coefficient B=-7.369, and a Beta coefficient of -.234 (see Table 7). Variables not in the equation (previous arrest) showed no linear relationship with duration, T=0.552, p<.58.

Table 6

Variance-Covariance Matrix of Regression Coefficients
(B).

	INSTOFF	SUBSTAB	PREVHOSP
INSTOFF	36.50480	.08572	.22324
SUBSTAB	1.39916	7.29789	.08333
PREVHOSP	5.17001	.86289	14.69165

Below Diagonal: Covariance   Above: Correlation

Table 7

Independent Variables in the Regression Equation

Variable	B	SE B	Beta
INSTOFF	20.403681	6.041920	.380933
SUBSTAB	9.678511	2.701460	.395309
PREVHOSP	-7.952681	3.832969	-.233994
(Constant)	-37.369335	20.644458	

Discussion

Level of Psychosis was not able to be tested as a determinant in this study due to the irregularity of it's availability in the charts reviewed. Only two of the fifty-five charts contained a completed Brief Psychotic Rating Scale (BPRS). Another measure of severity of symptomatology, the Global Assessment of Functioning (GAF) was present in all of the charts reviewed, however, inter-rater reliability would have been suspect, as many charts did not provide face validity. This was evidenced in the many charts that were reviewed that had GAF scores that changed within a range of 20 to 40 points over a one to two week period. The objectivity of this measurement of level of functioning did not allow for the use of Level of Psychosis as a variable in this study. It is suggested that future related studies look at the relevance of this variable to release practices, as more stringent controls of documentation standards regarding the BPRS and other similar assessment tools have been implemented in recent years.

Severity of Instant Offense had the expected effect on the Duration between recommendation and release into COT. Although this finding was expected, the relevance, according to Baldwin et. al. (1992), of instant offense should have no bearing on the length of

treatment or delay in placement into COT. It may be argued that the severity of the instant offense is an indicator of the levels of violence that a patient may engage. However, Abdalian et. al. (1992) found that the committing offense had little bearing on the crime of re-offense, if that patient was to re-offend. In general, it appears as if CONREP program administrators are more unsure of accepting patients with severe instant offenses than those with lesser crimes once they are determined by the treating hospital to be no longer dangerous.

It was also found that in this selected sample, there were few (1) cases where patients who had been committed for a crime of low level of seriousness. Also, fifty percent of the sample taken were committed for crimes which fell in the severe level of seriousness. A type II error could have been made in this instance in that there is truly no difference between groups of Instant Offense due to the over representation of severe offenders in the study. However, since the finding of the ANOVA gave a significance level with less than one percent error, accepting the hypothesis that more severe Instant Offense is related to greater Duration between recommendation for COT and acceptance into CONREP. For future research, it may be preferred to select a sample

to show an even distribution of all levels of
seriousness of crime.

The findings of the study in relation to Substance
Abuse show that CONREP is significantly more cautious
in the acceptance of severe substance abusers to their
outpatient programs. Although extensive substance
abuse treatment programs are available and often
utilized, it appears as though documentation of
progress in these programs is not sufficient to meet
the criterion for release of the CONREP evaluators.
Since the substance abuse treatment programs provided
are off-unit programs, it is possible that a potential
remedy would be improved communication and continuity
of care with the patient's interdisciplinary team.
Also, a clearer definition provided on a case by case
basis from the conditional release program as to
criterion for release may aid in the process of
effective treatment and release.

A Type II error may have also been made with the
variable Substance Abuse. The use of predetermined
levels provided an unequal distribution of cases among
the levels of Substance Abuse. Severe substance
abusers had up to three times the representation of the
other levels (29, 10, 6, 10; severe to none
respectively). This may have led to the overall
difference in mean scores between groups. It may be

suggested for further analysis to select samples to give equal representation to all levels of the variable. However, it is probable that the representation found in this study accurately represents the population found at Patton State Hospital, and can be generalized as it is to that population.

A Type I error may have been made in the statistical analysis of Previous Arrest. Although there was no significant difference between the levels of Previous Arrest, the mean of duration for those levels progressed as predicted through the hypothesis. Those patients with greater number of arrests had a greater mean duration between recommendation and acceptance for release. Greater sample size may have provided data to strengthen the realized trend to the point of significant difference so that the null hypothesis that there is no difference between these groups could be rejected.

The variable Previous Hospitalization provided significant results, however, but not in the direction as predicted in the hypothesis. It was found that Previous Hospitalization was related to a decrease in duration between recommendation for and acceptance to COT. It may be possible to attribute this finding to the idea that most hospitalizations occur in the

patient's home community. This would lead to a greater
knowledge of the patient by community professionals and
an increased level of comfort with reacceptance of the
patient in the community. Also attributable to the
findings in the analysis of Previous Hospitalization is
that with fewer hospitalizations, less is known about
the individual patient and the course of his or her
illness and it's manifestations. This discrepancy
could be rectified through the improvement of social
history evaluations, psychological testing, and
comprehensive psychiatric histories.

Instant Offense, Substance Abuse and Previous
Hospitalization were found to have a significant linear
relationship to duration. Each variable contributed to
the length of duration, but not to each other. The
covariance matrix showed that while each of the three
variables that were entered into the regression
equation (Substance Abuse, Instant Offense, and
Previous Hospitalization) impacted duration, there was
no significant predictability or relationship with the
other variables. Each of these variables was found to
measure a different and unique contributor to duration.

Opportunities for further research in this arena
are plentiful. Other factors that may add to the
explained variance of the prediction equation are:
ethnic identity, race, age at time of recommendation

for COT, presence of an Axis II diagnosis, or personality disorder, specific Axis I and II diagnoses, and individual counties of commitment. Another area of similar study would be the comparison of duration across gender lines; whether or not male and female durations are significantly different among equivalent criteria.

The results of this study may be applied to the future discharge planning for patients who are to be discharged into community outpatient treatment. Clinicians who have patients who fit the predictive indicators for delay into COT may be able to revise and strengthen areas of reports and assessments as discussed above. With the goal of streamlining the effective communication between the hospital interdisciplinary team and eventual CONREP treating team, patients in the future may encounter more time and energy efficient means of preparing for discharge and their return to the community

APPENDIX A

INSTANT OFFENSE RATING SCALE

Seriousness		Offense
HIGH	1	MURDER/MANSLAUGHTER
	2	RAPE
	3	KIDNAP
	4	MOLESTATION
MODERATE	5	ASSAULT/BATTERY
	6	ARSON
	7	CHILD CRUELTY
	8	ROBBERY
	9	EXTORTION
	10	BURGLARY
	11	THEFT
	12	WEAPONS
	13	FALSE IMPRISONMENT
LOW	14	FORGERY/VANDALISM
	15	DRUGS
	16	VICE/DUI
	17	VEHICULAR/HEALTH
	18	MISC. TRIVIAL
	19	ILLEGAL ABORTION

APPENDIX B

SUBSTANCE ABUSE RATING SCALE

NONE   No documented history

MILD   In frequent experimentation, infrequent

           alcohol or marijuana use and not more than

           one drug related arrest

MODERATE   Either long-term use of alcohol or marijuana,

           or several drug related arrests, or use of

           hard drugs ie. cocaine, heroin, PCP etc. more

           than once

SEVERE   Hard core substance abuse, many drug related

           arrests, prior treatment in substance abuse

           programs, and/or substance abuse was

           associated with the instant offense

APPENDIX C

DATA ABSTRACTION SHEET

RESEARCH #_____

DURATION_____

1   SEVERITY INSTANT OFFENSE_____

2   BPRS_____

3   SUBST. ABUSE_____

4   PREV. HOSP_____

5   PREV. ARRESTS_____

REFERENCES

Abdalian, Dabell, Polonsky, Rein and Williams. (1992).
    Mentally Disordered Parolees in a Conditional
    Release Program. Forensic Mental Health
    Association Conference. Apr. 16, 1992. Pacific
    Grove, California.

Allen Jon G, Coyne Lolafaye, Lyle Jan, Spohn Herbert
    E. (1992). Assessing the Need for Extended
    Psychiatric Hospitalization. Comprehensive
    Psychiatry. Sept-Oct Vol 33(9) 346-352.

Baldwin Lee J, Mendito Anthony R, Beck Niels C, Smith
    Sarah M. (1992). Factors Influencing Length of
    Hospitalization for NGRI Acquittees in a
    Maximum Security Facility. Journal of Psychiatry
    and Law. Sum Vol 20(2) 257-267

Bloom Joseph D, Williams Mary H, (1992). The
    Involvement of Schizophrenic Insanity Acquittees
    in The Mental Health and Criminal Justice System.
    Psychiatric Clinics of North America. Sep Vol
    15(3) 591-664.

Bloom Joseph D, Williams Mary H, Bigelow Douglas A,
    (1991). Monitored Conditional Release of Persons
    Found Not Guilty by Reason of Insanity. American
    Journal of Psychiatry. Apr Vol 148(4) 444-446.

Draine J, Solomon P, Meyerson A, (1994). Predictors of
    Reincarceration Among Patients who Received
    Psychiatric Services in Jail. Hospital and
    Community Psychiatry. 45:163-167.

Eisner Harry R, (1989). Returning The Not Guilty By
    Reason Of Insanity to The Community: A New Scale.
    Bulletin of the American Academy of Psychiatry and
    the Law. Vol 17(4) 401-413.

Greenberg William M, Shah Pritesh, Seide Marilyn.
    (1993). Recidivism on an Acute Psychiatric
    Forensic Service. Hospital and Community
    Psychiatry. Jan Vol 44(6) 583-585.

Harris Grant T., Rice Mannie E., Cormier Cathrine A.
    (1991). Length of Detention in Matched Group of
    Insanity Acquittees and Convicted Offenders.
    International Journal of Law and Psychiatry.
    Vol 14(3) 223-236.

Holcomb WR, Ahr PR, (1988). Arrest Rates Among Young
    Adult Psychiatric Patients Treated in Inpatient
    and Outpatient Settings. Hospital and Community
    Psychiatry. 40:52-57.

McCafferty Gerry, Dooley Jeanne. (1990).
    Involuntary Outpatient Commitment: An Update.
    Mental and Physical Disability Law Reporter. Jan.
    Vol 14(3) 277-287.

McFarland B, Faulkner 1, Bloom J et al. (1989). Chronic
    Mental Illness and the Criminal Justice System.
    Hospital and Community Psychiatry. 40:718-723.

McGreevy Margaret A, Steadman Henry J, Dvoskin Joel
    A, Dollard Norin. (1991). New York State's System
    of Managing Insanity Acquittees in the Community.
    Hospital and Community Psychiatry. May Vol 42(5)
    512-517.

Miller Robert D. (1993). The Criminalization of the
    Mentally Ill. Journal of Criminal Behavior and
    Mental Health. Vol 3(4) 241-250.

Miller Rodney K, Maier Gary J, Van-Rybeck Gregory J,
    Weidemann Judy A, (1989). Treating Patients
    Doing Time: A Forensic Perspective. Hospital and
    Community Psychiatry. Sep Vol 40(9) 960-962.

Miraglia Giglio, (1993). Refining An Aftercare Program
    for New York State Outpatient Insanity Acquittees.
    Psychiatric Quarterly. Fal Vol 64(3) 215-234.

Pogrebin Mark, Regoli Robert, Perry Ken. (1986). Not
    Guilty by Reason of Insanity: A Research Note.
    International Journal of Law and Psychiatry. Vol
    8(2) 237-241.

Silver Eric, Cirincione Carmen, Steadman Henry J.,
    (1994). Demythologizing Inaccurate Perceptions of
    the Insanity Defense. Law and Human Behavior.
    Feb 18(1) 63-70.

Silver Stuart B., Tellefsen Christianne, (1991).
    Administrative Issues in the Follow-up Treatment
    of Insanity Acquittees. Journal of Mental Health
    Administration. Fal Vol 18(3) 242-252.

Steadman Henry J., (1985). Empirical Research on the
    Insanity Defense. Annals of the American Academy
    of Political and Social Sciences. Jan 477 58-71.

Taylor Edward H., (1980). Biological Basis of
    Schizophrenia. <u>Social Work.</u> Mar-Apr 118-121.

Tellefsen Christianne, Cohen Marcia I., Silver Stuart
    B., Daugherty Catherine. (1992). Predicting
    Success on Conditional Release for Insanity
    Acquittees. <u>Bulletin of the American Academy of
    Psychiatry and the Law.</u> Vol 20(1) 87-100.

Weideranders Mark R., (1992). Recidivism of Disordered
    Offenders Who Were Conditionally VS
    Unconditionally Released. <u>Behavioral Science and
    the Law.</u> Vol 10(1) 141-148.

Weideranders Mark R.(1990). The Effectiveness of the
    Conditional Release Program a Report to the
    Legislature in response to Chapter 1416 Statutes
    of 1985. Department of Mental Health. Sacramento
    California.

Werner Paul D., Meloy J. Reid. (1992). Decision Making
    About Dangerousness in Releasing Patients From
    Long Term Psychiatric Hospitalization. <u>Journal of
    Psychiatry and Law.</u> Vol 20(1) 35-47.