Forensic Community Programs: Recommendations for the Management of NCRMD Patients in the Community

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ABSTRACT. Recent trends towards community support and rehabilitation for individuals found Not Criminally Responsible due to a Mental Disorder (NCRMD) has led to the development of forensic community programs (FCP). The authors of the present paper were contacted by professionals involved with an FCP established at a hospital in Nova Scotia, Canada. The professionals involved with this FCP were interested in improving the overall functioning (in terms of client management and treatment, and risk reduction) of the program. The current article will discuss the eight main considerations and recommendations that were provided...
Recent trends within the criminal justice system towards community support and rehabilitation have led to the development of forensic community programs (FCP). These FCPs have been used, in conjunction with psychiatric hospital services, as a management strategy for mentally ill offenders. Specifically, these outpatient programs have been created to both assist and monitor mentally ill offenders who have been found not criminally responsible, and who have been granted a conditional discharge into the community. Additionally, some individuals participating in FCPs may have been discharged directly into the community following their finding of Not Guilty by Reason of Insanity (NGRI) or Not Criminally Responsible due to a Mental Disorder (NCRMD), and were never inpatients at a forensic psychiatric facility.

In general, FCPs are responsible for providing client treatment plans, medication and symptom management, assessment and management of risk, client supervision, and rehabilitation measures to NCRMD clients in the community. Further, the directives of forensic community services are to ensure public safety while addressing the client’s individual rehabilitation needs (e.g., Lamb, Weinberger, & Gross, 1999).

Prior to the establishment of FCPs, services available for NCRMD individuals in the community were deemed to be inadequate; with support, supervision, and follow-up being minimal or non-existent. For example, Golding, Eaves, and Kowaz (1988) studied 188 NCRMD patients released into the community after psychiatric hospitalization. Longitudinal follow-up with these patients revealed an average of 2.4 rehospitalizations per individual, and a 63% rate of community supervision violations over a period of approximately 9.5 years. Similarly, McNamara and Andrasik (1982) evaluated recidivism rates in NCRMD patients released into the community. In their sample of 64 mentally
disordered male offenders, 28% were reincarcerated within approximately 2 years of release due to technical parole violations or the commission of new crimes. These researchers suggested that discharge assessments should include information on the post-release environment, and anticipated reactions to that environment, in order to provide a better prediction of community adjustment (McNamara & Andrasik, 1982). Although these studies demonstrated the potential for poor outcomes for NCRMD patients, they did not clearly identify problem areas in community service delivery. More recently, a study by Solomon, Draine, and Meyerson (1994) reported that the recidivism of mentally ill offenders was related to diminished services available to individuals—even when self-requested (as opposed to mandated) by clients. In their study, approximately 33 of 105 NCRMD clients were reincarcerated within 6 months of release into the community. Rehabilitative services were deemed to be lacking for the majority of these patients, in which case management programs monitored mentally ill offenders rather than offering comprehensive community services to enable successful reintegration (Solomon et al., 1994). It was noted that this situation was further complicated by the fact that many NCRMD offenders were unlikely to seek help themselves, and may have felt marginalized and controlled by community workers due to the deterioration of services (e.g., Vaughan & Stevenson, 2002). Research on mentally ill offenders, such as the above, demonstrates the need for development and planning of effective FCPs in order to address shortcomings in the services and treatments allocated for NCRMD patients. In fact, the need for FCPs and their importance to the individual, local community, and the public as a whole is evident.

For several decades now, community programs designed for the management of NCRMD patients has gradually been established on an international scale. As mentioned above, this has become more and more necessary with the move towards decentralization of mental health services for forensic patients from the prisons to community agencies (Laben & Spencer, 1976; Rothbard & Kuno, 2000). For example, in the United Kingdom, several programs have been devised that use a gradual release system from secure psychiatric detention facilities to reliance on community services have been devised (e.g., see Blackburn, 1996). In one such program, an outpatient hostel in London began to treat NCRMD offenders in 1974 and continues to service this population (e.g., the Effra Trust; Robertson & Gunn, 1998). Another example is the forensic outreach team (FOT) at the Maudsley Hospital, established in 1994. This team is comprised of community forensic nurses and psychiatrists, who
provide assessment, management, and treatment of NCRMD patients in conjunction with local community psychiatric agencies in London (Whittle & Scally, 1998). In this case, linkage between psychiatric hospital and community resources was used to provide an integrated service program for mentally ill offenders in the community (Whittle & Scally, 1998). Dale and Storey (2001) have suggested that programs for NCRMD patients in the U.K. need to address key issues in community services such as risk assessments and management, crisis intervention and relapse prevention, assertive follow-up procedures, establishing compliance with patients, providing comprehensive care, and applying a multidisciplinary/multiagency approach. The integration of such forensic specialist and local services is deemed essential in the successful reintegration of NCRMD patients discharged into the community (Dale & Storey, 2001; Sugarman, 1999).

The trend towards community based models of care for NCRMD patients also has been initiated by legal reform in Eastern European countries such as Germany (e.g., Mueller-Isberner, Freese, Joeckel, & Cabeza, 2000), Sweden (e.g., Belfrage & Fransson, 2000), and Finland (e.g., Eronen, Repo, Vartiainen, & Tiihonen, 2000). For example, restructuring of the Swedish forensic psychiatric services from inpatient to outpatient and community management of mentally ill individuals has been modeled after FCPs in Canada and the United States (Belfrage & Fransson, 2000). However, the treatment of mentally ill offenders in some Western European countries remains under the mandate of correctional and secure psychiatric facilities (Ruchkin, 2000), lacking necessary integration of community resources and management. For example, countries such as Russia and Poland have been relatively resistant to the implementation of international reform in the treatment of NCRMD patients (e.g., Ciszewski & Sutula, 2000; Ruchkin, 2000). In addition, legal reforms in Austria have now transferred responsibility for treatment and management of NCRMD patients away from mental health services (primarily psychiatric inpatients) to the Ministry of Justice, granting correctional control over this population of offenders (Schanda, Ortwein-Swoboda, Knecht, & Gruber, 2000). In contrast, large demands on correctional and psychiatric resources prompted legislation changes and the establishment of a community based mental health system in Japan, which functions in part to divert NCRMD offenders from prisons and hospitals (Kuno & Asukai, 2000; Nakatani, 2000).

The development of different models of FCPs has also been widespread in the United States, largely due to the prevalence of mentally disordered offenders and the limited correctional services that are avail-
A survey conducted with criminal justice professionals in Florida in 1983 highlighted the limitations of prisons and mental hospitals in dealing with mentally ill individuals (Nuehring & Raybin, 1986). In general, community support of this population was considered manageable as long as sufficient levels of monitoring, residential care, and treatment were implemented (Nuehring & Raybin, 1986). In line with this, it was estimated that 35-38% of NCRMD patients could be treated effectively in the community rather than in state psychiatric facilities if community services for evaluation and treatment were enhanced (Schutte, Malouff, Lucore, & Shern, 1988).

Mental health and correctional professionals in Massachusetts devised a forensic transition program to provide assistance for community reintegration and 3 months of follow-up after NCRMD patients were discharged (Hartwell & Orr, 1999). This program addressed the need to provide such community support, with 57% of mentally ill individuals discharged living in the community and requiring mental health services. In addition, psychiatric facilities in Wisconsin have implemented the use of a community preparation service (CPS) to aid in the community reintegration of NCRMD patients who have been detained in state hospitals for durations of 2 to 20 years (Maier, Morrow, & Miller, 1989). This service provides community living skills programs, release planning groups, patient buddy systems, meetings with community leaders, and a 3-month period of hospital to community orientation involving numerous community outings. Although follow-up data has not been reported to date on the subsequent success of NCRMD patients that have participated in this program, it was reported that no community excursions (including unsupervised outings) had resulted in criminal charges against patients during 7 years of operation (Maier et al., 1989).

Developments in Canadian law have reflected the increased need to deal appropriately with mentally ill individuals. The verdict of NCRMD, and subsequent use of this defense, was established in Canadian law (Bill C-30) on February 4, 1992, and legally changed the provisions made concerning accused individuals who were mentally ill (Roesch et al., 1997; Verdun-Jones, 1994). Under this legislation, the impetus for community management of individuals deemed to be NCRMD was further emphasized. In Canada, provincial forensic psychiatric services are responsible for maintaining public safety and providing treatment to clients who have been found by the courts to be Not Criminally Responsible Due to a Mental Disorder (NCRMD; section 16 of the Canadian Criminal Code). An individual is determined to be NCRMD if he/she is suffering from a mental disorder of a nature that has rendered them incapable of appreciating the
nature of the act they were charged with, or knowing that their actions were wrong. Potential dispositions for NCRMD individuals include absolute discharge (if the patient does not pose a “significant threat” to the public), conditional discharge, or an unspecified period of detention in a forensic psychiatric facility/hospital (Ogloff, Eaves, & Roesch, 2000). The rationale behind the indefinite detention of NCRMD patients is that intensive treatment is necessary to treat and/or stabilize the individual’s mental illness, and that both the public and the patient must be protected from any possible future violent or harmful behaviour that the individual may engage in. Further, detention and subsequent discharge dispositions rely on an assessment of the reintegration needs of NCRMD individuals (Whittemore, Ogloff, & Roesch, 1997). In order to accomplish these goals, Canadian provincial psychiatric services provide inpatient programs of varied security levels, as well as an increasing number of outpatient programs to aid in community support and mental health services. For example, approximately one-quarter of the NCRMD cases that were brought before the courts in the year following the implementation of the NCRMD legislation were granted immediate conditional discharges into the community (Davis, 1996).

The authors of the present paper were contacted by the professionals involved with the Forensic Community Program (FCP) established at the Nova Scotia Hospital in Dartmouth, Nova Scotia, Canada. This particular FCP commenced in May 1997 out of concerns regarding the lack of comprehensive aftercare for mentally disordered patients following discharge into the community. These NCRMD outpatients primarily consisted of men, all were diagnosed with an Axis I mental disorder, and offence histories ranged from public mischief and nuisance crimes to murder. The professionals involved with this program were interested in having the authors of the current paper examine the effectiveness of their FCP and (among other things) to make recommendations that would potentially improve the overall functioning of the program. The current article will discuss the eight main considerations and recommendations that were provided by the authors after an extensive review of the literature as well as the current structure of the Nova Scotia FCP. The specific goal of these recommendations was to increase the overall effectiveness (in terms of client management and treatment, and risk reduction) of the Nova Scotia Hospital’s FCP. However, the more general goal was that these recommendations could translate to virtually any community treatment program that is available for NCRMD individuals.
RECOMMENDATIONS

1. Necessity of community treatment programs for NCRMD individuals. Based on recidivism rates alone it is somewhat difficult to determine the level of need for outpatient community programs. For example, the actual rearrest and/or rehospitalization rates for NCRMD individuals is hard to determine and estimates have varied widely in previous studies. Heilbrun and Griffin (1998) examined the rate of rehospitalization for conditional release patients and found reported rehospitalization rates that ranged between 11 and 40%. Further, a recent major review of the literature by Edens and Otto (2001) found that the rates for rearrest for conditionally released NCRMD patients ranged between 30 and 60% over an average two- to five-year follow-up period. It should also briefly be noted that the accuracy of violence prediction for individuals with a mental disorder has proved to be particularly difficult due to low base rates of violent recidivism, and the questionable relationship between violence and mental disorder (Borum, 1996).

Some limited research has suggested that outpatient psychiatric care for NCRMD patients is generally not successful. For example, a study by Gandhi et al. (2001) reported that significantly more participants who had a personality disorder and who had received community-oriented care had contact with police compared to patients that received hospital-oriented care. Further, Kravitz and Kelly (1999) examined the need for rehospitalization and criminal recidivism in 43 NCRMD patients (aged 26-63) who were mandated to receive treatment in 1996 in a forensic psychiatric outpatient program in Chicago. Data were collected on socio-demographic, psychiatric, and criminal characteristics predating the index offense, rehospitalizations and new crimes/rearrests after the offense, as well as clinical and psychosocial functional outcomes after enrollment in the outpatient program. At the end of 1996, Kravitz and Kelly (1999) reviewed the outcomes for all 43 NCRMD patients. Since program enrollment, 20 subjects had been rehospitalized at least once, nine were in full remission, and 26 showed at least one indicator of difficulty reintegrating into the community. Further, seven (16 percent) had been rearrested for a new crime. The researchers concluded that even after treatment in a specialized forensic outpatient program, many of the subjects remained symptomatically and functionally impaired. Finally, Boyer, McAlpine, Pottick, and Olfsom (2000) found that 149/229 inpatients with a primary psychiatric diagnosis failed to even attend scheduled or rescheduled initial outpatient mental health appointments after hospital discharge.
However the majority of research has shown that an *efficient* community outpatient program does have the potential to provide beneficial services to the mentally disordered population. For example, studies have reported that there is a significant decrease in the recidivism rate of mentally-disordered offenders when additional case management services are implemented to serve their needs once they are released from prison (e.g., Dale & Storey, 2001; Ventura, Cassel, Jacoby et al., 1998). Additionally, the implementation of FCPs allow for ongoing monitoring of psychological changes that are indicative of an increased risk of harm in NCRMD clients. For example, a study by Grisso et al. (2000) indicated that reporting violent thoughts while hospitalized for a mental disorder was significantly related to engaging in violent behaviour within 20 weeks of discharge. The presence of an outpatient program may assist professionals in both identifying potential risk situations and more effectively monitoring their symptoms, prior to (and hopefully preventing) recidivism. Sometimes the increased supervision of a community program may lead to a period of rehospitalization, that may be necessary to effectively maintain a low level of risk for that individual in the community. Indeed, a recent paper by Kravitz and Kelly (1999) stressed that although the avoidance of rehospitalization was the most desirable outcome for an outpatient program, this scenario was certainly preferable to rearrest. Previous studies have shown that rearrest rates rise substantially once community-based forensic programs are no longer available for an individual who is suffering from a mental disorder. For example, Heilbrun and Griffin (1998) reviewed the outcomes of a number of conditional release community-based forensic programs for offenders suffering from a mental disorder and found rearrest rates of 2 to 16% during conditional release. However, when they examined studies that had included a long-term follow up after the offender’s conditional sentence had ended, rearrest rates were as high as 42 to 56%.

Further, psychiatric resources provided within a community program enables NCRMD clients to gain easier access to necessary treatment resources. Studies have revealed that there are frequently a large number of inmates who are suffering from a mental disorder within prison and not receiving sufficient treatment for their illness. For example, Hodgins and Cote (1990) found that only 36% of 112 offenders with major mental disorders even discussed their serious symptoms with professionals in the prison. Further, they reported that only 21% of the offenders with psychological problems were transferred to psychiatric care while in the penitentiary. A community program may be one of the best resources available to an NCRMD client (and potentially inmates
with some type of conditional sentence) to help reduce his/her likelihood of recidivism and still helping to manage his/her mental disorder.

Currently most correctional programs are evaluated on the basis of their effect on recidivism; however, a broader scope needs to be applied in evaluating the effects of treatment for an individual suffering from a mental disorder. Other measures are needed to validate the efficacy of mental health interventions, many of which are best employed within a community setting. For example, measurements of independent behavioural functioning, as well as an analyses of the actual level of use of various mental health services are important considerations when considering treatment success.

In addition to the reasons discussed above, there is a decreasing number of long-term beds in the Canadian mental health system and increased pressure on community programs to provide comprehensive mental health care (Goering et al., 2000). Indeed, one of the leading Canadian researchers in the field recently stressed the importance of providing effective post-release follow up and treatment for mentally disordered offenders (Ogloff, 1998). Further, Salekin and Rogers (2001) argued that monitoring the adjustment of a NCRMD patient in the community should be considered one of the four crucial goals of any treatment program (the other three goals were diagnosis, reduction of risk, and preparation for the community).

2. Community awareness of FCPs. Considering that patients involved with the FCP are being released into the community, one directive of the community program should be to increase public awareness and perception of NCRMD individuals. The actual characteristics of NCRMD individuals (e.g., generally commit non-violent crimes, and have a long history of serious mental illness) often do not fit with the public’s incorrect and misguided belief that many NCRMD individuals are “brutal killers” (e.g., Ogloff & Whittemore, 2001). Indeed, despite the fact that higher rates of incarceration have been reported for mentally disordered individuals, mentally disordered offenders are often incarcerated for less serious or summary convictions (e.g., Greenberg, Shah, & Seide, 1993). Another misperception is that the NCRMD defense is used much more frequently than is the case, and that it often serves as a loophole for a guilty individual to escape punishment (please refer to Perlin, 1996, for a more thorough review of this point). Forensic community programs might endeavor to work more closely with organizations and individuals within the community to raise awareness and understanding regarding NCRMD acquittees and mental illness in general.
3. Level of monitoring. The importance of close and regular contact with NCRMD individuals who are assigned to the community program seems critical. For example, in a substantial number of cases, the NCRMD individual may tend to reside with family or friends in a setting where he/she feels comfortable. However, recent research has shown that frequent contact with family members and friends may not always be beneficial for individuals with a mental illness (e.g., Steadman et al., 1998; Swanson et al., 1998). For example, Steadman et al. (1998) reported that individuals with a mental illness were more likely to engage in violence in their home, as opposed to non-disordered individuals who were more likely to engage in violence in a public setting. Therefore, it would appear particularly important that individuals involved in the community treatment program be closely monitored on a regular basis within their home environment.

Symptom monitoring also becomes relevant after an NCRMD client is released into the community where he/she often will be exposed to situations/stimuli that could exacerbate symptoms. Symptom-inducing situations encountered in the community should also be monitored not only for the management of mental illness, but due to the reported predictive link between increased symptomatology (e.g., violent thoughts) and perpetrated violence in the community (Grisso et al., 2000). In addition, factors that influence the individual’s ability to function socially and economically on an everyday basis are a necessary consideration of any outpatient maintenance program. In fact, some studies have suggested that both clinical assessment and actuarial instruments may not be as predictive of future violence as a handful of sociodemographic variables such as employment status (e.g., Menzies & Webster, 1995). Therefore, any change in the “sociodemographic” elements of an individual participating in the community program (e.g., loss of employment or a change in social relationships) should be closely monitored. Roskes and Feldman (1999) ascertained the major strength of FCPs as being a collaboration between treatment and monitoring agencies with the common goal of maintaining the offender in the community.

Necessary monitoring of the various sociodemographic variables must also be accompanied by up-to-date and accurate recording of information pertaining to NCRMD individuals. To help maintain accurate records regarding the potential of an individual for recidivism once he/she is admitted into the community program, it seems important to stay connected with as many institutions and individuals that are involved with the outpatient’s life as possible. It is recommended that FCPs maintain regular and close outpatient care over as long of a time
interval as resources will permit, while still stressing the importance of getting the patient to attend appropriate self-help groups in the community for potential problem areas, such as substance abuse.

Finally, relevant clinical interventions and monitoring before an individual is accepted into the FCP program are also essential to ensure a greater level of program success. For example, Boyer, McAlpine, Pottick, and Offson (2000) indicated that some clinical interventions did substantially increase the likelihood of maintaining successful outpatient care. One major factor was communication regarding the patients’ discharge plans between inpatient and outpatient clinicians. A second factor was whether the patient had started aspects of the outpatient program before final discharge, and a third factor was that there had been a higher level of family support and involvement during the patients’ hospital stay. Accurate and well-maintained records, as well as a comprehensive case management team consisting of community mental health professionals, should be established to appropriately address the needs of NCRMD individuals.

4. Assessment of psychopathy. The assessment of psychopathy, using the Psychopathy Checklist–Revised (PCL-R; Hare, 1991), has been widely adopted in prison and forensic psychiatric populations. In fact, in the Canadian correctional system, risk assessments routinely include an evaluation of psychopathy by forensic psychologists. However for those individuals who have been found NCRMD, a Psychopathy Checklist-Revised (Hare, 1991; PCL-R) assessment is still not as commonly conducted. Psychopathy is a serious mental disorder that negatively affects an individual across a variety of interpersonal and behavioural domains (e.g., Hart & Hare, 1997). A defining characteristic of this personality disorder is a profound affective deficit that is typically accompanied by a lack of respect for the rights of others and societal rules (e.g., Cleckley, 1976; Hare, 1998). A psychopathic individual can be described as a manipulative, calculating, callous and irresponsible individual who is likely to engage in a variety of antisocial behaviours (e.g., Hare, 1991; Hart & Hare, 1997). Further, recent research by Woodworth and Porter (2002) has suggested that in at least some circumstances psychopaths may be more likely to engage in instrumental and premeditated violence. The PCL-R, which assesses both personality traits and antisocial behaviours, is considered the most valid and reliable assessment tool within the field (e.g., Hart & Hare, 1997). In fact, the reliability and validity of the PCL-R have been extensively researched and it is well established with both male adult offenders and forensic patients (see Hare, Clark, Grann, & Thorton, 2000; Lilienfeld,
Although the PCL-R assessment is usually based on a review of file information and an interview with the offender, several studies (e.g., Grann, Langstrom, Tengstrom, Stalenheim, 1998) have shown that assessments based only on the offender’s file information are highly valid (see Hare, 1991).

With a prevalence of 15 to 25% in federal offender populations, psychopathy is an important risk factor for violent and criminal behaviour (e.g., Hemphill, Hare, & Wong, 1998). Psychopathy is strongly predictive of both criminal behaviour and violent recidivism (e.g., Cunningham & Reidy, 1998). Indeed, studies have shown that recidivism rates are higher for psychopathic offenders than for non-psychopathic offenders (e.g., Porter et al., 2001; Hart & Hare, 1997). Results of a meta-analysis by Hemphill, Hare, and Wong (1998) indicated that the correlation between psychopathy and criminal recidivism was even stronger than the correlation between personality disorders and criminal recidivism. In addition, they found that determining the presence of psychopathy was as effective as actuarial risk instruments that were specifically designed to determine an offender’s risk of general criminal recidivism. In fact, measures of psychopathy were actually more effective than actuarial risk instruments at predicting violent recidivism. Porter et al. (2001) investigated the complete criminal career and community release profiles of 317 Canadian federal offenders. They found that psychopathic offenders failed during community release significantly faster than non-psychopathic individuals. Although the mentally disordered individuals (inpatient and outpatients) in the current study generally had relatively low PCL-R scores in comparison to the general offender population, this does not imply that they are at little or no risk to reoffend. A lower PCL-R score should only be interpreted as implying that the individual is at a lower risk to reoffend. Further, a low PCL-R score is one useful indicator (taken in conjunction with other assessment tools and clinical judgment) that an individual who is being considered for the community program, may be at a lower risk for recidivism. However, it is strongly recommended that a PCL-R assessment be conducted on each patient by a well-trained evaluator before any final decision is made regarding possible admittance into the community program. In fact, Ogloff and Whittemore (2001) recently noted that “psychopathy eclipses all other known risk factors as a predictor of future violence” (p. 337).

5. Actuarial risk assessment tools. In addition to the PCL-R, many other objective risk assessment tools are available including the Dangerous Behavior Rating Scale, (Menzies et al., 1985), the Violence Risk Appraisal Guide (VRAG; Harris, Rice, & Quinsey, 1993), the Sex Of-
fender Risk Appraisal Guide (SORAG; Quinsey, Harris, Rice, & Cormier, 1998) and the Historical/Clinical/Risk Management 20-item scale (HCR-20; Webster et al., 1997). In terms of risk assessment for mentally disordered populations, there are two primary actuarial violence prediction tools that should be considered essential by any FCP (e.g., Heilbrun & Kramer, 2001). First, the VRAG was derived and validated from data on Canadian mentally disordered offenders (Harris, Rice & Quinsey, 1993). Based on two cross validation studies, Rice (1997) concluded that the adoption of the VRAG as an assessment tool with NCRMD patients would lead to a reduction in new crimes and new victims. Rice also concluded that the VRAG performed particularly well at predicting violent criminal behaviour among those NCRMD patients who had previously committed a violent crime. Second, the HCR-20 was designed to assess risk of future violence, and considers both clinical and historical factors, as well community conditions following hospitalization or incarceration. These “risk management” factors such as potential for exposure to destabilizers, and lack of personal support, are particularly pertinent for consideration by community treatment program providers. A recent article by Mossman (2000), suggests that the HCR-20 represents many of the current important and useful advances that have been made in terms of accurately predicting future violence. The HCR-20 can be reliably scored and has been shown to have some predictive power and validity when compared to other risk assessment instruments (Douglas & Webster, 1999). In fact, it is generally agreed upon that both the VRAG and the HCR-20 are useful “actuarial” methods in assessing risk that can be a beneficial addition to clinical judgement (e.g., Salekin & Rogers, 2001).

6. Combining clinical and actuarial tools. Professionals should not attempt to solely rely on actuarial assessments or clinical judgment, and ensure that they incorporate a combination of these tools. Current research has shown that decisions regarding the disposition of offenders are frequently more reliant on clinical judgment than actuarial tools (Hilton & Simmons, 2001). However, there are some compelling reasons why clinical assessments should be augmented with various objective risk assessment tools. For example, clinical assessments of offenders can predict risk of recidivism but often show a high level of heterogeneity. On the other hand, objective risk assessments, which use structured and standardized instruments, are frequently better predictors of violence and recidivism than clinical judgments of risk, and enhance the accuracy of clinical prediction for violent outcomes (Bonta et al., 1998). However, treatment providers should also be wary of relying
too heavily on the results of actuarial assessment tools. For example, Litwack (2001) has suggested that actuarial tools have not been satisfactorily demonstrated as superior to clinical assessments, cannot be meaningfully compared to clinical tools due to differing primary objectives, and have not been adequately validated for use in disposition decisions. Further, Litwack cautions against the sole reliance on actuarial assessment tools to predict risk of future violence or recidivism.

Professionals involved with FCPs should ensure that standard risk assessment tools are always employed in addition to clinical judgement. This can serve to both validate and support the clinical judgment of the mental health professional. Ideally (and in what is more frequently the case), good ‘clinical’ assessment will take into consideration various actuarial predictors and actuarial instruments will be informed by good clinical input, to a degree where the distinction between the two assessment styles becomes somewhat unnecessary (e.g., Litwack & Schlesinger, 1999).

7. Effective communication and understanding of risk. In recent years, there has been a shift in focus for both offenders and NCRMD clients who are being considered for release into the community. Mental health professionals are now trying to determine the level and magnitude of danger that an individual poses, rather than trying to specifically determine if an individual will or will not commit a violent or anti-social act (Monahan & Steadman, 1994). Mental health professionals involved with forensic community programs need to be confident that they have estimated the level of harm that a potential candidate for their program represents as accurately as possible, and that they have sufficiently communicated this information to decision makers such as criminal code and parole review boards. Echoing this sentiment, one of the leading researchers within the field of risk assessment suggested that adequate “risk communication” is one of the most essential parts of violence prediction (Monahan, 1996). In addition, mental health professionals involved in FCPs should endeavor to conduct regular literature reviews of all new and pertinent information regarding NCRMD patients and other mentally disordered individuals. The science of risk assessment is still being developed and refined, therefore clinicians need to be able to clearly demonstrate the rationale and theoretical/empirical background regarding their decisions on violence risk (Dolan & Doyle, 2000).

8. Incorporating elements of other community programs. Although more research is needed to examine the effectiveness of treatment for NCRMD clients within institutions and following release into the community (Ogloff & Whittemore, 2001), there are a few defining charac-
teristics of effective community treatment programs for mentally disordered offenders within North America. Most community treatment models focus on case management services for mentally disordered offenders. Case management involves collaborating with the client to formulate treatment and rehabilitation plans, advocacy, service brokering, monitoring treatment compliance, providing on-going support, and providing assistance with vocational goals (Johnson & Rubin, 1983; Soloman & Draine, 1995). In the United Kingdom, key areas associated with mentally disordered offenders in community programs are risk assessment and management, crisis intervention, prevention of relapse and recidivism, structured follow-up, compliance, comprehensive care, adequate supervision, and a multidisciplinary/multiagency approach (Dale & Storey, 2001). In Canada, case management programs are either intensive and attempt to provide directly a comprehensive continuous treatment and rehabilitation program, or are generic; being less intensive, less specialized and less comprehensive (Goering, Wasylenki, & Durbin, 2000). Goering et al. (2000) estimate that 25% of individuals with severe and persistent mental illnesses who are in treatment require an intensive approach. Key components of community treatment have been shown to be: the continuity of care for mentally disordered offenders, collaboration between systems (i.e., mental health, criminal justice, and corrections), transition of mentally disordered offenders from jails to the community, and housing initiatives (Solomon & Draine, 1995). For example, law enforcement agencies are frequently in contact with mentally ill offenders, yet lack the appropriate knowledge and resources to divert them to mental health professionals (Husted, Charter, & Perrou, 1995). Barriers to successful community integration include lack of social support, comorbidity of psychological disorders, and community adjustment issues (Roskes, Feldman, Arrington, & Leisher, 1999).

Due to the lack of research that has been conducted specifically on NCRMD client community treatment programs, procedures and goals that are used by other types of mental health community programs to enhance community safety should be reviewed by FCP health providers. For example, the Relapse Prevention Treatment and Supervisory mode supports the maintenance of change (within the community) of treated sex offenders and has three overall goals:

1. To increase the clients’ awareness and range of choices concerning their behavior
2. To develop specific coping skills and self-control capacities
3. To create a general sense of mastery or control over their lives.
To attain these goals, Relapse Prevention includes intervention procedures that are designed to help clients anticipate and cope with the occurrence of lapses and to modify the early antecedents of lapses. The interventions to be used with a particular client are determined by assessing high-risk situations and coping skills (Pithers & Cumming, 1995). Although designed for sex offenders, the relapse prevention plan provides criteria that would be relevant and potentially useful for FCP targeted at NCRMD individuals as well.

Interestingly, many of the general suggestions of Harris and Rice (1997) for community treatment programs could also be beneficial for the community case management of NCRMD patients. For example, they suggest that a successful community program cannot merely be “custodial community care or traditional casework.” Further, they suggest that the program must (a) be assertive and seek out their clients in their clients’ environment; (b) ensure that there is a high quality relationship between the community case manager and the outpatient; (c) attempt to minimize rather than emphasize their professional status; and (d) maintain long-term contact with clients (although it can be challenging from a logistical and financial standpoint).

**CONCLUDING COMMENTS**

Community programs like the FCP have been designed to provide NCRMD patients with an increased potential to function in the community outside of a hospital setting, while still monitoring their symptomatology and their level of risk.

We would suggest that community programs develop a report or assessment *template* that includes:

a. A current psychological assessment (based on a PCL-R interview guidelines and file review).

b. Actuarial assessment tools including the PCL-R, HCR-20, and the VRAG.

c. A document outlining the clinical judgment of the client’s level of risk written by the main professionals who have been involved in the care of the patient.

d. A list of reasons (based on the above 3 suggestions) why the offender should be accepted into the program.

We believe that this is an essential part of any program, as an increasing number of studies are finding that guided judgments based on a
structured assessment protocol are more accurate in predicting future risk of mentally disordered offenders than those based on general clinical assessment alone (Borum & Otto, 2000).

In closing, the majority of research has demonstrated that a FCP may be one of the best resources available to NCRMD patients to help reduce their likelihood of recidivism while still managing their mental disorder and providing them with a structured opportunity to function successfully in the community. We believe an understanding and adherence to the above 8 recommendations/considerations will help to increase the general effectiveness of the community treatment program, ensuring greater community safety as well as a higher level of patient success.

NOTE

1. For the purposes of this paper, these mentally ill offenders (or NGRI) will hereafter be referred to as NCRMD patients in accordance with the legal definition in the Criminal Code of Canada. The terminology of NGRI and NCRMD are frequently used interchangeably, and refer to the same legal disposition of offenders.

REFERENCES


