

Pepperdine University
Graduate School of Education and Psychology

TOWARD BETTER DISCHARGE DECISION-MAKING FOR VIOLENT OFFENDERS IN
FORENSIC MENTAL HEALTH SETTINGS: A CRITICAL ANALYSIS OF THE
LITERATURE

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

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May, 2017

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ABSTRACT

Throughout the United States are institutions abundant with violent offenders who have been found not guilty by reason of insanity (NGI). The decision to release these insanity acquittees into the community is a vital one, both for the patient and the larger community. While these decisions should be informed by evaluations that combine clinicians' opinions with validated tools of assessment, no standard of care regarding such evaluations exists. Forensic specialists are thus often left to base discharge decisions on clinical judgment alone. This dissertation assumed a critical review of the theoretical and empirical literature relevant to conditional release decisions of NGI patients, including the research on structured assessment of risk of future violence. Based on this critical review, the author proposed recommendations for five standards to enhance conditional release decision-making for violent offenders in forensic settings: (a) Adherence to professional and ethical conduct; (b) documentation of patient progress; (c) incorporation of empirically-validated risk assessment tools; (d) creation of a comprehensive release plan; (e) verification of patient's commitment to successful reintegration. This dissertation additionally examined the strengths and limitations of the critical review strategy, as well as delineated areas for research to empirically evaluate the recommended standards and promote improved quality of conditional release evaluation for NGI acquittees.

INTRODUCTION

Institutionalized in forensic psychiatric hospitals, there are large numbers of violent offenders who have been found not guilty by reason of mental disease or defect, or, to use a more widely known label, not guilty by reason of insanity (NGI). Nearly 43,000 individuals have been committed to state psychiatric facilities across the United States, many of whom have been found NGI (National Association of State Mental Health Program Directors, 2014). The majority of insanity pleas entered were felonies related to violent offenses (Bartol & Bartol, 2008; Cirincione, Steadman, & McGreevy, 1995). Additionally, the prevalence of serious mental illness in incarcerated individuals is staggering: It has been estimated that there are ten times more seriously mentally ill offenders in jails and prisons than in hospitals throughout the United States (McCarthy, 2014). Aside from the monumental cost in terms of human affliction, individuals with a history of violence who suffer from serious and chronic mental illness impose a very large financial cost on society. They are disproportionately more likely to utilize the most expensive mental health services in the most restrictive settings (e.g., involuntary in-patient treatment); (Carroll, Lyall, & Forrester, 2004; Cusack, Morrissey, Cuddeback, Prins, & Williams, 2010; Wiederanders, Bromley, & Choate, 1997).

Forensic mental health is a topic begging for examination, as it exists at the uneasy interface between community safety and ethical patient-centered practices (Carroll et al., 2004; Sullivan & Mullen, 2006). The mental health care of forensically committed patients remains a balancing act among protecting the community, upholding the civil rights of the patient, and providing competent mental health care. Forensic mental health specialists risk making two grave errors: (a) Releasing into the community offenders who go on to commit acts of violence and (b) maintaining the commitments for harmless individuals for an extended and indeterminate

period of time that can exceed the length of the sentence they would have received with a guilty plea. As the number of offenders with mental disorders continues to escalate (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010), there is an ever-increasing need for treatment, management, and rehabilitation services directed towards impacting recidivism, relapse, and successful reintegration of said individuals (Fitch, 2014). While risk assessment and risk management have materialized as pivotal elements across the majority of forensic practices, concerns have been raised over the inconsistency of forensic mental health services, as a whole. Such inconsistencies across evaluation procedures, treatment modality, service locations, and clinical staff have been shown to significantly reduce the effectiveness of mental health services (Shinkfield & Ogloff, 2015). This is likely due to the lack of empirically validated methods for measurement of patient progress and therapeutic outcomes within forensic mental health settings (Chambers et al., 2009; Mullen, 2000; Shinkfield & Ogloff, 2015; Sullivan & Mullen, 2006). Thus, forensic mental health providers are responsible to inform decisions related to patient progress, violence risk, and reintegration into the community without valid methods to support their recommendations. As a result, forensic mental health providers often resort to the use of clinical judgment alone for determination of treatment needs and discharge recommendations.

This dissertation focused on one aspect of clinical decision-making: recommendations for conditional release. It is vital, for the judicial system and the larger community, that psychologists contribute a solid research foundation to support their recommendations regarding discharge decisions for mentally ill offenders. The prediction of future violent behavior by such offenders is a matter of great importance for conditional release recommendations. In order to balance the needs and interests of the psychiatric patient with the demands of community safety, forensic psychologists need unified standards and guidelines for evaluation.

Despite the fact that recently some researchers have proposed the need for such standards as they pertain to forensic mental health assessment (Gowensmith, Bryant, & Vitacco, 2014; Heilbrun, 2001; Heilbrun, DeMatteo, Marczyk, & Goldstein, 2008; McDermott et al., 2008), there are surprisingly few research studies aimed at developing a body of knowledge for creating best practices or a standard of care for discharge decisions. This lack of accepted standards makes it difficult to determine what constitutes ethically competent recommendations regarding the return of NGI acquittees to the community. Without standards for decision-making, forensic mental health practitioners are at risk for legal ramifications, as well as for frustrations in their professional practice.

Purpose and Scope

The aim of this dissertation was to critically examine the literature relevant to the development of standards for the evaluation of the applications for conditional release of patients with NGI commitments. Specific goals included the following:

- I. To ascertain methods and instruments currently used to evaluate patients for conditional release and provide the basis for recommendations for judicial decisions;
- II. To examine the research on widely used instruments for assessing risk of future violence and assess their utility as part of evaluation of NGI acquittees who apply for conditional release; and
- III. To propose a framework for development of standards and for future research that would contribute to the development and validation of such standards and guidelines, in order to meet the needs of NGI patients, forensic mental health treatment providers, and the larger community.

The plan of action for the critical review is described in the next chapter. The Results of the Literature Review section provides the critical review of the literature, supplemented by literature table in Appendix A. The Discussion section addresses recommendations for standards and guidelines that will inform judicial decisions regarding conditional release of potentially violent offenders. I identified gaps in research as well as areas of strong consensus, and proposed areas for future research.

Throughout the literature, different terms have been used to identify individuals who have been committed to institutions on the basis of being found not guilty by reason of insanity. These terms include NGI or NGRI patients, NGI or NGRI acquittees, and insanity acquittees. To enhance consistency, the term *NGI acquittee(s)* was used throughout the following critical analysis.

METHOD

This dissertation provided a critical review of the theoretical and empirical literature relevant to conditional release decisions of NGI acquittees. The plan of action was a two-stage literature review: a preliminary review for the proposal and a comprehensive review for the final dissertation

The plan included the following procedures: (a) identification and collection of relevant literature using appropriate and comprehensive choices of keywords, combined to address specific questions and topics; (b) development of comprehensive literature table (Appendix A); (c) critical analysis of the documents acquired through the search; (d) development of a narrative synthesis of the reviewed literature that incorporates critical and evaluative commentary; and (e) development and refinement of topics to be addressed in the discussion chapter.

Keywords and Topics for Literature Search

The broad domain of the literature review can be variously labeled as *forensic psychology*, *forensic mental health care with offenders*, and *current practices in forensic settings*. The first step in developing the literature search strategy was selecting relevant search terms for the population of interest: *not guilty by reason of insanity*, *NGI*, *NGRI*, *not guilty by reason of mental disease or defect*, *mentally disordered offenders*, *insanity acquittees*, *guilty but insane*, or *forensically-committed patients*. Related search terms included *diminished responsibility*, *severe mental illness*, and *violent offenders*.

Forensic psychology and forensic mental health care with offenders. Search terms under the broad topic of practices in forensic mental health care included: *psychology*, *therapy*, *assessment*, *mental health*, *psychotherapy*, *forensic hospitals*, *violence assessment*, and *violence prediction*.

Legal history of the insanity defense and NGI commitment. In order to understand the current challenges for psychologists working with this particular forensic population, it was necessary to access legal, historical, and government sources. Search terms included *legal history of the insanity defense and NGI commitment, mentally disorders offenders and the NGI plea, and conditional release*. The intention of this part of the review was to place current challenges in a cultural and historical context.

Conditional release. I searched for information regarding the decision to release an NGI acquittee into the community on what is called conditional release. Search terms included: *conditional release, discharge decisions, risk assessment, structured professional judgment, and recidivism*. Contrasts between different states were examined. This section was important for clarifying where psychologists fit in the process, how much weight is given to their recommendations, and whether there is evidence of bias within the system.

Violence prediction and risk assessment. The literature analyzed included studies that utilized various measures used for predicting the risk of violence, including the terms *violence prediction and risk assessment*. Critical evaluation of these instruments was important for developing standards and guidelines for informing discharge decision-making. The measures highlighted included the Historical Clinical Risk Management-20 (HCR-20), Structured Assessment of Protective Factors for Violence Risk (SAPROF) and Violence Risk Appraisal Guide (VRAG).

Historical clinical risk management-20. The HCR-20 is a structured measure of risk that divides items into past (historical), present (clinical), and future (risk management) domains, encompassing both actuarial and dynamic variables (Appendix B). The HCR-20 has a substantial

base of predictive validity studies, with a link to recidivism and good interrater reliability (Witt, 2000).

Structured assessment of protective factors for violence risk. The SAPROF is a violence risk assessment tool specifically developed for the assessment of protective factors for adult offenders (Appendix C). Review of the literature on these risk assessment measures indicated that a combined evaluation of risk and protective factors was found to have substantial predictive validity for violent recidivism (de Vries Robbé, de Vogel, & Douglas, 2013)

Violence risk appraisal guide. The VRAG is a measure of actuarial risk of violence. That is to say, it measures violence risk based on historical and static data. While usage of this measure has been evidenced to be helpful in assessing level of dangerousness, current sentiments reflect utilizing both actuarial and dynamic variables to best predict dangerousness (Hilton, Simpson, & Ham, 2016; Witt, 2000).

The three instruments (HCR-20, SAPROF, and VRAG) were used as search terms, in combination with terms such as *psychometric properties, clinical utility, conditional release decisions, structured professional models, and cultural bias*. In addition, I searched for measures of violence assessment and prediction that might be used with non-forensic populations. The literature search addressed both actuarial and clinical approaches to assessment of risk for violent recidivism.

Standards of care in conditional release evaluations or discharge decision-making.

The literature gathered included opinions regarding whether enforceable standards of care are possible and necessary; analyses of disadvantages of not having standards of care; and documentation of standards of care in other countries. The search uncovered descriptions of the content and processes entailed in the creation of standards of care, as well as the challenges of

creating enforceable standards of care that meet the approval of diverse stakeholders. Toward this purpose, standards of care in related professional and forensic contexts were examined. In addition to standards for treatments and decision-making, this section documented the standards for forensic mental health practitioners that have been developed by major professional organizations such as the American Psychological Association, the International Association for Correctional and Forensic Psychology, and the American Psychiatric Association. In addition, the standards in selected other countries were examined. Search terms included: *standards of care*, *professional standards of practice*, and *development of best practices*,

Databases

Literature was obtained and reviewed from the fields of psychology, psychiatry, law, and sociology. Relevant literature was identified through searches on the PsycINFO database, WorldCat, ProQuest, Scopus, LexisNexis, Academic Search Elite, and Google Scholar.

Documents for Inclusion

Abstracts were reviewed for relevance to this study. Due to the relevance of historical events and perspectives, no documents were excluded based on their date of publication, format, or methodology. However, information and practice in documents dated before 1990 and non-academic documents were critically assessed for their accuracy and relevance. Scholarly research published in peer-reviewed journals after 1990 were utilized for issues related to evaluation of risk assessment instruments, and outcomes of release into the community such as recidivism rates. Legal literature and legislative documents were utilized to explore the history and current procedures as they related to mentally disordered offenders and NGI acquittees. For practical considerations, documents that were not published in English were excluded. Documents that

could not be obtained through the resources of the Pepperdine University library system were not included.

Development of Literature Table

The literature obtained was summarized on a literature table on an ongoing basis. The column headings are: Author/Year/Title, Type of Article, Research Questions, Research Approach/Designs, Sample/Measures/Data Collection, and Major Findings. Not every column was relevant for each article. As articles were read, the reference lists were searched for additional relevant articles. The table was split into three areas as pertinent to the topics of study in this critical review: Forensic Psychology and NGI Commitment; Study of Violence Prediction; and Standards and Best Practices (See Appendix A). The table contains only articles that were deemed relevant for the Results section of this dissertation. The References contain full bibliographic information for items in the table.

Plan for Critical Analysis

The critical analysis included critical examination of each document obtained. As each document was studied, the following issues were addressed: the credibility of the source, possible bias of the authors, flaws in the methodology, generalizability of the findings, whether results have been replicated, and whether there are alternate explanations for findings. For the Results of the Literature Review, the preliminary literature review from the proposal was combined with the results of the literature review strategy that was approved by the committee at the preliminary oral examination.

While I was writing the narrative synthesis of the literature, I found a clear distinction between description of the contents of articles and my critical analysis of such issues as the credibility of the source, the persuasiveness of the arguments, and important gaps in research.

Major topics for the discussion chapter were identified at the end of the Introduction section of this dissertation, including methods to inform judicial decisions; recommendations for standards and guidelines for sound decision making regarding conditional release for NGI acquittee; and proposal of a framework for future research to advance quality and consistency of conditional release evaluations and judicial decision making. Strengths and limitations of this study were discussed. That discussion included examination of the advantages and disadvantages of the critical analysis format and strategy, compared to other approaches that could have been used.

At the close of my dissertation I expressed my conclusions about the need for improved discharge decision-making procedures of patients who are committed to forensic facilities following NGI pleas. There was clarity regarding the clinical and research endeavors that are needed when working with this population in forensic facilities.

RESULTS OF THE LITERATURE REVIEW

Forensic Psychology and Forensic Mental Health

Forensic psychology has largely been conceptualized as the application of the professional practice of psychology to civil and criminal law (Otto & Weiner, 2013). When defined narrowly, forensic psychology would encompass the research and applied components of clinical psychology, counseling psychology, neuropsychology, and school psychology as they relate to legal decision-making and other aspects of litigation (Heilbrun et al., 2008). Forensic psychology also comprises the application of social, developmental, community, and human experimental psychology to legal issues, including assessment of competencies, criminal responsibility, and risk of future offending; crime prevention; and involuntary civil commitment (Heilbrun, Grisso, & Goldstein, 2009). Although clinical forensic practice is most often associated with assessment (e.g., evaluations and expert witness testimony), the provision of specialized treatment services is an additional, vital component of forensic psychology.

Under the specialty of forensic psychology, forensic mental health care (FMHC) is an area of specialization that, in the criminal sphere, involves the assessment, treatment, and management of individuals who are both mentally disordered and whose behaviors have resulted in, or pose a risk for, criminal offending (Hodgins, 2002; Mullen, 2000). While forensic services have long had the reputation of being coercive, correctional, or punitive, the future of forensic mental health remains firmly grounded in effective and evidence-based models of treatment and service delivery.

Mentally Disordered Offenders and the NGI Plea

Mentally disordered offenders are those individuals who have come into contact with the criminal justice system resultant of having committed, or being suspect to have committed, a

criminal offense, and who may possess an acute or chronic mental illness (Shinkfield & Ogloff, 2015). Within the subset of mentally disordered offenders are those who have been found not guilty by reason of mental disease or defect, also sometimes referred to as not guilty by reason of insanity or diminished capacity. For the purposes of this review such individuals were referred to as *NGI acquittee*, a term commonly used across the United States.

Legal History of the NGI Commitment

The history of the insanity defense can be dated back to the establishment of government: Punishing those who could not understand their actions has commonly been thought of as immoral (Friedman, 1993; Grachek, 2006; Plaut, 1983). There is written documentation of court dismissals on the basis of “madness” that date back to medieval England, as well as evidence of the court and Crown assessing the stability of a defendant’s mind by evaluating their memory and emotional stability (Turner, 2010).

Advances in the British legal system’s approach to mentally ill offenders paved the way for current practices in the United States. In the 18th century, legal standards for an NGI defense were highly variable. Oftentimes it was left for the court to determine whether the defendant could distinguish between good and evil, or discern the nature of their actions. The good and evil test, with its basis in biblical concepts, was one way by which the courts would decide the issue of insanity. Although determination of such was largely vague, defendants viewed as unable to discern between good and evil were considered to be insane in a court of law (Friedman, 1993). Another way the courts would preside over an insanity defense in the 18th century was the wild beast test, in which defendants could be acquitted by reason of insanity if they did not know what they were doing and thus their behavior was no more than what a wild beast would do (Clark, 1995). At that time, once a defendant was acquitted on the basis of insanity, they were released

into the community. The Criminal Lunatic Act of 1800 set a precedent that defendants acquitted due to insanity were required to be held in detention until deemed safe to be released back into society (Friedman, 1993). By the 19th century, insanity became widely accepted as more factual in nature and left for a jury to decide (Grachek, 2006).

An important milestone in the history of the insanity defense came in 1843 when Daniel M'Naughten, an Englishman, attempted to assassinate the British Prime Minister, Robert Peel, murdering one of his assistants instead. M'Naughten, a paranoid schizophrenic, evidenced persecutory ideation in his belief that the Prime Minister was threatening his life. Ultimately, M'Naughten was found not guilty on the basis of his being insane at the time of the offense. Subsequently, the English House of Lords established standards for the insanity defense, or the M'Naughten Rule, which put the burden of insanity on defendants and questioned whether or not they understood the moral consequence of their actions (Costanzo, 2004; Otto & Weiner, 2013). The M'Naughten standard was utilized in the United States throughout the next several decades up until the 1980s.

Another influential legal proceeding on the insanity defense was the case of *Durham v. United States*. In 1954, Monte Durham, a young American male with a substantial history of mental illness, was acquitted of his burglary charges on the basis that the crime was resultant of his mental condition (Clark, 1995). The subsequent Durham Rule dictated that an individual could be deemed legally insane if the committed act was the product of mental disease or defect (Costanzo, 2004; Lehman & Phelps, 2005). While the Durham Rule was progressive in its impact on the importance of mental health, it was criticized for being vague and relying heavily on mental health practitioners. As such, it was rejected by most states, and the M'Naughten Rule continued to be the primary basis for an insanity defense (Lehman & Phelps, 2005).

While the M’Naughten Rule implemented some standards into the insanity defense, it was not without limitations. In attempts to alleviate some of the problems with the M’Naughten Rule, primarily the narrow focus on the defendant’s inability to distinguish right from wrong, the idea of *irresistible impulse* was introduced in 1844, with the case of *Commonwealth v. Rogers* (Costanzo, 2004). On the basis of the irresistible impulse, in order to be found NGI, defendants would need to demonstrate an inability to control their behavior at the time of the offense, as a result of a mental disease or defect. In attempts to form a compromise between the constricted M’Naughten Rule and the expansive Durham Rule, the American Law Institute (ALI) promoted a new Model Penal Code Commission in 1964 (Lehman & Phelps, 2005). The ALI test stipulated that an individual was not criminally responsible if, at the time of the act, they lacked “substantial capacity” to “appreciate” or “conform” the unlawful conduct (Lehman & Phelps, 2005, p. 278). Thus, the insanity defense was expanded to include both cognitive and volitional elements. This modified insanity defense was adopted by a majority of the nation and all but one federal circuit (Lehman & Phelps, 2005).

The attempted assassination of President Ronald Reagan in 1981 brought intense scrutiny of the insanity defense. John Hinckley, an individual with schizophrenia, shot President Reagan and, as the defendant in *United States v. Hinckley*, claimed that he had not acted of his own volition, but rather was driven by a pathological obsession with a movie star. Hinckley was found NGI and was subsequently committed to institutional care. As a reaction to this judicial outcome, in 1984 Congress passed the Comprehensive Crime Control Act, containing the Insanity Defense Reform Act, which modified United States federal laws governing insanity pleas, making it substantially more difficult to be acquitted on the basis of insanity (Fersch, 2005). This law requires a confirmatory defense: The defendant must prove, by "clear and

convincing evidence," that "at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts" (CCP. Title 18, U.S.C. §§ 1, 1948). Since 1984 the insanity defense, as it is used in the United States, requires an affirmation of guilt (i.e., that the impermissible act was indeed committed by the defendant).

The Insanity Defense and NGI Commitment

The Insanity Defense Reform Act of 1984 applies in federal courts; the standards for the insanity defense vary broadly from state to state (Otto & Weiner, 2013). For instance, some jurisdictions adhere strictly to the federal components of the defense, while others permit the excuse of substance use, or a volitional element in which the defendant was unable to refrain from committing the offense, and some states (Kansas, Montana, Idaho, and Utah) do not allow the defense at all (National Association, 2014; Otto & Weiner, 2013; United States Insanity Defense, n.d.).

Although frequently addressed in the media and popular culture, the insanity defense has been rarely used. While rates differ across states, it has been estimated that the insanity defense is raised approximately 0.85% of the time (Lymburner & Roesch, 1999; Perlin, 2016). That is to say that fewer than one in 100 individuals charged with a crime plead NGI. Success rates for the defense are even lower, hovering at about 0.26% nationwide (Lymburner & Roesch, 1999). This is partially attributed to the fact that the majority of NGI defendants (in some studies as high at 70%) tend to vacate their insanity plea when found by evaluators to be legally sane (Lymburner & Roesch, 1999).

Research in both the United States and Canada had indicated that most typically an NGI acquittee is male, minimally educated, has a history of violent offenses and mental illness, and

has had prior contact with criminal and mental health systems (Cirincione et al., 1995; Lymburner & Roesch, 1999). While only a small percentage of NGI acquittees are charged with murder, the majority of NGI defendants are, in fact, charged with violent offenses (Cirincione et al., 1995). The presence of mental disease has been a constant factor in all insanity defense standards; however, determination of what constitutes such disease has not been clearly articulated (Lymburner & Roesch, 1999). Research has largely demonstrated that the majority of NGI acquittees were diagnosed with psychotic disorders; however, personality, mood, and substance abuse disorders were also common (Cirincione et al., 1995).

The insanity defense has often been considered to reflect a compromise between two beliefs: criminals should be punished for their crimes and mentally disordered offenders should be provided treatment. The defense has been a topic of controversy since its conception, as the appeal of such defense is that ideally, one would be sent to a psychiatric forensic facility for treatment, or conditionally released into the community, rather than be incarcerated. However, it is not uncommon for individuals who were committed on the basis of an insanity plea to be committed to forensic hospitals for a longer period of time than they would have served if they had just been found guilty of the offense (German & Singer, 1977). In fact, with the absence of standards of care in forensic mental health, as well as the presence of variability in discharge decision-making policies, NGI acquittees spent almost double the amount of time as defendants convicted for similar charges (Perlin, 2016). Furthermore, NGI acquittees have typically faced lengthy, and often lifetime community supervision periods once released (Perlin, 2016).

The NGI Process

While the specific criteria for the insanity defense continue to vary across state lines (and some states do not have such a plea), the common thread is that the defendant was not

responsible for criminal conduct if at the time of such conduct, as a result of mental disease or defect, the defendant lacked substantial capacity either to appreciate the wrongfulness of their conduct or conform their conduct to the requirements of the law. While the logistics vary from state to state, more often than not the finding that an individual is NGI is a two-part court process. The defendant must first be found guilty of committing the offense and subsequently be evaluated by a forensic mental health specialist to determine criminal responsibility. At the defendant's request, a judge orders that a criminal responsibility evaluation is conducted by a qualified evaluator (Wisconsin Department of Health Services, 2015). Typically, qualified evaluators include psychiatrists or clinical psychologists who have garnered specialized training or experience performing forensic evaluations (Otto & Weiner, 2013). These evaluators are often state appointees, but can be hired privately. While there is typically only one evaluation conducted, the prosecution may seek a second evaluation if it chooses. Once a defendant is evaluated, and opined by an evaluator to be criminally responsible or not, they are returned to court to proceed with a bench or jury trial to determine the final outcome (Wisconsin Department of Health Services, 2015).

As it is written in the U.S. Penal Code, a person who is deemed by the courts to be NGI is "committed to a suitable facility until such time as he is eligible for release" (CCP. Title 18, U.S.C. §§ 1, 1948). In the United States, this commitment is under the State's care and typically through the Department of Health and Human Services or Department of Behavioral Health. Once committed, an NGI acquittee is either placed in a forensic psychiatric hospital, or released to the community under legal, medical, and psychiatric supervision by the court. The decision of placement is dictated by the court, and often accompanied by a psychological or risk assessment. If an NGI acquittee wishes to be released to the community under legal supervision, that is to say

they have been conditionally released, said individuals have the burden of proof to establish “that [their] release would not create a substantial risk of bodily injury to another person or serious damage of property of another due to a present mental disease or defect” (CCP. Title 18, U.S.C. §§ 1, 1948).

These procedures illustrate the social policy that such individuals not be wrongfully placed in correctional institutions that often focus on punitive measures rather than rehabilitation and provide minimal mental health treatment. If such individuals received a fixed sentence without any mental health services, there is the risk that the incarcerated individual would still pose a danger to the community, upon release, resultant of an untreated mental illness. Conversely, from a societal standpoint, the NGI plea has garnered attention because of the belief that there is the danger that non-mentally disordered offenders may use false claims of NGI to avoid criminal responsibility (Carroll et al., 2004; Grachek, 2006). As such, distinguishing between offenders who act volitionally and those who suffer from an underlying mental illness is of utmost importance to all parties involved.

Current Practices of Conditional Release Evaluation

NGI acquittees are typically conditionally released to the community from psychiatric forensic mental health facilities. The specific conditions that they must satisfy typically include continued legal, medical, and psychiatric supervision or care. These release decisions are informed by forensic specialists or judicial officials and decided in a court of law. While conditional release processes and procedures vary by state and range from a simple approval by a judge to a complex process in which the hospital, state, and court provide approval, the aim is usually straightforward: protect the public from dangerous offenders. A secondary goal is typically, depending on the state, to provide adequate treatment and care for patients with mental

illnesses. Current literature reflects that rates of recidivism were substantially higher when violent offenders were released without outpatient service as a condition of release, a finding that substantiates the need to discuss and enhance current conditional release practices and decisions (California Department of State Hospitals, n.d.; Hayes, Kemp, Large, & Nielssen, 2014; Wiederanders et al., 1997).

NGI acquittees released to the community are almost universally released under some form of conditional release. Once released, NGI acquittees are typically under supervision for an extended period of time and expected to adhere to certain conditions that are most often related to their mental healthcare, such as medication compliance, refraining from substance use, and attendance at mental health and probation appointments. Additionally, they are required to abstain from further criminal behavior. Violations in conditions of release would typically result in increased supervision, or revocation of release in which the individual would likely be returned to a secure forensic mental health facility (Marshall, Vitacco, Read, & Harway, 2014).

Conditional release evaluations. The United States Penal Code stipulates that an NGI acquittee may be released from the State's care

when the director of the facility in which an acquitted person is hospitalized...determines that the person has recovered from his mental disease or defect to such an extent that his release... would no longer create a substantial risk of bodily injury to another person or serious damage to property of another. (CCP. Title 18, U.S.C. §§ 1, 1948)

As it is loosely written in the Penal Code, discharge procedures of NGI acquittees remain obscure and vague. In several states an individual who is committed to a forensic facility is legally entitled to petition for conditional release, rather than wait for the courts to issue such (Wisconsin Department of Health Services, 2015). In most states, NGI acquittees remain committed until released by the courts; however, there are circumstances when facilities may release without court-authorization (National Association, 2014).

The release process usually entails the patient undergoing an independent evaluation by a professional who is not affiliated with the institution in order to assess appropriateness for discharge (Nagtegall & Boonman, 2016). The procedures for evaluation and, ultimately, release of NGI acquittees vary immensely across state lines; however, they are statutorily informed by assessment of mental illness and perceived risk. That is to say, under the United States Penal Code, the decision to release a mentally disordered offender must be made on the basis of the individual's current mental illness and level of dangerousness (CCP. Title 18, U.S.C. §§ 1, 1948). The difficulty in the application of these evaluations, and thus judicial decisions regarding release, is then in the ambiguity of the legal and clinical definitions of mental illness and dangerousness, which are both required for continued commitment NGI acquittees.

Whereas the creation and utility of the Diagnostic and Statistical Manual of Mental Disorders (DSM) standardized the identification and classification of mental illness, in contrast, there is enormous ambiguity of predicting future risk of violent offending. Furthermore, although the purpose of conditional release evaluations—to assess for mental illness and dangerousness—appears uniform and cogent, the utilization of guidelines or standards related to the information and content of such evaluations is a rarity (McDermot et al., 2008). While there is no uniformity in such evaluations, the decision-making process often entails some form of formal or informal risk assessment to evaluate the individual's presumed risk of future violence based on clinical opinion or actuarial data. The evaluation, however conducted, is ultimately reviewed by a judge, who makes the final decision. If the judge upholds the evaluator's recommendation to discharge the NGI acquittee, the individual is released to the community or a transitional home, under stringent conditions mandated by the court. Currently, in the United States, there is typically no step-down program for reintegration into the community, and the patient is released to the

community, which has been evidenced to increase the propensity for maladjustment in the community (Nagteggall & Boonman, 2016).

Current practice procedures in conditional release: California. The Forensic Conditional Release Program (CONREP) is the Department of State Hospitals (DSH) system of community-based treatment, evaluation, and supervision for forensically committed individuals. DSH manages the California state hospital system, the main objective of which is to provide mental health services to patients committed into DSH facilities (California Department of State Hospitals, n.d.). In 1984, as a result of the Governor's Mental Health Initiative, CONREP became mandated as a state responsibility and became operational in 1986.

CONREP is a statewide program, varying county by county, that provides mandatory treatment and supervisory plans to NGI acquittees who have been released from state hospitals (California Department of State Hospitals, n.d.). CONREP provides services to patients who have typically undergone a lengthy stay in a state hospital and who have been released once psychiatric symptoms have stabilized and they are no longer perceived to be a threat to the community. In California, the medical director at a DSH site recommends eligible inpatients to mandatory outpatient treatment under CONREP. The facility director and the CONREP community program director must both agree and recommend to the court that the individual can be treated safely and effectively in the community (California Department of State Hospitals, n.d.; CCP. Title 18, U.S.C. §§ 1, 1948). The Court must then approve these recommendations. Current practice procedures for evaluating an individuals' eligibility for release under CONREP include a formal recommendation and evaluation process. Once an individual is referred by the committing institution for evaluation of discharge readiness, the court forwards the referral and criminal history to the CONREP program in the appropriate county. The CONREP program then

has 30 calendar days to conduct an evaluation of discharge readiness and submit a report to the court (Disability Rights California, 2009). The evaluation process includes a thorough chart review, consultation with the patient's treatment team, and an interview with the patient.

CONREP evaluation guidelines vary according to an individual's commitment type. Although no stringent guidelines exist for evaluations, CONREP evaluators are encouraged to consider a patient's (a) recent behavior, (b) level of dangerousness, (c) adherence to treatment, (d) medication compliance, (e) insight into mental illness, (f) treatment readiness and goals, (g) risk and protective factors in the community, (h) history with CONREP, (i) criminal history and insight into index offense, (j) current mental status, and (k) willingness to comply with CONREP terms and conditions. CONREP evaluators may also speak to collateral sources to gather additional information. CONREP evaluators then use this information, garnered by varying methodologies and oftentimes without the use of structured psychological assessments, to come to an opinion of whether or not an individual is ready to be released to the community or ordered to remain in the facility where currently committed for an indeterminate period of time. If the hospital director and CONREP liaison both recommend discharge to CONREP, a placement hearing is provided by the court, in which the patient has the burden of proof to legally demonstrate a preponderance of evidence, or "a 51% chance that the evidence presented is to be believed" (Disability Rights California, 2011, p. 10). If released into CONREP, an NGI acquittee is placed within the community or a transitional residential program within 21 days. Typically, CONREP placement is mandated to last one year; however, this can be extended indefinitely. Throughout placement in CONREP, an individual undergoes periodic assessments to re-evaluate the status of their mental illness and violence risk.

Current practice procedures in conditional release: Wisconsin. Throughout the state of Wisconsin, the standard for conditional release is perceived dangerousness. That is to say, the courts will not grant release if it “finds clear and convincing evidence that the person would pose a significant risk of bodily harm to himself or herself or to others or of serious property damage if conditionally released” (Wisconsin Department of Health Service, 2015, p. 51). The Wisconsin Statute stipulated that NGI acquittees may petition the committing court for conditional release every six months. Mental health institutions are required to submit a court letter when a patient petitions for conditional release to enhance the court’s ability to make informed discharge decisions (Wisconsin Department of Health Service, 2015). There are no statutory guidelines for what must be addressed in the letter, but it is recommended that the letter include consideration of the individual’s (a) dangerousness, (b) index offense, (c) mental health history and present mental condition, and (d) access to available community resources. The institution letter may or may not include a recommendation regarding conditional release. Once a petition is received, the courts may make a decision for release, or order the Department of Health Services to conduct a predispositional investigation or supplemental examination to evaluate readiness for release (Wisconsin Department of Health Services, 2015). These evaluations are conducted by hospital staff or independent court appointed examiners or case managers. Similar to those in other states, the evaluations are conducted in various ways, with no standardized method or inclusion of forensic instruments to enhance quality of report and thus efficacy of decision-making. The court appointed independent examiner is then expected to meet with the patient within 20 days of receiving the conditional release petition and submit a report within 30 days of evaluation.

Current practice procedures in conditional release: Missouri. Conditional release procedures are unique in the state of Missouri as Missouri law Chapter 552.040 authorizes the

courts to make conditional release decisions, set the criteria for release, and specify items that are required for consideration in evaluating readiness for release. The statute stipulates that the patient's treatment team submit application for the patient's release to the Missouri Forensic Review Committee, a body of forensic mental health professionals who review the application and provide a recommendation to a judge. Statutorily, six factors must be considered by the court when making conditional release decisions: (a) the nature of the index offense, (b) the patient's behavior while committed to the forensic facility, (c) the period of time that has elapsed between the hearing and the last reported unlawful or dangerous act, (d) a proposed release plan, (e) community or family support, and (f) prior history of conditional release and revocation of such (Criminal Proceedings Involving Mental Illness, Section 552.040.12, RSMo., 2004).

Dirks-Linhorst and Linhorst (2006) elaborated on the criteria and procedures. These six non-exclusive statutory criteria emphasize past violent behavior and mandate that predictions of dangerousness be assessed by the evaluator; however, forensic evaluators have freedom in choosing what methodologies to use to assess future risk. Prior to filing applications for conditional release, NGI acquittees typically engage in a series of brief, exploratory, monitored releases in the community (up to 96 hours), to assess behavior and predicted reintegration into the community. These stringent criteria for evaluation and procedures implemented have resulted in approximately half of the NGI acquittees in the state of Missouri living in the community, under conditional release, with few negative instances reported (Dirks-Linhorst & Linhorst, 2006).

Study of Violence Prediction

The quality of the decision to approve conditional release for an offender who has committed a violent crime is dependent on the validity of methods for predicting future violence.

The literature on violence prediction must be examined in order to develop standards for such decision-making.

Violence risk evokes concern across clinical, social, and legal domains. Swanson et al. (2000) noted that

the risk of violence creates dilemmas in the clinical realm by interrupting community tenure and continuity of care, in the legal realm by increasing concerns about professional liability, and in the public realm by heightening fear and stigma associated with mental health. (p. 324)

With the advent of managed care in both public and private mental health systems, and with clinicians increasingly held liable for the behavior of patients inadequately treated, concerns about the risk of violence have increased (Heilbrun et al., 2008; International Association for Correctional and Forensic Psychology, 2010).

While clinical outcome requirements vary across institutional settings (e.g., psychiatric hospitals, correctional facilities, or sex offender treatment centers), practitioners have argued that the most central and vital aim across forensic settings is violence reduction (Sullivan & Mullen, 2006; Swanson et al., 2000). Unquestionably, reducing recidivism rates is the primary goal of treatment and release decisions, across forensic and correctional settings. Ultimately, a reduction in rates of recidivism would indicate that offenders have successfully reintegrated into the community while likely pursuing noncriminal activities. The rate at which conditional release has been revoked for forensic patients released into the community has been evidenced to range from 35 to 50 percent (McDermot et al., 2008; Wiederanders et al., 1997). The degree to which discharge decisions are based on valid measures of an NGI acquittee's readiness for release is likely to play a pivotal role in rates of recidivism and re-offense. If forensic specialists and, in turn, the judges that ultimately order a patient's discharge enhance their ability to accurately predict future dangerousness and release offenders accordingly, errors in discharge decision-

making should decrease (e.g., releasing dangerous individuals prematurely, committing safe individuals for extended periods of time) and rates of recidivism should ideally plummet.

The study of violence prediction has long been a central activity by forensic researchers (Serin et al., 2016; Vitacco, Tabernik, Zavodny, Bailey, & Waggoner 2016). The progression of forensic risk assessment is thought to have occurred in three generations: (a) unstructured clinical judgment—first generation (b) actuarial risk assessment based on static factors—second generation, and (c) actuarial risk assessment based on dynamic factors—third generation (Bonta, 1996; Campbell, French, & Gendreau, 2009). More recently, a fourth generation of risk assessment has been highlighted in which a risk–need evaluation and case management plans are included in the assessment (Bonta & Wormith, 2008; Campbell et al., 2009).

Unstructured clinical judgment. Unstructured clinical judgment is the process by which predicted level of risk is subjectively determined without the aid of structured instruments (i.e., risk assessment tools). Historically, mental health practitioners have utilized unstructured clinical judgment, in which they made predictions about an individual's risk based on clinical impressions alone (Brown & Singh, 2014; Witt, 2000). While this method of assessing risk is flexible and case specific, it has garnered much criticism on the basis of relying too heavily on human interpretation that can be subject to bias (Brown & Singh, 2014), resulting in low interrater reliability and poor validity (Dolan & Doyle, 2000; Meehl, 1954). More specifically, these unstructured clinical judgments of risk evidenced weak and inconsistent predictive efficacy (Grove, Zald, Lebow, Snitz, & Nelson, 2000; Meehl, 1954; Monahan, 1996).

Actuarial assessment. Brown and Singh (2014) defined actuarial assessment tools as “structured instruments composed of risk and/or protective, static, and/or dynamic factors that are found to be associated with the adverse event of interest [violence recidivism] using a

statistical methodology” (p. 52). Actuarial approaches to risk assessment have been found to improve the consistency (Dolan & Doyle, 2000) and predictive validity (Grove et al., 2000) of risk assessments. Initially, actuarial assessments of risk included only static variables of risk, or those that are historical in nature (e.g., demographic and criminal history), and that have been found to relate to violent recidivism. Advances in violence prediction over the past 15 years have involved including dynamic variables of risk into assessment of risk. Dynamic risk variables are the factors that are empirically correlated with violence recidivism that are subject to change (e.g., substance abuse, criminal attitudes, impulsivity, social influences).

Studies on clinical prediction have largely evidenced the superiority of actuarial risk assessment over clinical estimations of risk (Goldstein & Weiner, 2003). In the realm of actuarial assessments there are those that measure static variables (e.g., historical and actuarial) and those that measure dynamic variables (i.e., those that are to change). While usage of static, actuarial measures have been evidenced to be helpful in assessing level of dangerousness, current sentiments reflect assessing both static and dynamic variables to best predict dangerousness (Hilton et al., 2016; Witt, 2000).

Actuarial risk assessment based on static factors. One of the largest studies on violence risk was conducted in 1998, and took place over the course of a decade. The MacArthur Violence Risk Assessment Study aimed to describe the science of predicting violence risk and ultimately to produce an actuarial violence risk assessment instrument that had strong ecological utility in the current forensic mental health system (Monahan et al., 2006; Steadman et al., 1998). The experimenters studied civilly committed patients and designed a study addressing risk factors, derived from the literature on violence by individual with mental disorders. The hope was that these risk factors could then be validated and in turn used in actuarial assessment of the

risk of violence. The factors studied included personal factors (e.g., demographic variables), historical factors (e.g., history of violence), contextual factors (e.g., social support), and clinical factors (e.g., specific symptoms); (Steadman et al., 1998). Some significant risk factors evidenced in the study included (a) gender (e.g., males were somewhat more likely than women to be violent), (b) prior violence, (c) neighborhood and race (e.g., neighborhoods with high violence and low socioeconomic status), (d) diagnosis (e.g., a diagnosis of a major mental disorder, with the exception of schizophrenia which was negatively correlated with violence), (e) psychopathy, as measured by the Hare Psychopathy Checklist, (f) delusions, (g) hallucinations, (h) violent thoughts, and (i) anger, as measured by an anger rating scale (Steadman et al., 1998). The study's findings were pivotal in understanding the history of violence and paving the foundation for the static, actuarial measures of risk.

Violence risk appraisal guide (VRAG). One of the most widely studied static, actuarial measures of risk of violence is the VRAG (Harris, Rice, & Quinsey, 1993; Quinsey, Harris, Rice, & Comier, 1998). The VRAG is a widely-used measure of actuarial risk, measuring violence risk based on historical and static data. The VRAG was developed on a sample of men, charged with serious criminal offenses, who were committed to a maximum-security forensic facility in Canada. The study yielded 12 variables as being associated with increased risk, for inclusion on the VRAG (Harris et al., 1993). These variables include (a) level of psychopathy, (b) separation from parents prior to age 16, (c) elementary school maladjustment, (d) age at the time of the offense, (e) victim injury in index offense, (f) diagnosis of schizophrenia, (g) marital status, (h) female victim during index offense, (i) failure on prior conditional release, (j) alcohol abuse history, (k) personality disorder, and (l) non-violent offense history. Items are weighed and total

scores place individuals in one of nine risk categories with associated estimates of recidivism rates.

In an early study conducted by Harris et al. (1993) the VRAG's utility to predict violence was evidenced to be statistically significant. When the scores were separated into high and low ranges, the results indicated that 55% of the high scoring group re-offended violently while only 19% of the low scoring group were convicted of a new violent incident. The VRAG was found to yield a high degree of accuracy (ROC area = 0.76) in terms of predicting future violence over the course of seven years (Quinsey et al., 1998). Additionally, in a meta-analysis conducted on a wide range of risk assessment instruments used for forensically committed adult offenders, Campbell et al. (2009) found that the VRAG had strong predictive validity for future violent reoffending ($r = .32$). The VRAG has been validated for use across a multitude of populations such as civil inpatients (Harris, Rice, & Camilleri, 2004; $r = .34$), sex offenders (Harris et al., 2003; ROC area up to 0.84), and mentally disordered offenders (Gray, Fitzgerald, & Taylor, 2007; AUC = 0.73). Rice and Harris (1995) analyzed data gathered by the VRAG across several populations of offenders and found that instrument predicted violent recidivism with high accuracy (AUCs of 0.75, 0.74, and 0.74 for 3.5, 6 and 10 years respectively). Overall, the instrument's predictive validity of violent behavior among mentally disordered offenders has been well recognized and replicated several dozen times in at least five different countries (Campbell et al., 2009; Harris et al., 2004; Kroner & Mills, 2001).

Classification of violence risk (COVR). Monahan et al. (2006) published the COVR based on the results of the MacArthur Study of Violence Risk. The COVR is a user-friendly, time sensitive software that uses actuarial data to estimate future risk of violence. The program leads an evaluator through a chart review and brief patient interview subsequent to generating a

report of predicted violence (ranging from 1% - 76%) and list of contributing risk factors (Monahan et al., 2006). A major limitation of the instrument is the paucity of research related to its psychometric properties. Doyle, Shaw, Carter, and Dolan (2010) investigated the validity of the COVR in a sample of acute psychiatric patients in England and found that the COVR did not demonstrate significant violence predictive validity (patients classified as average risk were violent in the follow-up, but none of the high-risk patients were violent). Additionally, the COVR was constructed and validated on samples of psychiatric inpatients and questions regarding generalizability are yet to be determined.

A major criticism of the COVR, the VRAG, and the MacArthur variables in general, lies inherently in the static nature of the variables assessed. An individual's risk of future dangerousness could shift, based on current and dynamic variables, and thus their estimated risk of violence should in turn be swayed by such change. For instance, it seems likely that an individual's estimated risk of violence associated with mental health diagnosis would differ if the individual were stable or medication compliant. The primary objective of treatment is arguably to ameliorate these variables of risk that are amenable to change, and thus those very variables should be taken into consideration when evaluating future risk of violence.

Actuarial risk assessment based on dynamic factors. The notion that assessments of risk should take into account variables that are dynamic has more recently been a topic of interest in the risk assessment literature. Hart (1998) stated that a major criticism of static, actuarial assessments is the tendency to ignore dynamic variables. Incorporating dynamic variables in risk assessment measures is based on the notion that risk of violent offending is dynamic and that variables that account for such can provide useful information in assessing an individual's violence risk, as well as their treatment needs. Harris and Hanson (2010) further elucidated that a

major flaw of second-generation risk assessment tools is the lack of consideration given to the clinical utility of risk factors. To alleviate this flaw, third-generation risk assessment tools were developed with the goal of containing empirically validated factors that were amenable to change and thus had clinical utility (i.e., helped guide treatment and assess change). Two risk assessment measures that have garnered much attention in recent literature, in terms of predicting violence risk and providing clinical utility, are the Historical Clinical Risk Management-20 (HCR-20), and the Structured Assessment of Protective Factors for Violence Risk (SAPROF).

Historical clinical risk management-20 (HCR-20). The HCR-20 belongs to the structured professional judgment (SPJ) model of risk assessment, which is intended to combine empirical knowledge of risk with clinical expertise (Dolan & Doyle, 2000; Hart, 1998). The HCR-20 is the most widely used and researched empirically-validated risk assessment tool (Serin et al., 2016). Douglas and Webster (1999) developed the instrument after reviewing the emerging and ongoing literature on actuarial clinical risk assessment, namely measures that are static in nature (Goldstein & Weiner, 2003). The HCR-20 highlights 20 variables empirically found to be associated with estimated risk of future violence (Appendix B). These items encompass historical variables, such as difficulties with violence, antisocial conduct, or trauma; clinical issues in the present, such as problems with insight, mental health symptomatology, or violent ideation; and risk management predictors for the future, such as estimated future difficulty with professional services, living situation, or compliance with treatment. The information gathered is then coded and used to classify an individual's predicted future violence, risk of serious physical harm, and risk of imminent violence into low, moderate and high. What places the HCR-20 apart from other risk measures is that it provides clinical utility through measuring both static and dynamic variables of risk (Douglas & Webster, 1999).

The HCR-20 was constructed to be applicable to a multitude of populations, including civil, forensic, and correctional offenders (Jung, Ledi, & Daniels, 2013), as well as to enhance discharge decision-making for individuals in these settings (Douglas, 2014; Douglas & Webster, 1999). According to its authors, since its inception, the three versions of the HCR-20 (published in 1995, 1997, and 2013 respectively) have been the subject of several hundred empirical studies with rigorous methodology (Douglas et al., 2014). Examination of the HCR-20 demonstrated high interrater reliability (total score, $r = .80$; Grey et al., 2004). Douglas and Webster (1999) administered the HCR-20 to a group of inmates convicted of violent offenses to assess whether the instrument evidenced clinical utility to account for past violence. They found that individuals with scores above the median had increased the odds of past violence and antisocial behavior by approximately four times (Douglas & Webster, 1999).

In a two-year follow-up study of a forensic population, Douglas, Ogloff, Nicholls, and Grant (1999) found that patients scoring above the median on the HCR-20 were six to thirteen times more likely to violently reoffend than those scoring below the median. In a follow-up study conducted by Douglas, Yeomans, and Boer (2005) the predictive validity of the HCR-20 was examined. This study demonstrated that the HCR-20 had sound predictive validity for violent recidivism over a mean follow-up period of 7.5 years ($AUC = .82$). Additionally, the examiners evaluated the predictive accuracy of each set of variables (i.e., historical, clinical, and risk management) independently and found that the clinical and risk management scales (i.e., dynamic variables) were the strongest predictors of violent recidivism (historical scale, $AUC = .72$; clinical scale, $AUC = .79$; risk management scale, $AUC = .80$).

In addition to having strong predictive validity related to violent recidivism, studies have demonstrated that the HCR-20 has strong predictability in terms of forensic hospital readmission

(Gray et al., 2004). In a meta-analysis conducted by Campbell et al. (2009), 88 studies examining the predictive validity of structured measures to predict general violence in adults were compared. They found the HCR-20 was shown to have a large effect size for misconduct ($k = 11$), recidivism ($k = 11$), and institutional violence (weighted effect size = .28). Overall, the HCR-20 has been evidenced to significantly predict violent recidivism across various settings (AUCs = .67 - .75; Jung et al., 2013; Mills, Kroner, & Hematti, 2007); hospital readmission (Gray et al., 2004) and future physical violence (AUC = .76; Douglas et al., 1999).

Risk-needs assessment: structured assessment of protective factors for violence risk.

Beyond the third-generation assessments, fourth-generation assessments are beginning to arise. Along with the growing sentiment toward dynamic risk factors, there is recognition of the importance of including dynamic protective factors in assessment of violence prediction (Bonta & Wormith, 2008; Rogers, 2000). Fourth-generation instruments include a risk-need assessment (i.e., risk and protective factors) integrated with a case management plan (Bonta & Wormith, 2008).

The SAPROF is a relatively newly developed fourth-generation risk assessment instrument that adheres to a risk-needs assessment of risk, assessing strengths and protective factors of an individual, as well as highlighting treatment needs and goals (Appendix C). It is a measure of factors thought to be protective against violence; in addition to predicting future violence it is useful for developing individualized treatment targets. The SAPROF was developed as a positive, dynamic, treatment-focused assessment tool meant to accompany traditional tools, such as the HCR-20, that adhere to the structured professional judgment model of risk assessments (de Vrie Robbé & Willis, 2017).

The SAPROF encompasses 17 protective factors (two static and 15 dynamic) that are internal (e.g., intelligence, secure attachment in childhood, empathy, coping, and self-control); motivational (e.g., work, leisure activities, financial management, motivation for treatment, attitudes towards authority, life goals, and medication); and external (e.g., social network, intimate relationship, professional care, living circumstances, supervision). The items are calculated into final protection judgments that are rated as low, moderate, or high. A small but growing body of literature has examined the predictive validity of the SAPROF across settings (e.g., sexual violence, community violence, and institutional violence). de Vries Robbé (2014) published a thesis arguing the soundness of the psychometric properties of the SAPROF. He examined 105 patients who rated as high, moderate, or low on the SAPROF (high scores indicating increased protective factors) post-discharge from a Dutch hospital. The study demonstrated that the protective factors encompassed by the SAPROF evidenced good predictive validity for a desistance from violent re-offending, as the high group violently recidivated less often at one, two, and three-year follow-up (0%, 0%, and 10% respectively) than the moderate (2%, 6%, and 10% respectively) and low (22%, 34% and 41% respectively) groups (de Vries Robbé, 2014).

Additionally, a retrospective study examining the predictive utility of the SAPROF with violent and sexual offenders showed good predictive validities for violent reconviction with short and long-term follow up (de Vries Robbé et al., 2013). de Vries Robbé, de Vogel, and Spa (2011) conducted a follow-up study of 188 male offenders (105 violent and 83 sexual offenders) who were scored on several instruments including the SAPROF and the HCR-20 at one, three, and eleven-years post-discharge. Results showed good predictive validity of the SAPROF (AUC = .85, .75, and .73 respectively) the HCR-20 (AUC = .84, .73, and .64 respectively), and the

combined instruments (AUC = .87, .76, and .70 respectively) for violent reconvictions with short and long-term follow up. Additionally, the authors calculated interrater reliabilities on the SAPROF which were evidenced to be strong (ICC = .88 for violent offenders and .85 for sexual offender; de Vries Robbé et al., 2011).

Abidin et al. (2013) compared the SAPROF with other validated risk instruments (e.g., HCR-20) and found that the instrument had a strong inverse correlation with the risk factors on the HCR-20, indicating a true protective effect. Additionally, the examiners prospectively evaluated 98 patients in a secure hospital setting and found that the SAPROF evidenced sound predictive validity for absence of violence (AUC = .85) and absence of self-harm (AUC = .77). Research on the predictive validity of the SAPROF is promising; however, research is ongoing and the instrument's ability to accurately predict desistance from violence has yet to be firmly established. A second major limitation with the empirical basis for the SAPROF is that one of the original developers of the instrument, de Vries Robbé, has authored much of the research currently available.

Combination of instruments. A few studies have examined the combination of the HCR-20 and the SAPROF (de Vries Robbé et al., 2011; de Vries Robbé & Willis, 2017). In these limited studies, risk assessments conducted utilizing combined HCR-20 and SAPROF scores were found to have the best predictive validity for violent recidivism, evidencing statistically significant more accurate predictions than either tool alone (de Vries Robbé et al., 2013; de Vries Robbé & Willis, 2017). Ultimately these findings, although limited, suggest that future violent behavior may more accurately be assessed when protective factors are integrated in the risk assessment. Overall, the HCR-20 and SAPROF, when used in conjunction with one another, aim to assess static and dynamic risk factors, as well as protective factors of an individual. Though

intended to be utilized as a complement to clinical impression, some research has supported the combination of these tools, with the addition of clinical judgment, as the most valid method for predicting patients' violence (de Vries Robbé et al., 2013). However, the psychometric properties of the combination of these instruments still need to be rigorously evaluated.

Spanning the last several decades, there have been a multitude of research studies that empirically linked structured predictors of risk with future violence; however, there still exists a tension amongst clinicians in their attitudes toward actuarial and clinical risk assessment (Serin et al., 2016; Witt, 2000). Perceived dangerousness of patients established by subjective clinical judgment has been evidenced to over-classify patients as high risk (McDermot et al., 2008). Over the past 20 years, there has been an influx of instruments that have been developed to predict risk with increased accuracy and validity. However, presumably due to limited resources and lengthy administration times, professionals rarely use these instruments when evaluating dangerousness for release recommendations (Davison, 1997; McDermot et al., 2008). More recently, the notion that clinicians should use structured professional judgment in risk assessments by combining clinical judgment with scientifically grounded tools has garnered much attention as these methods have been noted to accurately substantiate the evidence for dangerousness (Guy, Packer, & Warnken, 2012; Serin et al., 2016). As such, in recent literature, an increasing number of studies have addressed the importance of incorporating structured risk assessment into conditional release evaluations, bail hearings, sentencing proceedings, and pre-parole evaluations (Vitacco et al., 2016; Witt, 2000). However, there is currently no standard or requirement to do so, and clinicians are within their rights to inform decisions of risk based on clinical impression alone.

Standards in Conditional Release Evaluations

Professional practice in psychology is regulated by professional societies as well as state and federal governing bodies, all of which provide professional practice guidelines, specialty guidelines, and practice principles (American Psychological Association, 2013). These standards of practice, combined with case law and statutes, are then utilized to inform standards of care. Although often used interchangeably, *standard of practice* and *standard of care* are thought to be distinct and separate constructs (Heilbrun et al., 2008). Standards of practice have been defined as best practices, or the customary way of doing things in a particular field (Heilbrun et al., 2008). Oftentimes these standards are established within a field and described as professional standards. Heilbrun, Phillips, and Thornewill (2016) defined professional standards of practice as “those developed by national organizations representing a large proportion of individuals in the legal or medical/behavioral science fields in the United States” (p. 287). As following a standard of practice is thought to be aspirational in nature, breach of such may result in sanctions, but not civil liability (Heilbrun et al., 2008). Some professional standards may merely be suggestions rather than requirements, and failure to comply with them provides no basis for complaint or sanction (Heilbrun et al., 2016). However, standards developed by professional organizations attempt to operationalize best practice, and are thus useful in guiding policy and practice (Heilbrun et al., 2016).

A standard of care is the usual and customary professional practice in the community. It is the minimally acceptable standard of professional conduct in a context that is judicially determined by a court of law (Heilbrun et al., 2008). Adherence is mandatory and breach may result in professional liability, as it may be considered negligence (Heilbrun et al., 2008). A broad array of contributing factors is required to develop a standard of care. These include

statutes, case laws, licensing board regulations, professional codes of ethics, agreement of the professional community and relevant specialty guidelines.

Standards in Forensic Mental Health Care

Although the topic of interventions with hospitalized offenders is outside the scope of this dissertation, it is being discussed here in order to provide a sense of the status of standards within the field of FMHC. While the literature widely acknowledges the need for uniform and evidence-based interventions, in the United States there are no widely agreed upon standards of such in forensic mental health care.

There is consensus in other countries that, regardless of the commitment type, mental health services have a responsibility to provide substantive care and support to mentally disordered offenders with a propensity of acting violently, be it toward themselves or others (Mullen, 2000). Offenders, mentally ill or not, entrusted in the custody of agencies, whether correctional or forensic in nature, substantially benefit from the highest level of rehabilitative and mental health services that can be ethically and practically offered (International Association for Correctional and Forensic Psychology, 2010). Improving the provision of such mental health care services offers substantive benefits to offenders, agencies and the larger community. Quality mental health services contribute to maintaining institution security, enhancing successful community reintegration, and decreasing legal difficulties. However, no such quality is dictated in literature or legislature (Sullivan & Mullen, 2006).

There are many benefits of clearly articulated and widely accepted standards of care for forensic mental health. Adequate standards can enhance institution security and functioning such as reduction of patient and staff stress levels and helping facilitate offender participation in rehabilitative programming. Clinical services that follow research-based guidelines can increase

the likelihood of successful reintegration of mentally ill offenders through promoting adequate community-based mental health care follow-up, and appropriate release decisions, thereby contributing to reduced recidivism. Additionally, by adhering to the guidelines and standards posited, correctional organizations, agencies, and staff can reduce the occurrence of civil litigation or other legal actions that can result from inadequate forensic mental health services (International Association for Correctional and Forensic Psychology, 2010).

Over the past several decades, education and certification in forensic psychology has increased in distinction. Arguably, the most honorable distinction that can be achieved by a forensic mental health professional is diplomate status through the American Board of Forensic Psychology, an affiliated member of the American Board of Professional Psychology (ABPP). To receive such diplomate status in Forensic Psychology is an attestation that the ABPP has recognized an individual as possessing “specialized knowledge, competence, and practice” in forensic mental health, and “has been found to have the ability to articulate clearly the theoretical, ethical, and legal foundations for his or her work in forensic psychology” (ABPP, n.d., para 2). Despite the fact that such credentialing exists, there is no requirement that the discharge evaluations be conducted by a mental health professional with those qualifications.

There is a substantial lack of information related to issues of organization, legality, as well as content of treatment, management, and rehabilitation services that have been shown to impact recidivism, relapse, and autonomous functioning (Hodgins, 2002). The development of a standard of care for forensic mental health treatment may allow for greater success in meeting treatment outcomes, reduction in recidivism, and a more enhanced quality of care. Further, if forensic mental health services aspire to deliver adequate and substantive care for their patients, as well as provide the increased sense of safety expected from the more global communal

standpoint, it remains of utmost importance that we continue to evaluate emerging service models and begin to propose a standard to be held (Mullen, 2000).

Standard of care in a psychology specialty. Throughout the development of forensic psychology as its own unique specialization, the development of a consensus regarding acceptable practice of such has been a question of interest. As the practice of forensic psychology involves aspects of clinical psychology combined with additional legal and ethical issues, forensic psychologists are tasked with adhering to general professional practice guidelines established for clinical psychologists, as well as specialty guidelines for forensic psychologists (Heilbrun et al., 2016).

Specialty guidelines for forensic psychologists. The Specialty Guidelines for Forensic Psychologists were originally developed and published by the American Psychological Association in 1991 and later revised in 2011 (APA, 2013). The Specialty Guidelines for Forensic Psychologists aimed to improve the quality of forensic psychological services and were the only guidelines that addressed a complete specialty area and approved by the APA (Committee on Ethical Guidelines for Forensic Psychologists, 1991). The guidelines were informed by the APA's Ethical Principles of Psychologists and Code of Conduct (APA, 2002), and aimed to provide forensic psychologists with guidance in their ability to (a) identify competent forensic practice; (b) practice responsibly and competently; (c) manage relationships with all parties involved throughout cases of assessment, treatment, or consultation; and (d) handle ethical issues of privilege, privacy and confidentiality (Committee on Ethical Guidelines for Forensic Psychologists, 1991; Heilbrun et al., 2016). More specifically, the following areas were addressed within the Specialty Guidelines for Forensic Psychologists: responsibilities; competence; diligence; relationships; fees; informed consent, notification, and assent; conflicts

of practice; privacy, confidentiality and privilege; methods and procedures; assessment; and professional and other public communications (APA, 2013; Committee on Ethical Guidelines for Forensic Psychologists, 1991). The 2011 revision of the Specialty Guidelines for Forensic Psychologists (APA, 2012) was vital in that it included the topic of forensic psychological assessment as well as acknowledged the expanding field of forensic psychology (e.g., APA dedicated a division to matters of law and psychology, several journals were devoted to forensic psychology and empirical studies in the field of forensic psychology were increasing). These guidelines addressed the issue of treatment in forensic facilities as well as ethical issues related to forensic assessment (e.g., informed consent and privilege) but did not address the discharge decision making process; however, many of the ethical and assessment related principles can be applied to the forensic assessment specialty of conditional release evaluations.

Writers have discussed the need for guidelines and standards and criticized the standards that currently exist. Expanding guidelines for forensic evaluations is critically important, as inconsistencies in the quality and practice of forensic psychological assessments have been identified in the literature, with a highlighted need for more rigorous standards and elucidation of practice (Heilbrun & Brooks, 2010; Heilbrun et al., 2008; Otto & Heilbrun, 2002). Whereas the Specialty Guidelines for Forensic Psychologists aimed to guide professional conduct, they are described as broad in nature and explicitly stated to be aspirational recommendations rather than mandated standards of care; violation of them would not result disciplinary action or liability (APA, 2013). They made no pledge of acting as standards; however, they did address their potential impact toward the creation of a standard of care in the field of forensic psychology, as they overtly highlighted that “in cases in which a competent authority references the guidelines when formulating standards, the authority should consider that the guidelines attempted to

identify a high level of quality in forensic practice” (American Psychological Association, 2012, p. 2). As such, although the Specialty Guidelines for Forensic Psychologists offered guidance on informing uniform and ethical practices in forensic mental health care and assessment, which can then be extrapolated to inform standards for specialty areas such as discharge evaluations, they did not provide the much-needed specific, enforceable standards of care to be applied in such cases.

APA practice guidelines. Two sets of APA practice guidelines relevant to forensic practice were published during the 1990s. First, in 1994 APA released Guidelines for Child Custody Evaluations in Divorce Proceedings, with the primary objective to “promote proficiency in using expertise in child custody evaluations” (APA, 1994, p. 677). Second, in 1998, APA’s Council of Representatives adopted the Guidelines for Psychological Evaluations in Child Protection Matters (APA, 1998). Although these guidelines addressed a different population from NGI, the guidelines provided a model of the kind of rigor and detail that was missing for the task of discharge evaluation.

Unlike other guidelines published, the APA guidelines focused mostly on the format and process of the evaluation. These were set forth to facilitate quality of practice by psychologists conducting custody evaluations. Throughout both APA practice guidelines, issues related to evaluation purpose, role definition, competence, confidentiality, informed consent, and the structure of the evaluation were discussed in great detail (Heilbrun et al., 2016). Similar to the Specialty Guidelines for Forensic Psychologists, these APA practice guidelines were neither mandatory nor exhaustive, and were aspirational in nature.

As a result of the call for increased standardization for child custody evaluations, states have begun to adopt legally mandated standards of care for child custody evaluations. For

instance, the California Courts (2013) issued Title Five: Family and Juvenile Rules (Rules 5.1 – 5.906), an exhaustive list of legally mandated criteria that must be considered while conducting a child custody evaluation. These included issues of evaluator qualification, disclosures, scope of the evaluation, and ethics pertaining to child custody cases. The aforementioned standards and guidelines relevant to forensic psychology practice have become more prominent, leading to tremendous gains in the field; however, there are yet to be practice guidelines for the conditional release evaluations in forensic psychology that are comparable to the standards for custody evaluation. Such guidelines would standardize discharge practices, minimize variability in report quality, and increase the utility of these evaluations. The model of guidelines and standards for child custody evaluations may prove to be useful in developing a standard of care for the forensic assessment specialty area of conditional release.

Development of practice standards. Development of practice guidelines or standards is a lengthy and arduous process that includes the designation of a task force once a professional organization is convinced that such guidelines are necessary. Once such a task force convenes, achieving professional consensus based on scientific knowledge and clinical experience is required (Heilbrun et al., 2016). Current APA policy regarding the development and implementation of practice guidelines stipulates that (a) the need for practice guidelines must be clearly described; (b) the guidelines must be drafted by a professional body; and (c) the guidelines must undergo a lengthy period of internal and public reviews, during which they are subject to revision (APA, 2005). While the APA enforces violations of ethics, as per the Ethical Principles of Psychologists and Code of Conduct (APA, 2002), other documents, including the aforementioned APA approved guidelines for child custody evaluations, are advisory in nature. Heilbrun et al. (2008) argued that in order for practice guidelines to have a substantial impact on

improving the quality of forensic practice, they must be adopted by and incorporated into a document used by an organization with authority to enforce violations, or be adequately reflective of the standard of practice used by professionals in the field in order to inform court decisions regarding malpractice of the standard of care for the field.

Standard of care in forensic psychological assessment. There is a budding body of literature that highlights the need for, as well as the emergence of, a standard of care in forensic mental health assessment (Conroy, 2006; Grisso, 2010; Heilbrun, 2001; Heilbrun et al., 2008). This body of literature portrays that the practice of forensic mental health assessment requires attention to specific matters of organization, content, and nature above what is required from general clinical psychological evaluations. Heilbrun (2001) proposed a list of 29 principles aimed to enhance the quality of forensic psychological assessment through expanding areas related to report writing as well as training, research endeavors, collaborative policy changes, and courtroom testimony (Appendix D). These recommendations have highlighted the foundations for an emerging standard of care for forensic assessment, with a current movement in the profession that provides inclusionary criteria for such standards. Goldstein (2007) argued that a standard of care in forensic mental health assessment entails (a) ethical conduct, (b) knowledge of the legal system, (c) integration of information from a multitude of sources, (d) appropriate methodology, (e) appreciation for emerging and relevant literature related to the issue being evaluated, and (f) thoughtfulness in preparations and presentation of the results of the evaluation. Allan and Grisso (2014) further postulated that the essence of good forensic practice lies in adherence to ethical principles, standards, and guidelines. Researchers have thus argued that through adherence to standards of ethical and professional conduct, in conjunction with specialty guidelines in forensic psychology, a commitment to a standard of care in forensic

psychology can be upheld (Allan & Grisso, 2014; Kalmbach & Lyons, 2006). If such is widely believed true, then these same standards can be applied to conditional release evaluations, which fall under the umbrella of forensic psychological assessments.

Conditional release evaluations and discharge readiness. Conditional release evaluations, or the recommendation that an individual be retained in a forensic institution or released to the community, are vital to both the patient in question, and the surrounding community. The principal aim of a conditional release assessment is to formulate an opinion on the perceived risk of future violence. Readiness for release should be based on the prediction that the offender is a low enough risk to be discharged to the community without future violent recidivism. While the utilization of structured risk assessments in forensic evaluations (e.g., assessments of future violence risk, criminal responsibility, and competency to stand trial) has substantially increased over the past decade, conditional release evaluations appear to be deficient in standardized evaluation protocol (Gowensmith et al., 2014). Furthermore, studies on the effectiveness of violence prediction have found that unstructured clinical judgments have a lower predictive validity than those made using structured risk assessments (de Vogel, de Ruiter, Hildebrand, Bos, & Van de Ven, 2004).

The nature of conditional release evaluations has been a topic under recent scrutiny and examination. Studies have demonstrated that when compared to other forensic evaluations, reports on conditional release readiness have the lowest evaluator reliability (Nagtegall & Boonman, 2016; Nguyen, Acklin, Fuger, Gowensmith, & Ignacio, 2011). This is largely due to the variability in which evaluations are conducted and the inaccuracy with which discharge decisions are based. McDermott et al. (2008) examined the process by which clinicians made conditional release decisions over the past three decades. The study included a random sample of

all NGI acquittees released from Napa State Hospital between 1973 and 2006. The majority of patients (43%) were released from the institution in the 1990s and the average length of hospitalization was 10.5 years. Readiness for release documentation for each patient released were coded into six general areas: (a) compliance with treatment, (b) treatment responsiveness, (c) insight, (d) substance related problems, (e) aggressive behavior, and (f) any use of structured risk assessments. A variety of statistical methods were employed to evaluate patterns in decision-making, including analysis of variance and chi-square analyses. McDermott et al.'s (2008) findings suggested that examiners typically viewed responsiveness to and compliance with treatment ($n = 0.43$ and 0.42 respectively), presence or absence of substance use ($n = 0.22$), and aggressive behavior ($n = 0.26$) to be of primary concern when tasked with making conditional release recommendations. While some evaluators assessed risk of violence using structured risk assessments (mean score for readiness for release documentation including formal assessments of risk was 0.03), the majority used unaided clinical judgments. Their examination highlighted the immense variability in discharge decision-making evaluations and elucidated the need for data-driven conditional release decisions, guided by uniform standards of care (McDermott et al., 2008).

Summary of Best Practices: Conditional Release Evaluations

The call for the operationalization of a standard of care in forensic mental health assessment is apparent throughout the literature. As described in the previous pages, several researchers have highlighted criteria that would be vital in developing a standard of care in forensic psychological assessment (e.g., Goldstein, 2007; Heilbrun, 2001). More specifically, Goldstein (2007) highlighted that a framework for the development of a standard of care for forensic evaluations include (a) ethical conduct, (b) knowledge of the legal system, (c)

integration of information from a multitude of sources, (d) appropriate methodology, (e) appreciation for emerging and relevant literature related to the issue being evaluated, and (f) thoughtfulness in preparations and presentation of the results of the evaluation. Heilbrun (2001) proposed a list of principles aimed to enhance the quality of forensic psychological assessment through expanding areas related to (a) report writing, (b) training, (c) research endeavors, (d) collaborative policy changes, and (e) courtroom testimony.

Proposed Standards of Care in Conditional Release Evaluations

As a result of the critical examination of the literature, a set of five principles for the development of a standard of care for conditional release evaluations has been derived from (a) guidelines described in current practice procedures in conditional release evaluations, (b) criteria for standard of care in forensic mental health assessments proposed by researchers, and (c) deficits in the conditional release decision-making process illustrated throughout the literature. These five principles are: (a) professional and ethical conduct, (b) patient progress, (c) assessment of risk, (d) proposed release plan, and (e) evaluation of commitment to successful reintegration.

Principle 1: Adherence to professional and ethical conduct. Forensic mental health professionals are expected to engage in professional practice that is consistent with professional and ethical conduct (Goldstein, 2007). As the scope of forensic practice encompasses clinical elements supplemented by additional legal issues, forensic psychologists must execute in a manner consistent with the Ethical Principles of Psychologists and Code of Conduct, as well as specialty guidelines relevant to forensic practice (i.e., *Specialty Guidelines in Forensic Psychologists*; APA practice guidelines; Allan & Grisso, 2014; Committee on Ethical Guidelines for Forensic Psychologists, 1991). These same ideas are applicable when conducting

conditional release evaluations and should include standards for informed consent, disclosure of limits of confidentiality, integrity, impartiality and fairness, conflicts of interest, prejudicial language, and respecting rights and dignity of persons.

As any forensic evaluation may be reviewed in court, ethical and professional considerations in conducting such evaluations should include thoughtfully preparing and presenting the results of the evaluation in question so that the evaluator is prepared to testify effectively under cross-examination. Forensic evaluators are thus expected to adhere to the standard, dictated in the Specialty Guidelines for Forensic Psychologists, that the preparation and presentation of their evaluations be guided objectively (e.g., not swayed by the expectations of other parties involved) and by evidentiary reasoning (Committee on Ethical Guidelines for Forensic Psychologists, 1991; Goldstein, 2007; Kalmbach & Lyons, 2006).

Encompassed in adherence to professional and ethical code of conduct is the notion that a competent clinical psychologist must have a thorough understanding of the scope of their practice (Grisso, 1986). In a clinical psychological evaluation this relates to clinical aspects of psychology (e.g., symptoms, diagnoses, risk factors, cultural components, clinical psychological assessment instruments, etc.); however, when conducting forensic assessments this would further entail the legal aspects of the case (e.g., statutes, case laws, practice procedures, issues of expert testimony and consultation; Goldstein, 2007; Grisso, 1986). Additionally, evaluators should have specialized training, supervised experience, consultation, or credentials in forensic psychological assessments. In terms of conditional release evaluations, these legal issues would include items such as specific statutes and practice procedures in various states, as well as guidelines or requirements of the evaluation.

An appreciation for emerging and relevant literature is an additional component inherent in competence within a professional's scope of practice. Goldstein (2007) argued that a standard of care in forensic psychological assessment must include the need for a familiarity with relevant empirical research. An ethical and competent forensic evaluator should be reasonably knowledgeable regarding the field of literature that is relevant to the issue being evaluated in order to better inform legal decisions (Goldstein, 2007; Heilbrun, 2001). Appreciation for research findings relevant to particular groups of individuals (e.g., NGI acquittees), validity of forensic instruments (e.g., risk assessment tools), diagnostic categories, and outcome measures (e.g., efficacious treatment, rates of recidivism) would therefore be necessary in the development of a standard of care for conditional release evaluations.

Lastly, it is vital that the evaluative components of the conditional release evaluation are informed from a multitude of sources. To ethically and competently derive an opinion or conclusion, the evaluator should include integration from multiple data points (Goldstein, 2007). This includes gathering information that extends beyond an individual's account of his or her own history, as well as incorporating myriad sources to substantiate or discredit an evaluation.

Principle 2: Documentation of patient progress. Encompassed in the United States Penal Code is the stipulation that, aside from posing a danger to the community, the individual must recover from mental illness prior to being eligible for conditional release. This is largely due to the correlation between mental illness and risk of violence. This component is especially critical to evaluate because mental health instability has long been linked to risk of violence. Additionally, if NGI acquittees are remanded to facilities for periods longer than required (i.e., past the points at which their mental health symptomatology is stable and they are at low risk for violent reoffending), the committing institution risks being in violation of due process protection

and ethical patient care. To ensure both ethical patient care and enhanced community safety, conditional release evaluations should include an assessment of patient progress. These assessments should include information related to patient's behavior, insight, clinical symptomatology, and daily functioning throughout the course of their hospitalization. Although ideally institutions should develop standardized methods to track patient progress, relying on chart review, progress notes, treatment team meetings, and additional collateral information is likely sufficient pending the development for such methods.

Principle 3: Incorporation of empirically-validated risk assessment tools. The utilization of reliable and valid psychological instruments provides invaluable information when conducting evaluations. The inclusion of forensic psychological instruments, with clear psychometric properties, can enhance the credibility and quality of forensic reports. However, it is important to note that utilizing psychological instruments that are unsubstantiated, unnecessary, or invalid is largely believed to be unethical (Heilbrun, 2001). Thus, the usage of appropriate methodology is a vital standard for any evaluation (Goldstein, 2007; Heilbrun, 2001). Despite the fact that forensic assessments (i.e., structured risk assessment tools) are widely used in a plethora of forensic evaluations (e.g., competency to stand trial and risk assessments of violent offenders), they are much less commonly used in conditional release evaluations of NGI acquittees (Gowensmith et al., 2014; McDermot et al., 2008). Statutory regulations of conditional release dictate the release of a forensically committed patient to occur at the point at which they are no longer a danger to themselves or others (CCP. Title 18, U.S.C. §§ 1, 1948). Due to the statutory component of presumed risk inherent to release recommendations, structured assessments of risk, such as the HCR-20 combined with the SAPROF, should be utilized when conducting conditional release evaluations.

Research on the validity of predicted risk of violence indicates that clinical predictions of risk tend to overestimate one's risk of future violence. As such, the utilization of structured risk assessments has been demonstrated to increase the efficacy and validity of predicted level of risk. Additional studies have indicated that the predictability increased with accuracy when both static and dynamic variables were taken into consideration, and further when risk and protective measures were accounted (de Vries Robbé et al., 2013; Douglas & Webster, 1999). Furthermore, when protective factors were taken into consideration when predicting future risk, the prediction accuracy increased, although further studies must be conducted to substantiate these claims. Although its predictive validity has yet to be firmly established, the SAPROF is an instrument that has promising empirical foundation and that fits the current risk-needs model for risk assessment. Theoretically, accounting for protective factors against violence aids in the predictive validity and clinical utility of the assessment, and as such the inclusion of protective factors in a conditional release evaluation appears to be additive. By utilizing both the HCR-20, as well as the SAPROF in conditional release evaluations, a forensic evaluator would thus be able to assess an offender's estimation of dangerousness with increased efficacy and validity. However, as the empirical soundness of the SAPROF is still underway, it is firmly recommended that the HCR-20 be included in conditional release evaluations with the potential for supplementation with the SAPROF once its predictive validity has been evidenced more widely. These instruments, when combined, should identify the risk (static and dynamic), and protective variables of violence, as well as the characteristics that have been recommended or required to be considered in the conditional release decision-making process (e.g., CONREP recommendations, Wisconsin letter of readiness recommendations, and Missouri statutory guidelines). A review of

these instruments (Appendices B and C) will indicate the wide range of variables that would be assessment.

Encompassed within the HCR-20, an evaluator would gather information related to an offender's historical difficulty with (a) violence, (b) antisocial conduct, (c) relationships, (d) employment, (e) substance use, (f) mental illness (including personality disorders), (g) trauma, (h) violent attitudes, and (i) treatment or supervision response (including past difficulty with conditional release). Additionally, the HCR-20 would guide information gathering related to the offender's current difficulties with (a) insight (related to mental illness, violence risk, need for treatment), (b) violent ideation or intent, (c) mental health symptomatology, (d) instability (affective, behavioral, and cognitive), and (e) compliance with and responsiveness to treatment and/or supervision. Lastly, utilizing this instrument, a forensic evaluator can make guided estimations, based on the aforementioned static and dynamic variables, of an offender's future difficulties with (a) professional services and plans, (b) living situation, (c) personal support, (d) compliance with and responsiveness to treatment or supervision, and (e) stress or coping.

With the addition of the SAPROF, a forensic evaluator would be able to identify (a) internal protective factors (e.g., intelligence, secure attachment in childhood, empathy, coping, and self-control), (b) motivational protective factors (e.g., work, leisure activities, financial management, motivation for treatment, attitudes towards authority, life goals, and medication compliance), and (c) external protective factors (e.g., social network, intimate relationship, professional care, living circumstances, and responsiveness to supervision), all of which contribute to estimations of risk. Assessment of protective factors is thought to be additive to a comprehensive risk assessment using a risk-reduction model by identifying what a patient needs to increase desistance from violence, identifying resources that could be provided in the

community following conditional release. If the SAPROF is not used by the evaluators, the conditional release evaluation should still address protective factors as part of the structured clinical judgment model for assessing risk and providing a more comprehensive picture of the patient.

Principle 4: Creation of a comprehensive release plan. Current literature reflects that rates of recidivism are substantially higher when violent offenders are released without outpatient services. Therefore, standards for conditional release evaluations should require a proposed release plan, as well as an individual's insight related to the plan. These release plans should typically include community resources, medical and mental health care, medication compliance, substance abuse treatment, and treatment goals, all items that contribute to a successful conditional release. Specification of these plans, along with the NGI acquittee's insight related to them, should increase the validity of conditional release evaluations, as it would provide a more concrete understanding of the patient's goals, attitudes, and resources to aid in their successful release. For example, an ideal treatment plan would entail conditions of supervision, graduated changes in level of monitoring, ongoing medical and psychiatric care based on individual needs, as well as recreational activities, goals, family and community supports, and other protective factors against risk.

Principle 5: Verification of patient's commitment to successful reintegration. Lastly, standards for conditional release evaluations should require an evaluation of a patient's commitment to successful community reintegration. When NGI acquittees are conditionally released they are statutorily mandated to adhere to a multitude of legal, medical, and psychiatric supervision or care requirements. They are further required to abstain from further criminal behavior. A statement and evaluation of an acquittee's willingness to comply with the stipulated

conditional release terms and conditions would offer the evaluator insight into the patient's commitment to rejoin the community and desist from behaviors that would result in a revocation of their conditional release.

While the notion that a standard of care would be beneficial in increasing the validity and efficacy of conditional release evaluations has been evidenced, creating a standard of care for such is not without challenge. Careful consideration of individual factors should be thoughtfully examined and attended to, as is true for any uniform or standard practice (i.e., issues of diversity or special populations). Additionally, the process to develop a standard of care, as described in the literature review, is a lengthy and arduous one. Nevertheless, this list of five core standards, derived from a comprehensive, critical literature review, could provide the basis for mitigating the steps toward the development of standards that are greatly needed.

DISCUSSION

Throughout the United States are institutions filled with mentally disordered offenders who have been found NGI, many of whom have committed violent crimes. The majority of these patients, these NGI acquittees, have experienced extensive mental health and legal histories. Oftentimes these patients have had, and continue to have, numerous cycles of hospitalizations, incarcerations, and conditional release revocations. The lack of successful community reintegration in part suggests a failure by our current forensic mental health system to decrease both mental health symptomatology and recidivism. A main priority in dealing with mentally disordered offenders is ultimately a decrease in recidivism, or more globally, community safety and ethical patient care. More specifically, essential goals of forensic mental health institutions should be to provide treatment that will decrease the likelihood that an individual will reoffend and to conduct evaluations that increase the accuracy of predicting such violence risk.

To ensure adherence to due process protection and ethical patient care, NGI acquittees remain committed to forensic institutions until they are deemed to no longer pose a danger to society. The evaluation of presumed risk is often left to forensic mental health evaluators, who communicate their opinions to the designated judge. While conditional release evaluations and practice procedures vary state by state, there is a consensus, based in the literature and the United States Penal Code, that these release recommendations should be informed by the NGI acquittee's current state of mental illness and predicted risk of violence. However, there are no standards or guidelines directing how this information should be gathered or how these evaluations should be conducted. The purpose of this dissertation, guided by the lack of standards of care in conditional release evaluations, was to (a) ascertain methods and instruments currently used to evaluate patients for conditional release; (b) examine the research on widely

used instruments for assessing risk of future violence and assess their utility as part of evaluation of NGI acquittees who apply for conditional release; and (c) propose a framework for development of standards and for future research that would contribute to the development and validation of such standards and guidelines.

Current Methods Guiding Conditional Release Evaluations

According to the United States Penal Code, an NGI acquittee is to be released from the State's commitment at the point which it is concluded that "the person has recovered from his mental disease or defect to such an extent that his release... would no longer create a substantial risk of bodily injury to another person or serious damage to property of another" (CCP. Title 18, U.S.C. §§ 1, 1948). While there are no clear standards stipulated in the penal code for how this recovery is determined, it is apparent that the conditions that should be evaluated prior to release are an individual's (a) mental illness and (b) violence risk. When a patient's mental health symptomatology has been deemed stabilized, and their risk of future dangerousness is predicted to be low, they are to be released from the forensic institution. These determinations, or conditional release evaluations, are typically established by forensic mental health specialists, who evaluate a patient and provide their opinion in a court of law. Although the practice procedures surrounding conditional release evaluations vary throughout the United States, the main goal is to provide opinions of a patient's perceived readiness for release that are informed by the current state of their mental illness and risk of future violence.

As discussed in the Literature Review section, there is no uniformity in or guidelines for conducting or structuring conditional release evaluations. Due to the fact that public safety is of primary concern, the decision-making process to release violent offenders often entails some form of assessment of risk (formal or informal) to evaluate the individual's presumed risk of

future violence. These assessments are regarded as the most critical component of a conditional release evaluation and are either based on clinical opinion or objective data garnered from structured measures of risk. Most of the commonly used instruments for assessing risk of future violence fall into two categories: (a) those that measure static variables alone, and (b) those that include a measure of static and dynamic variables. Static variables that have been empirically found to be associated with risk include (a) gender (e.g., males are somewhat more likely than women to be violent), (b) prior violence, (c) neighborhood and race (e.g., neighborhoods with high violence and low socioeconomic status), (d) diagnosis (e.g., a diagnosis of a major mental disorder, with the exception of schizophrenia which was negatively correlated with violence), (e) psychopathy, as measured by the Hare Psychopathy Checklist, (f) delusions, (g) hallucinations, (h) violent thoughts, and (i) anger, as measured by an anger rating scale (Steadman et al., 1998). While these variables of risk have been demonstrated to be useful in determining risk of violence (e.g., the more variables an individual possess, the higher likelihood said individual poses a risk of violence), they offer little to the idea of change or study of risk reduction, as historical items are impossible to modify. Adding to the predictability of violence risk and to the study of risk reduction are dynamic variables associated with risk (i.e., those that are amenable to change).

Instruments assessing risk of future violence. Although the inclusion of formal, structured, risk assessment measures in conditional release evaluations is at the examiner's discretion, tools that have acquired attention in the recent literature on violence risk include the VRAG, HCR-20, and SAPROF. A discussion of the utility of these measures is of extreme importance, as the quality of conditional release evaluations is largely dependent on the validity of methods for predicting future violence. The critical analysis of the literature on measures of risk assessment supports the view that the most empirically studied and validated tools to predict

risk include the VRAG and HCR-20. The SAPROF, while relatively naïve in its empirical foundation, demonstrates promising support in terms of predictive validity and clinical utility because of its focus on protective factors, which can be incorporated into discharge planning.

The literature discussed in the Literature Review section highlights the psychometric properties and clinical utility of the aforementioned risk assessment instruments. The VRAG is a measure of actuarial risk with sound predictive utility (e.g., 55% of the high scoring group re-offended violently while only 19% of the low scoring group did; Harris et al., 1993). While the VRAG is considered to be a good predictor of future violence, criticism of the measure lies in the fact that it measures static data alone. The HCR-20, on the other hand, measures static and dynamic variables and is the most widely used and researched empirically-validated risk assessment tool (Serin et al., 2016). The HCR-20 encompasses historical (past), clinical (present), and risk management (future) variables associated with estimated risk. The HCR-20 is therefore thought to compose a more comprehensive estimate of violence risk and has been evidenced to have strong predictive validity. Those who were categorized to be high-risk based on the measure were found to be six to thirteen times more likely to reoffend in a follow-up study, strongly linked to future violence and hospital readmission.

In a shift toward developing risk assessments that fit a more encompassing risk–need model, the SAPROF was developed and meant to accompany a structured clinical judgment model risk assessment tools (e.g., the HCR-20). The SAPROF adheres to a risk–needs assessment of risk as it assesses strengths and protective factors of an individual, as well as highlighting treatment needs and goals. More recently, researchers have sought to evaluate the predictive validity of risk assessments by including factors empirically found to be protective against risk of violence; the SAPROF aims to do such by assessing for an individual’s level of

presumed risk while accounting for items that are found to lower such risk. As discussed in the Literature Review, investigation of the soundness of the psychometric properties of the SAPROF is underway. The SAPROF has been demonstrated to have good predictive validity for a desistance from violent re-offending, and its predictive utility with violent and sexual offenders showed good predictive validities for violent reconviction with short and long-term follow up. However, limited empirical evidence currently exists and an expansion of research for the SAPROF is necessary (de Vries Robbé et al., 2013). Research conducted by investigators who were not part of the team that developed the instruments is desirable.

Practice standards for conditional release evaluations across the United States. The critical analysis of the literature on practice standards for conditional release evaluations found that several states have developed guidelines to help increase the efficacy of conditional release evaluations. However, with the exception of Missouri whose guidelines are statutory, they are aspirational in nature. California's conditional release program, CONREP, encourages evaluators to consider a patient's (a) recent behavior, (b) level of dangerousness, (c) adherence to treatment, (d) medication compliance, (e) insight into mental illness, (f) treatment readiness and goals, (g) risk and protective factors in the community, (h) history with CONREP, (i) criminal history and insight into index offense, (j) current mental status, and (k) willingness to comply with CONREP terms and conditions when conducting evaluations of release readiness. The state of Wisconsin encourages a patient's treatment team to write a readiness letter to the court related to a patient's (a) dangerousness, (b) index offense, (c) mental health history and present mental condition, and (d) access to available community resources. Missouri's state statute section 552 requires that the court consider the following when making conditional release decisions: (a) the nature of the index offense, (b) the patient's behavior while committed to the forensic facility, (c) the period

of time that has elapsed between the hearing and the last reported unlawful or dangerous act, (d) a proposed release plan, (e) community or family support, and (f) prior history of conditional release and revocation of such.

Although all of these guidelines indicate that mental illness, or behaviors associated with such, as well as level of dangerousness be assessed prior to releasing an NGI acquittee from institutional commitment, there is no requirement of how these assessments are made. While the development of the DSM has aided in the standardization and clarification of mental disorders, predictions of violence risk remain more difficult and ambiguous. Sometimes these predictions are informed by structured risk assessments, while other times they are based on clinical opinion alone.

Practice procedures in conditional release abroad. In looking at the practice procedures in conditional release decision-making in other countries, researchers can aim to identify facets that are effective, and those that are limited, in attempts to model standards for conditional release evaluations to be utilized throughout the United States. For example, review of the discharge decision-making framework in the Netherlands may prove to be beneficial in enhancing such throughout the United States. In a study assessing conditional release readiness recommendations in the Netherlands, Nagtegal and Boonman (2016) found that recidivism rates were substantially higher for individuals whose release was contrary to the evaluator's recommendation (e.g., the judge granted release although the evaluator did not recommend it). Readiness recommendations in the Netherlands are largely uniform and systematic and, as such, they are more often than not in line with judiciary decisions (Nagtegal & Boonman, 2016). However, discharge decision-making is vastly different in the Netherlands than in the United States. In the Netherlands, a judge imposes a conditional release order and requires a prolonged

commitment hearing (Nagtegall & Boonman, 2016). A committee of individuals from the forensic hospital, the probation service, the public prosecutor's office and an independent psychiatrist (or a second independent behavioral expert if petitioned) is formed. Each member writes an autonomous report on the perceived readiness of the patient being considered for release. The reports must include a formulated opinion from each individual as to the perceived risk for future violence, as well as offer a recommendation on the patient's discharge readiness (Nagtegall & Boonman, 2016). Although there is no statutory requirement to include a structured risk assessment in these reports, such assessments (e.g., HCR-20) are recommended and are often administered throughout an NGI acquittee's commitment (e.g., when starting unsupervised leave and when the annual or biannual advice to the court is presented; de Ruiter & Hildebrand, 2007).

Additionally, the Netherlands employs a step-down transitional process prior to being discharged from a forensic institution. Most patients progress through four types of leave, with decreasing security and increasing time outside the hospital, before conditional release and ultimately final discharge, a process that is thought to reduce recidivism rates substantially (Nagtegall & Boonman, 2016). It can be argued that increasing the efficacy of conditional release evaluations in the United States, ideally through creating a standard of care to which the evaluations must be conducted by, may decrease recidivism, which further highlights the need to do such. Detailed review of conditional release practice procedures in other countries may further elucidate both valuable and problematic factors of such procedures that would aim to enhance current conditional release evaluation practices throughout the United States.

Violence prediction. As discussed in the Literature Review section, throughout the last several decades there has been an increase of research related to the study of violence prediction.

Historically, clinicians have largely made predictions of an individual's level of dangerousness on the basis of clinical impression alone. However, the literature on risk associated with violence has since changed the perception of how to assess risk. The development of structured risk assessment tools is supported by research aimed toward identifying risk factors associated with violence. These tools aim to identify and isolate these risk variables to better inform predictions of risk. Since the development of these structured tools, studies on clinical prediction of risk have largely evidenced the superiority of structured assessments of risk over clinical estimations. While these tools are commonly used in other forensic mental health assessments (e.g., court-ordered risk assessments), studies have shown that they are more of a rarity in evaluating NGI acquittees for conditional release readiness. This finding is of serious concern, given the fact that such evaluations are statutorily required to be informed by predictions of dangerousness, and, as summarized in the Literature Review, most clinicians disclosed that violence prediction is the primary concern when conducting conditional release evaluations.

There is promising research on the validity of assessment of risk when both static and dynamic variables of risk (i.e., elements which are fixed and those that are amenable to change) are taken into consideration. While static risk variables (i.e., mental health history, early childhood maladjustment, substance abuse history, history of violence) have been empirically linked to increased risk of violence, they must be supplemented by variables of risk that are subject to change (i.e., current difficulty with substance abuse and mental health symptomatology). It is vital that these variables be considered when predicting risk of violence because violence risk factors are ever changing and, as such, so is an individual's risk of violence. While an individual's history is compounded by static variables of risk that will remain, that individual's level of risk is also impacted by factors of risk that are amenable to change and,

more importantly, that are encouraged and facilitated to change. Not accounting for dynamic variables of risk is, in essence, ignoring a belief in rehabilitation, as change, after all, is the very goal of treatment. Overall, the inclusion of dynamic variables of risk is thought to enhance decision-making accuracy and reduce decision errors, such as premature release of dangerous individuals or extended commitment of harmless ones.

Additionally, the notion that clinicians should combine clinical judgment with scientifically grounded tools has garnered much attention as these methods have been noted to accurately substantiate the evidence for dangerousness. Overall, conducting assessments of risk that incorporate clinical judgment, static and dynamic variables of risk, as well as addressing an individual's protective factors, further enhances the accuracy of risk prediction and fit the current professional shift towards a comprehensive model of risk assessment that is risk-needs based. Due to the evidenced predictive validity and enhanced clinical utility of this integrative method, the development for a standard of care in conditional release evaluations should include an assessment of risk that encompasses a combination of the aforementioned variables.

Despite the evidence of the predictive validity of structured risk assessment measures, such as the VRAG and HCR-20, as well as the support in the literature on the SAPROF that accounting for protective factors enhances one's estimation of risk, there is no requirement or standard that evaluators include these tools in the discharge decision-making process. As a consequence of the lack of standards of care regarding discharge recommendations, individuals are often discharged to the community prematurely, or left in institutions for lengthy and indeterminate periods of time, in violation of their civil rights.

Advantages and Limitations of the Present Study

The critical analysis methodology used in this dissertation proved to be a useful approach

to acquiring a large amount of information on a complex topic: the social, legal, and clinical issues surrounding conditional release evaluation procedures for NGI acquittees. The critical analysis strategy further allowed for a comprehensive and thorough literature search that resulted in the acquisition and review of empirically validated research, which was used to propose a framework for development of standards of care for conditional release evaluations in order to meet the needs of NGI acquittees, forensic mental health treatment providers, and the larger community. Moreover, this strategy allowed for the successful pulling together of topics that had not yet been integrated. When integrated, these topics lay the groundwork for future research and possible policy changes related to conditional release evaluations. A summary of the literature reviewed for the present study is presented in the literature table (Appendix A).

Although the methodology employed in this project resulted in a comprehensive overview of the current methods for conditional release evaluations, and an analysis of such contributed to recommendations for a framework to enhance them, it was not without limitations. This project should be viewed as a preliminary step; there is no claim of support for the validity of the recommended standards of care for conditional release evaluations. To alleviate this deficit, it is recommended that follow-up studies be conducted to ascertain the accuracy of the (a) predictions of future risk of violence, and (b) conditional release evaluations, given the recommended methods provided in this project. Additionally, this project is limited by the paucity of literature related to the SAPROF as well as the narrow body of literature that does exist on the instrument (e.g., most of the studies published included the developer). Another limitation is the scarcity of literature related to conditional release evaluations and standards of care in forensic mental health settings. While the field of forensic psychological assessment has

garnered much attention over the last few decades, there is still a substantial body of literature yet to be created.

Recommendations for Future Research

Research endeavors aimed to advance the quality and uniformity of forensic mental health care and assessment are needed. Despite a consensus in the literature (Gowensmith et al., 2014; Heilbrun, 2001; Heilbrun et al., 2008; McDermott et al., 2008) that the assessment of forensic patients is a topic begging examination, there is extreme paucity of research in the field. Directions for future areas of study include further examination of the five proposed principles for conditional release evaluations: (a) adherence to professional and ethical conduct; (b) documentation of patient progress; (c) incorporation of empirically-validated risk assessment tools; (d) creation of a comprehensive release plan; and (e) verification of patient's commitment to successful reintegration. There is value in further studying the standards of care proposed in this project to assess how forensic clinicians perceive these recommendations, as well as which elements they believe are vital to enhance decisions regarding release readiness. For example, an open-ended survey inquiring about (a) the need for a standard of care for conditional release evaluations, (b) evaluator opinions regarding the standards of care posited in this study, and (c) evaluator rankings of the specific standards proposed in terms of importance in conditional release evaluations would garner much insight into the validity of methods recommended in this project. A qualitative analyses of responses from the surveys could be evaluated in order to ascertain forensic evaluator opinions toward the standards of care posited in this project, as well to highlight which standards specifically they felt enhanced discharge decision-making.

Evaluating the impact of the proposed standards on the judicial system, legislation, and the larger community would likely be vital to assess. For example, analysis of inquiries into

whether judges feel more comfortable having evaluators use the proposed standards, or the effect of having these principles available, including fiscal implications would further elucidate the true potential of the proposed standards.

Additionally, the extent to which the standards of care proposed in this project enhance the accuracy of conditional release evaluations still needs to be studied. Studies aimed toward identifying the rates of NGI acquittees who successfully reintegrate into the community may help determine the validity of the methods recommended in this project. More specifically, long-term follow-up studies need to be conducted to assess whether violence prediction and discharge decision-making are enhanced by the guidelines recommended in this project. This can be empirically investigated by researching rates of recidivisms of NGI acquittees released on the basis of the proposed conditional release evaluations as compared to those released through unregulated procedures. As the recommendations provided in this project are not mandated by any statute, nor are they required in conditional release considerations, studies of violence recidivism can hypothetically be assessed by identifying patients that would be eligible for conditional release given the standard proposed in this project and tracking their violent or unlawful behavior while they are still forensically committed.

Conclusion

Sociopolitical agendas will likely always be at play in dealing with the release of NGI acquittees, as their release is a topic that remains controversial. The stigma of mental illness, and more specifically the fear that violence risk remains high amongst mentally disordered offenders, is inherently involved in conditional release policy, as public safety is the core and fundamental aim of conditional release practices and procedures. Moreover, families of victims of NGI acquittees can be very passionate in opposing release on any terms, regardless of evaluation

standards. These issues may persist for a long time, pending societal change in understanding mental illness, new legislation, and firm ethical standards pertaining to the release of NGI acquittees. A vast step toward such change can come from implementing empirically validated standards of care that aim to provide a more uniform and valid assessment of readiness for conditional release. Once forensic mental health providers expand their ability to treat dangerous offenders, in part by reducing their risk of violence, and forensic evaluators enhance their ability to efficaciously and accurately predict future dangerousness and release offenders accordingly, rates of recidivism should ideally plummet. The way to enhance this ability to accurately decide which patients to release and which patients to retain is to create standards for evaluations of conditional release. These more accurate evaluations may enhance the quality of discharge decision-making for NGI acquittees, yielding increased rates of successful community reintegration and decreased rates of recidivism, which may in turn alleviate some of the societal fears surrounding the release of mentally disordered offenders.

The critical analysis undertaken in this dissertation has allowed for the elucidation of five principles for the development of a standard of care for conditional release evaluations: (a) adherence to professional and ethical conduct; (b) documentation of patient progress; (c) incorporation of empirically-validated risk assessment tools; (d) creation of a comprehensive release plan; and (e) verification of patient's commitment to successful reintegration. These principles have been derived from (a) guidelines described in current practice procedures in conditional release evaluations, (b) criteria for standard of care in forensic mental health assessments proposed by researchers, (c) deficits in the conditional release decision-making process illustrated throughout the literature, and (d) examination of standards in child custody evaluations, another forensic specialty. As such, the utilization of these five principles may

enhance the decision-making framework amongst NGI acquttees and provide a more uniform and valid assessment of conditional release readiness, which in turn may prove to be the change needed to decrease recidivism and alter the stigma related to mentally disordered offenders.

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APPENDIX A

Extended Review of the Literature

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Mullen, P. (2000) Forensic Mental Health	Editorial	Define forensic mental health and importance of such	Review of literature on risk assessment and forensic mental health	Literature analysis of prior studies on incarceration and violent offending	Major gaps in research and practice internationally in the area of forensic mental health Identifying and managing substance misuse and personality disorders in violent offenders will likely be central to development forensic mental health practices that may aim to reduce recidivism
APA (2013) Specialty Guidelines for Forensic Psychology	Guidelines				Guidelines: 1: Responsibilities 2: Competence 2.01: Scope of Competence 2.02: Gaining and Maintaining Competence 2.03: Representing Competencies 2.04: Knowledge of the Legal System and the Legal Rights of Individuals 2.05: Knowledge of the Scientific Foundation for Opinions and Testimony Forensic practitioners seek to provide opinions and testimony that are sufficiently based upon adequate scientific foundation, and reliable and valid principles and methods that have been applied appropriately to the facts of the case. 3: Diligence

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Chambers et al. (2009) Outcome Measures Used in Forensic Mental Health Research: A Structured Review	Literature Review	To identify, from literature, outcome measures used in forensic mental health research and assess their quality, where feasible	Analysis of literature published between 1990-2006. Details of outcome variables and measures were abstracted and evidence regarding most frequently occurring measures was assessed	450 varying instruments were used to assess outcomes incorporating over 1000 distinct variables	<p>4: Relationships 5: Fees 6: Informed Consent, Notification, and Assent 7: Conflicts of Practice 8: Privacy, Confidentiality and Privilege 9: Methods and Procedures 9.01: Use of Appropriate Methods Forensic practitioners strive to utilize appropriate methods and procedure in their work. 10: Assessment 11: Professional and Other public Communications</p> <p>Results: Very little evidence was found to support the measurement properties of commonly used instruments.</p> <p>Found clear evidence of emphasis on recidivism in outcome measures. The authors noted a substantial range of variables used to assess recidivism made up 40% of the measures used in forensic mental health research. However only 17% of these measures used a formal instrument.</p> <p>Concluding Remarks:</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Shinkfield, G., & Ogloff, J. (2015) Use and Interpretation of Routine Outcome Measures in Forensic Mental Health	Journal	To pilot an alternative method for monitoring mental health nurses' use of routine outcome measure tools and to examine the level of inter-rater reliability of ratings made with these measures in forensic mental health settings	Two routine outcome measure tools were examined for all patients These routine outcome measures had previously been completed by clinical staff	Data was collected from a forensic mental health inpatient facility in Australia The hospital provides secure care for up to 116 patients across seven wards (112 of these patients' files were examined) All patients within the hospital are detained under involuntary treatment orders and split up into forensic and civil patients	<p>There is little consistency in the use of outcome measures in forensic mental health research</p> <p>The authors argue that effort should be made to reach consensus on validated outcome measures in the field of forensic mental health to better inform practice and recommendations</p> <p>Results: The audit protocol examined was found to be effective in evaluating both the accuracy with which nurses were able to interpret routine outcome measure items and their degree of adherence with local procedures for completed said instruments</p> <p>Concluding Remarks: Despite these routine outcome measures having been developed for use in general mental health settings, they could be interpreted and rated with an adequate degree of reliability by nurses in a forensic mental health context</p> <p>Difficulties were observed in the applicability of several components of tools within a forensic environment By pleading the insanity defense,</p>
Grachek, J. (2006)	Legal	To offer	Review of mental health		

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
The Insanity Defense in the Twenty-First Century: How Recent United States Supreme Court Case Law Can Improve the System	Journal	recommendations for remedying the problem in which mentally ill offenders are not receiving the rehabilitation necessary by increasing the effectiveness of such treatment	law specifically related to the insanity defense		<p>the defendant acknowledges committing the crime, but asserts not guilty due to mental illness.</p> <p>A plea of NGRI claims that due to an extenuating circumstance (mental illness), the defendant should not be held morally accountable for the crime.</p> <p>Mental illness itself does not preclude criminal responsibility.</p> <p>In order to successfully plead the insanity defense, a defendant must not only show that he is mentally ill, but must also show that there was a nexus connecting the mental illness and the criminal offense</p> <p>Assessments of insanity and treatment of insanity acquittees have progressed since the 18th century.</p> <p>In prisons and state hospitals treatment is used more as a punitive than a rehabilitative tool</p> <p>The author recommends:</p> <ol style="list-style-type: none"> 1. Adoption of a guilty-except-for-insanity verdict and 2. Creation of a mental health sentencing board.

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
<p>German, J., & Singer, A. (1977)</p> <p>Punishing the Not Guilty: Hospitalizations of Persons Acquitted Not Guilty by Reason of Insanity</p>	<p>Legal Journal</p>	<p>To examine and discuss the commitment, treatment and method of release of individuals with an NGI commitment in the United States</p>			<p>The authors note that the commitment, treatment, and methods of release of NGI individuals are unconstitutional, violating the equal protection clause of the 14th amendment, as well as due process where they fail to provide adequate protection against deprivation of liberty.</p> <p>Often individuals committed on the basis of an NGI plea are kept longer than if they had been found guilty of the offense.</p> <p>Courts are often swayed more by the criminal act than the patient's mental health when making conditional release decisions.</p>
<p>Sullivan, D., & Mullen, P. (2006)</p> <p>Forensic Mental Health</p>	<p>Editorial</p>	<p>To argue for edition to the journal of forensic mental health and for and clarify the role of forensic mental health practice</p>			<p>Forensic mental health services:</p> <ol style="list-style-type: none"> 1. Providing opinions to civil and criminal courts 2. Assessing and managing mentally abnormal offenders 3. Assessing and managing the psychological impact of victimization 4. Assessing and managing risk. 5. Containing and caring for the mentally ill who have committed serious crimes 6. Working with general mental-health services to prevent reoffending

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Hodgins, S. (2002) Research Priorities in Forensic Mental Health	Editorial	To identify research priorities for the field of forensic mental health			<p>The authors argue that further development of forensic mental health is critically dependent on clinical and epidemiological research to shape future treatments and refine understanding of outcomes and support funding</p> <p>The author argues that there is a lack of information about the organization, legal powers, and content of treatment, management, and rehabilitation programs that have been shown to impact recidivism, relapse, and autonomous functioning</p> <p>The author contends that future research in the field of forensic mental health should be designed to contribute to the following:</p> <ol style="list-style-type: none"> 1. Improving the efficacy of models of service organization 2. Improving the efficacy of treatment, management, and rehabilitation programs 3. Improving the efficacy of the multiple components of such programs 4. Integrating risk assessment of violent behavior into treatment, management, and rehabilitation programs and improving the accuracy of violence prediction 5. Identifying the etiologies of

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Gowensmith, W., Bryant, A., & Vitacco, M. (2014)	Decision-Making in Post-Acquittal Hospital Release: How Do Forensic Evaluators Make Their Decisions?	To understand which factors are prioritized and which assessment methodologies are utilized by forensic evaluators in conditional release (CR) decision-making, as well as their views on the conditional release process	89 conditional release readiness evaluators from nine states were surveyed on a host of factors related to the assessment of readiness for CR 70 evaluators were psychologists and 19 psychologists 84 evaluators worked in outpatient settings 41 evaluators reported having received specialized training in CR readiness evaluations	The 89 evaluators were sampled from Hawaii, Georgia, Wisconsin, South Carolina, Minnesota, North Carolina, Colorado, California, and Oregon Evaluators reported conducting these evaluations for an average of 8.2 years with 55.1% of them having completed more than 20 CR readiness evaluations 17 questions related to demographics, training and experience were completed 7 questions directly related to making decisions on CR	offending and violence among individuals with mental disorders, including those with mental retardation, and brain damage 6. Preventing offending and violence among children at risk for mental disorders Results: Top factors considered when assessing CR readiness were found to be 1. Risk for violence (93.44%) 2. Adherence to medication (57.38) 3. Risk of substance use or abuse (37.7%) In terms of their own beliefs about CR, evaluators scored “absence of violence” as significantly more important than “absence of recidivism,” “clinical stability,” and “absence of re-hospitalization” As it relates to the psycholegal question regarding CR readiness, 57.6% of evaluators said that it was their job to review the viability of existing treatment plans, while 42.4% said their job was to independently ascertain what factors should be present before deciding on CR readiness 58% of evaluators reported using at least on forensic assessment

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
				<p>evaluations were completed</p> <p>These questions covered two topics:</p> <ol style="list-style-type: none"> 1. List of 21 potentially relevant factors that evaluators might routinely consider in a CR evaluation 2. Broader contextual questions about CR 	<p>instruments in their evaluations for CR readiness (38/45 reported using risk assessment instruments, 7/45 reported using a malingering measure)</p>
				<p>After providing consent, participants completed online surveys through Qualtrics (Denver, Colorado, USA)</p> <p>Responses were analyzed in aggregate</p>	<p>Concluding Remarks: Courts rely on opinions from forensic evaluators to determine NGRI acquittees' readiness for CR. However, how evaluators make these decisions are unknown</p>
					<p>CR readiness evaluators typically have neither clear statutory guidance nor standardized assessment protocols to guide them. There are no assessments specifically designed to assess readiness for CR, and statutes often provide ambiguous guidelines for formulating an opinion.</p>
					<p>The emerging literature has identified some measures predictive of community failure (and success) for persons on CR. However, the degree to which these factors are considered by forensic evaluators has not been sufficiently studied.</p>
					<p>Multiple studies have found that evaluators routinely prioritize non-empirically validated factors when making release decisions on</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
					<p>psychiatrically hospitalized patients</p> <p>A study in Hawaii conducted by Nguyen et al. (2011) evidenced that less than 9% of evaluators used forensic assessment instruments in CR readiness evaluations, and less than 50% of evaluators outlined a relationship between the acquittees' mental health symptoms and their associated risks for violence or recidivism upon release on CR</p> <p>Evaluators utilized a wide variety of methodologies when making their decision on CR readiness</p> <p>Evaluators conceptualizations of the CR process varied widely There is no clear rubric for decision-making on evaluations of readiness for CR</p> <p>Evaluators showed substantial disagreement on nearly every aspect of the CR evaluation process (e.g., predictive factors, their beliefs about various aspects of the CR process) Evaluator differences may stem in part from both ambiguous statutory guidance and the lack of standardized assessment measures for CR readiness</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
<p>McDermott et al. (2008)</p> <p>The Conditional Release of Insanity Acquittees: Three Decades of Decision-Making</p>	<p>To examine how clinicians make release decisions in a forensic facility, with particular attention paid to how such decision-making may have changed over time</p>	<p>Included a random sample of all persons released from Napa State Hospital (NSH) between November 13, 1974, and March 1, 2006, under the penal code commitment Not Guilty by Reason of Insanity (NGRI)</p> <p>A database tracking the outcome of all conditionally released patients was accessed</p> <p>Coders categorized documentation of readiness for release into six general areas:</p> <ol style="list-style-type: none"> 1. Compliance with treatment 2. Treatment responsiveness 3. Insight 4. Substance-related 	<p>Subjects were randomly sampled from seven categories of outcome</p> <p>Five groups had release revocation for one of the following reasons: 1. Dangerousness 2. Psychiatric decompensation 3. Substance use 4. Noncompliance 5. Reoffending</p> <p>The remaining two groups patients who were released from court jurisdiction and those still active in the program</p> <p>A variety of statistical methods were used to</p>	<p>The authors posit that these results highlight the difficulty and confusion evaluators face when conducting CR readiness evaluations and demonstrate the need for enhanced training, statutory guidance and standardized evaluation protocols for these evaluations</p> <p>Results: Data suggests that clinicians view three concerns to be of primary import when making release decisions: (1) responsiveness to and compliance with the treatment, (2) substance use, and (3) risk of violence.</p> <p>The authors uncovered varying patterns in release decision-making between the various decades reviewed</p> <p>In the early years, minimal attention was paid to risk of future violence</p> <p>In the 1990s and beyond, substance use appeared to be of more importance (even though the data did not evidence an actual increase in substance abuse), and more attention was paid to assessing future risk</p>	

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
			<p>problems</p> <p>5. Aggressive behavior</p> <p>6. Any use of structured risk assessments</p> <p>The procedure for coding release decisions included a careful review of the discharge documentation to evaluate whether any of the referenced criteria were reviewed as evidence of readiness for release</p>	<p>evaluate patterns in decision-making and changes in the patterns over time (i.e, analyses of variance and chi-square analyses)</p> <p>All analyses were conducted using SPSS 15 software</p>	<p>In the past decade significant attention has been paid to mental health and future dangerousness</p> <p>Few clinicians used structured assessments of either risk of violence or psychiatric symptoms in making release decisions</p> <p>Concluding Remarks: The factors for making conditional release decisions are similar and driven by Supreme Court rulings: whether there is a mental illness and whether, because of this mental illness, the person is dangerous.</p> <p>Procedures may vary by state; it is rare that guidance is provided regarding what information to use to assess an individual's need for continued commitment (exception in Missouri where the statute provides information on what to consider for release decision-making) Literature indicates that mental health professionals using unguided clinical decision-making are no more accurate than chance in predicting the risk of future violence</p> <p>The authors argue that the need for data-driven decisions in forensic</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
<p>Crocker, A., Nicholls, T., Charette, E., & Seto, M. (2014)</p> <p>Dynamic and Static Factors Associated with Discharge Dispositions: The National Trajectory Project of Individuals Found Not Criminally Responsible on Account of Mental Disorder (NCRMD) in Canada</p>	<p>Empirical Study</p>	<p>To examine the dynamic and static predictors of detention in custody, conditional discharge, and absolute discharge dispositions among persons found NCRMD across the three largest provinces in Canada</p>	<p>The National Trajectory Project (NTP) examined men and women found NCRMD in British Columbia (BC), Québec (QC), and Ontario (ON) between May 2000 and April 2005, followed until December 2008</p>	<p>Individuals who had at least one hearing with a review board were extracted from the NTP dataset (N=1794: QC=1089, ON=483, BC=222)</p> <p>Over the course of the study, 6743 review board hearings were examined (QC = 3505, ON = 2185, BC = 1053)</p> <p>All data were coded and entered by trained research assistants</p>	<p>systems tasked with making release decisions is critical</p> <p>While it appears that as facilities have become more sophisticated and research has increased on how to make such decisions, more structured assessments are used, this has been a relatively recent phenomenon</p> <p>The authors further argue that it is imperative that such assessments contain factors related to treatment response and substance use</p> <p>Results: Static and dynamic risk factors found in the HCR-20 influenced review board determinations, although a complete structured risk assessment is the exception, rather than the norm</p> <p>Data suggests that Particular attention was being paid to the behavior of the patient between hearings (e.g., violent acts, compliance with conditions)</p> <p>Severity of index offense was associated with review board decisions; though index severity is not related to recidivism</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
				<p>across the three provinces with regular quality check meetings and the use of a secure blog to discuss questions about coding and come to a consensus about difficult cases</p>	<p>Historical factors had more influence on the decision to detain someone, while clinical factors were more influential on an AD decision.</p> <p>Results further suggest that clinicians recommending less restrictive dispositions are more likely to include a comprehensive risk assessment with their recommendation</p> <p>Concluding Remarks: The majority of individuals found NCRMD in Canada spend some time in hospital before they are conditionally or absolutely (no conditions) discharged to the community</p> <p>Release decisions are made by a legally mandated review board</p> <p>By Canadian law, the decision to conditionally discharge an individual found NCRMD is guided by the need to protect the public, the accused mental condition, and other needs of the accused regarding community reintegration; however, presentation of a comprehensive structured risk assessment to the review board was</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
<p>Nguyen, A., Acklin, M., Fuger, K., Gowensmith, W.N., & Ignacio, L. (2011)</p> <p>Freedom in paradise: Quality of conditional release reports submitted to the Hawaii judiciary</p>		<p>To examine the quality of post-acquittal Conditional Release (CR) reports submitted to the Hawaii Judiciary</p>	<p>150 CR reports were rated using a 44-item report quality measure</p> <p>A survey instrument comprised of 44 items based on nationally-derived quality standards was used to examine the CR reports</p> <p>Interrater reliability trials indicated good to excellent agreement between quality ratings</p>	<p>Data was collected from archival records at the First Circuit Court of Hawaii in Honolulu (approximately 900,000 residents)</p> <p>The evaluations reviewed for this study were conducted on adults seeking post-acquittal conditional release from Hawaii State Hospital</p> <p>Ratings were analyzed using Cohen's kappa</p>	<p>not often seen.</p> <p>Results: Report quality was poor regardless of examiners' discipline, employer, or board certification status</p> <p>Variability was found in examiner methods, report formats, and findings</p> <p>Concordance rates for CR opinions were poor</p> <p>Level of agreement between the judicial determination and majority recommendations was also poor</p> <p>Despite evidence that formal risk assessment methods have better predictive validity than clinical judgment, utilization of risk assessment and methodologies was commonly omitted from the CR evaluations.</p> <p>Concluding Remarks: The authors suggest that reasons for the poor quality and level of agreement for report quality include a lack of standardization of procedures and/or use of forensic risk assessment instruments</p>
Conroy, M. (2006)	Editorial	To provide and overview of	Review of state specific guidelines, as well as		<p>Concluding Remarks: Some states have statutes that</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Report Writing and Testimony		recommended guidelines in forensic report writing and courtroom testimony	current literature on recommended guidelines to increase the utility of report writing		<p>include criteria for forensic report writing (these include competency, sex offender, insanity and sentencing evaluations)</p> <p>For evaluations that with no statutory criteria or standards prescribed, the authors recommend a careful reading of the court order and consultation with the attorney for guidance in report writing</p> <p>The authors posit the following standards regarding what should be included in a forensic report:</p> <ol style="list-style-type: none"> 1. Identification of charge and reason for referral 2. Documentation of confidentiality statement 3. Collateral sources 4. Procedures followed 5. Evidence and reasoning leading to forensic conclusions 6. Evidence that would contradict evaluator's opinion
<p>Otto, R., & Heilbrun, K. (2002)</p> <p>The Practice of Forensic Psychology: A Look Toward the Future in Light of the Past</p>	Editorial	<p>To highlight the need to</p> <ol style="list-style-type: none"> 1. distinguish between and identify levels of forensic knowledge and practice 2. establish 			<p>Concluding Remarks:</p> <p>The authors highlight a three part strategy to aid in advancing the field of forensic mental health:</p> <ol style="list-style-type: none"> 1. Updating the Specialty Guidelines for Forensic 2. Psychologists (Committee on Ethical Guidelines for Forensic Psychologists, 1991) and

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Heilbrun, K., & Brooks, S. (2010) Forensic psychology and forensic science: a proposed agenda for the next decade	Editorial	<p>guidelines for practice</p> <ol style="list-style-type: none"> 3. educate legal consumers 4. devote more attention to treatment issues in forensic contexts <ol style="list-style-type: none"> 1. To review the progress of forensic psychology over the past three decades 2. To analyze a multidisciplinary report addressing the current state of forensic science 3. To identify priorities for the field of forensic psychology for the next decade 			<p>developing and practice standards in a variety of areas within forensic psychology</p> <ol style="list-style-type: none"> 3. Conceptualizing the training of practicing psychologists on several levels within forensic psychology 4. Intensifying training efforts directed toward consumers of forensic psychology (i.e., judges, attorneys, mental health administrators, and policymakers) and better informing the general public about the nature of forensic psychology <p>Concluding Remarks: The authors review the maturing discipline of forensic mental health over the past 30 years</p> <p>They further highlight the necessity for continued work towards foundational research and evidence based practice in forensic mental health</p> <p>The authors posit the following goals for the future of forensic psychology</p> <ol style="list-style-type: none"> 1. Explore the Feasibility of Including Forensic Psychology Within the Proposed National Institute of Forensic Science

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
					<ol style="list-style-type: none"> 2. Improve the Quality of FMHA Practice Broadly 3. Expand the Scope of the Field to Include Important Innovations 4. Expand Consultation and Education to Include More Services to the Areas Described in the Previous Goal, Particularly in the Public Sector 5. Consider Diversity in Addressing Goals 1–4

Study of Violence Prediction

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Hayes, H., Kemp, R., Large, M., and Nielssen, O. (2014) A 21-Year Retrospective Outcome Study of New South Wales Forensic Patients Granted Conditional and Unconditional Release	Journal	To retrospectively examine the outcomes of forensic patients found NGI in New South Wales and subsequently released into the community	Retrospective examination of archival data	Data were collected from the New South Wales Mental Health Review Tribunal files for all patients who received and NGI verdict between 1990-2012 and who were released into the community during this time During the 21-year	Results: Reoffending by forensic patients released into the community is low -18% of conditionally released individuals reoffended -11.8% were convicted of a further offense -8.7% were charged with a violent offense -3.1% were convicted of a violent offense -3.7% were sentenced to terms of imprisonment

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Cusack et al. (2010) Criminal Justice Involvement, Behavioral Health Service Use, and Costs of Forensic Assertive Community Treatment: A Randomized Trial	Journal	Would offenders with serious mental illness who were diverted from jails benefit more from forensic assertive community treatment interventions (FACT) as evidenced by lower rates of recidivism, fewer hospitalization	Randomized clinical trial conducted in California for frequent jail inmates with serious mental illness that compares a FACT with treatment as usual (TAU)	<p>period studied, 364 offenders received NGI verdicts and were placed under the supervision of the Mental Health Tribunal</p> <p>197 of these were released into the community (including 85 who were granted unconditional release)</p> <p>Follow-up period averaged 8.4 years</p> <p>Outcomes reported at 12 and 24 months post-randomization</p> <p>Zero-inflated negative binomial regression to compare FACT and TAU participants at each time interval</p>	<p>None of the patients granted unconditional release from 1990-2010 went on to commit a further serious offense</p> <p>A large percentage of subjects were readmitted to hospital or had conditional release revoked at least once, suggesting early intervention in relapse of mental illness and non-compliance with conditions of release prevented reoffending.</p> <p>Concluding Remarks: Treatment and rehabilitation of forensic patients together with the decision-making procedures in New South Wales is effective in protecting the community from further offenses by mentally disordered offenders.</p> <p>Results: At 12 and 24 months FACT vs TAU participants had few jail bookings, greater outpatient contacts and fewer hospital days</p> <p>Concluding Remarks: FACT- forensic adaption of high-fidelity ACT programs can improve criminal justice and behavioral health outcomes for jail detainees with serious mental illness</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Carroll, A., Lyall M., & Forrester, A. (2004) Clinical Hopes and Public Fears in Forensic Mental Health	Political Editorial	and lower behavioral health and criminal justice costs The competing roles of political and ethical demands can be met by considering both the accuracy of the assessment of future risk and the seriousness of offense	Review of risk assessments and social/political views as they relate to the treatment and release of forensic patients		Providing appropriate behavioral health services can reduce criminal justice involvement Social, ethical and political demands are all involved when making decisions regarding mentally disordered offenders Authors argue that severity of index offense should be used in informing decisions related to duration of hospitalization. Release decisions are generally made by courts rather than clinicians but are influenced by clinical evidence with the most critical aspect being the likelihood of future violence Risk assessment is a complex process, involving considerations of many factors in addition to acute symptomatology In order to minimize uncertainty when assessing and managing risk of violence related to mental illness, services need to adopt a broad approach to treatment
de Vries Robbe, M., de Vogel, V., & Douglas, K. (2013)	Journal	To investigate the value of the two-sided approach	Retrospective coding of risk assessment data	The HCR-20 and SAPROF were coded retrospectively for a	Results: The combined evaluation of risk- and protective factors was found to

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Risk Factors and Protective Factors: A Two-Sided Dynamic Approach to Violence Risk Assessment		(using protective and risk factors) in assessing violence risk	Criminal records were collected from the Judicial Documentation register of the Dutch Ministry of Justice All patients in the current study had a follow-up period in the community of at least three years after discharge	sample of 188 patients with a history of violent or sexual offending and discharged from forensic psychiatric treatment For all patients the psychopathy Checklist-Revised (PCL-R) had previously been coded Nine trained raters coded the SAPROF and the HCR-20 for all cases at the end of treatment based on the available file information	have good predictive validity for violent recidivism after treatment Dynamic variables of both tools proved to be good predictors of violence, or desistance from, at short- and long-term follow-up Protective factors provided incremental predictive validity over the use of risk factors alone Concluding Remarks: The authors argue the potential of more elaborate dynamic risk assessments when including both risk and protective factors
Wiederanders, M., Bromley, D., & Choate, A. (1997) Forensic Conditional Release Programs and Outcomes in Three States	Literature Review	To review the effectiveness of conditional release programs by comparing results of three larger studies of said programs	The literature on forensic patient conditional release was examined using a combination of computer and manual methods. The UC library's MELVYL computer system was used to search more than 1,524,551 book articles, and 1,300 journals.	Inclusion criteria were as follows: 1) The work was a community follow-up research study with sample size of at least 100 persons judged not guilty by reason of insanity 2) Data on the quantities of aftercare services were provided 3) the recidivism	Results: Close similarities across states were found in population characteristics (proportions of patients who were male and with diagnoses of schizophrenia varied by only a few percentage points across states) Mean ages were all in the 30s The populations were predominantly white A difference was found in the mean

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
<p>Marshall et al. (2014) Predicting Voluntary and Involuntary Readmissions to</p>	<p>Quasi-longitudinal research study</p>	<p>To investigate factors associated with voluntary and involuntary</p>	<p>Quasi-longitudinal study that evaluated outcomes of individuals who gained conditional release (CR)</p>	<p>56 insanity acquittees on conditional release in the state of Maryland from 2007,</p>	<p>length of hospitalization prior to conditional release (with a low of 1.5 years in Oregon to a high of 3.8 years in California)</p> <p>California also had a high frequency of individual contact, group therapy, medication contact, and urine screening</p> <p>Rearrest rates were mildly varied, with California's being the lowest and New York's the highest (in descending order 7.8%, 5.8%, and 3.4%)</p> <p>Rehospitalization rates were similar across the three states (New York 55%; Oregon and California 49%)</p> <p>Concluding Remarks: Many countries and U.S. states use some sort of conditional release whereby patients can return to secure hospitals if their behavior does not adhere to a medication program or other treatment.</p> <p>A complex interrelationship exists among client contact rate, revocation rate, and reoffense rate.</p> <p>Results: For the sample of 356 subjects whose files were reviewed for the 3-year follow-up, a total of 48 were</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Forensic Hospitals by Insanity Acquittees in Maryland		readmissions to forensic hospitals	<p>in the state of Maryland</p> <p>The outcome variable was type of readmission to a forensic hospital</p> <p>The types of readmissions were either voluntary or involuntary</p>	<p>2008, and 2009 were investigated and monitored their community progress for a 3-year follow-up period</p> <p>Demographic and clinical information was gathered.</p> <p>Community functioning was assessed by examining the following areas:</p> <ol style="list-style-type: none"> 1. Number of reported arrests while on CR 2. Number of times substance abuse was reported while on CR 3. Type of housing 4. Number of housing changes while on CR 5. Number of times of non-compliance with treatment reported during CR 6. Number of community, non-forensic, psychiatric admissions while on CR 	<p>rearrested at least once (14% 3-year recidivism rate)</p> <p>Less than 1% of these recidivists were voluntary readmits</p> <p>The highest recidivism rate was 19%, which occurred for the forensic readmission group</p> <p>Concluding Remarks: Voluntarily readmitted insanity acquittees had fewer reported arrests on conditional release and fewer reported instances of non-compliance with treatment compared with insanity acquittees who were returned involuntarily to hospital Arrests and treatment non-compliance predicted involuntary readmission</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Swanson et. al. (2000) Involuntary Outpatient Commitment and Reduction of Violent Behaviour in Persons with Severe Mental Illness	Journal	To evaluate whether involuntary outpatient commitment may help reduce the incidence of violence among individuals with severe mental illness	A one-year randomized trial of the effectiveness of outpatient commitment in 262 subjects was conducted	<p>7. Duration in community prior to first psychiatric admission of any type</p> <p>All subjects were previously diagnosed with psychotic or major mood disorders</p> <p>Subjects were involuntarily hospitalized and awaiting outpatient commitments</p> <p>Subjects were randomly assigned to either release or court-ordered treatment post discharge and then followed up with 4 months later</p>	<p>Results: A significantly lower incidence of violent behavior occurred in subjects with greater than 6 month outpatient commitments</p> <p>Lowest risk of violence was associated with extended commitment periods and regular outpatient treatment (including adherence to prescribed medication and lack of substance use)</p> <p>Concluding Remarks: Violent behavior among individuals with severe mental illness is an issue of public concern and is often associated with illness relapse, hospital and forensic recidivism and poor outcomes in community-based treatments</p> <p>Outpatient commitments, particularly by improving medication compliance and diminishing substance misuse, may significantly reduce the risk of violence in individuals with severe mental illness</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Vitacco et. al. (2016) Projecting Risk: The Importance of the HCR-20 Risk Management Scale in Predicting Outcomes with Forensic Patients	Journal	To evaluate the predictive validity of the HCR-20 in outcomes with forensic patients and hospital recidivism	Retrospective evaluation of the outcome of individuals eligible for release from Georgia forensic hospitals Evaluated data from 116 forensic inpatients who underwent violent risk assessments, which included the Historical, Clinical, Risk-20 (HCR-20) Patient data was evaluated using analyses of variance and multinomial logistic regression	Patients eligible for release between 2006-2013 were evaluated as part of an opportunity to receive conditional release from forensic facilities	<p>Results: Of the 116 patients, 58 were never released, 39 were released and returned to a hospital, and 19 were released and never returned</p> <p>The risk management scale of the HCR-20 successfully predicted group membership in that higher scores were associated with a greater likelihood of not being released from a forensic facility or returning to a forensic facility after release (the risk management scale conveys information about the appropriateness of community placement, as well as about the resources the individual will need to have available to maximize his success in the community)</p> <p>Concluding Remarks: A critical issue is how to utilize clinical data to inform opinions on appropriateness for discharge</p> <p>Clinicians should consider community-based risk variables when evaluating forensic patients for potential discharge.</p>
Serin et. al. (2016) Using Dynamic Risk to	Journal	To highlight how decision accuracy of an offender's release	DRAOR assessments were completed monthly and then at 3-month	A sample of 563 Iowa clients, comprising mainly probationers	<p>Results: Of the 363 cases reviewed at follow-up 29% experienced</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Enhance Conditional Release Decisions in Prisoners to Improve Their Outcomes		and supervision process could be enhanced by the inclusion of dynamic factors	follow up Outcome was measured as any violation in revocation, and serious violation, and any new crime	(69.4%), with others on parole (5.2%), work release (7.8%), and special sentences (9.8%), was compiled This sample was initially examined utilizing the Dynamic Risk Assessment for Offender Re-entry (DRAOR; Serin, 2007) The DRAOR is a structured professional judgment (SPJ) instrument that considers stable and acute dynamic risk factors and protective factors	revocation violations, 22% had a serious violation and 12.6% were charged with a new crime Concluding Remarks: Risk measures used to anchor assessments is considered a best practice in release decision- making and community supervision by many paroling authorities and probation agencies Beginning with release decisions, a standardized review of dynamic risk factors provides a more accurate understanding and estimation of release suitability
Witt, P. (2000) Book Review A Practitioner's View of Risk Assessment: The HCR-20 and SVR-20	Book Review	Review of the HCR-20 and SVR-20 (sexual violence risk), as well as the use of the instruments in predicting risk			Mental health professionals assess risk in a variety of contexts Such risk assessments are used in matters spanning the criminal justice system (i.e., in bail hearings, sentencing proceedings, and in pre-parole evaluations) Clinicians historically have written reports and testified in court about an individual's risk based on clinical

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
<p>Hilton, N., Simpson, I., & Ham, E. (2016)</p> <p>The Increasing Influence of Risk Assessment on Forensic Patient Review Board Decisions</p>	Journal	<p>To investigate whether:</p> <ol style="list-style-type: none"> 1. Risk assessment instruments were cited by a forensic patient review board or 	<p>Review board hearings held in 2009-2012 pertaining to 63 different maximum security patients found NCR (Not Criminally Responsible) in Canada were examined</p>	<p>The sample was drawn from a longitudinal study of men admitted to Ontario's maximum security forensic hospital division (a 160-bed unit serving</p>	<p>impressions alone</p> <p>More recently, there has been a plethora research empirically linking predictors with future violence; however, there still exists a tension amongst clinicians between actuarial and clinical risk assessment</p> <p>The HCR-20 employs the division of terms into past (historical), present (clinical), and future (risk management) that encompass both actuarial and dynamic variables</p> <p>The author argues that both the HCR-20 and SVR-20 (which includes several components of the HCR-20) are well constructed instruments that integrate research and clinical practice</p> <p>Additionally, the HCR-20 has a base of predictive validity studies, with a link to recidivism and good interrater reliability indexes</p> <p>Results: Dispositions were most strongly associated with psychiatric testimony (consistent with previous studies)</p> <p>An association between clinical</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
<p>Douglas, K. (2014)</p> <p>Version 3 of the Historical-Clinical-Risk Management-20 (HCR-20^{V3}): Relevance to Violence Risk Assessment and Management in Forensic Conditional Release Contexts</p>	<p>Discussion/Review</p>	<p>To discuss the potential utility of the newly revised Historical-Clinical-Risk Management-20 (HCR-20, Version 3) within the conditional release context</p>	<p>Review of research on the HCR-20 Version 3 using approximately 800 participants across three settings (forensic psychiatric, civil psychiatric, correctional) and eight countries</p>	<p>the entire province housing only male patients)</p> <p>Data were coded from patients' medical records at two time points:</p> <ol style="list-style-type: none"> 1. Shortly after the admission assessment 2. Preindex offense history (to score VRAG) 	<p>opinions and risk assessment results was evident and significantly larger than in previous research</p> <p>There was no evidence that risk assessment was cited selectively in higher risk cases</p> <p>Dispositions were associated with scores on the VRAG, such that transferred patients had a lower risk of violent recidivism than detained ones</p> <p>Concluding Remarks: The authors recommend further efforts to measure the effect of non-pharmacological treatment participation and inpatient security decisions on forensic decision-making</p> <p>Concluding Remarks: The conditional release of insanity acquittees requires decisions both about community risk level and the contextual factors that may mitigate or aggravate risk</p> <p>Version 3 of the HCR-20 was developed to enhance decision-making about individuals, while remaining rooted in a solid empirical foundation</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Monahan, J., et al. (2006) The Classification of Violence Risk	Academic Journal	To review the development of the Classification of Violence Risk (COVR) and describe issues related to administration and interpretation			<p>The author argues that in addition to the fundamental estimate of risk level, release decision-makers must estimate the conditions that will mitigate or reduce risk (so as to foster these), and must also anticipate the conditions that would aggravate risk (so as to avoid these)</p> <p>He further argues that the HCR-20 Version 3, includes variables that address such issues (e.g., risk management items)</p> <p>Concluding Remarks: The Classification of Violence Risk (COVR) is an actuarial program designed to estimate the risk that a person hospitalized for mental disorder will be violent to others</p> <p>The authors argue the COVR software was constructed and validated only on samples of psychiatric inpatients in acute facilities and this its generalizeability remains to be empirically determines</p> <p>The authors further question whether repeated use of this tool can increase the likelihood of patients providing answers that would appear to minimize their perceived risk</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
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While it is not without limitations, the authors suggest that the COVR may be helpful to clinicians who are faced with discharge decision making for patients in acute hospital settings

Standards and Best Practices					
Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings

Heilbrun, K., DeMatteo D., Marczyk, G., & Goldstein A. (2008)	Literature Review	To differentiate between standard of care versus standards of practice in forensic mental health assessment	Literature analysis on standards of care/practice in forensic mental health Literature was reviewed related to the distinguishing characteristics of standards of care and practice, as well as historical and regulatory influence on such		Standard of care is defined by the authors as a judicial determination establishing minimally acceptable standards of professional conduct in a specific context Standards of practice are defined by the authors as the typical way of doing things in a particular field As the specialty of forensic mental health assessment matures, the need for a standard of care in such becomes clearer.
Standards of Practice and Care in Forensic Mental Health Assessment					
International Association for Correctional and Forensic Psychology. (2010)	Guidelines	Propose standards for psychological services in forensic institutions		Outline of Standards General Ethical Principles A. Administrations	The mission of forensic and correctional mental health is to provide the highest quality psychological services mentally ill offenders entrusted in their care, in keeping with human rights,
Standards for Psychological Services in Jails, Prisons,					

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Correctional Facilities, and Agencies				<p>and Operations</p> <p>B. Roles, Services, Staffing, and Professional Development</p> <p>C. Ethical Practice Guidelines</p> <p>D. Mental Health Services and Programs</p> <p>E. Mental Health Records</p> <p>F. Research</p>	<p>international treaties, civil rights, applicable legislation and community standards</p> <p>Increasing inmate and offender populations have continued to fuel the growing need for qualified mental health service professionals and providers. Administrators and providers have been challenged by the increasing mental health service needs of the growing number of mentally ill inmates and offenders, as well as the litigation that often accompanies the failure to provide those services.</p> <p>There is a need for the assessment and treatment of mental disorders spanning depression to those specific in correctional setting. There has also been an increased need for forensic assessment and expert testimony roles (i.e., risk assessment for parole boards involuntary commitment for treatment), and coordinating post release mental health services. As such a proposed standard stipulates that “mental health services include screening, assessment, diagnosis, and treatment of mental illness; crisis and suicide intervention; and prerelease planning for inmates who will need mental health services</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
<p>Plaut, V. (1983) Punishment versus Treatment of the Guilty but Mentally Ill</p>	<p>Legal</p>	<p>To discuss the legal and ethical components of the proposed “guilty but mentally ill” verdict proposed by 8 states. Discussion includes consequence and treatment of those found guilty but mentally ill</p>			<p>following release”</p> <p>Underlying the insanity defense is the assumption that those who commit criminal acts while “insane” should not be held criminally responsible for their behavior.</p> <p>As such, treatment, rather than punishment, is thought to be the appropriate response by society and ethical considerations</p> <p>The guilty but mentally ill verdict was largely a response to the presumed inadequacy of procedures for committing and subsequently releasing defendants found NGI</p> <p>In cases where one is found “guilty but mentally ill,” there is typically a period of confinement to be carried out. This differs from insanity acquittees as, in theory, the length of commitment depends on continuing findings of insanity and dangerousness. (when hospital staff can no longer support such findings, the insanity acquittee is released)</p> <p>Conversely, while an NGI verdict would ensure treatment for the offender, individuals who are guilty but mentally ill would have to rely</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Kalmbach, C., & Lyons, P. (2006) Ethical issues in conducting forensic evaluations	Editorial	To review ethical considerations mental health practitioners must take when conducting forensic evaluations			<p>on their constitutional rights to garner treatment</p> <p>Concluding Remarks: Professionals who choose to participate in the legal forum must ensure that their performance meets not only the standards of general practice for their profession, but also those pertaining to the forensic specialty</p> <p>The authors argue that they must also have a thorough knowledge of professional statutory regulations and current legal standards</p> <p>For every test administered and reported, the practitioner must have a thorough knowledge of reliability and validity, norm group composition, related multicultural issues (addressed in the following section), and awareness of conflicting evidence in the literature</p> <p>If there is no clearly identifiable reason to administer a psychological test, it should not be given</p> <p>An exception occurs where testing is statutorily mandated (e.g., all SVP evaluations in Texas must include a measure of psychopathy).</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
<p>Heilbrun, K., Phillips, S., & Thornewill, A. (2016)</p> <p>Professional Standards' Citations in Law and the Behavioral Sciences: Implications for Policy and Practice</p>	<p>Empirical Study</p>	<p>To consider the knowledge and usage of professional standards</p>	<p>The following standards from behavioral sciences and law were selected and reviewed:</p> <p>(1) Ethical Principles of Psychologists and Code of Conduct, (EPPCC)</p> <p>(2) Specialty Guidelines for Forensic Psychologists/Psychology (SGFP)</p> <p>(3) ABA Criminal Justice Mental Health Standards</p> <p>(4) ABA Juvenile Justice Standard</p>	<p>Citation counts were compiled using the most widely used electronic databases from both behavioral sciences and the law</p> <p>Databases included: Web of Science, PsycINFO, Criminal Justice Abstracts, Lexis-Nexis, Westlaw, and HeinOnline</p> <p>Total citation counts were calculated for each database for each set of standard reviewed</p>	<p>Forensic professionals are ethically obligated to be aware of such requirements, and to be adequately trained in the administration and interpretation of appropriate tools</p> <p>Forensic practitioners are required to have a thorough understanding of the legal doctrines and standards in the areas in which they purport to be expert</p> <p>A familiarity with both state and federal requirements is necessary</p> <p>Results: None of the standards reviewed exerted more than a modest effect on the published behavioral science literature</p> <p>Legal standards are rarely cited</p> <p>Concluding Remarks: The authors argue that the rarity in citation and usage of standards unfortunate, given the potential value of such standards in promoting more uniform and high-quality practice and better-informed policy</p> <p>They further exert that greater exposure of professional standards</p>

Author/Year/Title	Type of Article	Research Questions & Objectives	Research Approach/Design	Measures/Data Collection/Sample	Major Findings
Allan, A., & Grisso, T. (2014) Ethical Principles and the Communication of Forensic Mental Health Assessments	Academic Journal	To explore whether adhering to ethical principles can enhance forensic reports and communication	Review and discuss the most basic principles underlying professional ethical standards and guidelines (i.e., Fidelity and Responsibility, Integrity, Respecting Rights and Dignity of Persons, and Justice and Fairness)		<p>to researchers, practitioners, and policymakers through various mechanisms is recommended to increase their exposure and potential impact</p> <p>Conclusive Remarks: The authors argue that the basic premises underlying professional ethical standards can be used to guide organization, content, and/or style of forensic mental health report writing</p> <p>They further assert that ethics is the essence of good practice and therefore communication of FMHAs should be guided by ethical principle</p>

APPENDIX B

Rating Sheet for Version 3 of the HCR-20

Kevin S. Douglas, Stephen D. Hart, Christopher D. Webster, & Henrik Belfrage

Name	Record Number
DOB	Gender

Nature/Purpose of Evaluation

HCR-20 Items	Presence				Relevance			
	Omit	N	P	Y	Omit	N	P	Y
Historical Scale (History of problems with...)								
H1. Violence H2. Other Antisocial Behavior H3. Relationships H4. Employment H5. Substance Use H6. Major Mental Disorder H7. Personality Disorder H8. Traumatic Experience H9. Violent Attitudes H10. Treatment or Supervision Response OC-H Other Considerations								
Clinical Scale (Recent problem with...)								
C1. Insight C2. Violent Ideation or Intent C3. Symptoms of Major Mental Disorder C4. Instability C5. Treatment or Supervision Response OC-C Other Considerations								
Risk Management Scale (Future problems with...)								
R1. Professional Services and Plans R2. Living Situation R3. Personal Support R4. Treatment or Supervision Response R5. Stress or Coping OC-R Other Considerations								

Future Violence/Case Prioritization	Serious Physical Harm	Imminent Violence	Recommended Release Date
Low Moderate High	Low Moderate High	Low Moderate High	YY/MM/DD:

Evaluator	Signature	Date
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APPENDIX C

Coding sheet SAPROF (de Vogel et al., 2009)

To be used only in combination with the HCR-20 or related structured risk assessment instruments.

Name:		Number:		Date:	
Age:		Gender: __ Male __ Female			
Context risk assessment:					
Internal factors		Score	Key	Goal	
1	Intelligence				
2	Secure attachment in childhood				
3	Empathy				
4	Coping				
5	Self-control				
Motivational factors		Score	Key	Goal	
6	Work				
7	Leisure activities				
8	Financial management				
9	Motivation for treatment				
10	Attitudes towards authority				
11	Life goals				
12	Medication __ n/a				
External factors		Score	Key	Goal	
13	Social network				
14	Intimate relationship				
15	Professional care				
16	Living circumstances				
17	External control				

Other Considerations:

Final Protection Judgment and Integrative Final Risk Judgment SAPROF + HCR-20	Protection -Low -Moderate -High	Risk -Low -Moderate -High
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OBJ:OBJ:OBJ:OBJ:

Name(s) assessor(s):

Signature:

APPENDIX D

Principles of Forensic Mental Health Assessment (Heilbrun, 2001)

1. Identify relevant forensic issues.
2. Accept referrals only within area of expertise.
3. Decline the referral when evaluator impartiality is unlikely.
4. Clarify the evaluator's role with the attorney.
5. Clarify financial arrangements.
6. Obtain appropriate authorization.
7. Avoid playing the dual roles of therapist and forensic evaluator.
8. Determine the particular role to be played within forensic assessment if the referral is accepted.
9. Select the most appropriate model to guide data gathering, interpretation, and communication.
10. Use multiple sources of information for each area being assessed.
11. Use relevance and reliability (validity) as guides for seeking information and selecting data sources.
12. Obtain relevant historical information.
13. Assess clinical characteristics in relevant, reliable, and valid ways.
14. Assess legally relevant behavior.
15. Ensure that conditions for evaluation are quiet, private, and distraction-free.
16. Provide appropriate notification of purpose and/or obtain appropriate authorization before beginning.
17. Determine whether the individual understands the purpose of the evaluation and the associated limits on confidentiality.
18. Use third party information in assessing response style.
19. Use testing when indicated in assessing response style.

20. Use case-specific (idiographic) evidence in assessing clinical condition, functional abilities, and causal connection.
21. Use nomothetic evidence in assessing clinical condition, functional abilities, and causal connection.
22. Use scientific reasoning in assessing causal connection between clinical condition and functional abilities.
23. Do not answer the ultimate legal question.
24. Describe findings and limits so that they need change little under cross-examination.
25. Attribute information to sources.
26. Use plain language; avoid technical jargon.
27. Write report in sections, according to model and procedures.
28. Base testimony on the results of the properly performed FMHA.
29. Testify effectively.

APPENDIX E

GPS IRB Exemption Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

December 3, 2016

Sara Laniado Markowitz

Project Title: Toward better discharge decision-making for violent offenders in forensic mental health settings: A critical analysis

Re: Research Study Not Subject to IRB Review

Dear Ms. Markowitz:

Thank you for submitting your application, *Toward better discharge decision-making for violent offenders in forensic mental health settings: A critical analysis*, to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). After thorough review of your documents you have submitted, the GPS IRB has determined that your research is **not** subject to review because as you stated in your application your dissertation **research** study is a "critical review of the literature" and does not involve interaction with human subjects. If your dissertation research study is modified and thus involves interactions with human subjects it is at that time you will be required to submit an IRB application.

Should you have additional questions, please contact the Kevin Collins Manager of Institutional Review Board (IRB) at xxx-xxx-xxxx or via email at xx.xxx@pepperdine.edu or Dr. Judy Ho, Faculty Chair of GPS IRB at xxxxxx@pepperdine.edu. On behalf of the GPS IRB, I wish you continued success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph. D., ABPP, CFMHE
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Compliance Attorney
Dr. Barbara Ingram, Faculty Chair