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

Dennis Howard Littlefield
Eric Harley Summers

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INDICATORS OF DELAY BETWEEN RECOMMENDATION FOR
COMMUNITY OUTPATIENT TREATMENT AND RELEASE
INTO A CONDITIONAL RELEASE PROGRAM

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master
of
Social Work

by
Dennis Howard Littlefield
and
Eric Hartley Summers
June 1996
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ABSTRACT

A closed-case review of fifty-five charts of former Patton State Hospital patients determined to be not guilty by reason of insanity of a crime was conducted to determine factors which predicted a significant delay between recommendation for and acceptance into a conditional release program (CONREP). The variables Instant Offense, Substance Abuse, and Previous Hospitalization were found to be accurate predictors of delay between recommendation and acceptance into CONREP. Suggestions for further research were given.
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Introduction

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

In the area of forensic psychiatry, there is minimal research to determine the predictors of rehospitalization. Some research does describe those individuals found to have committed a crime but who
have been determined by a court of law to be not guilty by reason of insanity (NGRI). However, no clear patient profile has been developed that predicts, with accuracy, those NGRI patients who will re-offend or be re-hospitalized.

**Purpose of the Study**

The purpose of this study is to determine whether the factors which predict recidivism of NGRI patients in Community Out-patient Treatment (COT) also inhibit a patient’s release into a conditional release program (CONREP).

**Operational definitions.**

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

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

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

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

**Judicial System**

Once in the judicial system, a determination must be made whether the mentally ill meet the requirement of sanity, or, Mens Rea if the accused raises it as a defense. Mens Rea asks whether the individual realized that the act that he or she was committing was a crime,
and did they intend to commit a crime at the instant of offense (California Penal Code 1026). If this requirement is not met, they may be found Not Guilty by Reason of Insanity (NGRI). At this point, the assessment focus shifts from insanity to the patient’s level of danger to him/herself and others as well as their capacity to manage their behavior effectively enough to rejoin society.

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

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

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

**Community Placement**

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

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

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

Studies by McGreevy, Steadman, Dvoskin and Dollard (1991) indicate that communities can adequately meet the needs of NGRI acquittals and that the most common condition of release is participation in a treatment program. The court evaluates the patient’s ability to function in the community as well as the legal standards which address concerns for public safety and
community reactions to discharge. Clients may be clinically ready for discharge, according to the treating Inter-Disciplinary team, but may be required to continue in the hospital setting because of conflicting reports from the CONREP assessment as submitted to the court.

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

Literature Review

There is very little information available regarding the factors which affect the length of time elapsed prior to actual release following a recommendation for community release. According to Miller (1993), forensic patients committed involuntarily in Wisconsin were subjected to different release criteria than other committed patients. An overview of difficulties are discussed by Miller,
Maier, Van-Rybeck and Weidemann (1989) which support the need for equity in release standards. These difficulties include counter-transference and other objective issues on the part of those who evaluate patients for release. While counter-transference issues exist within all therapeutic contexts, the hospital treating team provides team interaction to counteract these issues, whereas many community release programs operate from the assessment of an individual.

Several studies indicate a particular need for utilization of CONREP services. Bloom and Williams (1992), recommend conditional release for schizophrenic patients with extensive histories of crime and hospital use. Greenberg, Shah and Seide (1993) believe that the chronically mentally ill are becoming entrenched in a fragmented system of treatment and incarceration. The researchers also suggest that because of limited ability to perform reality testing and the maintenance of bizarre beliefs and behavior, the severely psychiatrically ill are more likely to be recidivists.

According to Abdalian, Dabell, Polonsky, Rein and Williams (1992), primary predictors of COT revocation include seriousness of instant offense, severity of substance abuse history, and number of prior hospitalizations. The rate of those who re-offended
and fit the predictors established by Abdalian et. al. was nearly double those who re-offended but did not meet the predictors. Weideranders (1990), in a study of the effectiveness of the California Department of Mental Health Conditional Release Program, indicates that the number of prior offenses also assists in predicting revocation in addition to those predictors found in Abdalian et. al. (1992). Although these indicators of revocation predict who is most likely to be re-hospitalized, only 25% of those predicted in Weideranders’ 1990 study actually did re-offend. Although a majority of those patients who did re-offend, fit the predictor categories, a greater number of those who fit the profile of a recidivist did not re-offend.

Findings in a study predicting success on conditional release for insanity acquittees by Tellefsen, Cohen, Silver, and Daugherty (1992), concurred with the findings of Abdalian et. al. (1992). Predictors of failure in a Maryland CONREP program included seriousness of the instant offense, severity of psychiatric disturbance as well as substance abuse, specifically heroin, and the number of prior arrests (Tellefsen, et. al., 1992). Draine, Solomon and Meyerson (1994) also found that substance abuse and arrest record were positive indicators of a return to
incarceration. Holcomb and Ahr (1988) found that alcohol and drug abusers were twice as likely to be arrested for crimes as were non-addicted schizophrenic patients.

Direction of the Study

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

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

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

H2 The greater the presence of psychosis, the greater the time between recommendation for and acceptance into a COT program.
H3 The more severe the substance abuse history, the greater the time between recommendation for and acceptance into a COT program.

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

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

Significance of Data

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

Relevance of the Study

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

Subjects

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

Protection of Human Subjects and Informed Consent

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

Due to the nature of the study and the use of closed case chart review, it was not be feasible to return to the community to ask informed consent of the
subjects. No personal involvement of selected participants with this study was required at any time. Personal identifying information was also not used. However, human subjects approval for this project was given by the California State University, San Bernardino; Patton State Hospital Research Committee; The Executive Director and Medical Director of Patton State Hospital; the Deputy Director of the California Department of Mental Health, Long Term Care Services; and the State of California Health and Welfare Agency Committee for the Protection of Human Subjects.
Materials

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

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

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

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

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

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

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

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

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

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

One way Analysis of Variance (ANOVA) was computed for each of the independent variables. This test was used to determine the probability that there is no difference between groups divided among levels from a sample population in relation to a dependent variable. The scores of these tests show the probability that
they are from the same sample, and hence the chance that an error would be made in stating that they are not of the same sample distribution.

A 1 x 3 (Duration x Instant Offense) One-way ANOVA produced a significant difference between groups $F(2, 54) = 5.1671, p<.01$ (see Table 1). Post-hoc analysis using Tukey-B showed that there was a significant difference between the means of the moderate (17.0357) and high (39.6923) levels of instant offense, as predicted. Low severity of instant offense (n=1) did not register in the findings as the count could not produce a confidence interval.

A 1 x 4 (Duration x Substance Abuse) One-way ANOVA also found a significant difference between levels of substance abusers, $F(3, 51) = 3.1523, p<.04$ (see Table

---

**Table 1**

One-way ANOVA of Duration by Instant Offense

<table>
<thead>
<tr>
<th></th>
<th>DF</th>
<th>Sum of Squares</th>
<th>$F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>7437.2063</td>
<td>5.1671*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>52</td>
<td>37422.5027</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>44859.7091</td>
<td></td>
</tr>
</tbody>
</table>

* $p<.01$
Further analysis showed that the severe (mean=37.4828) substance abusers were significantly different from the none (mean=11.30), low

Table 2
Oneway ANOVA of Duration by Substance Abuse

<table>
<thead>
<tr>
<th></th>
<th>DF</th>
<th>Sum of Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>3</td>
<td>7017.0344</td>
<td>3.1523*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>51</td>
<td>37842.6747</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>44859.7091</td>
<td></td>
</tr>
</tbody>
</table>

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

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

In the 1 x 3 (Duration x Previous Hospitalization) Oneway ANOVA, a significant difference was found
between groups, $F(2, 52) = 3.7948, p<.03$ (see Table 3). However after further analysis it was determined that those with greater numbers of previous hospitalizations had a significantly lower duration than did the low hospitalization subgroup (high, 16.31; low, 38.92). Although this finding was significant, it did not show the direction as suggested in the hypothesis which predicted that the greater the number of hospitalizations, the greater the duration between recommendation for release and acceptance to the CONREP program.

Multiple regression analysis was used to determine predictability of the value of Duration (dependent variable) as a function of the effects of the independent variables (Substance Abuse, Instant...
Offense, Previous Arrest, Previous Hospitalization). Independent variables were entered into the equation using their strength of association or excluded from it from a lack of association to the dependent variable. Values were given listing strength of total association of the combination of the independent variables (Multiple R) and the percentage of variance explained by the entered independent variables (R Square and Adjusted R Square). Also given were the Beta weights and B values which measure strength in determination of change in the dependent variable and degree of change in the dependent variable with a change in one unit if the independent variable, respectively.

Multiple regression analysis with the "Forward" method of inclusion (PIN .050) was used to determine the strength of the relationship between the independent variables (Instant Offense, Substance Abuse, Previous Hospitalization, and Previous Arrest) and the dependent variable (Duration). The variable Previous Arrest was found not to have great enough contribution (PIN <.05 ) to be included in the regression equation. Instant Offense, Substance Abuse, and Previous Hospitalization entered in the regression equation showed a Multiple R value of.62157, giving an R Square of .38635, with an adjusted R Square of .35026 explaining 35% of the variance (see Table 4). A
Table 4

Multiple Regression with Dependent Variable DURATION

<table>
<thead>
<tr>
<th>Step</th>
<th>MultR</th>
<th>Rsq</th>
<th>F(Eqn)</th>
<th>Variable</th>
<th>BetaIn</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.4045</td>
<td>.1637</td>
<td>10.371*</td>
<td>InstOff</td>
<td>.4045</td>
</tr>
<tr>
<td>2</td>
<td>.5784</td>
<td>.3346</td>
<td>13.072**</td>
<td>SubstAb</td>
<td>.4144</td>
</tr>
<tr>
<td>3</td>
<td>.6216</td>
<td>.3864</td>
<td>10.703**</td>
<td>PrevHos</td>
<td>-.2340</td>
</tr>
</tbody>
</table>

* p<.002
**p<.001

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

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

The Variance-Covariance matrix suggests that the independent variables are not strongly correlated with each other. Covariance values below the diagonal show small variances implying that the independent variables do not co-vary either (see Table 6).
### Table 5

**Regression Analysis of Variance**

<table>
<thead>
<tr>
<th></th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>3</td>
<td>17331.68675</td>
<td>5777.22892</td>
<td>10.703*</td>
</tr>
<tr>
<td>Residual</td>
<td>51</td>
<td>27528.02234</td>
<td>539.76514</td>
<td></td>
</tr>
</tbody>
</table>

*E<.0001

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

25
Table 6

Variance-Covariance Matrix of Regression Coefficients (B).

<table>
<thead>
<tr>
<th></th>
<th>INSTOFF</th>
<th>SUBSTAB</th>
<th>PREVHOSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSTOFF</td>
<td>36.50480</td>
<td>.08572</td>
<td>.22324</td>
</tr>
<tr>
<td>SUBSTAB</td>
<td>1.39916</td>
<td>7.29789</td>
<td>.08333</td>
</tr>
<tr>
<td>PREVHOSP</td>
<td>5.17001</td>
<td>.86289</td>
<td>14.69165</td>
</tr>
</tbody>
</table>

Below Diagonal: Covariance  Above: Correlation

Table 7

Independent Variables in the Regression Equation

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSTOFF</td>
<td>20.403681</td>
<td>6.041920</td>
<td>.380933</td>
</tr>
<tr>
<td>SUBSTAB</td>
<td>9.678511</td>
<td>2.701460</td>
<td>.395309</td>
</tr>
<tr>
<td>PREVHOSP</td>
<td>-7.952681</td>
<td>3.832969</td>
<td>-.233994</td>
</tr>
<tr>
<td>(Constant)</td>
<td>-37.369335</td>
<td>20.644458</td>
<td></td>
</tr>
</tbody>
</table>
Discussion

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

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

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

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

A Type II error may have also been made with the variable Substance Abuse. The use of predetermined levels provided an unequal distribution of cases among the levels of Substance Abuse. Severe substance abusers had up to three times the representation of the other levels (29, 10, 6, 10; severe to none respectively). This may have led to the overall difference in mean scores between groups. It may be
suggested for further analysis to select samples to give equal representation to all levels of the variable. However, it is probable that the representation found in this study accurately represents the population found at Patton State Hospital, and can be generalized as it is to that population.

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

The variable Previous Hospitalization provided significant results, however, but not in the direction as predicted in the hypothesis. It was found that Previous Hospitalization was related to a decrease in duration between recommendation for and acceptance to COT. It may be possible to attribute this finding to the idea that most hospitalizations occur in the
patient's home community. This would lead to a greater knowledge of the patient by community professionals and an increased level of comfort with reacceptance of the patient in the community. Also attributable to the findings in the analysis of Previous Hospitalization is that with fewer hospitalizations, less is known about the individual patient and the course of his or her illness and its manifestations. This discrepancy could be rectified through the improvement of social history evaluations, psychological testing, and comprehensive psychiatric histories.

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

Opportunities for further research in this arena are plentiful. Other factors that may add to the explained variance of the prediction equation are: ethnic identity, race, age at time of recommendation.
for COT, presence of an Axis II diagnosis, or personality disorder, specific Axis I and II diagnoses, and individual counties of commitment. Another area of similar study would be the comparison of duration across gender lines; whether or not male and female durations are significantly different among equivalent criteria.

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

<table>
<thead>
<tr>
<th>Seriousness</th>
<th>Offense</th>
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<tbody>
<tr>
<td>HIGH</td>
<td>MURDER/MANSLAUGHTER</td>
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<tr>
<td></td>
<td>RAPE</td>
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<td>KIDNAP</td>
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<td>MODERATE</td>
<td>ASSAULT/BATTERY</td>
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<td>ARSON</td>
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<td>CHILD CRUELTY</td>
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<td>ROBBERY</td>
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<td>EXTORTION</td>
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<td>BURGLARY</td>
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<td>THEFT</td>
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<td>WEAPONS</td>
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<td></td>
<td>FALSE IMPRISONMENT</td>
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<td>LOW</td>
<td>FORGERY/VANDALISM</td>
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<td>DRUGS</td>
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<td>VICE/DUI</td>
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<td>VEHICULAR/HEALTH</td>
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<td>MISC. TRIVIAL</td>
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<td>ILLEGAL ABORTION</td>
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APPENDIX B

SUBSTANCE ABUSE RATING SCALE

NONE    No documented history

MILD    In frequent experimentation, infrequent alcohol or marijuana use and not more than one drug related arrest

MODERATE Either long-term use of alcohol or marijuana, or several drug related arrests, or use of hard drugs ie. cocaine, heroin, PCP etc. more than once

SEVERE Hard core substance abuse, many drug related arrests, prior treatment in substance abuse programs, and/or substance abuse was associated with the instant offense
# APPENDIX C

## DATA ABSTRACTION SHEET

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REFERENCES


