

# Community Placement for Insanity Acquittes: A Preliminary Study of Residential Programs and Person-Situation Fit

Kirk Heilbrun, PhD, Karen Lawson, MPH, Stacy Spier, MS, and John Libby, BA

The present study, one of the first of its kind, describes the characteristics of community living placements for insanity acquittes conditionally released following hospitalization, along with the "fit" between living placement and individual characteristics. Although the small number of insanity acquittes ( $n = 13$ ) and community placements ( $n = 9$ ) precluded meaningful statistical analyses of results, the study provides a model for studying the characteristics of placements as well as personal characteristics of acquittes, and the interaction between the two. It also suggests the possible importance of this interaction, operationalized as "fit" between characteristics and placement. Consistent with research findings for other criminal defendants and for nonforensic psychiatric patients released from hospitalization, a better fit between acquirer and community placement may be associated with increased likelihood of success on conditional release.

Research on the insanity defense and the individuals who use it has increased dramatically during the last two decades. There is now information on the characteristics of defendants who assert a Not Guilty by Reason of Insanity (NGRI) plea, and the differences between those who succeed and those who

are convicted.<sup>1-7</sup> Data are also available on the length of stay for those NGRI acquittes who are hospitalized following conviction.<sup>8-10</sup> Such length of stay data have been compared with periods of incarceration for individuals convicted of comparable offenses.<sup>11-15</sup>

While much of this kind of information on insanity acquittes has become available in the last 20 years, relatively little of it has been devoted to one of the major advances in the management and treatment of NGRI acquittes in the last decade: community-based treatment for such individuals.<sup>16</sup> There has been some

---

Dr. Heilbrun is clinical director, Forensic Unit, and associate professor, Department of Psychiatry, Medical College of Virginia, Central State Hospital, Petersburg, VA. K. Lawson and S. Spier are affiliated with the Department of Psychology, Florida State University, Tallahassee. J. Libby is affiliated with the University of North Carolina at Greensboro. Address correspondence to Kirk Heilbrun, PhD, Department of Psychiatry, Medical College of Virginia, Box 980253, MCV Station, Richmond, VA 23298.

empirical description of the characteristics of such treatment providers,<sup>17-18</sup> as well as characteristics and outcomes of NGRI acquittees in the community.<sup>19-23</sup> This is particularly true in Oregon, where the combination of a Psychiatric Security Review Board responsible for release, monitoring, and hospitalization with a university-based research team has yielded a great deal of information about insanity acquittees in the community.<sup>17, 24-26</sup>

However, little detail has been reported about the characteristics of community placements to which NGRI acquittees are transferred following release from hospitalization. Basic features of such placements, including patient to staff ratio, size, availability of on-site mental health services, and nature of social support can describe such placements in a more detailed and meaningful way than has yet been done.

"Goodness of fit" is a theoretical construct that has been used in describing the match between client needs or characteristics and nature of available service or placement. Research on the "fit" between individuals and institutional settings in the criminal justice system has been performed,<sup>27</sup> as well as that between individuals formerly in psychiatric hospitals and their community environment,<sup>28-30</sup> all suggesting that better fit is associated with more favorable outcome (typically, less frequent rearrest or rehospitalization). Some investigators<sup>29</sup> have labeled this "congruence framework," noting that the characteristics of the patient<sup>31-32</sup> or the placement itself<sup>33</sup> have at times reflected only minimal

association with favorable community outcome.

Given the increasing emphasis on and importance ascribed to community-based treatment of insanity acquittees, it would be useful to determine whether there would be any comparable association between acquittee-placement "fit" and outcome on conditional release. Is poor fit responsible (in some cases, at least) for an individual's failure to perform satisfactorily on conditional release? Can a model be developed, utilizing characteristics of defendants and of placements, that provides a way to judge goodness of fit?

The data reported here are a first step toward answering these questions. Since the study from which they are drawn was not focused specifically on these issues, the data are more limited than one might wish. Nonetheless, they are suggestive of directions for both future research and program planning.

## Method

### *Community Residential Placements*

A total of nine community residential facilities were identified for study. These particular facilities were selected both because they had accepted the acquittees in this study on conditional release following hospitalization, and because they are among the most frequently used community living placements for forensic patients in Florida. All placements were located in Florida cities. These facilities did not include other forensic units, civil units of state hospitals, or private homes. One facility that was included was the "Quarterway House," a

## **Community Placements for Insanity Acquittees**

halfway house for civil and forensic patients located on the grounds of Florida State Hospital. Of the nine facilities, a total of four were located in urban areas with a population greater than 250,000. Another three were located in cities with populations between 50,000 and 250,000, and two were in towns with populations less than 50,000.

### **Patients**

The patients ( $n = 13$ ) placed in these facilities were evaluated as part of a larger study of civilly committed and NGRI individuals released from hospitalization.<sup>1</sup> Subjects had been acquitted by reason of insanity on criminal charges ranging from burglary to murder, with 12 charges involving offenses against persons and one against property. Twelve of the subjects were male. Eight were African-American and five were white. Ages ranged from 25 to 48, with a mean age of 37.3. Years of education (highest grade completed) ranged from 7 to 18, with a mean of 11.8.

Following acquittal, subjects had been admitted to the Forensic Service, Florida State Hospital, and remained there until they had been recommended for conditional release by their respective treatment team. Their periods of hospitalization ranged from 27–75 months, with a mean duration of 44.8 months. As soon as the treatment team recommended that a patient was appropriate for conditional release, he or she was approached and asked to be part of the study. Consenting subjects were paid \$10 for their participation in an initial battery of tests and interviews that has

been described elsewhere,<sup>1</sup> and were also paid \$10 for participating in follow-up interviews while in their community placement.

### **Procedure**

The interviews with a residence administrative staff member was conducted by one of us (SS or JL) by telephone, in order to obtain information about each facility. Contact with residence staff had already been made during the personal visit, in which the follow-up subject interview for the subjects in the larger study had been conducted. The staff member being interviewed was asked several questions regarding the facility. Questions covered the areas of clients (residence capacity, actual number, age, race, and sex), residence staff (number, shift, role, and professional discipline), admission criteria, available mental health services (nature and location), jobs (expectations for clients' working, restrictions against working, assistance with obtaining, and range and availability within immediate area), access to public transportation within one mile, and available social support and activities. These areas were selected from the literature, consultation with colleagues,<sup>1</sup> and from standard Florida State Hospital practice on conditional release decision-making and planning.

The interviewer also obtained information about the physical characteristics of the residence. Dimensions of the common areas, kitchens, bathrooms, and bedrooms were estimated, and it was determined whether these areas were private or shared. Whether the fa-

cility was heated and air conditioned was also determined (in Florida, the latter can be more important than the former). Bedrooms were rated as cramped (less than 60 square feet per client if shared, less than 80 square feet if private), adequate (between 60 and 79 square feet per client if shared, 80–99 square feet if private), or large (more than 80 square feet per client if shared, more than 100 square feet if private). The common area was likewise rated as cramped (insufficient seats for all clients), adequate (seats for all clients), or large. Total square footage was also estimated, and a “density ratio” was calculated by dividing this total by the total number of clients. An overall “quality rating” was made by the interviewer, based on considerations such as maintenance, lighting, cleanliness, furnishings, and neighborhood. Finally, the client provided a global judgment of the safety of the residence, on a scale ranging from 1 (dangerous) to 6 (safe).

The “goodness of fit” between residence and client was rated on three dimensions: (1) monitoring (level and intensity of supervision); (2) treatment (nature, frequency, and extensiveness of mental health services); and (3) patient safety (whether the residence’s physical characteristics, location, staffing, and program requirements were a good fit with client clinical condition and self-protection skills). Level of fit was rated on a three-point scale as “low,” “moderate,” or “high” (low = 1, moderate = 2, and high = 3). The ratings were assigned by two of us (SS and JL) following a review of all data on patient character-

istics and clinical condition and residence characteristics. Raters were blind to conditional release outcome, since the final outcomes were not known at the time of the ratings.

In making the judgments on treatment “fit,” the raters had access to information about each patient’s course of treatment while hospitalized. This included information in the areas of medication (type, dosage, and frequency of administration), group and individual therapy (type and frequency of contact), psychoeducational interventions (skills training in various areas, supportive contact such as AA), and management (seclusion and restraint, behavioral interventions). Judgments regarding monitoring “fit” were made in light of information about patients’ levels of privileges (e.g., grounds passes, community visits) in the hospital prior to conditional release, as well as their need for supervision in such daily activities as taking medication, eating, sleeping, and attendance at work and activities. Finally, the judgment about safety “fit” incorporated each patient’s age, gender, physical condition, judgment, and history of aggression (both as a perpetrator and a victim).

In making these judgments, the raters assumed that the hospitalization period had yielded the optimal types and levels of treatment and monitoring for these 13 subjects, as each had progressed sufficiently well to be recommended for conditional release. Therefore, the raters tried to determine whether the treatment available in the community placement was very similar to that in the hospital

## Community Placements for Insanity Acquittees

("high fit"), somewhat similar ("moderate fit"), or dissimilar ("low fit"). A similar strategy was employed for rating "monitoring fit." The "safety fit" was determined by considering the patient's characteristics in the context of the community placement neighborhood, including physical features, crime level, and availability of public transportation.

Interrater reliability was addressed by holding several training sessions before beginning these ratings. Two cases were rated in common between the senior author and each of the other two raters (SS and JL). Five of the six ratings done in common between the senior author and each rater were identical; a total of 10 of the 12 common ratings (83%) were thus identical, suggesting reasonably good agreement when these factors were rated on a three-point scale.

Outcome of conditional release to the community was assessed using interviews conducted at the residential placement every two months for a six-month period (periods between 6 and 12 months are frequently used as outcome measures in research on NGRI conditional release.<sup>35</sup>) Three of the 13 subjects were rehospitalized during this period following a violation of conditional release. The reasons for this rehospitalization were recorded, with impressions obtained from both the subject and a collateral observer in the placement, who was also interviewed.

## Results

Total client capacity for the residential placements ranged from 7 to 116, with a mean of 34.8. The number of clients

occupying the placements at the time of the study ranged from 7 to 100, with a mean of 31.9. Only one placement described the absence of criteria for refusing to accept clients; the most commonly offered criteria for refusal were history of violence, particularly recent (six facilities), drug and alcohol abuse, particularly recent (three facilities), and history of arson (three facilities). Also cited were suicidal potential (two facilities), homicidal potential (one facility), status as a sex offender (one facility), and severe mental retardation (one facility).

Mental health services were available exclusively at the residential site for three facilities, with services available both on-site and off-site in another three. The remaining three facilities had mental health services for clients provided off-site only.

Clients were encouraged to obtain jobs in four of the nine placements. Three placements provided restrictions on their clients holding jobs, although these restrictions involved the loss of the client's disability payments if he/she obtained work rather than an outright prohibition. All placements in cities of 50,000 or more offered access to public transportation within one mile of the residence. The single placement in a small town that encouraged clients to obtain work offered such jobs within one mile of the placement itself, making public transportation unnecessary. Seven of the nine placements provided social support in the form of planned social activities scheduled at least once weekly.

Physical characteristics of the facilities

included climate control features and size. All placements were both heated and air conditioned. Bedrooms were rated as "large" in five of the nine facilities, and "adequate" in the other four. The common area was rated as "large" (more than enough seats for all clients) in seven facilities, and "adequate" (enough seats for all clients) in the other two. A "density ratio" (total square footage in the facility divided by the number of clients) was calculated for all placements except one, for which the interviewee could not estimate the overall dimensions. This ratio ranged from a low of 160:1 to a high of 286:1. Ratings of quality were assigned on a scale ranging from 1 (low) to 6 (high), incorporating maintenance, lighting, cleanliness, decoration, furnishing, and neighborhood. Ratings ranged from 2 (one facility) to 6 (three facilities).

Clients were considered to be successful if they had not violated the terms of their conditional release within a 6-month period after their release. Most of the CR "conditions" were consistent across clients, and involved medication compliance, keeping appointments with psychiatrists, counselors, and case managers, and abstinence from alcohol and drug use. Three clients were unsuccessful, with CR violation and rehospitalization occurring within this period. One client appeared unstable and rather low functioning even at the time he was released from the hospital, and his conditional release was violated after he made threats in his community placement. A second unsuccessful client cheeked his psychotropic medication and decom-

pensated; in addition to his medication dosage, he was also unhappy because there were no women at that time in the halfway house in which he was placed. The third unsuccessful client walked away from his residential placement. He described himself as clearly unhappy with this placement, stating that he wanted a job but wasn't able to obtain one.

One of the noteworthy aspects of these failures on conditional release was the poor "fit" between client and placement on the dimensions of Monitoring and Treatment; there was a difference in the rated fit on Monitoring between the successful group ( $\bar{X} = 2.5$ ) and the unsuccessful group ( $\bar{X} = 1.7$ ). There was also a difference in the rated fit on Treatment (successful  $\bar{X} = 2.5$ , unsuccessful  $\bar{X} = 2.0$ ). However, other variables evidently did not distinguish between these two groups, with the exception of patient: staff ratio and frequency of schedule social support (see Table I). Because the sample size in this study was too small to permit any meaningful statistical analysis, these differences should be regarded only as suggestive, and cannot be described as statistically significant.

## Discussion

Despite the increase in available information on insanity acquittees in the last two decades, there are still relatively little data available on the posthospital community adjustment of such individuals. Information that is available<sup>36</sup> has focused primarily on characteristics of the individual. As investigators begin to focus on this population, there are sev-

## Community Placements for Insanity Acquittes

**Table 1**  
**Characteristics of Community Residential Placements Housing Posthospital Insanity Acquittes**

	Group	
	Successful (N = 10)	Unsuccessful (N = 3)
Mean monitoring fit	2.5	1.7
Mean treatment fit	2.5	2.0
Mean safety fit	2.1	2.3
Patient : staff ratio	3.4:1	1.4:1
On-site mental health services	60%	67%
Mean quality rating	4.6	4.5
Mean density ratio	237:1	235:1
Social support scheduled weekly	60%	100%
Mean client GAF	57.7	55.7

eral indications that fit between the individuals and the characteristics of the community placement will be important. Previous research has suggested that fit may be a prime consideration in successful community outcome for those who have been previously hospitalized without criminal charges.<sup>28-33</sup> There are some indications that such fit is important in criminal justice<sup>26</sup> and violence prediction<sup>37-38</sup> contexts as well.

Further research on the characteristics of community placements, and the adjustment of NGRI acquittes in such placements, would allow the comparison of results of this group with those of a broader group of mental health clients. The study of housing in the community has recently accelerated, and useful information in this area is emerging.<sup>39-42</sup>

The present results suggest that person-situation fit may be an important consideration in community placement of insanity acquittes. Only preliminary conclusions about the empirical differences between "successful" and "unsuccessful" groups can be drawn, given the limited size of these groups in the pres-

ent study. It may be noteworthy, however, that differences in rated "fit" were in the expected direction on two of the three dimensions. This is consistent with information described earlier on the possible reasons for conditional release revocation in two of the three "failure" cases. The first, apparently a result of poor mental stability and making threats, can be attributed primarily to individual characteristics. However, in the second case, the subject "cheeked" his medication and decompensated, while indicating that he did so because he was unhappy that there were no women living in the halfway house. The third case seems even clearer: the subject wanted a job, disliked the placement because residents were not permitted to work, and walked off.

The present results also suggest that the availability of more staff per patient and more frequent social support may have a paradoxical effect in some cases, as higher levels on these variables can be observed in the group that failed on conditional release. However, the finding of higher social support associated

with greater likelihood of failure on conditional release was not observed in a much larger study of NGRI conditional release outcome in California,<sup>43</sup> in which social support was observed to be significantly higher for NGRI acquittees who successfully completed conditional release ( $n = 107$ ) than for those who reoffended ( $n = 14$ ) or were revoked ( $n = 133$ ). Thus, the present finding on social support should be treated with extreme caution.

The importance of successful post-hospital community adjustment for insanity acquittees may be described on two levels. From a "least restrictive alternative" perspective, it is desirable to provide individuals who do not need the security of a hospital setting with an appropriate living placement in the community. From a public protection standpoint, it is important to deter further criminal activity as one avenue for failing on conditional release in the community. Better fit between individual and placement may help to achieve both goals. The present results provide preliminary support for the importance of "fit" between client characteristics and conditional release placement, particularly in treatment and monitoring, as relatively poor fit was observed in two of the three cases in which conditional release was revoked within six months after hospital discharge. Further research is needed to test the extent and degree to which "fit" can explain performance on conditional release, and to describe the characteristics of NGRI acquittee community placements more generally.

Such research would involve studying

a much larger group of insanity acquittees who have been released from the hospital into community placements. This will necessarily involve collecting data from multiple sites, or data from a highly populated state collected over a number of years.<sup>43</sup> It is noteworthy that the present sample, while small, represented all of the planned conditional releases over a 20-month period from a hospital with virtually all of Florida's NGRI acquittees (more than 200). The limited number of NGRI subjects available in a single state, even a large one, can best be increased through collaborative, multi-site investigations.

The present study suggests that the assessment of person-situation fit in NGRI conditional release may be as important as in other criminal justice and psychiatric contexts. However, a more definitive judgment will require further research to develop an empirical base for this kind of assessment with insanity acquittees in the community. If "fit" does prove as useful a concept as it has in other areas, the applied benefits to clinicians, administrators, and legal decision makers may rival the scientific gains.

## References

1. The larger study of which this was a part was the pilot phase of the Risk Assessment Project, directed by Henry J. Steadman. The Risk Project is one of three areas of research in law and mental health currently funded by the John D. and Catherine T. MacArthur Foundation Research Network on Mental Health and Law (John Monahan, Director). We are grateful to Hank Steadman and Pamela Clark Robbins for their comments on the ideas expressed in this paper

## Community Placements for Insanity Acquittees

2. Pasewark R: A review of research on the insanity defense. *Ann Am Acad Polit Soc Sci* 484:100-14, 1986
3. Steadman HJ, Braff J: Defendants not guilty by reason of insanity, in *Mentally Disordered Offenders: Perspectives from Law and Social Science*. Edited by Monahan J, Steadman HJ. New York: Plenum Press, 1983
4. Boehnert C: Psychological and demographic factors associated with individuals using the insanity defense. *J Psychiatry Law* 13:9-31, 1985
5. Pasewark R, Lanthorn B: Dispositions of persons using the insanity plea in a rural state. *J Humanics* 5:87-98, 1977
6. Randolph R, Pasewark R: Characteristics, dispositions, and subsequent arrests of defendants pleading insanity in a rural state. *J Psychiatry Law* 11:345-60, 1983
7. Steadman HJ, Keitner L, Braff J, *et al*: Factors associated with a successful insanity plea. *Am J Psychiatry* 140:401-5, 1983
8. Cooke G, Sikorski C: Factors affecting length of hospitalization of persons adjudicated not guilty by reason of insanity. *Bull Am Acad Psychiatry Law* 2:251-61, 1974
9. Phillips B, Pasewark R: Insanity plea in Connecticut. *Bull Am Acad Psychiatry Law* 8:335-44, 1980
10. Steadman HJ, Pasewark R, Hawkins M, *et al*: Hospitalization length of insanity acquittees. *J Clin Psychology* 39:611-4, 1983
11. Heilbrun K, Heilbrun PG, Griffin N: Comparing females acquitted by reason of insanity, convicted, and civilly committed in Florida: 1977-1984. *Law Hum Behav* 12:295-311, 1988
12. Kahn M, Raifman L: Hospitalization versus imprisonment and the insanity plea. *Crim Just Behav* 8:483-90, 1981
13. Harris GT, Rice ME, Cormier CA: Length of detention in matched groups of insanity acquittees and convicted offenders. *Int J Law Psychiatry* 14:223-36, 1991
14. Pantle M, Pasewark R, Steadman HJ: Comparing institutionalization periods and subsequent arrests of insanity acquittees and convicted felons. *J Psychiatry Law* 8:305-16, 1980
15. Pasewark R, Pantle M, Steadman HJ: Detention and rearrest rates of persons found not guilty by reason of insanity and convicted felons. *Am J Psychiatry* 139:892-7, 1982
16. Bloom JD: The insanity defense since Hinckley. Presented at the Annual Meeting of the American Academy of Psychiatry and the Law, Washington, DC, 1989
17. Bloom JD, Williams MH, Bigelow DA: Monitored conditional release of persons found not guilty by reason of insanity. *Am J Psychiatry* 148:444-8, 1991
18. Cavanaugh JL, Wasylw OE: Treating the not guilty by reason of insanity outpatient: a two-year study. *Bull Am Acad Psychiatry Law* 13:407-15, 1985
19. McGreevy MA, Steadman HJ, Dvoskin JA, *et al*: New York state's system of managing insanity acquittees in the community. *Hosp Community Psychiatry* 42:512-7, 1991
20. Spodak MK, Silver SB, Wright CV: Criminality of discharged insanity acquittees: fifteen year experience in Maryland reviewed. *Bull Am Acad Psychiatry Law* 12:373-82, 1984
21. Lamb HR, Weinberger L, Gross B: Court-mandated outpatient treatment for persons found not guilty by reason of insanity: a five year follow-up. *Am J Psychiatry* 139:892-7, 1988
22. Lamb HR, Weinberger L, Gross B: Court-mandated outpatient treatment for insanity acquittees: clinical philosophy and implementation. *Hosp Community Psychiatry* 39:1080-4, 1988
23. Scott D, Zonana H, Getz M: Monitoring insanity acquittees: Connecticut's Psychiatric Security Review Board. *Hosp Community Psychiatry* 41:980-4, 1990
24. Bloom JD, Rogers JL, Manson SM: After Oregon's insanity defense: a comparison of conditional release and hospitalization. *Int J Law Psychiatry* 5:391-402, 1982
25. Bloom JD, Williams M, Rogers J, *et al*: Evaluation and treatment of insanity acquittees in the community. *Bull Am Acad Psychiatry Law* 14:231-44, 1986
26. Bigelow DA, Bloom JD, Williams MH: Costs of managing insanity acquittees under a psychiatric security review board system. *Hosp Community Psychiatry* 1:613-4, 1990
27. Gibbs JJ: Environmental congruence and symptoms of psychopathology: a further exploration of the effects of exposure to the jail environment. *Crim Just Behav* 18:351-374, 1991
28. Carpenter JO, Bourestan NC: Performance of psychiatric hospital discharges in strict and tolerant environments. *Community Ment Health J* 12:45-51, 1976
29. Coulton CJ, Holland TP, Fitch V: Person-environment congruence and psychiatric patient outcome in community care homes. *Admin Ment Health* 12:71-88, 1984
30. Lehmann S, Mitchell S, Cohen B: Environ-

- mental adaptation of the mental patient. *Am J Community Psychology* 6:115-124, 1978
31. Linn MW, Klett J, Caffey EM: Foster home characteristics and psychiatric patient outcome. *Arch Gen Psychiatry* 37:129-132, 1980
32. Linn MW, Klett J, Caffey EM: Relapse of psychiatric patients in foster care. *Am J Psychiatry* 139:778-783, 1982
33. Segal S, Everett-Dille L, Moyles EW: Congruent perceptions in the evaluation of community care facilities. *J Community Psychology* 7:60-68, 1979
34. Steadman H, Monahan J, Robbins P, et al: From dangerousness to risk assessment: implications for appropriate research strategies, in *Crime and Mental Disorder*. Edited by Hodgins S. Newbury Park, CA: Sage, 1993
35. Heilbrun K, Griffin P: Community-based treatment of insanity acquittees. *Int J Law Psychiatry* 16:1-18, 1993
36. Cohen MI, Spodak MK, Silver SB, Williams K: Predicting outcome of insanity acquittees released to the community. *Behav Sci Law* 6:515-30, 1988
37. Monahan J, Klassen D: Situational approaches to understanding and predicting individual violent behavior, in *Criminal Violence*. Edited by Wolfgang ME, Weiner NA. Beverly Hills, CA: Sage, 1982
38. Monahan J: *Predicting Violent Behavior: An Assessment of Clinical Techniques*. Beverly Hills, CA: Sage, 1981
39. Carling PJ: Housing and supports for persons with mental illness: emerging approaches to research and practice. *Hosp Community Psychiatry* 44:439-49, 1993
40. Tanzman B: An overview of surveys of mental health consumers' preferences for housing and support services. *Hosp Community Psychiatry* 44:450-5, 1993
41. Knisley MB, Fleming M: Implementing supported housing in state and local mental health systems. *Hosp Community Psychiatry* 44:456-61, 1993
42. Diamond RJ: The psychiatrist's role in supported housing. *Hosp Community Psychiatry* 44:461-4, 1993
43. Wiederanders MR, Choate PA: Beyond recidivism: Measuring adjustments of conditionally released insanity acquittees. *Psychological Assessment: J Consult Clin Psychology* 6:61-6, 1994