A Call for More Program Evaluation of Forensic Outpatient Clinics: The Need to Improve Effectiveness

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Reducing recidivism in violent offenders, whether or not they have an Axis I DSM-IV diagnosis, is a topic of great concern in our society today. There are a growing number of outpatient forensic mental health facilities in the United States that have the responsibility to treat this population. Given the limited public funds that are appropriated for this treatment, it is crucial not only to treat these persons with a view toward reducing further violent behavior but also to evaluate the treatment's effectiveness as it affects both the client and the community.[1] Too often, however, program evaluation is not conducted.

The purpose of this article is to show the value of program evaluation by giving an example of an independent evaluation of a forensic outpatient clinic. In an effort to increase the clinic's effectiveness, we assessed the treatment at this clinic, determined the outcome of the clinic's treatment, and developed recommendations consistent with the literature on the treatment of violent offenders.

This article grew out of the desire of a state department of corrections to conduct an independent evaluation of the treatment of violent offenders at a parole mental health outpatient clinic (PMHOC) under its jurisdiction, located in a large metropolitan city. This evaluation did not stem from any perceived problems in this clinic but was simply a desire on the part of the department to evaluate the effectiveness of the program.

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Literature Review: A First Step

Before conducting a program evaluation, the evaluators should know the current literature in the field. In recent years, the treatment of violence has been one of the most challenging areas for mental health professionals. There is an extensive body of literature on how violent offenders should be treated.[2–13] The most frequently discussed modalities of treatment include: behavior modification, cognitive behavioral strategies, anger management, and other psychotherapeutic approaches; intensive case management; administration of medications; drug and alcohol abuse programs; and family intervention.

Studies examining these treatment modalities have found that, despite some hopeful signs, there is little compelling evidence that these programs have been more than modestly successful.[1,13,14] Among the reasons cited for this lack of success are treatment resistance, including nonadherence to medication; difficulty in treating persons with antisocial personality disorders; poorly defined treatment philosophies and goals; insufficient collaboration between mental health and criminal justice system staff; substance abuse problems; countertransference issues; and lack of continuity of treatment staff.[2,7,10,11,13–17]

The Need for Program Evaluation: A Case in Point

The subjects studied in this program evaluation were 100 consecutive parolees, whose instant convictions were for violent crimes (see Table 1), referred by their parole officers in early 1997 to a state PMHOC. The median length of time the parolees

Table 1 Instant Convictions for 100 Parolees Referred to a Department of Corrections Mental Health Parole Outpatient Clinic

Offense	*n*	%
Assault with a deadly weapon	26	26
Armed robbery	22	22
Corporal injury to spouse	12	12
Attempted murder	10	10
Rape	8	8
Voluntary manslaughter	6	6
Cruelty to a child	4	4
Assault with intent to commit rape	3	3
Assault on a peace officer	2	2
Carjacking	2	2
Terrorist threats	2	2
Arson	1	1
Possession of explosives	1	1
Shooting at an inhabited building	1	1

were sentenced was 48 months, and the length of time served was 28 months. All of the subjects received a three-year period of parole.

The parolees ranged in age from 18 to 72 (median, 34 years). Ninety-three (93%) were men. Almost all (95%) of the subjects had a history of prior convictions. Eighty-four (84%) had prior arrests for violent crimes. Almost half (48%) had a diagnosis of a serious mental disorder, such as schizophrenia, schizoaffective disorder, bipolar disorder, or major depression. Overall, substance abuse was known to be present in 94 (94%) of the sample, and for many of these individuals, it appeared to us that drugs and alcohol had contributed to the violent behavior.

The treatments offered at the PMHOC included individual psychotherapy, crisis intervention, group therapy, anger management, psychopharmacologic treatment, and any combination of these. Treatment was scheduled either biweekly or monthly. The clinicians worked in collaboration with the parolees' parole agents who, despite large caseloads, were expected to serve, in effect, as case managers.

Of those referred to the PMHOC for evaluation and treatment, 80 (80%) were accepted into treatment; however, 54 (67%) of these persons did not complete treatment because they were uncooperative and/or failed to adhere to the conditions of parole. Perhaps more important, only 26 percent of those accepted for treatment had a good outcome, as defined by no arrests during the three-year follow-up period (48% had been rearrested at the one-year follow-up, 69% at the two-year follow-up, and 74% at the three-year follow-up). No significant difference in outcome was found in persons with serious mental illness and those with no serious mental illness. Twenty-seven (46%) of those reincarcerated were arrested for violent crimes. Generally, poor compliance with treatment and high rearrest percentages so soon after release into the community are not unusual among mentally ill offenders, whether violent or nonviolent.[8,13,14]

Treatment of Violent Offenders

The primary concern in the treatment of violent offenders under the jurisdiction of the criminal justice system (as for instance in the clinic evaluation reported in this article) is to assess any changes in mental condition that may indicate dangerousness and to reduce the threat of harm. To achieve these goals, the clinician must identify factors that contributed to the individual's previous violent behavior and develop a comprehensive program that addresses those factors. Such a program requires that the clinician perform a thorough evaluation of the client, review previous criminal and mental health records, develop and institute an overall treatment plan, and collaborate closely with involved criminal justice system staff. However, much of this did not occur in the clinic evaluated.

We found that the PMHOC clinicians did not have an opportunity to conduct a thorough evaluation of many of the subjects because the subjects did not return for their scheduled appointments. Moreover, in many cases, police and arrest reports and probation officers' reports were not sent to the PMHOC. Thus, the PMHOC staff were not as familiar with their clients' background and criminal history as they might have been. In addition, clinicians at the PMHOC carried large caseloads (approximately 160-180 clients). In our opinion, these caseloads were too large and adversely affected the clinicians' ability to know their clients, develop and implement sound treatment plans, and see their clients more frequently than monthly for medications and biweekly or monthly for group and individual therapy. Similarly, the parole officers' large caseloads (approximately 80-100 parolees, with some allowance made for those considered more difficult and/or high profile) affected their ability to monitor their clients properly and deal with problems before revocation of parole became necessary.

Given the size of the caseloads of both clinicians and parole officers, it is not surprising that, in many cases, there was a lack of close communication and

collaboration between them. Communication between the PMHOC clinicians and parole officers generally occurred when the clinician notified the parole officer of a client's failure to keep appointments and when the parole officer contacted the clinician to help assess a parolee's readiness for discharge from parole. It appeared that the PMHOC staff and parole officers generally did not act as a team to further the objectives of reducing the subject's threat of harm. A successful effort in treating violent offenders often depends greatly on collaboration between mental health and criminal justice system staff.[16,18]

In our opinion, the persons in this sample needed close monitoring of their adherence to both treatment and conditions of parole. For example, it has been demonstrated that there is a significantly better outcome when the court not only mandates but monitors mental health treatment on an ongoing basis.[19] Of paramount importance is the need to address the subjects' problems with drugs and alcohol, especially when severe mental illness is also present. Unfortunately, this clinic did not offer drug and alcohol rehabilitation but referred clients to such treatment elsewhere in the community. We also observed, as have others,[20] that there are some offenders whose mental disorders are so severe that they appear to need medium- or long-stay inpatient services.

Further, as stated earlier, parole agents were expected to act, in effect, as the subjects' case managers. However, we found little indication that they had the time to assure that the subjects had an appropriate living situation, adequate vocational assessment and vocational counseling by qualified professionals, alcohol and substance abuse treatment, and a strong support system. Moreover, it appeared that there was little family involvement, as evidenced by family conferences, or education of relatives about mental illness and how they can help in the treatment.

Problems in Treating Antisocial Personality Disorder

Many have suggested that the effectiveness of treatment programs in reducing violent and other criminal behavior is questionable at best for persons with severe antisocial traits or sociopathy.[7,13,14,21–23] This is supported by our finding that subjects with a previous history of incarceration in state prison, usually an indication of serious criminal behavior and severe sociopathy, were significantly more likely to have a poor outcome than those who did not have such a history. (Of the 80 subjects who were accepted into treatment at the PMHOC, significantly more subjects with no previous history of incarceration in state prison, prior to the instant offense, had a good outcome than those with a previous history of serving in the state prison (Yate's correction for continuity $\chi^2 = 13.51$, $df = 1$, $p < .001$).

Thus, even if all the treatment interventions proposed in the following sections were instituted with violent offenders, the outcomes might still be disappointing, except for those who do not have an antisocial personality disorder. As Gacono *et al.* wrote, "Had our chapter focused solely on treating psychopathy, it would have been brief" (Ref. 21, p 111).

An Intimidating Group

An important factor to consider in the treatment of violent offenders is that this is an intimidating group of individuals who have the potential to pose a threat of harm not only to others but to mental health staff who treat them. For example, some clinicians may be concerned that they might be harmed if they set limits or point out unwelcome truths, thereby antagonizing the client. Provisions must be made for the safety of mental health staff who work for an agency that assesses and treats offenders.[7] These treatment personnel need a sense of security sufficient for them to feel comfortable and safe in providing these services. As Berg *et al.* state, "When confronted with an aggressive, potentially violent patient, personal safety should always be a prime concern" (Ref. 24, p 11).

Treating professionals also must be willing to assume the liability risks this population poses to others and the possibility that another offense by the parolee might result in notoriety and unfavorable publicity for the agency and clinician.[25] Mental health professionals may be held accountable for their clients' harmful acts even when treatment was sound and met the professional community's standards of care. Thus, treating professionals must feel secure in knowing that they have the full support of their agency, that quality consultation and in-service training will be provided by their agency, and that malpractice insurance coverage is adequate.[25]

Although our findings are consistent with previous research, we must acknowledge that there are some limitations in this program evaluation. It was not a controlled study with random assignment to a

PMHOC and a control group. Also, a larger sample would have allowed us to break down the outcome analyses by such factors as diagnoses, type of crime, and type of treatment.

Recommendations Based on the Program Evaluation and the Literature

We speculate that the problems identified herein regarding treatment and supervision are not atypical and that similar problems would be found in many facilities around the nation that treat mentally ill offenders, if those facilities also had an independent program evaluation.

Just as important as identifying problems is the need to make recommendations for improvement. These should be based on the findings of the program evaluation and should utilize strategies reported in the literature as effective. The following interventions were proposed for improving the effectiveness of treating mentally ill violent offenders at the clinic that we evaluated. However, we believe that they can serve as an example of how a set of recommendations for improvement might be developed from program evaluations conducted in other clinics treating similar clients.

1. All clinicians working with this population should have training in treating offenders and familiarity with the criminal justice system.

2. Clinicians should perform a thorough evaluation of the client that focuses primarily on those factors that contributed previously to the individual's violent behavior. To do this, clinicians should be able to review all pertinent criminal and mental health records and collaborate closely with criminal justice system staff.

3. Clinicians and parole officers, together with the client, should formulate an overall treatment plan that includes an appropriate living situation, the type and frequency of treatment including medications, and vocational assessment and counseling by qualified vocational rehabilitation professionals.

4. Alcohol and substance abuse evaluation, treatment, and monitoring should be given the highest priority.

5. The treatment plan should provide a strong support system. In this context, family involvement and family psychoeducation should be included when feasible.

6. If scarce resources are going to be used for persons with antisocial personality disorders, these resources should be used selectively. The Hare Psychopathy Checklist, Revised (PCL-R)[26] would be a good screening tool.

7. Clinicians, parole agents, and other professionals involved with the client should function as a team. This team should engage in close monitoring of the client's compliance with and progress in areas noted in the treatment plan as well as other conditions of parole.

8. Intensive case management should be made available. There should be follow-up when individuals miss appointments.

9. Both clinicians and parole agents should carry small caseloads. Clinicians' caseloads should be small enough that they have the time to evaluate clients adequately, formulate a comprehensive treatment plan, and provide intensive treatment. Parole agents' caseloads should be small enough that they can monitor the clients' activities and compliance. With smaller caseloads, clinicians and parole agents should be more available to engage in collaborative efforts and work as a team.

10. Only mental health professionals who feel comfortable both in dealing with violent offenders and in exercising authority over them should work with this population. Further, effective actions should be taken by the agencies involved to protect every member of the team and make all of them feel safe.

A Final Word

The department of corrections reported on in this article is to be commended for wanting their clinic evaluated and asking for recommendations for improving it. There is also much to be learned in this evaluation for everyone in the field. Many facilities that are thought to be doing well may in fact have serious problems and may be accomplishing much less than they could. Program evaluation is often discussed but frequently is not conducted in a meaningful way.[1] We believe that all facilities should use evaluation data and a review of the current literature to identify problem areas and implement changes to increase their effectiveness in the outpatient treatment of offenders.

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