Evaluation and Treatment of Insanity Acquittees in the Community

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This paper describes the monitored outpatient treatment program for Psychiatry Security Review Board (PSRB) clients in the largest single community treatment agency in the Oregon system. We describe 161 persons referred to this agency for evaluation and treatment. Ninety-one PSRB clients received treatment and of this group 51% had their conditional release revoked by the PSRB. The most frequent cause of revocation was noncompliance with treatment. There were only 11 crimes committed during the study period, four of which were in the felony range. The majority of PSRB clients are chronically mentally ill persons. We discuss both the treatment approach and our results in light of a recently published research agenda for insanity acquittees.

The object of this paper is to focus on the treatment of insanity acquittees in the community. Recent years have seen a series of empirically based studies that have helped to put the insanity defense debate into a more scientifically based framework. However, the nature of psychiatric treatment offered to these individuals has rarely been reported. Summaries of the research literature, published in 1981 by Pasewark[1] and in 1983 by Steadman and Braff,[2] contain little information on the treatment of insanity acquittees. Steadman and Braff, in addition to reviewing the empirical literature in relation to the insanity defense, proposed a research agenda for further studies of the insanity defense. One question they raised is whether insanity acquittees resemble criminals or mental patients. The tentative conclusion reached by Steadman and Braff is that these acquittees may resemble neither to any great extent, having less past psychiatric hospital experience than psychiatric patients and less past experience in criminal justice than criminals. They speculate that:

> It may well be that in developing appropriate programs for NGRIs, standard models for prisoners or mental patients both are inappropriate. They may be a class unto themselves. Like much else about the insanity acquittee, these possible program implications are quite speculative. There is simply insufficient descriptive information about acquittees' demographic, criminal and mental hospital history, and current clinical characteristics from which rational program development can proceed.[3]

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This paper addresses this area of the research agenda identified by Steadman and Braff. Since their article was written, information now exists that better defines the population and points toward areas of treatment program development.

As to defining the population, reports from several jurisdictions give an overview of the not guilty by reason of insanity (NGRI) population as being dominated by schizophrenic patients who have extensive experience with both the criminal justice and mental health systems. In a series of detailed reports from Missouri, Petrilla and colleagues[4,5] have noted that psychosis is the primary diagnosis in 78 percent of insanity acquittees and that 79 percent of the group have past psychiatric histories. Data from our work in Oregon[6,7] demonstrate a similar distribution of psychiatric diagnostic patterns, with schizophrenia being the most frequently occurring diagnosis. Although we have not been able to investigate this area in detail, the Oregon Mental Health Division found past psychiatric hospitalization in over 70 percent of a small NGRI cohort.[8]

Several recent studies point out that the NGRI population also has extensive involvement in the criminal justice system prior to a successful NGRI finding. In a study from Maryland, Spodak *et al.*[9] demonstrated that a significant portion of a conditionally released and/or discharged NGRI cohort had arrests before their NGRI determination, and 56 percent were arrested at some point after their discharge from hospitalization. In Oregon we recently reviewed the lifetime arrest pattern from a group of insanity acquittees released from the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB) in the first three years of functioning of the Board.[10] In this group of predominantly schizophrenic NGRI acquittees we found that 83 percent had arrests before the one that led to PSRB placement and that 43 percent were arrested after the termination of PSRB jurisdiction.

Our conclusion is that, at least in certain jurisdictions, the typical insanity acquittee is a schizophrenic patient with significant past experience in both the criminal justice and mental health systems.[11] In many ways, these individuals resemble a subgroup of the young chronically mentally ill now so common in many of our communities.[12] Having defined the population in this manner, certain types of treatment programs have been identified as applicable to this population.[13,14]

There have been few reports of aftercare treatment programs for the insanity acquittee. First, it is important to note that most insanity defense treatment systems are heavily weighted toward institutional treatment with little attention to aftercare. Roth,[15] in a recent article on the treatment of the violent person, strongly advocates for aftercare following treatment in maximum-security inpatient facilities.

In a previous paper we described the aftercare-conditional release mechanism available under the Oregon PSRB system.[16] We believe that the conditional release option with monitored community treatment is one of the most impor-

tant aspects of the PSRB system. This area attracted the attention of the American Psychiatric Association in its position statement on the insanity defense.[17] Although we described conditional release previously, we did not describe the treatment made available to those on conditional release.[16]

Reports of community treatment programs for the insanity acquittee come from two areas of the country. Rogers and Cavanaugh[18] describe the formation of a university-based evaluation and treatment program for violent offenders, including insanity acquittees. They discuss the treatment of a group of 54 offenders, 71 percent of whom were schizophrenic. The treatment approach is defined as an "eclectic problem-oriented model" with emphasis on "biological and psychosocial approaches" to treatment. They also highlight a close working relationship with the courts, probation, and parole, which includes regular reporting to these agencies with the possibility of revocation and rehospitalization as it becomes necessary in the treatment program.

The largest and most consistent body of treatment information regarding the NGRI population has come from Maryland. Maryland law has mandated a five-year conditional release period[19] for those NGRI acquittees released from the forensic inpatient facility, the Clifton T. Perkins Hospital Center. In a series of reports, Goldmeier *et al.*[20,21] describe the establishment of a residential treatment program associated with the inpatient forensic unit designed to smooth the transition from hospital to community for the released insanity acquittee. The program facilitates entry into the community with a vocational emphasis, the use of appropriate medications, and the encouragement of involvement in outpatient treatment facilities. Revocation of conditional release and rehospitalization are also features of the Maryland treatment program.[22]

In this paper we will examine the treatment program offered by the largest single treatment agency in the PSRB community treatment system in Oregon. We present data on all persons referred to this program for evaluation and treatment during its first three years of operation. The study will describe characteristics of the persons referred to the program, detail the treatment offered by the program, and review the effects of this treatment program on the study population. We will conclude with a discussion of a refocused research agenda.

The Setting

In previous papers we have explored the PSRB system in detail.[6,23] To review briefly, all persons who have had a successful insanity defense and, in the opinion of the trial court judge, remain a danger to society are committed to the jurisdiction of the PSRB for a defined period of jurisdiction, not to exceed the length of the maximum sentence they could have received if they had been convicted. During this period of jurisdiction PSRB may place the individual either in a hospital or on conditional release. The state hospital forensic wards and the contracts for community placement are the responsibility of the Oregon

Mental Health Division (MHD). PSRB must discharge persons from jurisdiction if, at any one of its periodic hearings, the Board determines that the person is no longer mentally ill and/or no longer dangerous to society at large. The PSRB legislation sets a hierarchy of goals with societal safety as paramount and with treatment and rehabilitation of the PSRB client as secondary.

Most of the community contracts for PSRB clients, negotiated by the MHD, are with county mental health programs who are paid to provide community treatment for those PSRB clients on conditional release. One of the responsibilities of each community program is to report periodically to the PSRB on each patient's status. If the patient's mental status deteriorates or the patient again presents a danger, the program staff is responsible for prompt notification of PSRB, which may decide to revoke conditional release and return the patient to the hospital.

An attempt is made by both PSRB and the MHD to place persons on conditional release in their home communities, or as close to home as possible. The largest single contract agency in the state is located in Portland, Oregon's largest city, and is subcontracted through the county mental health program to a large community hospital day treatment program (DTP).

The DTP is an outpatient rehabilitative mental health service that focuses on adults with chronic psychopathology. The overall target population includes those chronically disturbed patients who need greater consistency, intensity, and continuity in their treatment experience than is typically available in an office practice, yet who are able to maintain emotional and behavioral control outside of an institutional setting. PSRB clients are a subset of the chronically mentally ill population treated at the DTP. The program is structured around a supportive social milieu, with each patient receiving an individualized treatment program that may involve as many as several contacts per day to one contact per week. Rehabilitation efforts occur in group settings as well as individual counseling and psychotherapy sessions. For posthospital patients basic reality testing and adjustment to community living are emphasized. Long-term goals include maintaining psychological health, learning the social skills necessary to remain in the community, developing vocational and avocational interests, and establishing time management strategies.

Group therapies are hierarchically arranged from basic skill development such as meal preparation, nutrition, medication management, and familiarization with community resources to intermediate level groups that focus on communication, assertiveness skills, sex education, simple stress management, coping strategies, anger identification, and resolution. Advanced groups are less didactic and more psychotherapy oriented.

Each patient is assigned an individual therapist who works with the patient to develop a treatment schedule and to identify treatment-related goals. The DTP operates on a nine-week rotating schedule. At the end of each nine-week

session, called a module, the patient's treatment objectives are evaluated, new goals are identified, and a new schedule is drawn up. Extensive case management services are available for patients who need them. These services include referral and follow-up with social service and welfare agencies, representation during denial appeals for disability benefits, assistance in obtaining housing, and the meeting of other environmental needs as necessary.

Method

We reviewed records of 161 PSRB clients evaluated for possible admission to the DTP between 1980 and 1983. Each subject may have had one or several evaluations for admission or readmission to the program. Figure 1 describes patient flow through the program. In order to organize the data, subjects were divided into two groups: (1) those accepted for treatment at least once regardless of the number of evaluations, and (2) those rejected for treatment on one or several evaluations. A total of 110 subjects (68%) were accepted for treatment on one or more evaluations and 51 (32%) were rejected. Of the 110 subjects accepted for treatment, 91 received treatment while 19 received no treatment for various reasons, including discharge from PSRB before actually entering the treatment program, relocating to a different area, or being judged inappropriate for treatment due to a deterioration of mental status between the time of evaluation and entry into the program.

The 91 subjects who received treatment formed the sample for the description of the treatment program. At the time the records were reviewed two years later, 21 subjects were still in treatment, 46 subjects had been revoked by the PSRB and returned to the forensic unit of the state hospital, 15 subjects had been discharged by the PSRB, and the remaining nine subjects had been transferred to another treatment facility or were no longer receiving treatment for other reasons.

For purposes of the record review the

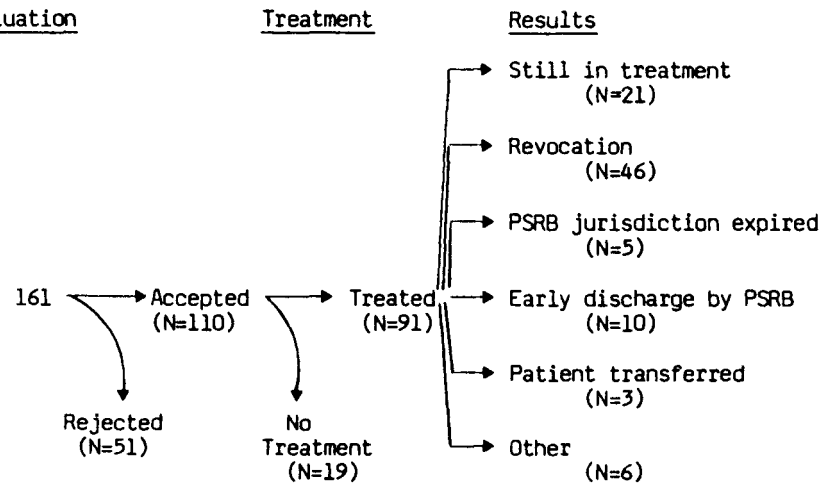

Figure 1. Overview of patient flow.

treatment program was divided into the following 12 treatment components: "A" level groups (basic skill-building groups); "B" level groups (more advanced interpersonal skill-building or process groups); individual treatment; family treatment; MD visits for medication management; occupational therapy; crisis-intervention counseling; home visits; voluntary hospitalization in a community hospital; voluntary hospitalization in a state hospital; advocacy services; and special staff conferences arranged because of problems arising in the patient's adjustment to treatment.

In addition to the components of the treatment program we also examined housing of these PSRB clients assigned to the DTP. The DTP runs its own sheltered housing unit for a small group of these patients. In addition to this one unit, other types of sheltered housing and independent living or living with relatives were examined.

Results

Demographic Data and Characteristics of the Rejected and Accepted Subjects There were no significant differences in the demographic characteristics of those subjects accepted for treatment (n = 110) compared with those subjects rejected for treatment (n = 51). The population was overwhelmingly male (91%) with a mean age of 33. Seventy-three percent were Caucasian, while 18 percent were black. The patients were predominantly single at the time of evaluation with 58 percent never having married and 26 percent having been divorced. Forty-one percent had less than a high school education, while 59 percent were high school graduates, the majority of whom had some post-high school training. Just under 50 percent of the population had clear histories of alcohol and drug abuse or dependence.

The majority of subjects (91%) evaluated had been committed to PSRB after being charged with a felony crime. We previously developed[16] a crime seriousness score, which was constructed taking into account statutory categories of criminal activity and the degree of harm or threat to persons. The scale includes both felonies and misdemeanors, and the resulting index ranged from 10 for murder, as the most serious, to 760 for harassment, as the least serious crime. The overall mean seriousness score for the present study sample was 215. Although the rejected sample had a more serious mean score (202) than the accepted sample (221), this difference was not statistically significant.

Diagnostic data are presented in Table 1. Diagnosis was determined by DTP staff psychiatrists using DSM-III criteria. Schizophrenia was the leading Axis I diagnosis (53%), followed by substance abuse (15%). There were no significant differences in diagnosis between those accepted and those rejected. Axis II diagnoses were made in 40 percent of cases examined by DTP psychiatrists. Significantly more persons with a diagnosis of antisocial personality were found in the rejected group ($\chi^2 = 7.05$, $df = 4$, $p < .01$)

The DTP evaluators gave multiple reasons for rejecting patients, the most

Table 1
DSM-III Diagnoses

Diagnosis	No.	%
Axis I		
Schizophrenia	86	54
Paranoid	42	26
Undifferentiated	31	19
Schizoaffective	9	6
Other	4	3
Substance abuse	24	15
Major affective disorder	13	8
Mental retardation	8	5
Organic mental disorder	6	4
Other	5	3
Deferred	18	11
Axis II		
No diagnosis	96	60
Antisocial	31	19
Other	18	11
Passive-aggressive	8	5
Borderline	8	5

*N = 161.

frequent being that the patient was not interested in treatment and/or supervision (n = 31, 61%). Other frequently cited reasons included that the patient was too acutely ill (n = 26, 51%), the patient was felt to be too dangerous (n = 24, 47%), or that the patient had a diagnosis of antisocial or borderline personality and was found to lack motivation and/or impulse control for treatment in this program (n = 19, 37%).

Description of Treatment Provided by the DTP The 91 subjects who entered the treatment program were involved in a total of 652 treatment modules or an average of seven treatment modules per subject. As discussed, each module lasted nine weeks, so that the average length of stay in the program was 63 weeks. Table 2 shows the 12 treatment components of the program, the percentage of the 652 treatment modules that included each component, and the average number of sessions within each treatment module. This means, for example, that 78 percent of the treatment modules contained individual therapy sessions and for those modules containing this treatment modality there were an average of seven sessions in the nine-week module. The most frequently occurring treatment categories were individual therapy, which was part of 78 percent of the modules, followed by home visits (65%), "A" level treatment groups (57%), and MD visits (57%).

When we look at the housing of these patients during their time in the DTP we find that during the 652 treatment modules 13 percent lived in the DTP sheltered housing, another 15 percent in other sheltered housing arrangements, 37 percent lived on their own, and 30 percent in other situations most often with either families of origin or with spouses, significant others and/or children. Data were missing in 5% of cases.

Comparison of Revoked and Remaining Subjects We chose to compare those subjects who remained in the DTP

Table 2
Summary of Treatment Offered by the DTP

Treatment	% of Modules	No. of Sessions
Individual	78	7
Home visit	65	5
"A" groups	58	16
MD visit	57	2
Occupation	45	17
"B" groups	24	10
Crisis intervention	13	1
Family	8	2
Hospital, state	5	1
Advocacy	5	1
Hospital, community	3	1
Staffing	1	1

(n = 21) with those revoked (n = 46). Several groups of PSRB clients were terminated from the DTP for administrative reasons unique to PSRB. Referring back to Figure 1 we find that five people were discharged because their time of jurisdiction lapsed whereas another 10 were discharged as no longer mentally ill and/or dangerous to society. Another three were transferred to other programs whereas six left for various other reasons. This left us with two groups who were deemed to need treatment: those able to adjust to the community and the treatment program (n = 21) and those who were not able to make such an adjustment (n = 46).

Before making the comparison between these two groups we determined that we were not dealing with a function of time with those remaining in the program being later admissions than those discharged. When we examined the issue of the time factor we found that those DTP patients who remained in the program were there for an average of 23 months, compared to only nine months for the revoked group, a highly significant time difference (analysis of variance, $F = 18.89$, $p < .0001$).

As with the earlier comparison of those accepted or rejected from the DTP there were no significant differences in demographic variables between those subjects remaining in treatment and those subjects revoked by the PSRB. The 21 subjects remaining in treatment at the time of data collection were involved in a total of 249 treatment modules, with a mean of 12 modules per person, whereas those subjects revoked by the PSRB were involved in 219 treatment modules, with a mean of five treatment modules. Table 3 shows the 12 treatment components, the percentage of treatment modules that included each component, and the average number of sessions within each treatment module for those subjects remaining in treatment and those subjects revoked by the PSRB. Those revoked from the program had less time in treatment and seem to be involved in more crises as evidenced by higher percentages of home visits,

Table 3
Comparison of Treatment Received by Patients Continuing in Therapy versus Those Revoked

Treatment	% of Modules		No. of Sessions	
	Remaining	Revoked	Remaining	Revoked
Individual	92	74	7	6
MD visit	63	58	2	1
"A" groups	63	53	17	14
Home visit	49	75	4	5
Occupation	46	44	19	14
"B" groups	23	23	12	8
Crisis intervention	10	19	1	1
Family	4	11	1	2
Advocacy	4	7	1	1
Hospital, community	2	5	1	1
Hospital, state	2	11	2	1
Staffing	1	3	1	1

Table 4
Comparison of Treatment Services Received by Patients Remaining in Treatment and Revoked

Treatment	Remaining (N = 21)		Revoked (N = 46)	
	No.	%	No.	%
Individual	21	100	39	85
MD visit	21	100	34	74
Home visit	19	90	38	83
"A" groups	19	90	34	74
Occupation	17	81	29	63
"B" groups	16	76	24	52
Crisis intervention	14	67	21	46
Family	6	29	13	28
Advocacy	6	29	6	13
Hospital, community	4	19	9	20
Hospital, state	4	19	16	35
Staffing	3	14	5	11

crisis intervention, and hospitalization. Table 4 compares the number and percentage of patients in each group who received each treatment component. The most frequently occurring treatment components for each group, in slightly different order, are individual treatment, MD visits, home visits, and "A" level groups. Table 4 presents a slightly different view of the treatment program when compared to Table 3. Except for the category of voluntary hospitalization in community or state hospital, the revoked group received less service in almost every program category. Table 4 also shows that those persons who do remain in the DTP were involved in crisis services at some point during their treatment careers and that the differences appearing in Table 3 may reflect differences that are a function of time in the program.

In the area of housing we decided to first look at each of the two groups during their first five treatment modules, about 45 weeks of treatment. We decided on this comparison in order to find a period of time at which both groups shared time in the program before revocation, which took place, on the average, in the fifth module. We found that during the first 45 weeks in the program, 54 percent of those revoked lived in some form of sheltered program whereas only 30 percent of those who remained in treatment lived in similar housing. Seventy percent of those who stayed in the program lived either on their own or in some family living situation whereas 44 percent of those revoked lived in similar circumstances. When we look at the total time in the DTP for both groups we find that the revoked patients spent 41 percent of their time living in sheltered housing and 55 percent of their time in independent living whereas those patients remaining in the program spent only 13 percent of their time in sheltered housing and 86 percent in independent living situations. There was progression in each group from the sheltered to the independent

Table 5
Reasons for Revocation

	Frequency	%
Deteriorating mental condition	34	74
Noncompliance (supervision)	34	74
Noncompliance (treatment)	30	65
Troublesome behavior	27	59
Elopement	18	39
New crime	11	24
Noncompliance (medications)	11	24
Substance abuse	11	24
Other	2	4

living situation but this was far greater for those patients who remained in the program when compared to those revoked.

Table 5 demonstrates multiple reasons for revocation, the most common being deteriorating mental condition, noncompliance with supervision and treatment, and exhibition of behaviors that were considered by staff as troublesome. Eleven new crimes were committed by clients in treatment at the DTP. These ranged from manslaughter, as the most serious, to false fire alarm, as the least serious. There were four felony charges and seven misdemeanors. The mean seriousness score for the new crimes was 504.

Discussion

This paper presented data on a single outpatient treatment program in the PSRB system during the first three years of its operation. Because of the focus on a single treatment program during its initial stages of development, the ability to generalize from these data is limited. Given this caution, there are, however, findings that deserve comment.

First, we have found an overwhelmingly male and Caucasian group with a mean age of 33. These findings mirror the overall PSRB population.[7] The DTP population was, however, skewed in the area of the seriousness of the crime that led to PSRB commitment, with 91 percent of those referred to the DTP having committed felony range crimes. The percentage of persons who committed misdemeanor crimes is about one half of the overall misdemeanor rate[7] of those committed to PSRB. The mean seriousness score of the crimes resulting in PSRB jurisdiction for the DTP patients was 215, more serious, for example, than the score of 437[10] obtained for those insanity acquittees who were discharged from PSRB jurisdiction during the first three years of its operation. This finding also indirectly confirms a previous finding that PSRB is willing to place persons on conditional release who had committed serious crimes before entering the system.[16]

Diagnostically this study allows some refinements over our previous reports. These data show that 50 percent of the DTP population had histories of substance abuse and that 40 percent of the group had Axis II diagnoses. We believe that the presence of substance abuse and personality disorder is an important area of diagnosis in this population.[10] This has been greatly underreported by us and others because of limitation of data. Schizophrenia was still the predominant diagnosis (53%). This percentage is less than we reported previously (67%),[7] based on data from state hospital files.

This important diagnostic question awaits a prospective research design using research diagnostic criteria.

When we look at entry into the program we find that with the exception of a diagnosis of antisocial or borderline personality none of the demographic, diagnostic, or crime-type information seemed to form the deciding line between acceptance or rejection into the program. This determination was apparently based on the assessment of motivation, treatment interest, ability to accept supervision, and mental status at the time of the evaluation.

The treatment philosophy and the treatment provided by the DTP was designed to meet the needs of chronically impaired individuals, including individual, group, and family treatment, medication management, occupational therapy and crisis-type services, home visits, and voluntary hospitalization. Even with this wide array of services and the tendency to select for motivation and interest in the program, 46 individuals, 51 percent of those treated, had their conditional release revoked by the PSRB upon recommendation by DTP staff. Were too many DTP patients revoked from conditional release? This percentage of revocation is comparable to the report by Goldmeier *et al.*[21] that 41 percent of the insanity acquittees placed in their residential setting were rehospitalized at some point in their stay in the program. Similarly, Rogers and Cavanaugh[18] reported that 25 percent of their highly selected population were rehospitalized during treatment. The percentage of revocation reported from the DTP was higher than the 32 percent revocation rate reported from our previous study on conditional release.[16] However, as mentioned, the population assigned to the DTP was heavily weighted toward those who had been involved in more serious crimes at the time of commitment to PSRB. The overriding emphasis of the PSRB on protecting public safety may account for the revocation. Revocation can be interpreted either as a failure of community treatment or as a success of community monitoring, which averts new crimes.

There are, however, some areas that the DTP might consider without risking public safety if it were to attempt to retain more patients in the program. The most frequently given reasons for the revocation of DTP patients were deteriorating mental status coupled with noncompliance with supervision and treatment. Given these data, the DTP could potentially strengthen its crisis services and psychiatric services to have a heavier impact on the crisis that may be associated with decompensation and noncompliance with treatment. The average length of time in the program for those revoked is about nine months. More intense crisis services at, and around, this time period might prove critical for some of the people eventually revoked. The housing data reported in this study show a progression from sheltered to independent living for both the successful and revoked groups. It may be that we are identifying a time-related crisis of adjustment to community care for which crisis services might be useful. Anecdotally, the DTP staff had come to this view on their own, and a review of the data from this study reinforced their

informal conclusions. In the final analysis the revocation rate of the DTP will need to be reviewed over a longer time period and in a framework of comparative program analysis with other outpatient treatment programs in the PSRB system. This research will have to compare both patient characteristics and the results of treatment in order to determine what might be an acceptable rate of revocation of conditional release and what might be done to keep more people in the community without risking public safety.

The protection of public safety, as mentioned, is critical to the PSRB mandate and deserves further comment. In this study, commission of new crimes by the DTP population occurred in 11 instances. Of the 11 crimes there were four felonies and seven misdemeanors. The manslaughter case was a vehicular homicide committed by a DTP client who was deteriorating mentally at the time of the offense. The other felony-range crimes included two charges of auto theft and one of sexual abuse. As noted, the mean seriousness score was far less serious than the score for the offenses that led to PSRB jurisdiction. The fact that less serious crimes generally seem to take place while on monitored outpatient treatment is a finding reported from Maryland[9] and in one of our previous reports.[10]

Although the reports from both Oregon and Maryland are encouraging in this area, there is definitely a controversy in the literature about issues of recidivism and its link to mental illness. In their proposed research agenda, Steadman and Braff[2] specifically recommend against recidivism studies as part of the research agenda on the insanity defense. They feel that the link between criminality and mental illness has not been demonstrated. The critical factors that have been deemed important in recidivism have been age, sex, race, socioeconomic status, and history of past criminal activities[24] rather than factors related to mental illness. These findings are no doubt true for overall crime statistics. However, we are not convinced that they apply equally well to persons with severe mental illness, particularly in the case of the PSRB population that is predominantly schizophrenic. Clinically, we have repeatedly seen a link between the cognitive impairment of the disease process and the criminal activity. There is much work to be done in this important area. Based on our studies of persons committed to PSRB and the subgroup described in this study of the DTP we believe that treatment programs can address recidivism through careful attention to mental status and to issues of compliance and by careful use of revocation and rehospitalization.

In conclusion we return to the research agenda put forward by Steadman and Braff[2] and outlined earlier in this paper. We believe that information reported since their formulation strongly suggests some redefinition of the agenda. With reports from Oregon, Missouri, and Maryland, we know enough about the insanity acquittees in these particular jurisdictions to conclude that they are a predominantly psychotic population with experience in both the criminal jus-

tice and mental health systems. Further, they seem to have many features of a subgroup and chronically mentally ill persons so common in many of our communities. Impressive strides have been made conceptually and in many areas of the country, programmatically, in the treatment of this group of mentally ill individuals. Modern management emphasizes continuity of care from the inpatient to the outpatient setting, a feature of mental health care often missing from the care of insanity acquittees. In the community treatment of this subgroup of the chronically mentally ill persons, monitored treatment is essential for management, with the hospital being readily available to handle both decompensation and noncompliance. This type of system has been developed by the PSRB and is illustrated in this first treatment report. We intend to undertake further research in this important area of mandated treatment in the community as it has major policy implications for large numbers of insanity acquittees and for even larger numbers of persons in the newly developing area of outpatient civil commitment.

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