APPENDIX F

TREATMENT APPROACHES FOR

INSANITY ACQUITTEES

Active Treatment Approaches for Insanity Acquittees

I. Treatment of Insanity Acquittees in DMHMRSAS Facilities addresses both symptom reduction and reduction of risk to community safety.

Insanity acquittees committed to the custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRAS) are in the unique position of requiring care in the context of their dual status as persons confined as a result of involvement with the criminal courts, and as psychiatric inpatients subject to the treatment parameters that govern nationally accredited psychiatric facilities. Addressing the treatment and management needs of individuals having such dual status presents a unique set of challenges to the professionals assigned to provide treatment to insanity acquittees.

During the past decade, there has been a general increase in efforts on the part of mental health experts, in accord with the tenets of Section 504 of both the Vocational Rehabilitation Act and the Americans with Disabilities Act (ADA), to provide care and treatment for the disabled that is both appropriate for the needs of the individual, and that is delivered within the least restrictive setting necessary for the care and safety of the individual and the community. Recently, at least one landmark U.S. Supreme Court decision (Olmstead v. L.C., 119 S. Ct. 2176, 2188; [1999]) has specifically applied the ADA standards to the individuals that are civilly confined in publicly operated state facilities. In the Olmstead ruling, the Court verified that there is a need for the implementation of comprehensive and efficacious treatment plans, geared toward providing care in appropriate and least restrictive settings, for individuals who are housed in long-term care facilities.

The confluence of forces that includes human rights mandates that both prescribe the need for active, least restrictive treatment, and proscribe the inappropriate confinement of those with psychiatric disabilities, on the one hand, and the legal mandate that proper caution be taken with the process of gradual release of insanity acquittees, on the other, has engendered the need for a highly active and responsive approach to providing mental health care to insanity acquittees. In practical terms, responding to the aforementioned mandates requires that psychiatric care and rehabilitation of insanity acquittees occur within an enriched treatment context that promotes symptom reduction and decreased risk to public safety, in as expeditious a manner as is appropriate.

The developing application of clinical risk assessment principles to the clinical decision making process with high risk patients, including insanity acquittees, has generated risk management approaches to treatment of such populations, as well. Heilbrun (1997), for example, asserted that the process for guiding the psychiatric care and treatment of high

risk forensic patients should combine active, ongoing risk assessment with treatment planning and service delivery. Such a program of care has been in place for some time in the DMHMRSAS facilities that provide treatment for insanity acquittees. Those individuals who are currently committed to the custody of the Commissioner of the DMHMRSAS as insanity acquittees are involved, from the point of first admission to the hospital for Temporary Custody, in the process of active, restorative and rehabilitative care that is provided to all patients hospitalized in DMHMRSAS psychiatric facilities. To ensure that the treatment provided conforms to current standards, the Office of Health and Quality Care, in conjunction with the Office of Forensic Services of the Division of Facility Management maintains a comprehensive program of staff training in the treatment of individuals having forensic legal status. In addition, it is the mission of each of the aforementioned Divisions to also ensure that all DMHMRSAS facilities provide care that is comprehensive and appropriate, and occurs within the least restrictive setting available.

II. General guidelines for provision of active treatment for insanity acquittees in DMHMRSAS facilities.

A. In accordance with departmental policy (DMHMRSAS departmental instruction 111(TX)01 *Requirements for Treatment and Habilitation Planning)*, each insanity acquittee will, to the extent feasible, actively participate in all aspects of the treatment planning process, on an ongoing basis, and in a manner that is reflected in the Comprehensive Treatment Plan.

B. For all insanity acquittees, conditional release from hospitalization shall be a primary goal of treatment.

C. Predischarge planning for acquittees shall be ongoing, as mandated by DMHMRSAS policy, and shall involve the active participation of the representative to the acquittee's treatment team from the community services board (CSB) that serves the jurisdiction to which he or she is likely to be discharged.

D. As soon as possible after the admission of an NGRI acquittee to a DMHMRSAS facility, the Comprehensive Treatment Plan for that acquittee, prepared in accordance with departmental policy and in a manner that is consistent with accreditation standards, shall be composed or revised to include all identified Risk Factors that are subject to treatment or preventive management, as delineated in Appendix A of this document, as clinical problems in need of active treatment.

E. The Comprehensive Treatment Plan shall also include all relevant treatment goals, objectives, interventions and treatment strategies aimed at ameliorating the symptoms and risk factors that promote the continued hospitalization of the acquittee. All revisions of the Comprehensive Treatment Plan for an acquittee shall, in conformance with facility standards, reflect any changes in the clinical status and treatment needs of the acquittee, with particular regard to all identified risk factors.

F. All relevant "protective factors" or patient strengths shall be cited and included in the treatment planning and implementation process.

G. All increases in privileges that are granted to the acquittee by the Forensic Review Panel or the Internal Forensic Privileging Committee shall be addressed in the acquittee's Comprehensive Treatment Plan, with regard to any corresponding need or eligibility of the acquittee for a change in treatment activities, and with regard to the manner in which the granted privileges shall be best implemented. Risk Management Plans developed to address changes in risk that are presented by increased levels of privilege, shall also be incorporated into the acquittee's Comprehensive Treatment Plan.

H. Treatment of each acquittee shall be consistent with the biopsychosocial model of psychiatric care, and shall include the multimodal application of medical, psychosocial, psychoeducational and psychotherapeutic interventions, in addressing the acquittee's treatment (and placement) needs. To the extent possible, treatment efforts shall be especially focused upon interventions that promote the development of improved acquittee strategies for self-management, self-control, and facilitation of an enhanced internal locus of emotional and behavioral control.

I. Any need of any acquittee for accommodative supports and interventions necessary to enable his or her full participation in the treatment program shall be addressed in the treatment planning process.

III. Insanity acquittees have special needs for treatment as a result of their legal status, history of criminal behavior, and mental illness linked with criminal behavior.

The development of effective psychotherapeutic and psychosocial treatments that reduce an individual's risk for violent and/or significant disruptive behavior has been the focus of much clinical research, for more than a decade. Treatment programs that focus upon Anger Management, in particular, have been widely applied in correctional and forensic mental health settings. The results of several major studies of the effects of anger management training upon individuals at high risk for violent behavior have yielded positive outcomes, particularly when used in conjunction with cognitive psychotherapy methods. A recent study of high-risk, violent offenders, for instance (Serin & Brown, 1997) found that completion of a comprehensive program of anger management therapy, prior to release from incarceration, was associated with a significant reduction in the rate of recidivism in the group that had received such treatment, when compared with controls.

Currently, each of the DMHMRSAS facilities that treat insanity acquittees has a highly structured and active program of individual and psychosocial treatments that is directed at addressing the range of risk factors and treatment needs presented by the insanity acquittees who have been placed in that facility. Mental health professionals who have

extensive training and expertise in forensic psychiatric treatment are responsible for conducting these programs. The treatment programs described below serve as examples of the range of psychosocial interventions that is currently available at each DMHMRSAS facility. These approaches to treatment for insanity acquittees may be useful in providing treatment/interventions in both the mental health facilities and community settings.

A. Aggression and Anger Control Therapy

1. This is treatment focusing specifically on the patterns of thinking, feeling, and behavior associated with an acquittee's aggression.

    a. Goal: decrease the risk of future aggression.

    b. In contrast to "management of aggression," a facility's method for controlling the immediate impact of an aggressive response and preventing further harm to others or the aggressive individual.

2. Three broad stages of aggression control therapy

    a. Stage 1---Mutual Discovery

        i. Acquittee gives a comprehensive history of aggression and the situations in which it is expressed, and learns to identify the triggers, fantasies, and feelings associated with it.
        ii. Behavioral repertoire of acquittee is identified and then divided into aggressive and non-aggressive behaviors.

    b. Stage 2---Building Alternative Responses to Aggression

        i. Focus here is on increasing the number of available options for handling potentially aggression-inducing situations in a nonviolent way.
        ii. Possible alternatives
            (1) avoidance
            (2) assertiveness
            (3) early warning and recognition
            (4) compliance and cooperation with "helping professionals"
            (5) effective management of symptoms

    c. Stage 3---Development of Plans

        i. Develop plan for handling important risk factors for aggression in a nonaggressive way, based on knowledge gained in first two

stages
ii. Develop written plan
iii. Acquittee practices plan and discusses it sufficiently often enough that he or she has a good working understanding of it

d. Stage 4---Relapse Prevention

i. Unstructured group focused on
ii. work with relapse prevention plan developed in Stage 3
iii. implementing that plan on a daily basis
iv. preparing and fine-tuning plan for use during conditional release.
v. This group could also include acquittees who have been revoked from their conditional release because of threat of aggression, incident in the community, etc.

B. Orientation for Acquittees

1. Group meetings to provide information and answer questions regarding status as an acquittee.

2. Possible topics.

a. Rights
b. Legal process
c. Understanding legal status
d. Use whenever moving to new legal status

i. Temporary custody
ii. Commitment to Commissioner
iii. Civil transfer
iv. Conditional release.
e. Petitions for release

3. The Human Rights Advocates should be encouraged to contribute to this group.

C. Forensic Peer Support Group

1. Ongoing, unstructured group meetings to provide support and opportunity for discussion of specific forensic concerns

2. Address special concerns of this group, such as

3. Anxiety of moving through criminal justice system

4. Publicity from past criminal offense(s)

5. Fear of moving into the community after long hospitalization

6. Dealing with less structure in the community

7. Difficulty making transitions

8. Stress of "doing time" (clinically, but not legally, ready for release)

9. Stigma of acquittee status

IV. Helpful references

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