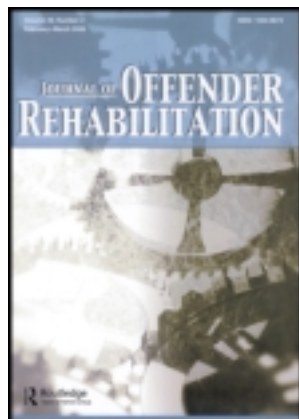


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Rebecca Cherner^a, Joan Nandlal^b, John Ecker^a, Tim Aubry^a & Donna Pettey^c

^a School of Psychology and Centre for Research on Educational and Community Services, University of Ottawa, Ottawa, Ontario, Canada

^b John Howard Society of Waterloo-Wellington, Ontario, Canada

^c Canadian Mental Health Association, Ottawa Branch, Ottawa, Ontario, Canada

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Findings of a Formative Evaluation of a Transitional Housing Program for Forensic Patients Discharged into the Community

REBECCA CHERNER

School of Psychology and Centre for Research on Educational and Community Services, University of Ottawa, Ottawa, Ontario, Canada

JOAN NANDLAL

John Howard Society of Waterloo-Wellington, Ontario, Canada

JOHN ECKER and TIM AUBRY

School of Psychology and Centre for Research on Educational and Community Services, University of Ottawa, Ottawa, Ontario, Canada

DONNA PETTEY

*Canadian Mental Health Association, Ottawa Branch,
Ottawa, Ontario, Canada*

Using results from a formative evaluation, this article describes the transitional rehabilitation housing pilot (TRHP) program located in two metropolitan Canadian cities. TRHP is an innovative community mental health service, created to support hospitalized forensic patients in their transition to living independently in the community. The evaluation used a multimethod, multi-informant approach to describe TRHP services and assess their quality. Results suggest that TRHP is serving the intended population and generally being implemented as planned. Stakeholders identified numerous strengths and weaknesses of the program. Findings are discussed in the context of previous research and their implications for future program development.

KEYWORDS *community-based rehabilitation, mental illness, offender rehabilitation, program evaluation, reintegration*

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Address correspondence to Tim Aubry, Centre for Research on Educational and Community Services, 34 Stewart St., Ottawa, ON, K1N 6N5, Canada. E-mail: taubry@uottawa.ca

To date, there is limited empirical literature that describes research findings on community-based programs that support the reintegration of forensic patients discharged from the hospital (Vitacco et al., 2008). Much of this research is focused on patient characteristics that are related to recidivism rather than describing transitional programs (Jacoby & Kozie-Peak, 1997; Renzaglia, Vess, Hodel, & McCrary, 2004). Vitacco and colleagues (2008) suggested that community-based programs must be intensive, address mental health issues and substance abuse, and offer continuity of care. Standardized risk assessment was also important in determining who should be released into the community.

Research on the discharge of psychiatric patients from the hospital provides some guidance around program characteristics that are important for reintegration into the community. For a general population of psychiatric patients that included forensic patients, a transitional discharge model which involved peer support and the establishment of a relationship with a community nurse was successful in reducing the length of stay of patients and improving quality of social relations (Forchuk, Martin, Chan, & Jensen, 2005). The importance of community support in reducing readmission of psychiatric patients to the hospital, diminishing symptoms, and increasing ability to live in the community has also been supported by other research (Reynolds et al., 2004). These findings suggest that a gradual transition to community programs with the availability of support facilitates a successful discharge from the hospital for psychiatric patients. The importance of hospital-community linkages have also been supported for a forensic population (Dimmek, 1994).

There is also a body of research on offenders with mental illness who have been discharged from prisons. Researchers in this area (e.g., Hammett, Roberts, & Kennedy, 2001) have advocated for a more holistic approach when dealing with the complexities of the mentally ill prison population, as, historically, offenders with mental illness have been discharged from prison and left on their own to secure community resources, housing, and occupational support. The importance of prison-community linkages has been stressed (Wolff, 2002; Hammett et al., 2001; Campanelli et al., 2005) and risk factors for reoffending include a history of untreated mental illness, co-occurring substance abuse, and homelessness (Dolan & Doyle, 2000).

Intensive case management (ICM) has traditionally been seen as an effective service enabling offenders with mental illness to remain out of jail and/or psychiatric hospitals, integrate into community, connect with community-based agencies, and learn how to manage their mental illness. Based on a review of research investigating the effectiveness of intensive case management with offenders with mental illness, Loveland and Boyle (2007) summarized the literature as yielding mixed results depending on what kind of case management was being delivered (ICM vs. Assertive Community Treatment [ACT] vs. brokered case management) and what outcomes were being assessed (recidivism, incarceration, minor charges, and involvement in illegal

activity). Specifically, case management proved to be a more effective option when compared to no treatment; however, Loveland and Boyle did not find differences in outcomes in those studies that compared more and less intensive case management. None of the reviewed studies had provided treatment that included case management combined with supportive housing.

Casper and Clark (2004) studied the impact of supportive housing for 39 forensic clients (i.e., individuals with a DSM-IV Axis I diagnosis and at least one stay in a prison or jail). The program provided rehabilitation services for the purpose of assisting clients to transition into permanent housing. Using a 4-year follow-up period, 54% of the clients had been discharged from the program. Of these clients, 24% had successfully transitioned to permanent housing, 24% had reoffended, 19% dropped out of the program, 19% went to other supervised housing, 9% had been rehospitalized and one consumer died. Cimino and Jennings (2001) examined a program that served forensic clients with substance disorders transitioning from the hospital. The program provided a secure, residential treatment facility, followed by a move to the community and continued support from case managers (up to 30 hours a week), including supportive counseling, housing support, financial assistance, supportive employment, transportation assistance, and access to day treatment. Of 18 clients, 17 remained in the community and none had recidivated or abused substances after an average of 508 days in the community (Cimino & Jennings, 2001).

Lamberti and colleagues (2001) emphasized the importance of integrated service delivery in improving client outcomes. Project Link, in New York, involved integrated healthcare (i.e., mental health and addictions treatment), criminal justice and social services for individuals with severe mental illness and a history of criminal involvement and nonadherence with outpatient treatment (Lamberti et al., 2001). One year after admission, clients had a significant decrease in the number of days in the hospital and jail compared to the year prior to their involvement in Project Link and showed an improvement in community functioning.

In sum, the literature suggests that important components of transitional programs for forensic patients include the provision of community support, the continuity of care and hospital-community linkages, case management, and integrated service delivery.

Description of the Intended Transitional Rehabilitation Housing Pilot (TRHP) Program

The purpose of the TRHPs was to facilitate the placement of forensic patients into transitional housing to support their reintegration into the community and eventual move into permanent housing. The two cities were chosen as the pilot sites in the province of Ontario because service utilization information in the province indicated these were the areas with the greatest need in term of forensic unit inpatient services. Table 1 presents a program logic

TABLE 1 Program Logic Model of TRHP

Inputs	Activities	Short-term outcomes	Long-term outcomes
City A: Housing stock: one apartment building with 1- and 2-bedroom units; remaining units in building occupied by other mental health consumers Rent supplements Staffing • 2 FTE community agency staff members • Hospital: nurse (1 FTE); psychiatric support as needed City B: Housing stock: one 4-bedroom house Rent supplements Staffing: • Hospital: 1 nurse (1 FTE); psychiatric support as needed • TCM: 1 FTE • Concurrent Disorders Treatment: .9 FTE • Supportive housing staff: 1 program manager, 5.5 FTE rehab worker positions, .5 FTE residential coordinator, 16 part-time relief workers as needed, and .5 FTE rehab work for the manager	Intake • Assessment • "Inreach" by agencies onto forensic rehab unit (City B) • Readiness-oriented programming (group and individual) in hospital • Engagement of client early in the process • Monthly intake meetings (City B) • Coordinated intake process (e.g., inpatient social workers at meetings; City A) Supervision and security • 24-hour supervision in the form of on-site staff support Programming • On-site and community programming • Intensive support for symptom management, decompensation • Psychosocial rehabilitation addressing mental health issues • Addictions-related services; concurrent disorder treatment • Personal and collaborative risk management planning • Skills teaching • Groups (City B): Illness management and recovery, wellness recovery action plan, recovery, community exploration • Link to generic mental health services • Outreach and education with community services • Weekly (City A) or biweekly (City B) case conferences • "Teaching apartment" available to clients (City B) Clinical supports • Psychiatric support provided by hospital	To improve forensic clients' access to generic housing and other services To reduce recidivism To turn over longer stay forensic treatment and rehab beds To prevent hospital readmission To reduce stigma for forensic clients	To promote community safety To promote a quality of life for forensic clients that is similar to that of individuals in generic housing and is characterized by successful citizenship/independence/community To promote community integration through the development of social networks, educational achievements, and vocational pursuits

model detailing the make-up of the program in each of the sites. In City A, the partnership involved a psychiatric hospital and one mental health agency whereas, in City B, the partnership comprised a psychiatric hospital and two community mental health agencies.

CLIENT POPULATION

The program was intended for forensic clients currently in a hospital whose functioning had stabilized and who “required additional support by the TRHP and are not appropriate and/or eligible for placement with other supportive housing environments or community service modalities” (Ontario Ministry of Health and Long-Term Care, 2010, p. 4). Clients were expected to transition to permanent housing and community mental health services within 12 months. Criteria also included a community placement and service plan (including risk management and monitoring requirements) agreed upon by TRHP and the referring source. The criteria did not specify levels of risk or functioning and left the referring source and program to determine persons’ eligibility once they met general criteria.

REFERRAL AND INTAKE PROCESS

Referrals to TRHP were to be made by hospital partners to the community partner(s) who would then conduct an intake for admission into TRHP. As part of this process, pertinent clinical information was to be provided by the hospital to the community partner including criminal history information and risk assessment information.

HOUSING

In City A, TRHP housing stock was to include one- and two-bedroom apartments in a building located in a lower-income neighborhood. In contrast, in City B, the housing was to include a four-bedroom residence located in a residential middle-class neighborhood and six self-contained, one-bedroom apartments scattered throughout various neighborhoods. As clients were under the purview of the Ontario Review Board, the TRHP had to be configured to ensure compliance with Ontario Review Board supervision requirements.

Clients at both sites were to receive rent subsidies to ensure that their housing costs did not exceed 30% of their income. They were to continue to receive rent subsidies after their discharge from the TRHP. Clients of the City A TRHP program were intended to move directly from hospital into an apartment in the TRHP building that included on-site, 24-hour support. They then were expected to move to other housing upon graduation from TRHP. In contrast, City B clients were expected to move into the four-bedroom

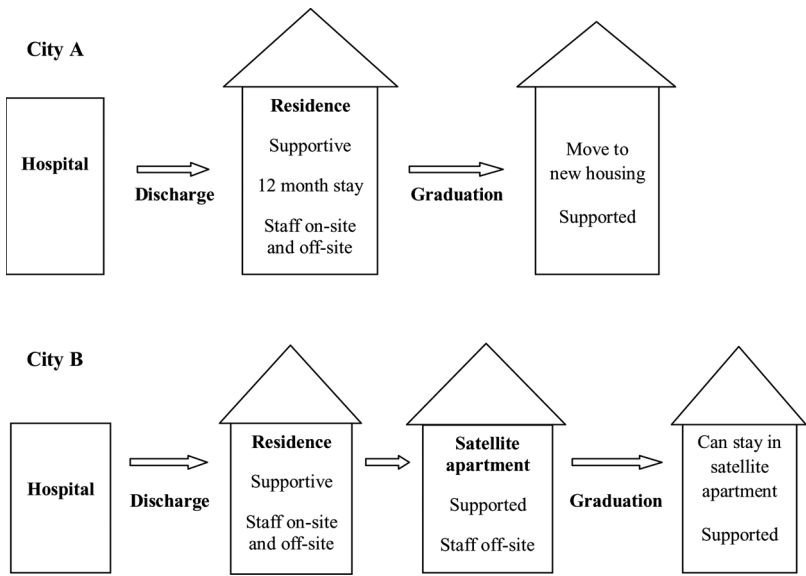


FIGURE 1 Description of intended housing flow-through for TRHP clients.

residence before transitioning into one of the six satellite apartments. Once they were in the satellite apartment, they were to continue involvement in the programming at the residence. Upon ending contact with the residential staff, they would remain in their apartments. Figure 1 provides a description of the transitional steps for the pilot program in the two cities.

STAFFING

In City A, clients were to receive support from transitional case managers (TCMs) who would staff the TRHP building. In City B, workers from one agency were to staff the residence and be available to monitor and provide support to clients 24 hours a day, in addition to offering group programs. In addition, TCMs from a second agency were to provide intensive case management to clients while they lived in the residence and satellite apartment. The hospital from which patients were discharged in each city was expected to provide 1.0 FTE on-site staff. Forensic psychiatric support was also to be provided by these hospitals.

SUPPORT

TRHP staff support was intended to focus on daily living skills training and facilitating community integration. Support was to be offered through both individual contact and group programs at both sites. In City A, the programming was to include life-skills training and social events. In City B, clients were to receive support addressing mental health, addictions,

and community living (e.g., social activities, financial management, recreation, health).

SUPERVISION

Both the apartment building in City A and the four-bedroom residence in City B were to have 24-hour supervision in the form of on-site staff support. Supervision requirements for individuals living in scattered apartments were to be met through phone contact, attendance at group meetings or other events, and through contact with staff in the community.

Study Objective

Few transitional programs, especially those that include a housing component, have been established to facilitate the integration of forensic patients from the hospital into the community. Consequently, there is a paucity of information on transitional programs for offenders who are discharged from a hospital. The conducted study, whose findings are presented in the article, evaluated the implementation of a new transitional program in two cities against the planned programs using a model-guided approach to evaluating program structures and processes (Brekke, 1987; Scheirer, 1994). The model-guided approach entails outlining the important components of the program, including clients, programs, and the delivery of the services; developing hypotheses (empirical specifications that can be tested, e.g., services to be delivered) about program implementation; collecting data; describing actual implementation and testing hypotheses; and providing recommendations (Brekke, 1987). The programs were created to support forensic patients discharged from the hospital in their transition to living independently in the community. In each city, the program involved a partnership between a psychiatric hospital and one or more community mental health agencies. The initial placements occurred in 2007 and data collection for the formative evaluation ended in October 2009.

METHODS

Data were collected through a review of program documents, focus groups with program staff, interviews with program staff and key informants, client interviews, and clinician ratings.

Review of Program Documents

Reviewed program documents included client charts, client recovery plans, minutes of project team meetings, and project proposals.

Focus Groups of Program Staff and Interviews With Program Staff and Key Informants

City A staff completed individual interviews and City B staff participated in focus groups. Interview and focus group protocols for staff included questions about the program goals, eligibility criteria, referral and assessment processes, intended and actual implementation, program strengths, and program weaknesses. Key informants were persons who were involved in designing, delivering and monitoring TRHP and included individuals working in the Ministry of Health and Long-Term Care, and managers at the agencies and hospitals. Individual interviews were conducted with key informants and addressed the program goals, contact with the program, intended and actual implementation, program strengths, and program weaknesses. Interviews were conducted in person or via phone. Data were collected from 38 program staff and 23 key informants, in total (City A: 15 staff, 13 key informants; City B: 23 staff, 10 key informants). Focus groups and key informant interviews were conducted 17 to 20 months after the beginning of the program in City A and 13 to 17 months after the program began in City B.

Client Interviews

Interviews were completed with nine clients in City A and 11 clients in City B at 6, 12, and 18 months. One client in City A and three in City B declined participation. Client interviews included qualitative questions related to their experiences with transitioning to living in the community, the services they received, their satisfaction with TRHP, and their perceptions regarding their recovery. Interviews also collected outcome data that is not reported in this article.

Clinician Ratings

Clinician ratings completed at program entry were used to provide information on the level of functioning and levels of risk for recidivism of clients. The Multnomah Community Ability Scale (MCAS; Barker & Baron, 1997; Barker, Barron, McFarland, & Bigelow, 1994a, b) was completed by THRP staff as a measure of level of functioning. The MCAS measures the level of community ability of individuals with psychiatric disability. The Historical, Clinical, Risk-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997) was used at baseline as a risk assessment instrument. The 20 items assess historical factors (10 items), clinical elements (five items), and risk management factors (five items).

Analysis of Qualitative Data

Interviews and focus groups were audio-recorded and verbatim transcripts (City A) or detailed notes (City B) were produced. To ensure the accuracy

and quality of the detailed notes in City B, the audio recordings were reviewed by the research team members and the notes were sent to each focus group participant to confirm the collected data. The audio recordings were also reviewed by team members throughout the data analysis process in order to ensure that the researchers were staying true to the data and letting the data guide the analysis. The qualitative data were analyzed using a modified grounded theory approach (Berg, 1989; Patton, 1990; Ryan & Bernard, 2000) to identify emergent themes in relation to the questions that guided the implementation evaluation. It was thought that this approach best suited the analysis because although there was a set of evaluation questions to answer and hypotheses present, all the interviews and focus groups involved semistructured questions. These semistructured questions focused on how key informants, staff, and clients experience the program and what factors influenced the implementation of the program.

A two-step process was used to analyze the data. First, a research team member independently coded the data. Next, the coding was verified through a review of coding by another member of the research team. Upon completion of the data analysis, a draft version of a write-up of the results was presented to selected interviewees for verification.

RESULTS

The presentation of the results is organized to answer the questions guiding the formative evaluation.

Is the Program Serving the Intended Population?

CITY A

The City A TRHP clients ($N=9$) were predominantly male, with one female client accepted into the program. The mean age of the clients was 33.33 years ($SD=7.19$). The average monthly income was \$1,198.43 and all clients received support from the Ontario Disability Support Plan. The number of hospitalizations before admission into TRHP ranged from 1 to approximately 13 ($M=4.89$, $SD=4.88$). The length of clients' last inpatient stay prior to admission to TRHP ranged from 17 months to 66 months ($M=34.67$, $SD=14.37$). Based on clinical information provided by hospitals, the majority of clients had a diagnosis of schizophrenia ($n=8$). Other mental health diagnoses included anxiety disorder ($n=1$), psychosis ($n=1$), personality disorder ($n=4$), and substance abuse ($n=4$). Five of the nine clients were diagnosed with a co-occurring substance use disorder and one also had a developmental disability.

At baseline, four of the City A clients were assessed on the HCR-20 at a low level of risk, two at a moderate level, and the level of risk of the

remaining three clients was unknown. Based on MCAS ratings, clients were assessed by TRHP staff at program entry to fall in the moderate to high-level range of functioning (range 56–82, $M = 72.88$, $SD = 9.16$). The index offences of the clients were varied. Assault and weapons charges were the most common. Other offences included attempted murder, theft, robbery, mischief, and breach of probation. All clients had detention orders with community access, meaning that they could reside in the community with hospital approval. The average length of stay for City A clients in the program was 22.82 months. One client in City A reoffended during data collection. Five (of nine) clients experienced a period of rehospitalization over the course of the program, only one of whom remained in the hospital at the end of data collection.

CITY B

All but one of the City B TRHP clients ($N = 11$) were men. The mean age of City B clients who participated in the evaluation was 33.27 years ($SD = 10.69$). The mean monthly income was \$1085.88 and 10 clients received support from the Ontario Disability Support Plan. Other sources of income included paid employment ($n = 1$), Canada Pension Plan ($n = 2$), and private insurance ($n = 1$). The number of hospitalizations before admission into TRHP ranged from 2 to 13 ($M = 6.09$, $SD = 3.42$). The length of the most recent inpatient hospitalization prior to admission to TRHP ranged from 6 to 21 months ($M = 15.09$ months, $SD = 8.73$). Ten of the City B clients had been diagnosed with schizophrenia or schizoaffective disorder. Other diagnoses included mood disorders ($n = 1$), antisocial personality disorder ($n = 2$), and other personality disorders ($n = 2$). Eight clients also had a co-occurring substance use disorder.

Prior to discharge from the hospital, two of the City B clients were rated on the HCR-20 as having a low level of risk, eight were assessed as having a moderate level of risk, and the level of risk for one client was unknown. According to the baseline MCAS scores, the majority of the clients were assessed as functioning at a high level (range 50–74, $M = 66.11$, $SD = 7.87$). The majority of the index offences involved assault and/or weapons offences. Other offenses included attempted murder and criminal harassment. All clients had detention orders with community access. The average length of stay for City B clients in the program was 19.15 months. Two clients in City B reoffended during the course of data collection. Six (of 11) clients experienced a period of rehospitalization, one of whom returned to TRHP, three who were to return to the community soon, and two were hospitalized indefinitely.

The restrictions placed on clients by the Ontario Review Board differed among individuals. Most clients could enter the community with indirect supervision (unaccompanied, but subject to reporting to designated person;

approximate whereabouts known to designated person), but required direct supervision (accompanied by staff or approved person) past a certain distance from the hospital, whereas others initially required supervised housing. One common requirement was to report to the hospital regularly (i.e., not less than once every 2 weeks). Some clients were required to abstain from use of alcohol or drugs and to participate in random urine screens to test for substance use.

Based on the characteristics of the TRHP client group in both cities, it was evident that the program is serving the targeted population, namely forensic patients who had for the most part experienced multiple hospitalizations, had been in the hospital for a significant period of time prior to entry into the program, and whose level of functioning indicates readiness for discharge into the community.

Is the Program Being Implemented as Planned?

REFERRAL AND INTAKE PROCESSES

In City A, potential candidates for TRHP were identified during weekly case conferences. Referrals were reviewed by the hospital's forensic outpatient services manager, the psychiatrist, and the manager of the TRHP program. TRHP staff worked on engaging new clients as soon as a referral was made. After assessment and formal acceptance into TRHP, a discharge plan was developed and all of the information gathered informed the risk management plan.

In City B, potential referrals were identified during the weekly interdisciplinary case conferences at the hospital, which were attended by the nurse who was affiliated with TRHP. Hospital staff then completed the referral package (disposition order of the provincial review board, a schedule of the client's weekly activities, a functional assessment, the HCR-20 and a report about the client's functioning and behavior in the hospital), which was reviewed by the TRHP program manager to determine the client's eligibility. The second part of the process was to determine whether the client was suitable for the program. The client met with the nurse and a residential staff member. Aspects of suitability included the client's potential for successfully re-integrating into the community, treatment goals, and stage of recovery from substance use.

HOUSING

As clients were under the purview of the Ontario Review Board, the TRHP had to be configured to ensure compliance with Ontario Review Board supervision requirements. In both cities program managers, staff, and clients commented that the provided housing units were clean, tidy, and furnished through the use of start-up funding. The condition of the apartments

engendered a sense of comfort and security among clients. In City A, clients lived in one- or two-bedroom apartments in a building leased by the community agency located in a lower-income neighborhood. These clients moved directly from the hospital into one of those apartments. They then were expected to move to other housing upon graduation from TRHP. This building also housed clients from another program run by the program agency, Mental Health and Justice (MHJ). The MHJ clients tended to be people who have been placed via diversion programs or who have been convicted and are on probation and come with lengthy criminal records.

In City B, the housing included a four-bedroom residence located in a residential middle-class neighborhood and six self-contained one-bedroom apartments scattered throughout various neighborhoods. Despite the initial expectation that City B clients were to move into the four-bedroom residence before transitioning into a satellite apartment, two clients moved directly from the hospital to a satellite apartment, which was a divergence from the intended implementation. Once clients were ready for greater independence, they were able to select an apartment in the neighborhood of their choice (i.e., satellite apartment). Upon ending contact with the residential staff, they could choose to remain in their apartments. All clients received rent subsidies so that their housing costs did not exceed 30% of their income. These subsidies were maintained after clients' discharge from the program.

STAFFING

In both cities, the staff group associated with the transitional housing unit corresponded in large part to the intended implementation, with on-site transitional support workers or case managers (TCMs) staffing the residence and access to psychiatric services through the hospitals. In City A, the hospital did not initially provide the expected 1.0 FTE nursing support to TRHP, although forensic psychiatric support was provided. The hospital later provided in-kind nursing support at the TRHP site; however, the nursing support was limited because it was reallocated from other hospital services.

The City B TRHP received nursing and psychiatric support from the hospital. Workers from one agency staffed the residence and were available to monitor and provide support to clients 24 hours a day, in addition to offering group programs. City B clients also received intensive case management from TCMs from the second agency throughout their involvement in TRHP. However, the delivery of TCM support differed from the intended implementation with respect to the number of TCMs involved in the program. In particular, several key informants noted that they had anticipated the TCM support to be delivered by one TCM, or a small group of TCMs dedicated to the program, rather than having this role shared by a larger number of TCMs who carried a mixed caseload (i.e., clients from several different programs). It should be noted that the service agreement did not specify the number of

TCMs or the expectation that case managers serve exclusively TRHP clients. Also, some clients had case managers from other agencies and, in those cases, those clients maintained their previous worker. Thus, a total of 12 TCMs provided services to TRHP clients in City B. It was perceived by some key informants that the TCMs had less involvement with TRHP clients than they would typically with other clients in the community, as the residential staff had daily contact with clients living in the residence.

SUPPORTS

Once clients were admitted in TRHP housing they had opportunities to participate in recovery-oriented independent living skills training (e.g., cooking, laundry) and evening drop-in social events provided by the residential staff. The support was intended to focus on daily living skills training and facilitating community integration. The staff members provided intense individualized supports that included goal planning, counseling, and support related to the client's needs (e.g., assistance with job applications, banking, mental health), and crisis intervention. In City A, program staff indicated that attendance at both skills training and social events was lower than originally anticipated for several reasons: clients were working or in school and unavailable to attend such events; clients were referred to and were participating in programming provided by services in the community such as an employment training program; clients had participated in many group-based activities prior to hospital discharge such that they opted not to attend; and clients conveyed while in the hospital that they were highly motivated to participate in rehabilitative activities but once in TRHP housing were less committed. These activities, and the freedom to choose whether to participate in them, were viewed by clients as a program characteristic that contributed to their recovery.

Extensive programming was offered in City B by the residential staff along with recreational and social activities, which were also available to clients in the satellite apartments after they had moved from the congregate transitional residence. These services were delivered to clients in different modalities and at different levels of intensity. Clients residing at the congregate residence tended to receive more intensive services, whereas those who had moved on to satellite apartments were less likely to attend groups and other activities offered on site at the residence. However, the clients in satellite apartments continued to receive support from their TCMs. It was expected that the nurse would provide both monitoring and education, however, the educational aspect of her role had not been as well developed as initially envisioned.

In both cities, clients seemed interested in social activities offered as part of the program but were less interested in group-based interventions focused on bolstering skills for independent living. One area in which clients

appeared to receive less focus in their work with TRHP staff was on education and work, even though many clients were interested in pursuing further education and obtaining employment.

SUPERVISION

Both the apartment building in City A and the four-bedroom residence in City B had 24-hour supervision in the form of on-site staff support. In City A, the role of the TRHP staff in monitoring substance use evolved. Initially, the TRHP staff members were involved in collecting urine screens for drug use; however, once the hospital provided nursing support, this role was carried out by hospital personnel. In City B, the supervision and monitoring evolved during the implementation of the program. Initially, the residential staff and managers had concerns about achieving a balance between supervising clients and assisting with recovery, but believed that they had found an acceptable balance between supervision and recovery. While the requirements of the hospital and ORB were met, the rigidity of the supervision lessened as it became evident that this high level of monitoring was not necessary. Supervision requirements for individuals living in scattered apartments were met through phone contact, attendance at group meetings or other events, and through contact with staff in the community.

In general, the delivery of housing and support corresponded well to planned implementation, although there was some adaptation of the program during implementation. There was more focus on community integration than expected, which was addressed by the development of a community integration group, by integrating clients into community services such as concurrent disorders groups offered by partnering community agencies in City A and City B, and discouraging clients from attending groups at the hospital. Given the clients' higher than expected level of functioning, there was less focus on basic skill development than anticipated, and some clients preferred more independence and less support. The program was client-centered and addressed clients' individual needs, which accounted for the range of services delivered and the difference among clients in the intensity of these services.

What are the Program's Strengths and Weaknesses?

STRENGTHS

Community and hospital partners of the program shared similar perceptions of TRHP in terms of the purposes of the program, namely that it was intended to assist forensic patients to adapt to living in the community and to achieve housing stability and community integration while continuing to function at a high level. There was also a high degree of agreement on the part of key informants with regard to the benefits of TRHP to clients and to the system.

Perceived benefits to clients included facilitating growth and recovery in a nonstigmatizing environment, putting in place opportunities for adopting normal roles in the community, and preventing rehospitalization. Perceived benefits to the mental health system included reduced costs because supportive housing is cheaper than a hospital inpatient stay. As well, the program served to increase the capacity of community agencies to work with this client group.

There was generally high praise from key informants and clients for the support that TRHP clients received from program staff. Their openness and availability was perceived as contributing to the creation of strong therapeutic relationships with clients. Clients described staff as friendly, encouraging, flexible, and helpful in preparing clients to live independently. The staff members were also described as motivated for the program to succeed and excited to be involved in a new and innovative program. Program managers were acknowledged for their support to staff and leadership in developing the program.

The improved quality of life for the clients was identified as an important strength of the program in both cities by staff and program managers. Clients were viewed by staff and key informants as benefiting from the program and enjoying their stay in the residences. They were described by a key informant as having an appreciation for the program and “feel(ing) lucky” to be involved. As one City B staff member stated, “There is a sense of pride for clients who are selected for [4-bedroom residence]”. It was also noted that the “word is out” in the forensic unit at the hospital that TRHP is a good program. Clients also described increased quality of life, such as making new friends, and the opportunity to live in the community.

Enhanced quality of life of clients was also attributed to community living. TRHP gave clients who would not otherwise be in the community, the opportunity to live outside the hospital. TRHP also provided an opportunity for people who had experienced significant challenges in reintegrating into the community in the past, as noted by a City B key informant:

It benefits clients because some clients would not have been discharged or they would likely be in a revolving door situation where they went out for a short time and would have had to be brought back to the hospital.

Clients also perceived their participation in TRHP as aiding in their recovery. Aspects of the program that were described as helpful by clients included the development of skills around relapse prevention, education about mental health and symptoms, and training of skills for independent living (e.g., cooking). There appeared to be variability in the perceived usefulness of this programming as some clients, especially in City A, opted not to attend and participate in these programs.

The partnerships developed between the hospital and community agencies in both cities were perceived as a strength by staff and program

managers. The broader context of philosophy and general service orientation shaped how the partners saw each other. Key informants noted that part of their challenge was managing the hospital's medical and forensic orientation with the recovery and client-centered lenses brought by those working in the community sector. Differences in treatment models can make it more challenging to work with partners for the benefit of clients, although the partners became more familiar with each other's approaches. In City B, several key informants noted the strong relationship that has developed among the partners. The City B partners noted that they have come to better understand and appreciate each agency's strengths, responsibilities, and ways of working, as described by a City B key informant:

There has been a tendency in the past for hospitals to say that community agencies don't understand their patients and for community agencies to say that hospitals don't get our realities. We have been able to work together for the benefit of the patients. In the end, we have been able to appreciate and grow. That is a main benefit. That is not even about the client, but it has huge benefit for the clients, not just TRHP clients.

The in-reach model of having TRHP workers begin to work with clients while still in the hospital was viewed as beneficial in both cities as was gradual integration into TRHP. In both cities, clients were able to visit their future residence for gradually increasing lengths of time beginning with a tour and culminating in overnight stays before discharge from the hospital. City B maintained a "teaching apartment" and clients who obtained a pass for an overnight stay or longer could stay in it to "try out" living on their own before moving to a satellite apartment.

WEAKNESSES

There was some suggestion by the hospital staff that community agency staff, while dedicated and terrific to work with, were seen as "green" in terms of their knowledge and experience in working with forensic clients. There was interest from staff of community agencies in both cities in receiving more training in forensic mental health. In both cities efforts were undertaken to support community agency staff in learning about the forensic system.

Roles and responsibilities are typically delineated in written agreements or memoranda of understanding between partners and often include mechanisms for resolving disputes. Staff and key informants observed that there was ambiguity regarding roles and responsibilities in both cities. In City A, one of the key issues that arose within the context of the partnership between the hospital and the community agency was the question of whose role and responsibility it was to promote medication compliance and facilitate urine

screens for drug use. Even though the service agreement outlined the roles and responsibilities of the City B partners, some staff roles were viewed by staff and key informants as less defined, in particular those of the TCMs versus residential staff. This lack of clarity resulted in confusion for clients and uncertainty about who was responsible for certain activities (i.e., initiating case conferences).

In City A, meetings were held between the hospital and the community agency to discuss issues in a collegial manner. However, TRHP staff continued to face challenges in getting timely and complete information regarding clients that was needed for service planning in advance of clients' program entry. In City A, partners clearly oriented to the costs of being involved in the partnership as reference was made to how job demands and workload increased as a function of being involved in the partnership. There was some suggestion that there had initially been hope that the partnership would net a decrease in workload for the hospital but, for some hospital stakeholders, this was seen as having not been borne out.

In City A, it was suggested that psychiatric support for TRHP clients was not covered through the program funds and thus placed additional demands on the hospital, which were viewed as stretched. It was also suggested, however, that carrying 10 additional clients should not place an onerous burden on the hospital and that had these clients been discharged into other housing settings, they would have remained outpatients of the hospital; therefore, the hospital would have needed to continue to provide psychiatric support in any event.

In City A, it was noted by key informants that the TRHP housing site was located in a neighborhood known for drug trafficking and prostitution, exposing clients and their guests to high risk behaviors. Moreover, the site was a lengthy trip via public transit for clients and staff who needed to travel to the hospital for medication monitoring and other clinical services on a regular basis.

In City B, as the clients were generally moderate-to-high functioning, there were concerns of them being "over-served." Staff and key informants mentioned that some clients had reported being too closely monitored, which can undermine their perceptions of autonomy and competence. Staff and key informants reported that some clients indicated feeling overwhelmed by the sheer number of staff with whom they interacted. Some of the clients expressed frustration regarding the amount of groups that they had to attend. Confidentiality concerns also arose, as some clients voiced their concern over sharing the same information with multiple people.

The engagement of the clients once they moved into the satellite apartments was a major concern for staff and key informants in City B. The two clients who directly transitioned to the satellite apartments from the hospital were not interested in rehabilitation-oriented programming and all clients were less engaged with TRHP programming once they moved to the satellite

apartments. Several of the satellite apartment clients admitted that they did not enjoy participating in groups. One of the clients mentioned that attending groups interfered with his employment. It is understandable that client engagement in structured TRHP programming could be difficult when clients have attained employment or have volunteering commitments. Another client noted that her apartment was located far from the residence, so the travel time to attend groups at the residence was lengthy. As well, some clients can be expected to relish the opportunity for independence, particularly given their long-term history of “high surveillance” hospitalization on forensic hospital wards.

In City B, the role of the TCM was a weakness mentioned by key informants and staff. The number of TCMs involved in TRHP was reported to be a concern, as it made it hard to maintain consistency with clients. It was suggested by some staff and key informants that having one TCM would be more effective, as this TCM could spend the majority of his or her time at the four-bedroom residence. However, this staffing model was not feasible, as the TCM would have only had a partial caseload for months when the program was initially implemented. The need for TCMs was also questioned for clients living in the residence, as they have access to a multitude of services from residential staff.

The City B service agreement did not explicitly outline an information-sharing mechanism. However, the hospital and community partner agencies all used different charting methods, including paper charts, predominantly electronic records, and a combination of paper and electronic records. The number of charts for each client and the difficulty in accessing them could impede information sharing between partners.

Given that many agencies, staff and managers were involved in the delivery of service in City B, it could be challenging to communicate promptly. At times it was unclear who should be contacted in different situations. Some hospital staff believed there was a need for increased communication and transparency among the partners, especially with respect to the eligibility criteria. Staff were also interested in further integration of services, such as the involvement of TRHP staff at the intake process and involvement of hospital staff in the referral process.

DISCUSSION

Overall, the program was serving a group of clients whose backgrounds and characteristics corresponded well with the targeted population. In both cities, individuals with low to moderate risk who generally have had fairly lengthy hospital stays and often had prior repeat hospitalizations were successfully placed in TRHP. These are individuals who, because of their forensic involvement and complex needs, would not otherwise have been housed in the

community. Some clients did experience a rehospitalization during their involvement in the program; however, program staff did not perceive rehospitalization as a failure. Rather, rehospitalization was viewed as part of the treatment process, a perspective also suggested by Heilbrun and Griffin (1993) in a review of community treatment programs for forensic patients. One limitation to the description of the target population was the possibility of a selection bias with respect to the clients. Four of the 24 TRHP clients declined to participate and it is unknown whether these individuals differ from the clients who participated.

For the most part, the program was being implemented as planned. Referral processes in both cities involved consultation and information exchange among partners and were consistent with the process planned in both cities. Workers provided intensive individualized supports. Social and recreational activities were offered in City A, although programming was limited due to challenges in meeting the needs of clients who were higher functioning. Extensive programming was offered in City B along with recreational and social activities. In both cities, clients seemed interested in social activities offered as part of the program but were less interested in and in need of group-based interventions focused on bolstering skills for independent living. Findings regarding the implementation of the program are potentially limited by a bias whereby staff, key informants, and clients may have wished to present the program in a positive light, as they were involved in the implementation (staff, key informants) or receiving services through the program (clients).

While some programs have provided linkages for their clients to new service providers as they transition to the community, either postprison (Hartwell & Orr, 1999; Edens, Peters, & Hills, 1997) or posthospital (Dimmek, 1994), there is a paucity of descriptions of transitional housing programs with extensive support for forensic patients transitioning from the hospital to the community. Cimino and Jennings (2001) described a progressive treatment model for forensic clients discharged from the hospital; however, the interim accommodation between the hospital and community was described as a secure, residential treatment facility, rather than transitional supportive housing. Other programs have offered extensive services to individuals with mental health issues and past justice system involvement, such as mental health and substance use treatment, health care, employment, and support with the criminal justice system (Campanelli et al., 2005; Lamberti et al., 2001). However, those programs were designed for clients from a variety of referral sources and not created to solely meet the specific needs of forensic patients transitioning from the hospital to the community.

The TRHPs have a number of strengths including a strong sense of shared purpose and commitment on the part of staff and a concerted effort to balance recovery-oriented principles and practices with the supervision responsibilities stemming from forensic system obligations. TRHP included linkages and integration of services among different service providers, an

element that has been identified as critical in previous research (Lamberti et al., 2001). There was also a healthy commitment to ongoing learning and an understanding that pilot programs are expected to experience growing pains. Within that context, it is not surprising that TRHPs also had weaknesses. Some of these weaknesses were in the process of being addressed such as confusion regarding roles and responsibilities. Other weaknesses, such as issues with the location and tenant mix at the City A site, are not easily remedied and are shared to shed light on potential ingredients for program success. The client concern about being overly monitored was consistent with findings reported in a study exploring postdischarge monitoring of forensic patients, who also expressed concerns about feeling overmonitored (Coffey, 2011). Coffey reported that clients described feelings of being controlled and faced challenges establishing new social identities. The monitoring by program staff was in line with the requirements of the ORB (i.e., capacity to monitor clients in premises on 24/7 basis, and knowing if a person was in the building, when they left and returned; Ontario Ministry of Health and Long Term Care, 2010).

From the descriptions provided in the literature, there are few comprehensive transitional programs for individuals with a forensic and mental health history, especially for patients being discharged from the hospital. Those programs that offer services to individuals with mental health and justice system involvement often provide support (Dimmek, 1994; Edens et al., 1997; Hartwell & Orr, 1999), while some provide some housing options (Campanelli et al., 2005; Cimino & Jennings, 2001; Lamberti et al., 2001). TRHP provides a comprehensive program initially based around limited-term supportive housing, with access to staff 24-hours a day, and the option of group programming or individual support targeted to address client needs. Subsequent to a period of 12 to 18 months, clients are transitioned into permanent supported housing that includes a regular apartment and a case manager.

Although the results of outcome studies of ICM for people with serious mental illness diverted from jail are mixed, comprehensive services that include housing, psychiatric treatment, vocational support, and addictions treatment were found to be important factors contributing to positive client outcomes (Loveland & Boyle, 2007). TRHP in both cities offered these comprehensive services, although the programs were planning on further strengthening certain components, such as vocational services in both cities and substance abuse treatment in City A.

Substance abuse treatment has been identified as an important component of services to be offered to forensic patients both in the hospital and community and to clients of ICM programs (Loveland & Boyle, 2007; Vitacco et al., 2008) as substance abuse has been linked to reoffending by offenders with mental illness (Farabee & Shen, 2004). The TRHPs have made an effort to include substance abuse treatment in their programming. Beginning in the hospital and continuing in the community, City B TRHP offered group-based

substance abuse treatment, with the option of additional individual support, to all TRHP clients with substance abuse problems. City A TRHP had begun to implement a comprehensive concurrent disorder treatment strategy.

Given the involvement of hospitals and community agencies, effective partnerships are key to the success of initiatives such as TRHP. In partnerships, organizations contribute resources and expertise with the expectation that they can achieve more by working together than if each worked in isolation (Claiborne & Lawson, 2005; Jolley, Lawless, & Hurley, 2008). Because partnerships are complex, changing and contextually derived there is no consensus as to the best way to assess them (Jolley et al., 2008). Three key dimensions are relevant to the TRHP partnership: (a) partners' understandings of the purpose and benefits of partnership, (b) communication and information sharing among partners, and (c) clarity of roles and responsibilities within the partnership (Blue-Banning, Summers, Frankland, & Beegle, 2004; Hosley, Gensheimer, & Yang, 2003; Reback, Cohen, Freese, & Shoptaw, 2002). Our findings regarding these partnership dimensions have several implications for the development of similar programs in other communities. Given the importance of developing a common understanding of the program, and the different philosophies that can exist within different systems and organizations (Johnson, Wistow, Schulz, & Hardy, 2003), it is important to create understanding across systems, in this case, between the hospital and community agency staff. To achieve this understanding the community agency staff who are less familiar with forensic clients could be provided with an orientation to enhance their readiness and capacity to work with this population. In turn, hospital staff should be oriented to the recovery-oriented psychosocial rehabilitation delivered by community agencies to assist clients towards recovery and to become integrated in the community.

Secondly, another critical partnership dimension that requires attention during the development of similar programs is communication between partners, including the hospital, community, and justice system (Heilbrun & Griffin, 1993). Partners should outline specific procedures and develop agreements to facilitate the sharing of clinical information in order to ensure the provision of quality services to the clients and to address potential safety issues.

Thirdly, establishing clear roles and responsibilities within the partnership is essential for it to be effective. In the TRHPs, there was initially a lack of communication around the roles and responsibilities between the staff of the different agencies. A clear effort to clarify the responsibilities of the staff was important to avoid over-servicing clients. Our findings also suggest that clients did not require TCM support during their stay in the residence. In addition to the issues around the dimensions of the partnerships, another area that has implications for other programs was the enhancement of vocational support. Clinical characteristics of clients in TRHP reflect a population experiencing moderate to high levels of functioning upon entry into the program. It was recommended that the TRHPs enhance their vocational

support to assist clients in this area that is central to their reintegration into the community.

This article has provided a description of a program evaluation comparing the implementation of an innovative pilot program that combines short-term supportive housing and permanent supported housing to help forensic patients transition from the hospital back into the community to the intended program. This program assists long-stay forensic patients who have committed a variety of index offenses and who are of low or moderate risk to reoffend with reintegration into the community. The high cost of institutionalization highlights the importance of developing transitional housing programs for this population.

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