Clinical Services Plan: Steering Committee Submission

COMMUNITY OF PRACTICE: LAW AND MENTAL ILLNESS (Submitted 2011)

SECTION A: VISION & DESCRIPTORS

Context: The quality of services and prospects for post-discharge success of clients served by Provincial Forensic Programs (plus those served by the civil divisions who have involvement with the criminal justice system) require a clearly articulated and comprehensively implemented therapeutic methodology that responds to their risk, treatment needs, and individual responsivity. Well established and validated psychotherapeutic and rehabilitative programs for forensic populations need to be offered to all those who would benefit. There is a large and well-developed body of knowledge on the appropriate assessment, treatment, and supervision of forensic clients that should guide this institution in the implementation of such services. The current clinical services planning exercise provides the opportunity to implement this knowledge.

VISION: **We recommend the adoption and full implementation of a comprehensive and thoroughly articulated clinical model. The recommended model is commonly called *Risk-Need-Responsivity* (RNR).**

SECTION B: RECOMMENDED ACTIONS

RECOMMENDATION 1A: Adopt and rigorously implement Risk-Need-Responsivity (RNR)

Description:

The RNR approach to service for forensic clients embodies three fundamental principles:

Risk: The intensity, duration, and extent of resources devoted to services (for treatment, supervision, levels of institutional security, etc.) should be in proportion to the risk that each client represents, particularly the risk of subsequent violent behavior (violent recidivism). According to the risk principle risk is measured objectively using validated formal actuarial tools, and clients of very lowest risk receive minimal service because intensive service can cause recidivism by low risk clients. All resources (treatment, supervision, secure custody, etc.) should be delivered in accordance with the measured level of risk. Here for example, this principle would often mean advocating strongly for immediate transfer to a nonforensic service for the lowest risk clients.

Need: Client characteristics that are related to recidivism or other antisocial behavior must be those targeted for intervention (treatment, community supervision, etc.). Extensive research has established what the principal criminogenic needs are; as examples: substance abuse,

antisocial values and attitudes, antisocial peer relationships, poor self regulation/features of antisocial personality, and lack of engagement in/resistance to remediation. Research also supports targeting anger and antisocial behavior within the institution. Among forensic clients, low self esteem, dysphoria, and psychotic diagnoses and symptoms cannot be defended as criminogenic needs. Clinicians should assess criminogenic needs (and other targets for intervention) using formal assessment tools.

Responsivity: Treatment should be conceptualized as the teaching of skills. Clients have different abilities and learning styles, so clinicians should tailor their teaching methods to individual clients, and build on clients' strengths. Most forensic clients learn well from true cognitive-behavioral and psychoeducational programs. Community supervision and other services can and should be delivered in a manner that facilitates active learning and engagement (as opposed to passively receiving assistance). This principal also states that service providers act as examples of appropriate conduct, exhibit respect and fairness, use positive techniques (as opposed to punitiveness), and are sensitive to relevant cultural, ethnic, and spiritual considerations.

Sometimes noncriminogenic needs are targeted to improve motivation or concentration and decrease distraction. On humanitarian and ethical grounds, help would be offered for some other noncriminogenic needs (enhancing inpatient's quality of life, for example).

Complete review of all the evidence pertaining to RNR for forensic clients is beyond the scope of the present submission. To save space and improve readability, citations to the relevant literature, some which is included in the accompanying annotated bibliography, are not included here. Please consult the annotated bibliography for more information. To briefly summarize, however, meta-analyses of intervention research indicate that effect sizes in reducing recidivism are associated with the degree to which services adhere to the RNR principles (as an example, a correlation of .56). Thus, services incorporating no RNR principles cause, on average, a small increase in recidivism. This is important for our forensic clients because many do not receive services offered according the RNR model. Those services adhering to one or two RNR principles achieve effect size reductions of .02 and .18, respectively (expressed as correlations). And those embodying all three achieve a mean effect size of .26. No other model of service for forensic populations musters the level of empirical support as that achieved by RNR.

RECOMMENDATION 1B: Specify in detail the treatments provided by each administrative program or clinical unit.

Description:

Specify in detail the treatments provided by each administrative program or clinical unit based on a fully articulated RNR model. Explicitly tie formal evaluation of clients' common clinical and criminogenic needs to specific pharmacologic and nondrug interventions and effectively operationalize RNR in the tasks performed by clinical units and individual clinicians. RNR can be

the overall model for all inpatient or outpatient units despite different clinical needs. For example, a clinical unit specializing in assaultive clients would require formal behavioral analyses of assaults by the individual client, that identifies the antecedents, behavioral topology, and consequences for that individual client. Then, detailed behavioral treatment plans would mandate changing the contingencies from ones that supported assaults to ones that support prosocial conduct. On a unit specializing in clients with concurrent disorders, formal assessment would measure substance use history, mental health symptoms, quality of life, and so on. Cognitive behavioral interventions would then help clients identify and change problems that facilitated substance abuse. As another example, some units might never provide community supervision for clients while such service might be common in the work of others. RNR specifies: which clients are considered for release (those of lowest available actuarial risk) and the intensity of supervision for each, the principal targets of supervision (e.g., sobriety, compliance with terms and conditions, prosocial attitudes), and the clinical approach (usually explicitly employing formal skill acquisition techniques). RNR is the overarching philosophy, but individual programs and clinicians implement RNR by formally assessing criminogenic needs and delivering evidence-based treatments targeting the identified needs. Clinical units would vary in the prevalence of particular needs, and so their particular programs would have a different focus. However, each client receives services specified in detail that strictly adhere to the RNR principles (because adherence has been shown to determine outcome).

RECOMMENDATION 1C: Specify in detail the clinical and therapeutic actions for each clinician

Description:

Specify in detail of the exact actions to be taken by each clinician on a daily basis. Most services provided on each program would therefore be manualized. Clinicians are trained for their roles and roles are manualized. Some features of the specification recommended here are:

a) Programmatic clinical activities are manualized for trained clinicians. Manuals describe in great, step-by-step detail the precise clinical actions taken. This does not mean a one-size-fits-all approach. Manuals should describe how services are customized to the needs of individual clients.

b) Informal ways of interacting with clients outside of formal clinical programs are also specified in detail for trained clinicians. This ensures that positive opportunities for learning and skill practice are continuously supported.

c) Memos and policy documents might serve as reminders of the mandate to adhere to the RNR model, but the integrity and proficiency of the program is measured against observed enactments of mandated behaviors and activities (discussed in the next section).

d) Some common indicators (e.g., proportion of clinical staff with particular professional qualifications, attendance, funds spent of classroom sessions, etc.) are replaced with indicators that are empirically related to service quality.

e) Staff skills in planning, structuring, and executing their own and others' activities are also important.

RECOMMENDATION 1D: Independently and systematically measure clinical/therapeutic fidelity

Description:

This comprises the independent, systematic, and comprehensive measurement of the fidelity (i.e., adherence to specifications described in the previous section) with which all clinical activities (treatment, informal interaction, community supervision, etc.) are conducted. This means the independent measurement, at the level of the clinical unit and individual clinician, of the degree to which specified clinical activities occur as described in manuals, role descriptions, and program schedules. This measurement therefore includes direct observational, online assessment of the proficiency with which informal, one-to-one interactions occur, as well as the fidelity with which more formal interventions are provided. Additional aspects of ensuring or assessing program fidelity or integrity are:

- valid, accurate measurement of important occurrences (e.g., restraints, administrative seclusions, assaults, other criminal conduct within the institution).
- routinely administered measures completed by clients reporting on the ward atmosphere and performance of staff are important adjuncts to the assessment of clinical fidelity.

RECOMMENDATION 1E: Systematically and independently measure clinical outcomes for all clients.

Description:

Measure post-discharge outcomes independently, systematically, validly, and comprehensively. One class of outcomes would apply to all former forensic clients (e.g., subsequent criminal or antisocial behavior). Another class would be specific to the reasons for each individual client's admission (e.g., fitness for trial, sexual misconduct in his home facility, etc.). We recommend gathering follow-up data for every forensic client. The information sources would vary somewhat depending on particular referral problems. Thus, while criminal record checks would be conducted on everyone, informants might also be staff of subsequent institutions, family members, courts, and individual police services, as well as former clients themselves. While resources are required for such data gathering, research has shown that resources can be redirected from activities that do not serve the overall clinical philosophy (RNR, in this instance) or from existing data gathering efforts that are not independent, systematic, and validated.

RECOMMENDATION 1F: Mandate clinical quality improvement as the joint analysis of fidelity and outcome data.

Description:

The analysis of the outcome data and fidelity measures in conjunction achieves the best

available means to improve clinical quality. Clinical activities that are implemented with high fidelity and are shown in research to have positive outcomes are the best candidates for expansion or enhancement. Activities implemented with high fidelity but shown to have null or negative outcomes are prime candidates for overhaul or replacement. Those implemented with low fidelity require actions to increase fidelity. If fidelity cannot be improved, low fidelity services should be replaced.

RECOMMENDATION 1G: Train all staff in the requisite clinical skills. When recruiting, recruit new staff who possess requisite skills. Provide evidence based clinical supervision. Make relevant clinical skills and their teaching and supervision the preeminent consideration in promotion.

Description:

Train existing clinicians in the requisite clinical and systemizing skills. Other personal attributes have been shown to affect client outcomes – effective service providers are, as examples, interpersonally warm, tolerant, flexible, nonauthoritarian, conscientious, and law abiding. These qualities can be measured and such measures should be included in personnel selection and promotion. When recruiting frontline clinicians, emphasize the possession of RNR skills and these other qualities. Clinical skill proficiency and the ability to teach and supervise clinical skills in turn should be the primary consideration in the recruiting and promotion of clinical managers and supervisors.

Research shows that classroom sessions, while often necessary, are rarely sufficient to impart the kinds of skills implied by the other recommendations here. On the job, ward based clinical training and supervision are, therefore, also required. Effective adjuncts to such training are standardized tests of proficiency with enhanced training for clinicians experiencing difficulty achieving acceptable scores.

Effective clinical supervision entails the use of the data on clinical fidelity (Recommendation 1D above) in teaching sessions with individual clinicians. Effective teaching of skills for clinical staff incorporate: breaking skills down into component behaviors, demonstration of the skill, practice, positive feedback, and methods to enhance generalization (e.g., shaping and fading). Frontline clinical managers and supervisors must be experts in the knowledge and skills required of the clinicians they supervise, and should spend the majority of their time in clinical (or clinical supervisory) activities; sufficient administrative assistance should be provided to ensure this.

RECOMMENDATION 1H: Engage a true RNR champion.

Description:

Research shows that optimal implementation of RNR (and other comprehensive clinical service models) depends on an institutional champion for these improvements. A true champion should be CEO or at least VP, but operate in a decentralized organization. A true champion would make the transformation sketched here top priority, implement incrementally, and be capable of inspiring optimism, enthusiasm, and be able to enlist the support of the clinical teams in

nonconfrontational ways. The champion should be able to lead a research team in the empirical study of the RNR transformation. Needless to say, the champion has to be a content clinician expert on all aspects of the transformation. Crucial features of an effective champion are the use of positive methods (i.e., contingent reward or reinforcement) to achieve change and clear leadership by example.

Alignment to Evaluation Criteria:

Evaluation Criteria	Evidence of Alignment to Evaluation Criteria
Responsiveness to Community Needs *The extent to which the recommendation improves accessibility and equity for its community of patients.*	• This set of recommendations offers the best available prospect for delivering, and being able to demonstrate, added value in protecting the province's communities from violent or antisocial behavior by forensic patients. • The term "community" might also be understood to refer to our forensic client population. Available information indicates that current services do not sufficiently assess clients' criminogenic needs (and strengths) nor provide appropriately responsive interventions (treatment, supervision, etc.) in accordance with actuarially assessed risk. These recommendations are specifically about the amelioration of those deficiencies.
Alignment to Regional Directives *The extent to which a recommendation is related to government mandates (e.g., protected programs) and legislated obligations, and/or contributes to achieving regional or provincial health services objectives.*	• We are not aware of specific regional (or provincial) directives to assess forensic clients' criminogenic needs (and strengths) and to provide appropriately responsive interventions (treatment, community supervision, etc.) in accordance with actuarially assessed risk. • We are not aware of specific regional (or provincial) directives to deliver and demonstrate added value in protecting the public from violent and antisocial behavior. • If such directives are not in place, they should be. If they are in place, this set of recommendations allows this institution to be in complete compliance, to be able to demonstrate such compliance, and indeed to be a leader in such compliance.
Alignment to Hospital Planning *The extent to which a recommendation contributes to advancing the strategic directions of the organization (i.e., "fit" with the organization's mission, vision, values, and goals/objectives).*	• These recommendations represent the best available means to ensure that our delivery of care matches this institution's vision, mission, values and goals as they pertain to our forensic patients.
Further Defines the Role of the Hospital as an Academic/Research Centre *The extent to which a recommendation helps advance the organization's reputation and/or further define the*	• The comprehensive implementation of RNR (or any other therapeutic model) along the lines described here is not in place at any other organization in Ontario and is very rare in the world. A demonstration research project illustrating the successful rigorous implementation of the present set of recommendations would place the hospital at the world forefront of forensic mental health services and applied

Evaluation Criteria	Evidence of Alignment to Evaluation Criteria
organization's role as an academic/research center.	research about such services. • The implementation of the present set of recommendations is entirely in keeping with, indeed best embodies the execution of, the clinical aspects of the strategic plan for research and academics.
Is Measureable/'SMART' *The extent to which the recommendation can be defined in terms of measurable outcomes and is Specific, Achievable, Realistic and Time-bound.*	• The present set of recommendations is the very embodiment and epitome of SMART, if enacted with time-bound commitments for implementation.
Demonstrates Investment in Our People *The extent to which a recommendation demonstrates consideration of benefits and mitigation of risks to the organization's human resources (eg: safety, recruitment, training, etc.).*	• See the sections above on selection, training, and promotion of clinical staff members. This set of recommendations calls for a significant investment in our people in a manner in which the outcome of that investment is evaluated. Experience indicates that mental health clinicians involved in active treatment experience higher morale, greater job satisfaction, better attendance, and less lost time due to injury. Institutions providing active, evidence based practice are safer places to work.
Supports Our Philosophy of Care & Role as a Tertiary Centre *The extent to which the recommendation advances client centred care and supports the recovery of our patients.*	• The present set of recommendations moves from visioning to truly operationalizing a therapeutic philosophy for all staff members and clients. RNR embodies, explicitly and implicitly, the very best of recovery approaches.
Advances Best Practice *The extent to which the recommendation employs, incorporates or facilitates the use of Best Practices in the delivery of patient care.*	• This set of recommendations about rigorous implementation of RNR does not merely advance best practice; it **is** best practice for forensic patients.
Supports the Hospital's facility to provide recreation, spiritual care, education and skill-building *The extent to which the recommendation either directly or indirectly supports the organization's ability to provide recreation, spiritual care, education and skill-building.*	• This set of recommendations and RNR are all about education and skill building both for clients and staff members. • Some problems in use of "recreation" time are criminogenic needs. • RNR is sensitive to cultural and spiritual considerations. • RNR allows for the provision of spiritual care in a patient-centered and healthy way. • Does spiritual here mean, "What would Jesus do?" Jesus would implement RNR as described here
Resource Implications *The extent to which the recommendation is able to address financial, human and other capacity issues.*	• To a substantial degree, current resources need to be repurposed to achieve the rigorous implementation of the recommendations briefly outlined here. Research indicates that comprehensive implementation of active treatment can be achieved by such repurposing of existing resources without greatly increasing funding

A BRIEF ANNOTATED BIBLIOGRAPHY ON THE ASSESSMENT AND TREATMENT OF FORENSIC PATIENTS AS RELATED TO RECOMMENDATIONS FROM THE LAW AND MENTAL ILLNESS COMMUNITY OF PRACTICE I

Notes: The term "forensic patient" here refers to a person with involvement in the criminal justice system and who also has, or appears to have, a mental disorder. Thus, the term includes various mentally disordered offenders: insanity acquittees, accused persons found unfit to stand trial, prisoners transferred to psychiatric facilities, persons undergoing pre-trial psychiatric assessment, and so on.

The scientific and professional literature on assessment and intervention for forensic populations is very large. Not addressed here, as examples, are the literatures on such special populations as sex offenders, fire setters, young offenders, psychopaths, and female offenders, all of whom might sometimes fall within this community of practice. Readers interested in more information are encouraged to consult the three books listed here and the reference lists of the publications that follow.

1. The Risk-Need-Responsivity (RNR) Model

Andrews, D.A. & Bonta, J. (2010). *The psychology of criminal conduct* (Fifth Edition). New Providence, NJ: M. Bender & Co. ***The textbook.***

Andrews, D. A. (2010). The impact of nonprogrammatic factors on criminal-justice interventions. *Law and Criminological Psychology, 16,* 1-23.

Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The risk-need responsivity (RNR) model. Does adding the good lives model contribute to effective crime prevention? *Criminal Justice and Behavior, 38,* 735-755.

Dowden, C., & Andrews, D. A. (2004). The importance of staff practice in delivering effective correctional treatment: A meta-analytic review of core correctional practice. *International Journal of Offender Therapy and Comparative Criminology, 48,* 203-214.

Gendreau, P. (1996). Offender rehabilitation: What we know and what needs to be done. *Criminal Justice and Behavior, 23,* 144-161.

Gendreau, P., Goggin, C., & Smith, P. (1999). The forgotten issue in effective correctional treatment: Program implementation. *International Journal of Offender Therapy and Comparative Criminology, 43,* 180-187.

These publications describe RNR in great detail including the definitions of Risk (actuarially measured), Need (associated with criminality and

recidivism), and Responsivity (efficacious styles of intervention). Especially valuable here too are several attempts to elucidate the components of effective implementation of RNR, including desirable qualities of administrators, clinical directors, treatment providers, clinical supervision, and training and personnel practices. The book listed first describes the LSI family of assessments which is the best available means to assess service-induced changes in relevant needs, but this is an area in need of better research and would be an ideal research topic for the implementation of RNR here.

2. Risk: Actuarial Assessment of Violence Risk and its Application

Almvik, R., Woods, P., & Rasmussen, K. (2000). The Brøset Violent Checklist: Sensitivity, specificity, and interrater reliability. *Journal of Interpersonal Violence*, *15*, 1284-1296.

The BVC is the best validated actuarial tool for short-term (24 hr) inpatient violence risk assessment and has six easily rated items.

Quinsey, V.L., Harris, G.T., Rice, M.E., & Cormier, C.A. (2006). *Violent offenders: Appraising and managing risk* (Second Edition). Washington, DC: American Psychological Association.

Describes the development, validation, scoring, and application of the* Violence Risk Appraisal Guide *(VRAG) and* Sex Offender Risk Appraisal Guide *(SORAG), the most well established and validated actuarial tools for the risk of violent recidivism in the community. The book also summarizes research conducted here on the assessment and treatment of forensic patients.

Harris, G.T., Rice, M.E., & Quinsey, V.L. (2010). Allegiance or fidelity? A clarifying reply. *Clinical Psychology: Science and Practice, 17*, 82-89.

The most complete available meta-analysis of the predictive accuracy of the VRAG/SORAG. Results indicated that the VRAG also predicted institutional violence.

Hilton, N.Z. & Simmons, J.L. (2001). Actuarial and clinical risk assessment in decisions to release mentally disordered offenders from maximum security. *Law and Human Behavior, 25*, 393-408.

McKee, S.A., Harris, G.T., & Rice, M.E. (2007). Improving forensic tribunal decisions: The role of the clinician. *Behavioral Sciences and the Law, 25*, 485-506.

These publications presented data indicating that the risk principle was applied poorly at this institution – clinical advice to the ORB was very weakly related to actuarially assessed risk so that ORB decisions were unrelated. The second study presented concrete methods to improve submissions to the ORB.

3. Needs: Which Are Criminogenic?

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin, 123,* 123-142.

McKee, S.A., Harris, G.T., & Rice, M.E. (2007). Improving forensic tribunal decisions: The role of the clinician. *Behavioral Sciences and the Law, 25*, 485-506.

Quinsey, V. L., Coleman, G., Jones, B., & Altrows, I. F. (1997). Proximal antecedents of eloping and reoffending among supervised mentally disordered offenders. *Journal of Interpersonal Violence, 12,* 794-813.

Quinsey, V. L., Jones, G. B., Book, A. S., & Barr, K. N. (2006). The dynamic prediction of antisocial behavior among forensic psychiatric patients. *Journal of Interpersonal Violence, 21,* 1539-1565.

The clearest evidence on changeable (or potentially changeable) criminogenic needs for forensic patients indicates that the high priority targets should be: substance abuse, anger, illegal or rule-breaking behavior, antisocial or unconventional attitudes and values, irresponsibility, denying all problems, lying and manipulativeness, lack of consideration or concern for others, impulsivity, unrealistic or grandiose plans, noncompliance with remediation and supervision, poor employment and relationship skills.

4. Responsivity and the Effectiveness of Interventions

Lipsey, M. W., & Wilson, D. B. (1993). The efficacy of psychological, educational, and behavioral treatment. *American Psychologist, 48,* 1181-1209.

Behavioral and cognitive-behavioral treatments are at least as efficacious as medical therapies.

Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology, 28,* 369-404.

Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law, 16,* 39-55.

Interventions are effective for forensic populations to the extent that they encompass RNR principles.

Hilton, N.Z. & Simmons, J.L. (1999). Adverse effects of poor behavior management on an inpatient's difficult behaviors. *Psychiatric Services, 50*, 964-966.

LePage, J. P., DelBen, K., Pollard, S., McGhee, M., VanHorn, L., Murphy, J., … Nogge, N. (2003). Reducing assaults on an acute psychiatric unit using a token economy: A 2-year follow-up. *Behavioral Interventions, 18,* 179-190.

Appropriately implemented behavioral programs are the treatment of choice for assaultive patients, while inappropriate management strategies exacerbate aggression.

5. **Responsivity and the Application of RNR to Forensic Patients**

Harris, G.T. & Rice, M.E. (1994). The violent patient. In R.T. Ammerman & M. Hersen (Eds.), *Handbook of prescriptive treatments for adults* (pp. 463-486). New York: Plenum.

Harris, G.T. & Rice, M.E. (1997). Mentally disordered offenders: What research says about effective service. In C.D. Webster & M.A. Jackson (Eds.), *Impulsivity: Theory, assessment and treatment* (pp. 361-393). New York: Guilford Press.

These publications specifically address the application of RNR to forensic patients and include an example of application to the design of services for an individual client.

Rice, M.E. & Harris, G.T. (1988). An empirical approach to the classification and treatment of maximum security psychiatric patients. *Behavioral Sciences and the Law, 6*, 497-514.

Rice, M.E., Harris, G.T., Cormier, C.A., Lang, C., Coleman, G., & Smith Krans, T. (2004). An evidence-based approach to planning services for forensic psychiatric patients. *Issues in Forensic Psychology, 5*, 13-49.

These publications illustrate how comprehensive needs assessment and other data combined with statistical methods can be used to identify clinically relevant commonalities in needs and among clients so as to facilitate the planning and organization of clinical services in forensic psychiatric facilities and agencies.

Rice, M.E. & Harris, G.T. (1997). The treatment of mentally disordered offenders. *Psychology, Public Policy & Law, 3,* 1-58.

Rice, M.E., Harris, G.T., & Quinsey, V.L. (1996). Treatment for forensic patients. In B. Sales & S. Shah (Eds.), *Mental health and law: Research, policy and services* (pp.141-189). New York: Carolina Academic Press.

Rice, M.E., Harris, G.T., Quinsey, V.L., & Cyr, M. (1990). Planning treatment programs in secure psychiatric facilities. In D. Weisstub (Ed.) *Law and mental health: International perspectives*, (pp. 162-230). New York: Pergamon.

These publications comprehensively review the evidence pertaining to the assessment and treatment of criminogenic and noncriminogenic needs among forensic patients. Recommendations as to the best available

assessment tools and treatment techniques are made for each set of needs. Recommendations about assuring program integrity are also provided.

6. More on Arranging the Institutional Environment

Rice, M.E., Harris, G.T., Varney, G.W., & Quinsey, V.L. (1989). *Violence in institutions: Understanding, prevention, and control*. Toronto: Hans Huber.

Effective training for clinical staff in the management of disturbed behavior improves knowledge, skill, morale, and self-reported effectiveness, and reduces violence, staff injuries, and lost work time claims.

Harris, G.T. (1989). The relationship between neuroleptic drug dose and the performance of psychiatric patients in a maximum security token economy program. *Journal of Behavior Therapy and Experimental Psychiatry, 20*, 57-67.

For many institutionalized forensic patients, drug treatment cannot yield adequate improvements in adjustment. Despite their greater requirements for effective administrative and clinical leadership, nondrug programs (such as RNR) are ethically, clinically, and professionally obligatory.

Seto, M.C., Harris, G.T., & Rice, M.E. (2004). The criminogenic, clinical, and social problems of forensic and civil psychiatric patients. *Law and Human Behavior, 28,* 577-586.

Many forensic patients can be appropriately diverted to nonforensic mental health services.

Harris, G.T. & Rice, M.E. (1992). Reducing violence in institutions: Maintaining behaviour change. In R. DeV. Peters, R.J. McMahon & V.L. Quinsey (Eds.) *Aggression and violence throughout the life span* (pp. 261-282). Newbury Park, CA: Sage.

Sturidsson, K., Turtell, I., Tengström, M., & Levander, M. (2007). Time use in forensic psychiatry: An exploratory study of patients' time use at a Swedish forensic psychiatric clinic. *International Journal of Forensic Mental Health, 6,* 79-86.

These publications illustrated that very little of forensic patients' time was spent in productive therapeutic activities and that there is often a trend towards reliance on ever increasing punitiveness in managing their behaviors. The recommended remedy for both problems is the rigorous implementation of the RNR model, specifically including the comprehensive and independent measurement of clinical fidelity and follow-up outcomes.