Failures in Forensic Psychiatric Transition to the Community: Implications for Risk Assessment and Recidivism

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ABSTRACT

This report details the case of Mr. C, a 53-year-old male with schizophrenia who was subject to custodial protection in Taiwan. Despite a history of a previous early release from custodial protection that was followed by recidivism, he is again seeking premature discharge based on reports of "good in-hospital performance." We argue that his first re-offense was a predictable failure of a system that over-relied on superficial behavioral compliance while neglecting to assess internalized recovery. This failure is rooted in three interconnected issues: (1) a clinical inability to differentiate between progress in programme completion (as measured by tools like the DUNDRUM-3) and genuine recovery (measured by the DUNDRUM-4); (2) the legal ambiguity of "risk of re-offending" under Taiwan's Criminal Code Article 87, which permits release based on inadequate evidence; and (3) a critical lack of transitional infrastructure to bridge the gap between secure care and the community. Drawing on international models, we propose a multi-staged transitional framework and advocate for a new, milestone-based standard for terminating custodial protection, prioritizing dynamic risk factors and validated recovery metrics over intuitive judgement or simple compliance of the patient.

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Key words: Forensic Psychiatry, Custodial Protection, Community Integration, Risk Assessment, Recidivism

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Introduction

The case of Mr. C exemplifies a critical and recurring challenge within Taiwan's forensic mental health system: the phenomenon of "transition failure." This occurs when individuals with severe mental illness, despite appearing stable and compliant within a highly structured hospital environment, rapidly decompensate and re-offend upon return to the unstructured and stress-laden reality of the community.[1] This "revolving door" scenario not only undermines public safety but also represents a profound therapeutic and systemic breakdown, perpetuating a cycle of institutionalization and re-offense that fails both the individual and society.

Mr. C's trajectory is particularly instructive in the context of recent amendments to Taiwan's Criminal Code. Spurred by public anxiety following several high-profile crimes,[2] the legislature amended Article 87 in 2022, moving the custodial protection system away from a fixed five-year maximum toward a model of potentially indefinite confinement. This new "5-3-1-1" structure allows for an initial five-year period, followed by court-approved extensions of three years, and subsequent one-year extensions with no upper limit, subject to annual review.[3] While intended to strengthen the social safety net, this legal shift raises significant constitutional questions regarding the principle of proportionality, as it allows for a potentially lifelong deprivation of liberty to be attached to offenses that may not be of the gravest nature.[4] Mr. C's case demonstrates that without addressing the foundational flaws in risk assessment, recovery evaluation, and community transition, simply extending periods of institutionalization is a reactive measure that fails to address the root causes of recidivism and may exacerbate issues of disproportionate liberty deprivation.

Case Presentation

Mr. C is a 53-year-old, single, unemployed male with a diagnosis of Paranoid Schizophrenia, first diagnosed around age 30. His longitudinal history is characterized by multiple psychiatric hospitalizations, typically precipitated by medication non-adherence secondary to a profound lack of insight into his illness. A timeline summarizing his case history is presented in (Table 1).

His first index offense occurred at age 40, when he assaulted another driver with a screwdriver following a car accident. He was sentenced to 8 months in prison and a 4-year pre-sentence custodial protection order. At age 41, he was admitted to a psychiatric hospital for this custodial protection. After only seven months, still at age 41, the hospital team deemed his performance "good" due to his cooperation with treatment, and he was granted an early termination of the custodial protection order. He was then transferred to prison to serve his 8-month sentence. Upon his release from prison at age 42, he initially attended outpatient follow-ups but his attendance became sporadic over the next three years.

At age 45, during an acute psychotic episode fueled by persecutory delusions that a telecommunications company was stealing his personal data, he entered a branch office and attacked a male employee with a pair of scissors, causing significant injury. He was subsequently arrested, during which he also assaulted a police officer. After a series of trials and appeals, he was ultimately convicted of assault and obstruction of a public official, and sentenced to 10 months in prison with another 4-year pre-sentence custodial protection order.

He is currently in his second period of custodial protection (since age 50). His clinical presentation

has again stabilized on a long-acting injectable (LAI) antipsychotic. He is described in clinical notes as "polite," "defensive," and "passively compliant" with ward activities. However, his insight remains poor; he denies current symptoms and believes he will not re-offend as long as he "gets enough sleep." Crucially, he and his elderly mother-who has limited ability to enforce treatment adherence-are actively petitioning for another early release, citing his "good performance" and drawing a direct parallel to the first failed discharge.

Discussion

The trajectory of Mr. C was not an anomaly but a predictable systemic failure. His case highlights the urgent need to reform how Taiwan's forensic system assesses progress, defines risk, and manages the transition from secure care to the community. His "revolving door" journey through the system is a direct result of clinical misinterpretation, legal ambiguity, and infrastructural deficits.

Table 1.

Age	Key Event	Status / Disposition
~30	First diagnosed with Paranoid Schizophrenia.	In Community
40		First Index Offense (Assaulted a driver with a screwdriver).
41		[Began 1st Custodial Protection] (Admitted to hospital).
41 (after 7 mos.)		[Early Termination of 1st Protection] (Granted due to "good performance").
41-42	Served 8-month prison sentence.	In Prison
42	Released from prison; began sporadic outpatient follow-up.	In Community (sporadic follow-up)
45		[Recidivism (2nd Offense)] (Attacked employee with scissors during psychotic episode; also assaulted police).
45-50	Period of trials and appeals.	(In Judicial Process)
50		[Began 2nd Custodial Protection] (Sentenced to 10 months prison + 4-year custodial protection order).
53 (Current)	Described as "passively compliant" in ward, but insight remains poor.	Inpatient Secure Care
53 (Current)		Again petitioning for early release, citing "good performance".

1. The Illusion of Progress: Mistaking Program Completion for Recovery

Mr. C's first early release was predicated on reports of "good in-hospital performance." This assessment, while accurate in its description of his behavior within a secure setting, represents a critical failure to distinguish between superficial compliance and genuine, internalized recovery. This distinction is precisely what modern structured professional judgment (SPJ) tools, such as the DUNDRUM toolkit, are designed to elucidate. Specifically, the DUNDRUM-3 (Programme Completion) scale measures progress across seven key domains, including physical health, mental health, substance use, problem behaviours, self-care, occupation, and social networks-typically rated on a 5-point scale from 4 (not ready to move down a level of security) to 0 (ready for independence). It measures the 'doing' of recovery.[5]

The DUNDRUM-3 (Program Completion) scale is a validated instrument that measures the process of therapy-what can be termed the "doing" of recovery. It assesses a patient's observable engagement in programs targeting seven "pillars" of care: physical health, mental health, substance use, problem behaviors, self-care, occupation, and social networks.[5] It is highly probable that Mr. C scored well on the D-3 during his first custodial protection. He attended his groups, adhered to staff-enforced medication, and was behaviorally stable in a controlled, low-stress environment. This is the "good performance" that led to his release.

However, his rapid relapse upon facing real-world stressors strongly suggests profound deficits on the DUNDRUM-4 (Recovery) scale, which measures the internalized outcomes of therapy, the "being" of recovery. The D-4 also uses a 0-4 scale but applies it to internalized outcomes. The D-4 assesses crucial internal states such as stability, genuine insight, a stable therapeutic alliance, victim sensitivity, and the ability to manage dynamic risk factors independently.[5,6] Mr. C's re-offense indicates his compliance was entirely contingent on the external controls of the institution. He learned the script of recovery without internalizing its principles. His current statement that he will be fine if he "gets enough sleep" is a classic manifestation of poor insight, a neurological deficit known as anosognosia, which prevents him from recognizing his illness and the need for ongoing treatment.[7] His "passively compliant" but "defensive" attitude suggests a superficial rapport with staff, not a genuine therapeutic alliance. The decision to release him was therefore based on a dangerous conflation: the system mistook his successful completion of the D-3 behavioral checklist for the achievement of D-4 recovery milestones. Differentiating "superficial compliance" from "internalized recovery" is a critical clinical challenge, as patients like Mr. C may learn a recovery "script" that is not sustained once external controls are removed. To make this distinction, clinicians must move beyond behavioral checklists. This requires using deeper strategies like situational assessments (probing responses to real-world stressors via vignettes),[8] motivational probing (exploring genuine beliefs about illness and victim impact , not just rote apologies),[9] and real-world testing (using graduated autonomy in a step-down phase) to observe if pro-social behaviors are maintained in less supervised environments.[10]

2. The Legal Vacuum: Ambiguity in "Risk of Re-offending"

This clinical misjudgment was enabled by a significant legal loophole in Taiwan's Criminal Code Article 87. The standard for terminating custodial protection

rests on the determination that there is no longer a "risk of re-offending or of endangering public safety" (再犯或有危害公共安全之虞).[3] This standard, however, is dangerously ambiguous and lacks operational definition. The law provides no structured criteria for how this "risk" should be assessed, what evidence is required, or what constitutes a sufficient reduction in risk to warrant release.

This legal vacuum creates a space where subjective and often superficial assessments can hold undue weight. In Mr. C's case, the court, lacking a clear framework to operationalize "risk," likely deferred entirely to the hospital's report of "good performance." This report, reflecting D-3 compliance rather than D-4 recovery, became the sole proxy for risk reduction. The system lacks a requirement to demonstrate, through structured assessment, that the patient has internalized the skills necessary to manage their dynamic risk factors (e.g., insight, stress management, medication adherence) outside of a secure setting. The ambiguity of the law effectively absolved the decision-makers of the need to probe deeper into the quality and sustainability of Mr. C's apparent progress, directly contributing to his premature release.

3. A Blueprint for Safer Transitions: A Multi-Staged, Milestone-Based Model

Mr. C's case is a stark illustration of "transition failure," a direct consequence of a system that lacks the intermediate steps and robust community support structures seen in more developed forensic systems like those in the UK and Germany.[11,12] To prevent the recurrence of such cases, we propose a concrete, multi-staged transitional model that moves away from a simple in-or-out dichotomy toward a graduated, evidence-based pathway.

3.1. Stage 1: Secure Inpatient Treatment (High/Medium Security): This initial stage mirrors the current model but with a refined focus. The primary goals are clinical stabilization and a comprehensive baseline assessment using validated SPJ tools like the HCR-20 V3.[13] The HCR-20 V3 is a 20-item SPJ tool designed to assess violence risk, structured into three domains: 10 Historical (H) items (static factors, e.g., past violence), 5 Clinical (C) items (current dynamic factors, e.g., insight, active symptoms), and 5 Risk Management (R) items (future-oriented dynamic factors, e.g., treatment responsivity, future stressors). Each item is scored 0 (absent), 1 (partially/possibly present), or 2 (present). The dynamic C and R items become the core focus for therapeutic intervention and for gauging readiness for release. This assessment identifies the specific historical (static) and dynamic (clinical, risk management) factors that must be targeted throughout the patient's treatment journey. Therapy would focus on foundational skills and beginning to address the most acute risk factors.

3.2. Stage 2: Transitional "Step-Down" Facility (Low Security/Community Residence): This is the critical missing link in Taiwan's current system. Drawing from established practice in the UK and Germany, this stage involves transferring the patient to a less secure, community-based residential facility, such as a specialized halfway house or supported accommodation.[14,15] Here, Mr. C could have been tested with graduated increases in autonomy-managing his own medication with supervision, taking unescorted leave, and facing real-world stressors in a supported environment. This stage provides the necessary real-world data to validate

D-4 recovery scores and determine if his "good behavior" was a robust, internalized skill set or merely an artifact of institutional structure.

3.3. Stage 3: Conditional Discharge with Forensic Assertive Community Treatment (FACT): Full release into the community should not be an unconditional termination of oversight. Instead, it should be a conditional discharge supported by a high-intensity, multidisciplinary team. Inspired by the UK's Community Treatment Orders (CTOs) under the Mental Health Act 1983 and Germany's "conduct supervision" (Führungsaufsicht) under the German Criminal Code (StGB), this stage would involve a court-mandated supervision plan.[16,17] This plan would be executed by a Forensic Assertive Community Treatment (FACT) team, an evidence-based model that provides integrated mental health treatment, substance abuse counseling, housing support, and proactive monitoring of both clinical symptoms and criminogenic risk factors.[18,19] Crucially, this legal framework would grant the team the authority to recall the patient to a secure setting for a short period of assessment and stabilization if they disengage from treatment or their risk escalates, thereby closing the dangerous supervision gap that currently exists.

4. Conclusion: A New Standard for Terminating Custodial Protection

The case of Mr. C compels a fundamental rethinking of how we determine readiness for release. The current system, with its ambiguous standards and infrastructural gaps, is dangerously susceptible to equating time served and superficial compliance with genuine risk reduction. We argue for a paradigm shift from a time-based to a milestone-based standard for terminating custodial protection.

Under this new standard, the termination of a custodial protection (監護處分) should not be considered until the patient has demonstrated, through validated, structured assessments, the achievement of specific, evidence-based milestones. These must include:

4.1. Sustained Improvement in Dynamic Risk: Demonstrable and stable low scores on the dynamic items of the HCR-20 V3 (Clinical and Risk Management scales), indicating that factors like lack of insight, active symptoms, and unresponsiveness to treatment have been meaningfully addressed.[13]

4.2. Evidence of Internalized Recovery: Consistently strong scores on the DUNDRUM-3 and DUNDRUM-4 scale, proving the patient has developed genuine insight, a stable therapeutic alliance, and victim empathy.[5,6]

4.3. Successful Navigation of Transitional Stages: The patient must have successfully progressed through a step-down facility, managing increased autonomy and community exposure without significant clinical deterioration or behavioral incidents.

Adopting such a milestone-based approach would align the legal decision-making process with clinical reality. It would force the system to look beyond the compliant patient in the sterile hospital environment and instead evaluate the resilient, self-managing individual ready for the complexities of the community. For patients like Mr. C, this would mean that release is not merely the end of a sentence, but the beginning of a supported and sustainable recovery, thereby providing a far more robust and reliable foundation for public safety.

Implementing this milestone-based model requires systemic changes in both professional education and clinical practice. Educationally, this means mandatory, application-focused training in SPJ instruments like the HCR-20 V3 and DUNDRUM toolkit for all clinical and judicial professionals, moving beyond rote scoring. Clinically, this demands integrated treatment planning that explicitly targets dynamic HCR-20 V3 (C/R) risk factors and DUNDRUM-4 recovery deficits, shifting goals from mere "symptom stability" to "mitigating risk" and "building internalized skills." This model also requires a purposeful transition, redefining step-down facilities as active "real-world assessment settings" to validate recovery under autonomy. Finally, empowered community teams (FACT) must have the resources and legal authority, analogous to UK's CTOs, to enact swift recalls when risk escalates, thus closing the community supervision gap.

Conflicts of Interest Statement

The authors declare that they have no conflicts of interest regarding the research, authorship, and/or publication of this article.

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監護處分個案之社區轉銜失敗：風險評估與再犯的啓示

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摘　要

本報告詳述C先生的個案，一位53歲診斷思覺失調症的男性，目前正在台灣接受監護處分。儘管他過去曾有提早結束監護後再犯的紀錄，現仍以「住院期間表現良好」為由，再次提出提早出院之請求。我們認為，他的首次再犯為一個可預見的系統性失誤，其根源在於系統過度依賴表面的行為順從，而忽略了對內化復元的評估。此失誤源於三個環環相扣的問題：(1) 臨床上未能區分「治療方案完成進度」(可由DUNDRUM-3等工具測量) 與「真實復元」(由DUNDRUM-4測量)的差異 ；(2) 台灣《刑法》第87條中對於「再犯風險」的法律定義模糊，導致釋放的證據基礎不足；以及 (3) 嚴重缺乏能銜接保全照護與社區生活的轉銜基礎設施。藉鑑國際模式，我們提出一個多階段的轉銜框架，並倡議一種新的、以里程碑為基礎的監護處分終止標準；此標準應優先考量動態風險因子和經過驗證的復元指標，而非依賴直覺判斷或病患表面的順從性。

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