

Forensic mental health versus criminal justice services: What Works best?

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Personal professional journey

- Atascadero, California FMH
- Broadmoor FMH
- Medium Secure Unit (Reaside) FMH
- Australian Criminal Justice – What Works era. Program evaluation. 2004 – all Australian states ran What Works programs cf New Zealand, Canada, UK since 1998
- Peaks DSPD since 2004 – back into FMH
- THE TWO CULTURES

What Works in Criminal Justice programs:

- Hugely researched (see Hollin and Palmer (2006) "Offending Behaviour Programs" for an overview of where WW now stands.

What Works Principles

- Risk
- Needs
- Responsivity
- Program Integrity
- Cognitive-behavioural dominance

Types of WW programs

- Violence treatment
- Sex offending treatment
- Substance abuse interventions
- Cognitive skills

6 problems in applying WW to Forensic Mental Health

- We know little about what treatments are effective
- Responsivity issues insufficiently addressed: Readiness for treatment
- Assessment of outcomes is inadequate
- Need to address long-term outcomes
- Non-programmatic/evaluative culture (clinical autonomy)
- Diversity of theoretical models (a strength?)

What treatments effective?

- Number of outcome studies relatively small (see overviews by McMurran; Khalifa and Gibbon, 2009; Duggan et al, 2007, 2008, 2009) et al
- Compare over 2000 outcome studies in what Works
- Evidence is limited and of uncertain scientific quality: small sample sizes, short follow-up periods, and a tendency to focus on community settings

Duggan et al (2007) review of all psychological interventions for PD

- This study only reviewed randomised controlled trials
- Just two of the 27 studies included participants from inpatient settings.
- Only two studies examined what works in the treatment of ASPD.
- Predominance of research into DBT (with 52% of the studies DBT-focused), to the neglect of other psychological treatments.
- Limited in its relevance to answering the question of what works in forensic mental health settings.

Duggan et al (2008) review of pharmacological treatments for PD

- significant methodological limitations were highlighted, including small participant numbers and limited duration of treatment and follow-up. These limitations severely restrict the conclusions that can be drawn regarding what works for treating personality disordered individuals
- findings were those favouring the use of anticonvulsants to reduce aggression and of antipsychotics to reduce perceptual and mental state disturbance

Treatment Outcome studies

- Few if any controlled studies of outcomes in high risk, forensic populations with high level of mental disorder
- Two non-RCT small-scale studies at Rampton indicating positive effects of DBT, particularly in reducing anger and self-harm
- Some promising work by McMurrin, Huband and others on impact of social problem solving training with forensic populations. Also Therapeutic Communities.

Other treatments

- Substance misuse treatments: some supportive evidence
- Learning disability (Taylor and Novaco) – anger management
- Schizophrenia associated with high risk of violence

Overall picture

- Previous research has utilised small samples . Outcome measures have often been limited and sometimes haven't included behavioural measures.
- Not all studies have utilised control groups and many have focused on one treatment approach rather than comparing several different approaches.
- Range of treatments and settings they have been tested in is limited.
- Tonkin

Responsivity Issues

- High responsivity -> better outcomes
- Underlying criminogenic factors may be the same in mentally disordered and mentally “normal” offenders. Hence mainstream WW programs should in principle be used with mentally disordered in FMH

Same criminogenic needs

- Violence: Howells (2008) "The two literatures (that on psychological/criminological and that on psychiatric factors)...are still largely separate.....the reference point for mental health professionals and researchers in understanding aggression and violence appears often to be what is known about disorders and mental illness rather than what is known about the causes, modification and prevention of violence.....psychiatric and other clinical observations about aggression and violence in patients in mental health settings need to be plotted onto existing psychological models of aggression" (page 369).

Same needs

- Sex offenders: "in conclusion, we would propose that the presentation of and theoretical approach to treating sexual offenders with comorbid mental health problems should be determined by what works with offenders without mental health problems. Similarities in the personality, developmental, environmental, social/cultural and psychosexual or physiological factors, and thus in offence behaviours of these two groups suggest that different theoretical perspectives and thus risk management strategies are not necessary.....mental health issues may be one of a number of dynamic factors that are relevant to offending...we recommend...the use of clinical formulation and functional analysis..."
- Lockmuller, Beech and Fisher (2008) page 472-473.

But..

- How are standard WW programmes to be adapted for the mentally disordered?
Neglected: Lawrence Jones and Louise Sainsbury at Rampton have addressed this in a forthcoming book, though largely in relation to PD rather than Axis1 Disorders

A specific responsivity factor likely to be important

- Treatment readiness and engagement
- Drieschner and colleagues in Holland
- NIHR grant

Readiness model

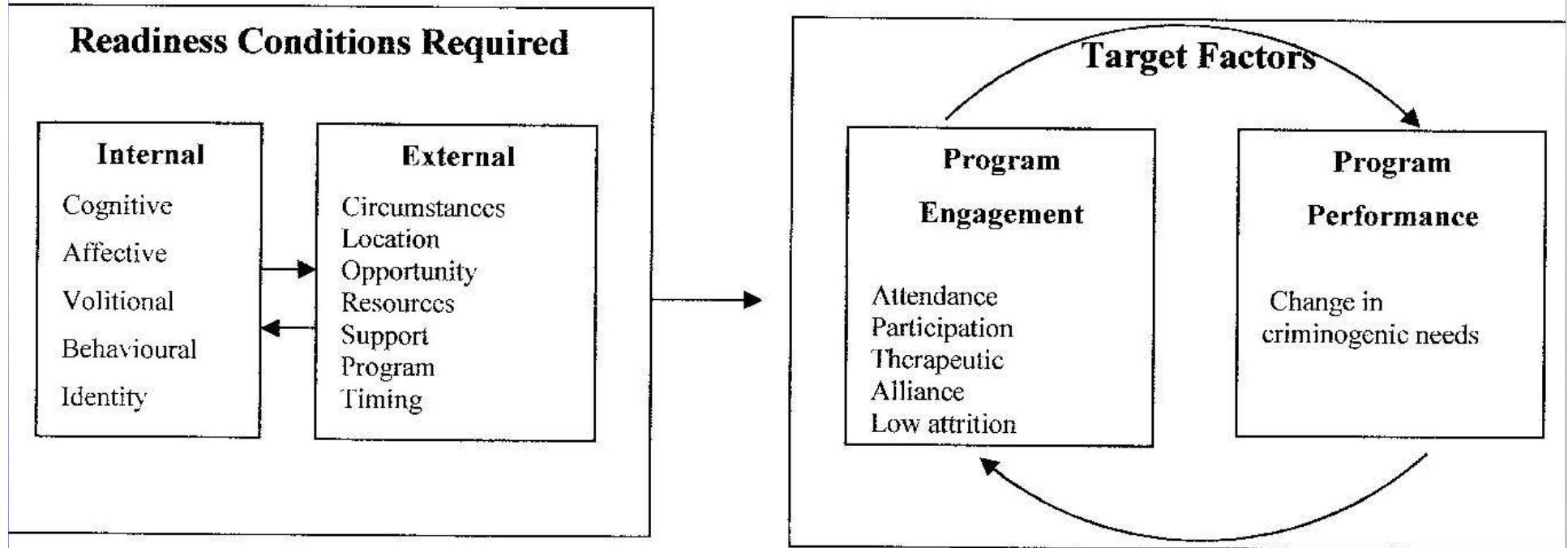


Figure 1: Readiness Model

Inadequate assessment of outcomes: two rather shocking papers

- Chambers et al (2009) reviewed all publication relating to FMH evaluation 1990-2006. 1038 outcome variables identified, 450 instruments. 21 domains of outcome variable:
- Recidivism, mental state, cognitive/perceptual, relationships, compliance, economic, satisfaction, social functioning, physical health, employment , aggression etc etc etc
- Few instruments were used across many studies
- Information was sparse as to reliability and validity of measures used

Gilbody, House and Sheldon (2003) Outcome Measurement in Psychiatry. CRD Report 24. NHS Centre for Reviews in Dissemination. York.

- “clinicians do not routinely measure outcome (patient-based or otherwise) in the context of their practice”
- “Substantial practical and attitudinal barriers were identified to the collection of standardized outcomes that will need to be addressed if current UK mental health policy is to be implemented” (page 87)
- “there is little correspondence between practice and research” (re outcomes measured)
- “ a general reluctance among clinicians to collect outcomes” (page 88)
- “standardized measures generally do not form part of routine care” (page 88)

Health service culture supportive of WW values and methods?

- Are health systems geared to systematic evaluation, disciplined collection of measures?
Principles of clinician autonomy
- Absence of structures and processes for quality control in programs- scientific standards and integrity.
- Accreditation – Steve Wong et al
- Gendreau chapter. CSAP criteria – in Hollin and Palmer (2006).

Strengths of FMH models

- Sustained and integrated care
- Clinical formulation driven (in theory).
Individualization of care is long accepted
- Relevant formulatory expertise
- Treatment embedded in a therapeutic climate?
- Geared for complexity

complexity

- Complexity of the treatment regime cf Peaks and Rampton. Reflects the complexity of the patients
- Axis 1, severe substance misuse, cognitive impairments, major abuse histories, personality disorder plus all the criminogenic factors.

Complexity of evaluation

- This produces complexity in the evaluation of outcomes. 3 types of evaluation:
 - Regime
 - Program
 - Quality.
- RCT methodologies struggle. Single case methods. See first and final chapters in Hollin and Palmer 2006.

Has FMH taken on board WW principles?

- Yes, but belatedly. 2001 versus 2009
- DSPD – best illustration of melding mental health and criminogenic perspective

conclusion

- Conclusion: a synthesis of criminological and mental health models is required. This would address the weaknesses of each and reinforce the strengths. A mutual taking on board of the strengths of the other's approach.

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