

Forensic mental health treatment: Do we really know what we are talking about?

Although most people would say they understand the word "treatment," it may have different meanings depending on the context in which it is used.

For example, psychiatric treatment can be defined as responding to mental disorder by using medication and/or teaching the patient to function independently, while correctional treatment refers to altering antisocial attitudes, behaviour and personality.

Obviously, problems may develop if it becomes unclear which definition is being used. For example, when "treatment" is used in a forensic environment, it is often implicitly assumed that it means treatment that will reduce recidivism. It is assumed that offenders' mental disorders are connected with their offences - even though the term is often intended to refer to psychiatric treatment.

This confusion raises a fundamental question. Is the goal of treating mentally disordered offenders to reduce recidivism or mental disorder? In fact, is mental health treatment likely to reduce criminal behaviour at all?

This article provides the answer to both questions - questions that must be answered and understood to provide the necessary context for any examination of forensic mental health treatment. Does mental disorder result in violence or criminality? The assumption that mental disorder leads to violence or criminality has persisted throughout history. Research has shown that although there is a relationship between the two, the relationship is not a strong one.⁽²⁾

Roughly 90% of individuals (incarcerated or not) with a major mental disorder are not likely to be violent. Further, personal-distress variables such as anxiety, self-esteem, depression and mental disorder are weak predictors of criminal behaviour, and clinical treatment of these variables does not reduce recidivism.⁽³⁾

In fact, some researchers have discovered a significant (but small) negative correlation between the diagnosis of schizophrenia and violent recidivism.⁽⁴⁾ Therefore, while a small number of mentally disordered offenders may be violent, most are not.⁽⁵⁾

Any link between mental disorder and acts of violence is very complex.⁽⁶⁾

For example, positive symptoms of schizophrenia may be associated with an increase in the tendency to engage in violent or criminal acts, while the existence of negative symptoms may be associated with a reduction in such tendencies.⁽⁷⁾

However, even this level of precision may not be accurate, as in the case of a delusional (positive symptom) paranoid patient who simply withdraws when he or she thinks people are talking about him or her.

Further, mental disorder categories were simply not designed to evaluate or predict criminal or violent

behaviour.⁽⁸⁾

In short, the relationship between mental disorder and violence or criminality is not as strong as most people think. It is unlikely that the typical mentally disordered patient will be dangerous solely as a result of their mental disorder.

Further, criminogenic variables such as antisocial attitudes, behaviour and personality best predict risk - even in offenders with a mental disorder. Mental health treatment may not equal reduced recidivism. The goal of mental health treatment is to address mental disorder, while the goal of correctional treatment is to decrease the likelihood of recidivism. These goals are not mutually exclusive, but they do not always work in tandem.

Correctional treatment targets criminogenic needs such as criminal associations, antisocial attitudes and criminal behaviour.⁽⁹⁾

Mental health treatment, on the other hand, attempts to ensure an ability to function - not just symptom-free, but to be able to look after daily needs, interact with others, find and keep a job, and enjoy leisure activities, sexual and social relationships, and a general sense of well-being.

Nevertheless, psychiatric or psychological treatment remains valid in a correctional environment. After all, would it be ethical to withhold treatment simply because the patient chooses to lead a criminal lifestyle when his or her symptoms are under control?

Further, the provision of essential mental health services is part of the Correctional Service of Canada's mandate.⁽¹⁰⁾ Evaluating mental health treatment Most correctional programs are evaluated on the basis of their effect on recidivism. This is fine for programs directed at criminogenic factors, but it is not likely to be very useful in evaluating the benefits of treating mental disorders. Such an examination might find weak treatment effects, if any.

Other measures are needed to validate the efficacy of the treatment, such as psychiatric rating scales, measurement of independent behavioural functioning and analysis of the use of mental health services.

However, in evaluating the effectiveness of such treatment, it is perhaps most important to return to the meaning of the word treatment.

It is very easy to get the term's two meanings confused when determining whether to keep an offender in mental health treatment.

For example, what if a sex offender is schizophrenic and is placed in mental health treatment? The treatment's main goal is to improve the offender's mental health and related functioning. Additional treatment, of course, targets the sexual component of the offence.

But suppose the offender will not discuss the offence. Should he or she have to leave the program? After all, if the ultimate goal is to reduce recidivism, why keep offenders in treatment if they refuse to address their criminal behaviour?

The problem with this reasoning is in the use of the word treatment. It seems to refer to criminogenic and mental health treatment interchangeably. The first priority in treating a patient for a mental disorder must remain treatment of that disorder, and that is how treatment must be evaluated.

However, in practice, psychiatric rehabilitation may help offenders better deal with factors that lead to their offending.

For example, their more effective use of leisure time and improved communication and assertiveness skills may help them stay away from criminal associates.

Mental health treatment may, therefore, reduce recidivism somewhat - even though this is not the main goal of such treatment.

In short, there may be a relationship between the symptoms of a small number of mentally disordered offenders and criminal behaviour. Therefore, the relationship between an offender's mental disorder and his or her criminal behaviour should be evaluated at the outset.

This will allow treatment expectations to be determined based on objective assessments, rather than on the assumption that there is a strong relationship between mental disorder and the risk of crime or violence.

Where there is no obvious relationship between an offender's mental disorder and criminal behaviour, it could then be decided independently what additional Treatment is required to target the specific factors that led to the individual's offending.

For example, our hypothetical sex offender may go on, following the completion of mental health programming, to receive sex offender programming.

It may also be possible for an offender to receive such treatment while receiving mental health treatment - if the offender is able to cope with both at once.

This is the current approach at the Service's Prairie Region Regional Psychiatric Centre. The centre provides a specific program in their psychiatric rehabilitation unit (Bow Unit) to help offenders understand their cycle of criminal behaviour, while they undergo full-time psychiatric rehabilitation. We must know what we are talking about It is crucial to clarify which definition of treatment (correctional or psychiatric) is being used when prescribing treatment.

The end result will be more informed treatment, with a clear idea of what may or may not be achieved. It is only then that we will truly be able to measure the effectiveness of various mental health treatment programs.

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- (2)J. Monahan, "Mental Disorder and Violent Behaviour," *American Psychologist*, 47, 4 (1992): 511-521.
- (3)Bonta, D. A. Andrews and L. L. Motiuk, *Dynamic Risk Assessment and Effective Treatment*, Paper presented at the annual meeting of the American Society of Criminology, Phoenix, October 28, 1993.
- (4)G. T. Harris, M. E. Rice and V. L. Quinsey, "Violent Recidivism of Mentally Disordered Offenders: The Development of a Statistical Prediction Instrument," *Criminal Justice and Behaviour*, 20, 4 (1993): 315-335.
- (5)L. A. Teplin, G. D. McClelland and K. A. Abram, "The Role of Mental Disorder and Substance Abuse in Predicting Violent Crime Among Released Offenders," *Mental Disorder and Crime*, S. Hodgins, ed. (Newbury Park: Sage Publications, 1993): 86-103.
- (6)S.A. Shah, "Recent Research on Crime and Mental Disorder: Some Implications for Programs and Research," *Mental Disorder and Crime*, S. Hodgins, ed. (Newbury Park: Sage Publications, 1993): 303-316.
- (7)Positive symptoms include hallucinations, delusions and inappropriate affects. Negative symptoms are such things as social withdrawal, or lack of energy or initiative.
- (8)Shah, "Recent Research on Crime and Mental Disorder: Some Implications for Programs and Research."
- (9)Bonta, Andrews and Motiuk, *Dynamic Risk Assessment and Effective Treatment*. See also J. Bonta, *Correctional Service of Canada Risk Assessment Course Participant's Manual - Session I: Explanation of Criminality* (Ottawa: Correctional Service of Canada, 1994).
- (10)J.P. Ogloff, R. Roesch and S.D. Hart, "Mental Health Services in Jails and Prisons: Legal, Clinical and Policy Issues," *Law and Psychology Review* (In press).