Evidence-Based Treatment in Forensic Settings

15

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15.1 Introduction

In the medical field, guidelines of good practice are meant to provide concise state-of-the-art information on treatment approaches for diseases and disorders, based on empirical evidence and/or expert consensus. Where available such guidelines should be based on the systematic review and meta-analysis of high-quality research evidence on a particular topic. Proponents of guideline-based provision of care argue that they improve quality of care by ensuring consistency and allowing individual practitioners to keep abreast with the latest evidence in their field. Critics contend that the strict following of guidelines undermines individual decision-making, deskills practitioners and might lead to the needs of individual patients not being met.

Following guidelines is not mandatory; they are one out of many tools to improve the quality of care and cannot replace individual clinical decision-making [1]. However, not following guidelines and hence best practice might lead to legal challenge if treatment is not successful or leads to harm, and the practitioner might have to explain reasons for diversion from the available evidence.

In comparison with general medicine and psychiatry, forensic psychiatry is lagging behind regarding the development of evidence-based treatment guidelines. This clearly is the case in Europe, where only researchers and practitioners from a minority of countries are involved in the professional debate on these issues. The degree of standardization of treatment programmes within forensic settings varies across European Union member states [2]. On the one hand, diverse standardized

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and evidence-based treatments are available for a large variety of mental disorders and offences, as is the case in Great Britain or the Netherlands. On the other hand, there seems to be a lack of data for the psychological treatment reality in most European forensic mental health institutions. The same heterogeneity seems to be evident in the training of psychological and medical professionals. Most states do not require staff of forensic mental health institutions to be especially trained for the work with delinquent patients. Also, a shortage of suitable candidates for the work with mentally disordered offenders (MDOs) may lead to the paraprofessional implementation of psychotherapeutic interventions (ibid.).

15.2 Legal Issues

The therapeutic scope can be specified by the respective legislation of a state [3]. In Germany and Austria, for example, the law allows for offenders with substance-related disorders to be treated in specialized facilities. The growing number of substance abusers in forensic settings (e.g. [4]) emphasizes the importance of specialized treatment and concepts of relapse prevention to reduce recidivism in this group. Nevertheless, some countries, e.g. the UK, specifically exclude individuals with substance abuse disorders from compulsory psychiatric treatment. Similar variability exists with regard to personality disorders. In addition, some countries require decreased criminal responsibility as entry criterion for admission to a forensic institution, while others may admit fully responsible or even non-offending patients to forensic care (see, e.g. [5]).

While scientific papers and conferences do reveal efforts to improve the quality of treatment and care in forensic psychiatric institutions, Italy has closed down all six remaining forensic inpatient hospitals, characterized as "seriously insufficient" by Barbui and Saraceno [6]. Whether the alternative small residential units will be successful in aiding the recovery of their residents remains to be seen. Economic and public pressure may limit their effectiveness. A parallel debate on abolishing the concept of legal incapacity may indicate a singular way to handle the challenging problem of treating mentally disturbed offenders in special institutions. Even more mentally ill offenders in the regular prison system may be a consequence.

15.3 Relevant Concepts

The authors of this chapter do not have the authority to conceive general guidelines of forensic treatment, but we aim to highlight concepts which, in our view, need to be considered in a respective debate. One such concept is the *risk–need–responsivity* model (RNR; [7]), which has been a frame of reference for the development of therapeutic programmes and assessment instruments over many years [8]. One may add that this refers most notably to the Anglo-American part of the world. On the European continent, educated forensic staff has prevailingly taken notice of the

RNR principles, though these have not always been translated into guiding principles of treatment.

The *Risk principle* of the RNR model requires practitioners to match the level of programme intensity to the offender's risk level (i.e. no expensive treatment for low-risk offenders, most intensive treatment for high-risk individuals). The *Need principle* calls to target "criminogenic needs", i.e. dynamic factors linked to the risk of reoffending (like antisocial peers and attitudes, drug abuse, impulsiveness); treatment providers are discouraged from focusing on non-criminogenic needs, such as discontent, low achievement motivation, anxiety or other symptoms of mental disorder. The *Responsivity principle* refers to the matching of treatment style and mode to the offender's learning style and abilities. According to Andrews and Bonta [9], interventions in accordance with the three principles are associated with significant risk reduction, while others are not or may even cause harm.

While the relevance of the three (RNR) principles is widely accepted, the delivery of RNR-based treatment programmes in the correctional system is criticized. According to Gannon and Ward [10], there are three reasons for the popularity of RNR: (1) participation in RNR programmes may reduce recidivism. (2) The RNR principles are simple and can be implemented to large groups of offenders within highly structured cost-effective treatment programmes, frequently delivered by less qualified staff. (3) The focus on risk reduction complies with the priority of security issues in the correctional system. The authors criticize the stringent manualization of treatment programmes, along with a risk of overreliance of therapists on a specific manual, thereby disregarding patients' needs and focusing too much on public safety measures instead of therapeutic goals [10].

The good lives model (GLM) has been suggested as an alternative or rather an extension to the RNR model. It stresses the similarity between the needs of offending and non-offending individuals and the crucial difficulties of offenders to fulfil their normal primary needs or goods in a socially compatible way. According to the model, there are 11 areas of primary goods: life (healthy living and functioning), knowledge, excellence in play (recreational activities), excellence in work (including mastery experiences), excellence in agency (autonomy, self-directedness), inner peace, relatedness (including intimate, romantic and family relationships), community (connectedness to wider social groups), spirituality, pleasure (feeling good in the here and now) and creativity. The GLM approach focuses on individual needs and the increase of the patients' ability to live a fulfilling, satisfactory life. In contrast to RNR, GLM considers the fulfilment of basic needs to be sufficient to (naturally) reduce criminogenic needs [11]. However, Andrews et al. [12] argue that the specific points and apparent changes suggested by the GLM are already covered by the RNR concept. They do, however, content that the strength-based focus of the GLM may be a positive addition.

There is little evidence clarifying which role the GLM plays in the practice of forensic treatments in Europe. In Germany, two papers have recently informed about the model in a major forensic psychiatric journal [13, 14]. There is considerable interest in the approach, reviving an individualized psychotherapy approach within forensic settings. This receptivity may have its origin in the strong

psychodynamic and psychoanalytic traditions in countries like Austria, France and Germany [15].

Specific treatment programmes discussed in the literature may be differentiated regarding their closeness to the RNR and the GLM concept. RNR-oriented programmes are generally cognitive behavioural by nature and highly structured and manualized and have a strong focus on risk factors and on later risk management. There are programmes for individual, group and aftercare outpatient settings. In the UK, multiple highly structured treatments are available and accredited [16]. Specific training may be required to deliver programmes, and ideally programme implementation and delivery will be monitored on an ongoing basis and staff supervised. The highly structured nature of these programmes, alongside their manualization, means that training may be specific to the programme, while no degree in a particular subject (such as psychology) or general psychotherapeutic education may be required to become a treatment programme facilitator.

15.4 Programmes in Practice

There is a multitude of treatment programmes claiming to fulfil RNR criteria. Among the empirically well-evaluated programmes are the Reasoning and Rehabilitation (R&R) programme and the sex offender treatment programme [17]. The R&R programme, introcuded by Ross, Fabioano and Ross in 1974 [18, 19] targets cognitive processes such as reasoning, atributions, self-evaluation, expectations, appraisal of the world and values, in order to enhance the client's competencies to cope with everyday problems and challenging situations. The effectiveness of the R&R approach has been evaluated in Canada, the USA, the UK and Sweden, and it has been found to achieve a moderate but significant reduction of reoffending rates [20, 21]. For example, in the study of Tong and Farrington, the relative risk of reoffending was reduced by 14% in the first year after discharge from the institution. However, it was pointed out that there is limited evidence regarding the effectiveness of cognitive skills programmes like R&R with mentally disordered offenders. In a randomized controlled trial, Cullen et al. [22] demonstrated that R&R completion had a positive effect on patients with severe mental illness. But a high rate (50%) of noncompletion presented a problem, discouraging too optimistic conclusions.

The sex offender treatment programme (SOTP) is an evidence-based group treatment programme in forensic settings and was originally developed for the implementation in prisons in the UK [23]. SOTP was designed to address the sexual offence and treat patients using cognitive behavioural techniques, in accordance with the prevailing research on sexual offending. The programme has been adapted to serve the needs of forensic psychiatric patients as well as subgroups of offenders (such as those with intellectual disabilities and, more recently, deniers) and has been implemented in other European countries, such as Germany [24]. However, there are numerous interventions targeting sexual offending, ranging from cognitive to medical approaches (such as chemical castration). Prominently, the relapse prevention approach, which was originally developed for drug abuse, is used and has been

adapted to reduce the risk of relapse. Schmucker [25] suggests complementing this approach with the humanistic goals of the GLM, in order to generate a more positive therapeutic atmosphere. Sex offender interventions have been subject to a great number of effectiveness studies and numerous meta-analyses summarizing their findings with some concluding that the effect of these programmes is absent or minimal and others producing more promising findings. The most recent meta-analysis of interventions [26], reviewing 11 other meta-analyses, concluded that sex offender treatment showed promise in reducing reoffending with effect size of about 10–20% and larger effects for treatment for adolescents compared to adults, surgical castration/hormonal medication compared to psychological interventions and community compared to institutional treatments.

The ongoing research activity surrounding sex offender interventions has allowed adjustments in line with research findings. For example, the prison SOTP in the UK has recently de-emphasized the focus on victim empathy after a number of studies have found that its inclusion in the programme is not only inefficient but potentially harmful [27]. Instead Mann et al. [28] identified the following criminogenic needs as targets for intervention: sexual preoccupation, deviant sexual interest, offence-supportive attitudes, emotional congruence with children, lack of intimacy, lifestyle impulsivity, poor cognitive problem-solving, resistance to rules, grievance and hostility and negative social influences.

A variety of violent offender treatment programmes (or similar, e.g. [29, 30]) have been implemented and proofed useful, though the empirical evidence regarding these programmes is somewhat more limited than for sex offender programmes ([31]; for a recent review see [32]).

Programmes more related to the GLM approach put more weight on the therapeutic relationship as an effective factor of treatment and are less rigidly manualized and less focused on risk factors. They do show more overlap with general psychological treatments [10]. According to the literature, RNR-based and cognitive behavioural programmes preponderate clearly in correctional and forensic settings, but in practice, general psychotherapeutic and even psychodynamic approaches still play a significant role. These approaches generally comply with the GLM demand to give interpersonal factors special attention.

A number of psychotherapeutic approaches, usually delivered on a 1:1 basis, but sometimes group based, or a combination of both, are in use in forensic settings which will be briefly described here, though it is important to note that there is virtually no evidence for their effectiveness in forensic settings and that, mostly, they have not been adapted specifically for use in such settings.

Psychodynamic therapy is characterized by its individual patient focus and in-depth search of the biographic and emotional roots of maladaptation and behavioural problems. The general efficacy of psychodynamic therapy approaches has been demonstrated empirically [33, 34]. Traditionally, psychodynamic therapy in forensic settings has had its place in Austria, Germany, France and the UK, though less so recently in the latter [15], in addition to other therapeutic approaches.

Transference-focused psychotherapy (TFP) constitutes a newer form of psychoanalytic therapy, designed to deal with severely personality distorted patients and to

accommodate current directions in psychotherapy research. There are specific recommendations for the use of TFP in forensic settings available, such as dealing with the dual relationship problem (emerging from two sets of norms associated with community protection versus fostering the patients' well-being) and its possible effect on the therapeutic process [35, 36].

Schema-oriented psychotherapy (SOPT) is an adaption of Young's schema therapy [37] to suit the needs of (forensic) patients with personality disorders. It is composed of a three-step programme, which is delivered in a group setting though it is sometimes used individually or in a group and individually in parallel. Ultimately, the goal of this therapy is to modify maladaptive coping strategies, in terms of working through identified "schemata" of thinking and responding by use of techniques such as role play and chair dialogue. In a recent study by Elsner and König [38], forensic patients who participated in a SOPT programme showed more improvement regarding self- and staff assessment and objective measures (like progress in the institution's phased plan) than a matched control group. Notably, the use of this approach in the treatment of patients with high psychopathy scores, a group of offenders very difficult to reach therapeutically, is also currently explored.

As a large group among violent and sex offenders have experienced severe deficits of early attachment, attachment theory has also become an inspiration to offender treatment [39]. Fostering clients' capacity for "mentalization" [40] is proposed to improve their behavioural control and affect regulation as well as strengthen their competence to manage everyday problems and reach a more fulfilling life.

Last but not the least, dialectical behaviour therapy (DBT), as introduced by Linehan et al. in 1991 [41], clearly fulfils the demands of the GLM concept. It is a broad, evidence-based cognitive behavioural approach originally developed for the treatment of (para)suicidal female patients with borderline personality disorder. It has been adapted for the use in forensic settings [42]. DBT is implemented in forensic settings, especially in Anglo-Saxon countries [43], but has also been found efficacious in outpatient forensic treatment of patients with a borderline personality disorder in the Netherlands [44] and Germany [45].

15.5 Discussion

Empirical evidence may hardly give last answers to the question which treatment approaches should be considered state of the art in forensic and correctional settings, certainly not in relation to a specific patient. Empirical evidence demonstrates that, when comparing two groups treated in different ways, significantly more patients have a positive outcome in one of the groups. But there is commonly a rather small share of clients whose adjusting may be specifically attributed to a specific intervention. Psychosocial programmes, when rigorously, evaluated show prevailingly, at most, small effects. We are still not close to answering questions like "what works for whom, in what contexts, under what conditions, with regards to what outcomes, and also why" [46, p. 2].

What also justifies some restraint is that studies evaluating model projects interventions instead of routine practice and rather small instead of large samples tend to find larger effect sizes, as well as studies run by researchers affiliated to the programme at stake (ibid.). It has also been stated that being able to benefit from a standard treatment programme rather indicates a less severe rather than a severe and complex disorder [47]. In addition, positive effects of a programme may not only indicate a direct impact of the programme, like modifying directly clients' attitudes. Programme delivery may also have an indirect effect through positively affecting staff–clients' communication and the institution's social climate (which would be a most valuable effect!). All together, there is no single approach which may be acknowledged "state of the art", but these critical observations should not dismiss the fact that there is support confirming the utility of concepts like RNR, GLM and programmes based on their principles.

Take-Home Messages

Against the background outlined above, the following conclusions should be considered when debating guidelines of treatment in forensic psychiatric settings:

- Forensic and correctional treatment programmes should give special attention to dynamic risk factors related to clients' recidivism; these factors need to be focused on in treatment planning and implementation and in aftercare.
- Clients' individual needs and goals must be considered and acknowledged, not least as this might motivate them to co-operate. One should not expect offenders to reach a stable social adjustment just by training them to avoid and control antisocial behaviour; positive "turning points" of life have proven to be closely linked to consistent desistance from crime [48], providing rather strong confirmation for a "good lives approach" in working with mentally disturbed offenders.
- Clients suffering from severe emotional instability may benefit from cognitive behavioural interventions and treatments explicitly fostering their skills to manage anxiety and anger, like DBT-F or schema therapy. Findings from attachment research need to be considered, which may foster therapists' awareness of relationship issues [39].
- Inpatient secure treatment settings should be closely linked to aftercare programmes providing support, coaching to cope with the challenges of daily life and some degree of control.
- Medication was not a topic considered in this chapter, yet may be essential in managing critical dispositions of behaviour, severe mental disorders and addiction. General psychiatric guidelines are relevant in this regard.

Postscript: At present, Europe is struggling with a welter of problems. At times, the European community seams closer to breaking apart than solving these problems. Whenever issues of forensic care are discussed in the (regional) public, "security" is a primary focus. Debating standards of correctional and forensic psychiatric care is very low in the European political agenda.

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