Chapter 1

EVIDENCE-BASED TREATMENT FOR MENTALLY DISORDERED OFFENDERS

RÜDIGER MÜLLER-ISBERNER AND SHEILAGH HODGINS*

Haina Forensic Psychiatric Hospital, Haina, Germany
**Université de Montréal, Quebec, Canada, and The Karolinska Institute, Stockholm, Sweden*

INTRODUCTION

Mentally disordered offenders, by definition, are mentally disordered individuals who commit crimes. However, the nature of the relationships between the various mental disorders and criminal behaviour are unclear. The term ''mentally disordered offender'' has been used to refer to many different types of offenders, for example, mentally ill inmates of correctional facilities, offenders who have been judged incompetent to stand trial, mentally disordered sex offenders, and offenders found guilty but not responsible or only partially responsible due to a mental disorder. The legal terms and definitions vary from one country to another. Even within one jurisdiction, the definitions of particular terms often change over time. Whether or not an offender is judged to be ''mentally disordered'' depends upon the particular practices of police, prosecutors and the courts on the insanity standards in the jurisdiction where the crime is committed, and on clinical assessments, more than on his/her psychopathology. Whether mentally

Violence, Crime and Mentally Disordered Offenders. Edited by S. Hodgins and R. Müller-Isberner.

disordered offenders are transferred to a psychiatric or a correctional setting, and whether they are treated in the community or in a secure hospital, depends far more on the laws, regulations, policies, practices and ideologies of public safety that are particular to each jurisdiction than on the psychopathology or history of criminality of the particular offender. It has been suggested that the kind of disposal, psychiatric or penal, rests as much upon chance as upon any more clearly discernible factors (Prins, 1993). The diversity of laws, regulations and organizations for the treatment of mentally disordered offenders is perplexing and beyond the scope of this book (for an overview, see a special issue of the *International Journal of Law and Psychiatry*, **16**, 1993, which describes some of these national differences).

Regardless of their legal status and how they are labelled, and regardless of where they are treated, in the mental health or the correctional system, mentally disordered offenders present multiple challenges to the administrators and clinicians who are charged with their care. Morality, professional ethics and public accountability demand that treatment be based on empirical evidence of effectiveness. No such basis currently exists for the treatment of mentally disordered offenders. However, scientific evidence and a wealth of clinical experience can be used to begin the long process of developing this necessary empirical base.

This chapter begins with brief descriptions of the principal types of mentally disordered offenders. Next, the procedures for assessing mentally disordered offenders are described, as they differ from those used to assess patients with no criminal record. Assessment is an integral part of treatment; the initial assessment provides the information which is used to develop an individualized treatment programme and subsequent assessments, conducted during treatment, measure progress. The chapter then examines three bodies of empirical findings that are relevant to the development of effective treatment programmes for mentally disordered offenders. These findings provide a solid basis on which to begin developing comprehensive and effective treatment programmes. However, many of the components of treatment that have been shown to be effective with other clienteles and in other situations have to be modified for use with mentally disordered offenders. These modifications involve taking account of the particularities of treatment within security hospitals, of organizational requirements, and of the ethical dilemmas encountered in treating mentally disordered offenders.

MENTALLY DISORDERED OFFENDERS

Persons with brain damage

Brain injury or disease is only rarely directly related to offending. Very rarely, disease or injury to particular cerebral structures leads to violent

outbursts. Somewhat more common, but still rare, are victims of brain injury who in the years following the trauma gradually undergo changes in personality and become more and more irritable and aggressive. Some commit violent offences and are subsequently institutionalized for long periods. Much more common among persons who have suffered a brain injury is persistent aggressive behaviour which does not lead to criminal charges. Similarly, among the elderly, various degenerative diseases are often characterized by aggressive behaviour. These behaviours are not usually prosecuted. However, they dominate the organization of institutional care for this population and seriously limit the possibilities for living with family or in other types of housing in the community. The expertise and treatments used in reducing aggressive behaviour among persons with brain damage, even when they are treated outside of a forensic system, are similar to those used with formally designated mentally disordered offenders.

Offenders with personality disorders

Most offenders present a pattern of symptoms that have been stable since early adolescence that are sufficient for a diagnosis of at least one personality disorder (see, for example, Hodgins & Côté, 1995). A perusal of the symptoms which constitute personality disorders (in either the DSM or ICD classifications) suggests strongly that several of the symptoms, or traits, constitute a vulnerability for behaviours that would lead to criminal charges. For example, in the DSM-IV, among the general criteria for personality disorders is the lack of impulse control. Among the Cluster A disorders, the two that are genetically related to schizophrenia—paranoid personality disorder and schizotypal personality disorder—include symptoms of suspiciousness, inability to trust others and paranoia. Given the defining characteristics of these disorders, it is not surprising how little is known about them. Persons with these disorders rarely consent to participate in research projects, and usually can only be intensely studied when they commit violent offences. Schizoid personality disorder, like the disorders which constitute what is referred to as the Cluster C disorders—avoidant, dependent, obsessive-compulsive personality disorder—may lower the risk of offending. Cluster B disorders—antisocial, borderline, histrionic and narcissistic—are clearly and directly associated with behaviour patterns that are likely to lead to prosecution in criminal court.

Personality disorders are often complicated by the presence of a long history of substance abuse and the consequent damage to the central nervous system. Less than average verbal intelligence, difficulties in concentration, less than the average level of formal education and little or no history of stable employment provide no base for the development of a non-criminal life-style.

How to conceptualize these constellations of behaviour patterns and characteristics and how to describe them in a way that is useful for treatment remain major obstacles to the development of effective interventions. Further, it is generally assumed that personality traits that emerge gradually through childhood and solidify in adulthood are resistant to change. The question is whether or not it is necessary to modify the personality traits in order to reduce recidivism. Can specific behavioural and cognitive training programmes produce sufficient change in the patterns of behaviour, attitudes, morality and ways of problem solving that are sufficient to alter a lifestyle? That is the challenge and it remains to be seen whether such programmes will produce changes that can support a new, legal life-styles.

These programmes will, for the majority of the individuals concerned, have to include intensive and rather long-term interventions aimed first at reducing and eliminating substance abuse and then at preventing the recurrence of the abuse when life gets tough. While clinicians have long known the difficulty of this task, recent evidence demonstrating hereditary vulnerabilities for abuse of various substances and the neurobiological bases of these dependencies explain, in part, the resistance to change (Bierut et al., 1998; Lappaleinen et al., 1998; Merikangas et al., 1998). These findings clearly indicate the necessity of intensive, highly structured, long-term programmes that help the individual to develop over time, behavioural and cognitive patterns that are inconsistent with abuse of alcohol and/or drugs.

Psychopathy

Psychopaths are a special category of offenders with personality disorders. They are special because they commit the most crimes, the most violent crimes, and because they are thought to be the least changeable of all offenders. This diagnosis does not appear in either the DSM-IV or ICD-10. It has been developed over the past 20 years in studies of incarcerated male offenders, and then used with female offenders, and a modified version with adolescents. The diagnosis is made using Hare's Psychopathy Checklist (PCL-R) (Hare, 1991). Clinicians trained to use the PCL-R obtain high inter-rater agreement and stable ratings over time. The validity of the diagnosis has been established by numerous studies showing that offenders diagnosed as psychopaths (using the PCL-R) have patterns of behaviour, cognition, emotional reactions and central and peripheral nervous system activity that are distinctive, even from offenders who meet criteria for antisocial personality disorder (Cooke, Forth & Hare, 1998).

The prevalence of psychopathy has never been studied in a general population sample. However, a rough estimate can be made from available statistics on antisocial personality disorder. All those who meet the criteria for

psychopathy also meet the diagnostic criteria for antisocial personality disorder (DSM-III, DSM-III-R, DSM-IV), but less than one-third of those who meet the criteria for antisocial personality disorder also meet the criteria for psychopathy. Since the prevalence of antisocial personality disorder has been documented at less than 7% in males and 2% in females, the prevalence of psychopathy would be considerably less (Robins, Tipp & Przybeck, 1991). In the justice system, however, psychopaths are numerous. For example, in Canada one in five men who are sentenced to two years or more of incarceration meet the criteria for psychopathy (Hare, 1991), as do between 11% and 20% of women (Côté, Hodgins & Toupin, in press). Whether or not the prevalence of psychopathy varies from one culture to another is still in question (see e.g. Cooke, 1997).

In treatment settings, whether inside or out of the prison system, psychopaths are disruptive. They do not simply refuse to comply with treatment, they often undermine the treatment of other offenders. When and if they do comply with treatment, they have been shown in the past to be able to manipulate it in order to use what they learn to perfect their antisocial skills. In treating psychopaths, therefore, clinicians and administrators not only have to be concerned with achieving efficacy but also with not making them worse than they are already.

Offenders with major mental disorders

The major mental disorders include schizophrenia, major depression, bipolar disorders and atypical (but non-toxic) psychoses. Schizophrenia and bipolar disorder afflict equal numbers of men and women and their prevalence rates are estimated to be approximately 0.85% and 1.6%, respectively (Hodgins, 1996) These rates are similar in all Western industrialized countries, except for the rate of bipolar disorder, which may be lower in Finland than elsewhere (Veijola et al., 1996). The prevalence of major depression is difficult to establish. It appears to be increasing and it varies, somewhat, from one country to another. While one US study estimated the prevalence to be 21.3% among women and 12.7% among men (Kessler et al., 1994) a cross-cultural comparative study which used a less sensitive diagnostic instrument obtained rates varying from 12–22% in women and 6–11% in men (Weissman et al., 1996) The major mental disorders onset in late adolescence or early adulthood and are characterized by recurring acute episodes and poor psychosocial functioning between the episodes (Hodgins, 1996). Among those born since the mid-1940s who developed their disorders in countries that have deinstitutionalized mental health services, the risk of criminality, and especially of violent criminality, is increased as compared to non-disordered persons in the same country (Hodgins, 1998). Recent

evidence suggests that while the risk of offending among persons who develop schizophrenia is higher, persons who develop major affective disorders are also at increased risk for violent offences (Brennan, Mednick & Hodgins, submitted). Other evidence suggests that those with an affective disorder, who are generally more compliant with treatment than those with schizophrenia, may recidivate more often because of inadequate and/or inappropriate community care (Hodgins, Lapalme & Toupin, in press). Epidemiological findings indicate that some of these persons display a stable pattern of antisocial behaviour from a young age and are often convicted for crimes before the major mental disorder is manifest (Hodgins, Côté, & Toupin, 1998). Among the others, the first offence occurs after the onset of the disorder. This risk of offending among persons with major mental disorders continues to grow even into the fourth decade of life (Hodgins et al., 1996).

Patients with major mental disorders who offend present multiple difficulties (positive symptoms, negative symptoms, impoverished life skills and social skills) associated with the major mental disorder, each of which requires a specific type of intervention. Those with a history of offending dating from adolescence present a well-entrenched antisocial life-style, which includes substance abuse. Consequently, they require a programme of treatment that includes multiple components designed to address the various aspects of the major mental disorder and to reduce antisocial behaviour and substance abuse. All of these various treatment components have to be coordinated and compliance ensured. Supervision and compulsory inpatient and outpatient care are often required. Special consideration needs to be given to schizophrenic patients with low intelligence who are unable to cope with and to learn in traditional psychoeducational treatment programmes.

Mentally retarded offenders

One large-scale epidemiological study and several studies of incarcerated offenders indicate that the prevalence of offending among both males and females who are mentally retarded is elevated in comparison with the general population (Crocker & Hodgins, 1997). Prosecution and conviction of such offenders often leads to tragedies because within correctional facilities they are targets for abuse by other inmates. Since policies of ''normalization'' of the retarded were implemented, and they go to school, live and work in the community, the issue of crimes by mentally retarded persons is considered taboo, politically incorrect, and consequently there is almost no research on the subject. This perpetuates the current situation and limits advances in knowledge that would contribute to identifying a solution to the

problem. For example, behaviour problems in early adolescence have been shown to characterize the majority of those who go on to offend as adults (Crocker & Hodgins, 1997). This finding, albeit from only one study, suggests that early intervention programmes that target the behaviour problems in childhood and teach prosocial skills might have a positive long-term impact in preventing crime. Yet, almost no research of this type goes on, primarily for ideological reasons. Other research has shown that mentally retarded adults who are arrested have difficulty in responding appropriately to police interrogations and may confess to offences that they did not commit (Clare & Gudjonsson, 1993, 1995).

There is a serious lack of specialized services for mentally retarded offenders. Psychiatrists and psychologists who do pre-trial assessments in order to advise the court on culpability seldom have any specific training in either assessing or treating such patients. Similarly, in forensic hospitals and in the community there are seldom specific programmes for such offenders. Not surprisingly, then, when we set out to edit this book we identified few experts in the world on this issue. In many cases their experience and knowledge was limited to the treatment of aggressive behaviour and behaviour problems of the severely retarded who lived in institutions.

Conclusion

As can be seen from these brief descriptions, mentally disordered offenders are a heterogeneous group. There are important differences both between and within diagnostic groups that are relevant to treatment. A general pattern of characteristics common to mentally disordered offenders can be identified. Most present a long history of difficulties, relating to both the primary mental disorder and antisocial behaviour. As adults seen in forensic settings, they present multiple problems, which include rather severe affective and cognitive deficits and poor life skills and social skills. Many of them, in addition, present a long history of substance abuse, a life-style conducive to deviant behaviour and a high risk of re-offending. Because of the severity and number of problems that they present, mentally disordered offenders tend to be difficult to assess. Often, if not usually, they are not interested in treatment and non-compliant. In general, they are difficult to manage, and both their mental health problems and their antisocial behaviour tend to be chronic (Eaves, Tien & Wilson, 1997). Treatment must include multiple components which target the different problems presented by the mentally disordered offender, it must be planned and organized in a long-term perspective, it must be intense and involve outreach (that is, clinicians must take responsibility for developing and ensuring compliance with treatment), and include close supervision.

ASSESSMENT OF RISK AND NEEDS

Those who undertake the task of treating mentally disordered offenders begin with an intensive two-part assessment of the patient. The first part involves assessing the risk of criminal and/or violent behaviours in the future. In the psychiatric literature this is referred to as ''predicting dangerousness''. As well as assessing the risk of future offending, the behaviours, cognitions and lack of skills that contribute to the offending are identified. This is necessary in order to design interventions that specifically and directly address the various problems. During the course of treatment, changes in the degree of risk and in the targets of treatment require periodic re-evaluation.

Repeated assessments during treatment measure progress. In contrast to the lack of empirical knowledge about effective interventions for reducing risk among mentally disordered offenders, there is a large and ever-growing body of literature on how to assess risk in this population.

The second component of the assessment focuses on the mental disorder and the associated problems, both acute and chronic, and also on characteristics of the patient that promote offending and/or violent behaviour.

At this stage all the information necessary for developing an individualized treatment programme is gathered. Multiple sources are tapped to gather the information, including interviews with the mentally disordered offender, tests that assess cognitive, behavioural and affective functioning, interviews with family and friends, and both mental health and criminal justice file information. Observation of the individual on an inpatient unit provides invaluable information.

Risk assessment

Clinicians treating mentally disordered offenders need to be familiar with procedures developed for the assessment of the risks of offending and/or violent behaviour. Such an assessment is necessary to determine whether or not treatment efforts designed to reduce recidivism are necessary at all. Further, the assessment of the risk of recidivism, which includes identifying situations which increase risk and those that decrease risk, is critical to determining the setting in which effective treatment can be provided and public safety protected. It has been demonstrated empirically that in order to assess accurately the risk of future criminal and/or violent behaviour, it is necessary to take account of actuarial data (historical information). Consequently, accurately documenting the history of antisocial behaviour is essential. The risk estimate based on actuarial data, it is thought, is modified only slightly by the addition of clinical information (Webster et al., 1994).

Instruments such as the Level of Service Inventory–Revised (LSI-R) (Andrews & Bonta, 1995), the Violence Prediction Scheme (Webster et al., 1994) and the HCR-20 (Douglas, 1999; Grann, Belfrage & Tengström, in press; Webster et al., 1997) have been shown to produce the most accurate predictions, and to be readily learned and applied by mental health professionals. The risk assessment has to be re-done whenever new information on the mentally disordered offender becomes available. Estimating the risk of reoffending and/or violent behaviour is often a time-consuming task because so much information is required from so many different sources. However, it has been clearly demonstrated that only by using multiple sources to reconstruct the history of the antisocial behaviour can valid estimates of risk be made. When assessing risk of potentially dangerous offender–patients, it is important to adopt an attitude of disbelief and scepticism: nothing should be taken at face value, all interview and file information must be cross-checked. While risk assessment is not the topic of this book, it is an integral part of effective treatment. Knowledge of the research in this area and the use of standardized, validated risk assessment instruments are essential for successful treatment of mentally disordered offenders.

Assessment of treatment needs

In order that the assessment provides all the information necessary for designing an individualized treatment programme, it focuses on symptoms and psychosocial problems, rather than on diagnoses. In addition, individual characteristics and/or situations that have been empirically related to criminal recidivism are identified. Treatment planning also requires an evaluation of individual characteristics that influence compliance and response to treatment (Andrews et al., 1990).

Two general categories of treatment needs are presented by mentally disordered offenders: (a) needs resulting from the specific deficits associated with a mental disorder; and (b) needs that have been identified as criminogenic (factors which promote or are associated with criminal behaviour). Once identified, these needs become treatment targets. Among mentally disordered persons, offending may be associated with a variety of psychological problems, neuropsychological deficits, dysfunctional cognitive processing and deviant interpersonal beliefs (Blackburn, 1997). Depending on the specific disorder, treatment needs can result from skill deficits, low intelligence and active symptoms, such as hallucinations, delusions, irritability and hyperactivity. In addition, the need for eliminating co-occurring substance abuse must be given a high priority, regardless of the other mental disorders that are present. Substance abuse not only increases the risk of offending and of violent behaviour, it decreases compliance with

all components of a treatment programme and in some disorders, for example the psychoses, it exacerbates symptoms (Swartz et al., 1998).

The assessment of risk and needs among mentally disordered offenders is not easy, as these patients are often uncooperative. Their motivation to complete assessments is usually rather low. When adequate time is available for observation and interviewing, most patients with major mental disorders, as well as those with severe intellectual deficits, usually present no serious problems for assessment. By contrast, those with personality disorders and delusional disorder can be difficult to assess accurately. This may be due to the presence of co-morbid disorders, and/or the reluctance of the patient to acknowledge symptoms, and/or the refusal of the patient to talk about his/her history and psychosocial functioning.

Mentally disordered offenders usually present multiple difficulties (Abram, 1989; Hodgins & Côté, 1995). Consequently, it is necessary to identify all the disorders that they have. Co-occurring disorders, especially substance use disorders and antisocial personality disorder, undermine treatment and increase the risk of recidivism (Borum et al., 1997; Swartz et al., 1998). These co-morbid disorders complicate treatment considerably, as they often interact negatively with the primary disorder. For example, while substance abuse exacerbates the symptoms of schizophrenia, schizophrenia makes placement in a drug rehabilitation programme impossible.

It must be noted that comprehensive assessments are not possible during an acute episode of a mental disorder. Best results are obtained when diagnoses are made by experienced clinicians using structured instruments during periods when there are no, or few, acute active symptoms. Thus, a period of treatment for the acute symptoms on an inpatient unit where there is no access to alcohol and drugs is usually essential.

Assessing criminogenic needs

It appears likely that the individual characteristics associated with antisocial behaviour among non-disordered offenders also play a role in the offending of those afflicted with mental disorders. Among non-disordered offenders, research has demonstrated that the most important risk factors include: pro-criminal attitudes, values, and beliefs; personal cognitive supports of crime (e.g. pro-criminal values, not considering the consequences of one's behaviour); pro-criminal friends and associates; inadequate socialization; impulsivity and/or a lack of self-control; restless aggressive energy; egocentrism; below-average verbal intelligence; a pattern of, and liking for, sensation seeking or novelty seeking; poor problem-solving skills; a history of antisocial behaviour from a young age, in a variety of settings and involving many different types of behaviour; criminality, mental disorder and

substance abuse in the family of origin; poor parenting, including little affection, caring and family cohesiveness, inadequate supervision, harsh and inconsistent discipline, neglect and abuse; and low levels of education and career success (Andrews & Bonta, 1994; Andrews, 1995). In order to design a treatment programme that is likely to succeed in modifying offending and/or violent behaviour and in providing the skills necessary to live in the community without offending, all of these characteristics have to be assessed.

Conclusion

Assessment is an integral part of treatment. The initial assessment provides the information necessary for the development of an individualized treatment programme. Repeated assessments provide measures of progress. The assessment of mentally disordered offenders involves gathering and verifying a great deal of historical information from multiple sources, as well as observation, testing and discussions with the patient. The first part of the assessment involves estimating the risk of future offending and/or violent behaviour. This part of the assessment is best conducted using standardized, validated instruments. In addition to providing a great deal of information on the patient's history, this part of the assessment determines in large part the setting in which treatment will be provided. The second part of the assessment focuses on identifying the numerous targets of treatment, as well as the limitations and strengths of the individual that need to be taken into account when developing and conducting treatment. The assessment is complicated not only because of the many different types of problems presented by mentally disordered offenders, but also by their lack of cooperation.

TREATMENT COMPONENTS THAT MAY PROVIDE A BASE FOR DEVELOPING EFFECTIVE TREATMENT PROGRAMMES

There is not much agreement among clinicians about what constitutes appropriate treatment for mentally disordered offenders. The problem is conceptualized in two distinct ways: the medical model identifies symptoms to be treated, while the psychological model identifies skill deficits and interventions designed to teach skills for avoiding difficulties in the future (Blackburn, 1997). There is currently little, or no, scientific literature on the effectiveness of comprehensive, multi-component treatment programmes for mentally disordered offenders. There are, however, three areas of study that provide an empirical basis for the development of such programmes.

These rather diverse, but highly relevant, areas of study provide knowledge about the initial ingredients for ''state-of-the-art'' treatment programmes (Harris & Rice, 1997; Müller-Isberner, 1998). The three areas of study are: (a) treatments and services for persons with major mental disorders that have been shown to be effective in reducing symptoms and increasing the level of psychosocial functioning; (b) rehabilitation programmes that have been shown to effectively reduce recidivism among non-disordered offenders; and (c) specialized forensic psychiatric community treatment programmes. Knowledge extracted from these different sources will be briefly reviewed.

The effective treatment of the major mental disorders

Effective services for persons with major mental disorders are comprehensive, with an emphasis on teaching and learning and enforcing compliance with medication. Comprehensive treatment programmes have been shown to reduce the number and severity of symptoms, improve the level of psychosocial functioning, and increase the patient's happiness and the public's safety. These important changes result from three components of treatment: medication, psychoeducation and case management.

Medication

There has been considerable progress in research on the pharmacological treatment of the primary symptoms of the major mental disorders and of aggressive behaviour, as described in Chapters 7 and 8. Appropriate medication taken on a long-term basis is one of the essential components of effective treatment for persons suffering from these disorders. The development of new medications has significantly improved the treatment of these patients. However, it is critical to remember that medication only improves one aspect of the problems presented by offenders with major mental disorders. Many patients resist taking medication, especially on a long-term basis, and therefore additional components of treatment designed to ensure compliance are required. A few of those afflicted with major mental disorders are unimproved by available medication. This usually leads to long-term hospitalization.

Life and social skills training and psychoeducation

The use of behavioural–psychoeducational methods to improve patients' skills has been an important development in the treatment of the major mental disorders (for review, see Mueser, Drake & Bond, 1997). Many

offenders with major mental disorders lack life skills (basic skills for personal hygiene, nutrition, looking after their living environment, using public transportation) and social skills (interacting in an appropriate manner with others, resolving conflicts without resorting to physical aggression, being sufficiently assertive to resist abuse by others). Psychoeducational interventions target social isolation and attempt to limit it through active interaction between the patient and the clinician. Opportunities for patients to share responsibility are offered. Specific contingency management techniques are used to teach patients with low levels of psychosocial functioning the behaviours necessary to allow them to leave the hospital and live in the community (Paul & Lentz 1977). Together with appropriately delivered medication, a combination of life skills, social skills and vocational training can lead to profound improvements (Benton & Schroeder, 1990; Liberman, 1988, 1992; Lukoff, Liberman & Nuechterlein, 1986; Payne & Halford, 1990; Wallace, 1993; Wallace & Liberman, 1985). All of these behavioural programmes focus on systematically providing positive consequences for independent, prosocial behaviours, while decreasing or eliminating reinforcements, generally attention, for dependent, symptomatic behaviour.

Skills training for patients' families provides information about major mental disorders, teaches them how to recognize and lessen stressors that may induce relapse, encourages acceptance of the patient, teaches effective communication and problem-solving skills, trains family members in the use of reward and encouragement as means to effect behaviour change, and teaches family members how to encourage compliance with medication and other components of treatment (Glick et al., 1990; Hogarty et al., 1991; Liberman, Falloon & Aitchison, 1984; Tarrier et al., 1989). Family skills training seems especially effective when implemented with families high in overinvolvement and criticism, and when provided continuously over a long period of time with refresher and consultation sessions (Liberman, 1988). The feasibility and effectiveness of intervening with the families of mentally disordered offenders remains to be demonstrated. However, the recent studies of Sue Estroff and her colleagues in the USA suggest that, in that country, mentally disordered persons often live with their families of origin and this environment contributes to both aggressive behaviour and victimization (Estroff et al., 1998).

Case management

Case management refers to the coordination, by a case manager, of the various components of a community treatment programme. Case managers help to ensure that patients comply with all the components of their individualized treatment programmes, and facilitate contacts with social service agencies to ensure adequate housing and income and, when

possible, appropriate employment. It is essentially an ''advocate and service broker'' model. Case management can also be provided by a team of individuals with sufficient expertise among them to provide all the necessary services. This is referred to as a ''full service and support'' model.

In order to be effective, case managers have to accept and respect patients' limitations. Putting too much pressure on them to get involved in interpersonal activities may trigger aggressive behaviour. Case management has been shown to be more cost-effective than traditional community support services and hospitalization (Bond et al., 1988; Hammaker, 1983; Rubin, 1992; Solomon, 1992; Solomon, Draine & Meyerson, 1994) These studies also suggest, however, that some case management services or styles have little, no, or even a negative impact on quality of life, symptoms, social adjustment and antisocial behaviour, compared to allowing patients to organize their own treatment. Most studies demonstrate that case management can reduce the frequency and duration of hospitalization (for review, see Mueser et al., 1997). Certain factors have been shown to be associated with case management that is effective. First, case management must be assertive. That is, effective case managers seek out their clients wherever they are in order to ensure compliance with all the components of the treatment programmes. Second, effective case management depends on the quality of the relationship between the case manager and the patient. Effective case managers tailor the intensity of the patients' social interactions to their fluctuating capacity to tolerate social stimulation. They give patients responsibility and permission to make some mistakes. They employ praise, reward, reinforcement and encouragement, rather than withdrawal, punishment and sanctions, in order to effect changes in behaviour. Third, effective case managers maintain long-term relationships with patients, either as individual clinicians or as small cohesive teams.

Conclusion

Thus, evaluation studies which demonstrate what are and what are not, effective treatments for persons with major mental disorders constitute the first domain of knowledge that is useful for developing treatment programmes for mentally disordered offenders in general. This literature highlights the importance of identifying the different types of problems presented by patients—cognitive symptoms, lack of emotional control, few life and social skills, the necessity of ensuring compliance with pharmacological treatments for reducing psychotic symptoms and for keeping them to a minimum over the long term, and for providing supervision and coordination of all the treatments and services deemed necessary for the patient. This is the first of the three sources of knowledge relevant to the development of effective treatment programmes for mentally disordered offenders.

The treatment of offenders

The second source of knowledge relevant to the development of effective treatment programmes for offenders with mental disorders is the large body of research on the rehabilitation of offenders (for review, see Andrews & Bonta, 1994; Gendreau, 1996; McGuire, 1995). The results of several meta-analyses are quite consistent in identifying positive crime prevention effects resulting from these interventions (for review, see Lösel, 1995). These analyses indicate that rehabilitation programmes lead to anywhere from a ''mild'' to a ''moderate'' reduction in recidivism. Taking account of the clinical appropriateness of the particular rehabilitation programme, the average correlation between the intervention and reduced recidivism reached 0.30. This indicates that psychologically appropriate treatment, as compared to control conditions, leads to a reduction of up to 50% in recidivism (Andrews et al., 1990; Lipsey, 1995).

The results of these meta-analyses demonstrate that the effective programmes were conducted in the community and that they were characterized by a high degree of structure and a behavioural or cognitive-behavioural orientation. In addition, treatment integrity was maintained. The staff were enthusiastic and the clients were at high risk to recidivate. Further, the effective programmes were multi-modal, targeting the many skill deficits presented by the offenders, and intensive, in terms of both the number of hours per day that clients were engaged in treatment-related activities and the overall length of programme. By contrast, punishment-based programmes, as well as client-centred casework and traditional psychotherapy, were shown to be considerably less effective. Some of these latter programmes were even shown to be harmful for certain offenders (McCord, 1978; Rice, Harris & Cormier, 1992) Finally, the meta-analyses provide little evidence to indicate that factors such as age, sex or race of the offender made a difference to treatment outcome.

Andrews and Bonta (1994) have developed a psychology of criminal conduct, which provides a conceptual basis for understanding, predicting and modifying criminal behaviour. They hypothesize that the factors which determine criminal conduct are not unlike those that determine all socially valued human behaviour (Andrews, 1995). The planning and delivery of effective offender rehabilitation involves taking account of individual differences in *risk*, *need* and *responsivity*. The *risk* principle suggests that intensive rehabilitation is best reserved for individuals at the highest risk for criminal conduct. This once more underlines the necessity of a comprehensive and valid risk assessment as a basis for designing any treatment programme. The *crimogenic need* principle suggests that the appropriate targets of treatment are those changeable characteristics of individuals and of their circumstances that have been demonstrated to be related to

criminal conduct. Andrews and his colleagues (1990) have identified the following intermediate targets for rehabilitation programmes: (a) *reducing* antisocial attitudes, antisocial feelings, antisocial friends and associates, chemical dependencies; (b) *increasing* affection for and communication with family members, monitoring and supervision by family members, identification with anti-criminal role models, self-control, self-management and problem-solving skills; (c) *replacing* the skills of lying, stealing and aggressive behaviour with more pro-social alternatives; (d) *modifying* the rewards and costs of criminal and non-criminal activities, so that non-criminal activities are preferred. In addition, it is necessary to provide some offenders with an undemanding, sheltered, supportive living arrangement. It is also necessary to change other attributes of offenders and their circumstances that individualized assessments of risk and need suggest are associated with criminal conduct. Finally, it is essential to teach the offender to recognize risky situations and to devise and rehearse with him/her a concrete plan for dealing with those situations (Andrews, 1995).

The *responsivity* principle suggests that approaches to treatment be matched to the intermediate targets (those targets listed above) and to the learning style of the individual offender. The most effective types of rehabilitation are based on learning theory, and they employ cognitive-behavioural and social learning techniques such as modelling, graduated practice, role playing, reinforcement, extinction, resource provision, concrete verbal suggestions and cognitive restructuring (Andrews, 1995). In order that these treatments are effective with offenders, establishing and maintaining the authority of staff is critical. Staff have to clearly and fairly distinguish between rules and requests and relate in open, enthusiastic and caring ways with the offenders. Staff must reinforce compliance with the various aspects of the rehabilitation programme, model and consistently reinforce anti-criminal thinking and behaviour and prosocial behaviours. Staff must design and implement the programme so that anti-criminal behaviour in settings such as home, school and work is increasingly rewarded (Andrews, 1995).

Conclusion

Knowledge of rehabilitation programmes that have been shown to be effective in reducing recidivism among offenders is the second source to be tapped in developing treatment programmes for mentally disordered offenders. Targeting individual characteristics—behaviours, cognitions, feelings—and situations that promote offending, and using behavioural and cognitive strategies to modify them, have proven to be effective. Not surprisingly, since the treatment is based on learning, individual capacities must be taken into account in planning the programme. Staff behaviour and

attitudes contribute to the success of these programmes. Notably, the programmes that were most effective were carried out in the community.

Evidence from specialized forensic psychiatric community treatment programmes

The third body of evidence that is relevant for developing effective treatment programmes for mentally disordered offenders is made up of a small number of evaluations of specialized community programmes for mentally disordered offenders. There are studies from Canada (Wilson, Tien & Eaves, 1995), Germany (Müller-Isberner, 1996) and the USA (Bloom, Williams & Bigelow, 1991; Heilbrun & Griffin, 1993; Wiederanders, 1992; Wiederanders, Bromley & Choate, 1997) which show that violence and crime can be prevented by assertive forensic psychiatric community programmes, even among mentally disordered offenders who are at high risk for re-offending.

Given the different legal and institutional frameworks in which these community programmes have been developed, it is surprising, but very encouraging, that they share a number of common features. The principal features common to the effective programmes include: (a) compulsory participation (ordered by a court or tribunal); (b) a recognition and acceptance by the mental health professionals who carry out the programme that they have a double mandate, which includes treating the mental disorder and preventing offending and/or violent behaviour; (c) legal powers for the mental health professionals to rapidly rehospitalize patients against their will if they think that they may offend and/or behave violently; (d) structure, intensity, and diversity to address the multiple problems presented by mentally disordered offenders; and (e) staff responsibility for ensuring compliance with all aspects of the programme.

As well as being more effective than residential programmes, community programmes offer another advantage. The close monitoring and intensive case management that are integral parts of these programmes provide opportunities for ongoing and frequent assessments of the patients' functioning, compliance with all of the components of treatment, and potential problems. In addition, such programmes have been demonstrated to be cost-effective (Bigelow, Bloom & Williams, 1990) and to have positive effects, not only in reducing offending and violent behaviour but also on the other problems presented by mentally disordered offenders (Wiederanders & Choate, 1994).

Conclusion

While there are currently few studies of comprehensive treatment programmes for mentally disordered offenders, there are three bodies of knowledge that provide information relevant for developing such programmes.

The first identifies three components of treatment that have been shown to be effective for the treatment of persons with major mental disorders—pharmacotherapy, psychoeducational training programmes and assertive case management. The second body of knowledge relevant to the development of treatment programmes for mentally disordered offenders includes the studies which have identified rehabilitation strategies that succeed in reducing recidivism among non-disordered offenders. The third relevant knowledge base includes the small number of specialized forensic community treatment programmes that have proved to be effective in limiting offending and/or violent behaviour. In order to develop comprehensive multi-component treatment programmes for mentally disordered offenders, it is necessary to modify and adapt knowledge from these three areas by taking account of the particularities of the provision of treatment for mentally disordered offenders. These include long-term compulsory treatment in high-security hospitals which may or may not be clinically indicated, an organizational structure that takes account of the characteristics and needs of the patients as well as the public's and the politicians' attitudes to mentally disordered offenders, and the difficulty of empirically demonstrating the effectiveness of treatment.

TREATMENT IN SECURE SETTINGS

The inpatient treatment of severely mentally disordered offenders is organized in some countries as part of the prison system (e.g. in Austria), in others as part of the mental health system (e.g. in Sweden), and in others in a government agency that is distinct from both the correctional and health systems (e.g. in Germany). Regardless of the system to which security hospitals belong, they all have a similar patient population and many common problems related to service delivery. Generally, the majority of the patients suffer from chronic disorders, and for many, finding a cure is an unrealistic goal. These patients present special problems related to their lack of motivation for treatment and multiple psychosocial deficits. Often, it is their offending and/or violent behaviour which makes transition to less restrictive environments hard to achieve. The goals of treatment in secure settings focus on symptom reduction, stabilization, and the development of life skills, social skills and skills to cope with stress, in an effort to enable these patients to move to less restrictive environments.

The delivery of service in security hospitals is plagued by several types of problems:

1. These institutions usually have no control over admissions and discharges. Consequently, overcrowding is frequent and leads to serious problems in maintaining the integrity of multi-modal treatment

programmes (Kerr & Roth, 1987). Unlike in general psychiatric hospitals, decisions about admission and discharge to security hospitals are influenced, at least to some extent, by concerns for public safety.

2. Secure hospitals admit and keep patients for whom no treatment can be provided.
3. Security hospitals are often disconnected from mainstream knowledge and clinical practice, and they have a tendency to develop a life of their own, in isolation from general mental health services. Consequently, they are often immune to external influence (e.g. to new evidence about an effective treatment that is published in the general psychiatric literature), expend too little effort in determining what needs to be done at the initial assessment stage, and fail to match patients to programmes adequately (Webster, Hucker & Grossman, 1993). A decade ago, Quinsey (1988) concluded that: ''Today, treatment programmes in secure psychiatric institutions are noteworthy primarily by their absence, poor implementation, unevaluated status, lack of conceptual sophistication, and incomplete description and documentation'' (p. 444). There is no evidence that fundamental and widespread changes have occurred since Quinsey evaluated the situation.
4. Security hospitals are often located in rural areas. Such a location facilitates the initial steps of programmes which gradually re-integrate patients into the community, but limits the final stages, which may include finding a job, appropriate housing and leisure activities. Further, the location of security hospitals often makes it difficult to integrate patients' families into the treatment programme. On the other hand, rural settings provide distinct advantages for the re-integration of patients. In rural settings patients are supervised informally, like it or not, by the local inhabitants. This informal supervision can be used positively, and in some cases it permits the patients more access to the community than would be possible in urban centres. Encouraging the patients to live in such rural areas after discharge, rather than returning to their old neighbourhoods, may help reduce both relapse and recidivism.
5. Secure hospitals have a tendency to block treatment efforts because staff consider security and order to be their priorities.
6. Security hospitals are places where the rejection and exploitation of severely ill patients occurs at the hands of patients with higher levels of psychosocial functioning. Therefore, secure hospital treatment should be reserved for those cases in which any less restrictive alternative presents a serious risk to public safety.

Despite all of these problems, large security hospitals, if organized properly, may be advantageous in that they can provide a variety of specialized treatment programmes. As described earlier, mentally disordered offenders are a highly heterogeneous group. Consequently, this diversity must be

reflected in the way security hospitals are organized. In order to provide different ward milieux adapted to the specific needs of particular types of patients, wards have to be specialized, admitting only patients of a certain type who present similar levels of risk and a similar needs profile. Both empirical and clinical strategies have been used to try and identify the subtypes of patients that are relevant to treatment in security hospitals. Quinsey, Cyr and Lavallé (1988) used cluster analyses of patient characteristics and identified seven types of patients in a security hospital in Ontario: good citizens, social isolates, personality disorders, institutional management problems, institutionalized psychotics, psychotics, and the mentally retarded. These same types were identified in a sample from a security hospital in Quebec. The practical implications and use of this typology for treatment planning and organization have been described (Harris & Rice, 1990; Rice et al., 1990). A clinically derived model of specialization in a secure hospital has also been described (Müller-Isberner & Jöckel, 1994). The implementation of specialized wards has been found to lead to remarkable changes inside a security hospital, including increased calmness on the wards, more structured treatment components, a reduction in the number of incidents, a reduction in the number of complaints by patients against staff, an increase in ward staff's identification with their work, and an improvement in long-term outcome (Müller-Isberner, 1993).

Maximum security hospitals are required to keep their patients for lengthy periods of time. While patients today usually stay in general psychiatric hospitals less then one month, patients admitted to secure hospitals may stay for a number of years. Although often hard to achieve over this long period of time, patient management must stay linked to individualized treatment programmes aimed at reintegration into the community.

Tensions and violence on wards result both from confinement in a close community of disordered persons and from symptoms of mental disorders. In some cases, seclusion and enforced medication are required. However, interventions by staff that are based on an understanding of the antecedents of disruptive behaviour can often prevent aggressive behaviours and thereby avoid the use of these rather drastic methods (Harris & Rice, 1992).

Institutional programmes have traditionally emphasized occupational and educational training in a highly structured environment. Interventions in security hospitals include group and individual psychotherapy, therapeutic communities, social skills training, anger management, problem-solving training, token economies and behavioural procedures for teaching life and social skills. In institutional settings, contingency management systems have proved to be effective for extinguishing cognitive symptoms and aggressive behaviour, for promoting pro-social, non-symptomatic behaviour, and for encouraging participation in behavioural and cognitive-behavioural training sessions.

As institutions tend to take responsibility away from patients, a structured concerted effort is necessary to allow patients gradually to assume more and more responsibility for themselves and their care.

During residential stays, risks and needs must be reassessed continuously. Gradually, the patient can be allowed more and more privileges. As patients are seen frequently, the assessment of the risk of future offending and violent behaviour is made for short periods. These predictions for limited periods of time and in clearly defined situations tend to be quite valid (Gretenkord & Müller-Isberner, 1991).

Treatment is by no means finished when symptoms are under control and life skills have been learned. The task is then to identify an environment into which the patient can be safely discharged. Careful evaluation of the patient before and during treatment will enable staff to define the sorts of environment in which he/she will likely comply with treatment and refrain from antisocial behaviour. However, sometimes it is hard to convince the patient that not any place is a good place for him/her, that long-term medication is essential, and that treatment and supervision while living in the community is both necessary and inevitable.

As patients who have been treated in high-security hospitals are highly unpopular in general psychiatric services, attempts to transfer them to less secure facilities often fail. This is usually due to a reluctance by general psychiatric staff and administrators to accept patients with criminal records of severe violence. Even when transfers are made, patients are often returned to the security hospital because of aggressive behaviour, hostility or a low level of functioning. For example, one study found that a history of long-term care and assaultiveness in hospital were negatively related to successful referral from a security hospital to general psychiatric services, and that other clinical variables and the history of offending played no role (Brown, Shubsachs & Larkin, 1992). As noted above, conditional release with court-ordered participation in a community treatment programme has been shown to be effective and less costly than prolonged detention for many chronically disordered offenders. It is likely that such programmes will grow in number and provide the follow-up to inpatient care in a security hospital. However, the evaluations of the effective community programmes suggest that rapid access to inpatient wards for short periods is necessary to prevent both relapse and recidivism. The security hospital may be the most appropriate setting for such re-admissions.

Conclusion

In adapting what has been learned about the effective treatment of persons with major mental disorders, the successful rehabilitation of offenders and

specialized community programmes that reduce recidivism, to developing comprehensive multi-modal treatment programmes for mentally disordered offenders, it is necessary to take account of the fact that many of these patients are treated in security hospitals. The decision to send the patient to a security hospital is usually not made by mental health professionals, neither is the determination of the length of stay. In addition to the fact that treatment staff in these institutions cannot make decisions about either admission or discharge, many other problems have historically plagued these institutions. However, large security hospitals provide the advantage of being able to provide a variety of specialized programmes adapted to the needs of the different types of mentally disordered offenders.

ORGANIZATION OF SERVICES FOR MENTALLY DISORDERED OFFENDERS

Staff

The importance of the ''human factor'' cannot be over-estimated in the treatment of mentally disordered offenders. In selecting staff, regardless of their specific role, important selection criteria include the ability to keep a distance from the patients and not to get over-involved in their problems, while being caring, empathic and enthusiastic about the prospects of recovery. The education and training of front-line staff who actually do most of the treatment is essential for success. They must be specifically trained for the tasks that they will carry out, for example, in understanding, setting up and managing behavioural and cognitive-behavioural interventions, psycho-educational training techniques, and strategies to anticipate, prevent and manage aggressive behaviour. Those involved with the patient need a clear understanding of the patient's problems and limitations, and how these may affect behaviour and functioning. Staff members should interact frequently with patients and model pro-social values and non-aggressive ways of resolving conflicts. They must try to be empathetic, while at the same time firmly but fairly enforcing the rules. Staff must understand that a patient's antisocial behaviour is not necessarily deliberately rebellious but simply uncontrolled. Those who appear to contradict rules without regard for the consequences, and in spite of repeated warnings, may simply be unable to inhibit certain behaviours. Stability of staff and clarity of their roles and purpose are other factors which are critical for success. Staff shortages and frequent changes in staff threaten the integrity of the treatment programme. It has been shown that a disciplined ward regime leads to more positive change in cognitive and social functioning and less offending than

do therapeutic communities or programmes which focus on education and counselling (Craft & Craft, 1984). In sum, front-line staff have to be sufficiently stable and strong themselves to cope with mentally disordered offenders, they have to be adequately and appropriately trained for the jobs they are required to do, they have to be supervised, and they have to be supported. Acknowledging their competencies and successes and providing support is especially important for those who work with antisocial offenders. These patients frequently make complaints about staff and make appeals to the courts and various government agencies complaining about their treatment. While the accusations all have to be thoroughly investigated, staff must be actively supported by their superiors when the accusations are shown not to be true.

The specialists, in most cases psychiatrists and psychologists, assess the patient and then design and direct the individualized treatment programme. They provide the leadership for the multidisciplinary treatment team and this requires intelligence, enthusiasm, clarity of purpose, communication skills, sincerity, emotional stability and courage (Harris & Rice, 1997). These specialists also work individually with each patient in an effort to explain the nature of their disorders, symptoms, deficits and behaviour patterns. In order for treatment to be successful, it is necessary that patients accept the conclusions drawn by staff after the initial assessment and also the individualized treatment programme that has been developed on the basis of these conclusions. Helping patients to understand is a challenge requiring considerable clinical skill and a sympathetic acceptance of patients' limitations. It has been shown to be an essential ingredient of successful treatment (Sellars, Hollin & Howells, 1993).

Funding, support and protection

Those who conduct treatment for mentally disordered offenders have to take care of the bureaucratic and political environment. It is their task to care for those who provide the resources. Administrators must ensure coordination between mental health services, correctional services, social services who provide housing and income, educational services, and all of the other agencies who may be involved with the patients. The idea of treating mentally disordered offenders does not sell itself! Both residential and community programmes need administrators who are supportive and knowledgeable in dealing with the legislature and governmental agencies who provide funding. As treatment programmes for mentally disordered offenders need to be intensive and long-lasting, adequate long-term funding must be assured. Consequently, programme directors and administrators must provide information to senior bureaucrats, agencies and law makers

that will ensure continuous adequate financing. To ensure this stable funding, they must establish good contacts with the public, disseminating the idea that treatment leads to a reduction in crime.

The notion that mentally disordered offenders should and can be treated requires advocacy. This means that those working in the field need to spend some of their time educating policy makers and those who make decisions about funding. The returns on the investment need to be stressed. Convincing the political decision makers that the treatment of mentally disordered offenders is cost-effective is probably the best way to ensure long-term, adequate funding. It is important not to oversell treatment. Offender treatment is not a cure for criminality. Rather, the accumulated evidence suggests that treatment can lead to small or moderate reductions in recidivism rates. These are significant, however, as even small reductions in the number and severity of crimes that are committed have important human and financial implications.

Recidivism discredits treatment. When offences are committed by patients, it is important to deal adequately with the media in order to limit the damage that the event can do in undermining treatment for all mentally disordered offenders. Madness, violence, sex and crime is a mixture that inevitably attracts attention. Mentally disordered offenders combine characteristics that provoke fears and fantasies of mystery, magic and demons. This public reaction results in a serious threat to the provision of services for all mentally disordered offenders. Therefore, when a patient re-offends, an organized, structured and strongly worded public response must be made rapidly. The best strategy may be to contact editors and journalists who have a sense of responsibility and an understanding of the enormous powers that the media have to influence public opinion and decision makers, and to provide them with the information necessary to put the offence in a larger context. It is important to provide them with statistics on recidivism of similar types of offenders, comparing treated and untreated cases. Additionally, it is essential to make clear that treatment staff always consider public safety in making decisions regarding their patients and that they do not ally with patients against the public. Hopefully, providing such information will encourage journalists to report and discuss the incident in a way that is supportive of on-going treatment programmes.

Outcomes

In order to improve the effectiveness of treatment and to ensure accountability and continued funding, a four-step programme of evaluation is required. The first step involves systematizing, structuring and making usable all the information that is collected during the initial assessment of the

patient. The second step involves measuring the impact of each component of the treatment programme. For example, nurses rate symptoms on standardized, validated scales before and while the patient takes a particular medication or a particular combination of medications, the number of incidents of aggressive behaviour is documented in the week preceding and during the time a patient takes a medication which is supposed to reduce his/her aggressive behaviour, life skills are measured before, at the end and several months after a life skills training programme. The third step involves identifying how the various treatment components should be organized in order to maximize their effectiveness. The fourth step in the evaluation measures the impact of the treatment programme as a whole by following patients in the community and documenting relapse and recidivism. This is the only way that the programmes can be improved and that accountability is assured. Such information is seldom tabulated as a matter of routine. This means that clinicians and administrators of treatment programmes for mentally disordered offenders rarely receive accurate feedback about the impact of their work. Consequently, they have no empirical basis for modifying treatment programmes.

Although many mentally disordered offenders do achieve adequate levels of recovery, as measured by lower levels of offending and/or violent behaviour, this clinical fact is not reflected in the scientific literature. As the subsequent chapters in this book document, there are remarkably few studies demonstrating a positive effect of either a treatment programme or a specific component of a treatment programme. In 1993, Webster and his colleagues asked:

> . . . whether it is the clinicians who cannot do the job or the researchers who cannot or will not amass disinterested evidence to show what in fact clinicians can and cannot do for schizophrenic, mood-disordered, and organically impaired forensic patients and offenders (p. 88).

ETHICAL ISSUES

Mental health treatment services provided to mentally disordered offenders must be designed, directed and carried out by sensitive and psychologically informed clinicians. All aspects of treatment, and their application to individual cases, must be legal, ethical, decent and cost-effective. Although mental health professionals and their organizations cannot shoulder responsibility either for the inevitable ethical dilemmas in which they find themselves, or for the establishment of questionable policies, they need to be sensitive to and concerned about some problematic implications of their roles and functions. Some special ethical and policy dilemmas associated

with the handling of mentally disordered offenders can be identified (for a broader discussion, see Shah, 1993).

Mental health professionals do not function as agents of the patients when they provide services in coercive contexts and for purposes other than the well-being of the patient. In these situations, other parties (the mental health and criminal justice systems) and interests (public safety) are also involved. It is seldom clear, in such situations, precisely where health professionals' allegiances and obligations lie and to what extent patients have been informed about these matters. Ethical principles require that mental health professionals provide such information to patients before initiating assessment and treatment. Another conflict arises from the combination of the roles of therapist and evaluator, for example in assessing a patient's readiness for discharge.

When mental health professionals are not functioning primarily as agents of their patients, the usual assumptions and understandings about confidentiality do not apply. The mental health professionals are required, for example, to submit progress reports to courts and/or legal tribunals. Again, considerations of fundamental fairness require that patients be informed about the nature and limits of confidentiality in each particular context.

When mental health professionals work with forensic patients, they have a professional and ethical obligation to educate themselves about the relevant legal issues and their implications for service provision. A related concern is when mental health professionals go beyond providing information about the patient's status, and draw conclusions about issues that are the domain of the courts or of a particular legal tribunal. In so doing, they take over the roles and responsibilities that belong to those who are designated to make decisions.

While certain decisions about the patients are made by persons other than the treating clinicians, in many jurisdictions treatment providers have considerable powers to decide about levels of security. For example, the lowest security level which can be decided by staff may differ little from actual discharge. While public safety is a dominant concern, the rights of patients must also be recognized.

Some ethical dilemmas result from the fact that some interventions (e.g. medication) may increase the likelihood of the most desired outcome (no criminal recidivism), while at the same time worsening others (decrease in happiness and quality of life). Again, this issue has to be discussed openly with the patient.

A mental disorder combined with a high risk of recidivism can lead to extended, and in some cases even indeterminate, periods of institutionalization. Being sent by the criminal court to the mental health system for treatment often involves longer periods of confinement in security hospitals than if the offender had been convicted and sentenced to prison. This situation

poses problems for administrators and clinicians who work within these institutions because the length of time the patient is detained cannot be justified on clinical grounds. The ethical dilemma is further complicated when adequate treatment resources are not available and/or when treatment has never been shown to have a positive effect or has been shown to have a negative impact, for example, in the case of psychopaths (Rice, Harris & Cormier, 1992). In these cases, diversion to the mental health system often means incapacitation or preventive detention in which containment rather than treatment is the primary goal.

CONCLUDING REMARKS

While there is currently no empirical base for the treatment of mentally disordered offenders, components of treatment that have been shown to be effective for a number of the problems presented by mentally disordered offenders have been identified. Modifying and adapting these interventions, organizing them as parts of long-term treatment and management programmes and evaluating the impact, is the challenge of the next decade. This challenge requires the collaboration of policy makers, administrators, clinicians and researchers. As Lipsey (1995) has shown, collaboration between clinicians and researchers leads to increased efficacy of treatment. Furthermore, collaboration ensures that service providers are not marginalized from new developments and that scientists become more aware of the practical problems of establishing treatment programmes and of maintaining their integrity.

REFERENCES

Abram, K. M. (1989). The effect of co-occurring disorders on criminal careers: interaction of antisocial personality, alcoholism, and drug disorders. *International Journal of Law and Psychiatry*, **12**, 133–148.

Andrews, D. (1995). The psychology of criminal conduct and clinical criminology. In L. Stewart L. Stermac & C. Webster (Eds), *Clinical Criminology: Toward Effective Correctional Treatment* (pp. 130–150). Toronto: Correctional Service of Canada.

Andrews, D. A. & Bonta, J. L. (1994). *The Psychology of Criminal Conduct*. Cincinnati, OH: Anderson.

Andrews, D. A. & Bonta, J. L. (1995). *The Level of Service Inventory Revised*. Toronto: Multi-Health Systems.

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.

Benton, M. K. & Schroeder, H. E. (1990). Social skills training with schizophrenics: a meta-analytic evaluation. *Journal of Consulting and Clinical Psychology*, **58**, 741–747.

Bierut, L. J., Dinwiddie, S. H. Begleiter, H., Crowe R. R., Hesselbrock, V., Nurnberger, J. I., Porjesz, B., Schuckit, M. A. & Reich, T. (1998). Familial transmission of substance dependence: alcohol, marijuana, cocaine, and habitual smoking. *Archives of General Psychiatry*, **55**, 982–988.

Bigelow, D. A., Bloom, J. D. & Williams, M. H. (1990). Costs of managing insanity acquittees under a psychiatric security review board system. *Hospital and Community Psychiatry*, **41**, 613–614.

Blackburn, R. (1997). Mentally disordered offenders. In C. Hollin (Ed.), *Working with Offenders. Psychological Practice in Offender Rehabilitation* (pp. 119–149) Chichester: Wiley.

Bloom, J. D., Williams, M. H. & Bigelow, D. A. (1991). Monitored conditional release of persons found not guilty by reason of insanity. *American Journal of Psychiatry*, **148**, 444–448.

Bond, G. R., Miller, L. D., Krumwied, R. D. & Ward, R. (1988). Assertive case management in three CMHCs: a controlled study. *Hospital and Community Psychiatry*, **39**, 411–418.

Borum, R., Swanson, J., Swartz, M. & Hiday, V. (1997). Substance abuse, violent behavior, and police encounters among persons with severe mental disorders. *Journal of Contemporary Criminal Justice*, **13**, 236–250.

Brennan, P. A., Mednick, S. A. & Hodgins, S. (1998). Psychotic disorders and criminal violence in a total birth cohort (manuscript submitted for publication).

Brown, S., Shubsachs, A. & Larkin, E. (1992). Outcome of referrals from Rampton Hospital to local mental health services, 1988–1990. *Journal of Forensic Psychiatry*, **3**, 463–475.

Clare, I. H. C. & Gudjonsson, G. H. (1993). Interrogative suggestibility, confabulation and acquiescence in people with mild learning disabilities (mental handicap): implications for reliability during police interrogations. *British Journal of Clinical Psychology*, **32**, 295–301.

Clare, I. H. C. & Gudjonsson, G. H. (1995). The vulnerability of suspects with intellectual disabilities during police interviews: a review and experimental study of decision-making. *Mental Handicap Research*, **8**, 110–128.

Cooke, D. J. (1997). Psychopaths: oversexed, overplayed but not over here? *Criminal Behaviour and Mental Health*, **7**(3), 3–11.

Cooke, D., Forth, A. & Hare, R. D. (Eds) (1998). *Psychopathy: Theory, Research and Implications for Society.* Dordrecht: Kluwer Academic.

Côté, G., Hodgins, S. & Toupin, J. (in press). Psychopathie: prévalence et spécificité clinique. In T. H. Pham (Ed.), *Psychopathie Théorie et Recherche*. Lille Presses Universitaires du Septentrion.

Craft, M. & Craft, A. (Eds) (1984). *Mentally Abnormal Offenders.* London: Baillière Tindall.

Crocker, A. G. & Hodgins, S. (1997). The criminality of non-institutionalized mentally retarded persons: evidence from a birth cohort followed to age 30. *Criminal Justice and Behavior*, **24**, 432–454.

Douglas, K. (1999). HCR-20 Violence risk assessment scheme: Overview, and annotated bibliography. Unpublished manuscript, Simon Fraser University.

Eaves, D., Tien, G. & Wilson, D. (1997). A systems approach to the management of impulsive behaviour. In C. Webster & M. Jackson (Eds). *Impulsivity* (pp. 409–433). New York: Guilford.

Estroff, S. E., Swanson, J. W., Lachicotte, W. S., Swartz, M. & Bolduc, M. (1998). Risk reconsidered: targets of violence in the social networks of people with serious psychiatric disorders. *Social Psychiatry and Epidemiology*, **33**(1), 95–101.

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

Glick, I. D., Spender, J. H., Clarkin, J. F., Haas, G. L., Lewis, A. B., Peyser, J., DeMane, Good-Ellis, M., Harris, E. & Lestelle, V. (1990). A randomized clinical trial of inpatient family intervention. IV. Follow-up results for subjects with schizophrenia. *Schizophrenia Research*, **3**, 187–200.

Grann, M., Belfrage, H. & Tengström, A. (in press). Actuarial assessment of risk for violence: predictive validity of the VRAG and the historical part of the HCR-20. *Criminal Justice and Behavior*.

Gretenkord, L. & Müller-Isberner, R. (1991). Entweichungen aus dem Maßregelvollzug—Analyse eines Symptoms. *Monatsschrift für Kriminologie und Strafrechtsreform*, **74**, 305–315.

Hammaker, R. (1983). A client outcome evaluation of the statewide implementation of community support services. *Psychosocial Rehabilitation Journal*, **7**, 1–10.

Hare, R. D. (1991). *Manual for the Hare Psychopathy Checklist-Revised*. Toronto: Multi-Health Systems.

Harris, G. T. & Rice, M. E. (1990). An empirical approach to classification and treatment planning for psychiatric inpatients. *Journal of Clinical Psychology*, **46**, 3–14.

Harris, G. T. & Rice, M. E. (1992). Reducing violence in institutions: maintaining behavior change. In R. Peters, R. J. McMahon & V. L. Quinsey (Eds), *Aggression and Violence Throughout the Life Span* (pp. 261–282). Newbury Park, CA: Sage.

Harris, G. & Rice, M. (1997). Mentally disordered offenders: what treatment research says about effective service. In C. Webster & M. Jackson (Eds), *Impulsivity* (pp. 361–393). New York: Guilford.

Heilbrun, K. & Griffin, P. (1993). Community-based forensic treatment of insanity aquittees. *International Journal of Law and Psychiatry*, **16**, 133–150.

Hodgins, S. (1996). The major mental disorders: new evidence requires new policy and practice. *Canadian Psychology*, **37**, 95–111.

Hodgins, S. (1998). Epidemiological investigations of the associations between major mental disorders and crime: methodological limitations and validity of the conclusions. *Social Psychiatry and Epidemiology*, **33**(1), 29–37.

Hodgins, S. & Côté, G. (1995). Major mental disorder among Canadian penitentiary inmates. In L. Stewart, L. Stermac & C. Webster (Eds), *Clinical Criminology: Toward Effective Correctional Treatment* (pp. 6–20). Toronto: Solliciteur Général et Service Correctionnel du Canada.

Hodgins, S., Côté, G. & Toupin, J. (1998). Major mental disorders and crime: an etiological hypothesis. In D. Cooke, A. Forth & R. D. Hare (Eds), *Psychopathy: Theory, Research and Implications for Society.* (pp. 231–256). Dordrecht: Kluwer Academic.

Hodgins. S., Lapalme. M. & Toupin, J. (in press). Criminal activities and substance use of patients with major affective disorders and schizophrenia: a two year follow-up. *Journal of Affective Disorders*.

Hodgins, S., Mednick, S. A., Brennan, P., Schulsinger, F. & Engberg, M. (1996). Mental disorder and crime: evidence from a Danish birth cohort. *Archives of General Psychiatry*, **53**, 489–496.

Hogarty. G. E., Anderson, C. M., Reiss, D. J., Kornblith, S. J., Greenwald, D. P., Ulrich, F. & Carter, M. (1991). Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia. *Archives of General Psychiatry*, **48**, 340–347.

Kerr, C. A. & Roth. J. A. (1987). *Survey of Facilities and Programs for Mentally Disordered Offenders* (DHHS Publication No. (Adm) 86–1493). Washington, DC: National Institute of Mental Health, US Department of Health and Human Services.

Kessler et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry*, **51**, 8–19.

Lappalainen, J., Long, J. C., Eggert. M., Ozake, N., Tobin, R. W., Brown, G. L., Naukkarinen, H., Virkkunen, M., Linnoila, M. & Goldman, D. (1998). Linkage of antisocial alcoholism to the serotonin 5-HT_{1B} receptor gene in two populations. *Archives of General Psychiatry*, **55**, 989–995.

Liberman, R. P. (1988). Behavioral family management. In R. P. Liberman (Ed.), *Psychiatric Rehabilitation of Chronic Mental Patients* (pp. 200–244). Washington, DC: American Psychiatric Press.

Liberman, R. P. (1992). Future prospects for psychiatric rehabilitation. In R. P. Liberman (Ed.), *Handbook of Psychiatric Rehabilitation* (pp. 317–325). New York: Macmillan.

Liberman, R. P., Falloon I. R. & Aitchison, R. A. (1984). Multiple family therapy for schizophrenia: a behavioral, problem-solving approach. *Psychosocial Rehabilitation Journal*, **7**, 60–77.

Lipsey, M. W. (1995). What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents? In J. McGuire (Ed.), *What Works: Reducing Reoffending* (pp. 63–78). Chichester: Wiley.

Lösel, F. (1995). The efficacy of correctional treatment: a review and synthesis of meta-evaluations. In J. McGuire (Ed.), *What Works: Reducing Reoffending* (pp. 79–111). Chichester: Wiley.

Lukoff, D., Liberman, R. P. & Nuechterlein, K. (1986). Symptom monitoring in the rehabilitation of schizophrenic patients. *Schizophrenia Bulletin*, **12**, 578–602.

McCord, J. (1978). A thirty-year follow-up of treatment effects. *American Psychologist*, **33**, 284–289.

McGuire, J. (1995). *What Works: Reducing Reoffending*. Chichester: Wiley.

Merikangas, K. R., Stolar M., Stevens D. E., Goulet J., Preisig M. A., Fenton B., Zhang H., O'Maley, S. S. & Rounsaville, B. J. (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry*, **55**, 973–979.

Müller-Isberner, R. (1993). Managing insane offenders. *International Bulletin of Law & Mental Health*, **4**, 28–30.

Müller-Isberner, R. (1996). Forensic psychiatric aftercare following hospital order treatment. *International Journal of Law and Psychiatry*, **19**, 81–86.

Müller-Isberner, R. (1998). Ein differenziertes Behandlungskonzept für den psychiatrischen Massregelvollzug. Organisationsfragen und methodische Aspekte. In E. Wagner & W. Werdenich (Eds), *Forensische Psychotherapie* (pp. 197–209). Vienna: Facultas Universitätsverlag.

Müller-Isberner, R. & Jöckel, D. (1994). Differenzierte Kriminaltherapie. *Krankenhauspsychiatrie*, **5**, 170–172.

Mueser, K. T., Drake, R. E. & Bond, G. R. (1997). Recent advances in psychiatric rehabilitation for patients with severe mental illness. *Harvard Review Psychiatry*, **5**, 123–137.

Paul, G. L. & Lentz R. J. (1977). *Psychosocial Treatment of Chronic Mental Patients: Milieu versus Social Learning Programs*. Cambridge, MA: Harvard University Press.

Payne, P. V. & Halford, W. K. (1990). Clinical section: social skills training with chronic schizophrenic patients living in community settings. *Behavioural Psychotherapy*, **18**, 49–64.

Prins, H. (1993). Service provision and facilities for the mentally disordered offender. In K. Howells & C. R. Hollins (Eds), *Clinical Approaches to the Mentally Disordered Offender* (pp. 35–67). Chichester: Wiley.

Quinsey, V. L. (1988). Assessment of the treatability of forensic patients. *Behavioural Sciences and the Law*, **6**, 443–452.

Quinsey, V. L., Cyr, M. & Lavallé, Y. J. (1988). Treatment opportunities in a maximum security psychiatric hospital: a problem survey. *International Journal of Law and Psychiatry*, **11**, 179-194.

Rice, M. E., Harris, G. T. & Cormier C. (1992). Evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered of fenders. *Law and Human Behavior*, **16**, 399–412.

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*, Vol. 51 (pp. 162–230). Elmsford, NY: Pergamon.

Robins, L. N., Tipp, J. & Przybeck, T. (1991). Antisocial personality: the diagnosis. In L. N. Robins & D. A. Regier (Eds), *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study* (pp. 258–290). New York: Free Press.

Rubin, A. (1992). Is case management effective for people with serious mental illness? A research review. *Health and Social Work*, **17**, 138–150.

Sellars, C., Hollin, C. & Howells, K. (1993). Mental illness neurological and organic disorder, and criminal behaviour. In K. Howells & C. R. Hollins (Eds), *Clinical Approaches to the Mentally Disordered Offender* (pp. 71–86). Chichester: Wiley.

Shah, S. A. (1993). A clinical approach to the mentally disordered offender: an overview and some major issues. In K. Howells & C. R. Hollin (Eds), *Clinical Approaches to the Mentally Disordered Offender* (pp. 211–236). Chichester: Wiley.

Solomon, P. (1992). The efficacy of case management services for severely mentally disabled clients. *Community Mental Health Journal*, **28**, 163–180.

Solomon, P., Draine, J. & Meyerson, A. (1994). Jail recidivism and receipt of community mental health services. *Hospital and Community Psychiatry*, **45**, 793–797.

Swartz, M. S., Swanson, J. W., Hiday, V. A., Borum, R., Wagnes, R. & Burns, B. J. (1998). Taking the wrong drugs: the role of substance abuse and medication noncompliance and violence among severely mentally ill individuals. *Social Psychiatry & Psychiatric Epidemiology*, **33**(1), S75–80.

Tarrier, N., Barrowclough, C., Vaughn, C., Bamrah, J., Porceddu, K., Watts, S., & Freeman, H. (1989). Community management of schizophrenia: a two year follow-up of a behavioural intervention with families. *British Journal of Psychiatry*, **154**. 625–628.

Veijola, J., Räsänen, P., Isohanni, M. & Tiihonen, J. (1996). Low incidence of mania in Northern Finland. *The British Journal of Psychiatry*, **168**, 520–521.

Wallace C. J. (1993). Psychiatric rehabilitation. *Psychopharmacology Bulletin*, **29**, 537–548.

Wallace, C. J. & Liberman, R. P. (1985). Social skills training for patients with schizophrenia: a controlled clinical trial. *Psychiatry Research*, **15**, 239–247.

Webster, C. D., Hucker, S. J. & Grossman, M. G. (1993). Clinical programmes for mentally ill offenders. In K. Howells C. R. Hollins (Eds), *Clinical Approaches to the Mentally Disordered Offender* (pp. 87–109). Chichester: Wiley

Webster, C. D., Harris, G. T., Rice, M. E., Cormier, C. & Quinsey, V. L. (1994). *The Violence Prediction Scheme: Assessing Dangerousness in High Risk Men.* Toronto: University of Toronto, Centre of Criminology.

Webster, C. D., Douglas, K. S., Eaves, D. & Hart, S. D. (1997). *HCR-20. Assessing the Risk of Violence, Version 2*. Burnaby: Simon Fraser University and British Columbia Forensic Services Commission.

Weissman, M. M., Bland, R. C., Canino G. J., Faravelli, C., Greenwald, S., Hwu, H.-G. Joyce, P. R., Karam, E. G., Lee, C. K., Lellouch, J., Lépine J.-P., Newman, S. C., Rubio-Stipec, M., Wells, J. E., Wickramaratne, P. J., Wittchen, H.-U. & Yeh, E.-K. (1996). Cross-national epidemiology of major depression and bipolar disorder. *Journal of the American Medical Association*, **276**(4), 293–299.

Wiederanders, M. (1992). Recidivism of disordered offenders who were conditionally vs. unconditionally released. *Behavioral Sciences and the Law*, **10**, 141–148.

Wiederanders, M. R. & Choate P. A. (1994). Beyond recidivism: measuring community adjustments of conditionally released insanity acquittees. *Psychological Assessment*, **6**, 61–66.

Wiederanders, M., Bromley, D. & Choate, P. (1997). Forensic conditional release programs and outcomes in three states. *International Journal of Law and Psychiatry*, **20**, 249–257.

Wilson, D., Tien G. & Eaves, D. (1995). Increasing the community tenure of mentally disordered offenders: an assertive case management program. *International Journal of Law and Psychiatry*, **18**, 61–69.