# Forensic psychiatry: risk and recovery, resources and research

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# What is forensic psychiatry?

- Provision of largely tertiary health services
- For people who have already shown a capacity for serious harm to others
- And often to themselves
- And who, commonly, others have harmed/will harm
- Who have serious mental disorders – often two or three or more – and poor physical health


- We must have specialist training
- The services must interact effectively with a range of other agencies, especially in the criminal justice system
- We must have high calibre research

# What are we good at?

- Engaging with hard to reach people with psychosis and other mental health problems
- Treatment of psychosis in the context of other mental disorders
- Tertiary prevention of harm to others while individuals remain in our care

# What are we less good at?

- Primary prevention of harm to others
- Serious impact outside our services
- Research and real innovation

# CONTAINMENT AND REDUCTION OF RISK

# The nature of risk

Adams, 1995

- They are all guessing; if they knew for certain, they would not be dealing with risk
- Human behaviour will always be unpredictable; it will always be responsive to human behaviour - including yours

- Can we know the risks we face? No, but we must act as if we do. So,
  - ❖Some act, knowing their knowledge is partial and conditional
  - ❖Others divert from how to act in uncertainty by focusing on the impossible - removing uncertainty
    1. in beliefs, conjuring certainty out of ignorance
    2. in science, as if uncertainty is temporary, surmountable by research

# What risks?

## To others

- active physical harm to others
- Fire setting
- reckless harm/ omission errors
- other harm - accusations, threats, provocation

## To self

- self harm
- exploitation
- revenge attacks
- substance misuse
- poor treatment compliance
- physical illness
- absconding
- media interest

# The risks of risk assessment

# Effectiveness of actuarial risk assessments: group comparisons Buchanan & Leese, 2001

- included *prediction* studies with original data
  in peer reviewed journals since 1970-2000
  clinical judgement or statistically derived rating of dangerousness
  sensitivity and specificity could be calculated
- 21 studies
- overall sensitivity 0.52 (0.42-0.73) – i.e. for every 10 people who would be violent 5 would be identified and 5 missed
- overall specificity 0.68 (0.59-0.76) – i.e. 6 people must be detained to prevent one from acting violently during that year

(assuming a base rate of violence of 9.5%)

# Use of risk assessment instruments to predict violence Fazel et al, 2012

- Search: January 1995-January 2011
- 'replication studies' of nine most commonly used tools in clinical practice
- 73 samples, 24,827 people, 13 countries
- Of those judged to be at moderate-high risk of given behaviour:
  - ✓ 41% people at violence risk went on to offend violently
  - ✓23% people at sexual risk went on to offend sexually
  - ✓52% generic risk went on to commit any offence
  - ✓False negatives <10%

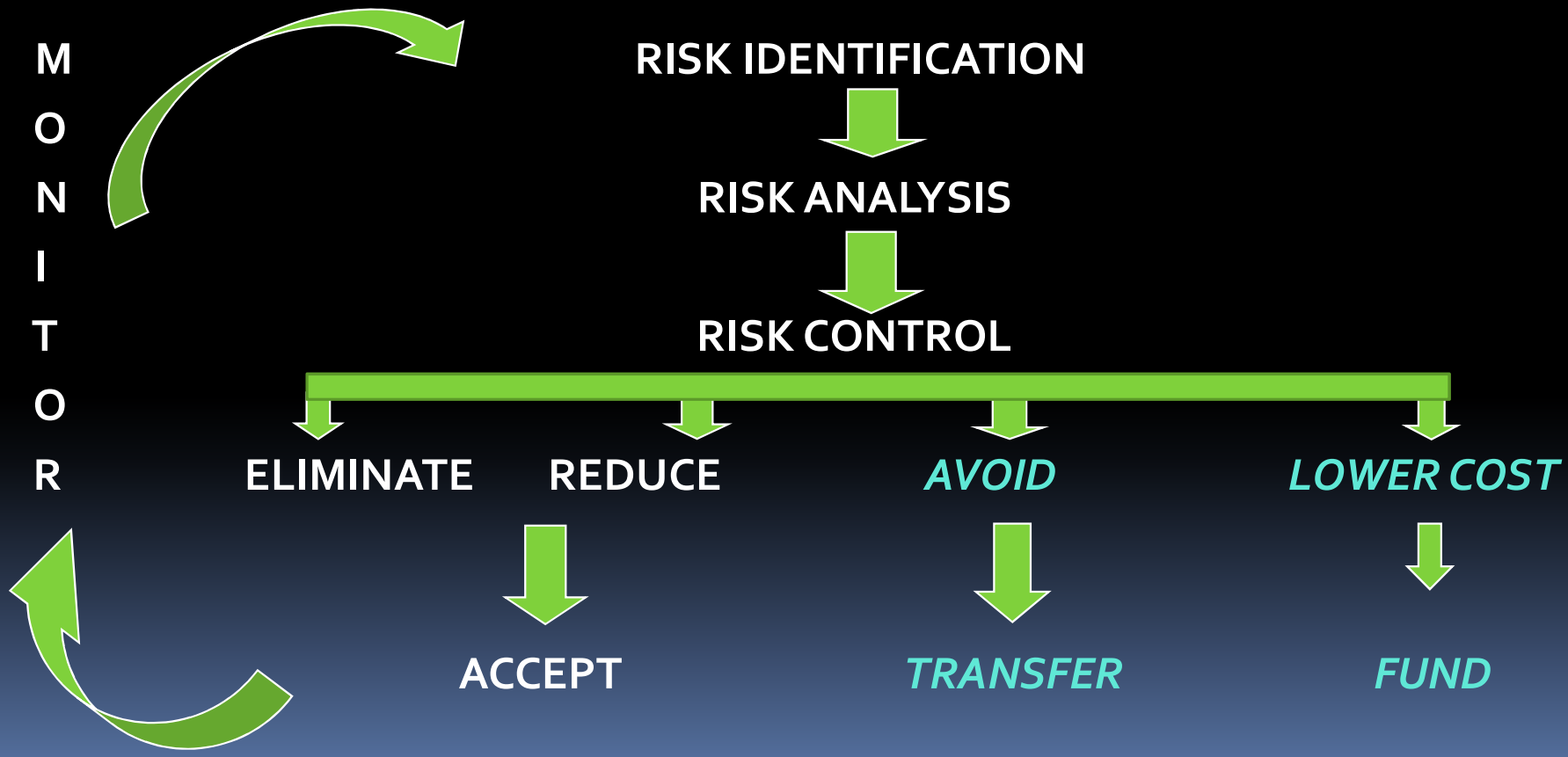
# Risks and benefits of risk assessment in clinical practice

- Unnecessary detention
- Other unnecessary curtailment of freedoms
- Discrimination
- Stigmatisation
- False sense of security

- Systematising decision making
- Transparency of decision making
- Benchmarking clinical decision making Davoren et al 2012,2013,2015

Distinguish between threat assessment and risk assessment

# Assuming responsibility for risk assessment and management is a continuous and dynamic process



# Risk management and harm prevention?

- Can we evidence interim changes indicative of longer term safety? Belfrage & Douglas, 2002
- Harm prevention more effective than risk evaluation Munro & Rumgay 2000
- Communicating about risk:

*A risk management plan is only as good as the time and effort put into communicating its findings to others* Department of Health, 2007

  - ✓The language of risk Monahan et al, 2000; Heilbrun et al, 2004; Gigerenzer, 2008
  - ✓Risk assessment and management in clinical partnerships – patients included
  - ✓Interagency risk assessment and management Taylor & Yakely, 2013

- And Public Health: 'A society sincerely concerned about reducing violence will seek broad measures that address risks for violence among persons both with and without mental health problems' Mossman, 2009

# BEYOND RISK REDUCTION TO RECOVERY?

# Clinical recovery?

- More than 2/3 patients in forensic mental health services have schizophrenia
- Recovery – requires clinical remission and social function criteria:
  - ✓1 year+ with no positive or negative symptoms
  - ✓'adequate' psychosocial functioning [GAF>65]
  - ✓No psychiatric hospitalisation in 5 years
- Systematic review of longitudinal studies from reference data-base inception (1823+) to October 2011 Jääskeläinen et al, 2013
  - ✓50 studies – up to 15 year follow-ups
  - ✓Annual recovery rate 1-2 people per 100
  - ✓Median over 10 years 14%
- And people with the complex, medication resistant illnesses in forensic psychiatry services?

# Recovery movement - 'recovery' is what the patients say it is? Andresen et al 2003

- Psychological recovery from the consequences of the illness incorporating:
    1. finding hope
    2. re-establishment of identity
    3. finding meaning in life
    4. taking responsibility for recovery
- With five stages:
    i. moratorium
    ii. awareness
    iii. preparation
    iv. rebuilding
    v. growth

# Application to Forensic Psychiatry

- All the illness variables and 'recovery' from
- Offending behaviours
- Stigma
- Own victim experiences
- Attaining a good therapeutic alliance Coney, 2000; Dressington et al, 2011
- Capacity for perspective taking Bragado Jimenez & Taylor, 2018

*'Recovering' from a serious offence?*
*I didn't do it*
*I might have done it, but they made me do it*
*I did it but was helpless*
*I did it*
*I did it and I don't want to do it again*
*Murray Cox 1996*

# Measurement of recovery with patients who have offended? Davoren et al (Kennedy) 2015

- **Stability** 0-4 [no predictable pattern - no relapse/recurrence of problem behaviour]
- **Insight** 0-4 [does not accept any aspect of illness, disability, problem behaviour, legal obligations, no treatment engagement – acknowledges all these things and cooperates]
- **Therapeutic rapport** 0-4 [does not tolerate supervision, subverts, negative attitudes to carers and professionals – spontaneously maintains contact and seeks help]
- **Leave** 0-4 [high risk of absconding, preoccupied with former victim/new potential victim – lives in the community and tolerates home visits]
- **Dynamic risk** 0-4 [HCR-20 R items: low & stable- high & unstable]
- **Victim sensitivity issues** 0-4 [insensitive to victim needs/ victim against patient/ high media interest – patient remorseful for victim/no victim hostility/no media interest]
- **Hope** 0-4 [no hope for future or alternative, less structured lifestyle – living in the community and hopes for improvement to quality of life]

# Recovery as evidenced by post-discharge placements? Jamieson & Taylor, 2002

- Secure hospital discharges of 1984
- Data bases searched:
  - ✓Office of National Statistics mortality database
  - ✓High security hospital readmission records
  - ✓Home Office Mental Health Unit
  - ✓Sequential placement tracing
  - ✓GP [primary care] registration
  - ✓Home Office Offenders' Index
  - ✓Police National Computer
  - ✓Electoral Roll

*** best indicator of community placement**

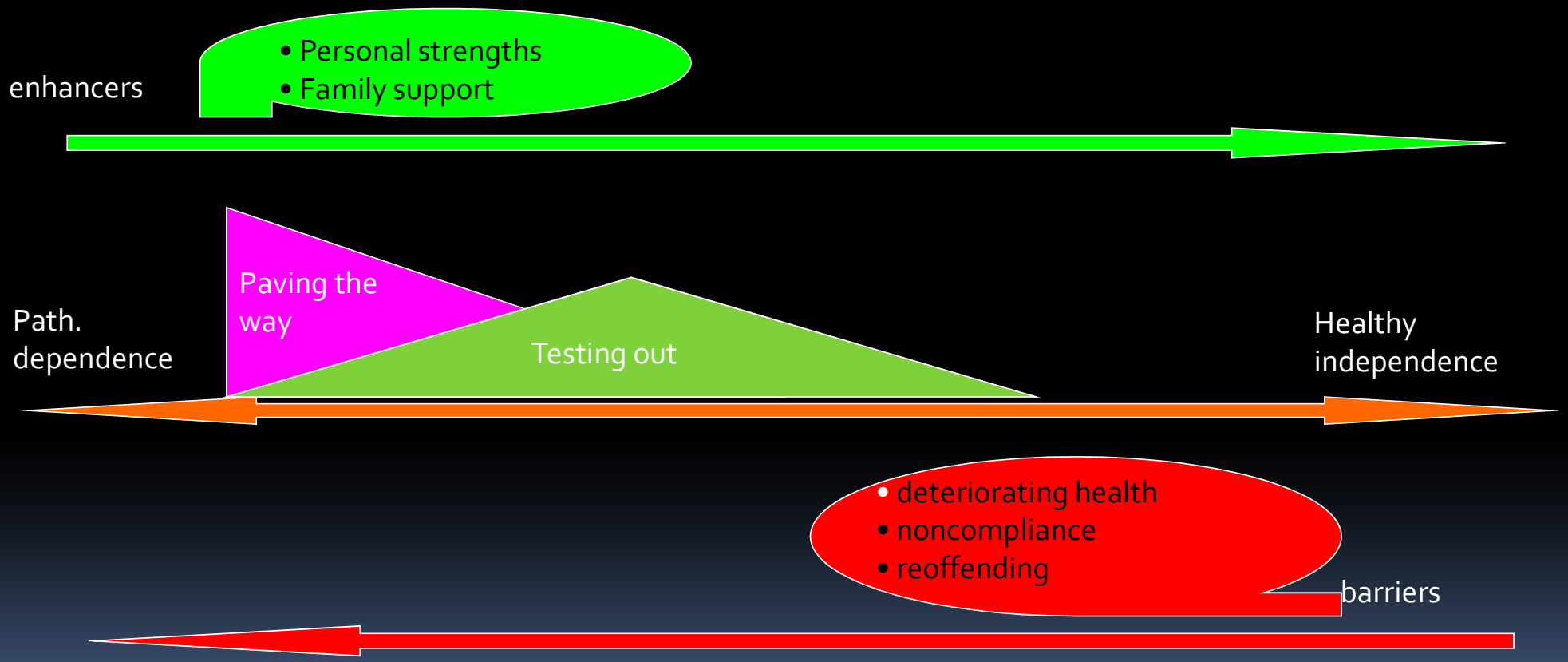
***29 (18%) 160 eligible cases only identifiable by this information**

# Core concern and dynamic outcome model for people with psychosis who have been violent: a multidisciplinary and interagency model

A grounded theory emergent from open interviews with clinicians, mental health lawyers and Home Office officials

Jamieson et al 2006

# The model


enhancers
• Personal strengths
• Family support
Paving the way
Testing out
Path. dependence
Healthy independence
• deteriorating health
• noncompliance
• reoffending
barriers

# Pathways models

Recognise

- Different needs at different stages
- Co-delivery of services
- Movement between services
- Share the resource burden

- Need someone to 'hold the story'

# Risk and 'recovery' - Outcome measures for forensic psychiatry?

- **Characteristics:**
  - ✓Important to everyone - giving or receiving or commissioning services
  - ✓Simple
  - ✓Reliable
  - ✓Valid
- **Levels**

**Service**

- ✓ Does the service deliver as planned?
- ✓ Service comparison
- ✓ Protecting and developing service

**Individual**

- ✓ Does the intervention work?
- ✓ Shaping outcomes
- ✓ Clarity of communication between clinicians and others

# MEETING NEEDS: RESOURCES

# Forensic mental health services cost a lot – why?

- UK Forensic MH services are 'high cost, low volume' services' – consume about 1% NHS budget for 6000-8000 inpatients
- Seven principles of commissioning https://www.rcpsych.ac.uk/pdf/jcpmh-forensic-guide.pdf

✓ High quality patient centred services, with patients co-commissioning

✓ Based on patient need and mindful of 'protected groups' Equality Act 2010

✓ Timely access

✓ Complex needs require wide ranging therapeutic solutions

✓ Integrated healthcare pathways

✓ Interfacing effectively with all parts of the criminal justice system

✓ Mindful of Ministry of Justice and of victim obligations

# Funding threats to the high quality required

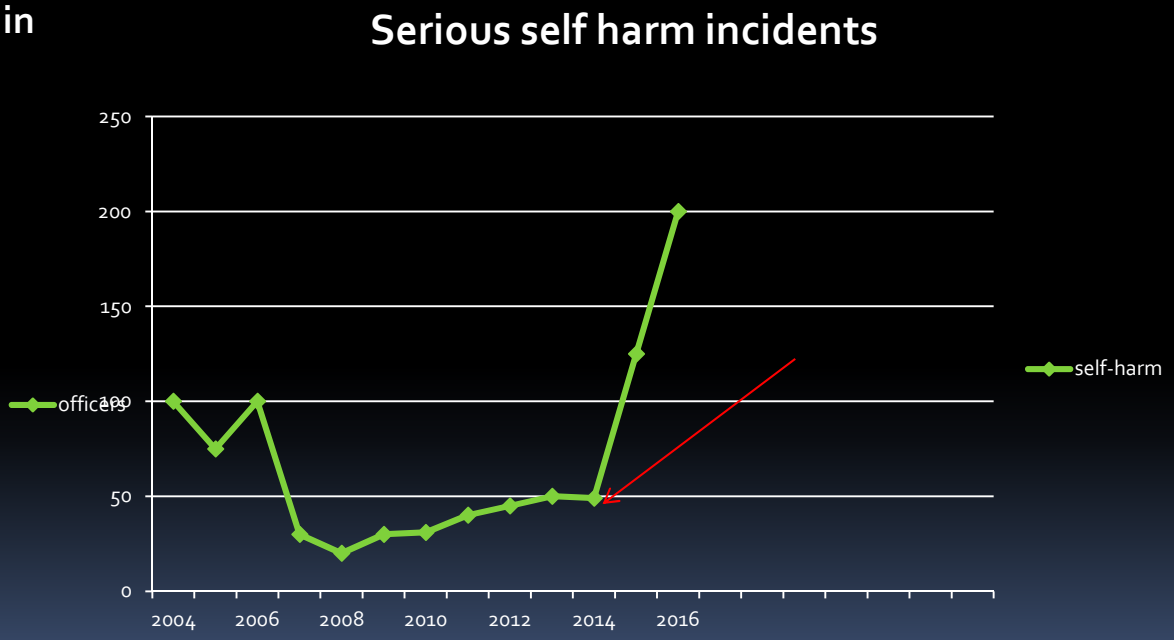
- Reducing resources
  - ✓Funding cuts
  - ✓New models/new legislation within same resources
  - ✓Redistribution of resources and activities – the health service prison balance
- The costs of reduction
  - ✓Weakening the base for staff, training, development and support
  - ✓Impoverishing the environment for patients
  - ✓Weakening treatment for patients - the *Third Man* effect
  - ✓Failure to invest sufficiently in research and *evidence based* development

# Saving money by cutting services? UK prison findings

*HM Prisons Inspectorate*
*Prisons & Probations Ombudsman*
*Office for National Statistics*
Research

- 2013: Number of frontline (grade 3 or 4) prison officers was cut by 41% in publicly run prisons, 30% overall across England and Wales
- 2016: death rate among prisoners in England and Wales reached an all time high, including deaths by suicide.
  - Using the standard estimate that a suicide carries an economic burden of about £1.7million, deaths by suicide alone cost the country over £200,000m
- Self-harm and violence rates escalated too
- Use of illicit substances is higher than it has ever been

# Changes in prison officer numbers and serious self harm incidents by prisoners in one prison

# RESEARCH IN FORENSIC MENTAL HEALTH: TOO SCARCE A RESOURCE

# Research at its best

- Predicates change for the better
- Thus diminishing stigma
- Contains costs
- Safeguards professional credibility and services
- Supports recruitment and retention

# How can more and better research be accomplished?

- Protected time
- Funds
  - Availability
  - Knowing how to apply
- Reduced bureaucracy of research
  - Simpler ethics approval processes
  - Support for research management
- Enhanced skills
  - Systematic Reviewing skills
  - Research Design skills
  - Statistical skills
- Availability of academic support/supervision and capacity building

# To what extent do forensic mental health services require specific research?

- We see broadly the same mental disorders as any other psychiatric speciality?

- Conditions such *as antisocial behaviour by people with mental disorders* can only be adequately researched within this group
- Standard randomised controlled trials of relevant treatments almost by definition exclude antisocial and/or complex cases
- Unique characteristics of some cases
- Ethical issues

# How far we have to go

Treatments for people with personality disorder

– 'usable outcomes' or personality change

Duggan et al, 2010

- Cochrane review: 17 RCTs of psychological treatments for sex offenders
- 13,290 RCTs registered on the Cochrane Database for schizophrenia - 21% psychological interventions
- 16,483 trials on the Cochrane Depression, Anxiety & Neurosis Register
- Schizophrenia and depression are perhaps commoner conditions than sex offending, but the contrast is stark

Duggan & Dennis 2014

# 10 steps forward

1. Articulate our position more clearly
2. Build from basics
3. Abandon stereotypes
4. Radical thinking
5. Use of technology
6. Creativity with blockages
7. Doing more with less
8. Managing regulation
9. Product targeting
10. Clarity of message – conveying it and living it well

***1. Articulate our position more clearly***

- ❖ Per life lost, 'we' spend less on research into violence than on most other conditions impacting on health
- ❖ That must change
- ❖ Forensic mental health research could make a difference

***2. Building from basics***

- ❖ We need to know more about life course of relevant symptoms of disorder in context

***3. Abandon stereotypes***

- ❖ No condition is defined by untreatability

***4. Radical thinking***

- ❖ Alternatives to prison
- ❖ Biofeedback for behavioural disorders

***5. Use of technology***

- ❖ Evaluation of patient engagement and monitoring through apps

***6. Creativity with blockages***

- ❖ Clinicians engaging in n-of-1 trials
- ❖ Bringing in other research experts
- ❖ Appropriate diversion of 'quality assurance' funds

***7. Doing more with less***

- ❖ Engaging undergraduates, volunteers
- ❖ But never underplay skills
- ❖ Knowing when to end a research line

***8. Managing regulation***

- ❖ Promoting the ethical problem of not advancing treatment/change through research
- ❖ Setting up the structures for accurate, easy responses
- ❖ Engage 'experts by experience' in the process

9. ***Product targeting***

- ❖ Who is interested?
- ❖ Crowd funding?
- ❖ Dedicated forensic mental health funding streams

10. ***Clarity of creed – conveying it and living it well***

- ❖ Sound forensic mental health research can save lives and reduce health and criminal justice costs – help us do it

# In conclusion

- One of our cornerstones is assessment of risk of serious harm being inflicted on others by people who have mental disorder
  - The ultimate trial of risk assessment and management probably not feasible, but
  - Research into this has been extensive and teaches us to be circumspect in use of risk assessment, although as a framework for treatment and transparency it may be helpful

- One of the current ideals is a 'recovery model' to be shared with our patients
  - The name is an example of how we should be wary of use of words in this field. It contains potentially useful ideas – but the value of the approach needs research evaluation

# More conclusions

- Resources are finite and always under threat
  - We need to be aware that apparent cuts/'cost savings' may be very costly as well as dangerous and miserable for our patients - and for us
    - and to be able to show that and argue our case
- Research is one of the areas of our work which is undernourished by resource, and susceptible to government drives
  - Some primary research may belong in other areas of psychiatry, psychology, basic sciences and legal and social fields – but some can only be done by us with our clientele. We can and must develop this