

# A new standard of care for forensic mental health treatment: prioritizing forensic intervention

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Many forensic psychiatric settings serve unique populations who have, in addition to traditional psychiatric symptoms, diverse legal and criminogenic needs. A lack of clear treatment standards that address all aspects of forensic care can lead to inefficient or inappropriate interventions and contribute to institutional violence.

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## Introduction

Forensic populations are increasing; however mental health treatment paradigms have not changed to accommodate this new population. The recovery principles that currently guide psychiatric delivery systems do not account for forensic environments, which are in themselves “settings in which self-determination is already strongly curtailed,” nor do they answer the question of how a system designed to divert individuals from legal consequences based on their lack of competency or responsibility can at the same time be treated with a model that emphasizes full agency.<sup>1</sup> This leads to a paradox for forensic hospital systems that are simultaneously trying to meet treatment standards grounded in recovery philosophy while at the same time addressing the unique needs of a forensic population (see Table 1).

## How Should State Hospitals Treat Forensic Patients? Is This an Unsolvable Problem?

There is a new forensic population housed in state hospital systems. Many of these state hospitals are older facilities that employ clinical policies developed during the reforms of the 1960s and 1970s. These “state” hospitals are often now referred to as “forensic hospitals,”

most often due to the changed patient population rather than any updated infrastructure or practice. In general, state hospital systems have multiple oversight mechanisms. Despite these strict monitoring practices, state/forensic hospitals can be plagued with problems, most notably inpatient violence, which frequently makes national headlines (sometimes international headlines), creating a treatment paradox in forensic psychiatry.<sup>2–20</sup>

For example, a single week of national headlines in 2014 illustrates the current problems confronted by facilities that are trying to deliver humane mental health services to populations with high levels of inpatient violence. On one day, the *Hartford Courant* reported on the controversial placement of a patient found not guilty by reason of insanity, because he was held on bail at a correctional institution rather than returned to the state/forensic hospital where he had allegedly committed numerous serious assaults on patients and other staff. The patient was suing to return to the state/forensic hospital citing an entitlement to treatment.<sup>21</sup> At issue was his level of violence risk and the inability of the hospital to provide the same level of safety as the correctional setting. The following day, the *Associated Press* reported that four Hawaii State Hospital employees were suing the state due to the unsafe work environment created by assaultive psychiatric inpatients in their state hospital.<sup>22</sup> Later that same week, the *Portland Press Herald* reported on a controversy involving the allegedly punitive and controlling environment at the state/forensic hospital in Maine; in the same article, a psychiatrist on staff described the forensic unit as the most dangerous inpatient psychiatric unit that he had ever seen.<sup>23</sup> Thus, three state/forensic

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hospitals attempted to handle the same situation (uncontrollable violence in inpatient forensic populations) three different ways, and all three approaches were flawed, controversial, and worthy of media attention. This week was not an anomaly; the issue of inpatient violence, especially among forensic patients and especially in state/forensic hospitals, has been widely reported in the media over recent years.<sup>2-23</sup> This is confounding, because most state/forensic hospitals receive a extensive amount of external oversight from state, private, advocacy, and federal agencies. Tremendous resources are expended trying to meet the mandated conditions of what these various agencies define as the standard of care for inpatient psychiatric facilities.

Frequently, this includes implementation of recovery principles, recovery-based multifocal treatment planning, active treatment in the form of multiple hours of group therapy each week, and the development of treatment malls. However, most forensic patients are sent to state/forensic hospitals not to recover from their mental illness, but as a result of involvement in the criminal justice system. In many cases the recovery-based treatment planning and subsequent active treatment delivery do little to address the forensic or criminogenic needs of these patients, and failing to address these needs in lieu of comprehensive care based on recovery principles has the unintended effect of neglecting the most salient immediate clinical needs. Hence we have the continual cycle of violence, treatment disruption, and administrative changes in response to treatment and systemic failures that can be found in many state/forensic hospitals across the country.

Have state/forensic hospitals been handed an unsolvable problem, or is there a sweet spot between applied recovery principles and appropriate forensic treatment that will ensure that individuals with a combination of

mental health and criminogenic needs will receive appropriate treatment in an appropriate environment? Is it time to develop new standards of care for forensic settings that prioritize the forensic and legal needs of these individuals?

### Who Are Forensic Psychiatric Patients?

Broadly defined, forensic psychiatric patients are mental health patients who also have some involvement with the criminal justice system. Historically, the term “forensic patient” was used to describe a narrow class of individuals: those found “not guilty by reason of insanity” (NGRI) and those found “incompetent to stand trial” (IST). Adding to those traditional forensic commitments are inmates sentenced to correctional facilities (jails and prisons) who have mental illness; there is now a tremendous focus on the growing need for forensic psychiatric services in these settings.<sup>24,25</sup> Newer commitment types, such as sexually violent predators (individuals who have completed a prison term but are retained for treatment due to a nexus between a psychiatric disorder and their sexual predation) and individuals who have completed a prison term but who are committed because they pose a high risk of violence due to their psychiatric disorder (referred to as “mentally disordered offenders” in California) add further diversity to this growing population. There is even some suggestion that the term “forensic patient” should be expanded to include patients involuntarily committed by a civil court.<sup>26</sup> Anecdotal reports indicate an increasing level of criminal behavior and violence even in these “civil” commitments, perhaps due to the successful social movement that ensures that people who can be safely treated in the community *are* treated in the

TABLE 1. The forensic paradox

Recovery principles <sup>55</sup>	Forensic commitment criteria <sup>56-59</sup>
<p>Recovery is person-driven.</p> <p>Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) toward those goals.</p> <p>Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.</p>	<p>The defendant is unable to understand the charges and/or does not have the ability to aid attorney in own defense.</p>
<p>Recovery is holistic.</p> <p>Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.</p>	<p>It must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.</p> <p>“Sexually violent predator” means a person who has been convicted of a sexually violent offense against one or more victims and who has a diagnosed mental disorder that makes the person a danger to the health and safety of others, in that it is likely that he or she will engage in sexually violent criminal behavior.</p>
	<p>As a result of the severe mental disorder, the prisoner represents a “substantial danger of physical harm to others.”</p>

community, thereby increasing the concentration of violence in involuntary civil state hospital settings. Regardless, the fact that forensic treatment needs are growing, both in state psychiatric institutions as well as correctional environments, is clear.<sup>27-30</sup> The most well-supported explanation for this growth is the phenomenon of the “criminalization” of mentally ill populations. In short, this social trend began when mental health patients who would have been served in state institutions were instead deinstitutionalized. For a variety of reasons, most notably withdrawal of federal funding, these patients were not provided with adequate care or treatment in the community, and thus began drifting into illegal activities and arrest. Therefore, many forensic patients end up in correctional environments, while others are captured by mental health law and adjudicated to state mental hospitals.<sup>31-35</sup> There is evidence that this growing population has features of both mental illness and criminal thinking.<sup>36-41</sup> There is also evidence that forensic hospitals are no longer treating categorical diagnoses, but are instead treating violence, and this poses a challenge to these facilities.<sup>42,43</sup>

### The Current Standard of Care for State Hospitals Does Not Work for Forensic Populations

The definition of the term “standard of care” has much more of a legal basis than a medical one, but in general it can be summarized as how similarly qualified practitioners would have managed care under the same or similar circumstances.<sup>44</sup> Existing treatment standards for psychiatric inpatients represent an entirely appropriate evolution of practice following the institutional abuses of the 1950s and 1960s. But they are not appropriate for violent forensic populations, precisely because circumstances have changed, including patient profiles and precipitants for hospitalization.

One historical English law test for the standard of care, the Bolam test, was ultimately rejected because it “allows the standard in law to be set subjectively by expert witnesses” in favor of the Bolitho decision that “standards proclaimed must be justified on a logical basis and must have considered the risks and benefits of competing options.”<sup>45</sup> Given the increasing struggles to safely and humanely treat the growing forensic population, examining the current standard of care from a perspective of logic and risk/benefit analysis is warranted. While there are multiple guidelines for treating psychiatric patients in public, private, and even in correctional settings, very little exists on treating forensic patients in state hospital settings, rendering mandates somewhat subjective.<sup>46-48</sup> For the forensic patients found not guilty by reason of insanity or incompetent to stand trial, guidelines tend to focus on

initial evaluation rather than subsequent treatment of dangerousness, barriers to trial competency, and/or criminogenic needs.

Complicating the treatment of mental illness in the modern state/forensic psychiatric facility is the recognition that many forensic patients evidence both bona fide mental health symptoms *and* criminogenic thinking, contributing to what may be a new type of patient with new treatment needs.<sup>36-41</sup> As such, a standard of treatment designed to facilitate recovery in a civilly committed patient without concomitant criminal behaviors and/or criminal justice system involvement may not be effective for this new population. An examination of forensic commitment criteria indicates that most forensic commitment language can be translated into two primary discharge criteria: restoration of competence and/or the ability to be safely treated in the community. It is therefore logical that forensic treatment would be focused on restoration to competence and/or mitigation of violence risk, with an eye toward addressing learned criminogenic attitudes. However, as a carryover from the standards set for the older state hospital system, treatment is often not focused this way, but rather on reduction of symptoms of psychiatric disorders within a holistic framework of recovery concepts such as self-direction and autonomy. This is not to suggest that treating psychiatric disorders with a recovery framework is not important, but rather that for forensic patients, addressing their forensic commitment criteria and reducing criminal behavior, including violence, is more so. As such, the recovery approach in the state/forensic psychiatric hospital would be better seen as part of a continuum of care where the patient can be discharged to the community after violence mitigation is successful, for recovery in that setting.<sup>49</sup>

For example, approximately 15–20% of patients referred as incompetent to stand trial may actually be malingering to avoid adjudication.<sup>50,51</sup> For those individuals, screening for malingering and follow-up forensic evaluation should be the focus of treatment, rather than recovery from a mental illness that is feigned to begin with. For patients who evidence predatory aggression rooted in psychopathic characteristics, principles of self-direction are inappropriate and put other patients at risk. For patients who have been diverted from court or prison because they are not competent or not criminally responsible, the concept of autonomy can be difficult to reconcile.

It appears that the standard of care needs to be defined for these commitment types as well as other patients now confined to state/forensic facilities, including those serving criminal sentences and referred from prisons, those referred from prisons as a condition of parole, sex offenders, and even seriously ill and violent civilly committed individuals who are unable to be safely treated in the community.<sup>52</sup>

## Why a New Standard Will Matter

In current forensic treatment environments, uncontrolled inpatient violence interferes with patient and staff safety, as well as treatment delivery. Available interventions to control violence include seclusion and restraint, 1:1 observation, and PRN medications. Both seclusion and restraint, and PRN medication are heavily weighted toward psychotic violence, which is easier to predict and medicate, but far less common, than other types of inpatient aggression.<sup>53,54</sup> Prediction and prevention of inpatient aggression in a forensic setting is more appropriately done via violence risk assessment techniques and proper level of custodial security based on overall risk level, rather than “imminent” risk level based on antecedent behaviors that might not exist in the predatory or impulsive patient. Utilizing the presence of 1:1 observation is the practice devoting one staff member to observe an individual who has been identified as potentially violent to others. In many cases, this practice provides that patient with a target, puts our level of care staff at unacceptable risk, and drives up overtime and worker’s compensation costs. Additionally, outcomes measures such as symptom reduction and length of stay do not necessarily measure whether the forensic goals (competency, violence mitigation) have been met. Focusing care primarily on outdated emergency interventions and recovery-based treatment planning, rather than reduction of risk and restoration of competency, can result in the unintended consequence of delaying discharge and violating the major dimensions needed to support recovery principles, such as the need for a stable and safe place to live.<sup>55</sup>

## Conclusion

Evidence suggests that there is a new type of patient, and that we therefore need a new standard of treatment. Modern forensic treatment should not be primarily focused on recovery from a mental illness, but instead on reducing violence and meeting forensic discharge criteria in order to eventually return patients to recovery environments in the community.

## Disclosures

The author does not have anything to disclose.

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