

Research for forensic mental health – looking to the future

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Why research?

Good research predicates change for the better. Diseases and behavioural disorders with a prospect of recovery carry little stigma, but conditions perceived as irremediable engender fear and hostility - to those suffering from them and to their therapists. Discovery of new ways of understanding and treating relevant disorders provides the main hope for many individual offender patients and for the safety of others. It is in everyone's interests that forensic mental health services are, as far as possible, evidence based. Service funders and commissioners have rightly started to require evidence to justify their costs. A strong, unique programme of research and a community of skilled researchers are essentials for professional credibility, and thus recruitment and retention of the most skilled practitioners (Taylor et al., 2009).

A problem with relevant evidence in this field is that its clientele often have exceptional presentations of mental disorder and of aggressive behaviours and their presentation so complex that only complex interventions will do. We do not excel at appropriate application of research findings in this field.

Drake (2014) has observed:

Many efficacious practices do not transfer to routine settings because they are too complicated, do not attract the target population, cannot be maintained at high fidelity, cannot be supported by data systems, do not fit into the current care structure, and so on.

So, implementation of research findings may itself be an area for field specific systematic inquiry. It is an ethical imperative that practitioners should constantly question:

- What am I doing without evidence?
- What am I doing in spite of the evidence?
- What evidence do we have that ought to change the way we are practising, but has not yet done that? – and why?

In a field where so much depends on behavioural interactions over time as well as primary disorder process, acknowledgement of confounders and/or conflicting information is essential and yet may also obfuscate. Provision of unequivocal knowledge in a form that everyone can understand risks self-defeating oversimplification. Nevertheless, the forensic research community should lead towards consistently evidenced rationale for interventions, randomised controlled trials of these - as justifiable if harder to achieve than in more open environments - and then final evaluation in the 'dirty' reality of everyday practice. In this context, governments too might be persuadable towards testing their new policies or legislation, often consequent on public response to a single notorious case, before indefinite, community-wide implementation. The latter has a successful precedent in the process of implementing mandated outpatient commitment in New York (Swartz et al, 2009).

How far have we come?

The 1970s and '80s brought significant changes in clinical practice, training and research in the field. Before 'the watershed', research was mainly with people already selected for hospitalisation or imprisonment. Afterwards, population based epidemiological studies became prominent and significant relationships between mental disorder and violence, albeit small and complicated, were finally established (e.g. Fazel et al, 2006; 2009). Longitudinal study of pathways into offending (Farrington, 2014) ceased to be exclusive to criminologists when study of developmental trajectories through *illness* to violence was established (Arseneault et al, 2000; 2003). Brain-imaging developments allowed enhanced exploration of immediately proximate mediating mechanisms (e.g. Kumari et al, 2013). In token of burgeoning research, a range of specialist forensic mental health journals emerged in the 1970s and 80s.

It has been both advantageous and disadvantageous that the most frequently encountered disorders in forensic mental health services are common in other psychiatric specialties. This may better reflect the rather recent emergence of the specialism from its generic roots than the reality of need, but it has meant that much relevant research has not required specialist training in clinical forensic psychiatry or psychology as much mainstream schizophrenia research, for example, could be relevant to about two-thirds of offender inpatients. People with violence histories as well as schizophrenia were, however, routinely and explicitly excluded from treatment studies – for example of cognitive behavioural therapies – until Haddock and colleagues (2009). From a wider perspective, the common ground in disorder may have limited the specialty's research infrastructure development – few university departments have a critical mass of specialist academics. Further, health faculties have largely ignored some vital areas, such as sex offending or fire-setting.

Generic psychiatric journals retain a modest interest in forensic mental health research. Given common ground in mental disorders, it is possible to construe almost any article as relevant, but there are few articles which refer specifically to offending or violence or the interface between psychiatry and psychology and the law and criminal justice system. Two examples – *British Journal of Psychiatry* and *Psychological Medicine* – gave about 5% of space to this field through 2014, with very large, population based studies or systematic reviews with substantial yields favoured; the US based *American Journal of Psychiatry* and *JAMA Psychiatry* offered much the same with, perhaps significantly, the more practice based *Psychiatric Services* giving a little more space and variety.

Specialist journals add a rich variety of studies of offenders, offender patients and the systems in which they find themselves. US based journals with international reach tend towards legal process research. In 2014, for example, *Behavioral Sciences and the Law's* thematic coverage was of child witness research, conditional release, terrorism in the 20th century, women as expert witnesses and the world wide web and people with disabilities; the *International Journal of Law and Psychiatry* took new directions for behavioural health and criminal justice interventions, police response to mentally ill people and historical perspectives on forensic psychiatry; the *Journal of the American Academy of Psychiatry and the Law* (AAPL) took DSM-5, forensic publishing and AAPL guidelines. *Criminal Behaviour and Mental Health's* one thematic issue compared self- and officially-reported criminal careers. The *International Journal of Forensic Mental Health Services* also had one thematic issue – on the HCR-20, as this structured professional judgement tool went into its third version.

Where next?

Have we gone far enough along some research trajectories? After a second systematic review of mental disorder among prisoners, finding 109 separate studies of 33,588 prisoners in 24 countries, Fazel and Seewald (2012) wrote:

High levels of psychiatric morbidity are consistently reported in prisoners from many countries over four decades.

Given consistency of findings, is it time to stop basic disorder counts? Assessment of need could be more useful. Many people with mental disorder should not be in prison, but perhaps few should be in hospital. Service development cannot be properly informed by disorder categories alone and yet, as far as we know, still the only nationally representative studies to make clinical estimates of prisoners' placement needs are from the 1990's UK (Gunn et al, 1991; Maden et al, 1995).

With respect to significant gaps in knowledge, how would we know? A broadly based evidence inquiry website set up by one of us (JW) for one mental health trust (<http://best.awp.nhs.uk/>) received over 400 requests for evidence in four years. About two-thirds fell within the web-team's remit, of which about half were answerable with at least some quality evidence; half were not. Questions about cognitive impairment or mood disorders could generally be answered, but those in specialist areas, including forensic mental health, or about personality disorders were less likely to be answerable. This tells not only of knowledge gaps, but gaps which practitioners want filling.

Systematic reviews were designed to weigh existing evidence and highlight where it is lacking. It is, however, almost impossible to get a systematic review published if no – or very few – papers are identified. Are publishers limiting the value of such outputs? Would a repository of negative

systematic reviews in our field be an advantage? In the meantime, some published work is revealing. Duggan et al., reviewing pharmacological (2008) and psychological treatments (2007) for personality disorder, found that 'usable outcomes' tended to reflect epiphenomena rather than core personality change. While significant gains of any kind are worthwhile, strategies for maintaining benefit are likely to differ according to whether trait or state change has been achieved. Duggan and Dennis (2014), reviewing evidence for treatment of sex offenders, offer the kernel of the problem:

Although RCTs in any area of healthcare are difficult to conduct, other specialities have overcome the challenges that they present. The 17 RCTs that we were able to identify in our Cochrane reviews contrast markedly with 13,290 RCTs registered on the Cochrane Database for schizophrenia, 21% of which are evaluations of psychological interventions ... and 16,483 trials on the Cochrane Depression, Anxiety and Neurosis Register. Even allowing that schizophrenia and depression are much commoner conditions than sex offending, and that the RCTs in these areas are still far from perfect, the contrast is stark.

Further vital research into sex offending lies in its prevention. The Dukelfeld project (Beier et al., 2009 a&b), established in Germany, operates on the principle 'you are not guilty because of your sexual desire, but you are responsible for your sexual behaviour. There is help, don't become an offender!' Trials of the programme elsewhere would seem important.

Building a platform from intervention developments through their evaluation is as important to us as to other clinical fields. Studies with various samples have shown that delusions explain serious violence by only some people with psychosis (e.g. Taylor, 1985); this is partly explained by comorbidities (e.g. Taylor et al 1998), which themselves require treatment. Particularly where comorbidity is absent or minimal, however, characteristics of the delusions appear critical, including their affective impact (Buchanan et al, 1993). This finding in a small sample has been replicated in

larger samples (Coid et al., 2013; Ullrich et al, 2014), confirming that anger consequent upon delusions is a critical mediator between delusion and violence. In a US prisoner cohort study, only *untreated* psychosis was associated with violence (Keers et al, 2014). With a delusions assessment tool (Taylor et al, 1994) to supplement wider mental state assessments, we have the wherewithal to classify violent people with psychosis, make treatment more specific to their needs and evaluate the efficacy of this strategy. Platform work which has already taken off includes the Manchester group's identification of the periods of highest risk for self-harm and suicide along the prisoner pathway (Pratt et al., 2010) being followed by a randomised controlled trial of critical time intervention for released mentally ill prisoners (<http://www.nets.nihr.ac.uk/projects/hsdr/09100415>) and the Cardiff group's route from describing need among alcohol-misusing short-term prisoners (Kissell et al, 2014) to a trial of groups for them (<http://www.controlled-trials.com/ISRCTN68904585>).

Finally, in this far from exhaustive account, there is the continuing need for a gold-standard outcome measure. To date, the absence of a negative – desistance from re-offending – has been favoured. Important though this is, it skirts change in health and societal reintegration, and how change interacts with change to alter a situation further. A testable dynamic model inpatient recovery, for example, emerged from open interviews with a wide range of people involved in their discharge decisions (Jamieson et al., 2006). According to this, the focus would be on dependence, the pathological extreme characterised by need for intensive staff input and high security. The desired outcome is healthy independence, characterised by good enough health to be able to make competent decisions about one's own lifestyle. Reoffending appears in the model, but as one contributor to change; its absence is one component of healthy independence while its reoccurrence enforces renewed dependency.

Funding the dream

Good research requires funding and academic capacity. Money is necessary but not sufficient. Capacity encompasses both skills and a minimum sufficient team/network for the research to be sustainable. So, actual research and capacity building have to go hand in hand. Where is the money for this? It is possible and necessary to enter competition with other specialties to national/international funding councils, but success depends on co-operation with peers and other relevant experts. Government and government sponsored bodies periodically declare funding streams which might fit, and occasionally dedicated programmes. Considerable monies, for example, were made available for research into 'Dangerous and Severe Personality Disorder' (DSPD) (see Duggan, 2011). Probably beneficial, such initiatives inevitably also bring constraints – partly through what then cannot be funded because of perceptions of sufficient investment and partly by limiting research to areas with little connection to clinical or research rationales. The research community should be more ready to take the initiative in advising on and steering strategy. A range of third sector organisations also may fund small projects. There has not, until now, been the independence of a charity dedicated to research in this field. *Crime in Mind*, with activities initially confined to the UK, will launch later this year.

In this developing field, with the constraints of editorial space we have left many exciting areas untouched. We would like this to be the start of an international dialogue on ways forward.

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