
NHS
Education for Scotland
The Matrix Evidence Tables
FORENSIC SERVICES
CLICK ANYWHERE TO CONTINUE
The Scottish Government

INDEX

INTRODUCTION

THIS SECTION APPLIES TO PATIENTS WHO PRESENT A RISK OF SERIOUS HARM TO OTHERS SUCH THAT THEY REQUIRE SPECIALIST 'FORENSIC' EXPERTISE IN THEIR MANAGEMENT. 'FORENSIC PATIENTS' ARE SOMETIMES REFERRED TO AS MENTALLY DISORDERED OFFENDERS ALTHOUGH NOT ALL HAVE CRIMINAL CONVICTIONS. THEY MAY BE MANAGED IN SECURE HOSPITAL SETTINGS OR BY COMMUNITY MENTAL HEALTH SERVICES.

The majority of forensic patients also present with personality disorder, co-morbid with mental illness, substance misuse and/or cognitive deficits. Such highly complex and enduring problems demand highly specialist, individually tailored psychological interventions delivered by practitioners with the highest levels of training. However, forensic patients may also have simpler underlying or associated difficulties which may respond to less intensive interventions. A model of matched stepped care can therefore be applied and in the absence of evidence pertaining specifically to forensic patients, the tables contained in the rest of the Matrix can be used as a guide to treatment planning (e.g. substance misuse, psychosis).

The tables in this section relate to offending behaviours for which there is an evidence base relating specifically to forensic patients. For some offending behaviours or related problems, the evidence base remains in its infancy for offenders with mental disorder and as such no matrix table is presented at all (e.g. fire-setting, intimate partner violence, stalking and severe personality disorder).

Where no standardised or single treatment is available or suitable, the appropriate approach will be to seek to understand and treat the underlying problems. In these cases highly specialist psychological practitioners are required to use the available evidence to select, modify, adapt and evaluate psychological treatments to match the patient's risks and needs and be responsive to their particular learning styles and any cognitive deficits.

A number of factors must also be taken into account to ensure the safe and effective delivery of psychological therapies in forensic mental health services. These are outlined in brief below and a fuller explanation is available in "A Guide to Delivering Psychological Therapies in Forensic Mental Health Services in Scotland" (Forensic Managed Care Network, in preparation).

The identification and formulation of psychological needs and delivery of psychological therapy must

INDEX
BACK
NEXT

ONE

be carried out as part of a risk assessment and management process. This process is concerned with identifying and addressing the full range of patients' risks and needs. It allows for the appropriate sequencing of interventions relative to other aspects of the recovery or care plan and regular reviews of this based on progress. Practitioners with highly specialist skills in the assessment of risk of harm to self and others are required to review patients' progress in psychological therapy in terms of the impact on risk.

TWO

The majority of sexual and violent offenders have personality disorder, particularly those who cause serious harm and/or who offend repeatedly. Where these patients present to mental health services because of their co-morbid mental illness or learning disability, the type and range of personality difficulties must also be assessed. These will range from simple personality disorder (only one DSM-IV cluster diagnosis) to complex and severe personality disorder (meeting criteria for several disorders spanning more than one cluster) to psychopathy. Although personality disorder is rarely the reason someone presents to mental health practitioners, understanding the effects of personality disorder plays a crucial role in addressing offending behaviour, in delivering treatment for other conditions and in determining poor emotional, interpersonal and behavioural functioning which can significantly impact on management. Psychological interventions for those with personality disorders should aim to: (1) help staff formulate, interact with and manage the patient (2) improve personality functioning through specific therapies; (3) reduce risk of re-offending through appropriately responsive offending behaviour programmes.

All forensic patients should be subject to the Care Programming Approach (CPA). This ensures adherence to an appropriate risk assessment and management process and

INDEX
BACK
NEXT

THREE

provides a mechanism for reviewing risk management plans including those addressing psychological needs.

FOUR

Motivation to engage in treatment, known as 'readiness to change', seems to influence an offender's response to psychological work. While motivational strategies with individual patients may help, a positive therapeutic ethos is also essential for readiness. Effective multidisciplinary working, robust supervision and reflective practice systems, a psychologically-minded workforce, and paying close attention to the organisational, physical, social and psychological environment are important factors in this.

FIVE

Strengths based approaches, such as the 'Good Lives' model, show promise with offenders and are consistent with the philosophy of 'recovery' from mental disorder. In line with this, interventions should be designed to enable individuals to make positive choices and changes in their lives and to capitalise on natural opportunities to develop non-offending and mentally healthy lifestyles. Occupational, social, creative and learning opportunities form a key part of this as does the promotion of physical exercise and wellbeing.

The rights of the patient must be carefully balanced against the rights of the public to be

INDEX
BACK
NEXT

SIX

protected from harm.

SEVEN

Mental health services have a duty to cooperate with other agencies (e.g. the Mental Health Tribunal Service, Multi-Agency Public Protection Arrangements, the Parole Board for Scotland, Scottish Government, Scottish Courts, Risk Management Authority and the Scottish Prison Service etc). This may require that information about patients' psychological needs or progress in therapy which is relevant to their risk management is shared.

DEFINED IN THE MAIN MATRIX APPLY. HOWEVER, THE FOLLOWING SHOULD BE NOTED:

- The tables are divided into sections pertaining to major clinical and behavioural problems, but it is

IN INTERPRETING THE TABLES, THE CRITERIA FOR A, B AND C EVIDENCE AS

important to recognise that these divisions are to some extent arbitrary as most forensic patients have multiple and interlinked problems.

- Studies of non-mentally disordered offenders are generally more widespread and are worthy of mention in the forensic mental health matrix as it is highly likely that at least some forensic patients (particularly those with personality disorders) will occur in non-offender samples. However it is also the case that many studies have specific exclusion criteria such that offenders with mental health problems are not likely to form part of the sample. Studies of offender populations where there is no formal assessment of mental disorder but are nevertheless of particularly high quality (RCTs or meta-analyses or systematic review) will be given a B rating in the tables.
- The references in the tables provide an example of the best level of evidence in relation to each treatment at present.

INDEX
BACK
NEXT

INTENSITY OF INTERVENTION

THE FOLLOWING DESCRIPTIONS RELATE TO INTERVENTIONS FOR FORENSIC PATIENTS. ALTHOUGH IN GENERAL LOW INTENSITY INTERVENTIONS WILL BE SHORTER, THIS WILL DEPEND ON THE RESPONSIVITY NEEDS OF EACH PATIENT. IN ADDRESSING THE MENTAL HEALTH NEEDS OF FORENSIC PATIENTS, THE GUIDANCE CONTAINED IN THE ORIGINAL MATRIX SHOULD BE USED AS A GUIDE.

Low Intensity interventions are brief interventions aimed at current distress or transient or mild mental health problems but may have a limited effect on overall functioning or risk of re-offending.

High Intensity denotes a standardised psychological therapy delivered to a formal protocol or model for mental health problems with significant effect on functioning and where there is a significant effect on risk of re-offending and future risk of harm.

Specialist interventions are standardised high intensity psychological therapies developed and modified for specific patient groups. These are aimed at moderate/severe mental health problems with significant effect on functioning. The interventions themselves are generally targeted at patients with more complex risk and needs and are directly related to offending behaviour and its causes.

Highly Specialist interventions are psychological therapies or interventions based on case formulations that may be drawn from a range of psychological models and are individually tailored to the patient's mental health problems and where risk assessment and management are key drivers in the execution of the therapy.

INDEX
BACK
NEXT

ANGER-RELATED AGGRESSION

Table showing strongest level of evidence from interventions used with adult male patients where anger dyscontrol is a principle cause of aggressive and violent behaviour. Some other approaches show promise but lack controlled trials. The routine allocation of violent offenders to anger interventions may be ineffective or counterproductive so the presence of anger as a problem requires to be formerly established.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild - Moderate	Secondary specialist or outpatient service or tertiary forensic mental health service in secure hospital, prison or community	High Intensity	CBT Anger Management	A [1]
Complex	Secondary specialist or outpatient service or tertiary forensic mental health service in secure hospital, prison or community	Specialist-Highly Specialist	CBT Anger Management	A [2] B [3]

REFERENCES >

INDEX
BACK
NEXT

GENERAL VIOLENCE

Table showing strongest level of evidence from broad interventions used with adult male patients to address violent behaviour which is more wilful/considered or instrumental in nature as opposed to principally resulting from anger dyscontrol. Violence is defined here as "actual attempted, or threatened harm to a person or persons…violence is behaviour which is obviously likely to cause harm to another person or persons" (1). Due to the multiple causal factors for violence and the heterogeneous nature of client population there is no single conceptual model to guide general violence interventions.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Moderate - Severe	Tertiary forensic mental health service in secure hospital, prison or community	High Intensity	CBT	B [2]

REFERENCES >

INDEX
BACK
NEXT

SEXUAL OFFENDING

The following interventions are recommended for adult males who are assessed as posing a risk of sexual offending. These may be individuals who have committed sexual offences, individuals who have been sexually aggressive without facing criminal charges or individuals who present with urges, fantasies or behaviours indicating a risk of sexual offending. The table sets out the primary recommendations regarding psychological treatment within forensic mental health services.

Research has generally been conducted with groups of male sexual offenders who have committed rape and child sexual abuse. There is little evidence to indicate whether child and adult offenders should be treated separately. Specific programmes have been developed for internet offenders but outcome research is still awaited. Similarly limited evidence exists with regard to treatment outcome for female offenders, sexual murderers, and unconvicted sexual offenders. Denial is unrelated to risk of recidivism (except perhaps in lower risk incest offenders) and treatment can be modified to meet the needs of deniers.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Medium to high risk of sexual recidivism	Tertiary forensic mental health service	High Intensity	CBT	B [1]
Individuals with paraphilias (deviant sexual interests)	Tertiary forensic mental health service	High Intensity – Highly Specialist	Behaviour modification	C [2]

REFERENCES >

INDEX
BACK
NEXT

GENERAL OFFENDING BEHAVIOUR

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
All levels of severity	Secondary / specialist outpatient Or tertiary forensic mental health	High intensity to highly specialist	CBT	B [1, 2]

REFERENCES >

INDEX
BACK
NEXT

CONTRIBUTORS TO TABLES

ANGER-RELATED AGGRESSION:	Mark Ramm
SERIOUS (GENERAL) VIOLENCE:	Mark Ramm
SEXUAL OFFENDING:	Rajan Darjee and Lynda Todd
GENERAL OFFENDING BEHAVIOUR:	Ruth Stocks and Rajan Darjee

REVIEWERS OF EVIDENCE FOR WHICH NO TABLE IS PRESENTED

DUE TO INSUFFICIENT EVIDENCE BASE TO SUPPORT SPECIFIC INTERVENTIONS:

PERSONALITY DISORDER:	Rajan Darjee, Lorraine Johnstone and Siobhan Murphy
INTIMATE PARTNER VIOLENCE:	Liz Gilchrist
STALKING:	Anna Sutherland and Catherine Creamer
FIRE SETTING:	Morag Slesser
SUBSTANCE MISUSE:	Ruth Stocks

INDEX
BACK
NEXT

REFERENCES

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Click the BACK button on the right to return to previous view

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Click the BACK button on the right to return to previous view

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Click the BACK button on the right to return to previous view

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Click the BACK button on the right to return to previous view

INDEX
BACK
NEXT

INDEX
BACK

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