The Treatment of Mentally Disordered Offenders: A National Survey of Psychiatrists

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A nationwide (U.S.) survey of major public mental hospitals treating patients who are incompetent for trial, not guilty by reason of insanity, mentally disordered sex offenders, or mentally ill inmates was conducted. Responses were received from 71 percent of the 115 facilities surveyed. Respondents were the directors of psychiatry from the respective facilities. The pattern of treatments delivered generally appeared clinically appropriate. However, behavioral and cognitive-behavioral treatments were reported infrequently, even in areas in which they would be particularly useful.

The question of what kinds of treatments are delivered to mentally disordered offenders[1] has received remarkably little research attention. While there are descriptions of treatment approaches for recurring problems such as violence[2] and sexual offending,[3–8] and for individuals in particular legal categories,[9,10] there has been no systematic study of the treatments delivered to mentally disordered offenders who are hospitalized in forensic institutions. Why this should be so in unclear. Mental health service delivery in jails has been systematically examined,[11] and there have been a number of previous national surveys of forensic facilities and patients[12–19] that have provided data on institutional and patient characteristics. None of these, however, provided detailed information on treatment.

To address the question of what kinds of treatments are provided to mentally disordered offenders in forensic facilities, we undertook a national survey of all public inpatient mental health facilities in the United States providing treatment to individuals who are incompetent to stand trial, not guilty by reason of insanity, mentally disordered sex offenders, or mentally ill inmates transferred to specialized correctional units. Our goal was to determine what kinds of treatments were being provided, for what problems, with what frequency, and with what kinds of patients.

Methods

Facilities An initial listing of all forensic facilities in the United States was

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obtained from lists used in previous surveys.[13,14] This was modified and updated by telephone contact with the respective offices of the forensic program director and corrections mental health director in each state. Facilities were selected for study only if they were one of the major state institutions in which mentally disordered offenders were treated. Excluded were community-based or regional forensic facilities, or correctional facilities with a single mental health unit. A total of 115 facilities meeting this criterion were identified.

Respondents Surveys were sent to the directors of each facility, who then passed them on to the director of psychiatry within the hospital. Psychiatrists were surveyed because of their probable familiarity with both the medical and nonmedical treatments being delivered to patients in these forensic hospitals.

Procedure The entire survey was done over a six-month period, using the total design method.[20] At the beginning of this six-month period, the initial survey (which totaled six pages) was sent. A follow-up postcard was sent out approximately two weeks after the initial survey mailing. This was followed by two more letters (the second certified), mailed three weeks apart, to those who had not responded within two months.

The six-page survey consisted of a treatment by disorder/behavior matrix, and each respondent was asked to check a cell whenever a particular treatment was administered within that facility to patients with a particular disorder/behavior. Treatments and disorders/behaviors were obtained by a review of the relevant literature. Types of treatments presented to respondents included psychotropic drugs, reality therapy, sexual dysfunction therapy/sex education, social skills or assertion training, cognitive-behavioral therapy, contingency management systems, aversion therapy, other behavioral techniques, anger control, dynamic psychotherapy, milieu therapy, vocational training, individual counseling (any kind), group therapy (any kind), AA/NA, and activity therapy.

Disorders/behaviors in the following categories were described: mental and emotional disorders, violent/aggressive behavior toward others, self-injurious or suicidal behavior, criminal sexual deviancy, and substance abuse. The categories were selected to represent the kinds of disorders/behaviors most often treated in mentally disordered offenders. Respondents were informed that "a given patient may have (and be treated for) more than one of these disorders." This meant that a respondent rating 100 patients, for example, might actually provide 300 affirmative ratings, since it was possible for a single patient to receive affirmative ratings in multiple categories.

Results

Usable responses were obtained from 71 percent of the facilities' respective psychiatric directors. The data were summarized according to the types of disorders treated and the treatment techniques. Two major questions were addressed: (1) What kinds of disorders are treated with the various forms of treat-

ments? (2) What percentage of patients actually receive each treatment?

What Kinds of Disorders Are Treated by the Different Forms of Treatments? Of the 16 forms of treatment, eight are described as variably administered according to the nature of the disorder: psychotropic drugs, sexual dysfunction therapy, contingency management systems, aversion therapy, other behavioral techniques, anger control, dynamic psychotherapy, and AA/NA. The pattern of treatment by disorder administration is generally in the clinically indicated direction (see Table 1). Psychotropic medication, for example, is frequently reported in the treatment of mental and emotional disorders (92%), violent/aggressive behavior (92%), and self-injurious or suicidal behavior (84%), but not for criminal sexual deviancy (24%) or substance abuse (43%). By contrast, sexual dysfunction therapy/sex education is rarely used to treat mental disorders (24%), violent behavior (11%), self-injurious behavior (5%), or substance abuse (11%), but is more often reported (51%) in treating criminal sexual deviancy.

This pattern, while in a "clinically indicated" direction, also reflects the distressing infrequency of administration of certain kinds of relevant treatment. This is the case with anger control, a relatively new, cognitive-behaviorally based form of intervention.[21,22] Anger control is rarely reported in disorders for which it would be marginally useful, such as substance abuse and criminal sexual deviancy. However, it is reported by more than half of the responding facilities in treating violent/aggressive behavior toward others (62%).

The remaining eight kinds of treat-

Table 1
Percentage of Institutions Reporting Presence of Various Treatments for Different Disorders in Mentally Disordered Offenders

Treatment	Disorders				
	Mental/ Emotional	Violence/ Aggression	Self-Injury	Sexual Deviance	Substance Abuse
Psychotropic drugs	92	92	84	24	43
Reality therapy	41	27	35	30	27
Sexual dysfunction	24	11	5	51	43
Social skills/assertion	65	57	57	51	43
Cognitive/behavioral	35	35	38	41	24
Contingency management	35	46	35	19	27
Aversion therapy	0	3	0	16	3
Other behavioral	27	35	8	7	6
Anger control	16	62	32	22	16
Dynamic psychotherapy	51	35	35	22	22
Milieu therapy	76	70	70	65	65
Vocational training	54	43	46	43	43
Individual counseling	78	81	84	70	70
Group therapy	81	68	65	65	62
AA and/or NA	27	14	14	16	68
Activity therapy	78	78	68	57	59

ment are reportedly administered in a fairly constant fashion across disorders. These include treatments that are frequently (i.e., more than 50%) reported, such as social skills/assertion training, milieu therapy, individual therapy, group therapy, and activity therapy. They also include treatments reported with moderate frequency (between 26% and 49%), such as reality therapy, cognitive-behavioral therapy, and vocational training.

What Percentage of Patients Received Each Treatment? The second question involved the percentage of patients receiving the various forms of treatment. As can be seen in Table 2, the treatments being delivered to the highest percentages of patients were medication, group therapy, individual therapy, and activity therapy, with mean percentages all above 50 percent. Moderately high percentages were also seen for token economy/contingency management, vocational training, reality therapy, sexual dysfunction, social skills/assertion training, and cognitive-behavioral therapy. Very low percentages of patient involvement were reported for aversion therapy.

Table 2
Percentage of Mentally Disordered Offenders Receiving Each Treatment

Treatment	Male	Female
Psychotropic drugs	73.0	71.0
Reality therapy	36.4	39.3
Sexual dysfunction	25.8	15.7
Social skills/assertion	47.7	46.6
Cognitive/behavioral	30.6	26.2
Contingency management	26.4	28.3
Aversion therapy	2.3	.5
Vocational training	38.6	42.7
Individual counseling	55.0	61.7
Group therapy	68.5	66.4
Activity therapy	74.8	83.9

Discussion

The combination of treatments and disorders generally appeared to reflect a good fit between type of treatment delivered and nature of disorder reported. However, some treatments were reportedly delivered infrequently when they appeared particularly relevant. This was particularly true for behavioral and cognitive-behavioral interventions. Treatments in this class, which should theoretically be well represented in the treatment of interpersonal violence[2] and criminal sexual deviancy,[3–8] were relatively infrequent. This may reflect a lack of technical expertise among the staff of some institutions in this area, with a consequent need for increased professional resources in the delivery of behaviorally based treatments.

One of the potential implications for these findings is that treatment outcome in mentally disordered offenders has been difficult to predict[23–33] because mentally disordered offenders often receive a course of treatment that is insufficiently individualized and not necessarily consistent with current trends in practice. This may mean that restructuring to produce more individualized treatment assignment and delivery in some institutions, particularly the larger ones, would be appropriate. It is also likely, however, that several of the groups identified in this survey are largely overlapping, and that the tendency toward similar treatment profiles is a function of this clinical reality as well.

As in any survey-based design, there is always the concern about completeness. Although the response rate was reasonably high (71%), our data still do not include reports from the remaining 29 percent of facilities treating mentally disordered offenders. Nor did we include community-based forensic treatment facilities, which are playing an increasingly important role in treating mentally disordered offenders.[34] Current results must be considered in this context.

The focus on the treatment of mentally disordered offenders has appropriately expanded beyond institutions to include community-based settings such as jails[11,15] and mental health centers.[35] The establishment of psychiatric security review boards has facilitated such research in Oregon[36,37] and Connecticut.[38] Yet institutions will inevitably continue to retain much of the responsibility for treating mentally disordered offenders. The present study is an early step toward understanding the normative aspects of such treatment.

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