

HELP: An Educational Forensic Psychiatric Assessment Program

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This paper describes the establishment of an educational group, Health through Education in Law and Psychiatry (HELP), within an inpatient forensic psychiatric assessment service. Until recently HELP sessions have been provided twice weekly to suitable patients during their stay of some 30 days at the Metropolitan Toronto Forensic Service (METFORS). We first outline very briefly the function of METFORS, then describe the HELP project broadly, and finally discuss the rationale of the program in greater detail. Our point is that programs of this type form an added resource in assessment and in the early stages of treatment. We also argue that, along with the accepted clinical role in assessment, forensic psychiatrists and colleagues in related disciplines can serve a valuable role as teacher and therapist.

The Metropolitan Toronto Forensic Service (METFORS) was established in 1977 to provide psychiatric assessments for courts.¹⁻⁴ It consists of a Brief Assessment Unit (BAU), where an accused in custody is examined over the period of a working day and a report is

written for court on the basis of that brief evaluation. This brief examination will usually meet the needs of the court seeking information concerning fitness for bail, fitness for trial, and possible mental illness. Only a very small fraction are remanded for opinions concerning an insanity defence. In a small number of cases the examining psychiatrist may decide that the patient's mental disorder warrants temporary transfer of the accused from the judicial or correctional systems into the mental health system. In a larger number of cases, about 25 percent of those seen in the BAU, complexities may occur that demand a further examination best achieved by the remand of an accused to our 23-bed Inpatient Unit, where he or she remains for the better part of a

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month. It is this latter group for whom the HELP program is provided.

The HELP Program

Each didactic session of the program is devoted to a topic in law or psychiatry. Basic material is presented in lecture form assisted by blackboard headings, written material, and videotape presentations. The lecturer then encourages patient participation in seminar form, allowing the expression of personal experience but directing it toward the theme under discussion. The keynote is "relevance" and the patients are constrained to organize their experience so that it will contribute to the group's understanding of the chosen topic. It is an exercise in cognitive control that leads to more effective communication and consequent education.

Our twice-weekly sessions usually include about eight patients. We exclude frankly psychotic and overtly disruptive patients and have had some problems in coping with the marked divergences in intelligence and educational backgrounds of our patients. Hence, we endeavor to be somewhat selective. However, our tendency is to include as many patients as we can and to insist upon attendance at the whole series of sessions. The latter has not proved to be a serious problem because the bulk of our patients really enjoy the sessions and most think they should occur on a daily basis. The instructors repeatedly make it clear to participants that, although asked to function as students rather than patients during the course of HELP sessions, the program is an integral part of the assessment as a

whole. Teaching is a decided challenge as difficult concepts in psychiatry and in law need to be expressed in simple terms and instructors cannot fall back on vague and esoteric technical vocabularies to evade insistent demands for "plain talk." We have been repeatedly struck by the fact that many of our patients, even those who have been hospitalized on several occasions, have very little idea of the intended functions of different kinds of mental health workers.

The topics we currently cover are outlined in a manual for patients.⁵ These topics are organized around such questions as the following: Who are the mental health professionals? What is "fitness to stand trial"? What is the "insanity defence"? What is emotional illness? What are the "physical treatments" in psychiatry? What is psychotherapy? What is behavioral therapy? How can impulses be controlled? Why should families be involved? We have also held experimental sessions on "procedures in the courtroom," "theories of criminal behavior," "surviving on the inside—how to do time," and "surviving on the outside—getting a job and place to stay." The manual contains, after each brief section, a list of questions. Although we have attempted to use these questions with individual patients before and after the HELP program in preliminary research efforts, their main value is in the group itself. We find it useful, at the end of the session, to pose questions to the group as a whole, not only providing a measure of fun but also allowing a sense of closure. We have found it beneficial, al-

most necessary, to have two teachers for any one session. The change in style from one lecturer to the other enlivens the presentation and stimulates the patients to intervene. Impromptu role playing can highlight the pros and cons of various themes and adds a dramatic quality to the session, which encourages the patients to think about issues and perhaps take sides. The end result can be a lively exchange of ideas. Originally, the authors served as sole teachers and organizers. In recent years, we have been aided by a psychologist and a social worker as well as by resident psychiatrists and law students. Sometimes we have also been helped through the addition of a part-time coordinator who has greatly assisted in effecting smooth organization and in providing continuity.

The aims of HELP are evaluative, educational, and therapeutic. MET-FORS, as already noted, is basically an assessment unit. We try to build an evaluative element into everything our patients do, from matters of their daily self-care and use of time and programs to the specific tests that they complete and the interviews in which they engage. We are observing the nature of the patients' participation, their cognitive styles and strategies, and particularly the quality of their insights as they apply new information or new interpretations to their own cases. From this information we think we can increase the objectivity of our conclusions about the patients' competence to function in psychological treatments. If treatment is to be recommended to the court, then it is important that it be conveyed.

General Rationale of the HELP Program

The education of the patient is a main goal of this program. We attempt to provide a sense of mastery and believe that the better informed the patients, the more effectively will they deal with their current crises as they proceed through the court system. The defendants' awareness of what the court is seeking mobilizes their resources to enable them to contribute to their own defense and so be competent to stand trial in the full sense of that term. In no way whatever is it geared to help patients to "beat the system." It is simply that a patient pleading insanity should know the consequences of that action. These consequences are not always made clear to patients by their lawyers. There is a huge literature on this topic, one which responsible mental health professionals have to command. That literature needs to be developed and expanded among professional colleagues but it ought also to touch the lives of the patients. The fact that the information is in the public domain is not sufficient. It requires simplification in some instances and it often needs to be repeated. Further, the HELP program provides information about the true nature of emotional disorder and tries to reduce the prejudices that potential patients may have that impede acceptance of their difficulties and the motivation to deal with them. Explanation of medical and psychiatric terms can do much to secure the patients' grasp of technical vocabularies that directly affect them. The discussion concerning treatment can reduce resistance based on irra-

tional concepts while information about local available resources may open doors for the reluctant patient. We have concluded that patients may become more compliant about taking medication after seeing that the psychiatrist-instructor not only knows what can be accomplished by different types of medication but also understands problems associated with side effects. The session on "how to do time" in the event of incarceration is a new addition to our program for which we are still accumulating some practical and realistic wisdom to pass on to our anxious patients facing a custodial sentence. It highlights the prophylactic aspect of these sessions. These and other points are now discussed in greater detail.⁶

Sense of Mastery Patients remanded for psychiatric assessment are often unsure of the purpose of the evaluation, the expectations of others, and the way in which eventual results relayed to the court may influence their position. Some patients cannot think very clearly when they first come. Their lives have suddenly undergone great disruption. Others arrive with self-defeating ideas about their own defense. Even though they may, according to the record, have had extensive dealings with either the criminal justice system or the mental health system or both in the past, we have often been struck by our patients' relative ignorance about these social organizations and about the way that their lives are affected by these organizations. Patients lack knowledge about the functions that these systems are intended to serve. The patients seem to have adopted an unduly passive atti-

tude, one often fueled with a good deal of latent hostility. They are caught up in the "double-revolving door" and often display little hope that they can find an exit.⁷

In the HELP program we take the view that our patients have little knowledge and therefore little power. The basic aim is to give them information on the premise that it could be useful as they go to trial. The roles of the prosecution, the defense, and the judge have to be defined and explained with some care. Mock trials can be very useful. Sometimes we carry these out spontaneously in the group; sometimes they are planned ahead. It is usually simple to get patients' interest in this way and it is easy to direct the proceedings so that key issues can be explored as the mock trial proceeds. After a little practice, our patients often surprise us with their inventiveness and resourcefulness. Not only do the patients come with lack of knowledge, they also do not know how to express themselves firmly but deferentially in court-like proceedings. They come with "power-less" language⁸ and our aim is to help them to overcome this difficulty. Moreover, the therapist-instructors frequently benefit from being exposed to the language of the prisoner-patients.⁹

We hypothesize that, as a result of participation in HELP, patients do achieve, over weeks, a sense of accomplishment. By the end of assessment we hope that they will feel more generally capable and self-assured. It is not so much that they have "got through" a psychiatric assessment but that they have, in effect, completed a course. For

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many patients, most of whom have poor records of success in school, this is a new and welcome experience.

Crisis Orientation HELP is crisis oriented. Patients are worried about the charges and may show at first all the consequent features of ego disorganization. They need to release their feelings and to be supported while they reorganize their defenses and gain some measure of mastery over the situation. The HELP program attempts to capitalize on this latter phenomenon. Information about the law and its functions with special application to the cases of the accused assists in clarifying the rights and obligations of the individual as well as those of the state. In the latter case the accused patients may come to appreciate the necessary functions of the police and the resultant bureaucracy of the legal system in pursuing law and order. Whereas mention of the system might otherwise evoke criticism and anger, the accused patients may come to feel less irrationally persecuted by hostile others and to view their predicament (whether guilty or innocent) in a more realistic light. Such a person is thereby much better equipped to proceed to trial and to appreciate the consequences thereof. A sentence of some kind becomes, under these circumstances, a proper deterrence in that it is more truly correctional than punitive.

Impersonal Control Conventional forensic psychiatric interviews are usually contrived as rather direct explorations of the patient's personal existence. Not unexpectedly, the patient feels under attack and obliged to be on the defensive. To a greater extent

than occurs in most conventional psychiatric practice, forensic psychiatrists cannot avoid the fact that they are "persons in authority." The role relations are structured to place the patient as the one "being acted upon." As is well known, patients under such circumstances frequently respond deceptively.¹⁰

In HELP, the aim is to render the control impersonal by focusing on external situations enabling patients to distance themselves somewhat from problems that are threatening for them to consider personally (e.g., mental illness). The idea is to help them to see their difficulties objectively by decreasing attention to their specific and particular problems. We make disciplined attempts to help patients alter their outlooks, if only temporarily and if only under particular circumstances. Within reason, any change of outlook, indicating some measure of openness of mind, may be of benefit (e.g., as a means of assessing suitability for treatment). We believe that HELP-type assessments can substantially aid in the difficult issue of gauging prognosis.

Patient Perspective In the preceding section, we have already implied that HELP-type programs rest on the assumption that gains may accrue from altering the ordinary balance of power. Very generally, it has been our experience that in HELP-type groups some patients show, when the onus is on them, qualities that have hitherto gone unnoticed. One difficulty with conventional psychiatric assessments is that clinicians, sometimes despite valiant efforts to do otherwise, find ever more

negative material about their patients as the assessments proceed.¹¹ A HELP-type approach can do much to offset this otherwise inherent difficulty.

Stigma Reduction The great majority of forensic psychiatric patients leave forensic psychiatric assessment with some kind of diagnostic term attached to their records and so to themselves.¹² In recent years psychiatrists and other mental health workers have been instructed at length about the damaging consequences of labeling.¹³ The task in HELP is to tackle this difficulty by careful explanation of the nature of emotional disorders and attempts to capture some of the positive benefits of diagnosis. The act of making a diagnosis is one thing; helping a patient to accept the formulation is another. Some of our patients must be convinced to accommodate psychiatric opinion willingly. However, there are benefits to diagnosis that can be explained to patients. These benefits help to reduce the sense that we as clinicians are imposing a descriptive scheme that undermines the patients' individuality and imposes a stigma.

Increased Compliance One aim in the HELP program is to enhance compliance with the legal and psychiatric systems by describing what the law is trying to do, supported in this instance by psychiatry. We have to explain to patients that in most instances it is appropriate that they face their charges and that evidence be heard, regardless of their guilt or innocence. Our goal is to build a bridge to the law by offering an outline of the legal system. We explain how the system works and en-

courage the patients to deal with it as it is. Overly strong attempts to resist may mean that patients obtain a distorted appraisal and may function poorly in court as a result.

As far as compliance on the ward is concerned, perhaps the most important area for discussion comes with medication and side effects. In this instance a good deal can be accomplished by explaining that, often, drugs take several days if not weeks to become effective. Having a doctor state clearly what kinds of side effects accompany different classes of common medications does much to alleviate anxiety in patients, especially when it is pointed out that such symptoms can often be managed quite easily.

Cognitive Exploration There is some opinion to suggest that criminals suffer from a form of thought disorder.¹⁴ This term refers not to a psychotic process but to a type of wrong thinking wherein inadequate and inappropriate premises give rise to thought sequences resulting in criminal behavior as a "logical" consequence. Offenders feel justified because to them they have responded in a reasonable manner under the circumstances as they perceive them. This thought disorder tends to be a closed system that effectively blocks out the self-criticism that would alert the undisturbed person to the relevant antecedents and consequences of this line of thinking.

The goal of the didactic seminar is to involve the group in thinking about legal, moral, and psychological issues. The seminar provides an occasion for evaluating the way that particular pa-

tients perceive certain issues in their lives, the conclusions that they draw, and the thought processes that they use in arriving at such conclusions. The "cognitive style" of the patients may be delineated in this way and their possibly wrong thinking about abstract issues may be applied to the concrete issues in their lives. This cognitive exploration may also point out the particular blocks in learning that seem to impede patients' intellectual maturation. Finally, as with any educational endeavor, the aim of a didactic group is not merely the impartation of particular knowledge but the training of the mind. We try to expose patients to calm, balanced judgment and to show how enjoyment of thinking itself can be a process of gratification. After such a mental workout, it is not unusual for patients to comment on the stimulating and satisfying hour that they have spent.

Therapeutic Alliance This is essentially an issue of collaboration, which is based on an empathic relationship between therapist and patient. Many forensic patients coming into an assessment situation have never before been exposed to mental health professionals. It is characteristic for these patients to put up a wall of withdrawal, defensiveness, suspicion, and hostility; often they never go beyond this impenetrable wall. However, with some prolonged contact in a less threatening environment, rejecting attitudes may be modified with a chance for the development of an empathic relationship, albeit simple and tentative. For such a patient this may be the start of a whole new style of collaboration with others over mu-

tually relevant issues. The therapeutic alliance is the very basis for personality and attitudinal change in psychotherapy and the key to the therapeutic alliance is empathy. Empathy is reciprocal. Not only does it involve the awareness by patients of the therapist's appreciation of their problems but it also implies the patients' ability to experience in themselves that awareness in their therapist. Patients have made an emotional (i.e., empathic) contact with the therapist and there has been set up thereby a channel of feeling between the self of the patient and that of the therapist. In this way, an empathic flow can take place between them.

This phenomenon occurs in all good psychotherapy, regardless of the technique. However, we feel that the didactic format of the HELP group may contribute to this by the discussion of sensitive issues in a context that is not apt to be directly threatening to the individual patients. Similarly the therapist (now teacher) is able to engage more freely in self-disclosure of his own personal material by way of examples of the issues under discussion. This facilitates empathic flow from patient to teacher. We suggest that the didactic seminar style of therapy deals with transference and countertransference issues in a somewhat different way from that which occurs in regular psychotherapy, although we appreciate that it may not go far enough in this regard. Nonetheless, the basis of a therapeutic alliance may be forged in this particular type of interaction between patient and professional.

Moral Emphasis Values are an es-

sential matter in clinical psychology and psychiatry, both of which lean so heavily on interpersonal relationships. This is especially true with the forensic patient. Criminal law deals with crime and punishment—what one must not do and, to a lesser extent, what one must do. These restrictions are based on a common acceptance of reasonable human behavior in a particular social climate. Breaking the law immediately raises for lawbreakers the issue of the nature of “reasonable behavior” in a given set of circumstances. They need to view their own behavior in light of the society in which they live and to be sensitive to the effects of that behavior on others. Hence, there arises a perusal of rights, wrongs, duties, and obligations, which is central to the consideration of moral issues.

The alleged offenders must follow the group along this journey of exploration into moral values as they define society's expectations of its members' appropriate conduct and, in so doing, measure their own degree of responsibility for falling short of those expectations. The HELP group attempts to delineate the moral issues involved in the court processes. The accused patients can then apply them to their own predicament. For example, the group raises such questions as the following: Why should a person be mentally fit in order to face trial? Why should the law allow involuntary hospitalization and treatment? Why should drunkenness be no true defense? Why is it wrong to steal? to assault? to rape? These questions are raised as abstract considerations although always in the most sim-

ple and, indeed, concrete terms. Moral thinking is stimulated in patients-pupils without obvious attempts to challenge directly their own behavior in this regard. This indirect approach permits some patients the freedom to make their own self-confrontations.

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