



## Genesis of change: Substance use treatment for forensic patients with mental health concerns

Mc Fadden, D., Barrett, E. L., Prior, K., Miles, H., & Hemraj, S. (2022). Genesis of change: Substance use treatment for forensic patients with mental health concerns. *Drug and Alcohol Review*, 41(1), 256-259. <https://doi.org/10.1111/dar.13344>

[Link to publication record in Ulster University Research Portal](#)

**Published in:**  
Drug and Alcohol Review

**Publication Status:**  
Published (in print/issue): 01/01/2022

**DOI:**  
[10.1111/dar.13344](https://doi.org/10.1111/dar.13344)

**Document Version**  
Publisher's PDF, also known as Version of record

**General rights**  
Copyright for the publications made accessible via Ulster University's Research Portal is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

**Take down policy**  
The Research Portal is Ulster University's institutional repository that provides access to Ulster's research outputs. Every effort has been made to ensure that content in the Research Portal does not infringe any person's rights, or applicable UK laws. If you discover content in the Research Portal that you believe breaches copyright or violates any law, please contact [pure-support@ulster.ac.uk](mailto:pure-support@ulster.ac.uk).

## COMMENTARY

## Genesis of change: Substance use treatment for forensic patients with mental health concerns

DANIEL McFADDEN<sup>1,2</sup> , KATRINA PRIOR<sup>1</sup>, HELEN MILES<sup>3</sup>, SUNNY HEMRAJ<sup>4</sup> & EMMA L. BARRETT<sup>1</sup>

<sup>1</sup>The Matilda Centre for Research in Mental Health and Substance Use, The University of Sydney, Sydney, Australia, <sup>2</sup>School of Applied Social and Policy Sciences, Ulster University, Derry, UK, <sup>3</sup>Institute of Psychiatry, Psychology and Neurosciences, Kings College London, London, UK, and <sup>4</sup>BEING – Mental Health Consumers, Sydney, Australia

### Abstract

Substance use disorders are highly prevalent among forensic patients. They are associated with many challenges for patients with these problems, including their ability to rehabilitate and successfully move through secure forensic mental health services, as well as increasing risk for recidivism. Traditionally, forensic services have been more adept at focusing on and treating the primary mental health diagnosis alone and have been less likely to prioritise this co-occurring patient need. Opportunities exist to foster effective treatment strategies for substance use disorders, and past research has produced positive outcomes among forensic patients in studies in both Australia and the UK to navigate a new course for patients with these problems. By providing empirically validated, co-produced and culturally competent treatment responses, forensic patients living with substance use disorders will have the opportunity to significantly improve their wellbeing and progress through the system. They will also be more prepared and equipped to face challenges upon discharge into the community, including increased availability of alcohol and other drugs, social stigma and barriers to employment. Moreover, by prioritising effective substance use treatment programs during inpatient rehabilitation, services can reduce the levels of post-discharge recidivism. [McFadden D, Prior K, Miles H, Hemraj S, Barrett EL. Genesis of change: Substance use treatment for forensic patients with mental health concerns. *Drug Alcohol Rev* 2021]

**Key words:** substance use, treatment, mental illness, forensic patient, rehabilitation.

### What Is the Scale and Impact of This Issue?

Substance use disorders are highly prevalent among forensic patients (i.e. individuals who have committed a crime and been found not guilty by reason of mental illness). Between 60 and 75% of forensic inpatients meet the DSM-IV and DSM-5 diagnostic criteria for substance use disorder [1–4]. Although the link between substance use and offending is acknowledged [5,6], it has not always been accompanied by adequate changes to forensic mental health service delivery [7].

There is a range of challenges faced by forensic patients with substance use histories in the UK and Australia; both during their treatment in forensic

services and upon their release into the community. Forensic services tend to lack treatments that fully support patients in their rehabilitation, with treatments varying in design and levels of sophistication [7–9]. The presence of severe, complex mental illness can also prevent patients from engaging fully in rehabilitation programs. This can combine with distrust of authority and prohibit the formation of a strong therapeutic relationship, necessary and central to improved outcomes [10,11].

Even when patients are treated within the forensic mental health system and subsequently discharged, the presence of a comorbid substance use disorder can make living in the community challenging. Individuals

Daniel McFadden B.SocStudies, Lecturer in Social Work, Katrina Prior PhD, Research Fellow, Helen Miles D.Clin Psych, Consultant Clinical and Forensic Psychologist, Sunny Hemraj, Mental Health Advocate, Emma Louise Barrett M.Psych [For], PhD, Senior Research Fellow. Correspondence to: Mr Daniel McFadden, School of Applied Social and Policy Sciences, MaGee Campus, Ulster University, Northland Road, Derry, Northern Ireland, BT487JL, UK. Tel: +353873514252; E-mail: d.mcfadden@ulster.ac.uk

Received 25 January 2021; accepted for publication 5 June 2021.

with severe mental disorders can be at risk of engaging in violent behaviour [12,13]. This could be due to the impact of intoxication, withdrawal symptoms, dependence and mental health symptoms all of which can influence an individual's ability to control their behaviour [14]. A long-term follow-up study of 550 forensic patients found that having a history of substance use problems was positively associated with reconviction post-release [15]. Half (49%) of the patients were reconvicted over the 20-year period [15]. Other studies have found significant associations between drug and alcohol use and reoffending post-discharge [16].

Forensic patients also experience severe discrimination when discharged into the community. It has been argued that the stigmatisation of people with mental disorders fuels the societal belief that mental disorders and violence are strongly connected, for instance, a community-based survey found that respondents were more likely to predict someone would commit a crime in the future if they had a mental illness than if they did not have one [17]. The association between mental health and criminal behaviour is largely influenced by other factors, such as age, sex and educational level [18], with studies demonstrating that only around one-sixth (17%) of crimes committed by individuals with mental illness are actually related to the symptoms of their mental disorder [19]. Despite the overwhelming majority of violent acts being committed by individuals without mental illness [20], this prejudice continues to have a detrimental impact on forensic patients reintegrating into the community.

Collectively, these challenges can make a complex rehabilitation pathway even more complicated. As forensic patients with substance use disorders enter the forensic system, they require treatments that adequately address their presenting needs and equip them for eventual discharge into the community, so they aren't further disadvantaged. Empirically validated, co-produced (i.e. designed in collaboration with service users) and culturally competent interventions targeted at this group are needed to mitigate these challenges and contribute to their recovery. However, it is acknowledged that the social, political and institutional obstacles to appropriate care continue to present a formidable challenge to health-care delivery within these settings.

### **What Do We Know about the Treatment of Substance Use Disorders among Forensic Patients?**

Substance use disorder treatment in non-forensic contexts provides a useful blueprint for the development

of robust and effective treatment strategies for forensic populations. The efficacy of cognitive behavioural therapy and motivational interviewing have been established through numerous studies in inpatient psychiatric settings [21,22] and among the general psychiatric population with substance use disorders [23–25]. In comparison, psychoeducation, the most frequently employed approach in forensic settings, has been shown to be largely ineffective, with no cognitive or behavioural change [22,26,27].

Concerningly, we continue to see a stagnation in the efforts to implement and evaluate these evidence-based cognitive behavioural therapy and motivational interviewing treatment approaches in forensic settings. As previously outlined, substance use plays a major role in the offending behaviour of many forensic patients, yet it can be considered an afterthought to other clinical issues facing forensic patients [2]. Some preliminary studies have attempted to pave the way for progress in this area [28–32]. However, progress in this area is hampered by the lack of clinical studies and larger randomised controlled trials with long-term follow ups and control groups to confirm the efficacy findings. Forensic services world-wide also struggle with a lack of staff resources to provide up-to-date, evidence-based treatment programs due to increasing caseloads and competing workload priorities. Equally, many clinicians in these settings do not have specialised expertise in substance use treatment, as these are often targeted in separate services.

### **Treatment Requirements for Forensic Patients: A Diverse Approach for a Diverse Population**

Forensic patients have a multitude of clinical characteristics, which require specific treatment considerations in order to ensure the treatment is not only efficacious, but also acceptable to the patient cohort. In the Australian forensic setting, Aboriginal and Torres Strait Islander people, female patients and culturally and linguistically diverse (CALD) groups require these special considerations. Each group has their own specific treatment needs, which need to be addressed with evidence-based treatment programs. For example, Aboriginal and Torres Strait Islander patients are substantially overrepresented, making up approximately 17–30% of the forensic population in Australia [33,34] and for this reason, the importance of cultural competence in mental health treatment is now seen as a core requirement in forensic treatment settings [34].

Another patient group that requires specific consideration when designing and implementing forensic

treatment services are female patients, who typically make up a small yet important proportion of forensic patients [29]. Female patients, who often have significant histories of physical and sexual abuse [35], require a space in which they can comfortably and safely discuss their experience of trauma and its relationship to their substance use, preferably not in the company of male forensic patients [36]. CALD groups have their own individual needs and their own cultural perceptions of substance use and what is required to start and stay on a road to recovery, which will often involve family support from these same cultural backgrounds [37]. Recovery plans generated as part of these treatment programs must be cognizant of these specific needs.

### The Power of Co-production in Treatment Development and Evaluation

'Co-production' in health care involves clinicians and patients working together to design and deliver services [38]. The use of co-production in the design, delivery and evaluation of mental health services has gained significant traction in recent years and is now seen as integral to recovery-oriented services [39]. Those engaging in co-production in research outline that it is morally required of researchers to include feedback and opinions of those whom the research is intended to impact most [40]. This change has created a shift from service users being passive recipients to co-creators of their own treatment and care, empowering them to lead in their own recovery. Despite research indicating that service users *have a strong desire to be heard in relation to the provision of their treatment and also research and evaluation* [41-44], evidence of co-production for substance using populations is scarce [45]. The differences in treating mental illness and substance use disorders are substantial and co-production techniques must parallel this. Where mental illness has become less stigmatised, this has not happened to the same degree for substance use disorders [46]. Services should engage an approach that is cognizant of the need to empower service users to become the leaders of their own health care.

### What Next?

An opportunity exists to address substance use disorders among forensic patients; a critical need that is often unprioritised. Empirically supported treatment strategies, with culturally competent and trauma-informed approaches, education and training for staff

as well as co-designed and co-delivered programs, can meet the rehabilitation needs of this group. The Substance Use Treatment Program trialled in the UK and Australia [29,32] has shown some promise in addressing these issues; however, further research is required. Culturally competent treatment approaches co-produced with Aboriginal and Torres Strait Islander communities in Australian settings are of particular importance due to both the gaps in tailored service provision and the rehabilitation challenges experienced by this group in their communities upon release. Forensic patients face significant challenges in their rehabilitation pathway. Those with comorbid substance use disorders could benefit greatly from improved service provision, enabling them to reduce their risk levels and move through secure care pathways at a quicker pace and to face the challenges associated with daily life upon discharge. Forensic mental health service providers can play a key role in providing effective treatment so that this population can effectively survive and thrive in the community.

### Acknowledgements

The project was supported by the NSW Health Education and Training Institute via the Mental Health Research Award and a NSW Mental Health Commission Lived Experience Framework grant.

### Conflict of Interest

The authors have no conflicts of interest.

### References

- [1] Eagle K, Ma T, Sinclair B. Integrated substance use rehabilitation in a secure forensic facility. *J Forensic Pract* 2019;21:50-60.
- [2] Ogloff JR, Lemphers A, Dwyer C. Dual diagnosis in an Australian forensic psychiatric hospital: prevalence and implications for services. *Behav Sci Law* 2004;22:543-62.
- [3] Van der Kraan J, Verkes RJ, Goethals K, Vissers A, Brazil I, Bulten E. Substance use disorders in forensic psychiatric patients. *Int J Law Psychiatry* 2014;37:155-9.
- [4] Ojansuu I, Putkonen H, Lähteenvuo M, Tiihonen J. Substance abuse and excessive mortality among forensic psychiatric patients: a Finnish Nationwide cohort study. *Front. Psychiatry* 2019;10:678.
- [5] Derry A. The clinical response to substance use problems in forensic mental health services. *Br J Forensic Pract* 2008;10:20-3.
- [6] Link NW, Hamilton LK. The reciprocal lagged effects of substance use and recidivism in a prisoner reentry context. *Health Justice* 2017;5:8.
- [7] Mallion JS, Tyler N, Miles HL. What is the evidence for offense-specific group treatment programs for forensic patients? *Int J Forensic Ment Health* 2019;19:1-13.
- [8] Sandbrook J, Clark T, Cocksedge KA. Addressing substance misuse in medium secure settings in the UK and Ireland - a survey of current practice. *J Forensic Pract* 2015;17:192-203.

- [9] Whyte S, Harrison C. Substance misuse services in secure psychiatric units. *Med Sci Law* 2004;44:71–4.
- [10] Martin DJ, Garske JP, Davis MK. Relation of the therapeutic Alliance with outcome and other variables: a meta-analytic review. *J Consult Clin Psychol* 2000;68:438–50.
- [11] Flückiger C, Del Re AC, Wampold BE, Horvath AO. The alliance in adult psychotherapy: a meta-analytic synthesis. *Psychotherapy (Chicago, Ill)* 2018;55:316–40.
- [12] Fazel S, Gulati G, Linsell L, Geddes JR, Grann M. Schizophrenia and violence: systematic review and meta-analysis. *PLoS Med* 2009;6:e1000120-e.
- [13] Wright S, Gournay K, Glorney E, Thornicroft G. Mental illness, substance abuse, demographics and offending: dual diagnosis in the suburbs. *J Forensic Psychiatry* 2002;13:35–52.
- [14] Ogloff JRP, Talevski D, Lemphers A, Wood M, Simmons M. Co-occurring mental illness, substance use disorders, and antisocial personality disorder among clients of forensic mental health services. *Psychiatr Rehabil J* 2015;38:16.
- [15] Davies S, Clarke M, Hollin C, Duggan C. Long-term outcomes after discharge from medium secure care: a cause for concern. *Br J Psychiatry* 2007;191:70–4.
- [16] Scott F, Whyte S, Burnett R, Hawley C, Maden T. A national survey of substance misuse and treatment outcome in psychiatric patients in medium security. *J Forensic Psychiatry Psychol* 2004;15:595–605.
- [17] Nee C, Witt C. Public perceptions of risk in criminality: the effects of mental illness and social disadvantage. *Psychiatry Res* 2013;209:675–83.
- [18] Rueve ME, Welton RS. Violence and mental illness. *Psychiatry* 2008;5:34–48.
- [19] Peterson JK, Skeem J, Kennealy P, Bray B, Zvonkovic A. How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness? *Law Hum Behav* 2014;38:439–49.
- [20] Varshney M, Mahapatra A, Krishnan V, Gupta R, Deb KS. Violence and mental illness: what is the true story? *J Epidemiol Community Health* 2016;70:223–5.
- [21] Drake RE, Mueser KT, Brunette MF, McHugo GJ. A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatr. Rehabil. J.* 2004;27:360–74.
- [22] McMurren M. Expert paper: dual diagnosis of mental disorder and substance misuse. London: Department of Health, 2002.
- [23] Hulse GK, Tait RJ. Five-year outcomes of a brief alcohol intervention for adult in-patients with psychiatric disorders. *Addiction* 2003;98:1061–8.
- [24] Martino S, Carroll K, Nich C, Rounsaville B. A randomized controlled pilot study of motivational interviewing for patients with psychotic and drug use disorders. *Addiction* 2006;101:1479–92.
- [25] Satre DD, Weisner C, Travis A, Lu Y, Sterling SA, Leibowitz A. A randomized clinical trial of motivational interviewing to reduce alcohol and drug use among patients with depression (technical report). *J Consult Clin Psychol* 2016;84:571.
- [26] Ritchie G, Billcliff N, McMahon J, Thomson L. The detection and treatment of substance abuse in offenders with major mental illness: an intervention study. *Med Sci Law* 2004;44:317–26.
- [27] Jeffery DP, Ley A, McLaren S, Siegfried N. Psychosocial treatment programmes for people with both severe mental illness and substance misuse. *Cochrane Database Syst Rev* 2000;2:238–58.
- [28] Ritchie G, Weldon S, Freeman L, MacPherson G, Davies K. Outcomes of a drug and alcohol relapse prevention programme in a population of mentally disordered offenders. *Br J Forensic Pract* 2011;13:32–43.
- [29] Miles H. “A new horizon?”: evaluation of an integrated Substance Use Treatment Programme (SUTP) for mentally disordered offenders. *Adv Dual Diagn* 2015;8:90–101.
- [30] Miles H, Duteil L, Welsby I, Haider D. ‘Just say no’: a preliminary evaluation of a three-stage model of integrated treatment for substance use problems in conditions of medium security. *J Forensic Psychiatry Psychol* 2007;18:141–59.
- [31] Derry A, Batson A. Getting out and staying out: does substance use treatment have an effect on outcome of mentally disordered offenders after discharge from medium secure service? *Br J Forensic Pract* 2008;10:13–7.
- [32] McFadden D, Prior K, Barrett EL. A Substance Use Treatment Programme for mentally ill forensic patients in an Australian setting: a pilot study of feasibility, acceptability and preliminary efficacy. *Int J Ment Health Addiction* 2020. [Epub ahead of print].
- [33] JHFMHN. Forensic mental health patient survey report. Sydney: Justice Health and Forensic Mental Health Network, 2016.
- [34] Durey A, Wynaden D, Barr L, Ali M. Improving forensic mental health care for Aboriginal Australians: challenges and opportunities. *Int J Ment Health Nurs* 2014;23:195–202.
- [35] De Vogel V, Stam J, Bouman YHA, Ter Horst P, Lancel M. Violent women: a multicentre study into gender differences in forensic psychiatric patients. *J Forensic Psychiatry Psychol* 2016;27:145–68.
- [36] Long CG, Fulton B, Fitzgerald K-A, Hollin CR. Group substance abuse treatment for women in secure services. *Ment Health Subst Use* 2010;3:227–37.
- [37] Gainsbury SM. Cultural competence in the treatment of addictions: theory, practice and evidence. *Clin Psychol Psychotherap* 2017;24:987–1001.
- [38] Batalden M, Batalden P, Margolis P *et al.* Coproduction of healthcare service. *Br Med J: Qual Saf* 2016;25:509–17.
- [39] Collins P, Naughton L, Heslin R, Ryan M. Advancing recovery in Ireland: a guidance paper on implementing organisational and cultural change in mental health services in Ireland. 2016.
- [40] Amering M, Schrank B, Wallcraft J. In: Amering M, Schrank B, Wallcraft J, eds. *Handbook of service user involvement in mental health research*. Chichester: Wiley-Blackwell, 2009.
- [41] Horgan A, Manning F, Bocking J *et al.* ‘To be treated as a human’: using co-production to explore experts by experience involvement in mental health nursing education – the COMMUNE project. *Int J Ment Health Nurs* 2018;27:1282–91.
- [42] Pinfold V, Szymczynska P, Hamilton S *et al.* Co-production in mental health research: reflections from the people study. *Ment Health Rev* 2015;20:220–31.
- [43] Billsborough J, Mailey P, Hicks A *et al.* Listen, empower us and take action now!: reflexive-collaborative exploration of support needs in bipolar disorder when ‘going up’ and ‘going down’. *J Ment Health* 2014;23:9–14.
- [44] Happell B, Roper C. Consumer participation in mental health research: articulating a model to guide practice. *Aust N Z J Psychiatry* 2007;15:237–41.
- [45] Cairns J, Nicholls J. Co-production in substance use research. *Drugs Alcohol Today* 2018;18:6–16.
- [46] Crapanzano K, Hammarlund R, Ahmad B, Hunsinger N, Kullar R. The association between perceived stigma and substance use disorder treatment outcomes: a review. *Subst Abuse Rehabil* 2018;10:1–12.