

# SECURE TREATMENT SETTING

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**Primary Disciplinary Field(s):** Forensic Psychology, Criminology, Correctional Mental Health, Social Work

### 1. Core Definition

The **Secure Treatment Setting** (STS) is a highly specialized residential care facility characterized by perimeter security and stringent internal controls, designed specifically to provide intensive therapeutic and rehabilitative services. Unlike conventional psychiatric hospitals or community mental health centers, the STS is fundamentally locked, ensuring the safety of the residents, staff, and the surrounding community. This institutional structure is necessary because the patient population typically consists of individuals, often legally classified as felons or those involved in the criminal justice system, who suffer concurrently from severe mental illnesses, developmental disabilities, or complex behavioral disorders that necessitate a managed, restrictive environment.

The core mission of a Secure Treatment Setting is the successful integration of security measures--traditional to correctional facilities--with a genuine therapeutic milieu found in clinical environments. This synthesis is critical. The security infrastructure, which may include high fencing, controlled access points, and continuous surveillance, addresses the immediate risks associated with violence, self-harm, and elopement. Simultaneously, the environment must foster healing and skill development, preventing the setting from devolving into a purely custodial or punitive institution. The primary therapeutic goal is behavioral stabilization and the reduction of future dangerousness, paving the way for eventual transition to less restrictive care levels.

These facilities serve a distinct population that general mental health services cannot safely accommodate. Residents may be those found Not Guilty by Reason of Insanity (NGRI), those deemed Incompetent to Stand Trial (IST), or individuals who have completed a correctional sentence but require continued involuntary commitment due to ongoing mental instability and demonstrated risk. Therefore, the STS functions as a critical nexus point where the requirements of the criminal justice system (public protection) intersect with the ethical mandate of the mental health system (treatment and rehabilitation).

### 2. Etymology and Historical Development

The concept of secure treatment settings traces its origins back to the 19th-century mental asylums, which, by their nature, were often closed and custodial. However, modern STSs developed significantly following mid-20th century legal reforms. Initially, individuals with severe mental illnesses who committed crimes were frequently housed directly within state penitentiaries or in general state hospitals without specialized forensic units. The lack of tailored care led to poor outcomes and significant ethical concerns regarding the failure to provide adequate treatment.

A major turning point came with the deinstitutionalization movement of the 1960s and 1970s. While intended to liberate patients from restrictive hospitals, it resulted in many mentally ill individuals cycling through emergency rooms and, critically, into the criminal justice system--a phenomenon termed "transinstitutionalization." As courts increasingly recognized the constitutional right to treatment for committed individuals, the need for specialized facilities that could balance liberty rights with public safety became urgent. States were compelled to establish dedicated forensic hospitals or secure units to manage high-risk, high-need populations.

Contemporary Secure Treatment Settings are a direct result of this legal and social evolution, aiming to overcome the therapeutic failures of earlier custodial models. Today, the focus is on developing dynamic, risk-responsive treatment protocols informed by evidence-based practice (EBP) in forensic psychology and psychiatry. This historical trajectory reflects a continuous struggle to define the boundary between punishment and treatment for individuals whose criminal behavior is inextricably linked to their clinical disability.

### 3. Key Characteristics

The operational characteristics of a Secure Treatment Setting distinguish it starkly from typical residential care. The most obvious characteristic is the physical **security infrastructure**. This includes multi-layered access control, perimeter security (often reinforced walls or fences), hardened building materials, and highly sophisticated surveillance systems. Access to internal units, treatment rooms, and outdoor spaces is strictly regulated, necessitating constant communication between clinical and security staff to ensure procedural compliance.

A second defining characteristic is the mandatory presence of a **multidisciplinary forensic team**. Unlike standard behavioral health facilities, an STS staff must include personnel cross-trained in clinical risk assessment and security protocols. This team typically involves forensic psychiatrists, psychologists, social workers, occupational therapists, rehabilitation specialists, and specialized correctional officers or security technicians. Effective operation relies on the seamless collaboration of these disciplines to manage complex clinical issues within a security framework, necessitating regular communication regarding risk level and treatment progress.

Finally, the therapeutic approach within an STS is characterized by a **structured and behaviorally focused milieu**. The treatment schedule is highly regimented, emphasizing skill acquisition tailored to reducing criminogenic factors. This environment often utilizes token economies, behavioral contracts, and highly structured group therapy designed specifically for individuals with histories of violence, substance abuse, and impulse control deficits. The objective is not merely symptom management but fundamental behavioral change necessary for safe community reintegration.

## 4. Target Population

The target population of a Secure Treatment Setting is defined by a confluence of legal status, clinical diagnosis, and demonstrated risk. The individuals served are often legally mandated patients--those adjudicated as felons or having committed serious offenses--who also possess a primary diagnosis of a severe mental illness (SMI) such as schizophrenia, bipolar disorder, major depressive disorder with psychotic features, or a significant developmental or intellectual disability. The defining factor is that, due to their mental state, they pose a substantial risk of danger to themselves or others, necessitating restrictive custody.

A significant subgroup within the STS population consists of forensic patients: individuals found Not Guilty by Reason of Insanity (NGRI) or those held for restoration of competency (Incompetent to Stand Trial, IST). These individuals are committed to the facility not for punishment, but for treatment aimed at restoring mental capacity or reducing the dangerousness that stemmed from their mental illness at the time of the offense. Their commitment is indefinite and contingent upon clinical improvement and judicial review, rather than a fixed sentence.

The unique challenges presented by this population require specialized clinical competence. Staff must be adept at treating co-occurring disorders, managing acute crises (including high risk of assault and self-harm), and utilizing specialized risk assessment tools (e.g., HCR-20, PCL-R) to measure and document progress toward safe discharge criteria. Treatment must address both the clinical symptoms (e.g., delusions, mood instability) and the criminogenic needs (e.g., poor decision-making, antisocial attitudes) simultaneously.

## 5. Regulatory Framework and Legal Basis

Secure Treatment Settings operate under a complex and rigorous legal framework, primarily governed by mental health law and constitutional standards related to due process and the right to treatment. Because commitment to an STS represents a significant deprivation of liberty, the facilities are subject to intense legal scrutiny. The justification for holding a person in such a restrictive environment must always adhere to the principle of the "least restrictive alternative" necessary to ensure safety.

Legal oversight mandates periodic judicial hearings to review the commitment status of every forensic patient. These reviews determine whether the individual still meets the criteria for dangerousness and mental instability that necessitated the secure setting. Furthermore, key legal precedents ensure that residents have the right to humane conditions, adequate professional staff, and individualized treatment plans designed to move them toward discharge. Failure to provide constitutionally adequate treatment can lead to court intervention and mandate systemic changes within the facility.

In addition to state and federal legal mandates, facilities typically seek accreditation from independent bodies like The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). These organizations enforce standards covering safety, quality of care, administrative efficiency, and patient rights. Compliance with these standards is essential for maintaining operational licensure and demonstrating accountability for the highly restrictive nature of the care provided.

## 6. Therapeutic Models Utilized

The therapeutic efficacy of a Secure Treatment Setting hinges upon the utilization of specialized psychological models adapted for high-risk populations. Traditional talk therapy is often insufficient; thus, therapies rooted in behavioral science and risk management are prioritized. A cornerstone of treatment is **Cognitive Behavioral Therapy (CBT)**, particularly adapted for correctional and forensic settings (e.g., CBT for Violence Reduction or Anger Management), which focuses on identifying and changing the distorted thinking patterns that contribute to aggressive or criminal behavior.

For residents with severe emotional regulation difficulties, particularly those with diagnoses overlapping with Borderline Personality Disorder (BPD) or trauma, Dialectical Behavior Therapy (DBT) is frequently implemented. DBT skills training helps residents learn mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness, essential skills for navigating life outside of a secure environment without resorting to harmful coping mechanisms.

Additionally, the overall treatment approach includes extensive psychoeducation and life skills training, often managed through a tiered system of privileges that rewards prosocial behavior. Pharmacological management, overseen by forensic psychiatrists, plays a vital role in stabilizing the acute symptoms of severe mental illnesses, ensuring that residents are clinically stable enough to fully participate in the behavioral and psychological interventions designed to reduce their risk profile.

## 7. Significance and Impact

Secure Treatment Settings play a critical role in the public health and safety infrastructure by managing and treating the most challenging segments of the population--those who pose a significant risk but are also suffering from severe clinical disorders. By consolidating this high-need population into specialized facilities, the STS provides an environment where intensive, costly, and resource-heavy treatment can be safely administered, which would be impossible in community settings.

The long-term impact is measured primarily by successful community reintegration and reduced recidivism. An effective STS works to mitigate both clinical risk (relapse of mental illness) and

criminogenic risk (re-offense). Through competency restoration and behavioral stabilization, these facilities facilitate the gradual transition of individuals back into society or into less restrictive residential care, fulfilling the state's dual obligation to protect the public and provide treatment to the mentally ill.

Societally, the existence of STSs prevents the cyclical crisis management that occurs when severely disturbed individuals are released untreated or are left in environments (like jails) ill-equipped to handle their complex needs. They serve as essential decompression units, stabilizing individuals until they are clinically capable of engaging with the judicial process or living safely under supervision, thus ensuring a more structured and humane approach to forensic populations.

## 8. Debates and Criticisms

Secure Treatment Settings are often the subject of intense debate, primarily focusing on the ethical dilemma inherent in blending high security with therapeutic freedom. Critics argue that the restrictive, locked nature of the facility can sometimes undermine the therapeutic process, leading to a sense of custodial hopelessness rather than genuine recovery. This tension raises questions about the definition of 'treatment' when it is delivered in an environment that often mirrors a correctional facility.

Another significant area of criticism involves the potential for the overuse of restrictive interventions, such as seclusion, physical restraints, and involuntary medication. While necessary for acute crisis management, the routine application of these measures can be seen as violating patient rights and promoting an environment of control rather than empowerment. Continuous external oversight is necessary to ensure these measures are used only as a last resort, in compliance with strict protocols.

Furthermore, operational costs and efficacy are often scrutinized. Secure treatment is highly expensive due to the required staffing ratios, specialized clinical expertise, and robust physical infrastructure. Debates persist regarding whether the long duration of stay typical in these settings translates into superior long-term outcomes compared to alternative, potentially less costly, and less restrictive models of care, emphasizing the necessity for continuous outcome measurement and research.

## Further Reading

[Forensic psychology](#) (Wikipedia)

[Forensic Psychiatry](#) (American Psychiatric Association)

[Involuntary Commitment and Mental Health Law](#) (Wikipedia)