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Psychiatric monitoring of not guilty by reason of insanity outpatients

Fernando Almeida [a], Diana Moreira [a, b, *], Helena Moura [c], Victor Mota [c]

[a] Social and Behavioral Sciences Department, Maia University Institute, Portugal
[b] Laboratory of Neuropsychophysiology, Faculty of Psychology and Educational Sciences, University of Porto, Portugal
[c] Magalhães Lemos Hospital, Portugal

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ABSTRACT

Individuals deemed Not Guilty by Reason of Insanity (NGRI) by the courts, under Article 20 of the Portuguese Criminal Code, have often committed very serious crimes. It is unreasonable to consider that these patients were usually kept without adequate supervision after the security measure had been declared extinct. They often decompensated after leaving the institution where they complied with the security measure, and/or relapsed to alcohol and drug abuse. Very often, severe repeated crime erupted again. Considering this, there was an urgent need to keep a follow-up assessment of these patients in order to prevent them from relapsing in crime. This work presents the results of a psychiatric follow-up project with NGRI outpatients. The main goals of the project were: ensuring follow-up and appropriate therapeutic responses for these patients, maintaining all individuals in a care network, and preventing them from decompensating. The team consisted of a psychiatrist, a nurse, and a psychologist. Seventy-two patients were monitored during two years. Results demonstrated the unequivocal need to follow up decompensated patients after the court order is extinguished. Suggestions are presented for a better framing and psychiatric follow-up of these patients.

1. Introduction

For many years, it was not shown that the relationship between mental illness and crime pointed to an increased prevalence of crimes of assault perpetrated by severely mentally ill patients, especially when they were decompensated.

Almeida[1] studied the criminal trajectory of 33 schizophrenic individuals (19 men) between 1991 and 2003. He found that the patients had committed a total of 42 crimes, 74.0% against people and 24.0% against property, but only 2.4% of those crimes had been reported to the authorities. This suggests that crimes committed by individuals with severe mental illness are often viewed with a great deal of tolerance and complacency.

Eriksson, Romelsjo, Stenbacka, and Tengstrom[10] conducted a prospective and longitudinal study of a birth cohort followed up through registers over 35 years. The cohort consisted of 49,398 males conscripted into the Swedish Army in 1969–1970, of whom 377 were later diagnosed with schizophrenia. Twenty-five percent of schizophrenic patients were criminally convicted, compared to 6.0% of subjects without schizophrenia. The diagnosis of schizophrenia increased by 2.7 times the risk of being convicted of an offence and by four times the risk of being convicted of a crime. Fazel and Grann,[14] in a population of patients suffering from schizophrenia or non-schizophrenic psychosis, found a prevalence of violent behavior of 6.6%, while Ran et al.[32] found a prevalence of 10.0% in schizophrenic patients.

Swinson et al.[40] studied the homicides that occurred in England and Wales between January 1997 and December 2006. During this period, 5884 murderers were convicted, of whom 605 (10.2%) had a mental illness at the time of the offence and, among these, 348 (5.9%) suffered from schizophrenic psychosis. During this period, there was an average annual increase of 2.0% in homicides among the general population and an average annual increase of 4.0% in the number of homicides committed by schizophrenics, which is due to the increase of drug use. Furthermore, it is important to keep in mind that some patients have premorbid personality disorder, including psychopathy, which is a predictive factor of the highest order of offensive behavior of social and legal norm.[44]

The term NGRI covers heterogeneous and poorly defined groups,[21] including: insanity acquittees, people found guilty but mentally ill, people found unfit to stand trial, mentally disordered

* Corresponding author. Faculty of Psychology and Educational Sciences, University of Porto, Rua Alfredo Allen, 4200-135, Porto, Portugal. Tel.: +351 226 079 725; fax: +351 226 079 700.
E-mail address: dianapmoreira@gmail.com (D. Moreira).

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sex offenders, sexual predators, and prisoners transferred to mental health facilities. Other definitions also cover people assessed for competency within jails and people referred to mental health courts. The overwhelming majority are men (e.g., Ref. [37]).

Although the different jurisdictions show distinct rates of prevalence (e.g. Refs. [13,27,38,41,42]) many prisoners meet unequivocally criteria for serious mental disorders.

Prior to the introduction of modern rehabilitation services and developments in antipsychotic medication, several early follow-up studies were conducted, which might have reduced reoffending by forensic patients.[9]

Rates of violent reoffending following release are of the greatest concern to the community.[45] They have ranged from 4.0% in a period of 3.6 years[45] to 20.0% at an average period of 6.5 years after discharge.[35] Samples that included mentally disordered offenders release from high-security hospitals showed higher rates of violent recidivism, ranging from 6.0% at 2 years to 20.0% at 6.2 years.[5,9,25] Assertive aftercare and supervision seemed to reduce rearrest rates after the conditional release programs.[6,26,30,45,47]

Recidivist homicide has been defined as a homicide committed after the conclusion of proceedings for an earlier homicide offence.[7] From the six studies described on Bjørkly and Waage's[7] systematic review on recidivism among homicide offenders, only one from Finland provided information about psychiatric diagnosis of schizophrenia, concluding that schizophrenia might be a risk factor for homicide recidivism.[11,12,31,43] Also, a study from Chuvash Republic (Russia)[19] and another from Scandinavia[39] mention earlier homicides committed by schizophrenic offenders – who might eventually be released into the community.[3,20]

In a systematic and meta-analysis of homicide recidivism and schizophrenia, the pooled estimate of the proportion of homicide offenders with schizophrenia who were homicide recidivists was 2.3%.[20]

A study from Nilsson, Wallinius, Gustavson, Anckarsater, and Kerekes[29] – later confirmed by other long-term follow-up studies on mentally disordered offenders and patients discharged from special hospitals[17,25,29,48] – found that regardless of the length of follow-up period, only 20.0% of individuals were reconvicted for violent or violence-related crimes during the total follow-up period, resulting in a total reconviction rate of 27.0% when non-violent crimes were included.

A state-wide sample of 127 NGRI acquittees released into the community after spending a mean of 61.6 months ($SD = 76.5$) in the hospital was evaluated by Vitacco, Vauter, Erickson, and Ragatz.[46] One hundred individuals were committed to the hospital for lengthier treatment (M hospital time = 77.2 months, $SD = 79.8$), but 27 individuals were released to the community after a relatively short hospital stay (M hospital time = 5.6 months, $SD = 3.0$). Regarding release, 96 (75.6%) of 127 individuals maintained their conditional release.

The current Portuguese Criminal Code (CP) features, in Chapter VII[d] (Articles 91 to 103),[33,34] a set of guidelines that have to be met for the subject to be declared NGRI, in the terms of Article 20 of the Portuguese CP, for committing a crime as a result of a serious mental disorder.

According to Article 91, Paragraph 1, whoever has committed a typical unlawful act and is declared NGRI, under Article 20, is ordered by the court to be admitted in a healing, treatment, or security establishment, when, by virtue of the mental disorder and the severity of the act committed, there are grounds for concern that he/she will commit other actions of the same kind. Paragraph 2 of the same article states that a person NGRI who has committed a crime against persons or an offence of common danger punishable with imprisonment for over five years, has to be admitted to a hospital for at least three years, unless release proves compatible with the defense of the legal order and social peace. Consequently, these individuals are admitted to institutions distributed throughout the country, such as, the Clinic for Psychiatry and Mental Health of Santa Cruz do Bispo (CPSMSCB) (North of Portugal), Sobral Cid Hospital (Center of Portugal), and Caxias's Hospital (South of Portugal).

The concern with social violence is intensified when persons who have been found NGRI are returned to the community.[24]

It is known that the majority of individuals who have been deemed NGRI and are/were subject to security measures, suffer from psychosis, particularly schizophrenic psychosis, and have committed crimes, mostly very serious and mainly against people, including murder.[1] Keeping these patients without adequate supervision after they leave the institutions is unacceptable and unreasonable, especially after the measure of hospitalization is declared extinct. Many of these patients have absent or insufficient morbid consciousness, unstable and disadvantaged families, and they lack competent and careful supervision. As the time in freedom extends, many patients breaking treatment and therapy engage themselves in risky behaviors, including alcohol and drug abuse, which contribute to the decompensation of the illness they suffer from, and repeated crime, often severe, erupts again.[3]

Therefore, it is imperative to accurately monitor the mental health of patients, in order to avoid or minimize damage that a repeated state of insanity, caused by a serious mental disorder, may entail.[2]

2. Project "Psychiatric Monitoring of NGRI Outpatients"

2.1. Characterization

The project "Psychiatric Monitoring of NGRI Outpatients" was implemented in Magalhães Lemos Hospital (HML) (Porto, north of Portugal) and focused on individuals deemed NGRI by the courts and who regularly leave the CPSMSCB, after completing the security measure or being on probation.

Seventy-two participants, living within a 60 km radius from Porto, integrated the project.

The project was implemented between February 1, 2010 and January 31, 2012.

The team consisted of a psychiatrist, a psychologist, and a nurse.

Regarding the psychiatric outpatient care, in the event that the patient needed regular monitoring in a psychiatric institution (e.g., HML), the team only monitored the evolution of the patient without interfering in the doctor-patient relationship, particularly, concerning the medication. However, the team established a member for monitoring and helping the patient (making home visits, gathering information with the family, and at the place of residence on the patient's evolution, behavior and needs, for example). Patients who were not psychiatrically monitored (because they abandoned or never attended the doctor's appointments) were temporarily included in the team's consultation, until they were integrated into the Local Service of Mental Health (LSMH) of their area of residence. For those patients, the involuntary commitment plan would be activated.

2.2. Objectives

The overall goal was ensuring follow-up and appropriate therapy for these patients. The specific objectives consisted in integrate

[d] Chapter VII of the Criminal Code refers to the Hospitalization of NGRI individuals suffering from mental disorders.