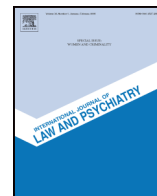




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The evaluation stage of the Hoeven Outcome Monitor (HOM): Towards an evidence based groundwork in forensic mental health☆

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ABSTRACT

This study examined if a macro-, meso-, and micro outcome measurement instrument that constitutes the evaluation stage of a Dutch forensic psychiatric outcome monitor, the Hoeven Outcome Monitor (HOM), can provide a first step towards a more evidence based groundwork in forensic mental health. General, serious, very serious, special, and tbs meriting recidivism during treatment, after treatment, and overall were charted for forensic psychiatric patients discharged from a Dutch forensic psychiatric centre between 1999 and 2008 (N = 164). Re-conviction data were obtained from the official Criminal Records System, and the mean follow-up time was 116.2 months. First, the results showed that the macro-measurements provide comparative outcome measures to generate insight into the overall effectiveness of forensic psychiatric treatment. Second, the meso-measurements yielded clinically relevant treatment outcome data for all discharged patients to generate a complete view of treatment effectiveness. Finally, the micro-measurements allowed access to detailed patient and treatment effectiveness assessments that provides the empirical foundation to conduct aetiological research into the prediction and control of high-risk behaviour. Thus, an outcome measurement instrument in line with Evidence Based Medicine and best practice guidelines was designed that provides an empirically sound evaluation framework for treatment effectiveness, and an impetus for the development of effective interventions to generate an evidence based groundwork in forensic mental health.

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1. Introduction

Ensuring safety in society is one of the primary objectives of Forensic Mental Health care (FMH). In the Netherlands, high-risk criminal offenders are placed on the Dutch 'terbeschikkingstelling' (tbs) court order measure in a forensic psychiatric centre (FPC) if they meet the following criteria: (a) they have committed a violent and/or sexual offence that carries a maximum sentence of at least four years, (b) they cannot be held fully accountable for their actions due to 'developmental or pathological disorder of mental capabilities', and (c) 'imposition of this order is required for the safety of others or for the safety of the general public or property' (article 37a Penal Code). The tbs court order is an Entrustment Act, not a punishment. As such, the order does not seek retribution, but rehabilitation of the forensic psychiatric patient. The main objective of the tbs court order is resocialization of the forensic psychiatric patient through mandatory forensic psychiatric treatment to increase safety in society. As such, a FPC has a public task that is

governed by the Ministry of Security and Justice to reduce the risk of re-offending of high-risk offenders through mandatory forensic psychiatric treatment (Keune & Van Binsbergen, 2012; Van Marle, 2002). With this approach forensic care is situated between penal law and General Mental Health (GMH). As such it is organized around conflicting dispositions, interests, and objectives (Barnao & Ward, 2015; McCormick, Peterson-Badali, & Skilling, 2015), as shown in forensic law and practice. This crossroad has resulted in a lack of specific empirical knowledge regarding this offender group, which has impeded the development of evidence based interventions and treatment programs in FMH (Barnao & Ward, 2015; Keune, De Vogel, & Van Marle, 2016; McCormick et al., 2015). This lack of empirical evidence regarding effective treatment interventions in forensic psychiatry has created a demand for methodological sound recidivism research to evaluate and enhance forensic psychiatric treatment, and to provide a more evidence based approach in FMH (Keune et al., 2016). To meet this need, the FPC Van der Hoeven Kliniek (VdHK) is developing an outcome monitor in line with Evidence Based Medicine (EBM) guidelines (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996), the Hoeven Outcome Monitor (HOM). In line with EBM guidelines, the HOM is subdivided into three sequential stages, (1) the evaluation stage to demonstrate the effectiveness of treatment, (2) the aetiology stage to research

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'what works for which patient', and (3) the implementation stage to implement treatment guidelines. A previous study (Keune et al., 2016) provides a full description of the origin of the HOM and the methodological development of the evaluation stage. With the completion of the evaluation stage, the outcome data of the evaluation stage are presented in this sequel study.

First, a short introduction into the complex context of Dutch law and Dutch forensic psychiatry will be discussed. Second, to provide more background into the origin of the HOM, we will review the complex junction of penal law and GMH in clinical practice, which has resulted in a shortage of evidence based interventions and programs in FMH. Finally, a short introduction into the design and methodological development of the evaluation stage is provided.

1.1. Forensic law: a complex context

In Dutch forensic law, the complex junction of penal law and GMH is shown in the imposition and discharge from a FPC that is subjected to a judicial and/or forensic assessment.

Contingent on the degree of accountability, the tbs court order can be imposed with an additional prison sentence, which is to be served before admittance to a FPC. Before trial, two behavioural experts assess the degree of accountability. Outcomes range from fully responsible, to not responsible on account of the mental capacities of the patient at the time of the offence. The level of culpability has a linear association to the duration of the prison sentence; the more a patient can be held responsible, the longer the prison sentence. In the case of no culpability, no prison sentence is imposed and the patient is directly admitted to a FPC (Edworthy, Sampson, & Völlm, 2016; Van Marle, 2002).

Most often the tbs court order is imposed for an indefinite duration for serious sexual and/or violent offences with bodily harm. To review if the order is still warranted for the safety of the general public, the order is assessed every one or two years by a court ruling. To advise the Penal Court in their decision-making process to (un)conditionally release the patient or to prolong the order, a forensic assessment is completed by the FPC, which consists of a risk assessment and treatment evaluation. The court can (un)conditionally release a patient in accordance with this advice (i.e., conform discharge), or despite this advice (i.e., contrary discharge) (Drost, 2006; Van Marle, 2002). In the case the tbs court order is imposed for an offence without bodily harm, the so-called maximized tbs court order is imposed. Because this order is limited in time and is terminated after four years irrespective of treatment benefit and/or risk level reduction, no court ruling and/or forensic assessment into the termination is required.

In the case of no treatment benefit, a patient is transferred to a different FPC for a second treatment attempt. However, with several failed treatment attempts, the patient is transferred to a longstay facility, where placement is on humanitarian grounds instead of risk reducing treatment interventions (Edworthy et al., 2016). In these instances no court ruling is required, as transference is not initiated by the Ministry of Security and Justice, and placement is by forensic assessment only. Finally, in case of re-conviction, a patient is transferred to prison by imposition of a separate court ruling, which precludes a court review and/or forensic assessment in the current order.

1.2. Forensic practice: a complex offender group

In terms of forensic practice, the complex junction of penal law and GMH is shown in the order's special preventive treatment objective, which is the resocialization of the forensic psychiatric patient through mandatory forensic psychiatric treatment. As explicated in Keune et al. (2016), unlike penal law that is dominated by generic measures to reduce re-offending behaviour, or GMH practice that is focused on a patient's symptom reduction of mental illnesses, forensic practice is focused on the reduction of an individual offender's risk level through forensic psychiatric treatment. However, treatments that are considered

valid in GMH, are applied in FMH without reference to the different patient characteristics and the corresponding treatment objectives of forensic care (Barnao & Ward, 2015; De Beurs & Barendregt, 2008; Warburton, 2015). A new treatment paradigm is called for that accounts for the unique needs of this specific offender group (Barnao & Ward, 2015; Schaufenbil, Kornbluh, Stahl, & Warburton, 2015; Warburton, 2015). In addition to a more complex and severe psychopathology in forensic psychiatric populations (Taylor, Walker, Hillier, Murphy, & Gunn, 2015; Van Marle, 2002), forensic treatment is focused on reduction of re-offending behaviour, which is not always causally linked to the reduction of disorder related symptoms (Andrews & Bonta, 2010; Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014; Skeem, Winter, Kennealy, Loudon, & Tatar, 2014). In line with EBM and 'What Works' (WW) principles (Andrews & Bonta, 2010), each specific offender programme that aims to reduce re-offending behaviour (e.g., FMH), should be based on an empirical understanding of these offender groups. However, existing research on the prediction and control of high-risk behaviour in FMH, has been fragmented because the same determinants of recidivism that apply to the general offender group are being examined, using an a-theoretical approach with general outcome measures (Andrews & Bonta, 2010; Liem, 2013; Quinsey, Harris, Rice, & Cormier, 2006; Vinkers, De Beurs, Barendregt, Rinne, & Hoek, 2011). As such, empirical knowledge regarding the prediction and control of high-risk behaviour in forensic psychiatric patients is partial and incomplete (Andrews & Bonta, 2010; Barnao & Ward, 2015; Epperson et al., 2014; Lindqvist & Skipworth, 2000; Peterson et al., 2014; Quinsey et al., 2006). Due to this lack of empirical knowledge into the reduction of high-risk behaviour in this specific offender group, existing treatment programmes in FMH are often not evidence based and evidence based risk-reduction interventions for this population are scarce (Morgan et al., 2012).

Evidence based interventions designed to reduce re-offending risk are based on the 'WW' approach to offender rehabilitation (Andrews & Bonta, 2010; Heilbrun, 2009; Howells, Day, & Thomas-Peter, 2004). Andrews and Bonta (2010), the founders of the 'WW' approach, have evolved this approach into the concept of 'Psychology of Criminal Conduct' (PCC) to account for both inter- and intra-individual variation in criminal behaviour. The practical application of PCC has led to the development of an empirically based theoretical model of correctional assessment and treatment, the Risk-Need-Responsivity model (RNR-model), which is currently considered best practice in offender rehabilitation research and practice. Numerous international empirical studies and meta-analyses substantiate the importance of adhering to the RNR-model in treatment programmes aimed at reducing recidivism (Andrews, 2012). To summarize, the RNR-model explains which offenders should be treated (Risk principle), what should be treated (Need principle) and how offenders should be treated (Responsivity principle) to reduce re-offending behaviour (Andrews & Bonta, 2010). Thus, when reducing recidivism is the main objective of the intervention, as in the case of forensic psychiatric treatment, research into determinants of high-risk behaviour should adhere to the core principles of the RNR-model. However, due to a shortage of empirical evidence, the applicability of the RNR-model to the forensic psychiatric population is largely unknown. More research on the applicability of this model to this specific offender population is needed to develop a more evidence based approach in FMH (Skeem, Steadman, & Manchak, 2015). Specific RNR-studies are recommended wherein explanations of criminal conduct are directly related to the risk of re-offending (Andrews & Bonta, 2010). International studies in evidence based risk assessment have also highlighted the use of recidivism research to improve the prediction and control of high-risk behaviour, and as an empirical check for hypotheses regarding the origin, the continuation, and the prevention of criminal behaviour (Heilbrun, 2009; Peterson et al., 2014; Quinsey et al., 2006; Webster & Hucker, 2007). In line with EBM and best practice guidelines, theoretically relevant determinants should be studied that are linked to questions on how to reduce

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