International Journal of Law and Psychiatry xxx (2017) xxx–xxx

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

Critical incidents and judicial response during medium security treatment

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ARTICLE INFO

Article history:
Received 5 February 2016
Accepted 8 December 2016
Available online xxxx

Keywords:
Incident
Forensic psychiatry
Prosecution
Medium security

ABSTRACT

This study examined inpatient incidents in three Flemish forensic medium security units and analyzed the subsequent judicial reactions to these incidents. During medium security treatment, incidents were reported for more than half of the participants. The most frequently registered incidents were non-violent in nature, such as absconding and treatment non-compliance. The base rate for physically violent incidents was low. Although crime-related incidents during medium security treatment were rarely prosecuted and adjudicated, the base rate of revocation – and hence drop-out from treatment – as a result of these incidents was high.

1. Introduction

Forensic psychiatric patients have traditionally been stigmatized as more violent, more difficult to treat and less compliant than other patients (Lamb, Weinberger, & Gross, 1999; Schanda, Stompe, & Ortwein-Swoboda, 2009). As a result, general psychiatric institutions are reluctant to treat these patients (Muller-Isberner, 1996) and local communities are opposed to the presence of forensic units because of concerns regarding public safety, for example in case of absconding (Gradillas, Williams, Walsh, & Fahy, 2007).

1.1. Critical incidents during (medium security) forensic psychiatric treatment

A consensus definition of what is understood by a critical inpatient incident is non-existing (Gradillas et al., 2007). Some scholars refer to all inpatient incidents as serious rule violations. For example, Main and Gudjonsson (2006) found that 57% of forensic inpatients reported at least one serious rule violation, defined as absconding, using illicit drugs or consuming alcohol, being violent to staff or patients, damaging property, and fire setting. In the present study, violent and non-violent incidents were separately addressed. In addition, in order to examine judicial responses, it seemed relevant to separate critical incidents falling under offense coding categories from critical incidents referring to treatment interfering behavior.

In the literature, inpatient violence or violence occurring during forensic psychiatric treatment has received substantial attention, in first instance because it affects the stability of an institution, the staff turnover and also because it has a negative impact on the therapeutic process (Gow, Choo, Darjee, Gould, & Steele, 2010; Quanbeck, 2006). However, to determine the number and characteristics of violent incidents in these forensic psychiatric settings, the definition of a violent (or aggressive) incident should be carefully scrutinized since – besides physical violence towards others – also verbal violence and/or violence towards self or objects can be included (Alia-Klein, O'Rourke, Goldstein, & Malaspina, 2007; Cullen et al., 2015; Daffern, Duggan, Huband, & Thomas, 2008; Decaire, Bedard, Riendeau, & Forrest, 2006; Gow et al., 2010; Gudjonsson, Rabe-Hesketh, & Wilson, 2000). Unfortunately, the proportion of each subtype of violence is not always separately described in research (Daffern et al., 2008; Decaire et al., 2006). In some studies, a distinction was made between physical assaults and other types of violence (Gudjonsson et al., 2000). Gudjonsson et al. (2000), who rated the severity of all incidents at a medium secure unit during a time interval of 16 years, found that 47% of the incidents comprised physical violence against persons (76% of these incidents caused however no injury or pain) and 53% comprised verbal violence, damage to property, arson and self-injury. In the study of Gow et al. (2010), only 17.2% of the incidents on a medium secure unit comprised physical

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http://dx.doi.org/10.1016/j.ijlp.2016.12.001
0160-2527/

violence whereas 21.8% comprised verbal abuse and 17.6% threats. Overall, a literature review found that the patient base rate for general aggression in forensic settings was 47.7% and the base rate for physical violence was 19.1% (Bowers et al., 2011), with higher percentages for physical violence in single studies, e.g., 28.2% in Gow et al. (2010). Sexual violence and arson were less frequently observed (Blattner & Dolan, 2009; Gow et al., 2010).

Next to physical and verbal violence, also non-violent incidents are reported in forensic units treating offenders with a mental illness, such as violations of hospital rules, treatment non-adherence, the use of alcohol and illicit drugs, and absconding (Abidin et al., 2013; Blattner & Dolan, 2009; Gow et al., 2010; Hillbrand, 1995). Patient base rates of absconding ranged from 4.8% to 21.7% (Blattner & Dolan, 2009; Cullen et al., 2015; Gow et al., 2010). Absconding was only in a minority of cases accompanied by offenses (Gradillas et al., 2007). A recent UK prospective cohort study of medium and low secure forensic psychiatric wards showed that recent verbal aggression and recent substance use was predictive of absconding (i.e., failure to return from leave, incidents of escape, and absconding while on escorted leave) (Cullen et al., 2015). Research focusing specifically on non-violent incidents during forensic psychiatric treatment is scarce (Blattner & Dolan, 2009; Gradillas et al., 2007). Yet, in the study of Decaire et al. (2006) on a minimum security forensic unit in a medium secure psychiatric hospital in Canada, 42.3% of the recorded incidents on the unit concerned non-violent incidents such as absconding and violation of ward rules. These authors also hypothesized that staff is more discrete in reporting non-violent incidents than violent incidents, so this number could be an underestimation.

Studying non-violent and (verbally) violent incidents is nevertheless important because both can affect the treatment process by resulting in early treatment termination. Drop-out from treatment can have serious consequences since research has shown that drop-out is associated with recidivism (McMurran & Theodosi, 2007; Olver & Wong, 2009). In a medium secure unit for personality disordered male offenders in the UK, 37% of the patients were expelled from treatment due to rule-breaking behavior, verbal assault, physical assault, or drug offenses and 35.8% was transferred back to prison because they were not actively engaging with the treatment program (McCarthy & Duggan, 2010). Thus, besides rule-breaking behavior, treatment non-engagement can be another reason for drop-out. Another study found that women with low treatment engagement were involved in more adverse incidents, including both physical and verbal aggression during their medium security stay (Abidin et al., 2013; Blattner & Dolan, 2009; Gow et al., 2010; Hillbrand, 1995). Treatment non-engagement can thus be regarded as a specific form of a non-violent incident that is related to poor treatment outcome.

1.2. Reporting incidents to the legal authorities

To the best of our knowledge, empirical studies specifically focusing on the reporting of violent and/or non-violent (e.g., theft or drug-related offenses) crime-related incidents during forensic psychiatric treatment to police or judicial authorities are quasi non-existent. Only one study briefly described the characteristics of 41 successful prosecutions of 30 Rampton Hospital inpatients for violent offenses against staff and indicated a need for more research in this area (Clark, McInerney, & Brown, 2012). Van Leeuwen and Harte (2011) described judicial reactions towards violent patients in general psychiatric services. In the Netherlands, only one out of four incidents of institutional physical violence towards mental health professionals was reported to the police (Harte, Van Leeuwen, & Theuws, 2013).

Jurisprudential, therapeutic, as well as ethical issues seem to form barriers to report incidents or to prosecute patients, particularly in case where patients are already detained in forensic settings. Ambivalence exists within mental health services to report violent incidents to the criminal justice system. Many mental health professionals are unwilling to consider a course of action that may be punitive for the patient involved, reasoning that such an action might hamper the treatment relationship (e.g., by breaching patients' confidentiality) and it might harm the patient. These consequences seem inconsistent with their role as caregiver. Furthermore, even when incidents are reported to police services, judicial authorities appear to be reluctant to prosecute and convict those patients (Dinwiddie & Briska, 2004). Several barriers can hamper prosecution such as an inability to collect the necessary information concerning the crime and the intention of the perpetrator (due to confidentiality issues) as well as doubts about whether the threshold for prosecution and eventual outcome at court is justified (Clark et al., 2012). For instance, in the aforementioned Dutch study, only 10% of the physical violent incidents reported to the police were brought to court (Harte et al., 2013). The study by Clark et al. (2012) in a forensic hospital showed that there was no clear presumption that patients would be prosecuted for assaults on staff, despite the zero tolerance policy for this type of assaults.

1.3. Present study

The present study adds to the scant literature on critical incidents in forensic psychiatric settings by examining incidents occurring during treatment in a sample of medium security forensic patients. First, the period prevalence and characteristics of violent as well as non-violent incidents and the patients involved were examined. Second, the judicial reaction to the reported (crime-related) incidents was investigated. In line with previous research findings it was hypothesized that 1) physically violent incidents would be less prevalent than verbally violent and non-violent incidents and 2) crime-related incident reports would be rarely prosecuted and adjudicated.

2. Material and methods

2.1. Setting and participants

This multicenter study was conducted at three medium security units located in the Flemish communities of Bierbeek, Zelzate and Rekem. Medium security units provide a treatment setting for patients found not guilty for reason of insanity (NGRI or *interned*) who do not require care in a high secure hospital, but who are considered unsuitable for a general psychiatric ward or outpatient care (see Jeandarme, Habets, Oei, & Bogaerts, 2016 for a description of the Belgian forensic psychiatric system). Referral to a medium security unit is provided under conditional release and is linked to specified conditions. The imposed conditions can be divided into orders (following hospital rules, being compliant with the treatment and directions of the probation officer) and prohibitions which typically include both general conditions (not committing new offenses, not using drugs) and individualized conditions (e.g., restraining order). The supervision of the abovementioned conditions is done by a regional court, the multidisciplinary Commission for the Protection of Society (CPS), chaired by a judge. A public prosecutor is present at the hearings and advises the CPS on (conditional) release, but only the official members of the CPS (a judge, a psychiatrist and a lawyer) take part in the formal decision making process. Violent (and other) incidents occurring during the treatment are reported to the CPS on a regular basis by the medium security units and/or the probation officer. When conditions are breached (either due to new offenses or due to other incidents such as absconding), the public prosecutor can decide to re-incarceration in prison, which implies a revocation of the conditional release. The reason for this re-incarceration is that, at the time of the study, high security forensic units were non-existent in Flanders, thus medium security patients could not be transferred to a high security unit and transfers to another medium security occurred only in rare occasions (Jeandarme et al., 2016; Vandevelde et al., 2011).

Please cite this article as: Jeandarme, I., et al., Critical incidents and judicial response during medium security treatment, *International Journal of Law and Psychiatry* (2017), http://dx.doi.org/10.1016/j.ijlp.2016.12.001