International Journal of Law and Psychiatry 60 (2018) 45–50

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

Relational caring and contact after treatment. An evaluation study on criminal recidivism

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ARTICLE INFO

Article history:
Received 23 April 2018
Received in revised form 28 June 2018
Accepted 19 July 2018
Available online xxxx

Keywords:
Forensic psychiatry
Contact after treatment
Rehabilitation
Risk factors

ABSTRACT

Background: Criminal recidivism within two years after discharge from secure Forensic Psychiatric Hospitals (FPHs) is high, that is, over 36% for short-term judicial measures. It is assumed that relational care during treatment and continued voluntary contact and informal care after discharge, are factors that contribute to the reduction of criminal recidivism.
Objective: To examine whether the provision of relational care and continued contact after treatment can be effective in reducing criminal recidivism two years after discharge (prevalence and time to re-offense) in patients who received treatment according to article 37 of the Dutch Penal Law (i.e., a hospital order for one year) compared to patients with the same order receiving Care As Usual.
Methods: An evaluation study of criminal recidivism in adult patients ($N = 111$) residing in 4 FPHs in the Netherlands two years after discharge. The intervention 'relational care' group was compared with a historical control group from the same hospital before the new approach had been introduced, and a concurrent control group from three other FPHs in the Netherlands.
Results: In the intervention group 15,6% of the participants reoffended within two years following discharge, which was significantly lower than recidivism in the historical (46,5%) and concurrent (47,8%) control group. The odds-ratio for recidivism in the intervention group was 0.245 (95% CI: 0.076–0.797) which was significant at $p = .019$.
Conclusions: Patients who received relational care and subsequently were provided with voluntary contact after treatment recidivated later and at a lower rate than patients from two control groups receiving CAU. Relational care and the voluntary continuation of contact and informal (after)care, which was build up during the treatment period, may bridge the difficult period that patients face when they have left the forensic psychiatric hospital.

1. Criminal recidivism and predictors of recidivism

Policy programs in the field of Dutch criminal law often aim at the reduction of recidivism; measures are taken to lower the risk of prosecuted offenders relapsing into criminal behavior. Although criminal recidivism is decreasing, a substantial part of crime in the Netherlands is committed by persons who have been prosecuted before. Therefore, crime prevention is also the prevention of recidivism (Wartna et al., 2011). A meta-analysis by Wartna, Alberda, and Verweij (2013) showed that reduction of recidivism is executed more successfully after long-term treatment measures than after short-term measures (two years or shorter) or when no treatment was provided. Within two years after discharge from prison, 47,1% had reoffended (Wartna, Tollenaar, Verweij, Alberda, & Essers, 2016). After long-term forensic treatment, the recidivism rate was 20,7% (Boonmann, Wartna, Bregman, Schapers, & Beijersbergen, 2015). Habitual offenders can be referred to a special program of detention and forensic care. Two years after this program, 73,4% had reoffended (Boonmann et al., 2015).

Previous studies showed that well-known predictors of recidivism are substance abuse (Andrews & Bonta, 2010; Zara & Farrington, 2006), age at first offense – 'the younger, the higher the odds on recidivism' (Zara & Farrington, 2006) –, comorbidity of psychiatric disorders and a substance use related disorder (Arsenault, Moffitt, Caspi, et al., 2010; Coid, Yang, Roberts, et al., 2006; Swanson, Holzer, Ganju, et al., 1990). In their study on violations of conditional release after a verdict of Not Guilty by Reasons of Insanity (NGRI), Monson, Gunnin, Fogel, and Kyle (2001) found that belonging to a minority group, a diagnosis of substance abuse and prior convictions were significant predictors of violation of conditions. From a Dutch study amongst patients with

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https://doi.org/10.1016/j.ijlp.2018.07.011
0160-2527/

long- term forensic mandatory treatment, the extent of criminal history (the larger, the higher the odds of recidivism) was a predictor of recidivism (Boonmann et al., 2015).

In The Netherlands, a criminal offender who has been judged not accountable because of a deficient development or a psychiatric disorder can be sentenced to the measure of the article 37 of the Dutch Penal Law. This means that the patient will be involuntarily admitted to a psychiatric hospital for a period of one year maximal (hospital order). This kind of measure can only be applied when the person is dangerous to himself, to others or to the safety of persons and goods in general. Apart from the coerced admission, this measure also implies that the subject will be discharged of further prosecution.

The litigant can be placed in a general psychiatric hospital, a forensic-psychiatric ward of a mental health institution, or in a forensic-psychiatric hospital. The forensic institutions have different levels of security. Of the above mentioned, the forensic-psychiatric hospital has the highest level of security. The selection of the appropriate institution is done by the Netherlands Institute of Forensic Psychiatry and Psychology (NIFP), section Indications Forensic Care (IFZ). Decisions on indication are based upon criteria like gender, diagnostic information and the required security level, type of residency and the living environment that is needed.

2. Forensic care

The goal of forensic care is to provide incremental rehabilitation for patients, in order that after treatment they will be able to function in society without offending. By means of guidance, treatment or training, an important focus of this rehabilitation is to diminish criminal recidivism, meaning the objective of reducing the risk that someone will re-offend after discharge (Wartna et al., 2013). In this respect, forensic care aims to enhance social security. The reduction of criminal recidivism through treatment is the most important mission of forensic psychiatry.

From previous studies (Nowak & Nugter, 2014; Peek & Nugter, 2009), we know that criminal recidivism amongst (often psychotically vulnerable) patients who have undergone a 'hospital order' is high. Within two years after treatment in a forensic ward of a psychiatric hospital, between 36,6% and 43,5% of the patients reoffended.

Due to the relatively high recidivism, a revolving door is created: after detention and treatment in a forensic psychiatric hospital patients are referred to regular care. Almost half of the group commits another crime within two years after discharge of the forensic hospital and returns to the forensic system. This benefits no one: not the patients, not the victims and not society. The hardship and the damage caused in society are severe and substantial (Outheusden Van & Schaftenaar, 2016). This evokes the question if there is a way to decrease recidivism after forensic psychiatric treatment?

3. Intervention and hypothesis

Since 2012, the forensic psychiatric hospital Inforsa has been developing a practice of 'relational care and sustainable connection'. The treatment is based on the vision and principles of relational care, the Presence approach (Baart, 2001; Baart, 2002), which provides a concept of good care and successful practices of care. Not only illness, disability, individual care needs and impairment are guiding principles in treatment or support, but even more the pain, suffering, loneliness and banishment patients experience, as well as their yearning for acceptance, engagement and participation. In order to connect with these yearnings, professional caregivers have to provide care based on their relationship with the patient, which has been designated as the 'presence approach' (Baart, 2002). It is *in* this relationship that the patient will gradually show his fear, pain and yearning. At the level of individual methods, special emphasis goes to the winning of trust, the maintenance of personal contact and participation (support/coaching) in the handling of existential questions and critical moments of decision.

Relational care differs from the 'therapeutic relationship' or 'working alliance' in that these therapeutic factors constitute strategically used instruments to reach a certain goal (becoming better, developing skills, using medication). In the 'presence approach', the relational component has a meaning on its own, independent from any instrumental purposes. Relational care during treatment contributes to trust in patients. They become able to show who they are (and accept that), and receive support to reorganize their lives. The 'presence approach' is, in its way, a critique on the intervention-based care planning in which, as a rule, solutions are a compromise between what the client wishes to achieve and what methodically can be done, controlled or predicted. In order to induce the solution, the social worker adds, according to a previously determined plan and only temporarily, some expertise to the client system, which is assumed to guarantee an efficient, effective and competent procedure (Baart, 2002).

In the Dutch (forensic) healthcare system, patients can be referred to another facility with the appropriate level of care (residential or outpatient) after having ended care in a particular health care facility. However, aftercare given by the same professional staff is not common when intensity of treatment diminishes, and patients may therefore be referred to other institutions. The 'presence approach' brings in the opportunity to stay in contact *after* the treatment has ended (the sustainable connection with the patient). This was realized at the facility where the research took place. The relationship between patient and professional caregiver may be useful for treatment, but in particular has a value in it self, and gives meaning to both patients and professional staff. By keeping in voluntary contact after treatment, not only continuity of care is guaranteed (patients may be referred to other health care facilities), but also continuity of meaningful and supportive relationships.

In order to examine the benefits of relational care and sustainable connection in terms of re-offending, an evaluation study was conducted on criminal recidivism (prevalence and time to re-offense) of patients with a hospital order, receiving treatment in a FPH, over a two years period. The intervention group, which received relational care and a continuation of voluntary contact and informal care after discharge, was compared with a historical control group of patients receiving Care As Usual (CAU) before the new approach had been introduced, and a concurrent control group of patients from three other FPHs in the Netherlands. It was hypothesized that the intervention group would show less recidivism compared to the two control groups.

4. Material and methods

4.1. Implementation of relational care

The implementation of relational care started in 2012 with the development of core values and subsequent development of a new policy. Staff members (management and caregivers) were trained in the 'presence approach' and monthly meetings with all employees were scheduled to discuss, develop the policy and reflect on their experiences. Changes appeared over a period of time, although 'contact after treatment' was offered to all ex patients since September 2012.

4.2. Population and follow-up period

All ex-patients who were admitted with a hospital order and discharged in two different periods of time, without committing a crime during treatment, were included in the study. The relational care (RC) group received relational care during treatment and voluntary contact afterwards, which included all patients discharged from FPH Inforsa between September 2012 and March 2015. The participants in this group were not aware of any changes in policy after the implementation of relational care. Only the first group of ex-patients receiving 'contact after treatment', could have known that they were the first to