Forensic psychiatric treatment evaluation: The clinical evaluation of treatment progress with repeated forensic routine outcome monitoring measures ☆

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ABSTRACT

The likelihood of recidivism is considered to be the most important outcome measure in forensic psychiatry. Therefore, forensic psychiatric treatment focuses on the reduction of the risk of recidivism by treating dynamic risk and protective factors, aiming to reduce risk factors while enhancing protective factors during treatment.

The goal of this study is to assess treatment progress with the Instrument for Forensic Treatment Evaluation (IFTE) in a Dutch forensic psychiatric centre (n = 240). Latent Class Analysis was conducted to reconfirm previously found patient profiles. Patient profiles were based on risk factors, psychopathology, and offence type. Repeated measures ANOVAs were conducted to assess treatment progress for the whole patient group, for high and low risk patients, and for patients who had been in treatment for a period longer and shorter than one year.

Latent Class Analysis has not reconfirmed the previously found profiles, therefore a repeated measures ANOVA was not conducted on profile level. On group-level, no significant progress was found. Though, patients with low protective behaviour, low resocialization scores, and high problem behaviour scores displayed significant treatment progress. Patients with low problematic behaviour showed a significant increase of problematic behaviour and patients with high protective behaviour a decrease of protective behaviour. Results indicated an interaction effect between time of admission and the factor resocialization skills, however this effect was not found for the other two factors. Results imply that higher risk patients can show more treatment progress than lower risk patients.

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1. Introduction

The Risk-Need-Responsivity model (RNR model; Bonta & Andrews, 2007) is one of the leading theoretical models in the treatment of offenders. The risk principle implies that the frequency and intensity of treatment and the level of security should match the nature and severity of criminogenic needs (i.e., dynamic risk factors directly related to criminal behaviour) (Bonta & Andrews, 2007). The need principle emphasises that the criminogenic needs related to the offending behaviour should be addressed in treatment. The responsivity principle implies that treatment must be in accordance with offenders' characteristics, learning styles, and abilities (Bonta & Andrews, 2007; Ward, Melser, & Yates, 2007). With crime-related needs reduced, skills enhanced, and treatment matched to the level of risk and patient characteristics, offenders can thus be prepared for rehabilitation.

The main treatment objectives – criminogenic needs – are related to self-regulation skills (Bonta & Andrews, 2007; Ward et al., 2007). Self-regulation is the offender's ability to alter deviant behaviour and responses (Baumeister & Vohs, 2007), involving, for instance, withholding behaviour and behaviour aiming to attain a desired goal (Rothman, Baldwin, Hertel, & Fuglestad, 2011). Self-regulation failure can result in disruptive or deviant behaviour caused by limited self-control (Wagner & Heatherton, 2015) and uncontrolled impulses (Bogaerts, Vanheule, & DeClercq, 2005; Bogaerts, Vervaeke, & Goethals, 2004). Strengthening self-regulatory skills, therefore, is important to control problematic behaviour and enhance protective behaviour and resocialization skills.

A core problem in forensic psychiatry, however, is the heterogeneity of the forensic population in terms of type of offence, psychopathology, and risk factors. De Jonge, Nijman, and Lammers (2009) recommend that future studies should focus on differences in psychopathology and offence types in relation to treatment progress. Patient profiles can contribute to homogeneity and can support researchers and clinicians to provide insight into the levels of risk, criminogenic needs, and self-regulatory skills for different patient groups. Several studies have examined patient profiles based on psychopathology, risk factors,

and/or crimes committed (Bogaerts & Spreen, 2011; Van Nieuwenhuizen et al., 2011; Van der Veeken, Bogaerts, & Lucieer, 2017; Yiend et al., 2017).

Recently, Van der Veeken et al. (2017) identified four patient profiles by clustering axis I and II psychopathology, type of offence, and historical and dynamic risk factors. The first antisocial profile includes patients with mainly a cluster B personality disorder, with 50.6% being diagnosed with an antisocial personality disorder and a substance use disorder (SUD) (53%). Patients in this profile show high historical risk factors, such as criminal antecedents, a problematic history of school and work, and lower dynamic risk factors, such as hostility and problematic treatment attitude. They show higher Psychopathy checklist-revised (PCL-R; Hare, 1991) scores ($M = 24.19$, $SD = 6.16$), with the factor two score ($M = 12.54$, $SD = 2.95$) higher than the factor one score ($M = 9.18$, $SD = 3.44$). The second mixed profile displays frequent cluster B diagnoses (45% one cluster B personality disorder and 15% two cluster B personality disorders or one cluster B and one cluster A disorder), often in co-morbidity with psychotic disorders (49%) or SUDs (38% primary SUD, 56% secondary SUD). They display high historical and dynamic risk factors and show high PCL-R scores ($M = 24.16$, $SD = 7.04$). Both the first and the second profile display a mix of offences, such as homicide, assault, and violent property offences.

The third profile consists of patients with mainly a pervasive developmental disorder (14% primary diagnosis, 10% secondary diagnosis), paedophilia (24% primary diagnosis, 9% secondary diagnosis), or other (31%), such as an affective disorder, paraphilia, or a dysthymic disorder. Patients in this profile display low historical risk factors and high dynamic risk factors, particularly limited empathic skills, social skills, and crime responsibility. They are often convicted of child sexual abuse or homicide. They show lower PCL-R scores ($M = 15.72$, $SD = 5.91$), but, if we look at the four-facet model of the PCL-R (Hare & Neumann, 2005), their affective facet score is high ($M = 6.33$, $SD = 1.56$).

The fourth profile includes patients with psychotic disorders (23% primary diagnosis, 5% secondary diagnosis), with a low cluster B comorbidity (19%). Some offenders have been convicted of homicide (42%) and show low historical risk factors such as criminal history and previous violation of rules, low dynamic risk factors, particularly impulsivity and hostility, and low PCL-R scores ($M = 13.19$, $SD = 6.13$) Van der Veeken et al., 2017).

Treatment evaluation at the patient-profile level could provide insight into treatment progress for the identified patient groups differing in pathology, risk factors, and offence type. To our knowledge, this would be the first study on forensic treatment progress related to patient profiles and in line with the recommendations made by De Jonge et al. (2009). Routine outcome monitoring (ROM) is developed to routinely evaluate a patient's treatment progress over time (Ellwood, 1988). ROM has been widely studied in general mental healthcare but is still in its infancy in forensic psychiatry. As monitoring problematic behaviour, protective behaviour, and resocialization skills is a core mission in evaluating treatment progress in forensic psychiatry, the Instrument for Forensic Treatment Evaluation (IFTE) has been developed (Schuringa, Spreen, & Bogaerts, 2014). The IFTE assesses protective behaviour, problem behaviour, and resocialization skills (Schuringa et al., 2014), and can be used to monitor criminogenic needs and the development of self-regulation skills, such as protective behaviour and resocialisation skills. Recent studies have shown good psychometric properties of the IFTE (Van der Veeken, Bogaerts, & Lucieer, in review; Schuringa et al., 2014) and a moderate predictive contribution in the prediction of the likelihood of future incidents during inpatient treatment (Van der Veeken, Bogaerts, & Lucieer, 2016; Schuringa, Heininga, Spreen, & Bogaerts, 2016).

The general goal of this study was to assess treatment progress for the whole group of forensic psychiatric patients over six measurement periods. We expected that treatment progress would have differed between different patient profiles. Before that, we wanted to reassess the profiles previously found in the study of Van der Veeken et al.

(2017) based on historical and dynamic risk factors, psychopathology, and type of offence.

In line with Andrews and Dowden's (2006) findings that patients with a higher risk profile benefit more from treatment, we expected that patients who show high problematic behaviour, or low protective behaviour, and less appropriate resocialization skills would have shown more treatment progress than patients who show low problematic behaviour, high protective behaviour, and appropriate resocialization skills at the first IFTE assessment.

Finally, the study by Nijman, De Kruyk, and Van Nieuwenhuizen (2004), showed that most behavioural changes occur during the first 14 months of treatment. We expected to find the same pattern in our patient population. ROM assessments were implemented for all patients in two forensic psychiatric centres, regardless how long they had already been in treatment. Therefore, we also wanted to assess if patients who had been in treatment for a period shorter than 12 months at the first ROM assessment would show more progress on problem behaviour, protective behaviour, and resocialization skills than patients who had been in treatment for a longer period since the first ROM assessment, similar to the results found by Nijman et al. (2004).

2. Method

2.1. Procedure

This study was conducted in two forensic psychiatric centres (FPCs) in the Netherlands. Patients who are going through a FPC are involuntary admitted with a tbs-measure (disposal by order of the state, meaning; terbeschikkingstelling) and receive inpatient care (Van Marle, 2002). In the case of an offence with a minimal penalty of four years, a person can receive a tbs-measure when a mental disorder is present at the time of the offence and the mental disorder is related to the offence; when the risk of reoffending is high, and when the offender cannot be held fully accountable for the crime (De Boer, Whyte, & Maden, 2008). Accountability can vary from fully unaccountable to fully accountable in five gradations. Persons who are considered to be of (severely) diminished accountability can receive a prison sentence, before the tbs-measure starts (De Boer et al., 2008). A tbs-measure can be extended every one or two years by a judge when the risk of recidivism is still problematic. The main goal of a tbs-measure is to rehabilitate and integrate the patient back into society with a low risk of recidivism. Patients receive care and treatment by a multidisciplinary team, including psychiatrists, psychologists, social workers, art and psychomotor therapists and others. Routine outcome monitoring (ROM) has been implemented in both FPCs since 2011. During implementation, all therapists were informed about the procedure and received information about the questionnaires.

Treatment evaluation with the IFTE occurs every four to six months for all patients, parallel to the multidisciplinary treatment evaluation meetings. For most patients, several evaluators (e.g., head of treatment, psychologist, and coaches) filled in the IFTE, obtaining a multi-perspective view of the patients' changes compared with the previous scores four to six months earlier. The treatment team could access the IFTE with a shortened instruction in a patient's individual document, and subsequently the assessments could be conducted in the patients' electronic patient file (EPF). The treatment team receives a report of the ROM measurement in preparation of the treatment evaluation meeting.

IFTEs with a minimum period of three months between two evaluations and evaluations rated by at least one psychologist, psychiatrist, or coach were included in this study. All data used in this study concern primary treatment information and were retrieved from patient files. Additional informed consent was not required. Data were anonymized for the analyses, and APA ethical guidelines were considered during the conduction of this study.