International Journal of Law and Psychiatry xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

Reconviction and revocation rates in Flanders after medium security treatment

Inge Jeandarme [a,1,*], Petra Habets [a,1], T.I. Oei [b,2], Stefan Bogaerts [c,d,e,2]

[a] Knowledge Centre Forensic Psychiatric Care (KeFor) OPZC Rekem, Rekem, Belgium
[b] Department of Criminal Law, Tilburg University, Tilburg, The Netherlands
[c] School of Social and Behavioral Sciences, Developmental Psychology, Tilburg University, Tilburg, The Netherlands
[d] KARID, Fivoor, The Netherlands
[e] FPC, Gent, Belgium

ARTICLE INFO

Available online xxxx

Keywords:
Recidivism
Conditional release
Forensic psychiatric patients
Mental health supervision
Medium security treatment

ABSTRACT

Aim: To examine the criminal outcome of Flemish forensic psychiatric patients ('internees') after medium security treatment. Also, the effect of conditional release on recidivism of two subgroups (internees under conditional release and internees who received unconditional release) was examined.
Method: Reconviction rates and revocation rates were collected for all participants. Kaplan–Meier survival analyses were used to investigate recidivism rates while controlling for time at risk.
Results: During the 10-year period, 502 offenders were discharged from medium security treatment. Over a follow-up period averaging 3.6 years, 7.4% of discharged patients were reconvicted or received a new 'not guilty by reason of insanity' (NGRI) verdict for a violent offence. One-quarter of the population had their conditional release revoked. Part of the study population was granted unconditional release. Reconviction rates were higher after unconditional release in comparison to conditional release.
Conclusions: The results of this study suggest that the court supervision of NGRI patients in Flanders is effective in protecting the community from further offending.

1. Introduction

Treatment outcome in forensic mental health is best measured over a broad range of areas, including clinical and humanitarian ones (Yiend et al., 2011). However, the prevention of future criminal behavior is the most important goal in forensic psychiatric treatment (Menghini, Ducro, & Pham, 2005). Different types of recidivism have been studied in offenders who were found 'not guilty for reason of insanity' (NGRI), such as reconvictions, re-arrest, revocation and (re)incarceration rates and self-report (Heilbrun & Griffin, 1993). Reconviction rates underestimate the real size of recidivism but are considered to be a reliable measure of recidivism (Wartna, 2009). In the current study, general recidivism and violent recidivism were examined. General recidivism refers to reconvictions regarding any type of crime; violent recidivism refers to reconvictions associated with (sexual) violent reoffending.

It is difficult to determine whether recidivism rates are consistent with the success or failure of a forensic treatment because it is difficult to relate treatment results directly to recidivism as a number of factors during time at risk can influence individuals. In adult forensic populations, as far as we know, no meta-analyses show clear consistent associations between forensic treatment and a reduction in recidivism. In a research synthesis by Morgan et al. (2012), treatment effects of service providers to offenders with mental illness were examined across studies. Some studies suggested that forensic interventions can reduce symptoms of distress and improve offender's ability to cope with their problems, resulting in adapted behavioural markers such as institutional adjustment. Another meta-analysis mentioned a positive effect of interventions in terms of reducing continued criminal justice system involvement of any kind (e.g., decrease in time spent in detention and arrests after treatment). A similar positive trend was found for number of new convictions. In addition, violation of conditions appeared to be negatively correlated to treatment. Larger effect sizes were found for interventions comprising both an institutional and community component and some degree of voluntariness (Martin, Dorken, Wamboldt, & Wootten, 2012).

Regarding the Risk–Need–Responsivity principles (Andrews, Bonta, & Hoge, 1990) and the Good Lives Model (Andrews, Bonta, & Wormith, 2011; Ward & Stewart, 2003), offenders can be divided into low, medium and high risk offenders depending on their treatment and criminogenic needs (low, medium and high care), level of risk and protective factors (low, medium and high risk) and responsivity (degree of connection in the treatment) (Schuringa, Spreen, & Bogaerts, 2014). By weighting these three principles, judges can decide what the most suitable level of security is for offenders (low, medium

* Corresponding author at: Daalbroekstraat 106, 3621 Rekem. Tel.: +32 495 27 01 57.
E-mail addresses: inge.jeandarme@opzcrekem.be (I. Jeandarme), Petra.habets@opzcrekem.be (P. Habets), T.I.Oei@uvt.nl (T.I. Oei), S.Bogaerts@uvt.nl (S. Bogaerts).
[1] Daalbroekstraat 106, 3621 Rekem. Tel.: +32 89 84 77 64.
[2] Warandelaan 2, 5037 AB Tilburg. Tel.: +31 13 466 8103.

http://dx.doi.org/10.1016/j.ijlp.2016.02.033
0160-2527/

and high security). Medium security units typically refer to a medium risk and security level according to its environmental, relational and procedural security characteristics. However, deciding whether an offender is eligible for one of the three levels of security remains arbitrary. Despite attempts, objective criteria to determine which setting is most appropriate for which type offender are lacking (e.g., Collins & Davies, 2005).

1.1. Medium security treatment and recidivism rates

International studies on (medium security) forensic psychiatric treatment have presented a mixed picture of recidivism rates that seems to vary from 7.1% to 63% for general recidivism and from 1.8% to 46% for violent recidivism over different follow-up periods of 1 to 10.8 years in NGRI populations (for an overview, see Hayes, Kemp, Large, & Nielssen, 2014) (studies not reported in Hayes et al., 2014; Edwards, Steed, & Murray, 2002; Friendship, McClintock, Rutter, & Maden, 1999; Harris, Rice, & Cormier, 2002; Lund, Hofvander, Forsman, Anckarsater, & Nilsson, 2013; Maden, Scott, Burnett, Lewis, & Skapinakis, 2004; Müller-Isberner, Freese, Jockel, & Gonzalez Cabeza, 2000; Nilsson, Wallinius, Gustavson, Anckarsäter, & Kerekes, 2011; Nowak & Nugter, 2014; Seifert & Moller-Mussavi, 2005; Tabita, de Santi, & Kjellin, 2012). To the best of our knowledge, no meta-analysis of recidivism rates in NGRI patients is currently available. In their meta-analysis of mainly American studies, Bonta, Blais, and Wilson (2014) found 39% general recidivism and 23% violent recidivism during a follow-up period of 4.9 years in a more heterogeneous group of offenders subjected to mental health intervention.

In Flanders, reconviction rates for NGRI acquittees are scarce and incomplete. In the southern part of Belgium (Wallonia), recidivism rates in medium and high risk offenders ranged from 21.4% to 34.4% for general recidivism and from 5.2% to 17.4% for violent recidivism after a follow-up period ranging from 2.5 to 4.2 years (Ducro & Pham, 2006; Menghini et al., 2005; Pham & Ducro, 2008; Pham, Ducro, Marghem, & Réveillère, 2005). A nationwide Belgian study on re-imprisonment after release from prison revealed a very high percentage (62.3%) of re-imprisonment in NGRI acquittees after 5.7 to 8.7 years (Robert & Maes, 2012).

Different insanity acquittee systems have been described in the literature (e.g., Dirks-Linhorst & Linhorst, 2006), most of them primarily focusing on public safety as their primary goal. Key components of the conditional release process of NGRI acquittees include the development and monitoring of conditions of release and access to revocation and inpatient hospitalization when violations of conditions occur (Dirks-Linhorst & Linhorst, 2006). In the context of risk management and the prevention of recidivism, most conditionally released individuals are required to follow treatment and (probation) supervision. Not adhering to prescribed rules and ancillary conditions often results in a return to a secure, inpatient facility for further treatment and/or confinement. Therefore, in NGRI populations, typically two outcome metrics related to "failure" are being used: the acquisition of new criminal charges and/or conditional release revocation due to criminal acts or rule violations. Literature demonstrates that revocations for rule violations are higher than revocations for acquisition of new criminal charges (Vitacco, Vauter, Erickson, & Ragatz, 2014; Wiederanders, 1992). Revocation rates of rule violations range from 5% to 49% (Bertman-Pate et al., 2004; Callahan & Silver, 1998; Green et al., 2014; Manguno-Mire, Coffman, DeLand, Thompson, & Myers, 2014; Vitacco et al., 2008; Vitacco et al., 2014; Wiederanders, Bromley, & Choate, 1997) over different follow-up periods ranging from 1.7 to 5.1 years.

Conditional release and monitored aftercare programs following intramural treatment are considered to be effective to ensure safe transitions from secure facilities to community life. However, regimens of treatment and supervision are seldom reported or quantified, and studies of the effectiveness of conditional release programs are difficult to compare (Wiederanders et al., 1997). Although there has been past research confirming that postrelease supervision and community treatment can reduce recidivism (e.g., Wiederanders, 1992), a systematic review shows that little empirical evidence exists to conclude that long term supervision remains effective (van Gestel, van der Knaap, & Hendriks, 2006). In addition, studies have shown that recidivism can be reduced by implementing (forensic) ambulatory care after release (i.e., Home Office restrictions requiring patients to accept supervision and treatment following discharge: Coid, Hickey, Kahtan, Zhang, & Yang, 2007; specialised forensic outpatient clinics: Schmidt-Quernheim & Seifert, 2014).

1.2. Current study

This study was conducted among offenders found not criminally responsible for a committed crime (in Belgium referred to as 'internees') and focused on recidivism after treatment in a medium security unit (MSU). First, a brief background about Belgian legislation and practice is given because it differs from most countries.

1.2.1. Legislative background

Under Belgian law, internment is a safety measure imposed by a (investigating) judge to an offender if the latter is found not guilty by reason of insanity (NGRI). Offenders can be interned if it is proven that they have committed an offence[3] and they are found irresponsible or 'severely diminished responsible' at the moment of the trial as a consequence of either a status of insanity or a serious mental deficiency which makes the person unable to (fully) control his actions. While in most cases a psychiatrist (and psychologist) will perform a forensic psychiatric evaluation to determine criminal responsibility, this is not mandatory, nor does a common law standard for legal insanity exists. Internment is not a punishment, nor can it be combined with a criminal sanction. It is an indefinite safety measure aiming to prevent (further) harm to society and provide treatment for the internee (Goethals, 1997). On a Belgian population of about eleven million inhabitants, about 300 to 400 people are annually placed under this internment measure (Department of criminal justice policies, 2012). Over the years, the number of internees has been rising; at the end of 2013, there were about 3820 internees in Belgium (Deckers et al., 2014).

A multidisciplinary court chaired by a judge, the 'Commission for the Protection of Society' (CPS), is responsible for the implementation of the internment. While the prosecutor advices the court, only the other members of the CPS (psychiatrist, lawyer and judge) decide in which type of setting the internee will be treated and when he or she will be conditionally or unconditionally released. Automatic hospitalization is not required at the time of acquittal since conditional release into the community is also an option. According to the specific treatment needs (low, medium or high care), risk of recidivism (low, medium or high risk) and security level (low, medium or high security) assessed by the mental health probation officer or the psychosocial prison team, internees in theory can either reside in prison, or in forensic psychiatric units, regular psychiatric units or even protected houses or the community receiving ambulatory care. However, forensic beds were not implemented in Flanders until 2001, when the first medium security units emerged and only recently a high security forensic hospital opened (FPC Ghent since the end of 2014). As a consequence, many Flemish internees (1087 in 2013) deemed too dangerous for community supervision still remain in prison without adequate treatment (Deckers et al., 2014; Moens & Pauwelyn, 2012; Vandevelde et al., 2011). Every six months, the internee can appear before the CPS to ask for his or her conditional release. When an internee is treated outside the prison system, the internee is 'conditionally released' under the authority of the CPS. On conditional release, the patient's liberty is dependent on their adhering to several requirements, usually including

[3] All offences for which the Criminal Law sets a minimum penalty of at least 8 days are included.

Please cite this article as: Jeandarme, I., et al., Reconviction and revocation rates in Flanders after medium security treatment, *International Journal of Law and Psychiatry* (2016), http://dx.doi.org/10.1016/j.ijlp.2016.02.033