



## Substance use disorders in forensic psychiatric patients



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### ABSTRACT

There is a lack of detailed information on the role of substance use disorders (SUD) as a substantial factor in offences and treatment in forensic psychiatric patients. The aim of this study was to get a better understanding of these specifics. Clinical records of 193 male patients admitted to a Dutch forensic psychiatric hospital were scrutinized on anamnestic, diagnostic and risk assessment data. One of the central findings was that the prevalence of SUDs was high. Patients with an SUD had a more extensive criminal history, unstable and deviant lifestyle and higher risk of violent behavior than patients without a substance use disorder. No differences were found in duration of treatment, aggressive incidents and leave. Another important finding was that a distinction could be made between patients with substance use as a primary criminogenic risk factor and patients with substance use as a secondary risk factor. Although substance use is identified as a general risk factor, this study supports the idea of sub categorization of patients with an SUD and emphasizes the need for a different treatment approach. Further study is needed to identify specific treatment approaches, based on more differentiated profiles of these patients.

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### 1. Introduction

Use of drugs and/or alcohol is associated with criminal behavior (Bennett, Holloway, & Farrington, 2008). The probability of exhibiting criminal behavior appears to be three to four times higher among drug users than among non-users and several studies have described this relationship (Elbogen & Johnson, 2009; Newcomb, Galaif, & Carmona, 2001; Philips, 2000; Steadman et al., 1998; Swanson, 1994). A decrease of substance use is related to a decrease of criminal behavior and recidivism (Gossop, Trakada, Stewart, & Witton, 2005). In contrast, an increase of substance use seems related to a greater risk of recidivism (Joe, Chastain, Marsh, & Simpson, 1990). Results from the National Epidemiologic Survey on Alcohol and Related Conditions in the United States (Elbogen & Johnson, 2009) indicate that the incidence of violence was higher among people with severe mental illness, but only for those characterized by a substance use disorder (SUD). In forensic psychiatric patients, being diagnosed with an SUD in patients at/during admission was found to be predictive of future reconvictions (Philippe, Koeter, van der Staak, & van den Brink, 2006). Patients who re-offend have been found to be more likely to use alcohol and/or drugs during treatment compared to patients who do not re-offend (Hildebrand, Spreen, Schönberger, Augustinus, & Hesper, 2006). In line with these findings, substance abuse or dependence is

regarded as a risk factor according to widely used instruments for the assessment of violence risk, such as the Historical Clinical Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997).

Furthermore, alcohol and/or drug disorders are associated with a number of factors that indirectly enhance risk of recurrence of criminal behavior. In general, patients with an SUD have greater difficulty in areas such as family relationships, employment, legal matters, housing, and health. These patients are considered a difficult group in the therapeutic settings due to their inclination towards extreme emotional reactions, high rates of comorbid psychiatric diagnoses, and the difficulty of getting them engaged in effective treatment until abstinence is achieved (Najavits & Weiss, 1994). Forensic psychiatric patients evading treatment more often use alcohol and/or drugs during treatment than patients who do not evade from treatment (Hildebrand et al., 2006).

Substance abuse or dependence is common among detained patients (Andersen, 2004; Wheatley, 1998). Likewise, prior substance abuse or dependence also seems to be common among forensic psychiatric patients in The Netherlands. Seventy percent of the Dutch forensic psychiatric patients are or have been abusing substances or show dependency at the time of admission (Greeven, 1997). Based on data registered by Dutch forensic psychiatric hospitals during 1995–2000, it was found that two out of three patients abused or were dependent on substances at the time of the offence (van Emmerik & Brouwers, 2001).

Importantly, however, the aforementioned studies provide relatively general insights into the impact of SUDs in forensic psychiatric settings.

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More in-depth details about the impact of SUDs during offences and also on the reactivity to treatment are still lacking for forensic psychiatric patients. For instance, clinical practice suggests that forensic patients with SUDs can be subdivided into a group with substance use as a primary criminogenic risk factor and another group with substance use as a secondary risk factor. In patients with substance use as a primary criminogenic risk factor the history of offence is directly related to substance use and/or substance use mediated the index offence. These patients often have a long-term pattern of substance use related to offences. However, for patients with substance use as a secondary risk factor the abuse is just one of several other criminogenic needs. Thus, probably different profiles exist between patients with and without SUDs, as well as within-group subdivisions. However, until now there has been no characterization of these between- and within-group differences in forensic psychiatric patients.

The aim of the present study was to contrast forensic psychiatric patients with SUDs against forensic psychiatric patients without SUDs on variables related to criminal behavior and treatment in order to get a better understanding of the specific factors that characterize each group. Gaining more specific knowledge about the potential differences between and within these two types of populations will promote the need to develop interventions that are tailored to the specific (differential) needs of each group.

## 2. Method

### 2.1. Sample

The cross-sectional study was conducted in 2009 in a Dutch forensic psychiatric hospital, the Pompe Foundation in Nijmegen. Records of 193 patients<sup>1</sup> (all male) in the clinic were included.

Patients in clinical care were either treated on wards for psychotic patients (26%) or on wards for non-psychotic patients (74%). These wards differed in treatment climate, i.e. psychotic patients resided on wards that provided a high amount of structure and a low level of expressed emotions. Of the 193 patients, 66.5% were native and 33.5% were immigrants by origin (at least one parent born outside the Netherlands). The average age was 41 years ( $SD = 9.73$ ) and the average treatment duration was 78 months ( $SD = 48.2$ ). The most common index offences<sup>2</sup> were (attempted) murder or manslaughter (42%), other violent offences (21%), and sexual offences against adults (20%). Other offences were sexual offences against minors (15%), arson (10%), threat (10%) and property crimes (with violence; 9%).

### 2.2. Procedure

Privacy of the patients was assured in accordance with the policy of the institution and analyses were conducted on anonymized data. Because this study was based on patient records, no informed consent was required. The clinical records of all patients were scrutinized and existing anamnestic and diagnostic data were retrieved from various reports by using a code book with strict criteria.<sup>3</sup> Besides prevalence of SUDs, the study also included information on context, motives, offence(s), insight, substance use during treatment, psychopathy, risk assessment, duration of treatment, aggressive incidents and leave. The variables were scored by an investigator. If the information in the records did not meet the requirements of the code book the records were excluded. Reliability checks were carried out by means of independent evaluation of ten randomly chosen files by two other

investigators. Their scorings were tested for reliability. The average Kappa-values for all variables were moderate to large and an overall agreement of 82% was found.

### 2.3. Instruments

Axis-I diagnoses were established according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; [American Psychiatric Association, 1994](#)). Patients were assessed at the time of conviction by a multidisciplinary team of psychiatrists and psychologists, mostly in the Observation Clinic of the Ministry of Justice (Pieter Baan Center, Utrecht). [Table 1](#) provides information concerning the clinical disorders that were present in our sample.

Psychopathy was established using the PCL-R scores extracted from the clinical records. The Psychopathy Checklist-Revised (PCL-R; [Hare, 2003](#)) is a clinical rating scale consisting of 20 items that load on one of two factors: Factor 1 denotes disrupted interpersonal-affective behavior such as “selfish, callous and remorseless use of others” and Factor 2 labeled consists of items describing a “chronically unstable, antisocial and socially deviant lifestyle”. Each item is scored as either 0 (not present), 1 (possibly present) or 2 (definitely present) to yield a maximum total score of 40 (Factor 1 range 0–16, Factor 2 range 0–18). Three items do not load on either of these factors. The scores are used to predict risk for criminal re-offence and probability of rehabilitation.

To assess the risk of violent behavior, the first HCR-20 scores after admission to hospital, retrieved from the clinical records, were included. The HCR-20 ([Webster et al., 1997](#)) is a checklist for indexing the risk of an individual to exhibit violent behavior. It consists of 20 items: 10 historical variables, 5 clinical variables, and 5 risk management variables. It includes variables that capture relevant past, present, and future considerations and it can be regarded as an important first step in the risk assessment process. Each item is scored by a number of clinicians as either 0 (not present), 1 (possibly present) or 2 (definitely present) to yield a maximum total score of 40. By means of consensus between clinicians, the scores and a clinical risk rating (low/moderate/high risk) are determined. For statistical analyses, scores were dichotomized into a score indicating a severe problem (HCR-score of 2) and another indicating no (severe) problem (HCR-score of 0 or 1). The item on substance use problems was excluded because patients with an SUD could score higher on the HCR-20 just because substance use is included as a risk factor in this instrument. This exclusion was carried out in order to reduce the chance of a potential bias in the distribution of the total scores brought about by a ceiling effect on this specific item.

Relapse in substance use and leave were determined by consulting the ‘Monitor Informatiesysteem Terbeschikkingstelling (MITS)’, a registration system to monitor patient information.

Aggressive incidents were set by the Staff Observation Aggression Scale-Revised (SOAS-R; [Nijman et al., 1999](#)) and the Social Dysfunction and Aggression Scale (SDAS; [Wistedt et al., 1990](#)). The SOAS-R is an instrument for monitoring the frequency, nature, and severity of aggressive incidents (acting out, (verbal) threat, (sexual) violence,

**Table 1**  
Clinical disorders in forensic psychiatric patients ( $N = 193$ ).

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)	No SUD %	SUPN %	SUSN %
No clinical disorder	35	–	–
Sexual and gender identity disorders	32	–	8
Schizophrenia and other psychotic disorders	27	23	27
Disorders in infancy, childhood, or adolescence	5	12	6
Mood disorders	3	4	7
Impulse-control disorders	5	8	8
Anxiety disorders	2	–	7
Other	3	8	11

Patients can be diagnosed for more than one clinical disorder, therefore the percentage per group is over 100%.

<sup>1</sup> The Pompe Foundation has no admission criteria, patients are randomly assigned.

<sup>2</sup> The index offence is the offence for which the patient is convicted and that has led to their current admission. Patients can be convicted for more than one offence, therefore the percentage is over 100%.

<sup>3</sup> The code book can be obtained from the author.

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