

# **A Care Program for Long-term Forensic Psychiatric Care (LFPC)**

## **(Abstract)**

This care program (CP) describes the status quo in the long-term forensic psychiatric care (LFPC) in the Netherlands, as well as ideas for further development of coherence, transparency, goal-directedness, quality, and evaluation of LFPC in order to realize a learning practice. The CP is certainly not a static instrument or strict protocol, but more a first initiative to a guideline.

### **For non-Dutch readers:**

Although this version of the CP reflects the Dutch situation, our ultimate goal is to make an internationally applicable program, which optimally addresses the issues relevant in all countries and at the same time leaves enough space for national differences. Our aim is to create a forum where best practices can be shared and adjusted to the local situation. We also would like to invite you to suggest improvements to the concept presented here:

- Is the program balanced?
- Did we miss any key issues?
- Would you add other modules?
- Would you approach LFPC differently?
- Etc., etc.

Please, let us know.

## **The status quo of LFPC**

### **General**

LFPC is concerned with forensic psychiatric patients with a long-term risk of reoffending who (1) got the TBS order<sup>1</sup> with a so-called long stay indication<sup>2</sup>, or (2) are chronic psychiatric patients who for a long time disrupted society, present risks and respond insufficiently to treatment. For example, the following groups of patients are involved.

- Chronic psychotic patients who have committed a criminal offence
- Sexual delinquents who remain fixated on their deviant sexuality experience
- Patients with an offence-related personality disturbance
- Patients with an offence-related addiction problem
- Intellectually handicapped patients who have committed a criminal offence and cannot sufficiently control their impulses

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<sup>1</sup> The acronym TBS stands for 'placement under a hospital order'. TBS is a treatment measure the court imposes on people who have committed serious offences and suffer from a psychiatric illness or disorder, which influences their behavior to a greater or lesser extent.

<http://english.justitie.nl/themes/tbs/index.aspx>

<sup>2</sup> The long stay indication involves patients who did not respond to forensic psychiatric treatment (TBS) in the sense that their risk of reoffending did not sufficiently decrease. Resocialisation is thus no longer considered a realistic option. Consequently, the treatment of these patients is not aimed at a return to society.

LFPC is concerned with care as well as safety and protection of society. It offers patients a supporting and structuring living environment and tailored psychiatric, somatic, and psychosocial care and support. This care and support are registered in an individual nursing and treatment plan. The plan focuses on risk management, while aiming at stabilization of functioning, a relatively autonomous existence, and as high as possible quality of life. However, where the TBS order is involved (the 'long stay indication'), the plan is not primarily aiming at a return to society, though the necessity of the inflicted limitations has to be tested each year. Still, the treatment of patients in LFPC is based on humanitarian considerations and the right to as decent as possible existence.

This CP aims at interventions with a proven effectiveness. A higher quality of life is here a pivotal point. Because it concerns a small and heterogeneous group of patients, while control groups, randomized assignment of patients and a double blind approach are impossible to realize in LFPC, randomized clinical trials and evidence based practice are not feasible here. Consequently, one has to settle for best evidence en best practices.

The present CP adheres to the 'what works' principles, which together make up the 'risk-needs-responsiveness model', extended with the principle of treatment integrity, the degree to which the treatment is executed correctly and fully. Cost-effectiveness is of course also a factor in the choice of the available interventions.

Within LFPC, different groups of patients need different levels of treatment, care, and protection. This differentiation has to be still sharpened (see the enclosed differentiation model in Addendum I). However, specialized measurement instruments for this purpose are not yet available.

Forensic psychiatric work goes hand in hand with the administration of (criminal) justice. For that reason, the CP pays attention to the relevant (Dutch) juridical framework.

### **Admission and diagnostics**

The CP examines the different organizational aspects of the admission stage. This stage leads to a first tailored nursing and treatment plan for each patient. The resulting report includes a diagnostic report of the core problems, which encompasses a DSM-IV-TR classification, a descriptive diagnosis, and a risk assessment. The report also provides leads for treatment and serves as a reference point for measuring possible changes. The diagnostics in LFPC include the following elements.

- File research
- Psychiatric diagnostics, with special attention for co-morbidity
- Psychological diagnostics (clinical and neuropsychological symptoms, personality traits, coping skills, motivation, aggression and impulse control, frustration tolerance)
- Observation of behavior on the ward and during various activities
- Risk assessment (risk and protective factors: scores, substantiating and conclusion)
- Offence analysis, as far as relevant for LFPC
- Indication of the required care and security level
- Quality of life analysis
- Somatic diagnostics, also preventive, as this is a relatively unhealthy population
- Social environment and network analysis
- Assessment of cultural background and its implications

Additional investigation is indicated in the cases of (a) ambiguity of the diagnosis or (b) a possibility of a new treatment attempt. Where applicable, diagnostics are repeated yearly.

Before the actual intake, employees of LFPC visit the patient in question. The patient gets information about the LFPC clinic and can ask questions. After the intake, patients get acquainted with their fellow patients, the ward and the treatment team, and familiarize themselves with the life within LFPC. This often involves a mourning process. Some patients accept their new situation relatively easily and focus on the possibilities which are still available. However, many patients remain focused on their release and don't accept LFPC. For that reason, the periods when continuation of staying within LFPC is discussed are often especially turbulent.

The goal of the treatment and guidance stage is stabilizing the psychiatric problems, as well as controlling and, if possible, decreasing the risk of reoffending, aiming at the individual needs for care and rehabilitation. Rehabilitation here means that patients, within the existing limits, actualize as much as possible their personal potential and autonomy. Providing meaning is a central theme in LFPC. Socio-therapists play an important role in this respect, as they strive to provide an optimal living environment. Developments are regularly evaluated in intermediate meetings.

Due to the setting, offence-related behavior usually occurs less frequently in LFPC. Tendencies to such behavior also become difficult to spot. This can be partially attributed to the fact that patients are no longer under the stress of treatment aiming at the return to society. For patients it is sometimes confusing that in their everyday life an appeal is made on their healthy behavior, while the meetings about continuation of staying within LFPC are foremost concerned with their illness. Diminished problem awareness can play a role here too.

### **Personnel**

The work is done by multidisciplinary teams, in which patient evaluations are regularly held. A team can consist of:

- A care or unit manager,
- A sociotherapist, forensic psychiatric care worker or sociotherapeutical worker
- A psychologist, who is often the treatment coordinator,
- A psychiatrist,
- A rehabilitation worker or trainer,
- A social worker or system-diagnostics practitioner.

If needed, the treatment team can be supplemented by:

- A general practitioner,
- A movement therapist,
- A creative arts therapist,
- Work supervisors,
- A 'leisure time guide',
- Nurses of the medical department etc.

Much attention is paid to the well-being and development of personnel, for example by means of coaching, peer supervision, professional intervention following crises, promotion of expertise and periodical job rotation.

## **Security**

For each patient LFPC aims at a fitting indication concerning the following forms of security.

- Physical prevention, that is protection against direct danger by personnel and material means. For example:
  - Security provided directly by the architecture of the buildings,
  - Surveillance equipment such as electronic surveillance, video, beepers and lighting,
  - Employees with specific control and de-escalation skills,
  - Strict rules for the daily procedures, violence, threat, weapons and drugs.
- Social control, the protection stemming from a positive relation between patients and caretakers, and between patients among themselves, by means of:
  - A good selection, education and coaching of personnel,
  - Principles such as ‘an agreement is an agreement’, ‘respect’ and ‘individualized responsibility’,
  - A good ward climate,
  - A treatment tailored to the offence-related issues.
- Security stemming from organizational policy issues such as:
  - Quality of life as a part of the individual nursing and treatment plan,
  - A thorough risk assessment,
  - A clear description of the offence scenario,
  - A thorough signaling plan, that is: a plan which focuses on signaling individual everyday problem behavior, and which provides both the patient and his environment with guidelines to deal with that behavior,
  - A plan for offence prevention within the institution,
  - Rehabilitation activities such as well-structured daily activities, possibilities for leave taking, network contacts etc.

## **Guidance and rehabilitation**

Guidance and rehabilitation include the following elements.

- Pharmacotherapy
- Treatment of co-morbid disturbances (psychosis, personality disturbances, addiction, intellectual handicap, somatic afflictions)
- Geriatric care
- Psycho-education for patient and family
- Interventions to extend or strengthen the patient’s social network
- A signaling plan
- A supporting and individualized socio-therapeutic environment, encompassing:
  - Options for stimulus regulation,
  - Clear structuring of time, space and activity, including a proper circadian rhythm,
  - Prevention of self-destructive and aggressive behavior,
  - If necessary, helping patients with their daily personal care,
  - Promoting healthy eating habits,
  - Promoting meaningful activities, also during leisure time,
  - Promoting the highest possible form of autonomy,
  - Promoting and supporting an environment without drugs,
  - A methodical and goal-oriented approach of problematic behavior,
  - Promoting individual responsibility taking,
  - Individualized and flexible treatment and guidance,
  - Promoting norms and values ensuing a friendly climate and appropriate expressed emotions,

- Extra attention to the pharmacological treatment and diligence towards medication,
- Attention to self-care and care for the environment,
- Goal-setting for the psychological condition,
- Goal-setting for the physical condition,
- Insight in the financial situation of patients,
- Attention to relations, intimacy and sexuality.
- Work, in specially designed working areas. This involves:
  - Daily activities: easily executable, well-structured stimulation programs,
  - Assembly tasks: easily executable work together with others in a production situation,
  - Woodwork,carpentry
  - Gardening,
  - General and technical services: working in the cleaning department, laundry department, bicycle repair shop, storage room, shop, logistics department etc.,
  - Art: drawing, painting, clay modeling, stained glass etc.
- Education, such as reading and writing skills
- Pastoral care
- Leaves to enable the patient to participate in society in a responsible way and to maintain his network
- Indicated psychotherapeutic interventions

## **Discharge**

As LFPC does not exist very long in its present form, and because patients are often hard to place in another institution, there is little experience with discharge. Possible discharge stems mostly from evaluation of the yearly diagnostics. In the case of patients with a diminished offence risk and a remaining psychological vulnerability, attempts are made to transfer the patients to another institution with appropriate levels of care and security (possibly in general psychiatry). In the case of an improvement in patient's motivation, or when new treatment options open up, the patient may be transferred to a regular forensic psychiatric treatment institution, with a focus on resocialization and diminishing the risk of reoffending. However, societal upheaval and considerations regarding the victims of LFPC patients have to be taken into account. Moreover, the options of crisis management and the roles of the different parties in it must be clearly described.

## **Recommendations**

When it comes to recommendations, there is much overlap with regular forensic psychiatric care. Moreover, the limited size of LFPC demands some modesty in this respect.

### **Care and security differentiation**

In LFPC, a well-founded differentiation should be set up, geared to the diverse care and security needs of different groups of patients. The differentiation intended here distinguishes three levels of security and three levels of care. To this end, the following matters must be developed.

- Unambiguous inclusion and exclusion criteria to determine whether patients need a high, medium or low level of security
- Unambiguous inclusion and exclusion criteria to determine whether patients need a high, medium or low level of care

- A clear decision model for this differentiation
- A standardized procedure with checks and balances for managing the decision process

The implementation of the differentiation is currently in a beginning stage. It yet remains to be seen how the differentiation can be optimally executed, and what its introduction will involve. The actual introduction has to be subjected to a precise monitoring, and the resulting data can be used to research the effectiveness and efficiency of the differentiation. The research results can then provide leads for the direction and content of possible improvements of the differentiation.

The principle of more independent living units ought to be further developed. In these living units, patients can get maximal autonomy within a LFPC institution. This can contribute to substantiating the differentiation of the levels of care and security. In this way, the level of independence a patient can manage can be safely tested. At the same time can be tested whether a patient can cope with diminished surveillance. A patient able to cope for a prolonged period of time with these circumstances can then remain living in the independent unit or can be possibly transferred to another kind of care.

Another possible instrument here is differentiation of the leave options. Unguided leave is now still impossible for TBS patients with a long stay status. In the future however, this could possibly help to get to more differentiation in individual security levels. In addition, such a differentiation might result in a smoother transition to a less protected institution in the care chain.

### **Diagnostics**

The treatment records supplied by the involved forensic psychiatric institutions vary in completeness. Incomplete records make it difficult for LFPC institutions to offer a patient the right kind of care immediately. Therefore, it is recommended to make agreements in this respect at the national level. In addition, national agreements should be made concerning a standardized form and content of the patient records.

It is important to pay attention to the motivation of patients, not only at the beginning but during their entire stay. As patients differ in acceptance of LFPC, it is also of importance to examine what motivates a patient later on.

Considering the specific characteristics of LFPC and its patients, it makes sense to explore the possibilities for the development of instruments that are custom-tailored to LFPC. Further development of these instruments should entail examining and improving their validity and reliability. Existing instruments, developed elsewhere in the forensic psychiatric field, can serve as a point of departure. Considering the limited size of LFPC, international cooperation in this respect is necessary. This involves, among others, the following instruments.

- An instrument for risk taxation
- An instrument to map protective factors
- An instrument for to systematic behavioral observations and recording its results in standardized way
- A scale for the required care level
- A scale for the required security level

These instruments would help to map changes in risk of reoffending and possibilities for treatment. They also would offer leads to improve the quality of life, as well as the quality of treatment and guidance.

For a good assessment of the continuation of the long stay status, testable criteria should be developed, as well as methods to examine as objectively as possible whether this status is still necessary.

### **Improving the treatment environment, treatment, and guidance**

Generally spoken, the quality testing systems of the regular forensic psychiatric care offer a good point of departure when it comes to guaranteeing the quality of the offered care. However, because of the unique characteristics of LFPC, special quality criteria that are custom-tailored to LFPC field should be developed.

Physical factors play an important part in bringing about an optimal LFPC environment. It is recommended to research the influence of such factors on the patients. Such research can give leads to optimization of the physical environment. International exchange of knowledge in this respect by mutual visits will be crucial.

Concerning the care and treatment regimes, evaluation research has to be done. The outcomes can be then used to make continuous improvements. Here as well, international research and exchange of knowledge would be very welcome.

Also, it is useful to study possible new treatment methods for this group. An international think tank would be very welcome here.

It must be examined whether it makes sense to establish a separate ward for older patients in LFPC. In addition, it is recommended to examine the demand for nursing care in LFPC and how intensive that care should be.

### **Theory and research**

As said before, theory and research need to focus on a CP that is based – as much as possible – on best evidence and best practices, as a real evidence-based approach is research-technically impossible.

As the usual statistical social-scientific approach is only applicable to a limited degree, alternative research designs and methods of data processing must be explored. In this context, one can think of qualitative research, single case studies, and methods of data mining.

It is essential to collect relevant, anonymous patient data in a shared database for research purposes. In this respect, it is also crucial that the CP in the end leads to more standardized data.

To be able to have sufficient respondents to do some statistical research after all, international cooperation is necessary.

At a conceptual level, it would be useful for the forensic psychiatric field to come to an agreement about the definition of a number of key concepts. An unambiguous and sensible definition of the concept of risk, for example, might make it possible to talk about in a more meaningful way about risk and security profiles.

To reinforce the theoretical foundation of the research, it is worthwhile to assess to which degree it is possible within LFPC to integrate the What Works Model (including treatment integrity) with the Good Lives Model and the Rehabilitation Model.

**Relations**

It deserves recommendation to examine the place of sexuality in LFPC.

A guideline should be made for patients who want to get married.