# Long Term Forensic Psychiatric Care in Belgium

## First Experiences in Flanders

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# Short History: Belgium and Forensic Psychiatric Care

1930: Progressive law for offenders with psychiatric problems/mental disabilities
Not guilty by reason of insanity (NGRI)

But: The progressive law stayed theory
Since mid-80's: 23 convictions from the European Court of Human Rights
Peak: 10% of prison-population NGRI (>1.100)

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# Forensic Psychiatric Care for NGRI: 1998 – 2016

1998 Start specialized teams for sexual delinquents. Also for, but no specific focus on, sexual delinquents NGRI

2001 3 Medium Security Facilities and 3 units for people with mental disabilities

2014 Extra capacity in Non-Forensic Psychiatric Care

2015 First High-Security Forensic Psychiatric Center

2016 Unit Long Term Forensic Psychiatric Care.

201x ...

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Academic Psychiatric Center Sint-Kamillus, Bierbeek
Medium Security Forensic Psychiatry since 2001

- 3 units Medium Security treatment
  Schizophrenia and Personality Disorders
- 2 units Medium Security treatment (longer term) and Long Term 'Medium Security' Care
  Schizophrenia and Personality Disorders
- 1 team for Outreachment
  Forensic FACT
- 1 unit Medium Security Treatment (since April 2018)
  Mental Disability
- 1 unit Long Term Forensic Psychiatric Care (LFP)

# LFP

Long Term Forensic Psychiatric Care
High Security
Capacity: 30 men
April 2016

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# Inclusion - Exclusion

Inclusion

- Patiënts with a sustained risk level
- Limited/no possibilities for resocialisation

Exclusion

- Level op group-functioning
- High risk on aggression
- High risk on escape

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# Goals

- Quality of Life
- Protection

# Theoretical Principles

## Good Lives Model (Ward, 2002)

Everybody is in search of activities that contribute to their general well-being.

## Criminal Behavior

Maladjusted behavior: inappropriate means of securing the defined goals in function of the general well-being.

# Theory: Consequences

Risk oriented approach

- Start = Risk Assessment
- Additionally = Patient motivation and responsivity of the patient

GLM-approach

- Start = Patient's goals (contributing to quality of life)
- Analysis of the capacities and risks in obtaining these goals

# Theory in Practice

- Before admission: clear about the unit's objectives
- No treatment (Therapy vs Activities)
- Participation!
  Rules vs Agreements
  Importance of the group
- Basic (Care) Needs (somatic care, Freedom, Responsibilities. . . )
- Restore network
- 'Yes, unless. . . '

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# Security Measures

Infrastructure and Procedures

- 4m fence
- Camera-system
- Training of staff members
- Alarm-system

Relational Security

- 'Therapeutic' relationship = core of our security-measures
- Giving Responsibilities to patients
- No drugs/alcohol
- No violence

# Evaluation

Patient is part of the evaluation process! Quality of Life

- Interview + Questionnaire (FQL-SV)

Protection

- Risk Assessment

**Goal**

To adjust the offered treatment (environment) so that it corresponds with the needs and possibilities of the patient, with security of the patient(s) and his environment in mind.

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# Research

Risk Assessment?
Current instruments: treatment perspective
Few (?) instruments: evaluation of risk in the current setting, without future perspectives taken into account
Limitations: not in psychiatric context

# Goal

To develop and validate a

- Contextualized assessment of adaptation in a forensic psychiatric context
- Daily indicators of transgressive behavior
- Self-perspective
- Relevance of Personality Pathology
- Supportive of Risk Assessment

# Progress

- Construction of the instrument
- Extensive literature review
- Pilot study
- Initial psychometric properties and validation study

Interesting connections between our instrument and the AMPD (DSM-5)

# Future

- Within-person variance of adaptation and personality factors
- Cross validation across a larger forensic sample
- Further exploration of the contribution of model to risk assessment

# Questions?

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