



Clinical practice

Psychiatric monitoring of not guilty by reason of insanity outpatients

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ARTICLE INFO

Article history:

Received 7 July 2015

Received in revised form

19 November 2015

Accepted 23 November 2015

Available online 8 December 2015

Keywords:

NGRI

Treatment

Outpatient

Psychosis

ABSTRACT

Individuals deemed Not Guilty by Reason of Insanity (NGRI) by the courts, under Article 20 of the Portuguese Criminal Code, have often committed very serious crimes. It is unreasonable to consider that these patients were usually kept without adequate supervision after the security measure had been declared extinct. They often decompensated after leaving the institution where they complied with the security measure, and/or relapsed to alcohol and drug abuse. Very often, severe repeated crime erupted again. Considering this, there was an urgent need to keep a follow-up assessment of these patients in order to prevent them from relapsing in crime. This work presents the results of a psychiatric follow-up project with NGRI outpatients. The main goals of the project were: ensuring follow-up and appropriate therapeutic responses for these patients, maintaining all individuals in a care network, and preventing them from decompensating. The team consisted of a psychiatrist, a nurse, and a psychologist. Seventy-two patients were monitored during two years. Results demonstrated the unequivocal need to follow up decompensated patients after the court order is extinguished. Suggestions are presented for a better framing and psychiatric follow-up of these patients.

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1. Introduction

For many years, it was not shown that the relationship between mental illness and crime pointed to an increased prevalence of crimes of assault perpetrated by severely mentally ill patients, especially when they were decompensated.

Almeida¹ studied the criminal trajectory of 33 schizophrenic individuals (19 men) between 1991 and 2003. He found that the patients had committed a total of 42 crimes, 74.0% against people and 24.0% against property, but only 2.4% of those crimes had been reported to the authorities. This suggests that crimes committed by individuals with severe mental illness are often viewed with a great deal of tolerance and complacency.

Eriksson, Romelsjö, Stenbacka, and Tengstrom¹⁰ conducted a prospective and longitudinal study of a birth cohort followed up through registers over 35 years. The cohort consisted of 49,398 males conscripted into the Swedish Army in 1969–1970, of whom 377 were later diagnosed with schizophrenia. Twenty-five percent

of schizophrenic patients were criminally convicted, compared to 6.0% of subjects without schizophrenia. The diagnosis of schizophrenia increased by 2.7 times the risk of being convicted of an offence and by four times the risk of being convicted of a crime. Fazel and Grann,¹⁴ in a population of patients suffering from schizophrenia or non-schizophrenic psychosis, found a prevalence of violent behavior of 6.6%, while Ran et al.³² found a prevalence of 10.0% in schizophrenic patients.

Swinson et al.⁴⁰ studied the homicides that occurred in England and Wales between January 1997 and December 2006. During this period, 5884 murderers were convicted, of whom 605 (10.2%) had a mental illness at the time of the offence and, among these, 348 (5.9%) suffered from schizophrenic psychosis. During this period, there was an average annual increase of 2.0% in homicides among the general population and an average annual increase of 4.0% in the number of homicides committed by schizophrenics, which is due to the increase of drug use. Furthermore, it is important to keep in mind that some patients have premorbid personality disorder, including psychopathy, which is a predictive factor of the highest order of offensive behavior of social and legal norm.⁴⁴

The term NGRI covers heterogeneous and poorly defined groups,²¹ including: insanity acquittees, people found guilty but mentally ill, people found unfit to stand trial, mentally disordered

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sex offenders, sexual predators, and prisoners transferred to mental health facilities. Other definitions also cover people assessed for competency within jails and people referred to mental health courts. The overwhelming majority are men (e.g., Ref. ³⁷).

Although the different jurisdictions show distinct rates of prevalence (e.g. Refs. ^{13,27,38,41,42}) many prisoners meet unequivocally criteria for serious mental disorders.

Prior to the introduction of modern rehabilitation services and developments in antipsychotic medication, several early follow-up studies were conducted, which might have reduced reoffending by forensic patients.⁹

Rates of violent reoffending following release are of the greatest concern to the community.⁴⁵ They have ranged from 4.0% in a period of 3.6 years⁴⁵ to 20.0% at an average period of 6.5 years after discharge.³⁵ Samples that included mentally disordered offenders release from high-security hospitals showed higher rates of violent recidivism, ranging from 6.0% at 2 years to 20.0% at 6.2 years.^{5,9,25} Assertive aftercare and supervision seemed to reduce rearrest rates after the conditional release programs.^{6,26,30,45,47}

Recidivist homicide has been defined as a homicide committed after the conclusion of proceedings for an earlier homicide offence.⁷ From the six studies described on Bjørkly and Waage's⁷ systematic review on recidivism among homicide offenders, only one from Finland provided information about psychiatric diagnosis of schizophrenia, concluding that schizophrenia might be a risk factor for homicide recidivism.^{11,12,31,43} Also, a study from Chuvash Republic (Russia)¹⁹ and another from Scandinavia³⁹ mention earlier homicides committed by schizophrenic offenders – who might eventually be released into the community.^{3,20}

In a systematic and meta-analysis of homicide recidivism and schizophrenia, the pooled estimate of the proportion of homicide offenders with schizophrenia who were homicide recidivists was 2.3%.²⁰

A study from Nilsson, Wallinius, Gustavson, Anckarsater, and Kerekes²⁹ – later confirmed by other long-term follow-up studies on mentally disordered offenders and patients discharged from special hospitals^{17,25,29,48} – found that regardless of the length of follow-up period, only 20.0% of individuals were reconvicted for violent or violence-related crimes during the total follow-up period, resulting in a total reconviction rate of 27.0% when non-violent crimes were included.

A state-wide sample of 127 NGRI acquittees released into the community after spending a mean of 61.6 months ($SD = 76.5$) in the hospital was evaluated by Vitacco, Vauter, Erickson, and Ragatz.⁴⁶ One hundred individuals were committed to the hospital for lengthier treatment (M hospital time = 77.2 months, $SD = 79.8$), but 27 individuals were released to the community after a relatively short hospital stay (M hospital time = 5.6 months, $SD = 3.0$). Regarding release, 96 (75.6%) of 127 individuals maintained their conditional release.

The current Portuguese Criminal Code (CP) features, in Chapter VII^d (Articles 91 to 103),^{33,34} a set of guidelines that have to be met for the subject to be declared NGRI, in the terms of Article 20 of the Portuguese CP, for committing a crime as a result of a serious mental disorder.

According to Article 91, Paragraph 1, whoever has committed a typical unlawful act and is declared NGRI, under Article 20, is ordered by the court to be admitted in a healing, treatment, or security establishment, when, by virtue of the mental disorder and the severity of the act committed, there are grounds for concern that he/she will commit other actions of the same kind. Paragraph 2

of the same article states that a person NGRI who has committed a crime against persons or an offence of common danger punishable with imprisonment for over five years, has to be admitted to a hospital for at least three years, unless release proves compatible with the defense of the legal order and social peace. Consequently, these individuals are admitted to institutions distributed throughout the country, such as, the Clinic for Psychiatry and Mental Health of Santa Cruz do Bispo (CPSMSCB) (North of Portugal), Sobral Cid Hospital (Center of Portugal), and Caxias's Hospital (South of Portugal).

The concern with social violence is intensified when persons who have been found NGRI are returned to the community.²⁴

It is known that the majority of individuals who have been deemed NGRI and are/were subject to security measures, suffer from psychosis, particularly schizophrenic psychosis, and have committed crimes, mostly very serious and mainly against people, including murder.¹ Keeping these patients without adequate supervision after they leave the institutions is unacceptable and unreasonable, especially after the measure of hospitalization is declared extinct. Many of these patients have absent or insufficient morbid consciousness, unstable and disadvantaged families, and they lack competent and careful supervision. As the time in freedom extends, many patients breaking treatment and therapy engage themselves in risky behaviors, including alcohol and drug abuse, which contribute to the decompensation of the illness they suffer from, and repeated crime, often severe, erupts again.³

Therefore, it is imperative to accurately monitor the mental health of patients, in order to avoid or minimize damage that a repeated state of insanity, caused by a serious mental disorder, may entail.²

2. Project “Psychiatric Monitoring of NGRI Outpatients”

2.1. Characterization

The project “Psychiatric Monitoring of NGRI Outpatients” was implemented in Magalhães Lemos Hospital (HML) (Porto, north of Portugal) and focused on individuals deemed NGRI by the courts and who regularly leave the CPSMSCB, after completing the security measure or being on probation.

Seventy-two participants, living within a 60 km radius from Porto, integrated the project.

The project was implemented between February 1, 2010 and January 31, 2012.

The team consisted of a psychiatrist, a psychologist, and a nurse.

Regarding the psychiatric outpatient care, in the event that the patient needed regular monitoring in a psychiatric institution (e.g., HML), the team only monitored the evolution of the patient without interfering in the doctor-patient relationship, particularly, concerning the medication. However, the team established a member for monitoring and helping the patient (making home visits, gathering information with the family, and at the place of residence on the patient's evolution, behavior and needs, for example). Patients who were not psychiatrically monitored (because they abandoned or never attended the doctor's appointments) were temporarily included in the team's consultation, until they were integrated into the Local Service of Mental Health (LSMH) of their area of residence. For those patients, the involuntary commitment plan would be activated.

2.2. Objectives

The overall goal was ensuring follow-up and appropriate therapy for these patients. The specific objectives consisted in integrate

^d Chapter VII of the Criminal Code refers to the Hospitalization of NGRI individuals suffering from mental disorders.

and maintain all individuals in a care network and prevent them from decompensating, thus preventing crime relapse.

The planned project tasks consisted of:

1. conducting the epidemiologic survey of the phenomenon, namely: identifying target individuals; identifying their places of residence; and getting to know the subject, his/her family and his/her residence;
2. contacting other relevant providers in the subject's follow-up (general practitioner, social worker from the area of residence);
3. visiting patients at home periodically, done by the nurse and/or psychologist;
4. doing home consultation by the psychiatrist, when considered necessary by the members of the team;
5. developing a patient report, updated regularly, covering clinical and psychiatric elements, including medical and nursing documentation, a social report, and other elements considered appropriate (e.g., evolution of the legal process).

3. Method

3.1. Participants

A survey was carried out at the CPSMSCB for individuals who, from January 1, 2000 to September 30, 2010, were placed on probation.

The sample was composed of 72 participants (69 male; 52 single; M age = 43.0; SD = 10.7, Max age = 74; Min age = 24; 30 were illiterate or did not complete primary education) residing within a radius of 60 km from the city of Porto.

Inclusion criteria comprise having Portuguese nationality, having been deemed NGRI between 2000 and 2010, and having fulfilled safety measures at the CPSMSCB. Participants who have a nationality other than Portuguese and participants who have fulfilled safety measures at the Sobral Cid Hospital or the Caxias Hospital were excluded. Diagnosis was made accordingly Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) Table 1.⁴

3.2. Instruments and procedure

Socio-demographic Data. Socio-demographic data and patients' characteristics were gathered using the Legal Proceedings, as

well as contacts with the patients and their families (e.g., name, age, sex, marital status, birthplace, education, occupation, employment).

Clinical Data. Clinical evaluation using the data from the Legal Proceedings, the knowledge provided by the patient and family, and the data provided by physician(s) and possibly by the social worker who followed the patient (e.g., psychiatric diagnoses, age of diagnosis, substance use (including alcohol), prior treatment, prior psychiatric admissions).

Criminal History. (e.g., prior convictions, previous convictions for violent offences).

Offence Data. (e.g., date of offence, most serious offence, relationship to victim, number of victims, use of weapons).

Progress Through the Forensic Mental Health System. (e.g., dates of offences, date of apprehension, date of verdict, fitness for trial, dates of transfer between facilities, leave privileges granted, date of conditional release, readmission to psychiatric facilities).

After the individuals were identified, telephone contact was made with the patients' families to schedule an interview with both the patient and the family. If the patient was compensated, the team contacted the family after three months; if the patient was decompensated, the team tried his/her integration into a psychiatric care service; if the patient did not accept this intervention, the team made a second home visit, with the presence of the team's psychiatrist, who, when it was warranted, triggered the involuntary commitment of the patient. Exceptionally, and even if the local psychiatric service consulted the patient, the psychiatrist of the team treated the patient at HML.

4. Results

The results section is divided into a broader and general description of the population involved in the project, followed by a description of specific case studies, which clearly benefited from the project intervention.

4.1. Characterization of the population

From the 72 participants identified until January 31, 2012, efforts were made to establish contact with all of them, of whom: 43 patients were being monitored by the project team; six were admitted into Psychiatric Hospitals; two were institutionalized; one was not at his place of residence despite five attempts made to

Table 1
Characterization of the population.

Characterization	
Socio-demographics	<ul style="list-style-type: none"> - Of the 72 patients followed, 95.8% were male, 70.8% were single, with an average age of 43 years (SD = 10.7; Max = 74; Min = 24). Concerning literacy, 40.3% were illiterate or did not complete primary education. - Regarding the sources of income of the 43 subjects followed at the end of the project: 22 receive social pension, 11 are retired on the grounds of disability, four do not have any source of income, one has a subsidy for participating in an occupational program, one earns a salary as an employee at the City Hall, four have undetermined income. - Thirty-three of the 43 subjects lived with their families, five live in a Guest House/Bedroom, four lived in a rented house, and one was currently at the Shelter House of International Medical Aid (AMI) (Porto).
Psychopathological Features	<ul style="list-style-type: none"> - The most frequent among this population was psychosis (51.4%), followed by mental retardation (37.5%). - Among psychoses, schizophrenic psychosis was the most represented one (89.2%) whereas for intellectual disability, light mental retardation (55.6%) and moderate mental retardation (37.0%) prevailed.
Psychiatric Co-morbidity	<ul style="list-style-type: none"> - Sixty-three percent of subjects had more than one psychopathological condition, representing a higher hazard potential. - In 76.0% of individuals with psychiatric co-morbidity, the second diagnosis was related to substance abuse, and there was a consensus on the dominant role of alcohol in the genesis of antisocial behavior.
Criminal typology	<ul style="list-style-type: none"> - The criminal behavior of this population occurred mainly against people, followed by crime against property. Theft accounted for 55.6% of crimes against property, followed by robbery (27.8%), and damage (11.1%). - Nine of the 10 crimes against life in society were related to fire. - Offence to physical integrity was the most represented crime (48.8%), while consummated homicide and attempted homicide achieved, together, 32.6%. Sexual crimes were entirely committed by individuals with mental retardation. - Concerning the legal status of the patients, we found that 79.2% were in freedom and 20.8% on probation.

interview him; four of the addresses obtained in the lawsuits of patients were not updated; five refused to be accompanied by the project team. It seems important to note that only one of these five patients was on probation, and the other ones had completed the security measure at the time they were contacted; six passed away, two of them during the term of the project; five patients whose data collection was conducted exclusively with clinical processes at CPMSCB were acquitted.

4.2. Results from specific case studies

Team Intervention. The team intervention was particularly relevant in nine situations: four patients suffering from paranoid schizophrenic psychosis, two of which with psychiatric comorbidity as a result of substance abuse; two patients suffering from paranoid psychosis; one patient suffering from mild mental retardation and substance abuse; one patient suffering from severe mental retardation and alcohol abuse; and a patient who had a prefrontal syndrome and concomitant alcohol abuse. We

emphasize that the six decompensated psychotic patients had no accompaniment or psychiatric treatment for too long. They perpetrated multiple behavioral changes, including aggressive behavior and the murderous potential of some of them was very serious [Table 2](#).

5. Discussion

The team intervention with these patients might have prevented murder situations, consummated or attempted (specially in nine patients), or serious bodily injury, or property damage. This is due to the fact that the implementation of the project allowed the compensation of patients who were inserted in the community without treatment, some of which for over a year.

For most patients, their families remained their foundation and fundamental support, even in situations when family members were the victims of the patient's criminal behavior.²⁴ When families, due to exhaustion or any other reason, are not an effective support for patients, particularly in the context of psychiatric

Table 2
Case studies more relevant.

Diagnosis	Crime	Before intervention	After intervention
Paranoid schizophrenia substance abuse	Arson	Without psychiatric care due to lack of response from the Hospital Psychiatric Service in the area since November 2010, when evidence began to freedom.	Followed up by the project team psychiatrist particularly to control medication. Contact with local mental health service to try to expedite the process.
Severe mental retardation alcohol abuse	Qualified homicide	At the time of intervention there were behavioral changes (threats, insults, etc.), despite being accompanied in psychiatry. Relative with whom he lived (aunt) threatened to put him out of the house. Kept high consumption of alcohol.	Admitted to Valongo Hospital. Achieved placement in the social center about where he lived and is checked daily by technicians.
Paranoid schizophrenia	Theft	Without follow-up since 2009. Relatives and neighbors afraid of the patient's behavior. Decompensated, with auditory hallucinations and persecutory delusions. Discrediting the family in the health system and the patient's real disease — mental health service removed patient from the list of patients.	Two involuntary commitments. Comply with medication and is supported by the family. "Abysmal" change in his behavior. In the team's last visit the patient was perplexed by behaviors he had committed; the discourse was coherent and critical judgment entirely appropriate.
Paranoid schizophrenia	Thefts	Without psychiatric follow-up. Refusing any medication. Mother complained of beatings, insults and damage (broken windows and doors). Neighbors complained, including damage to property. Exuberant activity, persecutory, delusional.	Referral to psychiatric service. Involuntary commitment in psychiatric service hospital. Antipsychotic retard. Reduced intra-family conflict and disruptive behavior.
<i>Folie à Deux</i>	Damage	Intervention began with a husband who committed the crime of damage. The diagnose of <i>Folie à Deux</i> was essential to submit the wife (dominant component) to treatment, given the exuberant activity and raving that she had obviously suffering for nearly six years. Had never been subjected to psychiatric treatment.	Began monitoring the psychiatric patient. Inpatient (10 days). Currently holds delusional and hallucinatory residual activity, much less disturbing.
Paranoid schizophrenic psychosis alcohol abuse	Attempted murder	Aggressive and inappropriate behavior towards his family and neighbors. Refused medication (broke the antipsychotic bulbs and denied he did so). Resumed excessive alcohol consumption, coming home drunk several times.	Contact with mental health service accompanying the patient. Family awareness of the need for monitoring of the psychiatric service. Improved monitoring of the wearer. Takes medication regularly.
Mild mental retardation substance abuse	Thefts	Intra-family conflict. Inappropriate behavior. Consumption toxics. Empty and without life project.	Articulation with the Social Welfare Institute. He began a work activity. Intra-family conflict has decreased substantially.
Paranoid psychosis	Physical integrity offense	Denies illness, refuses treatment, and reports everything to a case of mistaken identity. Keeps delusional activity. Inappropriate behavior towards his family and neighbors.	It was sent a medical report in order to communicate and assist the social reintegration of the techniques in his report to the court.
Prefrontal syndrome alcohol abuse	Maltreatment of children and spouses. Threats.	He kept drinking. Behavior presented a threat to use weapon, verbal abuse, and damage to objects. Lives in a smaller residence five years and still lies with parents because he feels afraid of his grandfather.	Assistant psychiatrist contacted. The user was admitted to treat alcoholism.

treatment, the likelihood of decompensation and remaining decompensated for long periods of time is much higher.³

The implementation of Decree-Law 36/98, of July 24,³³ in the two strands of involuntary commitment and outpatient compulsory treatment, allowed a fast and effective compensation of psychotic patients, some of whom were severely decompensated and committed crimes not related, the most part of them, to the authorities.¹

A different situation is that of subjects who, having been considered NGRI at the time of the unlawful act, are intellectually disabled, often with co-morbidity, in particular with associated signs of substance abuse. Some of these individuals do not meet the eligibility criteria for the application of the Decree-Law 36/98,³³ which hinders their compensation and prevention of criminal recidivism.

Regarding situations where the lack of support in the community is manifest, usually consisting in family support, security measures will be stretched to the limit of the penal framework for that objective type of illicit, at the end of which the subject remains unsupported on the outside. Upon being placed in the community, the lack of support remains. The right to freedom is not questioned, nor is an extension of the security measure proposed. Rather, it is defended that the initiatives to keep the subject within the community should organize more consistently in the period of probation, with an effective connection between structures of Justice and Health, particularly, the LSMH, Social Security and the community-based structures that are in connection with it, such as the Private Institutions of Social Solidarity (IPSS). We think it is indispensable to promote an inter-institutional relationship.

The above indicates the defense of not only an assessment prior to releasing the subject in the community, and that cannot be limited to issuing letters of referral to the General Practitioner, and eventually another sent to the LSMH, but rather a suitable monitoring of the patient (NGRI) to the consultations, with the transmission of relevant clinical and judicial information, and a more adequate monitoring of the psychiatric treatment of the patient in the community. This work should be prepared when the subject is still fulfilling the security measure. Mental health services do have some role in preventing homicides,^{22,23} including by focusing on comorbid substance use of patients with an established diagnosis of psychotic illness,^{15,16} and by earlier treatment of first episode psychosis.²⁸ It is essential the existence of coordination between different entities (legal/correctional and mental health) from the moment the patient (NGRI) is released after serving a security measure, with its effective integration into an official unit of psychiatric care.⁹ There is lack of legislation requiring the official mental health services effectively follow-up individuals deemed NGRI and who completed a safety measure.^{8,36} There is also lack of legislation forcing mental health professionals to alert health authorities when these individuals do not comply with prescribed therapy.³

Promoting the independence and well-being of patients was a key goal of this project, also contributing to the maintenance of social peace, which requires timely monitoring and evaluation of the clinical condition and functionality of the subject, through an articulation work in a network which would allow to assess and foster the skills of the individual as a social being.

The implementation of this project showed that patients who committed a crime and were deemed NGRI relapse and perpetrate criminal behavior in a substantial number when released and are not properly monitored by psychiatric services, and particularly when they discontinue the medication. The project allowed to interrupt and prevent diverse criminal behaviors, some of which very serious, and that could result in murder.

The findings clearly demonstrate the impact that the monitoring and the proper treatment of these patients is not always as effective

as their pathology justifies it, and it unequivocally stresses that, if that strict monitoring is not conducted, the criminal relapse is inevitable and not negligible.

The results of this study underscore the success of programs designed to work with NGRI in the community.

Conflict of interest

The authors do not have any interests that might be interpreted as influencing the research.

Funding

None declared.

Ethical approval

The study was conducted according to APA ethical standards.

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