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Financing of forensic psychiatry in view of treatment quality and threat to public safety

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Summary

Stay in a psychiatric hospital of persons who committed the gravest criminal acts while in a state of insanity aims to ensure their effective treatment (therapeutic function), but above all to prevent the repetition of prohibited acts of significant harm to the community (preventive function). Forensic patients are provided with suitable medical, psychiatric, rehabilitation and resocialization care. The court imposes an indefinite detention. In view of the dual purpose of the stay in a psychiatric hospital, both therapeutic and preventive, the treatment costs generated by forensic wards are higher than those of general psychiatric wards. This prompts person from outside psychiatry, who do not understand the nature of preventive measures, to call for continuing reductions in the expenditure on forensic psychiatric care. It is, therefore, worth analyzing the possible meaning and results of the attempts to economize forensic psychiatry, to find savings and to manipulate financing system under the pretence of economic incentive to improve treatment quality. In this paper, the authors address and discuss the above and other issues.

Key words: preventive measures, financing, psychiatric detention

Introduction

In mid-2017, the community of mental health professionals, persons responsible for organizing psychiatric care and, particularly, representatives of forensic psychiatry, were outraged by a letter of the Patient Ombudsman addressed to the Minister of Health, with courtesy copy to the most important representatives of the government bodies: the President of the Republic of Poland, the Prime Minister, the Minister of Health, the Minister of Justice, the Polish Ombudsman as well as the Psychiatric Commission for Preventive Measures. The letter presented the Patient Ombudsman's request to consider a change in the financing of treatment offered as part of preventive measures by applying the model used for general psychiatric wards. This would, supposedly, form economic incentive for improving the effectiveness of treatment offered to detention

patients, whereas in reality it may translate directly into shortened length of hospital stay (due to economic, not therapeutic reasons) of forensic patients.

For sure the Patient Ombudsman had no wrong intentions when presenting the said concept. His motivation to introduce the suggested measures could stem from recent opinions, often reproduced in the media, that detention lasts far too many years and the patients are isolated for an excessively long time in view of the acts for which the criminal code stipulates a much lower sentence.

It is easy to draw conclusions and opinions based on scant media knowledge. The key to find good solutions to the emerging problems is their in-depth and comprehensive analysis.

As it is widely known, the therapeutic and custodial measures, applied as part of preventive measures to perpetrators of prohibited acts committed in a state of insanity or limited sanity, were introduced under the Polish Criminal Code as early as in 1932. In a slightly modified form, they remained binding in the Criminal Code of 1997, whereas the so-called Great Amendment of the Criminal Code in July 2015 expanded the list of preventive measures, thus establishing their new catalogue, with outpatient services. This enabled the courts to choose the most optimal measure from the point of view of its pertinence and usefulness. Still, based on unpublished data of the Psychiatric Commission for Preventive Measures to the Minister of Health, preventive measure in the form of stay in a psychiatric facility still remains most frequently imposed by criminal courts.

At the same time, the measure, as the harshest and limiting both liberty and civil freedoms to the greatest extent, is adjudicated for an unlimited period of time and, therefore, gives rise to the highest number of controversies and concerns [1]. It is also often a subject of speculations in media, political and social circles. On one hand, social expectations push toward ensuring the necessary security to citizens and their protection against persons posing a threat. On the other hand, defenders of human rights blame the system/doctors for an excessive detention of patients in forensic wards of psychiatric hospitals and manipulation of the detention time to ensure continuous funding for the treatment facility.

Frictions and mistakes are easy when the issues are analyzed only superficially. It often results from lack of understanding of the need and reason for the forensic patient's hospitalization lasting longer than an average psychiatric stay, which requires a taxpayer to provide an above-average financing level for treatment provided by forensic psychiatry wards. The above rationale results from the specific purpose behind the courts' decision to impose stay in a closed psychiatric facility – not only therapeutic but also preventive. It should be stressed that the specificity of a long-term psychiatric care over a forensic patient has been already determined at a legislative level, which defines preventive measures and stresses their special nature. They have, therefore, become a permanent component of the doctrine and court rulings.

The scope of ruling, the nature and purpose of stay in a psychiatric facility implemented as part of preventive measure

The court's ruling of a stay in a psychiatric facility as part of preventive measure is possible only with respect to a group of perpetrators specifically defined in the Criminal Code, only when it is necessary to prevent the repetition of the prohibited act and when other measures are insufficient (Article 93a § 1 of the Criminal Code) [2]. Article 93g § 1 of the Criminal Code stipulates that the court may impose (obligatory) stay in a psychiatric institution on an insane perpetrator if it is highly probable that he would again commit the act of significant harm to the community due to his mental illness or mental retardation. Against a perpetrator whose sanity during the act was significantly limited, the court, by ruling the punishment of imprisonment without parole, or 25 years' imprisonment, or life-time imprisonment, also imposes a stay in an suitable psychiatric facility in case of negative criminal prognosis, as stipulated in § 1 (Article 93g § 2 of the Criminal Code [2]). Moreover, Article 93g § 3 of the Criminal Code [2] obliges the court to impose a stay in a suitable psychiatric facility on a perpetrator sentenced for crimes stipulated in Article 148 of the Criminal Code, Article 156 of the Criminal Code, Article 197 of the Criminal Code, Article 198 of the Criminal Code, Article 199 § 2 of the Criminal Code or Article 200 § 1 of the Criminal Code, committed in relation to sexual preference disorders, when he is sentenced to imprisonment without parole, 25 years' imprisonment or life-time imprisonment, if it is highly probable that the perpetrator would commit a crime against life, health and/or sexual freedom in relation to his sexual preference disorder.

The very circle of persons committed by the court to a psychiatric facility under Article 93g of the Criminal Code [2] points to the nature and purpose of preventive measure in the form of a stay in a psychiatric facility. The court imposes the measure only on the most dangerous offenders who pose a threat to society and broadly understood legal order, and who, at the same time, require psychiatric treatment in a closed ward environment. This plays, therefore, both therapeutic (as in general psychiatric wards) and preventive function. Moreover, another goal of the stay in a detention ward is social re-adaptation of a patient being in a state of insanity or significantly limited sanity so that he is ready to re-enter society and perform social functions properly. The perpetrator is placed in a psychiatric facility not only to isolate him but also to treat him, thus eliminating the threat he poses and preventing him from committing another act harmful to the community [3].

Such broad goals determine the length of detention as well as differentiate certain therapeutic methods and conditions for stay in a psychiatric facility concluded as part of preventive measures from hospitalization taking place in a general psychiatric ward, regulated under the Act on mental health care [4]. In forensic wards the patients are offered, in addition to pharmacological and psychotherapeutic care (psychologist, occupational therapist, and addiction therapist), a wide range of socio-therapeutic, rehabilitation and resocialization effects. The work with forensic patients is conducted in many steps and on many levels. Any improvement takes place not only when the

patient responds successfully to pharmacotherapy, but also when he is able to critically assess his crime and when his attitude and behavior show that he does not pose a threat to himself or others. The last factor affects to the greatest extent the decision whether the patient is ready to be moved to a ward with a basic security level or to leave the facility and function on his own in the society in a way that is not threatening to the legal order.

The effectiveness of forensic psychiatry is not only the matter of adequate therapeutic procedures but also of continuous monitoring and assessment of the risk of breaking the law, which in fact poses legal rather than medical and therapeutic problem. The process of estimating the probability of repeating a prohibited act is based on complex rules and procedures, still uncommon in our country, that require the application of diagnostic and prognostic models that take into account new specialist tools, such as HCR-20, SAPROF, DANDRUM [5, 6].

The probability of repeating a prohibited act versus the length of stay in forensic psychiatry wards

World literature on forensic psychiatry applies a notion of 'long stay patient' which is sometimes understood differently. This, in turn, is related to patients' varied average length of stay in detention wards in different countries. Research conducted in England showed that an average length of patients' stay in forensic wards with the maximum security level lasts up to eight years [7], 16% of patients stay for more than 10 years, whereas 3% longer than 20 years [8]. The stay in wards with lower security level lasts 2–5 years. In Germany and the Netherlands, a tendency is noted to lengthen the stay of detention patients [9].

For the past years, not only in Europe but also around the world, research has been conducted on the factors conditioning the length of stay in forensic wards, as well as on the factors characteristic for patients staying in the wards for many years in order to show improvement and readiness to be released. It has been noted that the patients staying the longest are those who had committed the gravest criminal acts, often with the use of violence, who have a long criminal history, suffer from mental disturbances (with a long history of illness), are drug-resistant, and often suffer from co-existing personality disorders (mainly dissocial personality). Organic factors and low level of cognition, hence limited abilities of social learning, have been also stressed [9].

Combination of biological (medical) factors with crime-inducing behavior and lack of criticism about the committed act do not allow treating such patients in the same manner as general psychiatric patients. They also do not allow measuring the effectiveness of treatment solely based on positive response to pharmacotherapy and health improvement. Recovery, or more often – a temporary improvement, of the disorder being the primary reason for the committed crime, together with safeguard measures, does not imply that preventive measures should be stopped, because the most important factor for releasing a patient from detention is his absence of threat to

himself or others and the belief that after release the patient will be able to continue his treatment on an outpatient basis.

Effectiveness of treatment in forensic wards vs. economic factors

Both patients and their doctors, but most of all the society, are keen to continually improve the quality of treatment offered in forensic psychiatry wards because each "incompletely" cured patient, after leaving the detention ward, may pose a threat to the legal order and individual safety. There is a need to develop systemic solutions supporting institutions that apply preventive measures in striving to improve the quality of provided treatment. This goal is served with different methods, but each one of them requires allocating higher financing resources, rather than restricting them.

The concept, or postulate, to approximate the financing method for providing treatment in forensic psychiatry and general psychiatry wards, as presented by the Patient Ombudsman, should be assessed negatively. Improved service quality (or incentive to treat patients more effectively) in forensic psychiatry is supposedly to take place based on financing mechanism that implies setting a time limit for the patients' stay in forensic wards above which the payment for treatment would be limited (corrective indicators)[1], similarly as in the case of general psychiatry or drug treatment wards.

This opinion stems from wrong beliefs: firstly, that settlement of detention hospitalization costs, which is irrespective of the length of stay of individual patients, may result in lack of economic incentive to improve quality and effectiveness of provided treatment; secondly, that release of the patient from detention is to lead to negative financial results for the hospital because it will decrease the level of funding by a given number of person-days. This is to lead to wrong conclusions that releasing patients from detention would adversely affect the economic interest of therapeutic institution.

The opinion presented above, purporting that it is in the hospital's economic interest to keep forensic patients longer than it is necessary for them to achieve therapeutic goals so that no free beds are generated, is wrong in the very assumption it is based on. Everyday practice of forensic psychiatry deals not with the excess of free beds in hospitals, which would justify the extension of patients' stay against the need, but on the contrary, with constantly full occupancy at the detention facilities.

Release from/end of psychiatric detention

Under Article 93d of the Criminal Code [2] the length of stay in a psychiatric facility is not fixed by court in advance because at the time of the ruling it is unknown when the patients would improve enough not to pose threat after the release. The court,

[1] Settlement of the excess time is effected using a corrective indicator of 0.7 for general psychiatry wards and of 0.5 for drug treatment wards.

however, terminates the preventive measure when its prolonged use is no longer necessary (Article 93b § 2 of the Criminal Code [2]).

The court is informed about the health, progress in medical and/or therapeutic treatment of a patient placed in a detention ward at least every 6 months through written opinion of the head of psychiatric facility. The opinion is usually prepared by the attending physician and a psychologist. They are obliged to provide information not only on clinical aspects but also whether the present state of the patient makes him prone to commit the prohibited act again. Their conclusions form a suggestion for the court whether to extend or end the detention.

The decision on ending the detention is undertaken impartially by the court based on the psychiatrists' and psychologists' opinions and conclusions on the medical condition of the patient, as well as assessment of his ability to exist on his own and continue treatment as an outpatient in such a way that does not pose threat to health and life. The court also takes into consideration the overall facts and legal situation of the patient, the history of his criminal and life-threatening behavior as well as the possibilities of successful prevention.

Sometimes the court, against the opinion of the attending physicians and the opinion of the Psychiatric Commission for Preventive Measures to the Minister of Health, rejects the request to decrease the level of security from maximum to basic, which is the level immediately preceding the end of detention. It shows that impartial decisions of courts may be affected by psychiatric opinions to a limited extent.

It should be stressed, in the context of the problematic decision to end the detention, that psychiatric treatment may be an endless process and one that requires to maintain permanently a so-called pharmacologic straightjacket. In addition there are drug-resistant psychoses in case of which, despite administering neuroleptic drugs, not only the symptoms of the illness are not diminished but also the patient's threat to public safety is not reduced, which means that at any moment he is able to commit again a criminal act of significant harm to the community. In this respect limiting the suggested rate for treatment (person-day) in proportion to the length of stay may lead to medically reprehensible (but economically enforced) release of persons who are not fully recovered and continue to be dangerous. Inclusion of resocialization and rehabilitation elements aiming to adapt the patient to the life outside the hospital and to justify the medical opinion about absence of risk to commit offence again is possible only for a mentally healthy person, or at least cured enough to critically and responsibly relate both to his illness and the aggressive antisocial behaviors.

Release from detention takes place mostly at the level of basic forensic ward, which houses insane patients who have committed crimes punishable with fine or limitation of liberty. These cases, forming the majority of the ruled detentions, give rise to the greatest controversies – due to the principle of proportionality of punishment to the committed crime – stipulated in Article 93b § 3 of the Criminal Code [2], which is often violated by courts. It is worth remembering that it is impartial court, not the psychiatrist, that makes the decisions about placing the perpetrator

in a detention ward, after analyzing the whole case material, not just the clinical status of the patient being subject of the medical opinion. Patients' long-term stay in a detention ward, in view of disproportion of the measure to the committed crime punishable with a significantly lower sentence, results often from the necessity to apply further treatment in hospital settings. This is caused by lack of adequate social support for persons released from detention, which often leads to harmful interruption of treatment in outpatient settings, therefore, increasing the threat to health and life. Detention must be terminated taking into consideration the patient's ability to adapt to autonomous life after long hospitalization, such as showing independent and due concern over own state of health.

Wards with basic security level are "standard psychiatric wards" with financing similar to average person-day. Applying the suggested economic calculation, which is to enforce the incentive to improve "therapeutic quality", i.e., reduced funding as the length of detention increases, may result in discharging from hospitals (wards with basic security level) "cured" patients whose health status is comparable to "non-forensic" patients. The latter cooperate with families and outpatient clinics more fully, whereas "forensic" patients, who despite being equally "cured" still pose a threat, join families where the threat may materialize in a tragic manner. There is a chance of overlooking a risk element, such as domestic violence, which applies to over 90% of the so-called punishable threats, and/or violation of bodily integrity of family members, etc., resulting from mental disorder. In other words, although the intensity of symptoms lessens enough to stop hospitalization, the risk of violence is not decreased enough to allow further treatment outside the hospital, for example, in home environment. The above has been confirmed in the case law of the European Court of Human Rights which ruled that domestic court, by deciding to stop continuous isolation imposed as part of preventive measure, must equally take into account the interests of the perpetrator as well as society to which the perpetrator will return after the detention [10].

The future of forensic psychiatry

Future forensic psychiatry assumes a gradual transition from the isolation to therapeutic model with the use of specific opportunities offered by community preventive supervision. Forensic psychiatry in Poland may not remain impassive in view of the advancements and practices that arise following the development of community psychiatry and technical monitoring of perpetrators (electronic tagging). The effectiveness of therapy resulting from advanced psychopharmacology also plays an important role and its future role in forensic psychiatry is undisputable, especially in view of the possibilities offered by prolonged-release anti-psychotic medication (LAI) [11].

New solutions should provide for gradual transition – from hospital isolation – to supervision and therapy conducted in non-detention settings. Such model must permit to gradually phase out isolation but also allow a return to isolation if the patient gets worse or stops cooperating with clinicians and therapists.

The reform of criminal law two years ago (July 2015) offers such opportunities provided that an effort is made to develop complex models that take into account the accomplishments and possibilities offered by community psychiatry. The application of the new therapeutic and preventive model as well as its substantial transition to the outpatient environment also requires new and trustworthy control and verification methods. The introduction of obligatory use of new tools assessing the risk of repeating criminal acts will establish the expected safety guarantees. The new methods of risk assessment will be followed by simplified procedures concerning diagnosis, consultation and guarantees, but most of all the time of hospital isolation shortened to the minimum necessary. At this stage, however, it is difficult to accept the idea of limiting the time of stay and therapy in a detention ward only due to financial aspects.

Changes in the model of financing forensic psychiatry

While taking into consideration the above problems relating to the specificity of forensic psychiatry, out of concern for special standards of conduct toward patients remaining in detention, as well as taking into consideration the necessity to protect society against any threats posed by those patients who, undertreated and still posing threat to society, could be allowed to leave hospital for economic reasons (lack or decrease of finances), it should be stressed that it is necessary to make the expenditure available for hospital treatment of forensic and psychiatric patients more realistic in relation to the costs. Undoubtedly, it is necessary to increase the rates, not to look for savings in the system of psychiatric detention by limiting funds for implementation of a goal as important as the treatment itself, i.e., prevention.

The issue of financing psychiatric detention solely with the funds from the Ministry of Health allocated for treatment gives rise to controversies in view of the second purpose of detention, i.e., prevention, which does not form part of any medical procedure. In effect of long-term discussions among practitioners and representatives of justice administration a concept was developed to delegate some funds necessary to implement psychiatric detention from the Ministry of Justice. This concept was presented in 2016, in a formal opinion of the Health Care Section of the National Development Council, which is a consulting and advisory forum for the President of the Republic of Poland. Minutes from the Section meeting on 9th February 2016, devoted to the problems of mental health and psychiatric healthcare, included recommendations to the Minister of Health which, in point 10, indicated the need to develop "a change of the model of financing forensic psychiatry – budget delegation from the Ministry of Justice". Passing some costs from the Ministry of Health to the Ministry of Justice may seem only an accounting maneuver from the point of view of public funds. Nevertheless, it proves that diversity of the forensic psychiatry and its preventive purpose (in additional to therapeutic one) has been finally noted by the decision makers.

Forensic detention of mentally ill persons implements the state's obligation to provide, first and foremost, for public safety and only secondly to treat the person in

a specially established safety conditions, which obviously generates higher costs. It can be also assumed that the preventive measure, as an enforcement of valid court ruling, involving limitation of liberty by a compulsory placement in a psychiatric hospital, should be understood (and financed) as a duty of the Ministry of Justice. It is, however, rather difficult because the detention must be implemented within therapeutic, not penitentiary, system.

Conclusions

1. Deliberate delegation of funds aimed for public safety from justice administration to the health resort – for implementation of specific task, i.e., psychiatric detention, undoubtedly requires enforcement, preferably in the form of statutory regulations.
2. It is necessary to apply new diagnostic methods to assess the risk of repeating criminal acts of substantial social harm. The use of tools assessing the risk should be obligatory for the sake of certainty of proof in the opinions that qualify the patient to a higher or lower level of security, or overall release from detention.
3. Response to current social and political conditioning relating to psychiatry, particularly forensic psychiatry, sometimes requires social environment to react very quickly and to find answers to the raised questions. It is necessary to clear any doubts which otherwise may rapidly lead to wrong conclusions and generalizations.

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