# Crushed by the Belgian system: Lived experiences of forensic care trajectories by persons labelled as not criminally responsible

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## Abstract

**Background** Care trajectories of Persons labelled Not Criminally Responsible (PNCR) are often characterized by multiple transitions from one (forensic) mental health service to another and by long periods of admission. So far, little research has been conducted on forensic care trajectories, in particular on how PNCR perceive the trajectories they are subjected to.

**Methods** Data were obtained via semi-structured interviews (N = 23) with PNCR in various (forensic) mental health services in Belgium. A maximum variation sampling strategy was applied to recruit a heterogeneous group of PNCR and inductive thematic analysis adopted to analyse the data.

**Results** PNCR's experiences about care trajectories in Belgium are marked by an absent voice and passive position in the decision-making process in addition to a lack of support during transitions. Barriers for admission in (forensic) mental health services and the indeterminate duration of care trajectories contribute to overall negative lived experiences.

**Conclusion** Although some findings are interchangeable with general mental health care, PNCR's care trajectories differ by their undetermined nature, barriers for accessing care and power dynamics in compulsory forensic care. As concepts from prison sociology, such as tightness, power holders and pain of indeterminacy, seem to be equally relevant for the situation of PNCR, the balance between a criminal justice and mental health approach in forensic mental health care is questioned.

**Keywords** Forensic mental health, Forensic psychiatry, Persons labelled not criminally responsible, Forensic care trajectories, Service user perspective, Lived experiences

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## 1. Introduction

Persons labelled Not Criminally Responsible (PNCR) are adults considered unaccountable for (some of) their offences due to mental illness. In Belgium, they are subjected to a so-called

'internment measure' of undefined duration. This measure is applied to protect society while providing mental health care to PNCR (Ting To, Vanheule, De Smet, & Vandevelde, 2015; Völlm et al., 2018). In the last decades, the state of Belgium has been condemned several times by the European Court of Human Rights (ECHR) for the inhumane treatment of its PNCR in prison facilities (Heimans & Vander Beken, 2015). Subsequent policy reforms have positively impacted care provision for PNCR in Belgium. First, a new legislation on 'internment' came into effect in October 2016. Since then, only crimes that affect the physical and psychological integrity of others can lead to internment. The execution of the internment decision is now in the hands of the multidisciplinary Court for the Implementation of Sentences (Chamber for the Protection of Society). The new law further states that a forensic psychiatric assessment is a mandatory requirement before an internment decision can be made (De Clercq & Vander Laenen, 2019) and that prison is not an appropriate place for PNCR, while care should be provided in designated (forensic) mental health services (Casselman, De Ryke, Heimans, & Verpoorten, 2017; Vander Beken, 2017). Second, recent policy reforms at the federal department of Public Health aim to transfer all PNCR from prison to appropriate mental health care services that are structured in forensic care trajectories. Therefore, investments were made in extra in- and outpatient care capacity for PNCR (i.e. facilities, beds and staff) (Pesout & Pham, 2019). Considering the new legislation and policy reforms in Belgium, the changes that impacted the care trajectories of PNCR considerably concern the development of high security facilities, units for PNCR with specific mental health conditions (e.g. dual diagnosis or intellectual disability) and the creation of timeout modules that should prevent a return to prison. The result of this policy reform was a decline in the number of PNCR in prison facilities, from 1088 in 2014 to 537 in 2019. In 2019, 537 PNCR still resides in prison, 960 were compulsory placed in inpatient forensic mental health services and 1817 PNCR were on probation (Justice Department, n.d; K. Seynnaeve, personal communication, December 12, 2019). A probation measure necessitates PNCR to follow an in- or outpatient care trajectory while adhering to additional predetermined conditions (e.g. prohibition to use drugs or alcohol) (Vander Beken, 2017). However, despite efforts to increase care capacity and consequent transfers of PNCR from prison settings to (forensic) mental health care services, a considerable number of PNCR still resides in prison settings. These PNCR encounter exclusion criteria (e.g. intellectual disability or having committed a sexual offence) in (forensic) mental health care services, hence they cannot apply for probation, while there is shortage in capacity for compulsory placement.

A care trajectory is primarily constructed to promote recovery, and ultimately leads to discharge (Tucker, Brown, Kanyeredzi, McGrath, & Reavey, 2018). In the case of PNCR, care trajectories are supposed to support recovery as well as desistance from crime (Van Roeyen, Van Audenhove, & Vander Laenen, 2016), ultimately leading to the abrogation of the 'internment measure'. Care trajectories should be designed to meet patients' needs, such as evolving security- or care needs (Tucker et al., 2018). A personal, continuing care approach is intended to lead to smooth transitions from institutional to community care (Klingemann et al., 2019). In forensic mental health care, PNCR generally progress in trajectories stratified according to therapeutic security levels, ranging from high to low security. This means that their need for a certain level of therapeutic security should be the main indicator for progression in a care trajectory (Pillay, Oliver, Butler, & Kennedy, 2008). As such, PNCR should always be admitted in a (forensic) mental health service with an appropriate security level which is no higher than needed (Kennedy, 2002). Mental health care for PNCR in Belgium ranges from inpatient to outpatient forensic services, targeting PNCR exclusively. These specialised services include high-secure facilities (e.g. Forensic Psychiatric Centres or so-called 'Social Defence Institutions', the latter are prisons including mental health care staff), medium-secure units (separate and specialised units within general mental health care services), and specialised low-secure day care services, low-secure sheltered living homes and outreach teams. Specific subgroups of PNCR, such as women, mentally disabled PNCR or PNCR who committed a sexual offence, can also

be treated in designated units of medium- and low-secure mental health services (Cartuyvels & Cliquennois, 2015; Pesout & Pham, 2019). Additional capacity is provided in general mental health services, such as psychiatric hospitals, sheltered living homes and outreach teams. In the latter settings, PNCR are treated on the same wards and by the same teams as regular patients.

Decision-making processes on care trajectories of PNCR usually involve three professional bodies, i.e. the judge, a legal body of the court (e.g. Chamber for the Protection of Society (CPS) in Belgium) and care practitioners. While the judge and the CPS are professionals within the criminal justice system, care practitioners are part of the mental health care system. These bodies are expected to make decisions at different points of the care trajectory (Edworthy, Sampson, & Völlm, 2016). In Belgium, a judge imposes the 'internment measure', while the CPS follows up on its execution and approves referrals during the care trajectory. Care practitioners advise the CPS about the clinical state and progress of the PNCR. Only in the specific case of incarceration, the prison's psychosocial service follows up on PNCR and represents a fourth actor in the decision-making process, by advising the CPS during incarceration as an actor of the criminal justice system (Mertens & Vander Laenen, 2019). In case of probation, PNCR apply for admission in a (forensic) mental health care service. If this service agrees to provide care for this PNCR, CPS holds the final decision on approval or denial of this agreement. In case of compulsory placement, there are no clear guidelines for care practitioners or psychosocial services to inform PNCR's referral or triage decision, and thus this decision is mainly based on individual, professional expertise.

Academic interest in forensic service users' perspectives is growing. Recent studies examined PNCR perspectives on treatment (Askola et al., 2016), therapeutic relations with staff, the therapeutic climate at the ward and overall satisfaction with forensic services (Bressington, Stewart, Beer, & MacInnes, 2011) and, supported housing projects (Jordan, 2018). Others have focussed on (the effect of the Good Lives model on) rehabilitation (Barnao, Ward, & Casey, 2015; Barnao, Ward, & Casey, 2016) and 'what works' (Tapp, Warren, Fife-Schaw, Perkins, & Moore, 2013). Mertens and Vander Laenen (2019) analysed the lived experiences of female PNCR in Belgium; other studies explored PNCR's perspectives on forensic treatment (Ting To et al., 2015), recovery (Aga, Vander Laenen, Vandevelde, & Vanderplasschen, 2019) and desistance (Van Roeyen et al., 2016) and on the working alliance and procedural justice (Wittouck & Vander Beken, 2019).

International research focussing on PNCR care trajectories and its effectiveness are limited, in particular regarding PNCR's perspectives on their care trajectories. Crocker et al. (2015) found significant regional differences in length and discharge odds among PNCR's care trajectories in Canada. In some cases, PNCR perceive formal progress in their care trajectory as a movement 'backwards'. In regard to transition to a new ward, the assimilation process to the new group, space and relations is considered to slow down their progress towards discharge (Tucker et al., 2019). In Belgium, research into care trajectories is limited to older PNCR. De Smet et al. (2015) found that their trajectories are often long and diverse, marked by multiple incarcerations, releases, probations and admissions in forensic mental health care. In addition, his participants revealed how (forensic) mental health care services were perceived to be unresponsive to their needs in terms of medication, psychological and social support. Considering the recent development of forensic care trajectories in the rapidly expanding field of forensic mental health care in Belgium, we try to understand how PNCR perceive these care trajectories, specifically at transition moments, difficulties they encounter and which opportunities for improvement they experience. These insights can inform the evaluation of the recent policy reform in Belgium and improve forensic mental health practice in general. This study further contributes to the academic body of literature on PNCR's lived experiences, their needs and care trajectories.

## 2. Methodology

To gain insight into the lived experiences of PNCR, a qualitative research design consisting of semi-structured interviews was adopted. Interpretive semi-structured interviews privilege the participant's knowledge and allow discovering

their own experiences. Since little is known about this topic, exploring these experiences can lead to new information on PNCR's needs in care trajectories (McIntosh & Morse, 2015).

Interpretive semi-structured interviews were conducted in Dutch (by the first author) or French (by the third author), depending on the native language of the participant. During the interview, the participant and interviewer made up a timeline reflecting the care trajectory of the participants. Questions inquired on transition moments, where the concept 'trajectory' is clearly experienced (i.e. the transition from prison to, and between or within (forensic) mental health services), reasons for transitions, involvement of the PNCR in the referral decision and their appreciation of (the support during) this transition. In addition, their overall appreciation of the forensic care trajectory and perception of their future trajectory was explored. The timeline and interview schedule were based on those used by De Smet et al. (2015). For instance, the timeline interview schedule included questions such as "Where did you reside after you received the internment measure?", "How long did you reside there?", "Why did you leave?" and "where did you go afterwards?". Other questions of the interview schedule were "How did you experience the care you received?" and "Were you ever excluded from admission in a (forensic) mental health care service?". However, with respect to our focus on transition periods questions concerning this topic were added, for instance, "Do you know why you were transferred?", "Who was involved in this decision?" and "What did you experience as difficult during your transfer?"

### 2.1. Data collection

First, (forensic) mental health services were selected, based on their security levels and admission of both males and females. Respondents were recruited in high, medium, and low security (forensic and regular) care services throughout Belgium so as to include participants at different stages of their forensic care trajectory. PNCR in prison settings were excluded from recruitment as they are not involved in a care trajectory and – therefore - not able to reflect on this topic. Coordinator at the selected service were contacted through an information letter to obtain consent for participation in the study.

Second, mental health practitioners in these services made a first selection of eligible participants, based on following inclusion criteria: having sufficient verbal skills to participate in an interview and being mentally stable at the time of the interview, as assessed by the unit psychiatrist or psychologist. Given the heterogeneity of the PNCR population (Ting To et al., 2015), a maximum variation sampling strategy was applied. Consequently, mental health practitioners recruited participants with diverse features (gender, age, length of forensic care trajectory, diagnosis, and index offence). The instructions to determine this sample group where to select at least 1 female PNCR, at least one PNCR with a psychotic disorder, a personality disorder and an intellectual disability and at least one PNCR with a sexual, violent, property and drug related offence at every security level. As such, the sample would have every gender, diagnosis and offence represented at every security level. In addition, instructions were given to balance eligible participants by age and length of forensic care trajectory, thus including both younger and older participants and with varying lengths of care trajectory. The first and third author supervised this recruitment strategy, to ensure maximum variation was reached for the total sample of participants. Then, mental health practitioners presented the purpose of the study to the selected PNCR and asked for their permission to be included in the study. After obtaining oral consent, a meeting was arranged to conduct the interview. Prior to the interview, the information letter and informed consent form were discussed emphasizing anonymity and confidentiality of data collection and analysis. Based on this information, eligible persons provided written consent for participation in the study. Socio-demographic, diagnostic and offence related information was collected with participants' consent, using a standardized information form. The form was filled in by the unit psychologist at the time of the interview or afterwards.

23 semi-structured interviews were conducted with a mean duration of 35 min, the shorter being 20 min and the longer 1 h and 15 min. All interviews were conducted in the (forensic)

mental health service where the participant received mental health care. The interviewer and the participant could speak privately during the interview. To ensure anonymity, each participant received a unique code in addition to obscuring names of (forensic) mental health services, mental health practitioners, and other persons or places. Participants could request a summary of the results of the study, if they wished so.

### 2.2. Sample

Between January and June 2018, 23 PNCR participated in the research project, including 5 females and 18 males. Seven participants were admitted to a high security setting, ten to a medium security setting, and six to a low security setting. The average age of the participants was 43 years old. Three participants were between 18 and 27 years old, four were between 28 and 37 years old, eight were between 38 and 47 years old while six participants were between 48 and 57 years old. Only one participants was older than 58 years.

Duration of interment ranged from less than 1 year to 27 years. Four participants had been subjected to the 'internment measure' less than 4 years ago, while ten participants were subjected between 5 and 9 years subjected to the measure. For five participants this was between 15 and 19 years ago and, two have been subjected to the measure between 20 and 24 years. Two participants have been subjected to this measure for over 25 years.

Common diagnoses in this sample were personality-, psychotic-, and substance use disorders, although there were also participants with diagnoses of an intellectual disabilities or mood-, developmental-, and sexual disorders. Most participants had two (N = 10) or three (N = 8) diagnoses, while only three had one single diagnosis and one person had four diagnoses. The offence(s) that lead to the internment measure was/were in most cases violent offences (N=16) and property offences (N=9), but also sexual (N=4) and drug related offences (N=2). The diagnosis and index offence of one participant remained unknown.

### 2.3. Data analysis

Thematic analysis is a method used to identify and interpret meaningful themes in a data set (Braun & Clarke, 2012, p. 57), resulting in an understanding of collective or shared meanings and experiences. Due to the explorative nature of this study, no themes or code tree were identified prior to data collection and analysis. A predominantly inductive approach ensures data coding is driven by the data instead of theory-driven. This experiential orientation gives voice to experiences of the participants (Braun & Clarke, 2012).

All interviews were described at verbatim. The inductive thematic analysis was based on six steps and included 1. Familiarization with the data; 2. Generating initial codes; 3. Searching for themes; 4. Reviewing potential themes; 5. Defining and naming themes; 6. Producing the report (Braun & Clarke, 2012). After the familiarization with the data, initial codes on paper and in the software of NVivo 11 were generated simultaneous in each researcher's native language (i.e. first and third author). A first coding tree was developed in English (as a mutual language), based on seven (French or Dutch) interviews that were transcribed verbatim. These interviews were selected because of their meaningful content and sharp wording. This preliminary coding tree was discussed between the two researchers and validated by analysing the remaining interviews, resulting in a final coding tree in English. A deeper analysis consisted of independently identifying links between codes, generating and defining possible themes in Dutch and French. These themes were again discussed in English, until consensus was reached between the two researchers. In addition, an independent researcher connected to the Department for Special Needs Education at Ghent University analysed five randomly selected interviews and checked for agreement with the final coding tree and themes.

Each of the themes is conceptualised and illustrated with quotations (followed by gender and duration of the internment measure), to clarify the text or to empower the story of the participant. Some themes are strongly connected to each other. Such nexus will be highlighted and discussed.

## 3. Results

As a result of the thematic analysis, five main themes were identified. The first theme *'decision-making process'* relates to the position and the voice of PNCR in the decision-making process of their care trajectory. The theme *'transition moments'* describes PNCR's experiences of transition from one (forensic) mental health service to another and the support during these transitions. The theme *'structural factors influencing care trajectories'* focuses on identified barriers and facilitators advancing or obstructing a care trajectory. *'Relation to time'* describes lived experiences of the undetermined character of the 'internment measure' and finally, the theme of *'depiction of ending a care trajectory'* illustrates how PNCR portray their expectations regarding the end of their care trajectories.

### 3.1. Decision-making process

#### *3.1.1. Passive position*

PNCR consider decision-makers such as the judge, Chamber for the Protection of Society (CPS), care practitioners and the prison's psychosocial service as power holders. This concept was introduced by Bottoms and Tankebe (2012, p. 214), who define a power holder as a person who *"holds power over other citizens and can thus issue decisions and rules that are binding on them"*. The following participant describes the general organisation of decision-making and links it to his situation.

> *"It is the judge, the chairman of the Chamber* [CPS], *who decides where you should go. I did not agree. I wanted to go to another hospital but was ordered to be placed in X* [secure unit] *and nowhere else.* […] *The chairman, the psychologist, a psychiatrist, the prosecutor and my psychiatrist. It is a small group of five people who were present during the hearing and who made a decision, between them, without involving me."* (Male, 1 year interned).

During their care trajectory, participants often link a decision for a transition to a specific event, referring to their behaviour at a certain moment. This behaviour was then perceived to have provoked one of the power holders to decide if a transition to another (forensic) mental health service would be necessary.

> *"I briefly returned to prison because I had sexual contact with a boy in the ward at the beginning. This was discovered four months after the admission, and then I had to return to prison for one month, though I got directly the message 'Look, if you are motivated, you can come back in a month'."* (Female, 6 years interned).

All participants perceive their own behaviour as a major factor initiating the decision-making about their care trajectory. In their opinion, deviant behaviour (e.g. violating conditions or not abiding to institutional rules) often leads to a transition to prison or an institution with a higher security level or to the loss of liberties (e.g. permission to leave), while good behaviour leads to more liberties and a transition to a lower level of security.

In some cases, participants reflect upon the CPS' decisions. Those who agree with the decision acknowledge that this had a positive impact on their care trajectory. Others, however, have the feeling that the decision was made against their will. The following quotation illustrates how PNCR reflect upon these decisions.

> *"If I would have gone to a general* [low security] *psychiatric hospital, I probably would have relapsed in bad habits. Using drugs, escaping and so on, maybe committing offences."* (Male, 4 years interned).

> *"I had a meaningful occupation back then so why wouldn't they let me out? It is not as if I was doing nothing there all day long. I wanted to go out so I occupied myself."* (Male, 12 years interned).

In conclusion, a structured assessment of behaviour seems absent and decisions are primarily influences by these isolated events of behaviour. As such, participants feel observed in their behaviour though not consulted if that behaviour leads to decision-making. This top-down decision-making does not seem to lead to an overall acceptance of decisions for a transition or a compulsory placement. The experience of being in a passive position is substantially linked with the experience of lacking voice in the decision-making process.

*3.1.2. Lacking voice*

Participants express diverse opinions about having a voice in the decision-making process or during their care trajectory in general. More than half of the participants state they have no voice at all, while some participants feel they do have a voice, and others have mixed experiences. A few participants describe how third parties (e.g. parents or lawyers) help them to vocalize their interests.

Generally, participants experience having a voice as positive. They feel they are listened to, and can express their concerns about a referral to another (forensic) mental health service (such as longer distance or no motivation). Conversely, participants experience not having a voice as negative. However, one participant nuances her negative perception of having no voice, as she feels this is inherent to the compulsory care system, and thus, she accepts it. Her quotation reflects both the subjection to compulsory care and the ambiguous role of care staff within a compulsory care trajectory.

> *"No, but that is part of the coerced system here. At a given moment you say: 'Okay, I would like to go working and I cannot, I would like to go to a different ward but they will not allow me. They don't think I am ready yet and I think I am.' That collides, yes. In the beginning that collided very hard."* (Female, 6 years interned).

Moreover, some participants further elaborate on this topic and describe a false sense of having a voice. They feel they can express themselves though nobody listens and nothing changes.

> *"And then I had the luminous idea to appeal against the first decision of the Chamber for the Protection of Society while I was in prison X. And that appeal was processed in city Y, so I have experienced that too. But I will not replicate this. I won't say it is a charade but it will not be too far away from this. It is pro forma."* (Male, 5 years interned).

Participants not only describe a false sense of having a voice, but feel they are exposed to false options as well. Several participants report being offered to 'choose' between a (forensic) mental health service and a prison, while the prison was not seen as a genuine alternative.

Hence, although some participants feel that they (occasionally) have a voice, or that third parties represent their voice, most of them feel that decisions are imposed to them: many participants feel their voice is not being heard and that the options they are offered are false.

### 3.2. Transition moments

*3.2.1. Experienced transition*

The decision for a transition results in a transition itself. Mostly, the transition is described as a negative experience. Participants report they were often not prepared for the new setting and did not know what awaited them. They mention no particular support during transitions, except when family members or care staff are allowed to organise the transfer to a new setting, which was not always the case.

> *"I was lucky that they allowed me… It was in my case my son, who just came to pick me up in prison X with the promise to drop me off here."* (Male, 5 years interned).

One participant with a very long care trajectory and multiple transitions construes how he eventually tries to detach himself from the process.

> *"Eventually it is always like… For me, just a change of building."* (Male, 19 years interned)

The dominant role of power holders in the decision-making process inevitably influences the lived experience of PNCR during transitions between settings and may result in feelings of being powerless. Although participants acknowledge that their own behaviour could have led to a decision, often followed by a transition, they seem to lack any active participation in both the decision-making and transition process. Besides their passive position in decision-making and transition, the lack of support in these processes seem to further exacerbate feelings of powerlessness.

*3.2.2. Lacking support*

Participants report three types of support (i.e. emotional, practical and informational) during the transition from one setting to another. They expect these types of support provided by care

practitioners or by the prison's psychosocial service, such as receiving information about the transition or emotional support in anticipation of/during the transition to the new (forensic) mental health service. The majority of the participants describe a lack of emotional and informational support during their transitions.

> *"They never gave me the information. They opened the door, they let me go. I took the train and went home."* (Male, 27 years interned)

Similar to third parties representing the participants' voice, some receive support from family members or a lawyer. Occasionally, even prison guards provide support.

> *"We could look on the internet together with the prison guards. And what did we see? Those high walls. It was from one prison to another prison."* (Male, 11 years interned)

> *"I was especially scared because I did not know where I was going to, I did not know what it was going to look like. They said we should stay there years, five years minimum. And I did not want to rot there. Just one prison guard who told me it was more open, who tried to reassure me."* (Female, 1 year interned)

The lack of support contributes heavily to the impact of a transition in the PNCR's care trajectory. Lack of support, whether emotional, practical or informational, leaves PNCR unprepared and uninformed about their transition, even leading to detachment as a coping mechanism.

## 3.3. Structural factors influencing care trajectories

In addition to PNCR's perceived powerless position in the decision-making and transition process, structural factors are influencing their care trajectory, being the transition from prison to (forensic) mental health services or transitions between and within (forensic) mental health services. While discussing the transitions during their care trajectory, participants inevitably elaborate on the difficulties they encounter to get admitted to a (forensic) mental health service. Facilitating factors can counter these difficulties but were mentioned less frequently by the participants.

Their psychiatric condition, the committed offence, the regional aspect and the commitment of a mental health service to admit PNCR were considered to be hindering as well as facilitating. For example, one could be rejected or accepted by a (forensic) mental health service due to his or her intellectual disability. Similarly, one could be rejected or accepted by a (forensic) mental health service when he or she committed a sexual offence. These examples are formally known as inclusion and exclusion criteria of (forensic) mental health services. Additionally, participants report on (forensic) mental health services preferring to treat PNCR originating from the same region, resulting in a rejection of PNCR from other regions, although not all participants have been confronted with this barrier. Last, some general mental health services appear to reject requests by any PNCR because they are not obliged to admit these persons, while other services are committed to providing mental health care to PNCR.

### *3.3.1. Barriers*

Most participants describe a long period of writing admission letters, with the help of the prison's psychosocial service, to various (forensic) mental health services. The writing often results in numerous negative responses from these services, citing diverse reasons for their rejection, causing feelings of hopelessness to some participants.

> *"Eventually I refused things the psychosocial service proposed to me, just because I knew it was going to be negative. I said that to the psychosocial service: 'Do not even bother anymore'."* (Male, 15 years interned)

Other barriers for trajectories to, between or within (forensic) mental health services are long waiting lists for admission, one's personal history in a mental health service (e.g. aggression incidents) and one's personal situation with other patients.

> *"In institution X I was rejected because there was a guy who harassed my girlfriend. I was not allowed in his proximity. Risk towards the patient and towards me, I think."* (Male, 15 years interned)

Disagreement on the PNCR's care trajectories by the power holders is not common but mentioned as a barrier by some participants. For instance,

this participant describes how his psychiatrist believes in him but was antagonised by the judge, as a member of the CPS.

> *"The psychiatrist had nothing to say. The psychiatrist was positive every time but they [CPS] said no. They maintained a permission to leave of three days a week. That's all they wanted. The psychologist, the psychiatrist and the nurses are trying to get me out. The head nurse was not happy. Judge X was an old man. He blocked it."* (Male, 21 years interned)

Some participants even express difficulties to develop a rehabilitation project because of difficult relations with staff members in (forensic) mental health services. This seems to result in long care trajectories within secure units without the possibility to make a relevant transition. In this case, the participant found the implementation of the new internment legislation in Belgium to further hamper his situation.

> *"I did find an apartment, but there was no more commission* [for the protection of society]. *The commission said* [before] *'Ok, released on trial as soon as the apartment is found', that was the formulation. You arrive, the social worker says 'Oh no I do not agree! To seek does not mean to find'. And then you don't know what to do anymore. I stayed two more years in this setting because he [the social worker] didn't send the file and I couldn't appeal it because of the transition to the new law."* (Male, 26 years interned)

*3.3.2. Facilitators*

Participants describe good behaviour, motivation for treatment, having a meaningful daytime occupation, and specifically for prison settings expressing a demand for help, taking the initiative to write to (forensic) mental health services and the help of the prison's psychosocial service with these requests as facilitators for admission in a (forensic) mental health services. Demographic variables are considered to have an impact on the transition from prison settings to (forensic) mental health services as well. For example, one participant mentions she was admitted very quickly to a medium security facility because she was young and female.

PNCR's security profile was considered as a facilitator for admission in specific secured facilities. For example, if they posed a medium risk, they could get admitted more easily in a medium security facility. Moreover, the patient turnover is regarded to have an influence on admissions as well. If the patient turnover in a (forensic) mental health service is high, they can be admitted sooner.

Only one participant explicitly mentioned Belgium's new internment policy, which caused him to be transferred from prison to a high security facility.

> *"Also because we all had to leave the prisons, according to 'Brussels* [the policy makers]*', so no PNCR could stay there."* (Male, 11 years interned)

### 3.4. Relation to time

The duration of an internment measure in Belgium is undetermined. In general, all participants perceive their care trajectories as very long. Some consider this long duration as justified, while others fiercely disagree. However, all participants experience how the undetermined duration results in feelings of insecurity, another perception of time as well as an opportunity for a personal recovery process. Since the duration of the internment measure is undetermined, the CPS can extend it without limitations. Ultimately, this results in feelings of despair, as reported by several participants.

> *"I want to live outside, go and live alone. An apartment, you know? Just a little bit longer, I need to have patience. But, the trajectories here are five or six years. I know people who stay here for eighteen or nineteen years. Please, don't do that to me."* (Male, 5 years interned).

Participants also tend to describe a skewed sense of time (being both slow and fast), due to the long duration of imprisonment or long waiting times before admission to a forensic mental health service. However, the predominant experience of time was "slow" and "long".

> *"Time passes by so quickly and fast. If you go to a hospital, you do not move forward, you understand?"* (Male, 27 years interned)

> *"Everything is very long here. My case will only be presented in the Chamber* [CPS] *in March. But the permissions to leave that I had in prison are not valid here. That means I have to apply for them again. And*

*so I didn't leave the facility for eight months since I was admitted here* [secure unit]." (Female, 1 year interned)

Despite participants felt that time passes slowly, most of them perceive this long period as an opportunity for personal recovery. They describe how much they have learned during that time. Moreover, they perceive time as a necessary factor in their recovery process.

*"In the beginning that I was here, I heard people saying: 'I have been here five years' or 'I have been here eight years'. So I would have said 'How is it possible that it takes so long?'. But now that I am sane, I think about my own problems that I have had, and time played an important role."* (Male, 8 years interned)

### 3.5. Depiction of ending a care trajectory

All participants give a particular interpretation to the end of their care trajectory. For them, it means going back to (voluntary) work or starting an education. It means investment in their family or relationship and a meaningful occupation (such as sports, travel or community work).

*"I always had responsibilities in parishes. I do hospital visits for the elderly. I also visit older people or people who have had an accident. I will do their shopping. I go to a geriatric ward. It was a little bit more painful, but I start from the principle, it is a Protestant principle: when we have taken so much, we must be able to give a lot. I will not say it is my redemption on earth, but it helps me a lot. To see that we are able to do something else than harm."* (Male, 26 years interned).

Participants expect to live independently or in a supported living unit while having a good social and/or professional network. One participant explicitly states that he strives for the exclusion of problematic behaviour (e.g. addiction) from his future life. At an emotional level, participants perceive the end of their care trajectory as a moment of rest and enjoyment. One participant even describes it as "a moment for himself", while another refer to the retrieval of a sense of being a human being.

*"Personally, I would say that to rehabilitate myself as a human being, because that's not always obvious. It would be a good thing."* (Male, 26 years interned).

Most participants are keen to abrogate the internment measure. In any case, some participants perceive the internment measure as a safety net, which enables them to find support of familiar caregivers when needed.

## 4. Discussion

The aims of a (forensic) care trajectory are recovery and desistance from crime with respect for PNCR's needs and in continuity of care. However, the results from our interviews with PNCR show apparent deficits in the implementation of care trajectories in Belgian forensic mental health care with respect to these aims. The lack of support and voice in the decision-making and transition processes indicate an explicit absence of both relational and longitudinal continuity of care, as defined in Nicaise et al. (2020), in addition to a lack of opportunities for PNCR to express their needs. Our concern is that, in the absence of these vital preconditions, objectives such as recovery and desistance from crime become difficult to achieve. Our results are not surprising, as other Belgian researchers such as De Smet et al. (2015) previously demonstrated a lack of voice in decision-making processes, unresponsiveness to PNCR's needs concerning medication, psychological and social support and exclusion from (forensic) mental health services in older PNCR. As such, their findings seem to be valid for the total PNCR population in Belgium, despite recent policy reforms that increased care capacity and introduced care trajectories for PNCR. Still, crucial preconditions for reintegration of PNCR are not provided.

Several challenges are not exclusive for forensic mental health care, as some experiences are interchangeable with findings in general mental health care. For example, service users in general mental health care also experience a lack of voice at transition points (Wright, Rowley, Chopra, Gregoriou, & Waring, 2015). Moreover, elements of personal recovery among PNCR, such as future perspectives and meaningful occupation, are identical to those in general mental health care clients (Aga et al., 2019). In the end, PNCR primarily seem to pursue social and personal rehabilitation, 'a normal life' with employment or education and satisfying social or professional

networks. Similarly, these objectives often seem to be disregarded by power holders in general mental health care as well (Craig, 2018; Van der Meer & Wunderink, 2018). Shared decision-making (SDM) is increasingly recommended as an answer to these challenges and is considered to enhance positive outcomes, although rarely fully integrated in mental health practices. SDM emphasizes participation and encourages egalitarian decision-making between all stakeholders, being clinicians, patients and their family or social network (Bradley & Green, 2018; Dahlqvist-Jönsson, Schön, Rosenberg, Sandlund, & Svedberg, 2015; Slade, 2017).

Importantly, forensic care trajectories and forensic recovery are distinctively characterized by its undetermined nature. This indeterminacy leads to feelings of insecurity and despair (Aga et al., 2019). Participants in this study look forward to freedom, finally being liberated from the dominating power and tightness of the criminal justice and mental health system. Crewe (2011a) introduced the concept of tightness in the prison system, and we believe this concept is equally applicable to the situation of PNCR in Belgium. Tightness is considered to represent the experience of power as "both firm and soft". Soft power is enforced through staff-prisoner relationships and through policies to regulate PNCR's behaviour. Soft power also captures the smothering feeling of not knowing how to behave themselves for fear of getting things wrong (Crewe, 2011a, 2011b). As such, time is an important and ever returning issue in all accounts of the participants. This has been referred to as 'the pain of uncertainty and indeterminacy' for prisoners with undefined sentences (Crewe, 2011a). This concept has been recently applied to female PNCR's situation and seems to be applicable to all PNCR in Belgium, stressing the emotional turmoil inherent to the indeterminacy of the 'internment measure' (Mertens & Vander Laenen, 2019). Participants' account of numerous barriers in their care trajectories, in particular with regard to strict inclusion and exclusion criteria employed by (forensic) mental health services, add to the feelings of insecurity and despair. The reform of these criteria and implementation of structured triage decision-making (based on effective indicators such as therapeutic security needs), could add to the amelioration PNCRs' situation. In respect of clarifying the process of triage decisions, this could lead to a better informing of PNCR about the possibilities in their care trajectory and thus facilitating their participation in the decision-making process.

Similar to shared decision-making, Wittouck and Vander Beken (2019), plead for a procedurally just approach in forensic mental health care. In their article, they state that, despite the compulsory character of forensic mental health care, better results can be expected of an approach consisting of participatory and respectful treatment in working alliances (i.e. fairness, respect, voice, validation, motivation and information). This means PNCR should be considered as "dignified and active actors with a voice during these interactions" (Wittouck & Vander Beken, 2019, p.10), in order to empower this vulnerable group of people and to restore the power imbalance currently present in forensic mental health care. Not only does this empower PNCR and enhance recovery, it also enhances law-abiding behaviour which is in the society's interest (Bottoms & Tankebe, 2012; Wittouck & Vander Beken, 2019). As such, SDM and a procedurally just approach are compatible in advocating for an active and supportive collaboration between PNCR and mental health or judicial actors in decision-making processes and broader working alliances to enhance recovery and desistance from crime. However, identical challenges in implementing these strategies might arise in forensic mental health care as in general mental health care. Research revealed that perceiving persons with a severe mental illness as competent and equal actors in the decision-making process is the key challenge for practitioners in general mental health care (Dahlqvist-Jönsson et al., 2015), and we assume this is not different for PNCR in forensic mental health care.

Some limitations must be taken into account when considering the results of this study. First, we attempted to include a heterogeneous sample of persons labelled not criminally responsible. However, selection bias is possible considering our sampling technique and the use of gatekeepers. We did not make any sub analyses or differentiations based on the security level, duration of the internment measure or other characteristics of our participants. As such, it

remains unclear whether any differences in the experiences of these subgroups are present. Second, this study adopted a qualitative method to investigate and comprehend the lived experiences of study participants. However, it is possible that participants might have suffered from recall bias by the (im)possibility to remember all transitions they have experienced due to the time interval (McKenna, Simpson, & Coverdale, 2003). Third, the sample size is rather small considering the heterogeneity of the large group of PNCR in Belgium. Practical constraints (e.g. time, funding) did not allow to recruit, interview and analyse data among a larger sample. In this respect, future research on this topic is needed to adequately comprehend PNCR's needs and perspectives on care trajectories. It would be interesting to validate these results in a larger sample of PNCR or to compare PNCR subgroups' experiences. For instance, do lived experiences of care trajectories differ according to PNCR's security level or diagnosis? Similarly, since a large body of knowledge about PNCR's perspectives has been produced in some countries (e.g. Belgium), and every country has its specific organisation of forensic mental health care, it would be interesting to compare results internationally. Finally, follow-up research is needed in Belgium when the policy reform initiatives are more grounded in practice might provide valuable comparative results.

In conclusion, PNCR experience a considerable lack of power and support during their care trajectories. Structural factors, such as limited patient turnover, exclusion-criteria and the undefined nature of an internment measure, seem to exacerbate feelings of despair and insecurity. As such, the implementation of a procedurally just approach and shared decision-making in forensic mental health care are regarded as first steps towards empowerment and rehabilitation of PNCR. In evaluation of the policy reforms in Belgium, the implementation of these strategies is an important recommendation. However, the pain of indeterminacy has not been altered by the new internment legislation in Belgium and continues to negatively impact PNCR's lived experiences. Moreover, as many of the concepts from prison sociology (such as 'tightness' (Crewe (2011a)) and 'power holders' (Bottoms and Tankebe (2012))) seem to be equally relevant for the situation of PNCR, we may wonder to what extent the forensic mental health care system is an extension of the prison system, in which PNCR are passive subjects in relation to power holders. For instance, research on Belgian PNCR has shown more positive experiences among PNCR in prison settings compared to those in forensic mental health services, as the latter are experienced as overly strict and controlling or unresponsive to PNCR's needs (De Smet et al., 2015; Mertens & Vander Laenen, 2019; Ting To et al., 2015). Does the criminal justice approach overrule the mental health approach in forensic mental health care? Or can it be that the forensic mental health system adopts a criminal justice approach? As forensic mental health care capacity expanded rapidly in Belgium during the last decade, one hypothesis might be that some services are struggling to create a new identity, being forensic mental health care and combining risk management and psychiatric treatment as opposed to the well-established services in general mental health care system. Forensic mental health training is still in its infancy in Belgium, but could be one factor to restore the balance between care and control, in addition to the implementation of the proposed strategies of SDM and procedural justice.

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### Declaration of Competing Interest

None.

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