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Treatment Perspectives on Interned Mentally Ill Offenders in a Forensic Psychiatric Centre (FPC): A Delphi Study on Experts' Opinions

The study aims to map the treatment perspectives of international experts on treating mentally ill offenders in a Forensic Psychiatric Centre using the Delphi method. The four-round Delphi study reveals high conformity on the proposed treatment-related issues. However, some points of divergence remain. Three controversies underpinning these disagreements are discussed. The first controversy regards the treatment and control debate. The second controversy concerns the dual role of assessment in forensic mental health. The third controversy describes the potential entry conditions for treatment in a Forensic Psychiatric Centre. Further research is needed to scientifically underpin the above mentioned debates. In this regard, the study suggests a close collaboration between practitioners and researchers.

Keywords: Mentally ill offenders; treatment; forensic psychiatric centre: delphi method

Introduction

Recently, there has been an increasing interest in the precarious situation of mentally ill offenders (MIO). A disproportionately high number of people with mental disorders has been reported in prison populations (Andersen, 2004; Black, Arndt, Hale, &

Rogerson, 2004; Brugha et al., 2005; Fazel & Danesh, 2002; Fazel & Lubbe, 2005; Markowitz, 2006; Torrey, 1995). International figures vary widely from 2% to 94% (e.g. Assadi et al., 2006; Bland, Newman, & Thompson, 1998; Davidson et al., 1995; Goyal et al., 2011; Naidoo & Mkize, 2012; Gunn, Maden, & Swinton, 1991; Teplin, 1990; for review see Andersen, 2004) often depending on the research methodology, the definition of mental illness (Toch, 2007), the disorders that were included and the setting (Andersen, 2004). Yet, available figures on MIO in European prisons is described as ‘alarmingly’ scarce (Dressing, Kief, & Salize, 2009). Besides the absence of a systematic collection of statistics on mental disorders in most European prisons, there has been an increasing concern regarding the availability and provision of adapted treatment both inside (e.g. Adams & Ferrandino, 2008; Arboleda-Flórez, 2009; Salize, Dressing, & Kief, 2007) and outside prison walls (e.g. Arboleda-Flórez, 2006; Rice & Harris, 1997). These issues have especially grown in importance in Belgium, since the development of a forensic treatment service is still in its infancy (e.g. Boers, Vandeveldel, Soyez, De Smet, & To, 2011; Casselman, 2000; Cosyns, Van Peteghem, Raes, & Sabbe, 2006; Naudts et al., 2005). Therefore, the Belgian situation lends itself well for a profound analysis and discussion of the challenges concerning the treatment of MIO, which can be relevant for the situation in other countries.

In Belgium, the law provided the possibility to the judge to ask for the internment of MIO. Offenders can be interned if they have committed a delinquent act for which they are ‘declared irresponsible or “severely diminished responsible” (...) at the moment of the trial as a consequence of either a status of insanity or a serious mental deficiency which makes the person unable to (fully) control his acts’ (Vandeveldel et al., 2011:72). This internment procedure is considered a safety measure to protect society. With regard to the offender, internment aims to provide psychiatric

treatment. However, this law has not always been applied properly (Vandeveldel et al., 2011), since MIO have not always received treatment according to the current standards of psychiatric care (Cosyns, Koeck, & Verellen, 2008). This situation is most pressing in correctional settings, as up to a quarter of Belgian mentally ill offenders reside in prison in which they are often deprived from adequate treatment (De Clerck, 2010; Vandeveldel et al., 2011).

In order to adequately address the treatment needs of incarcerated mentally ill offenders, the concept of a continuum of forensic mental health care could offer promising opportunities to treat and care for mentally ill offenders in a continuous and coordinated manner (Cosyns, 2005; De Clerk, 2010; Mental Health Commission, 2011, Vandeveldel et al., 2011). Therefore, in 2006, the Belgian Government decided to build two Forensic Psychiatric Centre's (FPCs), where interned MIO can reside in a secure treatment and care institution (De Clerck, 2010). This can be considered a necessary first step in the development of a continuum of forensic mental health care (Cosyns, 2005).

Despite these first initiatives, the content and organization of the treatment programs in the upcoming FPCs are still unclear. International literature has pointed to different treatment perspectives on several treatment-related issues (e.g. Barlow & Wolfson, 1997; Clearly & Warren, 1998; Menger, 2008; Mezey, Hassell, & Bartlett, 2005, Parhar, Wormith, Derkzen, & Beauregard, 2008). More specific, in Belgium, the study of Boers et al. (2011) also revealed different opinions on various treatment-related issues. The study inventoried the current practices of 18 Belgian institutions, using interviews and document analysis, concluding that the different treatment perspectives might stem from the heterogeneity of the clients. The study focuses on treatment aspects (e.g. treatment objectives & therapeutic approach), structural-organizational aspects

(e.g. staff, continuum of forensic mental health care & inclusion and exclusion criteria) and setting-specific aspects. These divergent treatment perspectives have raised the question as to what experts think about integrating these findings in a consistent treatment framework. Therefore, this study aims to map the treatment perspectives of (inter)national experts on these treatment-related issues using the Delphi method, which will be discussed in relation to the international scientific knowledge. It analyses and discusses data collected in Belgium, which will be used as a starting point to elaborate the challenges with regard to the treatment of MIO more in general.

Method

The experts' opinions on treating MIO in a FPC were gathered by means of the Delphi method. This method is a structured research process that utilizes a series of questionnaire rounds to achieve consensus of opinion (Keeney et al., 2001) about a complex problem (Brown, 1968) or to make decisions when there is insufficient or contradictory information (Hasson et al., 2000; Jones & Hunter, 1995). It was applied in this study because of the specific features in light of our research question: (1) it enabled us to guide various opinions towards a final decision (McKenna, 1994; Helmer, 1983, Limestone & Turoff, 1975 and Dalkey, 1972, cited in Yousuf, 2007); (2) it allowed the anonymous inclusion of experts across several locations and expertises (Jairath & Weinstein, 1994); (3) it avoided the (in)advertent dominance of a specific expert on the consensus process (Jairath & Weinstein, 1994; Keeney et al., 2001, 2006; Sumsion, 1998); (4) it allowed efficient and rapid collection of expert opinions in an inexpensive and practical way (McKenna, 1994; Sumsion, 1998); (5) the participants had time to consider their responses, which might not be possible in the context of face-to-face meetings (Sumsion, 1998; Yousuf, 2007); and (6) it attempted to address the

‘what could/should be’ issues, whereas common surveys rather try to identify the ‘what is’ answers (Miller, 2006 cited in Hsu & Sandford, 2007).

Delphi panel

Both nationally and internationally recognized experts with elaborate knowledge on the treatment of MIO were included in the Delphi panel. They were carefully selected by reviewing recent (inter)national peer-reviewed literature, international lectures on the treatment of MIO and through consultation of the steering committee of the research project (which consisted of 18 Belgian forensic mental health professionals from the academic field as well as the mental health practice and from a wide range of disciplines, e.g. legal, nursing, psychiatric,...). The experts were selected based on their treatment experience with MIO. For international experts, treatment experience was defined as experience in treating MIO in institutions similar to the future Belgian FPC. For Belgian experts, on the other hand, treatment experience was defined as experience in treating MIO who are likely to be admitted to the future FPC.

In total, 39 experts were identified and approached by e-mail, where they were informed on the Belgian situation of MIO and the study’s aim and procedure. Twenty of the 39 experts agreed to participate in the initial qualitative round of the Delphi study and were asked to sign an informed consent form. Eventually, only 10 of the 20 respondents participated in this first round. One non-respondent explicitly reported no longer wanting to participate in the Delphi study, due to time constraints. Information on other non-respondents was not obtained. Given the exploratory character of this first round, the total sample of initial participants (20 - 1=19) was re-invited to participate in the remainder of the Delphi process. For the successive rounds, only ‘round 2’-participants were invited, thus maintaining a stable Delphi panel of 14 experts with experience in treating MIO. Although no clear rules exist on the minimum or maximum

number of experts in a Delphi panel (Keeney et al., 2006), a group size of at least 13 experts was aimed at, since Dalkey et al. (1972, cited in Ludwig, 1997) found a high reliability of group responses for a sample of 13 experts. In our Delphi panel 9 of 14 experts had additional research experience regarding the topic under study and 9 of the 14 experts had both policy experience and experience in treating mentally ill offenders. The Delphi panel comprised five women and nine men. One half of the panel included international experts (Finland, Germany, United Kingdom, Denmark, Norway and 2 experts from the Netherlands), while the other half was Belgian. The majority (10 out of 14) of the experts were psychiatrists. The response rate was 73.7% in round 2, 92.9% in round 3 and 71.4 % in the last round of the Delphi process. This implies that the response rate of 70% recommended by Sumsion (1998) was achieved.

The importance of completing all rounds of the Delphi study was emphasized in the onset of the procedure, and repeated in the personally addressed reminder e-mails that were sent to non-responders in order to minimize attrition. Since poor response rates in the final rounds of a Delphi study is a common occurrence (McKenna, 1994), special attention was paid to ongoing e-mail and telephone communication with the participants throughout the whole Delphi process.

Delphi process

The Delphi process consisted of four rounds, which were conducted in English, using LimeSurvey (i.e. an online application to conduct surveys, <http://www.limesurvey.org/>) and e-mail correspondence. Results of each round were analyzed and fed back to the experts in a report containing the overall group results (defined as the median, the associated interquartile range and a bar chart with the distribution of the absolute

numbers of responses) and the experts' own response for each statement. The experts were then asked to reexamine their own opinions in light of the overall group results.

The first qualitative round of the Delphi process comprised 9 open-ended questions designed to elicit as many ideas as possible on the potential content and organization of treatment in an FPC in Belgium. This first Delphi round resulted in a list of 49 statements and two additional questions and were fed back to the participants through a structured questionnaire.

In the second round of the Delphi process, the expert panel rated the 49 statements using a 6-point scale ranging from 'strongly agree' (1) to 'strongly disagree' (6) and filled out two additional questions when applicable (depending on the score on the preceding statement). The data were analyzed using SPSS (version PASW statistics 18.0) and were treated as ordinal data, reporting medians and interquartile ranges (IQR). The numerical definition of group consensus was based on the consensus rule applied in the study of Green (1982, cited in Hsu & Sandford, 2007). Statements that were rated 4 or higher on the 6-point scale by at least 80% of the participants and that had a median of 5 or 6 were judged to have reached group consensus in a negative way, indicating general disagreement with the statement. Statements that were rated 2 or lower on the 6-point scale by at least 80% of the participants and that had a median of 1 or 2 were judged to have met group consensus in a positive way, indicating an overall agreement with the statement.

In the third round of the Delphi process, the experts were asked to re-rate the statements for which no group consensus was reached. Furthermore, they were asked to elucidate their own scores. Along with the numerical results of this third round, the arguments for agreement and disagreement of the experts were anonymously summarized in the feedback report (cf. Michelbrink, 2006).

In the fourth and final round of the Delphi process, the experts were –once more- asked to re-rate the statements for which no group consensus was reached. In this round counter-arguments or critiques against the arguments formulated in the third round were additionally asked, following the Delphi procedure of Brown (1968). The search for arguments in the third round, as well as the subsequent feedback of the other experts in the fourth round, served as a stimulant for experts to identify considerations they might have neglected through inadvertence. Additionally, this methodology allows participants to give weight to factors they were initially inclined to dismiss as unimportant (Brown, 1968; Hasson et al., 2000).

Results

Consensus items

Group consensus was reached for 80% of all statements (i.e. 39 of 49 statements) (See appendix). After round 2 consensus was found for 30 of 49 statements. After round 3, consensus was reached for four additional statements, and after round 4 for another four statement. For an overview of all statements where consensus was reached we refer to the appendix. The statements where no consensus was reached are presented in Table 1.

Table 1 near here

In the following sections, the results are classified under eight themes : (1) treatment objectives, (2) classification subgroups, (3) diagnosis and assessment, (4) treatment, (5) therapeutic approach, (6) evidence-based practice, (7) staff and (8) transmural collaboration (i.e. collaboration of the FPC with external community based

services). Rationales for agreeing or disagreeing with the statements, given by different experts, are also presented.

Treatment objectives

Overall, the panel of experts agreed on the necessity of the proposed treatment objectives of treating MIO in an FPC: 1. relapse prevention, 2. treatment of the psychiatric disorder, 3. improving quality of life, 4. promoting reintegration into society, and 5. activating and motivating MIO as a preliminary treatment (statements 1–5, see appendix 1 for the full statements). However, no consensus could be found regarding the equivalence of the treatment objectives (statement 6). Some experts argued that the treatment objective of treating MIO in an FPC should be ‘multi-factorial’, i.e. consisting of different factors or sub-objectives, and that these sub-objectives should not be independent of each other. Furthermore, seven experts stated that the different treatment objectives are equally important. However, these treatment objectives do not necessarily have the same importance in every step of the treatment program. Five of the seven respondents who believed in a hierarchy of treatment objectives, pointed to relapse prevention as the most important treatment objective when ranking these objectives according to importance .

Classification subgroups

Generally, participants disagreed with the statement that older MIO (age 50+) should be spatially separated from the other MIO (statement 10). The experts argued that although older and younger MIO have different treatment needs, it is not necessary to separate them. Conversely, no conformity was reached for the other statements regarding the classification of subgroups within an FPC. Even though eight out of ten experts

believed that MIO with some types of psychiatric disorders could not be treated within the same ward of an FPC (statement 7), no consensus was reached according to the consensus rule. Experts particularly pointed to (aggressive) MIO diagnosed with an anti-social personality disorder and sexual offenders to be segregated from other MIO, due to their specific treatment needs. However, some respondents suggested the separation of subgroups within a specific time frame: *“some types of psychiatric disorders cannot be treated within the same ward of an FPC at the beginning, but can be treated together at the end of the treatment”*. Furthermore, no consensus could be reached whether it would be better to classify MIO according to their support needs rather than to their psychiatric diagnosis (statement 8), even though only one out of ten experts disagreed with this statement. The majority of participants believed that it would be better to classify according to support needs. They argued that DSM-based psychiatric diagnoses rather represent constructs that cannot grasp the heterogeneity and complexity of offenders’ problems. As such, MIO should be approached in a tailor-made way, starting from their personal problems: *“treat individuals more than disorders”* and *“think of people as ‘people’ and not prescriptive disorders”*. Finally, no agreement was found for the last statement regarding the spatial separation of male and female MIO in an FPC (statement 9). Three out of ten experts suggested a mixed division, arguing that a society representative setting should be strived for. However, the majority of experts would separate the female MIO from the male MIO in an FPC, mainly because of security reasons and differences in treatment needs. Nevertheless, some nuances were formulated. For example, one expert stated that female MIO should be separated from male MIO as regards their personal room and restrooms; however, the living spaces should be mixed. Another example is to separate female MIO from male MIO in the beginning of the treatment changing towards a mixed ward at a later

stage of treatment: “*separate wards are needed in the beginning, where the focus is on the treatment of the psychiatric disorder*” and “*...at an open rehabilitation stage, then accommodations may be successfully made to house both males and females. However for the most part, when the focus is on providing containment, assessment and treatment, this is best done when they are spatially separated.*”

Diagnosis and assessment

In general, the experts agreed that diagnosis and assessment in an FPC should follow a standardized procedure (statement 13). They further agreed that assessment in an FPC always serves a dual goal: i.e. risk assessment on the one hand and assessment of treatment needs on the other hand (statement 15). Moreover, they agreed that assessment should be organized before or at the beginning of a treatment episode and thereafter at regular intervals throughout the treatment process (statement 16). Concerning the location of diagnosis and assessment, the experts concluded that diagnosis and assessment should preferably be undertaken at a central admission ward of an FPC where newly enrolled MIO can reside temporarily (statement 12). However, no consensus was found for the statement that diagnosis and assessment should preferably be undertaken in the FPC (statement 11). The experts argued that diagnosis and assessment within an FPC is advantageous, as clinicians with the broadest expertise in diagnosis and assessment in the forensic setting will be present in such FPCs. Two Belgian experts also pointed to the problem of ‘*incorrect, incomplete or conflicting diagnoses*’ of prior expertise reports and the ‘*big difference in quality of the reports of the psychiatric experts*’. Finally, the participants agreed on the statement that the allocation of MIO in an FPC to the most appropriate treatment unit is only possible after

assessment based on a comprehensive battery of screening and assessment instruments (statement 14).

Treatment

No consensus could be reached regarding the character (treatment or care versus correctional character) of an FPC (statements 28–29). However, the arguments indicated that most participants preferred an FPC having primarily the character of a treatment, care or support institution without completely forgetting the correctional aspects. Disagreement remained on whether an FPC should impose inclusion and exclusion criteria (statement 26). An argument for imposing inclusion and exclusion criteria was specialization, which contributes to improved treatment outcomes according to some experts. On the other hand, other experts believed no inclusion and exclusion criteria should be imposed in an FPC, as in many cases no alternatives are available for the high-risk population entering such a setting (FPCs could be considered as *‘the last resorts’*). Furthermore, the debate on whether a minimal level of motivation to change in the MIO is essential to achieve treatment gains did not result in a consensus (statement 25). Some experts believed that minimal motivation is needed in order to obtain sustainable treatment results. Other experts stated that initial motivation is often absent in this population. According to these participants the motivation to reside outside the prison walls can be sufficient to initiate motivation to change, presuming that good treatment is provided. In general, the experts emphasized the importance of motivating MIO as a fundamental component in the treatment of MIO. Finally, consensus was not found on whether crime analysis is a criterion on which treatment in an FPC should be based (statement 23). Seven out of ten experts believed that crime analysis is the basis for treating MIO in an FPC, stating that the specialty of

forensic psychiatry lies in preventing crime. The remaining three experts acknowledged that crime analysis is an important part in treatment, but not as important as psychiatric treatment, care and support needs.

Therapeutic approach

In general, the experts largely agreed on the statements regarding the therapeutic approaches to be used within an FPC (statements 34–36). They suggested that techniques belonging to different therapeutic approaches, such as a psychodynamic approach, behavioral and cognitive approach, relational approach, humanistic approach, should be used (statement 34) and that the effective interventions from the different therapeutic approaches (statement 35) should be integrated. Furthermore, the experts stated that the treatment teams of an FPC should act from a common vision on treatment methodology and philosophy (statement 36).

Evidence-based practice

Group consensus was attained for all statements concerning evidence-based practice. All experts strongly agreed with the statement that in an FPC continuing education is desirable to ensure that current best evidence is underpinning interventions (statement 39). Furthermore, they believed that an FPC should work closely with researchers to continuously evaluate the treatments offered in the FPC (statement 37). Moreover, they suggested that an FPC should preferably have a scientific forensic research centre unit that develops evidence-based methods and counsels in the development of the forensic mental health care (statement 38). Experts argued that, ideally, scientific research should support clinical practice.

Staff

The participants agreed on all statements concerning staff issues in an FPC. There was consensus on the fact that practitioners in an FPC should work within multidisciplinary teams (statement 40), where a certain hierarchy within the team is present (statement 42), and where the responsibility of each member is clearly established (statement 41). Furthermore, there was agreement that staff in the FPC has a significant impact on the effectiveness of treatment (statement 47) and that staff members should possess specific skills and attitudes, gained through specific training to work in a forensic psychiatric setting (statement 43). The panel of experts also agreed that there should not be a clear distinction between the staff responsible for the treatment of the MIO and the staff responsible for the safety of the FPC (statement 44). They argued that safety is an important part of treatment. However, they nuanced that for the safety of the staff and the community, a security team that monitors the FPC as a whole could be deployed. Finally, the experts agreed that providing support and feedback to staff should be structurally built into the FPC (statement 46) and that a work climate where practitioners can ask advice, can express doubts and can admit assessment errors should be considered as a sign of effective professionalism (statement 45).

Transmural collaboration

Regarding the two statements considering transmural care (i.e. cooperation with other institutions; statements 48 and 49), consensus was reached: all experts agreed that intensive aftercare of mentally ill offenders requires close collaboration with external community-based services. Generally, it was stated that an FPC only provides added value when it connects to a continuum of forensic mental health services.

Discussion

High *conformity* in the expert panel emerged as an important finding in this study, as agreement was found for 80% of all proposed statements. The experts agreed that the proposed treatment objectives were important and shared opinions on the statements related to diagnosis, assessment and treatment of MIO. Concerning the therapeutic approaches to be implemented within an institution, there was an overall agreement among the experts. Further, prominent agreement was also found for perspectives regarding staffing, evidence-based practice and transmural collaboration.

Disagreement was mainly found for the standpoint concerning the equivalence of treatment objectives, for the perspectives regarding the classification of subgroups (classification based on support needs versus psychiatric disorder, classification based on gender and classification of some types of psychiatric disorders) and for some statements regarding treatment (motivation of MIO, crime analysis as the basis for treatment, inclusion and exclusion criteria in the FPC and the character of the FPC). In our understanding, the underlying controversies underpinning these disagreements can be summarized as (1) the balance between treatment and control, (2) the dual role of assessment and (3) the aspects with regard to potential treatment conditions. These underlying controversies are acknowledged by international authors (e.g. Adams & Ferrandino, 2008; Adshead & Sarkar, 2005; Fitzpatrick et al., 2010; Steadman, Morrissey, & Robbins, 1985; Weinberger & Sreenivasan, 1994) and will be discussed in relation to the Delphi results.

An important aspect relating to the first controversy (treatment and control balance) is the conflict between different treatment goals: patient versus public welfare (Adshead & Sarkar, 2005; Steadman et al., 1985). The Delphi experts are in favor of a multi-factorial goal when treating MIO. However, there is no consensus whether these

treatment objectives are equally important. The balance between treatment and control is delicate in forensic psychiatry as acknowledged by many authors (e.g. Adams & Ferrandino, 2008; Adshead & Sakar, 2005; Fitzpatrick et al., 2010): “*the treatment-custody conflict was recognized early on by Clemmer (1940), and since that time it has become clear that there is no simple and easy solution for the conflict*” (Adams & Ferrandino, 2008:917). This conflict also has an influence on the character of a forensic institution. Opinions of our Delphi panel concerning the character of future FPCs (treatment or care versus correctional character) remain divided. However, several studies stress the importance of the character and design of a ward environment (Dix & Williams, 1996; Karlin & Zeiss; 2006; Watson, 1998), as the design can provide an important and effective tool in the pursuit of a humane, efficient containment and a reduction of severe pathology (Gross et al., 1998). Therefore, we believe that developing a shared vision on the character of the institution and the treatment objective(s) are of utmost importance when developing a treatment program. In this respect, an extensive discussion regarding the broader treatment and control debate is essential.

The second controversy concerns the dual role of assessment in forensic mental health. According to Adams and Ferrandino (2008, p. 915) assessment serves two purposes: (1) to identify inmates who are likely to be a danger to themselves or others and (2) to identify mental health problems or potential mental health problems and evaluate their need for treatment. This controversy on the level of assessment is reflected in the aforementioned more general debate on treatment and control (Vandeveldt et al., 2011). Here too, it is important to have a good vision on the purpose of assessment as it resonates a different approach in forensic mental health. When risk management is the main focus, reflecting a risk centered approach to assessment and

treatment such as the Risk-Need-Responsivity (RNR) model of Andrews and Bonta (1994, 2010), disagreement nonetheless remains in the Delphi panel whether crime analysis should be the basis for the treatment in an FPC. Although crime analysis is seen as an important basis for treating MIO, some experts stress the complexity of problems. This in line with the findings of Ax and colleagues (2007) who argue that a multidimensional approach, which addresses several problems at once, would be beneficial in terms of a more individualized and holistic approach. A holistic perspective is also supported by the strength based approach, such as the Good Lives Model (GLM) (Ward, 2003; Ward & Steward, 2003), which emerged as an alternative approach for the RNR model. This model goes beyond the risk centered approach and views criminogenic needs (or dynamic risk factors) as internal or external obstacles to the acquisition of primary goods, while focusing on the individuals' strength (cf. review rehabilitation frameworks in forensic mental health, Robertson, Barneo & Ward, 2011). When risk management is not the main focus of assessment, another discussion occurs about whether to assess psychiatric disorder or the degree of support need. The Delphi experts express the importance of not solely focusing on the psychiatric diagnosis when treating mentally ill offenders, as it is relevant to approach forensic clients from their individual support needs. However, there is no consensus on whether it is better to classify MIO based on their support needs rather than their psychiatric disorder. As a consequence, it remains unclear which features should be assessed in order to provide appropriate treatment services. Clearly, more research is needed to clarify this, as Vandeveldde et al. (2011) state that assessment with no treatment purposes could be considered a 'waste of time' and even unethical. We believe that at the level of specific treatment facilities, clear choices should be made, and these choices should be monitored over time.

The third controversy regards the potential treatment conditions. Although the Delphi experts believe that ‘untreatable’ or ‘therapy-resistant’ MIO exist, often referring to psychopaths and pedophiles, further research is needed to study this population more in depth (e.g. existence of ‘untreatable’ MIO, definition of ‘untreatable’ MIO, prevalence of ‘untreatable’ MIO). The experts state that even though some MIO cannot be ‘cured’, they can receive care and their quality of life can be improved. The question arises whether an FPC is the last resort for those MIO, since there is no consensus within the Delphi panel whether inclusion or exclusion criteria can be imposed in such FPC. In other words, should the FPC be the last resort for ‘untreatable’ MIO or should it be considered as a treatment step in the continuum of forensic mental health care? The latter offers a less pessimistic view on ‘treatability’, which is in line with the conclusions of several review studies on the treatability of psychopathy (D’Silva, Duggan, & McCarthy, 2004; Salekin, Worley & Grimes, 2010) that “the validity of the untreatability assumption remains unanswered” (Felthous, 2011:404) and thus cannot be confirmed. This is also supported by the robust literature on favorable response of sexual paraphilias to treatment in offenders (e.g. Abracen & Looman, 2001; Lösel & Schmucker, 2005; Rösler & Witztum, 2000; Wood, Grossman, & Fitchtner, 2000) In any case, strategies have to be developed to prevent the clogging of the FPCs by potential ‘untreatable’ patients. In this regard, a close and structural collaboration with aftercare and long-stay institutions is relevant for whom a ‘cure’ is unrealistic, since continued support and maintenance are necessary (Blackburn, 2004). Furthermore, permanent registration of MIO in the continuum of forensic mental health care, with the aim of mapping the flow of MIO and preventing the clogging in any link in the continuum, is recommended (Cosyns, D’Hondt, Janssen, Maes, & Verellen, 2007) as this is necessary to identifying difficulties in the transition process between different

forensic mental health care services (e.g. from high to medium secure services, Grounds et al., 2004; Higgs & Shetty, 1991; Tetley, Evershed, & Krishnan, 2010). With regard to further research, we believe that 'untreatability' should be examined empirically as well as clinically: using a case study or twin approach (e.g. Müller-Isberner, 2011), for example; it can be explored at which level and in relation to which kind of interventions treatments are unsuccessful for certain offenders. Another debate within this controversy is whether a minimal motivation of the MIO to change is necessary to achieve an effective treatment. According to Parhar et al. (2008), complete ignorance of the offender's motivation for treatment may equate to coercion into treatment, which may not lead to the best treatment outcomes, particularly when treatment is located in custodial settings. In this respect, the issue emerges whether to view an individual's motivation for treatment as a selection criterion, i.e. treat only those individuals that are motivated, or a treatment need, i.e. an attempt to instill a desire for treatment in individuals who are unmotivated (McMurrin, 2002, cited in McMurrin and Ward, 2010). Nevertheless, Vandenbroucke (1996, p. 17) states that coercion is necessary in the treatment of some patients: "*without coercion they are expelled from treatment*". Overall, the Delphi experts consider enhancing motivation both an important treatment objective as well as a substantial part of treatment. Therefore, treatment interventions to motivate mentally ill offenders can be relevant. However, additional research on how and why these interventions, such as motivational interviewing, works is necessary (Miller & Rollnick, 2001, 2008).

Further research to clarify the abovementioned controversies is definitely needed, carried out in close collaboration between practitioners and researchers. Due to the complex nature of forensic psychiatric treatment, a structural embedment of research programs and/or departments in treatment facilities or well-developed

partnerships between research institutions and treatment services could be an interesting and relevant pathway.

Limitations of the study

Despite specific attention, the response rate in the final rounds of the Delphi study was rather low, though in line with what is commonly observed in Delphi studies (McKenna, 1994). Furthermore, the results might be dominated by the view of psychiatrist, since 10 of 14 experts were psychiatrists. This might have limited a wide range of expertise across other forensic mental health professionals. Another limitation was the stringency of our applied consensus rule, possibly causing an artificial disagreement. When, for example, only a percentage-rule of 70% is used, it would have resulted in 96% consensus (i.e. 47 out of 49 statements) instead of 80%. We can further speculate whether the divergence of the 10 statements in the last Delphi round (round 4) can be solved by introducing a subsequent fifth round. The intention to elaborate a fifth Delphi round, where respondents will have a last chance to re-rate the statements, taking the information of the previous round into account (i.e. the counter-arguments and critique against the arguments given in the previous) was not performed due to the reductions in response rate in our study. Starkweather, Gelwicks and Newcomer (1975) argue that the number of rounds could be decreased in order to minimize reductions in the amount of new information and the reductions in response rates resulting from respondent fatigue. Moreover, it is stated that after three questionnaires stability and consensus should have been reached (Walker & Selfe, 1996, cited in Keeney et al. 2001, 2006). Thus, the 'law of diminishing returns' will eventually have occurred (Keeney et al., 2006). Disagreement could also be the consequence of unclear statements. Although the formulation of each statement was carefully evaluated by the

research team and 2 independent colleagues, some terms in the statements could have remained ambiguous, such as ‘crime analyses’ in statement 23. This term might be interpreted in various ways, causing misunderstandings and consequently disagreement. Furthermore, the results can be influenced by the language used in the study, as the researchers and the majority of the Delphi panel (13 of 14 experts) are not native English speakers. Lastly, we have to be aware that the existence of a consensus does not mean that the ‘correct’ answer has been found (Jones and Hunter, 1995; Keeney et al., 2001).

Conclusion and future research

In this Delphi study the treatment perspectives of international experts on treating MIO were mapped. We especially focused on the points of divergence and described three underlying controversies underpinning these disagreements. The first controversy regards the treatment and control debate. This underlying controversy shines through in several topics in the Delphi study (e.g. the equivalence of treatment objective and the character of the FPC). An extensive discussion regarding this controversy is needed, since most ethical dilemmas in this field are the result of the unavoidable conflict between control on the one hand and treatment on the other hand. With this controversy in mind, choices have to be made driven by scientific research. The second controversy concerns the dual role of assessment in forensic psychiatry and is reflected in the aforementioned more general debate on treatment and control. Therefore, a clear vision on what to assess in order to provide appropriate treatment services is crucial. The third controversy describes the potential entry conditions for treatment. Research is needed to study the population of ‘untreatable’ MIO and the possible inclusion en exclusion

criteria that can be imposed in treatment settings, for example a minimal motivation for treatment.

In order to scientifically underpin the debate on the above mentioned controversies, further research is definitely needed. Due to its complex nature, a close collaboration between practitioners and researchers is essential, which could possibly be strived for by means of structurally integrating research in forensic psychiatric treatment programs and facilities, such as Forensic Psychiatric Centres.

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