Challenges in the mental health care of older incarcerated persons

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1. Summary

Background: The number of older incarcerated adults has exponentially risen within the past two decades. Even though they still represent a minority amongst the general prison population, they require vast amount of resources from prison mental health services. Their health needs are higher compared to the general population and to younger incarcerated adults. At the same time, we lack detailed knowledge on their needs and the applicability of current interventions to this particular subgroup. We therefore systematically explored their mental health needs profile with a specific focus on substance use issues. Moreover, a major limitation in the integration of literature on older incarcerated adults is the missing shared definition of this age group. For this reason, we assessed the problems of defining the older population and compared current understandings and arguments provided to support these choices.

In addition, in the Swiss prison context, the number of older adults mandated to psychotherapeutic treatment has risen the most drastically. The overall goal of these court-mandated treatment orders is to reduce risk of recidivism by treating mental health disorders that stand in direct connection with the crime committed. Such interventions come with specific challenges due to aspects such as the coercive and restrictive nature of prison environment, the involuntary admission to psychotherapeutic treatment, as well as the therapist's dual role to care and control. To date, we lack research exploring these factors on psychotherapeutic interventions, which could support mental health professionals in integrating these challenges into their clinical practice. This thesis therefore investigated the experiences of older incarcerated adults and mental health professionals with court-mandated treatment orders to explore current challenges and shortcomings in the delivery of psychotherapeutic and psychiatric treatment.

Methods: Systematic reviews of current literature were performed with the aim to investigate prevalence rates of mental health disorders with a specific focus on substance use issues as well as to shed light into current ways of defining this older age group, arguments used to support this choice, and the empirical evidence to back these definitions. This research project further used a mixed-methods approach, collecting qualitative and quantitative data from incarcerated persons as well as mental health professionals working in Swiss and Canadian correctional contexts. Quantitative data collection mainly encompassed data extraction from medical records. Additionally, pilot studies for the applicability of the routine outcome measure HoNOS-secure, the screening tool PHQ-9, and the structural diagnostic interview MINI were conducted. For qualitative data collection, semi-structured interviews were performed with older incarcerated adults receiving mental health care as well as mental health professionals working with patients who offended.

Results: Systematic review methodology revealed that definitions of the older age group vary and hamper the integration of already limited research. Based on our findings, we suggest the use of age

50 as cut-off to define the older age group for research and health care planning on national levels. Additionally, we confirmed the high rates of mental health disorders amongst this subgroup with psychiatric diagnoses of cognitive issues, alcohol misuse, and affective disorders being relatively more common in comparison to younger incarcerated adults. Qualitative interviews showed that patients and mental health professionals likewise struggled with integrating the involvement of the justice system into their psychotherapeutic work. In particular, limits to confidentiality needed to be handled transparently. Patients accepted mental health professionals sharing information with judicial authorities, as long as their private details were protected that were of no relevance to authorities' decision-making. Additionally, when mental health professionals accomplished to emphasize their caring role over their controlling responsibilities, patients reported beneficial treatment experiences. This was achieved by a supportive and respectful attitude that aimed at promoting the patient's well-being and progress in life. Therapists needed to master the balancing act between responding to patient's individual needs within the predefined framework of mandated interventions. When therapist managed to respond to these personal needs, relief from psychological burden and therefore positive effects from treatment participation motivated them to remain and engage in therapy. This psychological burden frequently originated in their difficulties in dealing with deprivation of freedom, harshness of prison environments, as well as accepting and understanding their crimes committed and their psychiatric diagnoses. Last, external pressures imposed by judicial authorities strongly affect patients' experiences with psychotherapeutic treatment. Predefined goals and authorities' decision-making currently lacks clarity and transparency. To augment patients' motivation to participate in treatment, the application of these external motivators should be used more favorably.

Discussion: This research project contributes to much-needed research on mental health of older incarcerated adults and their experiences with court-mandated interventions. We confirmed high prevalence rates of older incarcerated persons' mental health issues and outlined current definitions applied to this subgroup. This to advance a shared understanding of this population to facilitate the integration of available literature. Further, we showed that the involvement of the justice system substantially affects psychotherapeutic processes. We confirmed previous assumptions that the way MHPs integrate coercion and control in their clinical work, alters patients experiences with psychotherapy. We outline some pressing shortcomings of current treatment delivery and propose some strategies in alleviating the negative impact of external pressures. By this, we can potentially enhance patient motivation and alliance quality to improve clinical and criminal outcomes of incarcerated persons mandated to treatment. By increasing the effectiveness of such court-mandated treatments, we consequently not only enhance well-being of the individual patient but concurrently increase public's safety.

2. Introduction

The number of older adults involved with the criminal justice system is exponentially growing. They are a population with high prevalence rates of mental disorders and therefore require intensive resources from forensic mental health services. Psychotherapeutic interventions with incarcerated persons have shown improvements in regards to mental well-being and criminal recidivism. However, the effectiveness of the interventions with this specific population is still largely unknown while preliminary evidence produced mixed results. A potential reason for these mixed results are potentially mediating and moderating factors that have been largely ignored. Furthermore, as psychological support in the prison setting rend to be involuntary, such court-mandated treatment settings come with particular challenges such as coercion and control, a therapist's dual role, as well as the influences of risk assessment procedures. The effects of these challenges on treatment engagement and motivation is, however, largely unknown. This thesis therefore investigated the perception of these factors on the psychotherapeutic processes from service providers' and users' perspectives using qualitative methodology. In order to build the stage for my thesis, I will begin by first presenting the population of interest in this thesis, that is, the older incarcerated person. Thereafter, I will move into the context of my thesis, the provision of mental health care in prison and forensic settings. Finally, I delve into the challenges that I delineated above related to older adults seeking mental health care in this setting. These syntheses will in the end, lead to the specific aims that I address in my thesis.

2.1 Older incarcerated persons

The number of incarcerated persons is rising world-wide (Walmsley, 2016) while older individuals are the fastest growing age group within correctional institutions (Baidawi & Trotter, 2016; Di Lorito, Völlm, & Dening, 2018). In the United States, for instance, adults over the age of 55 grew by 400% between 1993 and 2013 which represents an increase from 3 to 10% of the total prison population (Carson & Sabol, 2016). In France, the number of persons aged 50 and older comprised 11.2% of the total prison population in 2015 and increased significantly over the past two decades (Combalbert et al., 2017). In the UK, prisoners aged 60 and older doubled between 2002 and 2011, and persons over the age of 50 represented 13% of the total prison population (Di Lorito et al., 2018). In Switzerland, the proportion of incarcerated adults over the age of 49 grow from 6.6% in 1984 to 17.7% in 2019 (Bundesamt für Statistik, 2020b).

The reasons for this exponential growth of the older population in correctional institutions is due to a convergence of trends (Leigey & Hodge, 2012; Yarnell, Kirwin, & Zonana, 2017). Their growth can partly be attributed to the aging of society, which is mirrored in the prison population. Rising crime rates by older people contribute to the increase of the older population within correctional institutions

(Fazel & Baillargeon, 2011; Sodhi-Berry, Knuiman, Alan, Morgan, & Preen, 2015). However, even though the overall aging of societies accounts for a part of this growth, the majority is explained by harsher sentencing policies and stricter correctional practices. Longer prison sentences and restrictive parole policies therefore contribute to a greater number of persons growing old within prison (Fazel & Baillargeon, 2011; Jang & Canada, 2014; Leigey & Hodge, 2012; Marti, Hostettler, & Richter, 2017; Maschi, Kwak, Ko, & Morrissey, 2012; Turner & Peacock, 2017; Wilkinson & Caulfield, 2017).

Older incarcerated persons can be classified into three broad groups that represent differing characteristics and needs (Nowotny, Cepeda, James-Hawkins, & Boardman, 2016). First, persons who offended at a young age and grew old in prison due to a long sentence. They have usually adjusted well to the institutional procedures but will either age and die in prison or pose challenges in regards to the reintegration. Second, persons who have been in and out of prison over their lifetime. These repeat offenders often lack coping skills in the community and frequently face substance use problems and other comorbidities. Third, persons who were imprisoned for the first time in their late life have often difficulties in adjusting to prison life. They have the highest risk to be victimized by other incarcerated persons but are more likely to have maintained community ties. These first-time offenders have mostly been contributing members of society and frequently do not perceive themselves as criminals (Aday, 1994; Beckett, Peternelj-Taylor, & Johnson, 2003; Gallagher, 2001; Morton, 1992; Nowotny et al., 2016; Uzoaba, 1998).

Older incarcerated persons are a population of high needs (Hayes, Burns, Turnbull, & Shaw, 2012). They have a complex disease profile with high prevalence rates for both, somatic and mental illnesses. In fact, the majority of older incarcerated persons suffer from at least one chronic health problem while at least one half suffers from mental health issues such as depressive symptoms or anxiety (Fazel, Hope, O'Donnell, & Jacoby, 2001; Kakoullis, Mesurier, & Kingston, 2010; Kingston, Le Mesurier, Yorston, Wardle, & Heath, 2011). At the same time, mental health issues of older incarcerated adults are often underdiagnosed and undertreated (Fazel, Hope, O'Donnell, & Jacoby, 2004; Kingston et al., 2011). Their health is further worse in comparison to younger incarcerated persons and people living in the community (Fazel, Hope, O'Donnell, Piper, & Jacoby, 2001; Wangmo et al., 2015). They are consequently a population of particularly high needs that require vast resources from forensic mental health care services.

In fact, older incarcerated persons have been identified as the main drivers of prison health care costs (Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017). While systematic data is missing, it is estimated that their healthcare costs are about two to five times higher than that of younger incarcerated adults (Courtney & Maschi, 2013; Hanson, 2017; Williams et al., 2010; Yarnell et al., 2017). The continuing rise of these costs challenges the quality and consistency of health care services (Maschi et al., 2011). To assess the current and potential future requirements and to estimate budgets,

we need knowledge of this population's specific needs, which is still lacking (Courtney & Maschi, 2013). As a consequence, most institutions lack interventions or accommodation that are tailored for older adults' issues (Maschi, Viola, Morgen, & Koskinen, 2015; Turner & Peacock, 2017). This inadequate treatment not only increases health care costs but also puts older adults at risk of developing mental health issues or exacerbating symptoms (Jang & Canada, 2014). One major obstacle in the estimation of current and future health care costs is the lack of an underlying definition of an older prisoner (Ahalt, Trestman, Rich, Greifinger, & Williams, 2013).

A shared understanding of older incarcerated persons will facilitate the integration and advancement of research and allows future planning of health care services (Kakoullis et al., 2010; Williams, Stern, Mellow, Safer, & Greifinger, 2012). A simple way in defining an older person is by the use of chronological age. However, currently applied ages to determine older incarcerated persons range from 45 to 65 years (Aday & Krabill, 2012; Stojkovic, 2007). In comparison, older persons in the general population are often classified based on chronological ages ranging from 60 years up (United Nations, 2015). This 10 to 15 years difference is due to the assumption that older persons living in detention are subject to premature aging. Meaning that an incarcerated person's health status is comparable to a 10 to 15 year older person from the general population (Cipriani, Danti, Carlesi, & Di Fiorino, 2017). However, empirical literature to substantiate this claim is unclear (Kakoullis et al., 2010).

In sum, the number of older incarcerated persons is exponentially rising while there is a lack of information on the specialized needs of this population. Due to their high disease burden, they are a population that requires very intensive care. At the same time, they present a different set of issues in comparison to the younger prison population while correctional institutions are currently insufficiently equipped to address older adult's chronic health issues. We therefore need to increase our knowledge of mental health needs of this population to plan healthcare services. This, to be able to allocate already limited resources appropriately to the persons in need.

2.2. Mental health care in correctional institutions

Psychotherapeutic interventions with offender populations improve psychiatric well-being and criminal recidivism (Leigh-Hunt & Perry, 2015; Morgan et al., 2012; Yoon, Slade, & Fazel, 2017). Even though empirical evidence is scarce (Bartlett et al., 2015; Heckman, Cropsey, & Olds-Davis, 2007; Morgan et al., 2012), studies have shown improvements on outcome markers such as mental well-being, negative affect, self-esteem and optimism, substance use, institutional adjustment, anger, hostility, and physical aggression (Morgan et al., 2012; Ross, Quayle, Newman, & Tansey, 2013; Shonin, Van Gordon, Slade, & Griffiths, 2013). Effective psychological treatments have therefore the

potential to not only enhance the individual's well-being but also to protect future victims, to further create a better prison environment while possibly decreasing prison expenditures (Himelstein, 2011).

Psychotherapeutic treatment in the prison context is supposed to follow the same evidence-based standards as outside the prison walls (Gannon & Ward, 2014). However, therapists face particular challenges when treating imprisoned individuals due to the coercive and restrictive nature of prison environment and patients' individual characteristics such as the severity of mental health issues and the high prevalence of comorbid conditions (Leigh-Hunt & Perry, 2015; Yoon et al., 2017). Psychotherapeutic interventions have mostly been studied with non-offending populations in community settings (Bartlett et al., 2015). The applicability of such interventions in the prison environment and their effectiveness amongst the incarcerated population is therefore unknown, indicating that we lack evidence-based treatment guidelines that are specific for this subgroup (Schalast, Lebbing, & Völlm, 2018).

In this regard, the Risk-Need-Responsivity (RNR) model provides an organizing framework to guide treatment and assessment of persons involved with the criminal justice system (Olver, 2016; Schalast et al., 2018; Schmidt, 2019; Taxman & Smith, 2020). It is the most widely accepted theoretical model to interpret offender treatment literature and influences correctional practice and policy (Andrews, Bonta, & Wormith, 2011). Interventions that adhere to its three principles risk, need, and responsivity have been shown to significantly reduce recidivism rates (Andrews & Bonta, 2010; Andrews et al., 1990). The risk principle is concerned with the match between service intensity and risk level of the client. The need principles states that the intervention should target dynamic risk factors that have been linked with the person's offending behavior. The responsivity principle highlights that treatment programs need to be tailored to the person's learning style to maximize engagement (Andrews et al., 1990). The RNR-model, however, mainly aims at reducing recidivism rates and has repeatedly been criticized for the over-emphasis of risk management (Taxman & Smith, 2020).

Within the past two decades, we have therefore seen, as a response to this, a greater emphasis on strength-based approaches in the treatment of incarcerated persons (Vandevelde et al., 2017). The Good Lives Model (GLM) provides an alternative or extension of the widely established RNR model of care. It is based on the notion that all human beings seek primary goods such as happiness, excellence in work and play, or friendship. Offending behavior reflects attempts to pursue these goods in ways that are unacceptable to society and damaging to the individual and others (Ward & Gannon, 2006). Both theoretical concepts, however, have been developed for the general offending population. Even though preliminary results suggest their applicability in the treatment of mentally ill persons, there is no direct support in effectiveness to treat the mentally ill incarcerated population (Barnao, Ward, & Casey, 2016; Olver, 2016; Schalast et al., 2018; Skeem, Steadman, & Manchak, 2015).

Nevertheless, these underlying concepts are widely applied in the criminal justice system and guide treatment of mentally ill-incarcerated persons.

In sum, individuals involved with the criminal justice system present with high prevalence rates of mental health disorders and are therefore a population of high needs. Interventions are either based on evidence-based treatment standards developed with the general population or follow principles of the GLM or RNR, which have originally been established for the general offending population. Thus, even though preliminary evidence suggests their applicability with mentally ill offenders, the precise effectiveness is still unknown. The eligibility of community-based treatment standards is particularly challenged in light of the coercive nature of prison environment and the severity of mental health issues amongst the incarcerated individuals. To enhance effectiveness of these interventions, to reduce psychiatric burden and criminal recidivism among older incarcerated persons, we need to enhance our knowledge on the specific needs and effective intervention strategies of this population.

2.3. Court-mandated treatment

A special situation in the treatment of incarcerated individuals represent court-mandated interventions. Persons can be mandated to treatment when the crime committed stands in direct connection with their mental health issue. The overall goal of such a court-mandated treatment is to ensure a patient's entry and participation in treatment to reduce the risk of reoffending (Hachtel, Vogel, & Huber, 2019; Prendergast, Greenwell, Farabee, & Hser, 2009; Ward, 2013). Court-mandated treatment orders infringe individual rights for freedom and patient autonomy (Goulet, Pariseau-Legault, Cote, Klein, & Crocker, 2019; Ondersma, Winhusen, & Lewis, 2010). The justification of their widespread imposition lies primarily in the protection of the public (Goulet et al., 2019; Prendergast et al., 2009; Urbanoski, 2010; Wild, Yuan, Rush, & Urbanoski, 2016; Wittouck & Vander Beken, 2019).

The number of persons undergoing court-mandated treatment is rising worldwide (Goulet et al., 2019). In Switzerland, for instance, this number almost tripled from 349 in year 1984 to 964 in year 2019 while the overall prison population grew only from 3229 to 5208 within the same period. The older prison population (persons over the age of 49) grew most drastically amongst the persons mandated to treatment. They made up 8.02% of all individuals sentenced to a measure in 1984, and made up 27.8 % of that population in 2019 (Bundesamt für Statistik, 2020a). In the Swiss prison context, the rising number of older incarcerated persons is therefore most noticeable amongst the ones mandated to treatment. With almost every third person being over the age of 49, they do not represent a minority any more but are a common group of patients.

Despite this exponential growth, there is little empirical data on the specific needs of this older age group (Baidawi & Trotter, 2015; Booth, 2016). Higher prevalence of somatic health issues may challenge the application of psychotherapeutic interventions meaning that response and effectiveness of treatments may differ in comparison to younger adults (Woods & Roth, 2005). Further, prevalence rates for specific mental health disorders differ for the older age group. For instance, in comparison to the younger age group, alcohol abuse is more common amongst older incarcerated persons than illegal substance use (Gallagher, 1990) while they are less likely to receive treatment for substance use (Arndt, Turvey, & Flaum, 2002). Even though the underlying principles of effective treatment will not differ between the younger and older age group, there are still reasons to treat the group of older persons separately.

Furthermore, court-mandated treatments are characterized by coercion and control through the involvement of the justice system in assuring treatment entry and participation as well as by linking treatment progress to privileges and eventual release. The impact of referring a person by legal imposition to psychotherapeutic treatment is often assessed by comparing outcomes of "self-referred" and "legally-referred" clients. This, however, has yielded mixed results with legally-referred interventions leading to better (Burke & Gregoire, 2007; Kelly, Finney, & Moos, 2005; Perron & Bright, 2008), similar (Anglin, Brecht, & Maddahian, 1989; Brecht, Anglin, & Wang, 1993; Grichting, Uchtenhagen, & Rehm, 2002; Polcin, 2001; Schaub et al., 2010), or inferior outcomes (Parhar, Wormith, Derkzen, & Beauregard, 2008; Werb et al., 2016). One potential reason for these inconsistencies might be the oversimplified equation of voluntary with self-referred and involuntary with legally-referred (Urbanoski, 2010).

An alternative concept is the idea of "perceived coercion", which is defined as the degree to which patients perceive a lack of control over their decision to enter and remain in treatment (Urbanoski, 2010). Studies that respected perceived coercion were not able to detect a direct link between the level of perceived coercion and the referral sources, which are classified into three broader domains: legal (criminal justice system), formal (employer or social assistance agencies), and informal mandates (friends and family) (Wild, Cunningham, & Ryan, 2006). For instance, Wild et al. (2016) have shown that 31% of self-referred patients have reported to feel coerced into treatment entry while 30% of the legally referred patients reported not to perceive any coercion regarding treatment participation. Other studies have shown that the level of perceived coercion does not greatly differ between legally mandated, employer mandated and self-referred clients (see Urbanoski, 2010).

Thus, perceived coercion cannot be equated with objective coercion, such as referral sources, suggesting that other factors interfere with the way coercion is perceived on the patient's side. For instance, Urbanoski (2010) argued that it is not the objective presence of external pressures per se but the threats to patient autonomy that matter. Other studies have shown that patients' ratings of the

therapeutic alliance were negatively linked to perceived coercion (Manchak, Skeem, & Rook, 2014; Sheehan & Burns, 2011). Further, some authors suggest a relationship between perceived coercion and a patient's motivation to engage in therapy. Some studies showed a negative link (Klag, O'Callaghan, & Creed, 2005; Wild, 2006) while others did not find any strong relations (Ondersma et al., 2010).

The evidence for court-mandated treatment orders is therefore mixed while the justification of their imposition lies primarily in the reduction of recidivism rates. Considering that, a legal referral is a threat to an individual's rights to autonomy and privacy, this imposition is ethically questionable due to the missing conclusive evidence (Goulet et al., 2019; Klag et al., 2005; Wild et al., 2016). A possible explanation of the mixed results, however, could be the neglect of intermediary factors such as perceived coercion and its correlates. The research efforts in this domain is still in its infancy calling for more clarification (Wild, 2006).

Thus, in the sections below, I aim to highlight different areas of forensic mental health care received within the court-ordered treatment that need further investigation. This will, for instance, include (a) risk assessment procedures and their consequences on the population at stake; (b) what we know about effectiveness of such court-ordered treatment: (c) therapists' dual loyalty conflicts and how that affects older individuals receiving court-mandated therapy; (d) therapists' characteristics influencing the quality of care provided; and (e) patients' motivation in regards to involuntary treatment admission.

2.4. Risk Assessments

Persons who are mandated to treatment by court order within the Swiss jurisdiction are sentenced to a so-called "measure" (Massnahme). The Swiss criminal code (SCC), which regulates penal law on a national level, is based on a two-tier system that differentiates between penalties (Strafen) and measures (Massnahmen). Measures can only be imposed when a penalty alone is not sufficient to counter the risk of further offending and the offender requires treatment or treatment is required in the interest of public safety. The person who committed a felony or misdemeanour must suffer from a serious mental disorder that stands in direct connection with the crime. The courts' decision to declare a measure is based on psychiatric assessments. These include estimations of (a) the necessity and the prospects of success of treatment of the offender; (b) the nature and the probability of possible additional offences; and (c) the ways in which the measure may be implemented. For all measures, criminal responsibility can be diminished, however, it is not a *sine qua non* condition for the judge to impose a therapeutic measure (Sachs, Habermeyer, & Ebner, 2014).

Release from a measure is granted based on the fulfillment of the requirements of the parole boards and the risk for further felonies (Helmus, 2018). Measures are, for this reason, reassessed at regular

time intervals. Treating therapists provide a written report to the authorities every year, indicating the patient's mental health status and progress in therapy. Additionally, psychiatric assessments by external experts are done at least every five years (Fink, 2018). Both will include an assessment of the patient's risk to reoffend, which supports risk management in the criminal justice system (Tully, Chou, & Browne, 2013).

The different types of risk assessment processes range between completely unstructured clinical assessments, over structured clinical judgement, to completely structured actuarial assessments (Skeem & Monahan, 2011). An unstructured clinical assessment provides a clinician's subjective prediction and presents with poor predictive validity. Its use has decreased since the introduction of formal risk assessment tools (Skeem & Monahan, 2011; Tully et al., 2013). A structured clinical assessment uses empirically based risk factors that guide their predictions in combination with a clinician's experience with a patient. They take into account dynamic risk factors and consider benefits of therapeutic change. For these reasons, they are helpful to inform treatment planning and risk management in the short-term (Anderson & Jenson, 2019; Singh, Grann, & Fazel, 2011; Tully et al., 2013). Actuarial assessments make use of risk assessment tools that quantify an individual's characteristics to estimate the likelihood of future misconduct (Brown & Singh, 2014; Singh et al., 2011).

Currently, there are over 120 risk assessment tools used in psychiatric settings while the different instruments show comparable results in predicting future offending (Singh et al., 2011; Skeem & Monahan, 2011). Actuarial tools are clear and standardized assessment procedures. They incorporate static risk factors such as demographics, history, diagnosis, and personality that are linked with reconviction rates. Their probabilistic estimates rely on group base rates, predict violence in the long-term, and result in a total risk score (Anderson & Jenson, 2019; Tully et al., 2013). Validity can be compromised by the use within a different population or within a different context (Singh et al., 2014; Singh et al., 2011). There is little data on predictive validity of most tools in the German language area, however few studies suggest their applicability (Endrass, Urbaniok, Held, Vetter, & Rossegger, 2009; Urbaniok, Endrass, Rossegger, & Noll, 2007; Urbaniok, Noll, Grunewald, Steinbach, & Endrass, 2006).

Furthermore, the overall value of these group-based tools to assess an individual's risk has been questioned. Several authors argue that their use in the individual case does not provide accurate predictions of future offending (Cooke & Michie, 2010). This, for instance, due to the margins of error for each individual risk assessment being too wide to make meaningful predictions (Hart, Michie, & Cooke, 2007). However, others argue that risk assessments can only produce two possible outcomes, violent or non-violent. The estimate derived from an assessment instruments will therefore naturally lead to a wide margin of error and does not reduce their validity (Hanson & Howard, 2010). Skeem

and Monahan (2011) argues that for this reason, group data can nonetheless be informative to the individual case.

Despite the controversies around risk assessment's predictive validity in the individual case, they are used to guide risk management within the criminal justice system. Their applicability has not only a great impact on the incarcerated person's future but also for society. The way complex factors such as a society's zero-risk attitude influence risk assessment procedures are unclear and lack empirical investigation.

2.5. Therapist's dual loyalty conflict

In court-mandated treatment settings, MHPs face ethical dilemmas due to their triangular relationship between themselves, their patients, and the justice system (Niveau & Welle, 2018; Pollähne, 2013). This puts MHPs in a position in which they do not only care for the patient but also take up a controlling role. They consequently have to balance individual rights and patient well-being with the interest of the public's safety (Goulet et al., 2019). This creates an ethical conflict, which is frequently referred to as dual loyalty conflict.

Ethical dilemmas arise due to MHPs being subject to two sets of norms arising from two distinct state institutions, the health and judicial system. Each institution defines what is recognized as acceptable conduct for every role, which creates challenges of conflicting expectations or responsibilities (Ward & Ward, 2016). The underlying normative guidelines of both institutions are at times contradictory and therefore incommensurable (Niveau & Welle, 2018). A central difficulty lies in the balancing between the patient's needs and interests, and the potential future harm that the community might suffer (Ward & Ward, 2016). Ethical codes and professional standards that are specific to the practice of forensic psychiatry have been developed for instance by the American Academy of Psychiatry and the Law (2005). However, not one normative framework has been uniformly accepted. Ward (2013) further argues that existing guidelines exclusively label the problem but lack concrete solutions and approaches to the ethical issues faced by clinicians' in daily practice.

An agreement on guiding principles as well as their specification to concrete scenarios is therefore lacking and most MHPs still struggle with dual loyalty (Pont, Stover, & Wolff, 2012). Considering that MHPs take up two classical roles as either forensic expert or treating therapist creating differing ethical dilemmas, Sadoff (2011) argued that separate normative guidelines should be developed for each of them as they encompass different roles, relationships, and duties. The ethical debate about the forensic expert's role as court-witness is linked to the above-mentioned issues on empirical and methodological validity of risk assessment procedures (Adshead, 2014). For treating therapists, the

most common scenarios arise from, first, the release of confidential information due to limited confidentiality during interactions with representatives of the justice system. For instance, therapists have to provide a written report on a patient's mental health status, treatment progress, and risk of recidivism. Second, therapists are frequently being asked to manage risk and restrictions posed on this population. The legal authorities decisions on privileges, leaves, and release dates are partially based on treating therapist's and forensic expert's assessment (Dowling, Hodge, & Withers, 2018; Pollähne, 2013). The way these conflicts are resolved differ greatly between professionals, institutions, and language regions. In regards to medical confidentiality, for instance, anything between complete break of confidentially to no information to be shared at all is practiced within the Swiss jurisdiction (Brägger, 2014; Graf, 2013).

A MHP's dual role, however, potentially influences the development and maintenance of therapeutic alliance (Dowling et al., 2018). This relationship between patient and MHP is the foundation of psychotherapeutic work and one of the central drivers to facilitate change (Blasko, Serran, & Abracen, 2018). The alliance is amongst the common factors of psychotherapy overarching different techniques (Fluckiger, Del Re, Wampold, & Horvath, 2018; Fluckiger, Horvath, Del Re, Symonds, & Holzer, 2015; Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin, Garske, & Davis, 2000) suggesting that this process factor is likewise important in court-mandated treatment settings (Blasko et al., 2018). The development and maintenance of the alliance is most dominantly influenced by therapist characteristics such as the ability to display genuineness and empathy (Nienhuis et al., 2018). However, we lack empirical evidence on how MHPs perceive and deal with their dual loyalty issues and can consequently not appraise its implications for the development and maintenance of therapeutic alliance. Considering that the tension between care and control is thought to reveal itself most dominantly in the alliance (Wittouck & Vander Beken, 2019), there is risk of providing care that is not along best practice recommendations (Gannon & Ward, 2014).

2.6. Therapist characteristics

Empathy (Elliott, Bohart, Watson, & Murphy, 2018; Soto, 2017), genuineness/congruence (Kolden, Wang, Austin, Chang, & Klein, 2018; Nienhuis et al., 2018), and positive regard (Farber, Suzuki, & Lynch, 2018) are amongst the most consistently reported therapist characteristics and activities that are common across all modalities. Evidence suggests that they are equally important in mandated treatment contexts as they were linked to patients responding more positively to psychotherapeutic treatment and enhancing their motivation to change (Blasko et al., 2018; Jeglic & Katsman, 2018; Marshall & Serran, 2004; Polaschek & Ross, 2010; Ross, Polaschek, & Ward, 2008).

However, the development and maintenance of a high quality alliance is challenged by the additional control dimension such as a MHP's involvement in restrictions and release dates (Dowling et al., 2018). Preliminary evidence suggest that strong dual role relationships that are characterized by a firm, fair, but caring style are linked with lower recidivism rates amongst mentally ill persons involved with the criminal justice system (Manchak et al., 2014). In other words, therapists who put equal emphasis on both, offender well-being and the protection of the public, were the most effective at reducing recidivism rates (Kennealy, Skeem, Manchak, & Louden, 2012). Suggesting that control does not necessarily come at the expense of affiliation and that a meaningful encounter is feasible in a coercive context (Manchak et al., 2014).

The way in which therapists handle this additional "control" dimension seems crucial for the effectiveness of the intervention. Literature suggest that incorporating the controlling role into therapeutic practice requires MHP to be (1) transparent about their involvement with the justice system and their position as power-holders, (2) to allow a certain degree of choice and control, (3) to display a respectful, caring and supportive attitude towards the patient, and (4) to have a directive, collaborative but non-confrontational communication style.

First, patients appreciate transparency regarding risk management and the limits to confidentiality, particularly with the beginning of therapy (Dowling et al., 2018; Elger, Handtke, & Wangmo, 2015a, 2015b). It was further appreciated if sufficient information was shared on treatment planning in particular when discussing nature and consequences of the intervention (Fortune et al., 2010; Livingston, Nijdam-Jones, & PEER, 2013; Tapp, Warren, Fife-Schaw, Perkins, & Moore, 2013).

Second, patients want their views taken into account and experience that their opinion counts, to be treated as dignified and active actors, and to be involved in the dialogue on unmet needs and future goals (Gault, 2009; Stuen, Rugkasa, Landheim, & Wynn, 2015; Wyder, Bland, Blythe, Matarasso, & Crompton, 2015). This to allow the patient to have a meaningful participation in the treatment process and to have a voice concerning their own treatment planning (Wittouck & Vander Beken, 2019). It is therefore important to provide some degree of choice and control to encourage the patient to participate in treatment (Dowling et al., 2018).

Third, during interactions with incarcerated persons, it is particularly important to display a positive, respectful, and caring attitude. In the same line but on the contrary, stereotyping and labelling attitudes were perceived as negatively affecting the development of trust and connectedness with the treating therapist (Epperson, Thompson, Lurigio, & Kim, 2017; Kras, 2013; Mezey, Kavuma, Turton, Demetriou, & Wright, 2010; Skeem, Encandela, & Louden, 2003; Stuen et al., 2015; Wyder et al., 2015). Activities that make patients feel valued and accepted in the treatment of offenders are activities and expressions that emphasize a respect for the patient but a clear disapproval of offending

behavior (Marshall et al., 2003). This might be particularly important as, for instance, sex offenders are frequently described to feel shame in relation to the crimes committed (Blasko et al., 2018).

Fourth, there is some evidence that a directive, authoritative but non-confrontational style is advantageous when treating patients who offended (Blasko et al., 2018; Meyer, Hachtel, & Graf, 2019). Appropriate directiveness in terms of encouraging the patient to deal effectively with problems, offering advice while showing rewarding behavior, improved treatment attrition and behavior change (Sandhu & Rose, 2012). A dominant, authoritarian or confrontational-style, in contrast, which is characterized as derogatory and aggressive interaction patterns, should be avoided (Jeglic & Katsman, 2018; Marshall & Serran, 2004; Polaschek & Ross, 2010; Ross et al., 2008).

While some underlying therapist characteristics might be similar across conditions, such as genuineness and empathy, the way they are developed and maintained might differ between specific therapy contexts (Heinonen & Nissen-Lie, 2020). Coercion and control challenge therapists working with mandated patients and therefore require them to pay particular attention on aspects such as to display transparency, to allow choice and control, and to emphasize a caring and supportive attitude while adopting a directive communication style.

2.7. Patient motivation

Motivation predicts treatment participation, completion, and outcome and is consequently a key aspect of psychotherapeutic work. The legal referral, however, has increasingly been criticized to interfere with a person's internal motivation to change as it might elicit resistance to engage in therapy (Snyder & Anderson, 2009). As previously introduced, the external pressures itself, might only have an indirect effect on a patient's motivation. Instead, the way that a patient perceives coercion might be a stronger determinant for patient engagement than the objective referral source. The relationship between perceived coercion and motivation is, to date, largely unexplored (Ondersma et al., 2010; Wild et al., 2006).

Offender motivation has been described within the framework of multiple theories such as the transtheoretical model of change (Prochaska, Johnson, & Lee, 2009), the context of change model (Burrowes & Needs, 2009), the self-determination theory (Ryan, Lynch, Vansteenkiste, & Deci, 2011; Urbanoski & Wild, 2012), and the Good Lives Model (GLM) (McMurran & Ward, 2004). The previously introduced RNR model does not provide a theory of motivation (Herzog-Evans, 2017). However, the GLM provides a comprehensive framework for offender motivation incorporating the above-mentioned motivation theories, which are well-validated amongst the general population while

respecting factors that have been shown to be important in enhancing offender motivation (McMurran, 2002).

The GLM bases its theoretical conception of motivation on the idea that all human behavior is goal-directed. Goals are further defined as states that people identify of value to themselves and actively aspire while their behaviors are driven by both external and internal motivators (McMurran & Ward, 2004). Intrinsically motivated behaviors are linked to basic human needs such as experiencing intimate relationships or autonomy. In respect to persons involved with the criminal justice system, specific internal motivators could be to avoid shame and guilt in relation to offenses committed (McMurran, 2002). Extrinsically motivated behaviors are rather under external control and are shown to achieve rewards or avoid punishment (McMurran & Ward, 2004). Within the criminal justice system, privileges, parole, and release dates usually act as external motivators (Tierney & McCabe, 2002; Urbanoski, 2010).

Intrinsic motivation is a stronger predictor of therapeutic change in the long-term in comparison to externally motivated behaviors (McMurran, 2002; Snyder & Anderson, 2009). The development of internal motivation throughout treatment is therefore crucial for treatment outcome. Further, the effect of external motivators on internal motivation, which patients who are mandated to treatment face, have been criticized to interfere with a patient's internal motivation and consequently to impede therapy progress (Klag et al., 2005; Wild et al., 2006). Here it might be crucial how these external pressures are applied and communicated, as preliminary results suggest that perceived coercion and motivation are correlated. For instance, Prendergast et al. (2009) showed that patients who perceived high coercion were more likely to score low on internal motivation to change. In contrast, patients who were low on perceived coercion displayed higher internal motivation to change. However, neither perceived coercion nor motivation predicted treatment completion or re-arrest rates.

2.8. Overall study aim and specific objectives

Court-mandated treatment settings involve specific challenges to psychotherapeutic work. To date, we lack knowledge on the effects of coercion and control, the therapist's dual loyalty conflict, and the involuntary admission of persons to psychotherapeutic treatment on the outcomes of such treatment, particularly for older incarcerated persons. However, these factors potentially alter treatment outcomes and might explain the mixed evidence of treatment effectiveness. We therefore investigated these factors using a qualitative study design, integrating service providers' and users' perspectives. In particular, we critically analysed the following six objectives to address the gap in the literature.

(1) Older adults involved with the criminal justice system have high prevalence rates of mental health disorders and frequently suffer from comorbid disorders. Available reviews and meta-analyses cover rates of mental health issues among older prisoners but fail to investigate the dual-diagnosis burden. We therefore integrated literature assessing mental health disorders with comorbid substance use disorders, using the systematic review methodology.
Further, one major limitation that any systematic review on older incarcerated people faces is the missing shared understanding of how to define an older incarcerated person. This leads to a variety of age groups included in current meta-analyses and reviews. We therefore systematically reviewed researchers' approaches in defining older offenders and the empirical base to support their decision. This to advance towards a shared understanding of older persons involved with the criminal justice system to facilitate the integration of literature of this under-researched population.

(2) MHPs working with incarcerated persons mandated to treatment face particular challenges during the therapeutic process. The involvement of the justice system puts therapists in a dual role to care and control, which potentially creates difficulties in developing and maintaining a trustful relationship. The external pressures exercised upon patients to enter, remain, and engage in treatment raise questions regarding their effects on patient motivation. Further aspects such as the coercive and restrictive nature of prison environment, the high diagnosis burden amongst older incarcerated persons, the impact of risk assessments on therapy processes as well as the integration of the crime committed into a person's life story are specific to this population. Nevertheless, research on therapists' characteristics and activities in dealing with these challenges is scarce. Considering that the overall goal of legally referring patients to treatment is to reduce recidivism, we need to find strategies to enhance the effectiveness of such court-mandated treatment orders to protect the public. The evidence base of court-mandated treatment orders is, however, mixed regarding recidivism rates and symptom load. One reason might be the neglect of intermediary factors such as the influence of the therapists' strategies in handling these particularities on outcome measures. We therefore investigated patients' and therapists' views on the effects of these above-mentioned influences on their therapy experiences. This, we sought to achieve by using qualitative methodology to gain in-depth explanations from both participant groups.

These two objectives addressed in this cumulative thesis using seven chapters in section 4, which appear as published or soon-to-be published manuscripts in peer-reviewed journals. Accordingly, the thesis includes the following articles (in the same order). Contributions of each author are listed:

Haesen, S., Merkt, H., Imber, A., Elger, B., & Wangmo, T. (2019). Substance use and other mental health disorders among older prisoners. *International Journal of Law and Psychiatry, 62*, 20-31. doi:10.1016/j.ijlp.2018.10.004

For this publication, Sophie Haesen took the lead. Mr. Imber and I contributed to selection of adequate articles and contributed to manuscript writing by revising the work of Ms. Haesen. Prof. Elger and PD Wangmo revised and edited the work.

Merkt, H., Haesen, S., Meyer, L., Kressig Reto, W., Elger Bernice, S., & Wangmo, T. (2020). Defining an age cut-off for older offenders: a systematic review of literature. *International Journal of Prisoner Health, 16*(2), 95-116. doi:10.1108/IJPH-11-2019-0060

For this systematic review, I took the lead in concepatualizing the work, analyses of the literature as well as manuscript writing and coordination between all co-authors. Ms Haesen and Meyer contributed to screening of the literature. PD Wangmo guided the literature analysis and revised the work repeatedly. Prof. Elger and Prof. Kressig supported in the editing and review process.

Merkt, H., Haesen, S., Eytan, A., Habermeyer, E., Aebi, M.F. Elger, B.S., & Wangmo, T. (2021). Forensic mental health professionals' perceptions of their dual loyalty conflict. *BMC Medical Ethics, 22*(1), 123. https://doi.org/10.1186/s12910-021-00688-2

Merkt, H., Wangmo, T., Pageau, F., Liebrenz, M, Devaud Cornaz, C., Elger Bernice, S., & Wangmo, T. (2021). Court-mandated patient's perspectives on the psychotherapist's dual loyalty conflict – between ally and enemy. *Frontiers in Psychology, 11*(3713). doi:10.3389/fpsyg.2020.592638

Seaward, H., Wangmo, T., Vogel, T., Graf, M., Egli-Alge, M., Liebrenz, M., Elger, B. (2021). What characterizes a good mental health professional in court-mandated treatment settings? – Findings from a qualitative study with older patients and mental health care professionals. *BMC Pscyhology, 9*(1)*, 121*. https://doi.org/10.1186/s40359-021-00624-4

Seaward, H., Wangmo, T., Egli-Alge, M., Hiersemenzel, Lutz-Peter, Graf, M., Elger, B., Habermeyer, E. (2021). Incarcerated older persons' motivation to engage in criminal court-mandated treatment: Findings from a qualitative interview study. *Forensic Science International: Mind and Law.*

For these four publications, I took the lead in conceptualizing and writing of the manuscript and contributed to data collection and analysis. PD Tenzin Wangmo and Prof. Bernice Elger designed the research project. PD Wangmo guided analysis of the interview data and revised the work repeatedly. The other co-authors supported data collection as well as the editing and review process.

Wangmo, T., Seaward, H., Elger Bernice, S. (2021). Forensic-Psychiatric Risk Evaluations: Perspectives of Forensic Psychiatric Experts and Older Incarcerated Persons From Switzerland. *Frontiers in Psychiatry, 12*(933). doi:10.3389/fpsyt.2021.643096

For this publication, PD Tenzin Wangmo took the lead. I contributed to data collection and analysis, as well as editing of the manuscript.

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3. Methods

The research project "Agequake2" investigated the mental health of older incarcerated persons in Swiss correctional institutions *(Mental health care and forensic evaluation of aging prisoners and persons serving security measures in Switzerland. Grant number: 166043)*. The overall goal of this study was to explore the current status of this population's mental health and the treatment they receive as well as possible challenges, short-comings, and solutions. We therefore investigated a set of issues using a mixed-methods approach, collecting qualitative and quantitative data, as well as carrying out systematic review of literature. We obtained ethics approval from the regional lead ethics committee (Ethikkommission Nordwest- und Zentralschweiz) which was followed by other local ethics committees.

With the qualitative data collection, we aimed at gaining insights into complex social issues such as experiences on aging in prison, living with a mental disorders, and their perspectives on prison mental health care. The quantitative data collection is meant to allow us to gain more profound knowledge on prevalence rates of mental health issues as well as treatments received (this part is yet to be completed. It is not part of my thesis but since this part is an integral part of the project I worked on and as I led and supervised the quantitative data collection, that work will be described as part of the methodology). Hence, I will outline data collection and analyses procedures for each part in detail below. As we finished data collection of all quantitative data end of February 2021 due to multiple set backs (e.g. Corona prison closings, increased security standards for data collection), I will only outline data collection and management for the quantitative data. Data analysis and publication of this data will follow after completion of my PhD.

3.1. Systematic Reviews

The reporting of both systematic reviews follows the reporting standards for systematic reviews presented by Moher et al. (2015). Please see table 1 for an overview on methodologies of each systematic review. This method was used to correspond to one research objectives delineated in chapter 2 and the study findings are presented in chapters 4.1.1 and 4.1.2. The research questions aimed for a clear and consistent definition of an older incarcerated person because there is lack of such clear-cut understanding on who should be considered "older" in the prison context. The second research question sought to find the prevalence rates of mental health disorders including substance use amongst older incarcerated persons. The information extracted during full-text analyses followed data extraction sheets specifically developed for each systematic review. This data was entered into Excel spread sheets by the main author and one co-author. To check the entered data for accuracy and quality, excel spread sheets were overlapped and checked a third time. Discrepancies between main and co-author were resolved by discussion.

Table 1 Overview on methodology of systematic reviews

	Defining an age cut-off for older offenders: a systematic review of literature	**Substance use and other mental health disorders among older prisoners**
Research question:	• How are older incarcerated persons defined in terms of chronological age cut-offs? • What arguments are provided to back this choice and what is the empirical base of each?	• What is the prevalence rates of mental health disorders and co-occurring substance use issues among older incarcerated adults?
Databases	PubMed, PsycInfo, SocINDEX, CINAHL, Google Scholar (first ten pages)	PubMed/MEDLINE, PsycINFO, EMBASE, CINAHL
Search string	older prisoner AND mental health (and related terms for each)	older AND prison AND mental AND substance (and related terms for each)
Eligibility criteria	• Language: English and German • Study population included older incarcerated persons • Main focus was on mental health	• Language: English, German, French • Study population includes older incarcerated adults • Study covered both: mental health issues and comorbid substance use issues
Title/Abstract Screening	HS (main author)	SH (main author)
Full Text Screening	HS and co-authors	SH and co-authors
Extracted information	Data on characteristics and properties of the studies.	
	Data relevant for the research question:	
	• Applied age cut-off • Reasons provided to support this choice • Literature cited to back the argument	• Prevalence rates of substance use and mental health disorders • Type of assessment for psychiatric disorders • Type of substances

3.2. Qualitative Data

The reporting of qualitative data collection follows the journal article reporting standards for qualtitative research in psychology (Levitt et al., 2018).

3.2.1. Data collection

We conducted semi-structured interviews with mental health professionals (MHP) and incarcerated older persons. Participants were recruited from two types of institutions, forensic-psychiatric settings and correctional institutions (closed prison settings). All participants were recruited applying a

purposive sampling method. Purposive sampling is a non-probability sampling method by which the researcher selects a certain type of respondents, who will be able to provide the information of interest (Campbell et al., 2020). The total number of study participants for each group was derived from the principle of data saturation. Thus, the number of participants was tentative at start and we identified the final number of participants throughout the coding process, when data saturation was reached. We applied the principles presented by Fusch and Ness (2015); the ability to obtain additional new information has been attained, further coding is no longer feasible, and there is enough information to replicate the study.

We interviewed each participant once and did not conduct any repeat interviews. We audio-recorded all interviews and took field notes after each interview. The interviewers were research assistants completing their doctoral education at the time of data collection (of which one was HS). They were both trained in interview techniques and qualitative methodology and received supervision from an experienced senior research (TW). They held the interviews in the language spoken by the participant, either French, English, German or Swiss German. Interviews followed a semi-structured interview guide specifically developed for the purpose of this study. Please see an overview of topics in table 2, the complete interview guides for each participant group can be found in the appendix.

Research assistants transcribed the interviews verbatim following a standardized transcription scheme. The interviews were transcribed in the language of the interview, except for Swiss German interviews, which was transcribed into Standard German. Swiss German is a spoken dialect and it is common practice to use Standard German in writing. More experienced research assistants checked the interviews for quality and accuracy of the transcriptions, during which they anonymized any identifying information. We did not return any transcripts to the participants for checking. We did not compensate any of the participants for their study participation.

Table 2. Topic guide for semi-structured interviews

Topic	**Patient-participants**	**Expert-participants**
Personal background information	Personal circumstances and social networks (within prison and relationships with outside)	Motivation to work with incarcerated persons, brief description of their work experience and current roles and responsibilities
Aging in the prison context	Relationships with younger persons in detention, satisfaction with work and free time activities offered, perception of prison environment, future plans	Aging in the prison context: exploration of their experiences in working with older patients, prominent therapy topics of older patients

Access to and quality of mental health care	Types of interventions, frequency and duration of treatments, opinion on access to and quality of mental health care, specific aspects of the interventions that helped/impeded therapy progress, perception of their current mental well-being, questions on possible stigma due to mental health issues	Characteristics of care and interaction with older patients, experiences with specific influences due to working in secure contexts (indefinite release dates, dual role conflict (use of elicitation technique), collaboration with other professions and representatives of the justice system)
Risk assessment	Perception of evaluations by forensic experts, experiences with the procedures.	Experiences in reporting to the authorities (characteristics, procedures, age as a variable in risk assessments, key criteria in reporting standards)

3.2.2. Patient-participants

We collected data from incarcerated older participants housed in 14 Swiss institutions from the two major language regions (German and French speaking). Participants were included if they were (a) 50 years and older, (b) received mental health care (at least one contact with mental health services), and (c) were sentenced to prison confinement in a Swiss institution (either measure or penalty). We contacted the head of mental health services and prison directors for approval of study participation. A designated contact person within the institution or as part of the mental health services organized participant recruitment. The contact person got in touch with possible participants, provided a short description of the research project, and handed over the written study information and informed consent for the participant to read it privately and in detail. If the participant agreed to participation, interview appointments were made between contact person, participant, and research team.

Interviewer and study participant met on the first time on the day of the interview, no previous contact had been established. We conducted the interviews in separate and private rooms within the institutions in which conversations could not be overheard. After we presented ourselves and described the purpose of study, we inquired for possible questions regarding study participation and the overall research project. We particularly emphasized the voluntary nature of study participation, the confidentiality of all data, and the right of refusal at all times. Following this, written informed consent was obtained and one copy of the informed consent was handed to the participant.

3.2.3. Expert-participants.

We included MHPs from Switzerland and Canada with work experience with mentally ill incarcerated persons. That is, the MHPs were trained in psychology, psychiatry, psychiatric nursing, social work, and occupational therapy. Participant recruitment differed slightly between countries. Swiss MHPs were recruited by two research assistants (of which one was HS). We contacted forensic-psychiatric and penal institutions to inquire for potential participants. We additionally recruited MHPs through the two major Swiss forensic associations "Schweizerische Gesellschaft für Rechtspsychologie" and "Swiss Society of Forensic Psychiatry". We contacted MHPs via phone or email and sent study information and informed consent when MHPs were interested in participating. Questions were clarified previously by phone and email. The interview was carried out at a place of participants' choice. This was either their office or a separate and private room within their institution or at the location of the research team. Remaining questions regarding study participation and the purpose of the research project were clarified on the day of the interview and thereafter informed consent was obtained.

Canadian participants from forensic-psychiatric institutions were recruited in a similar way by one research assistant (HS). For instance, MHPs from certain institutions were contacted via email and phone, after expressing interest, they received study information and informed consent. Interviews took place in person, via Skype or phone. Participants were always located in private rooms in which conversations could not be overheard. MHPs working for Correctional Service Canada (CSC) were recruited by CSC contact persons. CSC approved our research project and compiled a participant list. All interviews were done via phone or Skype.

Please see an overview on participant characteristics for the three participant groups in table 3.

Table 3 Sample characteristics.

		Patient-participants	Expert-participants	
			Switzerland	Canada
Time period of data collection		December 2017 – December 2018	April 2017 – January 2018	August 2017 – Nov. 2018
Interview length (in minutes)	*M;* *Range;* *SD*	69; 16 – 120; 26.19	71; 48 – 90; 14.16	60; 28-92; 11.49
Number of participants		50	29	34
Participant Characteristics	*Gender*	8 female 42 male	8 female 21 male	22 female 12 male
	Age	M = 60 Range = 50-76 SD = 7.34	-	-
Language region	*German-speaking*	29	16	-
	French-speaking	21	13	5
	English-speaking	-	-	29
Number of Participants per type of institution	*Penal institutions*	36	23	21
	Forensic-Psychiatric Institutions	14	6	13

3.2.4. Data analysis

Throughout the whole data analysis process, we followed the thematic analysis approach by Braun and Clarke (2006). The first phase of data analysis is dedicated to familiarizing with the data. Our project team realized this first step by reading and memoing individually four to eight interviews of each participant group. In the second and third phase, initial codes need to be generated and potential themes are identified. For this, interesting aspects in the interviews are coded across the interviews and combined into possible overarching topics. Five project team members met and developed initial codes and themes during coding sessions. Codes and themes were revised repeatedly to develop the

most suitable coding tree that all team members agreed to. After this, three study team members coded the remaining transcripts individually. In a fourth phase, we reviewed already established themes, discussed new codes, solved disagreements, and sorted the final thematic map. The last two phases, identified by Braun and Clarke (2006), are dedicated to defining and naming themes as well as producing a final report. For each subtopic, one team member took the lead in analysing relevant fragment of the data set in very detail for each research question. Themes and codes were refined and clear definitions and names established. One senior researcher (TW) would question the analysis and refit inconsistencies in the presented data while all other co-authors provided feedback at a later stage of data analysis and manuscript writing.

We further used the software program MAXQDA to facilitate and manage all data analysis. We analysed each interview in the language spoken with the participant. Citations were translated during the last phase of analysis by research assistants and checked by HS and a project member fluent in the respective language.

3.3. Quantitative data

The reporting of quantitative data collection follows the journal article reporting standards for quantitative research in psychology (Appelbaum et al., 2018). For all quantitative data collection, we recruited persons who had at least one contact with mental health services in Swiss forensic-psychiatric and penal institutions. Participants consisted of persons aged 50 years and over and the same number of persons under the age of 50.

3.3.1. Medical Records

For access to the participant's medical records, we did not require a declaration of consent from the participants. However, we informed all potential participants about our study who then could make use of their right to object. This procedure followed Art. 33 of the Swiss Federal Human Research Act. We informed potential participants through different procedures, making sure that they would fit best for each setting. In a few cases, we informed participants with an information sheet that was placed at a visible and accessible place such as the cafeteria or at the health services. Participants could then either put their name on a list next to this sheet or inform a contact person, who was not part of the research team. In case this procedure was not feasible, each potential participant was contacted in person. Meaning that either a team member of the research project team, a prison contact person, or a staff member of health care services talked to each incarcerated person. They were explained study purposes and their right to refuse. Through this process, we created a list of persons who wanted to

participate in the study. Thus, all persons incarcerated in each participating institution, were informed through either an information sheet or through individual contact.

We developed a data extraction sheet for the purposes of this research project. I will briefly described the included variables, the complete data extraction sheet can be found in the appendix. For each participant, we included all relevant information which was not older than 12 months from their current medical record.

We collected demographic information including year of birth, sex, nationality, language, marital status, number of children/grandchildren/siblings, education, religious belief. Sentencing information was classified according to the EU guidelines for the International Classification of Crime for Statistical Purposes (ICCS) (European Union, 2017). We accordingly classified the offenses for which the person was imprisoned into eleven broader levels: (1) Acts leading to death or intending to cause death, (2) acts causing harm or intending to cause harm to the person, (3) injurious acts of sexual nature, (4) acts against property involving violence or threat against a person, (5) acts against property only, (6) acts involving controlled drugs or other psychoactive substances, (7) acts involving fraud, deception or corruption, (8) acts against public order, authority, and provisions of the State, (9) Acts against public safety and state security, (10) Acts against the natural environment, and (11) Other criminal acts not elsewhere classified. We further inquired chronic somatic health conditions and chronic infectious diseases, as they possibly affect mental health. We collected ICD-10 codes and counted the total number of chronic somatic disease.

In regards to mental health disorders, we collected all diagnosed mental health issues and coded them according to ICD-10. We further gathered detailed information on psychopharmacological medication. This included dosage and frequency of medication intake, date of first and last medication intake, type of prescription, and patient compliance. In addition, we collected data on non-pharmacological interventions targeting mental health including type of therapy, frequency of treatment, group or individual therapy settings, date of first encounter, discipline of the professional providing the therapy. We also collected data on suicide attempts during and before incarceration. We inquired data on substance use including tobacco, alcohol, and illegal drugs such as cocaine, cannabis, and opioids. If applicable, we explored the degree of substance use problem and its relation to the index offense. For persons sentenced to measures, we additionally investigated risk assessment procedures. We included data on risk assessment instruments used, time points of assessments, and the background of the professional conducting the assessment. Please see table 4 for an overview on participant characteristics.

Table 4. Participant characteristics medical records

		All N=444	**Age group 50-** N=278	**Age group 50 and +** N= 166
Language Region	French	154	103	51
	German	290	175	115
Age	mean	44.70	24.45	58.84
	range	20-77	20-49	50-77
	SD	13.09	7.16	7.27
Gender	male	395	236	159
	female	48	41	7
	N/A	1	1	0
Institution	forensic-psychiatric	22	6	16
	penal	422	272	150

3.3.2. HoNOS-secure

The health of nation outcome scale (HoNOS) is a routine outcome measures which had been developed for patients of general psychiatric hospitals. It is used to rate health and social functioning of persons suffering from mental illness and can be applied to monitor treatment progress (Jacobs, 2009). It is a clinician-rated outcome measure including 12 scales which cover symptom load, functioning, social relationships, and environmental issues (Crawford et al., 2017). HoNOS-secure is an instrument that is derived from the general HoNOS but specifically adapted for the incarcerated population. The 12 scales are slightly adapted to secure settings and it comprises a 13th scale to assess security needs (Dickens, Sugarman, & Walker, 2007). The HoNOS items are rated retrospectively for the observed behavior while the security scale is rated prospectively for the near future (Eytan et al., 2015). Please see the appendix for a full version of the HoNOS-secure.

One validation study indicates the applicabilty of HoNOS-secure within the Swiss correctional context. It is based, however, on one institution only from the French speaking language region (Eytan et al., 2015). Previous to data collection, we therefore involved leading expert in the implementation of our HoNOS-secure pilot study, which aimed at covering multiple institutions within German and French speaking parts of Switzerland. We therefore organized a forum for discussion with the heads of mental health services from participating institutions within Switzerland including also the Swiss ANQ team responsible for quality assurance in Swiss psychiatric hospitals (Nationaler Verein für Qualitätsentwicklung in Spitälern und Kliniken), who are specialized in the data collection and analysis using HoNOS across Switzerland.

As a result from these discussions, we agreed on the use of HoNOS-secure at two time points with a six months time difference. We additionally specified the need for collection of additional information linked to the usability of the HoNOS-secure, since this was the first time that HoNOS-secure was used across German and French speaking parts of Switzerland. We therefore collected demographic information of the patient (year of birth, sex, sentencing information (Art. of SCC, date of entry into institution), type of institution, psychiatric diagnosis according to ICD-10, previous psychiatric treatments (time frames, types of treatments, type of treatment center), current intervention (type, starting point, frequency, individual vs. group setting, current goal of treatment), and applicability of HoNOS-secure (time, ease of use, difficulties in rating items, support in current treatment planning).

We subsequently organized training events for participating institutions that sent their MHPs to participate in the training events. An experienced HoNOS trainer and two research assistants guided the one-day program on details specific to the HoNOS-secure and the research project. Thereafter documents were sent out to every involved MHP including informed consent sheets, the HoNOS-secure and the additional data sheet. MHPs approached their patients, inquiring for interest in participating in the study. They contacted every person age 50 and over and a similar number of patients under the age of 50. They filled in the documents at two time points with a six-month difference. Please see table 5 for participant characteristics.

Table 5. Participant characteristics HoNOS-secure

		All N=29	**Age group 50-** N=12	**Age group 50 and +** N= 17
Language Region	French	6	2	4
	German	23	10	13
Age	mean	50.45	37.75	59.41
	range	28-78	28-48	51-78
	SD	13.78	6.39	9.00
Gender	male	20	8	13
	female	9	4	5
Institution	forensic-psychiatric	11	4	7
	penal	18	8	10

3.3.3. PHQ-9 and MINI

The Mini International Neuropsychiatric Interview (M.I.N.I.) is a brief structured interview to screen for major Axis 1 psychiatric disorders. The Patient Health Questionnaire (PHQ-9) is a screening instrument to assess depressive symptoms by self-assessment. The diagnostic criteria for both instruments are derived from DSM-IV and ICD-10. Please see the appendix for a full version of PHQ-9 and MINI.

In the participating institutions, we informed first through an information sheet about our research project that was put in a visible spot such as the cafeteria or health services. Additionally, treating MHPs informed their patients about the possibility to participate in this part of the study. Potential participants received study information and informed consent sheet from their MHPs. Thereafter, a prison contact person organized appointments between study participants and a team member of the research team. Interviews were held in a separate and private room within the institution, in which conversations could not be overheard. A research assistant, trained in performing the MINI, presented the study information and informed consent to the participant, explained the purpose of the research project and details of study participation. We emphasized the voluntary nature of their participation and their right to refusal at all times. The participant was given enough time to ask questions. After the participant signed the informed consent, one copy was handed to the participant. The research assistant conducted the MINI first and handed the PHQ-9 to the participant after completion of the structured interview. See table 6 for an overview on participant characteristics.

Table 6. Participant characteristics MINI and PHQ-9

		All N=39	**Age group 50-** N=10	**Age group 50 and +** N=29
Language Region	French	23	3	20
	German	16	7	19
Age	mean	37.92	37.6	61.59
	range	24-74	24-48	50-74
	SD	5.89	8.04	7.50
Gender	male	37	8	29
	female	2	2	0
Institution	forensic-psychiatric	16	4	12
	penal	23	6	17

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4. Results

4.1. Systematic Reviews

4.1.1. Substance use and other mental health disorders among older prisoners

Full citation:
Haesen, S., Merkt, H., Imber, A., Elger, B., & Wangmo, T. (2019). Substance use and other mental health disorders among older prisoners. *International Journal of Law and Psychiatry, 62*, 20-31. doi:10.1016/j.ijlp.2018.10.004

Rights and Permission:
The original article is included in the thesis of the other student, Ms. S. Haesen, who worked with me on the Agequake-2 in prisons project. Thus, it cannot be added as full-text in my thesis. Therefore, I am including a summary of the work. Please read the full-text, which is open-access, for more information.

This is a summary of the original article:

The number of older adults involved with the criminal justice system has grown exponentially (Baidawi & Trotter, 2016; Di Lorito, Völlm, & Dening, 2018). They present with a high burden of somatic and psychiatric diseases and are consequently the main drivers of rising prison healthcare costs (Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017; Courtney & Maschi, 2013; Hanson, 2017). To adequately allocate already limited resources of prison health care services, we need to target the specific needs of the imprisoned population. Since older incarcerated adults require the most intensive care, we need to expand our knowledge on their healthcare needs. The goal of this systematic review was to assess prevalence rates of mental health issues including substance use issues of older offenders. Substance use disorders have not always been considered a mental health issues and therefore frequently lack assessment in previous studies, this review will fill a gap in specifically addressing substance use issues.

Our results confirm previous claims that the burden of psychiatric diseases is higher amongst older incarcerated adults in comparison to their younger counterparts and to community-dwelling older adults (Anno, Graham, James, & Shansky, 2004; Binswanger, Krueger, & Steiner, 2009; Hunt et al., 2010; Moschetti et al., 2015; Sodhi-Berry, Knuiman, Alan, Morgan, & Preen, 2015). Their Prevalence rates ranged from 11.9% (Sodhi-Berry et al., 2015) to 93.9% (Lewis, Fields, & Rainey, 2006) for any psychiatric diagnosis, while the pooled estimate was 39.7%. Diagnoses that were particularly common for the older age group comprised affective disorders (Davoren et al., 2015; Fazel & Grann, 2002; Gates, Staples-Horne, Walker, & Turney, 2017; Koenig, Johnson, Bellard, Denker, & Fenlon, 1995; Sodhi-Berry et al., 2015) and cognitive issues (Gates et al., 2017; Sodhi-Berry et al., 2015). Personality disorders and psychotic symptoms, in contrast, were less frequent (Fazel & Grann, 2002; Hunt et al., 2010).

The prevalence of substance use amongst older incarcerated adults was particularly high, ranging from 5 % (Fazel, Hope, O'Donnell, & Jacoby, 2004) to 81% (Haugebrook, Zgoba, Maschi, Morgen, & Brown, 2010) with an average of 29.74 %. Older incarcerated adults were more likely to misuse alcohol while their younger counterparts more frequently consumed illicit drugs (Davoren et al., 2015; Lewis et al., 2006). In particular, only a small group of older adults used multiple substances simultaneously, which was common amongst the younger adults (Arndt, Turvey, & Flaum, 2002; Moschetti et al., 2015). The rates of substance use issues, however, were not drastically different between age groups (Williams et al., 2010) suggesting that only the type of substances abused changes with the age groups. Additionally, incarcerated older adults who suffered from mental health issues were significantly more likely to misuse substances compared to other adults involved with the criminal justice system (Koenig et al., 1995).

Our findings suggest that mental health including substance use issues are drastically underdiagnosed and undertreated amongst older adults involved with the criminal justice system (Arndt et al., 2002; Fazel et al., 2004; Moschetti et al., 2015; Overshott et al., 2012). Further, female older offenders constitute a small group within a minority of older incarcerated adults, for which reason, data could only be drawn from 12 studies with predominantly very low sample sizes. Some studies suggested even higher prevalence rates for older female adults involved with the criminal justice system (Moschetti et al., 2015). However, no further conclusions can be drawn for this particularly under researched group.

Differences in definitions of the older age group hampered the integration of the literature. Chronological age cut-offs that were applied by the 17 studies ranged from age 45 (Gates et al., 2017; Sodhi-Berry et al., 2015) to age 65 (Farragher & o Connor, 1995; Hunt et al., 2010). Further, the imposition of mental health issues and substance use issues varied between studies. For instance, some studies considered alcohol misuse only (Farragher & o Connor, 1995; Overshott et al., 2012), while other studies included all possible illegal and legal substances (Gates et al., 2017; Moschetti et al., 2015). Other reasons for the drastic differences in prevalence might be due to low sample sizes (Farragher & o Connor, 1995; Overshott et al., 2012) and diagnostics relying for instance on medical records only (Arndt et al., 2002).

In sum, older adults involved with the criminal justice system suffer from high rates of mental health issues including substance use disorders. They are more likely to be diagnosed with affective disorders than their younger counterparts while personality and psychotic disorders are less common. Substance use issues are equally frequent across all age groups but the type of substance used differs with the cohort. In particular, older adults are more likely to misuse alcohol while younger incarcerated adults more frequently misuse illicit drugs. Findings suggest comparable patterns between female and male older adults. However, the data involving older female adults is particularly scarce and can therefore

not be evaluated conclusively. Even though the older age group presents with particularly high health care needs, they are surprisingly undertreated.

Future research therefore needs to address adequate intervention strategies for the different age groups, including older adults. Untreated mental health issues contribute to institutional adjustment problems, reintegration issues and higher recidivism rates (Himelstein, 2011; Morgan et al., 2012; Ross, Quayle, Newman, & Tansey, 2013; Shonin, Van Gordon, Slade, & Griffiths, 2013). Even though the number of older adults has increased drastically over the past two decades, they still represent a minority within the prison population. Health care services might therefore be adjusted well to the younger population but lack knowledge and experience on the older age group. Older incarcerated adults therefore risk to be ignored or forgotten within this highly regulated system (Courtney & Maschi, 2013; Kingston, Le Mesurier, Yorston, Wardle, & Heath, 2011; Yarnell, Kirwin, & Zonana, 2017). Research and policy efforts need to raise awareness for minority groups within the criminal justice system, to ultimately reduce recidivism rates of all offenders.

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4.1.2. Defining an Age Cut-Off for Older Offenders: A Systematic Review of Literature

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Abstract

Background: In the literature, 65 years is commonly used as the age to designate an older person in the community. When studying older prisoners, there is much variation. The aim of this systematic review was to investigate how researchers define older offenders and for what reasons. ***Methods:*** We reviewed articles on health and well-being of older offenders to assess terminology used to describe this age group, the chosen age cut-offs distinguishing younger offenders from older offenders, the arguments provided to support this choice as well as the empirical base cited in this context. ***Results:*** Our findings show that the age cut-off of 50 years and the term 'older' were most frequently used by researchers in the field. We find seven main arguments given to underscore the use of specific age cut-off delineating older offenders. We outline the reasoning provided for each argument and evaluate it for its use to define older offenders. ***Discussion:*** With this review, we hope to stimulate the much-needed discussion advancing towards a uniform definition of the older offender. Such a uniform definition would make future research more comparable and ensure that there is no ambiguity when researchers state that the study population is 'older offenders'.

Introduction

In Gerontology literature, 65 years is the commonly used age cut-off to begin defining an older person, while the United Nation uses 60 years as the age cut-off (United Nations, Department of Economic and Social Affairs, & Population Division, 2015). Within this categorization as an older person, this group is further divided into the young-old (65 – 74 years), the middle-old (75 years – 84 years), and the oldest-old (85 years and older) (Alterovitz & Mendelsohn, 2013; Lee, Oh, Park, Choi, & Wee, 2018). At a minimal level, consistent age cut-off allows common understanding on who forms a particular population. At greater levels, it allows comparative research and formulation of public policy for that age group and its sub-groups. A uniform definition for 'older offenders' is an essential first step to improve healthcare for this population (Ahalt, Trestman, Rich, Greifinger, & Williams, 2013) as well as research and policies. This need has been repeatedly expressed by experts in the field of correctional health care (Kakoullis, Le Mesurier, & Kingston, 2010; Williams, Stern, Mellow, Safer, & Greifinger, 2012). However, we still lack agreement as to at what age a prisoner should be deemed 'older'.

The definition of an older offender is usually based on chronological age, using a certain age cut-off to differentiate between younger and older offenders. In available literature on older prisoners, the cut-off age varies from 45 years to 65 years (Aday & Krabill, 2012; Stojkovic, 2007; Yorston & Taylor, 2006). An explanation for the discrepancies in age cut-offs could depend on the data used by the researcher (Uzoaba, 1998). Other common reasons for choosing lower age cut-offs are based on the assumption that prisoners are subjected to premature aging, often called 'accelerated aging' (Cipriani, Danti, Carlesi, & Di Fiorino, 2017). However, the empirical evidence supporting this theory of 'accelerated aging' is unclear (Kakoullis et al., 2010). Thus, the chosen age cut-offs as well as the provided arguments to support this choice vary highly, making comparisons of data across studies difficult.

This missing shared understanding of the group of older offenders hinders the advancement of research on the health of older prisoners (Kakoullis et al., 2010) and consequently makes it difficult to plan health services (Hayes, Burns, Turnbull, & Shaw, 2012) as well as related issues such as programming (Aday, 1994), housing, and transition planning (Jang & Canada, 2014). This is of particular importance given the current rising trend in the numbers of older prisoners. They are proportionally the fastest growing age group in prison systems around the world (Aday & Krabill, 2012; Baidawi & Trotter, 2016; Di Lorito, Völlm, & Dening, 2018; Skarupski, Gross, Schrack, Deal, & Eber, 2018). Presently, prisoners over the age of 50 years, for instance, make up between 10% of the prison population in Ireland, 13% in the UK, and 18.8% in the USA, and 25% in Italy (Di Lorito et al., 2018). At the same time, they suffer from a greater disease and disability burden compared to both younger prisoners and older community-dwelling adults (Di Lorito et al., 2018; Fazel, Hope, O'Donnell, Piper, & Jacoby, 2001). Consequently, they are a population with high health care needs

and the main drivers of rising prison health care costs (Yarnell, Kirwin, & Zonana, 2017). Specifically, it is estimated that the cost of incarcerating an older prisoner is two to three times that of a younger prisoner within the American correctional system (Maschi, Viola, & Sun, 2013). With the already very limited resources in prison settings, it is therefore important to provide services that are adequate and cost-effective. To do so, it is necessary to target specific groups based on their needs. However, the available data on health care needs of older prisoners is scarce (Di Lorito et al., 2018) and the integration of the available literature is often hampered through missing agreements on how to define the older prisoner.

This review aims at providing a much needed overview of the current understandings on how older offenders are defined by different research groups. It highlights the chosen age cut-offs, the terminology used to describe this age group as well as the arguments provided to support this choice. Specific focus will be given to the literature cited to support each argument since researchers in the field have raised concern about the empirical evidence being unclear. In doing so, this paper fills a research gap by answering multiple calls to advance towards a uniform definition of older offenders.

Methods

This review follows the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Moher et al., 2015). The terms prisoner, inmate, offender, detained person, and person deprived of liberty are used interchangeably throughout this article. By using these terms, we describe people that are detained in correctional facilities such as prisons and jails and forensic psychiatric clinics.

Eligibility Criteria

The eligibility criteria were defined a priori. We set no time limit for the articles published and retrieved those published until 31st of January 2018. Opinions, dissertations, books, and book chapters were not included. Empirical peer-reviewed articles, written in English language, were included and reviewed against three inclusion and three exclusion criteria. Inclusion criteria were: (1) The studied population was persons deprived of liberty. (2) Older offenders had to either be the main study population or specifically mentioned as a sub-group. (3) The study had a focus on health and well-being of older offenders. Exclusion criteria were the following: (1) Articles that examined juvenile prisoners, ex-prisoners, parolees, veterans, or former war prisoners as their main study population. (2) A paper was also excluded, if older offenders were not specifically mentioned as a sub-group. (3) Lastly, papers on older offenders that were not focusing on their health and well-being (mental and/or somatic health) but rather on for instance criminogenic factors or offence patterns were also excluded.

Literature Search

The systematic search was conducted using the four electronic databases PubMed, PsycInfo, SocINDEX, and CINAHL. We additionally scanned the first 10 pages of Google Scholar to ensure that we had not missed important literature, however limited ourselves to 10 pages for the sake of feasibility. Two categories of search terms were used and combined using the 'AND' operand. Terms within the two categories were combined using the 'OR' operand. The first category of search terms aimed at yielding studies that related to the population of older offenders *(older prison* OR older offender* OR older inmate* OR elder* prison* OR elder* offender* OR elder* inmate* OR old prison* OR old offender* OR old inmate* OR ageing prison* OR ageing offender* OR ageing inmate* OR aging prison* OR aging offender* OR aging inmate*)*. The second category was chosen to select studies on mental or somatic health of older offenders *(health OR psycholog* OR mental health OR psychiatr*)*. The strategy was consistently used for all databases, except where minor modifications were needed to respond to the different characteristics of the databases. The initial title and abstract screening was done by the main author (HM) and one co-author (LM) applying the above-mentioned inclusion and exclusion criteria.

Study Coding

The consequent full text screening followed a data extraction form developed for this study. The main author as well as co-authors screened all articles to ensure reliability of extracted information. The coders worked independently and discrepancies were resolved through discussion to achieve consensus. The information that was obtained encompassed aspects such as characteristics of the article (title, year of publication, journal, country of study, funding, conflict of interest) and properties of the study (methodological approach, sampling methods, study design, type of data, and data collection method). Data on characteristics and properties of the study were analyzed descriptively. Further information obtained related to the research questions such as whether the older offender population was the main study population or a sub-group, which age cut-off was applied, what reasons were stated in relation to the chosen cut-off, and what studies were cited in connection with that. The different reasons were grouped into associated categories and the provided citations were searched for underlying empirical studies. In the search for empirical evidence, we took two steps (1) For each article in our sample, we checked the citations that were provided to substantiate the argument when choosing a cut-off. (2) These citations were further examined if (a) they were able to either directly support the fact stated or (b) they were citing any empirical literature to support this argument. For this part, we limited ourselves to empirical evidence going back to the year 1990. We outline the empirical evidence that was provided to back up each group of arguments.

Results

Study Selection

The total number of studies that was identified through our search strategy was 2327 of which 2243 were identified through electronic databases and 84 through Google Scholar. After removing the duplicates, we screened 2069 titles and abstracts. This resulted in 256 articles that were assessed for eligibility against the inclusion criteria. The final sample of studies that were included consisted of 100 articles (see Figure 1 and Table 1).

Study Characteristics

The publication years ranged from 1985 to 2017 with most of the studies published after the year of 2000. The majority of all studies were conducted in the United States (n=53), followed by the UK and Ireland (n=21), and Continental Europe (n=12). Only 3 studies were carried out in Canada, another 4 in Asia and the Middle East, and 7 in Australia and New Zealand. The main issues studied encompassed mental health including substance related disorders (n=35), both somatic and mental health (n=26), general health and well-being (n=22), end-of-life care/palliative care/dying in prison (n=7), and somatic health (n=6). Four studies that could not be grouped into one of these categories were classified as 'other'. These encompassed access to health care, gambling in relation to somatic and mental health, the impact of imprisonment on older offenders' well-being, and nutrition and exercise.

Twelve studies used qualitative methodology, 79 quantitative methodology, and 9 employed a mixed methods approach. The most dominant sampling technique was purposive/convenience sampling (n=70), 18 studies used all data from a certain population, 10 studies applied random sampling, and two studies combined two sampling methods (all data from a certain population and random sampling of a comparative group). Twenty-eight studies made use of documents (medical records, charts, forms) to collect their data, 21 used screenings and diagnostic tools, 12 conducted semi-structured interviews, 12 used self-report surveys and questionnaires, 1 study held focus groups, and 26 studies used a combination of data sources. The study sample size ranged from 7 to 234031 participants with the majority of studies (n=40) having less than 100 subjects, and only 14 studies had over 1001 participants. The percentage of older participants within the sample ranged from as little as 1.6% to 100% whilst most of the studies (n=82) conducted their research on older offenders only.

Terminology used for older prisoners and age cut-offs

The terminology that the authors of these included studies used to describe this population varied. Forty-six studies used the term 'older', 14 used 'elderly', 2 'geriatric', 1 'mature', 1 'aging' and 36 studies used multiple terms (e.g. older, elder) with interchangeable meanings (see Figure 3). We conducted a Pearson's Chi Squared Test to check whether there was a relation between the applied age cut-off and the terms used. Included were only studies that used one cut-off and a specific term. There was no significant interaction found (X^2 (30), $p = 0.09$).

The age cut-offs applied for the group of older offenders extended from the age of 40 to the age of 65 (see Figure 2). Among the included studies, the age of 50 was by far the most frequently chosen cut-off (n=42), 55 years was applied by 17 studies, and the age of 60 by 16 studies. Only one study used the age of 40 (Barry, Ford, & Trestman, 2014), 6 the age of 45 (Allen et al., 2013; Bishop & Merten, 2011; A. J. Bishop, G. K. Randall, & M. J. Merten, 2014; Gates, Staples-Horne, Walker, & Turney, 2017; Phillips et al., 2011; Sodhi-Berry, Knuiman, Alan, Morgan, & Preen, 2015), 3 used 62 years (Paradis, Broner, Maher, & O'Rourke, 2000; Rosner, Wiederlight, Harmon, & Cahn, 1991; Rosner, Wiederlight, & Schneider, 1985) and four used 65 years (Barak, Perry, & Elizur, 1995; Crawley & Sparks, 2005, 2006; Curtice, Parker, Wismayer, & Tomison, 2003). Within the category 'other', two studies presented data on all age groups while analyzing older offenders as specific sub-group (Harzke et al., 2010; Taylor & Parrott, 1988), one provided an average age of the older offenders included in the study (Aday, 1994), and 8 studies used multiple cut-offs for older offenders,e.g. 60 and 65 (Fazel & Grann, 2002), 50 and 60 (Colsher, Wallace, Loeffelholz, & Sales, 1992; Hayes et al., 2012), 45 and 50 (Baidawi, 2016; Baidawi & Trotter, 2016; Baidawi, Trotter, & Flynn, 2016; Baidawi, Trotter, & O'Connor, 2016), and 45 and 55 (Merten, Bishop, & Williams, 2012).

Rationales for choosing age cut-offs

For each study, we checked why the specific age cut-off had been chosen. In almost half of all studies included (n=44), the researchers had named no reasons for choosing their selected age cut-off (see for example: Aday, 1994; Colsher et al., 1992; Curtice et al., 2003; de Guzman et al., 2012; V. Sullivan et al., 2016). The remaining studies where the researchers have provided a reason for their chosen age cut-off are discussed below and an overview of the rationales is presented in Figure 4. If an article mentioned multiple reasons for choosing a cut-off, they were counted in all possible categories.

As the majority of prisoners are young and the prison environment is adapted to this group, prisoners could feel relatively old at a younger age and age issues (e.g. physical changes) may stand out earlier. Three studies provided reasons linked to this idea of how being older within a young environment may make age related issues more pronounced than what would generally be visible when living in the community. This was categorized into 'relative age' (Baidawi, Trotter, & O'Connor, 2016; Stoliker & Varanese, 2017; Wilson & Vito, 1986).

Studies that described arguments for 'pragmatic reasons' outlined the issue of small numbers of possible participants (Barry et al., 2014; Coid, Fazel, & Kahtan, 2002; Rodriguez, Boyce, & Hodges, 2017; Sodhi-Berry et al., 2015; Washington, 1989) and for these reasons chose lower cut-offs, which allowed them to assure statistical power (Sodhi-Berry et al., 2015).

Other researchers took age cut-offs provided by general institutions or representing general assumptions ('institutional cut-off'). For instance, Fazel and Grann (2002) used the cut-off (i.e. 65 years) that is used in geriatric psychiatry. Two research groups were bound to a certain age cut-off (i.e. 50 and 60 years) by a special facility for older inmates, in which they were conducting their research

(Marquart & Merianos, 2000; McGrath, 2002). Other studies used age cut-offs that determined the eligibility for social security retirement benefits (Crawley & Sparks, 2005, 2006; O'Hara et al., 2016; Rosner et al., 1991; Rosner et al., 1985) or definitions and recommendations provided by criminological or correctional institutes (Barry, Wakefield, Trestman, & Conwell, 2016a; Iftene, 2016; Sodhi-Berry et al., 2015).

One research group adjusted the age cut-off for indigenous people due to their 'shorter life expectancy' in comparison to the general Australian population (Baidawi, 2016; Baidawi & Trotter, 2016; Baidawi, Trotter, & Flynn, 2016; Baidawi, Trotter, & O'Connor, 2016). Their used age for older indigenous prisoner was 45 years.

The category 'other' was used for the following: one study provided an average age only (Aday, 1994) and one study based their age cut-off on clinical experience of one author (McLeod, Yorston, & Gibb, 2008).

Rodriguez et al. (2017) conducted a neuropsychological study and based their cut-off decision on findings of age-related changes in 'cognitive functioning'.

The concept of 'functional definition' refers to studies analyzing the impact of different ages with issues such as the burden on the health care system, rates of mental disorders and health and social needs. The age cut-off was determined based on the age that was linked to the biggest change in the dataset e.g. increase of rates of disorders (Harzke et al., 2010; Hayes et al., 2012; Rodriguez et al., 2017; Taylor & Parrott, 1988).

Twenty-six studies justified their age cut-off choice by stating that these cut-offs were the most frequently or widely used in research on older offenders. These studies also used the specific age cut-off to be consistent with previous research which represented the concept called 'frequent/common' (see for example: Kerber, Hickey, Astroth, & Kim, 2012; Leigey & Hodge, 2012; Leigey & Johnston, 2015; Loeb & Steffensmeier, 2006; Loeb & Steffensmeier, 2011; Loeb, Steffensmeier, & Lawrence, 2008).

Lastly, 30 studies stated the concept of 'accelerated aging'. Their stated reasons can be taken together as a comparison between the health status of prisoners and people living in the community, which would indicate a ten to fifteen year difference. Prisoner populations are therefore thought to have a biological age that is comparable to the age of community populations who are ten to fifteen years older. This poorer health status is described by the greater burden of illness, disability, functional impairment, chronic conditions, and comorbid conditions (see for example: Allen, Phillips, Roff, Cavanaugh, & Day, 2008; Barry, Wakefield, Trestman, & Conwell, 2016b; A. J. Bishop, G. Randall, & M. J. Merten, 2014; Combalbert et al., 2017; Falter, 1999; Heidari, Wangmo, Galli, Shaw, Elger, et al., 2017; Lightbody, Gow, & Gibb, 2010; Maschi, Gibson, Zgoba, & Morgen, 2011; Phillips, Allen, Salekin, & Cavanaugh, 2009; Trotter & Baidawi, 2015; Wangmo et al., 2016; Williams et al., 2014; Williams et al., 2006)

The causes that are thought to create this difference in health status are believed to be based on factors linked to the prisoners' life before imprisonment and/or imprisonment itself (Barry et al., 2016a; Courtney & Maschi, 2013; Davoren et al., 2015; Handtke & Wangmo, 2014; Loeb, Steffensmeier, & Myco, 2007; Merten et al., 2012; Nowotny, Cepeda, James-Hawkins, & Boardman, 2016; O'Hara et al., 2016; Sodhi-Berry et al., 2015; Wilkinson & Caulfield, 2017). Offenders have been shown to be more likely to originate from disadvantaged backgrounds with a lower socioeconomic status. Moreover, they frequently have a history of excessive drug and alcohol use, poor nutrition/ eating habits, personal neglect, lack of access to medical care, stressful life experiences, and a general tendency to engage in risky behaviors. It is further hypothesized that imprisonment itself has an impact on prisoners' health through high distress, separation from family, risk of isolation, fear of victimization and decreased access to health care during imprisonment when compared to people living outside prisons.

Empirical Evidence for age cut-off rationales

Frequent/Common: the most frequently cited study in this group was the review conducted by Loeb and AbuDagga (2006). It was provided as evidence by six studies using the age cut-off of 50. Their review reports, amongst others, on the "Frequency and Percent for Age Used to Denote Older Inmates" and presents 50 as the most commonly used age cut-off. The remaining studies did not cite any evidence that specifically outlined the frequency of age cut-offs in research of older offenders but stated comments such as "to be consistent with other studies". Three studies did not provide any citations.

Shorter Life Expectancy: The basic literature provided was the statistics on deaths published by the Australian Bureau of Statistics (2011). This study presents the life expectancy of the Australian population while differentiating between indigenous and non-indigenous people. Three additional studies did not provide any further evidence but lead to the same statistics.

Institutional Cut-off: The four studies referring to the state retirement age and the one referring to the cut-off in geriatric psychiatry did not cite a source. The age cut-offs defined by access to a special facility for older inmates did not outline their admission criteria. Three research groups referred to articles published by the criminological and correctional institutes of Australia, Canada, and the United States. The recommendation for age cut-offs of older indigenous prisoners provided by the Australian Institute for Criminology is based on the 'shorter life expectancy' argument (Baidawi et al., 2011).The reports cited from Canadian and American Institutes discussed the definition problem and the concept of 'accelerated aging' (Anno, Graham, James, & Shansky, 2004; Uzoaba, 1998). The empirical evidence cited in these reports was therefore considered in the corresponding reasoning groups (i.e. 'accelerated aging' and 'shorter life expectancy').

Pragmatic Reasons: there was not literature cited in this group.

Relative Age: the one review cited claims that most literature reviewed show that prisons are designed for younger and physically active inmates (Morton, 1992). Since we limited ourselves to

review literature back to 1990 due to our resource limitations, we did not screen the literature cited in this 1992 review and we did also not consider the other review cited (Rubenstein, 1984).

Cognitive Functioning: The neuropsychological study conducted by Rodriguez et al. (2017) referred to age-related change in cognitive functioning as a marker in aging. The two studies cited show evidence of declining executive functioning occurring most dominantly around the age of 50 (De Luca et al., 2003; Zhou, Fan, Lee, Wang, & Wang, 2011).

Functional Definition: Rodriguez et al. (2017) points out the so-called 'functional definition' which was based on (Stojkovic, 2007) referring to (Thomas, Thomas, & Greenberg, 2005) who cited an unpublished study conducted by the Florida Department of Corrections. They analyzed the impact of certain ages on their correctional health-care system, which showed a clear change at the age of 52-53. Inmates at this age accessed the health-care system far more frequently while this increase remained relatively stable for the following higher age groups. Based on this analysis, the Florida Department of Corrections defined the cut-off age for older offenders at 50 (see Thomas et al., 2005). Two studies (Harzke et al., 2010; Taylor & Parrott, 1988) analyzed the rates of mental and physical disorders for older offenders while comparing them with all other age groups in 10-year age brackets. Both research teams reported that the biggest changes occur in the fifties: while they did not calculate the exact threshold, they noticed this difference starting with the 55 to 64 age group. Additionally, one study investigated the health and social needs of older prisoners using the two age cut-offs 50 and 60. Based on their data, they described the age 50 to 54 as a transitory period but concluded the age of 50 as a useful cut-off since this age group was not drastically different to the over 60s (Hayes et al., 2012).

Other: no literature was cited in this group since one study provided an average age and one referred to the clinical experience of an expert.

Accelerated Aging: as this concept was the argument noted by the majority of studies, the amount of literature cited in relation was extensive. However, the empirical evidence cited in our sample to support the concept of 'accelerated aging' is scarce and can be split up in (1) direct comparisons and (2) indirect comparisons of health status. Direct comparisons between the health status of incarcerated and non-incarcerated populations were conducted by Loeb et al. (2008) and Combalbert et al. (2016). In the study performed by Loeb et al. (2008), the authors compared the health status of a sample of community-dwelling older men with a group of incarcerated individuals. The community sample was on average 15 years older while the health status between both samples was similar. The study conducted by Combalbert et al. (2016) also found a 10 year difference between the prisoner's and the community group's average age, but no difference in health status. Both studies therefore concluded that this indicates a 10 or 15 years difference in health status between incarcerated and non-incarcerated individuals. Another study cited in relation to health status, provided indirect comparisons between their own study results, representing the prisoners' sample, and prevalence rates

of the general population drawn from other publications. They concluded that the health of older prisoners is worse, compared to younger prisoners and community-dwelling individuals of the same age (S. Fazel et al., 2001).

Discussion

This systematic review surveyed literature on the health and well-being of older prisoners to investigate how researchers have so far defined the older offender population. Our findings show that the age cut-off 50 and the term 'older' were the most frequently ones applied. We find eight main arguments provided for a specific age cut-off delineating older offenders: 'accelerated aging, 'relative age', 'functional definition', 'pragmatic reasons', 'frequent/common', 'institutional cut-off', 'shorter life expectancy', and 'cognitive functioning'.

The majority of studies used the term 'older' to describe this population. This is in line with the recommendations provided by major associations such as the American Psychological Association and the American Geriatrics Society who favor the use of more neutral terms like 'older people' and 'older adults' as opposed to terms such as 'seniors' or 'elderly' (American Psychological Association, 2010; Lundebjerg, Trucil, Hammond, & Applegate, 2017). Moreover, other studies that surveyed older people found that respondents preferred to be described with terms such as 'seniors', 'senior citizen', 'retiree', 'senior', and 'older adult' (Chafetz, Holmes, Lande, Childress, & Glazer, 1998; Misurak, Crilly, & Kloseck, 2002). Misurak et al. (2002) additionally reviewed the use of terminology in scientific journals, which showed authors' tendency to use 'older adults'. Taken together, this suggests similar developments amongst authors of scientific articles, major associations, and older adults themselves to use more neutral descriptions such as 'older people' or 'older adults'.

A large proportion of the studies analyzed within this review used multiple terms (older, elder, elderly, geriatric) to describe the same population while the use of certain terminology (e.g. older, elderly, geriatric) could not be linked to specific age groups. Even though this gives a pleasant variety for the reader, it is overall a rather confusing use of terminology and the distinct terms might be understood differently by readers. To increase accuracy and congruency, we therefore suggest for future studies on health of older offenders to utilize the terminology 'older' to describe the target population.

As noted earlier, the researchers' reasoning to choose certain cut-offs were divided into eight categories. It was striking that in almost half of the included studies, researchers did not name any reasons why they chose certain cut-offs. Further, out of the arguments we consider the categories 'frequent/common', 'pragmatic reasoning', 'relative age' and 'institutional cut-off' are not useful in establishing a common age cut-off due to their variability on context and weak reasoning associated

with its usage. However, we consider the concepts of 'cognitive functioning' 'accelerated aging', 'functional definition', and 'shorter life expectancy' as promising approaches to advance towards a shared definition of older offenders. These four arguments consider the characteristics of the prisoner population by assessing their morbidity and mortality. We discuss each of these arguments in detail below.

The actual age cut-offs that were chosen for older offenders ranged between the age of 40 and 65 with the majority of studies using the age cut-off of 50. Loeb and AbuDagga (2006) described this trend of most studies utilizing the age of 50 to distinguish between the younger and older age group. The 'frequent/common' tendency has continued to date and has been specifically named as a reason for a chosen cut-off, making research more comparable and to be able to integrate results across single studies. However, this rationale was used to support different age cut-offs such as the age of 55 (Bolano, Ahalt, Ritchie, Stijacic-Cenzer, & Williams, 2016; Williams, Baillargeon, et al., 2010; Williams, McGuire, et al., 2010) and the age of 60 (Fazel & Grann, 2002; Fazel, Hope, O'Donnell, & Jacoby, 2004; O'Hara et al., 2016). This reasoning consequently did not increase comparability of studies but raised similar diversity in chosen age cut-offs.

The 'pragmatic reasoning' included the need to artificially lower the age limit in light of the number of older people in prison, which although growing, continues to form a minority within correctional systems. When conducting quantitative research on older offenders, researchers face the challenges of recruiting enough subjects within an already limited number of possible participants. On the one hand, this enables the researcher to conduct quantitative analyses with enough statistical power. On the other hand, artificially reducing the age cut-off for the reason of ensuring a bigger sample leads to presenting results of a certain age-group but not necessarily the age-group of interest. This could, consequently, slow down advances regarding data and knowledge on older offenders. Thus, such 'pragmatic reasoning' is, in our opinion, not useful and should be avoided.

The 'relative age' reasoning states that correctional facilities are designed for younger and physically active inmates and are not easily adaptable to the needs of older prisoners. Older prisoners are more likely to suffer from functional limitations and restricted by a lack of accessibility within the institutions (Morton, 1992). Even though "certain aspects of the prison environment can exacerbate the functional impairment" (Williams et al., 2006), penal institutions worldwide are highly diverse, which means that these aspects of the prison environment also differ. The impact of the prison environment on functional impairment is therefore difficult to compare and the applicability of the 'relative age' reasoning consequently questionable. Nevertheless, older prisoners' needs are important factors when planning healthcare on a more individual level. A prison environment that does not take into account physical limitations such as reduced mobility, impaired hearing and vision, infirmity, or incontinency can create a situation that is described as 'double punishment' (Baidawi et al., 2011).

Thus, we consider this argument as an important consideration when planning institutional care but not helpful to promote a shared understanding of older offenders in research.

Studies that adopted 'institutional cut-offs' were either based on cut-offs applied to the general population, admission criteria of certain units, or recommendations by criminological or correctional institutes. The latter used explanations such as 'accelerated aging' and 'shorter life expectancy' (see below) while researchers that applied cut-offs of the general population referred to official retirement age without further explaining their reasoning. This group of arguments did refer to other concepts and did therefore not add any additional unique considerations.

'Cognitive functioning' changes over the course of life while the distinct domains are affected at different rates. For example, executive functioning is thought to decline around the age of 50 in the general population (De Luca et al., 2003; Zhou et al., 2011) and was used to draw an age cut-off in a study on cognitive performance of older offenders (Rodriguez et al., 2017). This data-driven approach to choose an age cut-off could also be useful in the more general discussion on how to define an older offender. Cognitive performance can be influenced by lifestyle factors such as physical activity, cardiovascular diseases, and diet (Baumgart et al., 2015). As the prisoner population is often described as one with a history of risky behaviors that are linked to increased morbidity, (see 'accelerated aging'), they could consequently be affected by greater cognitive decline at a younger age (Combalbert et al., 2017). It is therefore questionable to what extent data from the general population can be used to define an age cut-off in the prisoner population. Yet, data on age-related cognitive changes exclusively collected from the prisoner population could be utilized as indicators to draw an age cut-off for older offenders.

The phenomenon of 'accelerated aging' among prisoners was mainly brought up by studies that used lower age cut-offs such as the age of 50 and 55 for older offenders. The reason for this lower age cut-off was described as the discrepancy in health status between the prisoner population and the general population. Empirical evidence that was named to confirm this theory was scarce, as highlighted by other authors (Gallagher, 2001; Kouyoumdjian, Andreev, Borschmann, Kinner, & McConnon, 2017; Williams, Goodwin, Baillargeon, Ahalt, & Walter, 2012). In total, three studies provided evidence on 'accelerated aging' through comparing the health status of non-incarcerated populations to the older offender population. They showed prisoners to have increased physical and psychiatric morbidity, which can be linked to 'accelerated aging' and early mortality (Combalbert et al., 2016; S. Fazel et al., 2001; Loeb et al., 2008). This was also confirmed by more recent studies that were not in our sample of empirical evidence (Di Lorito et al., 2018; Greene, Ahalt, Stijacic-Cenzer, Metzger, & Williams, 2018). However, other authors have argued that comparing the health status of prisoners with people living in the community of a different age group might be an oversimplification (Hayes et al., 2012).

The concept of 'accelerated aging' is closely linked to the 'shorter life expectancy' reasoning (Baidawi, 2016; Baidawi & Trotter, 2016; Baidawi, Trotter, & Flynn, 2016; Baidawi, Trotter, & O'Connor, 2016). Authors from Australia adjusted the age cut-off for indigenous people down to the age of 45 whilst choosing an age cut-off of 50 for the remaining prisoners and justified this by the difference in life expectancy between indigenous and non-indigenous Australians. Following this idea, one approach would be to compare mortality and life expectancy of the prisoner population with the general population and to adjust the age cut-off accordingly. Yet, even though there is evidence that there is an increased mortality during the period after release from prison (Zlodre & Fazel, 2012), it is unclear in what way prisoners might be subjected to 'accelerated aging'. Kouyoumdjian et al. (2017) argue that "adjusting a prisoner's age uniformly by 10 to 15 years (as the commonly advanced assertion suggests) would be overly simplistic, as age and sex seem to modify the effect of a history of incarceration on mortality rate and life expectancy" (p.8). Thus, even though the mortality risk for the prisoner population is higher for most of adulthood, this risk varies per age group and it is therefore difficult to give a general age-adjustment to all prisoners.

Finally, a consequence of the higher disease and disability burden amongst the older offender population, as mentioned above, is the high costs of providing health care (Ahalt et al., 2013). The impact of different age-groups on the correctional healthcare system has been analyzed by the Florida Department of Corrections (see Thomas et al., 2005) and was used by Rodriguez et al. (2017) to draw an age cut-off for older offenders. We grouped together arguments that used the idea of analyzing the effect of age onto aspects such as healthcare costs or rates of disorders to the concept 'functional definition'. An advantage of studies using datasets that comprise all age groups is that similarities and discrepancies between older and younger age groups can be outlined and the issues of older offenders can therefore be interpreted in a broader context. For example, Hayes et al. (2012) were able to identify the most pronounced changes in physical health, overall health, and social needs with age groups over 50 and therefore recommended drawing the cut-off at that age. Thus, age-related changes in, for instance, rates of mental disorder or prevalence rates become apparent that way. Of course, disadvantages can be greater expenses for data collection and analysis in a population that is hard to access and where research activity is limited. However, this might be a promising approach for the purpose of establishing a shared understanding of older offenders due to its potential to reveal age-related changes that are particular to the prisoner population.

Limitations

One limitation is that it is possible that we did not include all studies relating to the health of older offenders. This limitation could be due to the search terms used as well as available resources that allowed us to use English language data and four search engines only. We also did not screen reference lists of studies included in our review since 100 studies met our inclusion criteria and the

additional work burden would have been unfeasible. Furthermore, we believed that our results would not have changed even if we had screened the reference list for further studies. The main groups of arguments to define older offenders were evident much earlier during our data extraction process.

Moreover, we limited our analysis on how to define an older offender to chronological age only and did not explore any other constructions of age. Chronological age is a variable that is easy to obtain and therefore helpful for conducting research as well as for planning health care services on a broader level. However, the older population is known to be the most heterogeneous of all age groups (Atabay, 2009) and would therefore require additional subdividing to guarantee adequate allocation of health care services. One approach that is already being used in geriatrics is the use of diagnostic criteria to define a geriatric patient. For instance, the 'frailty syndrome' as proposed by Fried et al. (2001) could prove useful since it is linked to advanced age and higher health care needs. Future research should therefore consider evaluating additional ways to classify older offenders in order to further individualize and improve treatment.

Conclusions

'Accelerated aging' was described as a reason to use a lower age cut-off for older prisoners and is based on health status comparisons between prisoners and the general population. Health status included functional impairment and burden of illness and disability. Even though we categorized arguments for defining older offenders into differing approaches, they are interrelated. This was succinctly summarized by Williams et al. (2006) who noted that functional impairment predicts high healthcare costs, future functional decline, and mortality. Thus, to expand the conceptualization of accelerated aging, we suggest going beyond the comparison of health status only. The 'accelerated aging' concept would be enhanced if it incorporated the issues discussed in the additional rationales 'functional definition', 'shorter life expectancy', and 'cognitive functioning' that emerged through this review of literature. The arguments should consequently not be considered as stand-alone but as an enrichment to the concept of 'accelerated aging'. On this account, we recommend subsequent research activities pursue questions on issues such as age-related changes of prevalence rates of various diseases and cognitive functioning as well as life expectancy specific to the prisoner population.

Conflict of Interests

The authors declare that there is no conflict of interest.

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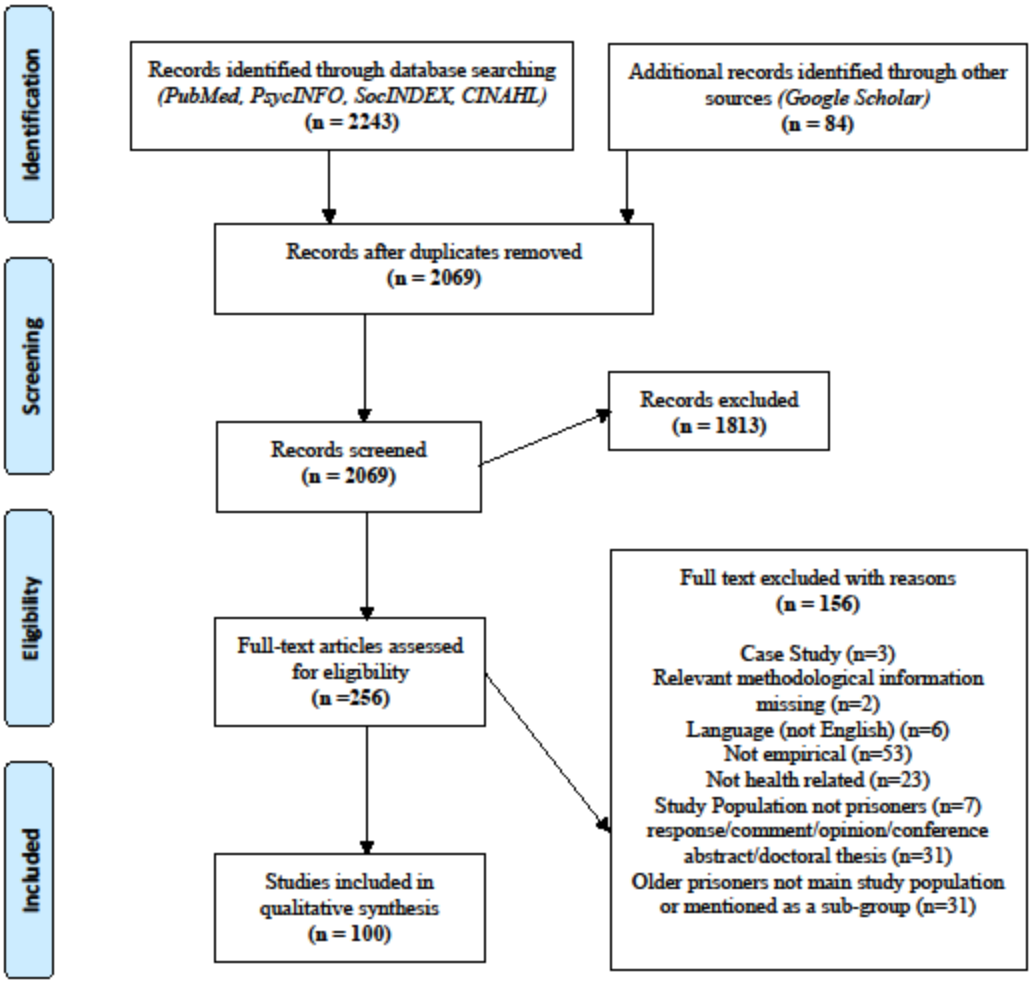
Figure 1. Selection of Studies



Adapted from: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement.* PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Figure 2. Applied age cut-offs

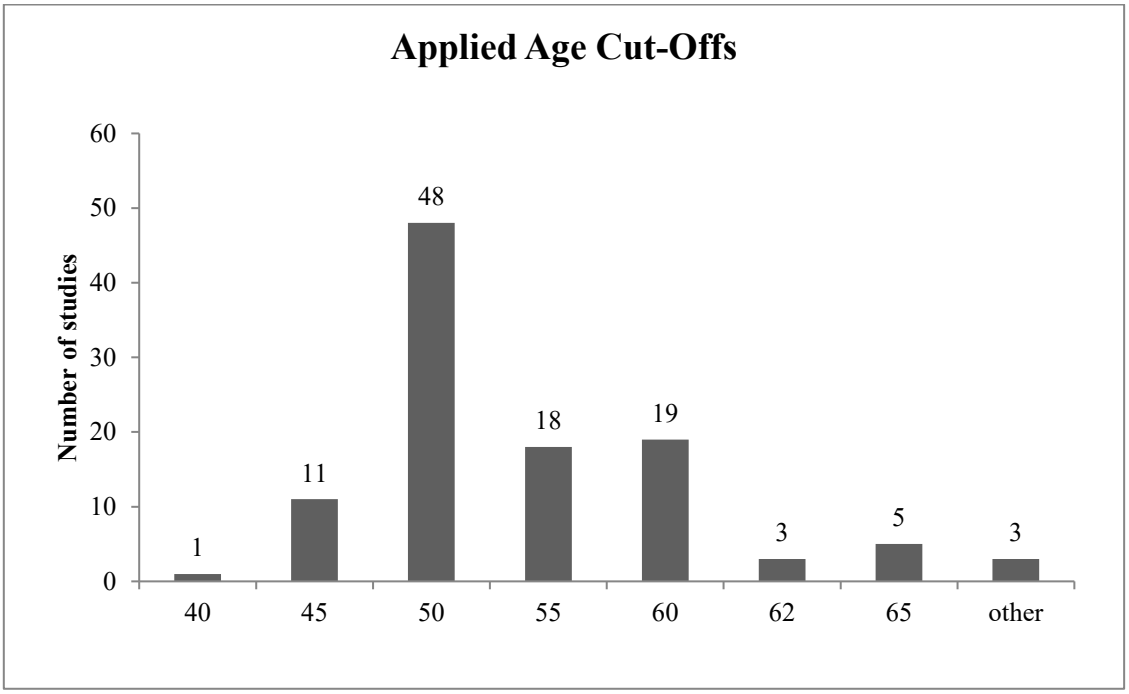


Figure 3. Terms used to describe the designated population

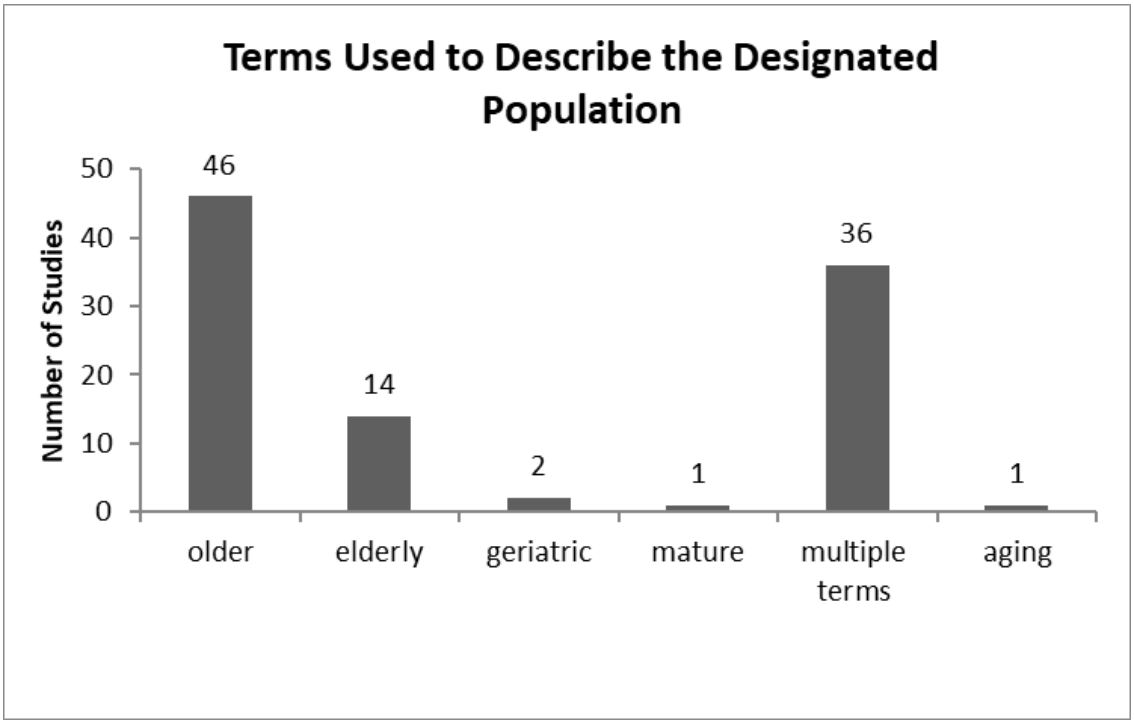


Figure 4. Reasons for chosen age cut-offs

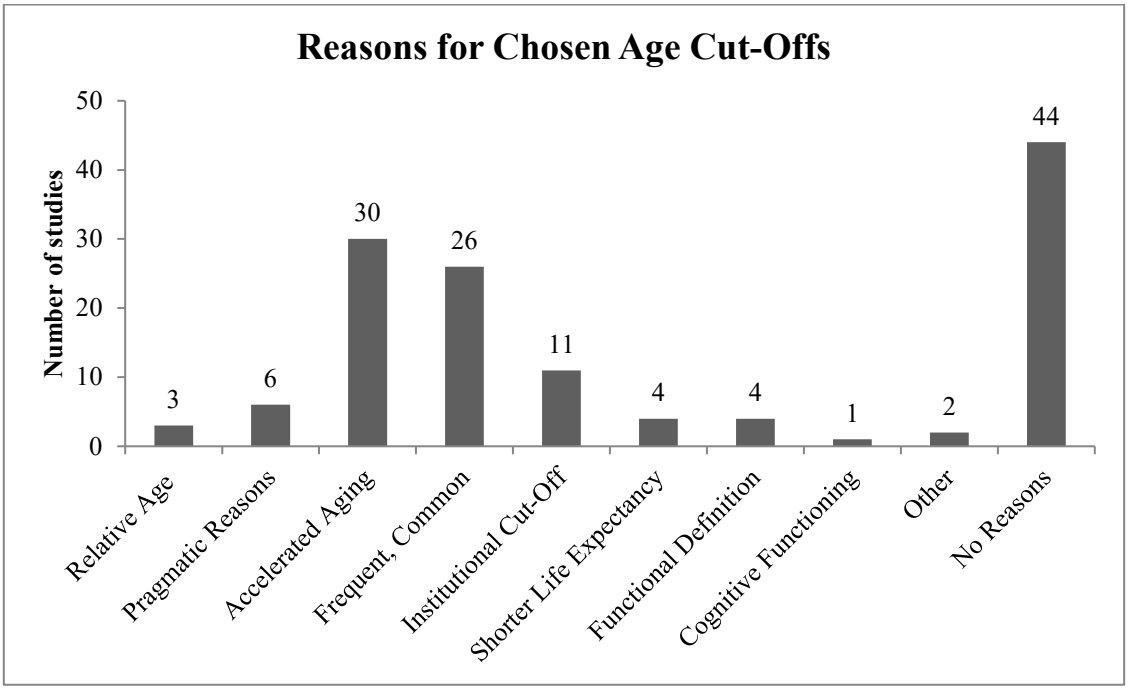


Table 1. Summary Characteristics of Included Studies

Paper ID	Title	Country of Study	Methodological Approach	Cut-off age
Aday (1994)	Aging in prison: A case study of new elderly offenders	USA	Qualitative	mean age
Aday (2005)	Aging Prisoners' Concerns Toward Dying in Prison	USA	Mixed Methods	50
Aday and Farney (2014)	Malign neglect: Assessing older women's health care experiences in prison	USA	Mixed Methods	50
Allen et al. (2013)	Does religiousness and spirituality moderate the relations between physical and mental health among aging prisoners?	USA	Quantitative	45
Allen et al. (2008)	Religiousness/Spirituality and Mental Health Among Older Male Inmates	USA	Quantitative	50
Al-Rousan, Rubenstein, Sieleni, Deol, and Wallace (2017)	Inside the nation's largest mental health institution: a prevalence study in a state prison system	USA	Quantitative	50
Arndt, Turvey, and Flaum (2002)	Older offenders, substance abuse, and treatment	USA	Quantitative	55
Baidawi (2016)	Older prisoners: psychological distress and associations with mental health history, cognitive functioning, socio-demographic, and criminal justice factors	Australia	Quantitative	45 and 50
Baidawi and Trotter (2016)	Psychological distress among older prisoners: Associations with health, health care utilization, and the prison environment	Australia	Quantitative	45 and 50
Baidawi, Trotter, and Flynn (2016)	Prison Experiences and Psychological Distress among Older Inmates	Australia	Quantitative	45 and 50
Baidawi, Trotter, and O'Connor (2016)	An integrated exploration of factors associated with psychological distress among older prisoners	Australia	Quantitative	45 and 50
Barak et al. (1995)	Elderly criminals: A study of the first criminal offense in old age	Israel	Quantitative	65
Barry et al. (2014)	Comorbid mental illness and poor physical function among newly admitted inmates in Connecticut's jails	USA	Quantitative	40

Barry et al. (2016a)	Active and passive suicidal ideation in older prisoners	USA	Quantitative	50
Barry et al. (2016b)	Disability in prison activities of daily living and likelihood of depression and suicidal ideation in older prisoners	USA	Quantitative	50
Beaufrère and Chariot (2015)	The health of older arrestees in police cells	France	Quantitative	60
Bishop and Merten (2011)	Risk of comorbid health impairment among older male inmates	USA	Quantitative	45
Alex J. Bishop et al. (2014)	Consideration of Forgiveness to Enhance the Health Status of Older Male Prisoners Confronting Spiritual, Social, or Emotional Vulnerability	USA	Quantitative	45
Bolano et al. (2016)	Detained and Distressed: Persistent Distressing Symptoms in a Population of Older Jail Inmates	USA	Quantitative	55
Caverley (2006)	Older mentally ill inmates: A descriptive study	USA	Quantitative	50
Coid et al. (2002)	Elderly patients admitted to secure forensic psychiatry services	UK/Ireland	Quantitative	60
Colsher et al. (1992)	Health Status of Older Male Prisoners: A Comprehensive Survey	USA	Quantitative	50 and 60
Combalbert et al. (2017)	Cognitive impairment, self-perceived health and quality of life of older prisoners	France	Quantitative	50
Combalbert et al. (2016)	Mental disorders and cognitive impairment in ageing offenders	France	Quantitative	50
Condon, Hek, and Harris (2008)	Choosing health in prison: prisoners' views on making healthy choices in English prisons	UK/Ireland	Qualitative	60
Courtney and Maschi (2013)	Trauma and stress among older adults in prison: Breaking the cycle of silence	USA	Quantitative	50
Crawley and Sparks (2005)	Hidden Injuries? Researching the Experiences of Older Men in English Prisons	UK/Ireland	Qualitative	65
Crawley and Sparks (2006)	Is there life after imprisonment?: How elderly men talk about imprisonment and release	UK/Ireland	Quantitative	65
Curtice et al. (2003)	The elderly offender: An 11-year survey of referrals to a regional forensic psychiatric service	UK/Ireland	Quantitative	65

Davoren et al. (2015)	Older men and older women remand prisoners: Mental illness, physical illness, offending patterns and needs	UK/Ireland	Quantitative	60
de Guzman, Imperial, Javier, and Kawasaki (2017)	As pliant as the bamboo: A grounded theory study of incarcerated Filipino elderly people's sense of resiliency	Phillipines	Qualitative	60
de Guzman et al. (2012)	For your eyes only: A Q-methodology on the ontology of happiness among chronically ill Filipino elderly in a penal institution	Phillipines	Mixed Methods	55
De Smet et al. (2017)	Factors related to the quality of life of older prisoners	Belgium	Quantitative	60
Deaton, Aday, and Wahidin (2009)	The Effect of Health and Penal Harm on Aging Female Prisoners' Views of Dying in Prison	USA	Mixed Methods	50
Falter (1999)	Selected Predictors of Health Services Needs of Inmates Over Age 50	USA	Quantitative	50
Fazel and Grann (2002)	Older criminals: A descriptive study of psychiatrically examined offenders in Sweden	Sweden	Quantitative	60 and 65
Fazel, Hope, O'Donnell, and Jacoby (2001)	Hidden psychiatric morbidity in elderly prisoners	UK/Ireland	Quantitative	60
Fazel, Hope, O'Donnell, and Jacoby (2002)	Psychiatric, demographic and personality characteristics of elderly sex offenders	UK/Ireland	Quantitative	60
Fazel et al. (2004)	Unmet treatment needs of older prisoners: a primary care survey	UK/Ireland	Quantitative	60
S. Fazel et al. (2001)	Health of elderly male prisoners: worse than the general population, worse than younger prisoners	UK/Ireland	Quantitative	60
Flatt, Williams, Barnes, Goldenson, and Ahalt (2017)	Post-traumatic stress disorder symptoms and associated health and social vulnerabilities in older jail inmates	USA	Quantitative	55
Gates et al. (2017)	Substance Use Disorders and Related Health Problems in an Aging Offender Population	USA	Quantitative	45
Handtke and Wangmo (2014)	Ageing prisoners' views on death and dying: Contemplating end-of-life in prison	Switzerland	Qualitative	50
Handtke, Bretschneider, Elger, and Wangmo (2015)	Easily forgotten: Elderly female prisoners	Switzerland	Mixed Methods	50

Handtke, Wangmo, Elger, and Bretschneider (2017)	New guidance for an old problem: Early release for seriously ill and elderly prisoners in Europe	Switzerland	Qualitative	50
Harzke et al. (2010)	Prevalence of chronic medical conditions among inmates in the Texas prison system	USA	Quantitative	all age groups
Haugebrook, Zgoba, Maschi, Morgen, and Brown (2010)	Trauma, stress, health, and mental health issues among ethnically diverse older adult prisoners	USA	Quantitative	55
Hayes et al. (2012)	The health and social needs of older male prisoners	UK/Ireland	Quantitative	50 and 60
Heidari, Wangmo, Galli, Shaw, and Elger (2017)	Accessibility of prison healthcare for elderly inmates, a qualitative assessment	Switzerland	Qualitative	50
Iftene (2016)	Unlocking the doors to Canadian older inmate mental health data: Rates and potential legal responses	Canada	Quantitative	50
Jordan (2013)	Health literacy: Advance directives among the African American aging prisoner population	USA	Quantitative	50
Kerber et al. (2012)	Gambling behaviors and perceived health among incarcerated older adults	USA	Quantitative	50
Kingston, Le Mesurier, Yorston, Wardle, and Heath (2011)	Psychiatric morbidity in older prisoners: Unrecognized and undertreated	UK/Ireland	Quantitative	50
Kratcoski and Babb (1990)	Adjustment of Older Inmates: An Analysis of Institutional Structure and Gender	USA	Mixed Methods	50
Leigey and Hodge (2012)	Gray Matters: Gender Differences in the Physical and Mental Health of Older Inmates	USA	Quantitative	50
Leigey and Johnston (2015)	The prevalence of overweight and obesity among aging female inmates	USA	Quantitative	50
Lewis, Fields, and Rainey (2006)	A Study of geriatric forensic evaluees: Who are the violent elderly?	USA	Quantitative	60
Lightbody et al. (2010)	A survey of older adult patients in special secure psychiatric care in Scotland from 1998 to 2007	UK/Ireland	Quantitative	55
Loeb and Steffensmeier (2006)	Older Male Prisoners: Health Status, Self-Efficacy Beliefs, and Health-Promoting Behaviors	USA	Quantitative	50

Loeb and Steffensmeier (2011)	Older Inmates' Pursuit of Good Health A Focus Group Study	USA	Qualitative	50
Loeb, Steffensmeier, and Kassab (2011)	Predictors of self-efficacy and self-rated health for older male inmates	USA	Quantitative	50
Loeb et al. (2008)	Comparing incarcerated and community-dwelling older men's health	USA	Quantitative	50
Loeb et al. (2007)	In their own words: older male prisoners' health beliefs and concerns for the future	USA	Qualitative	50
Marquart, Merianos, and Doucet (2000)	The health-related concerns of older prisoners: Implications for policy	USA	Mixed Methods	50
Maschi, Gibson, et al. (2011)	Trauma and life event stressors among young and older adult prisoners	USA	Quantitative	55
Maschi, Morgen, Zgoba, Courtney, and Ristow (2011)	Age, Cumulative Trauma and Stressful Life Events, and Post-traumatic Stress Symptoms Among Older Adults in Prison: Do Subjective Impressions Matter?	USA	Quantitative	55
Maschi, Viola, Morgen, and Koskinen (2015)	Trauma, stress, grief, loss, and separation among older adults in prison: the protective role of coping resources on physical and mental well-being	USA	Quantitative	50
McGrath (2002)	Oral health behind bars: a study of oral disease and its impact on the life quality of an older prison population	Hongkong	Quantitative	60
McLeod et al. (2008)	Referrals of older adults to forensic and psychiatric intensive care services: A retrospective case-note study in Scotland	UK/Ireland	Quantitative	55
Merten et al. (2012)	Prisoner Health and Valuation of Life, Loneliness, and Depressed Mood	USA	Quantitative	45 and 55
Murdoch, Morris, and Holmes (2008)	Depression in elderly life sentence prisoners	UK/Ireland	Quantitative	55
Nowotny et al. (2016)	Growing Old Behind Bars: Health Profiles of the Older Male Inmate Population in the United States	USA	Quantitative	50
O'Hara et al. (2016)	Links between depressive symptoms and unmet health and social care needs among older prisoners	UK/Ireland	Quantitative	60

Paradis et al. (2000)	Mentally Ill Elderly Jail Detainees Psychiatric, Psychosocial and Legal Factors	USA	Quantitative	62
L. L. Phillips et al. (2011)	Aging Prisoners' Treatment Selection: Does Prospect Theory Enhance Understanding of End-of-Life Medical Decisions?	USA	Quantitative	45
Phillips et al. (2009)	Care alternatives in prison systems: Factors influencing end-of-life treatment selection	USA	Quantitative	50
M. G. Rayel (2000)	Clinical and Demographic Characteristics of Elderly Offenders at a Maximum-Security Forensic Hospital	Canada	Quantitative	55
M. G. M. D. Rayel (2000)	Elderly Sexual Offenders Admitted to a Maximum-Security Forensic Hospital	Canada	Quantitative	55
Regan, Alderson, and Regan (2002)	Psychiatric disorders in aging prisoners	USA	Quantitative	55
Rodriguez et al. (2017)	A neuropsychological study of older adult first-time sex offenders	Australia	Quantitative	50
Rosner et al. (1985)	Geriatric Felons Examined at a Forensic Psychiatry Clinic	USA	Quantitative	62
Rosner et al. (1991)	Geriatric Offenders Examined at a Forensic Psychiatry Clinic	USA	Quantitative	62
Shah (2006)	An audit of a specialist old age psychiatry liaison service to a medium and a high secure forensic psychiatry unit	UK/Ireland	Quantitative	60
Sodhi-Berry et al. (2015)	Pre- and post-sentence mental health service use by a population cohort of older offenders (>=45 years) in Western Australia	Australia	Quantitative	45
Stoliker and Varanese (2017)	Spending the Golden Years Behind Bars: Predictors of Mental Health Issues Among Geriatric Prisoners	USA	Quantitative	50
Victoria Sullivan et al. (2016)	'You can't have them in here': experiences of accessing medication among older men on entry to prison	UK/Ireland	Qualitative	60
Taylor and Parrott (1988)	Elderly offenders: A study of age-related factors among custodially remanded prisoners	UK/Ireland	Quantitative	all age groups
Trotter and Baidawi (2015)	Older prisoners: Challenges for inmates and prison management	Australia	Mixed Methods	50

Wangmo et al. (2015)	Ageing prisoners' disease burden: is being old a better predictor than time served in prison?	Switzerland	Quantitative	50
Wangmo et al. (2016)	Aging Prisoners in Switzerland: An Analysis of Health Care Utilization	Switzerland	Quantitative	50
Washington Patricia (1989)	Mature Mentaly Ill Offenders in California Jails	USA	Quantitative	50
Wilkinson and Caulfield (2017)	The Perceived Benefits of an Arts Project for Health and Wellbeing of Older Offenders	UK/Ireland	Qualitative	50
Williams et al. (2014)	Pain Behind Bars: The Epidemiology of Pain in Older Jail Inmates in a County Jail	USA	Quantitative	55
Williams, Baillargeon, et al. (2010)	Medication Prescribing Practices for Older Prisoners in the Texas Prison System	USA	Quantitative	55
Williams et al. (2006)	Being Old and Doing Time: Functional Impairment and Adverse Experiences of Geriatric Female Prisoners	USA	Quantitative	55
Williams, McGuire, et al. (2010)	Coming home: Health status and homelessness risk of older pre-release prisoners	USA	Quantitative	55
Wilson and Vito (1986)	Imprisoned Elders: The Experience of One Institution	USA	Mixed Methods	50
Wong, Lumsden, Fenton, and Fenwick (1995)	Elderly offenders in a maximum security mental hospital	UK/Ireland	Quantitative	50
Yorston and Taylor (2009)	Older patients in an English high security hospital: A qualitative study of the experiences and attitudes of patients aged 60 and over and their care staff in Broadmoor Hospital	UK/Ireland	Qualitative	60
Zgoba, Jennings, Maschi, and Reingle (2012)	An exploration into the intersections of early and late sexual victimization and mental and physical health among an incarcerated sample of older male offenders	USA	Quantitative	50

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4.2. Mental health care of mandated patients

4.2.1. Forensic mental health professionals' perceptions of their dual loyalty conflict: Findings from a qualitative study

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Abstract

Background: Mental health professionals (MHP) working in court-mandated treatment settings face ethical dilemmas due to their dual role in assuring their patient's well-being while guaranteeing the security of the population. Clear practical guidelines to support these MHPs' decision-making are lacking, amongst others, due to the ethical conflicts within this field. This qualitative interview study contributes to the much-needed empirical research on how MHPs resolve these ethical conflicts in daily clinical practice. ***Methods:*** 31 MHPs working in court-mandated treatment settings were interviewed. The interviews were semi-structured and our in-depth analysis followed the thematic analysis approach. ***Results:*** We first outline how mental health professionals perceive their dual loyalty conflict and how they describe their affiliations with the medical and the justice system. Our findings indicate that this positioning was influenced by situational factors, drawing the MHPs at times closer to the caring or controlling poles. Second, our results illustrate how participating MHPs solve their dual loyalty conflict. Participants considered central to motivate the patient, to see the benefits of treatment and its goals. Further, transparent communication with patients and representatives of the justice system was highlighted as key to develop a trustful relationship with the patient and to manage the influences from the different players involved. ***Conclusions*****:** Even though individual positioning and opinions towards dealing with the influences of the justice system varied, the results of our research show that, in spite of varying positions, the underlying practice is not very different across participating MHPs. Several techniques that allow developing a high-quality therapeutic alliance with the patient are key elements of general psychotherapy. Transparency appears as the crucial factor when communicating with the patient and with representatives of the justice system. More specifically, patients need to be informed since the beginning of therapy about the limits of medical confidentiality. It is also recommended to develop guidelines that define the level of detailed information that should be disclosed when communicating with the authorities of the justice system.

Background

Mental health care professionals (MHPs) working in court-mandated treatment settings face ethical dilemmas because they are placed in a triangular relationship that involves them, their patients, and the judicial system (1, 2). The work of the MHPs is not only to care for the patient's mental health but also to assure public security. Hence, they play a double role, which forces them to find a balance between the individual patient's rights and ensuring the safety of the general population (3). Consequently, they face moral dilemmas towards ensuring the rights of their patients within a healthcare setting as well as caring for the welfare of the public who may be harmed should their patient be released into the community - which we refer to as *dual loyalty conflicts* - in their daily practice (1).

Different dual loyalty conflicts arise depending on the mental health professional's task. The first distinction can be made between forensic mental health professionals acting as experts at court proceedings and clinicians in therapeutic roles. It is argued that these professional roles result in differing ethical conflicts and therefore require separate ethical guidelines (4). For instance, in the therapeutic context, principles such as beneficence and non-maleficence apply to the patient-physician relationship, in prison as much as in the community (5). Appelbaum (6) argues that these concepts can not be applied to forensic assessments in court proceedings. In contrast, he considers the principles of truth telling and respect for persons should be the ethical underpinnings. As different set of norms apply to different roles, it is recommended that the roles should be strictly separated to different professionals (7). Further, even though similar principles apply to the physician-patient relationship in the therapeutic context, mental health professionals working in the criminal justice system face certain role conflicts. Bonner and Vandecreek (8) named typical scenarios such as being asked to alter clinical evaluations, to release confidential information, or to house an incarcerated person in segregation for "psych review". Further, court-mandated treatment settings present a specific challenge to mental health professionals because their role to treat and to evaluate subside. This paper focuses on the ethical dilemmas that arise in court-mandated treatment settings for persons deprived of liberty, which will be discussed in more detail in the following paragraphs.

Dual loyalty conflicts have the potential to compromise a mental health professional's behavior but also to infringe on the human rights of the patients undergoing treatment (9). In fact, mandated treatment settings have repeatedly been criticized for violations of patient's rights (3, 10). A violation that is often mentioned refers to medical confidentiality, which is broken when health professionals share information with representatives of the justice system. In particular, it must be possible for the supervisory authority to review the therapeutic procedure or the progress achieved. For this control function, which is ultimately also exercised in the patient's interest, the reports made for the review are of great importance, but these reports could contain confidential information.

The way in which confidentiality is handled by mental health professionals in the correctional context varies from a complete break of it to almost no information sharing (11). This contrast is found not only in daily practice but also in international guidelines. It is true that the majority of international guidelines recommend that healthcare should be provided in complete loyalty to the mandated patients (see 12); however, several guidelines such as those of Physicians for Human Rights (13) and the Penal Reform International (14) state that, if the role conflict is previously explained to the patient, then it is morally and legally acceptable to break confidentiality. In the same line, a qualitative study conducted in Switzerland found that mental health professionals regularly inform their patients that confidentiality will be breached when care is provided within the context of a court-ordered therapy (15, 16).

In practice, the field of forensic psychiatry is subject to sets of norms that emanate from two distinct state institutions – the health and judicial system. These two sets of norms use different nomenclatures and therefore they are incommensurable. This is particularly true, as pointed out by Lau and Sachs (17), when one tries to apply the principle of medical confidentiality in court-mandated settings. Confronted with this problem, therapists would take advantage of a harmonized set of guidelines to be applied in court-mandated settings

In fact, what is under debate is which guiding principles should be applied within this context. In the same spirit, experts have pointed out the lack of shared underlying normative ethical guidelines (1, 18), formalized training, and institutional mechanisms to guide mental health professionals in

dealing with potential conflicts of interests (9). In particular, Niveau and Welle (1) consider that the field of forensic psychiatry has two conflicting ethics, meaning that the MHP's behavior is influenced by moral principles originating from the two distinct state institutions, and no clear directives on how to solve their incompatibilities (please see for example (1, 6) for a detailed discussion of the ethical clash). In sum, it is widely known that mental health professionals working in mandated treatment settings regularly face ethical dilemmas, and that there is no clear guidance to support their decision-making.

Despite these controversies, mandated treatments are still common practice in at least 75 jurisdictions across the world (3). In Switzerland, as the criminal code has a system of measures for dangerous and mentally ill persons, the number of ill individuals sentenced to mandated treatments is necessarily higher than in countries that consider them as criminally irresponsible and treat them outside the criminal justice system. At the same time, it is a particularly interesting location for forensic psychiatry, as the perceived set of norms linked to this profession are supposed to be drastically different between the French- and German-speaking language regions (19). In terms of a potential violation of the patient's rights by disclosing information about the treatment, practitioners from the French speaking region feel that they are bound to the patient only, while clinicians from the German-speaking region are more closely affiliated with the justice system. Thus, a crack is running through forensic and correctional practice (20) which is thought to show itself clearly at the language barrier. However, this difference could be due to a different ideology (*Weltanschauung)*, which can be traced back to the differences in the catholic and the protestant ethics, famously identified by Weber (21). The protestant work ethic can be perceived in the alignment of most German speaking practitioners with the criminal justice system, while the French speaking ones choose the side of the patient, in what can be seen as an analogy of the position of both ethics toward the poor and the State. In that perspective, the "Catholic principle of tolerating a lesser evil for the sake of a greater good" (22) seems to justify hiding information to the criminal justice system in order to protect the patient.

Regardless of the causes of these different approaches, mental health professionals face dual loyalty issues in their daily practice. Little is known about the strategies they use to deal with these

conflicts. The aim of this qualitative interview study is to start filling that gap by investigating the way in which Swiss mental health care professionals perceive and resolve the dual loyalty conflict.

Methods

This article follows the "Journal article reporting guidelines" for qualitative research by (23). Further, we follow the recommendation of Tran, Baggio (24) and describe the population at stake with terminologies such as "person with mental health condition living in detention" or "incarcerated person with mental health condition", they are used interchangeably.

Study Design

This qualitative study is part of a larger Swiss-wide research project on mental health of older persons in detention (*'Agequake in Prisons –second part)*. As part of that project, we not only gathered qualitative data from mental health professionals (described below) but also from older incarcerated persons, as well as quantitative information on their mental health condition from medical records and standardized surveys. As older persons in prison are a minority and there is little data on the mental health of this population (25), the overall goal of the qualitative data collection was to gain insights into their experiences on aging in prison, living with a mental disorders, and their perspectives on prison mental health care. As these are complex social processes that we, to date, know little about, we applied an explorative qualitative approach to capture these social phenomena. TW and BE conceptualized the research project. Both have many years of research experience on the topic of older incarcerated persons as well as in employing qualitative methodology (15, 16, 26-28). Two research assistants completing their doctoral education conducted the interviews. They were trained in qualitative data collection and received supervision throughout the data collection process. Ethics approval was obtained from the regional ethics committee (Ethikkommission Nordwest- und Zentralschweiz) and from the local ethics committees.

Data Collection

Face-to-face interviews were conducted between April 2017 and January 2018 with mental health care professionals working with incarcerated persons. We applied convenience and purposive

sampling in order to include opinions from professionals with diverse backgrounds. We included mental health professionals with a background in mental health (psychiatry, psychology, and psychiatric nursing) working with incarcerated patients and a minimum of 10 years work experience. We contacted MHPs working at psychiatric clinics that house forensic units and forensic psychiatric services that provide mental health care to correctional institutions (for more details on the study recruitment procedures, see Table 1). Data analysis was conducted along the on-going data collection. Thus, we were able to identify when data saturation was reached and were able to include more participants if needed. We identified data saturation applying the principles presented by (29); the ability to obtain additional new information has been attained, further coding is no longer feasible, there is enough information to replicate the study.

We completed 31 interviews in the three major language regions (German, French, and Italian speaking). At the time of data analysis, we decided to exclude the two participants from the Italian speaking part of the country since they were not involved in providing mental health care. This resulted in 29 interviews with mental health professionals with experience in the treatment of persons with mental health conditions living in detention. Please see Table 1 for details on the study recruitment process and participant characteristics.

All participants were first contacted via email or phone, then they received information about the study and the informed consent form by email before the interview, and finally they were interviewed personally by the researchers. At the scheduled time and place of the personal interview, the researchers explained again the purpose of the study, specified that all data was treated confidentially and reminded that refusal to participate was possible at any time. Thereafter, written informed consent was obtained. There was no compensation provided for study participation.

An interview guide developed for the purpose of this study guided the discussions with the study participants. The open-ended questions within this interview guide covered topics on mental health care in prisons while specifically probing on role conflicts and dual loyalty issues that are inherent to the position of a mental health care professional providing court-mandated treatments. Opinions on the dual loyalty conflict were additionally encouraged through the use of an elicitation

technique, which consisted in asking the mental health professionals to position themselves using a coin within a triangle that we constructed to represent this conflict (see Figure 1. Elicitation technique on dual loyalty conflict). The use of this triangle graphic reflects the idea of the dual loyalty that they may perceive: (a) between them being agents of the healthcare system towards patients who are mandated to seek therapy, and (b) between their patients and the society (judicial side) (see 1). Therefore, the dual-role conflict is a result of this triangular relationship as the clinician has to take up two roles: treating the patient to ensure his rehabilitation into the community and evaluating the patient's risk to the society, thereby enabling the justice system to continue incarcerating the patient. Both roles come with different sets of norms, which at times, can be contradictory from the perspective of a healthcare personnel. ~~This results in ethical dilemmas, which health professional resolve in daily clinical practice.~~ Further, we did not define our understanding of the triangle to the participants but targeted at eliciting their perception of this triangle. Hereby, we aimed at shedding light into their personal understanding of dual loyalty conflicts and their actions taken from this. They were specifically asked to reflect on inpatient involuntary treatment orders and to separate this from other kinds of mental health treatments with incarcerated persons.

The interviews took place in person and were conducted by two research assistants (either HM or SH). They were trained in qualitative interview techniques and were working on their doctoral degree at the time of interviews. Interviewer and participant met the first time on the day of the interview, thus, there was no relationship prior to data collection. Only one interview meeting took place with each participant and no repeat interview was done. Interviews were held in the language spoken by the participant, either French, German or Swiss German. Thereafter the interviews were transcribed verbatim in the language of the interview, except for Swiss German interviews, which were transcribed in Standard German. Swiss German is a spoken dialect and it is common practice to use Standard German in writing. The interview length ranged from 48 to 90 minutes, with an average of 67 minutes. All interviews were audio-recorded upon the consent of the participant and transcribed verbatim, paying particular attention to the anonymization of the information collected.

Context of court-mandated treatment settings

In light of our analysis, it is important to outline the Swiss correctional context to illustrate potential areas in which mental health professionals might be affected by dual loyalty conflicts.

The Swiss Criminal Code (SCC) distinguishes between custodial sentences and so-called "measures". If the crime stands in connection with a severe mental disorder, a person can be sentenced to a "therapeutic measure" on the basis of a thorough forensic psychiatric assessment (Art. 59 ff. Swiss Criminal Code (SCC)). According to the law, a therapeutic measure can be pronounced only if it can be expected that this sentence will divert the person from committing new offenses related to the mental disorder diagnosed in the assessment. Although responsibility is usually diminished or abolished when the above-mentioned criteria is met, this is not a *sine qua non* condition for the judge to order a therapeutic measure.

Adults can be sentenced to inpatient psychotherapeutic treatment to treat mental health issues (Art. 59 SCC) or substance use disorders (Art. 60 SCC) or outpatient treatment (Art. 63 SCC). A person is sentenced to a security measure (Article 64 SCC) when the mental health illness connected with the crime is considered especially severe and potentially 'untreatable'. In these cases, issues related to treatment remain in the background, the main concern being public safety.

Key differences in relation to mental health care between Swiss custodial sentences and measures are related to placement, treatment, and release conditions. First, persons convicted to a custodial sentence are housed in correctional institutions, which include open and closed regimes. Persons sentenced to inpatient therapeutic measures should be placed in so-called "therapeutic measures centers" or forensic-psychiatric units or institutions. An outpatient therapeutic measure can take place either in the community or in a correctional institution. In reality, they are often placed in ordinary correctional institutions due to the lack of specialized facilities, especially in the French and Italian speaking areas of the country. Second, treatment conditions for persons sentenced to a custodial sentence should follow similar standards as in the community (e.g. in relation to medical confidentiality). Persons sentenced to a measure receive mandatory treatment, which is thus involuntary. Further, medical confidentiality is limited as the authorities expect regular reports on the person's mental condition and therapy progress. Third, persons sentenced to a custodial sentence have

a definite end-date to their imprisonment while a person sentenced to a "measure" has no definite end date. The reason is that even though these measures are time-limited, they can be prolonged repeatedly (with the exception of Art. 60 SCC, which can only be prolonged once). Their release depends on their mental health and their progress in therapy, which includes their risk of reoffending.

Psychotherapy sessions with persons mandated to stationary treatment take place within the institution. The fact that a mental health professional works in prison can be seen as a reason enough for a patient to doubt his or her professional independence. Further, mental health care professionals are through their physical ties in touch with other professionals. Depending on the setting, the extent and types of interactions with other professionals vary. For instance, mental health care professionals working in a forensic-psychiatric institution will be part of the team and in regular exchange. Others who work in a correctional institution might only "come in" for psychotherapy session and might not be part of the team. Their exchange with other prison staff will therefore be to a lesser extent. The treating mental health professionals have to provide at least yearly a report on their patient's mental health and therapy progress to the authorities. Their relation with the authorities might range from sending a written report to the authorities to personal encounters with the person responsible. For instance, in some parts of the German speaking language region, the authorities participate at yearly treatment planning conferences, during which also the patient is also being heard. Thus, dual loyalty conflicts can arise from the interactions with prison staff, the authorities, and other staff subordinated to the judicial system. The nature of these dual loyalty conflicts might differ depending on the type of institution and the specific treatment conditions in each setting.

Current practice of training and specialization of mental health professionals working with court-mandated patients is diverse. Most mental health professionals working in correctional and forensic-psychiatric institutions have a background in general psychiatry and psychotherapy. Further specialized education is often provided on an institutional level. A specialist title can be acquired for forensic psychiatry, psychology, and forensic nursing.

Data Analysis

Data were processed using the software program MAXQDA. Our analysis was framed within the thematic analysis approach (30). In order to build a uniform coding tree, eight interviews were first read and coded together by five project members. This allowed the study team to discuss different nuances that were visible in the data and to reach consensus on the dimensions identified by each code, its name and its definition. Thereafter, three study team members (HM, SH, TW) individually coded all the remaining transcripts and came together to discuss the new codes, solve disagreements, and sorted the final coding tree. All analysis took place in the language of the interviews.

Taking into account the richness of the information collected and the broader scope of the interviews, only coded data related to dual loyalty and the elicitation technique were extracted and examined in this paper. HM carefully read this data segment in its entirety and reanalyzed them according to the purpose of this study. This in-depth examination of one topic was also conducted applying thematic analysis. The results were discussed with all the co-authors. They are presented following to major themes "Where do I align myself? Understanding dual loyalty" and "Solving dual loyalty conflicts and the therapeutic alliance concerns". Both topics are further divided into subthemes, which are the outcome of the researchers' agreement on the key issues relevant to the issue of dual loyalty. In the results below, we use PD to refer to our participants from the German-speaking part and PF represents our participants from the French-speaking part of the country. The quotes presented in the results sections were translated into English after completion of the data analysis. HM translated the codes from the original language into English, the translations were checked by an English native speaker.

Results

Where do I align myself? Understanding dual loyalty

Justice system, health system or both

The elicitation technique was successful in provoking responses linked to dual loyalty conflicts that mental health professionals face while working in court-mandated treatment settings. They found the use of this technique illustrative of their situation: "It's exactly this triangle that you

plotted. Yes, we are part of a triangle…" or "Well, these are of course those fundamental conflicts we deal with in this job.". Participants stated that within this triangle of mutual dependence among the patient, health care providers, and the justice system, nothing works without the other parties involved. The participants described the nature of this interrelatedness somewhat differently.

For instance, a few participants would take up a position in the middle of the triangle because they perceive themselves as accountable towards all players and having to integrate the differing demands. They also characterized the interrelatedness as a work collaboration in which each player has to fulfill his or her role. Another participant also positioned himself in the middle due to his management position, which places him/her as a go-between from the mental health professionals to the justice system: "There in the middle. Committed to all three.". Another stated: "We try to integrate it all as a whole, so that's why I positioned myself in the middle and because we are really working in collaboration.". Elaborating on the position in the middle, one participant explained: "Well, on the one hand you are a representative of the health system, on the other hand you try to be there for the patients and then also again you are working with the justice system and are also part of this system. I think with the middle it is just right.".

The other respondents tended to privilege one of the sides of the triangle and positioned themselves a bit closer to the medical system, the judicial system or the patient. However, the differences in these positions cannot be linked to a particular stance taken. Several interviewees reasoned that they understood themselves as being representatives of the medical system in light of the caregiving role that they had, but inevitably connected with the justice system due to security imperatives and the crime committed by their patient:

> "So I'm part of the medical system, so I'm, uh, I'm integrated into the medical system, I'm paid by the medical system, uh, that's clear, but it's true that when you work in the field of forensics, and that's what it is [...] the specificity of forensics - the judicial field - is not accessory."

> "I'm a player of the health care system, so first of all, I'm going to refer to the system to which I belong. ..., we have to address security imperatives, which are what they are, we can't just do anything, there's the crime which has its place in care taking, which are things that we address."

Others underlined that the justice system is the sponsor that pays for treatment, defines its goals, and provides the framework for the therapeutic setting. For instance, one participant said: "I am commissioned by the judiciary to look after the health of these patients; yes, within the framework of the judicial system." This accountability to the justice system was described as a responsibility to the general population, towards safety of society: "Of course [there is] also an accountability towards third parties, precisely the justice system or somehow also towards the general population." and "It's about protecting the community but, at the same time, protecting the community, the patient is also part of the community." It is relevant for our analysis to point out that the respondents' positions in the triangle were not systematically different between the participants of the two language regions. The only trend was that no French speaking participants positioned him-/herself on the side of the justice system. The majority of participants, however, considered that their job is to care for the mental health of their patients while trying to integrate the demands from all the players involved. This vision was irrespective of the stance they took and the language region they came from. Nevertheless, they considered that the accountability towards the justice system affected their therapeutic practice with the patient because of the security needs that arise when one works in corrections.

Only two participants took extreme positions, and they represent exceptions to the prevailing stance presented above in relation to the conflict between the well-being of the patient and that of the society. One interviewee from the German speaking region positioned himself close to the patient but on the side of the judicial system. This expert described the well-being of the individual as a nice side-effect of the risk-reduction goal. He/she noted that the goal of risk reduction is above the goal of individual well-being: "The main goal is the victim-prevention. If in doing so, the person becomes healthier and happier, then that's all right with us but it is not the declared goal." Another respondent from the French speaking region claimed that the only mandate was to take care of the patient's health.

According to this position, mental health professionals should never give their opinion on safety and security aspects: “The doctor often gives an opinion on aspects that are not medical, [but] he is there to care for the person, he is not there to give an opinion on the dangerousness.”

Situational factors influencing one’s own positioning

Many respondents manifested that it is very important to be aware of the different players, as well as of the influences and demands, in order to deal with the dual loyalty conflict. They considered that it is crucial to have an explicit and clearly communicated standpoint towards the patient, and to be realistic about one’s own role, position, and expectations. Underscoring the challenges of this clear standpoint, one participant noted: “This sometimes causes great difficulties and requires us to be extremely transparent towards everyone. And it requires that we are also realistic towards ourselves/ that we are realistic as well.”

The study participants further reported that professionals working in a correctional context would position themselves towards the justice or the medical system differently than their colleagues. This difference was described as a consequence of the basic conflict that mental health professionals tend to resolve in differing ways.

> “Institutions for court-mandated treatments always fluctuate/oscillate between the [two] poles, am I more on the treatment pole or more on the security pole? This is the kind of tension that we always have to manage and that also tilts, and some employees are more on one side, some more on the other and the professionally demanding [issue] is to practice both: To guarantee sufficient security and to give importance to individual needs of each patient within the scope of the possible.”

Nonetheless, the triangle was depicted as a dynamic model in which one’s own position changes according to situational factors. “Sometimes you are more here, sometimes more there, sometimes more there… But you always have to go back to the middle to look: Where am I positioned?”; “Time and again, there are moments in which you're just kind of swinging, and in limbo.”

Some respondents hesitated when asked to position themselves due to the many possible situations that they would face in their work life. “It’s hard to say because I see the whole, right? It needs everything (8 sec. pause). Yes, you have to… there are so many situations!”. A few participants pointed out that while directly working with the patient, they would position themselves very close to him/her. The justice system would sometimes even slip into the background: “sometimes the side of the authorities gets forgotten because of therapeutic alliance. The skill is to obtain a good therapeutic relationship although you always have to take the authorities into account.”; “For example when I therapeutically work with the patient, then I move here to the patient.” However, whilst writing the report to the justice system, some participants would feel themselves further away, taking a step back from the patient-centered position to be able to assess the patient from an outside perspective. “If, for example, I have to write a report, then I am part of and perceive myself as part of the justice system. There I have to look at the patient from […] outside [the patient-physician relationship].” The same respondent highlighted end-of-life situations as an example of a case in which the justice system becomes less important, as the quality of life and a dignified death of the patient are central.

The burden of dual loyalty

The ethical, but also administrative, burden that dual loyalty poses on the mental health professionals becomes apparent in the following two examples. One respondent expresses his envy towards the chaplains in this way:

> “Sometimes I am a little jealous of them. They can… they do very good work but they don’t have the obligation to document it, they never have to write a therapy report and they are not involved in the triangular relationship – authorities, therapist, patient – that you have with the patients in court-mandated treatments. When we do therapy with patients in court-mandated treatments we are accountable to the authorities. And we have to regularly write therapy reports, the chaplains don’t have to do all that.”

Another respondent pointed out that mental health professionals often feel as being the only ones that the imprisoned patient can trust, even if the latter is aware of their accountability to the justice system.

One interviewee expressed his/her wish of incorporating professionals from institutions with no attachment to the justice system as counselors for the incarcerated persons.

> "That the burden is not born as one-sidedly as we sometimes feel, it would be helpful if there was another player who would then also actively defend the rights [of incarcerated patients] in the sense of an assistance relationship [to the incarcerated patient]."

Solving dual loyalty conflicts and the therapeutic alliance concerns

Motivating the Patient: Seeing the benefits of the treatment and its goals

Study respondents differed in the way they prioritized their two missions of ensuring patient health and protecting public security. They highlighted it as a specific challenge of their work in light of the need to integrate and balance the contradicting demands arising from both missions. Some respondents resolve this conflict by predefining the goal of risk reduction for the patient, stating that it is in the patient's own interest that he/she does not reoffend. Thus, they combine the two missions in a single treatment objective: "It is actually in his interest that he does not produce victims and that he does not do dysfunctional things that harm other people." Noting the same point, another participant put it as:

> "If one is really interested in the patient, in the humanity [issues] which are part of those patient cases, we have to guide them to regain their humanity. That means not commit an offence anymore, diminish the risk of a relapse. And one cannot do this work ignoring the justice system."

These participants accept that their patients will not always agree with that agenda, but they nevertheless try to motivate them insisting on the fact that the treatment is in their own interest and will help them not only to enhance their mental well-being but also to ensure that they are less likely to reoffend. They further pointed out that the mandatory aspect of therapy can often act as an initial means to motivate the patients to participate in the treatment. They consider that, if they manage to build a therapeutic relationship at the beginning, then the mandatory aspects will later occupy a second role, as patients will want to engage in therapy out of their own volition.

> "That strongly depends on the motivation. If a patient says: 'Yes, I know I have a problem, I want to change something' then one can… Once a year one has to write a report, then that works. If someone comes because he is obliged to and [he has] no personal initiative at all, no understanding or something like that, then of course it is extremely difficult to find an alliance, an access in the first place."

Building trust and therapeutic alliance

Irrespective of the positioning within the triangle and the alignment with either the justice or the medical system, all participants agreed that the objectives can only be achieved through the construction of a strong and trustful relationship with the patient. Participants claimed that they have to provide therapy, which is not possible without the patient's collaboration. Respondents also highlighted mental health professionals have to be committed to the patient and show a certain dedication to build trust and a therapeutic alliance. This is succinctly expressed by one participant: "But it is the patient, it is him who is in the centre of everything." Thus, even though the priority of treatment goals may differ, they concurred with a need for a strong therapeutic alliance and underlined that it is not possible to reach any goal without being devoted to the patient. One participant described this point in the following way: "One must not forget the patient. If the therapeutic alliance is not there and the trust is not there – and of course it also needs a certain commitment to the therapy – then one cannot do therapy.".

Furthermore, participants pointed out that a cornerstone in developing an alliance is to win the patients' trust. They stated that patients are generally apprehensive of opening up to them due to their concern about the mental health professionals acting in the interest of the justice system. Their clients would be particularly worried about the mental health professional's assessments and about the limits of medical confidentiality. Participants underlining these fears stated: "…trust in the therapist, that he/she is not just a 'police agent' who may be trying to unmask other crimes. Well, those are the concerns." "Fear of being dependent on the judgement of forensic experts, which is generally always bad with prisoners - this is the prejudice, which is pronounced in court-mandated treatment settings."

Transparency as a technique to establish therapeutic alliance

Several respondents spontaneously pointed out that one of the fundamental questions is whether it is at all possible to establish a therapeutic alliance in the context of a court-mandated treatment.

> "And then, of course, there is always the question of how far it is possible to build up a so-called trusting therapeutic relationship within the framework of a court-mandated treatment, if the patient always knows that the legal system sits breathing down one's neck, and anyway, it is unfavorable for me if I tell during therapy that I had a relapse."

The vast majority of participants emphasised the importance of transparency in order to resolve this conflict. They highlighted that it was crucial to be very clear, realistic, and open about the conditions. This strategy was perceived as being well-appreciated by the patients and also as a main driver in motivating the patient. "We have not only, but mostly made good experiences if we say that honestly at the beginning." "I think this is an essential point to motivate the patients to engage in their therapy. That they understand as well as possible what is actually going on." Transparency was further specified to be different from shared decision making, i.e. the patient will not have the right to decide which information is transmitted to the authorities and which clinical aspects will remain confidential: "So, here knowledge plays a role and transparency, but not a codetermination in what happens with the information." The most common example of being transparent mentioned by the interviewees from both language regions is that mental health professionals should provide the patient with some insight about the report they have to write for the justice system *before* that report is sent off. "We tell him that we will write a report about him, we show it to him when it is written, but he does not choose what goes in." "Here, we have a very open attitude. We also hand over the reports that we write to the prisoners."

Several respondents from the German speaking region stated that on-going feedback and direct feedback towards the patient is important during the entire therapy process, and not only when the report is being written. One respondent even explained that they would include the patient in the

meetings with representatives from the justice system: “And the patient is then also heard in these meetings, about his wishes and ideas”. Another reported:

> “We also constantly say how we perceive it. So, if you think someone sticks to the surface, for example, and doesn't go into depth, then we say it. Not just after a year, when we have to write a report, but constantly.”

Study participants from the French speaking region pointed out that they would only provide a detailed report to the justice system if the patient releases them from their medical confidentiality obligation. However, they would inform the patient about the negative consequences that they might face if they refuse to make the report available.

> “If the patient doesn't authorize us to give the information to the authorities, we simply tell the authorities that we are working with this patient but that he doesn't authorize us to inform them. So that's it. It's negative for the patient, that's how it is. But it's very rare that the patient refuses. Normally they are ok with the fact of informing the authorities. We explain to them that it's really to their advantage.”

Another respondent from the French speaking region gave an example of lack of transparency and the problematic consequences if the patient is not aware from the beginning of the therapy that the mental health professional has the legal and ethical obligation to inform other prison staff of risks such as patient’s propensity to be aggressive.

> “That we have not had the time to warn him, it’s just a question of sequence – if there was a danger, I… I think that we always have to warn the patient ‘listen, there I do not agree; you cannot tell me this, things like that’ finally there is a violence that has surged, it is necessary to work on where this comes from, what is happening, but we cannot let this information remain ‘passive’ – [that is] we cannot be the receptors and be the silent witnesses of a hetero-aggressive risk.”

Overall, participants agree that the specific challenge of their field is to build a trustful therapeutic alliance in spite of the dual loyalty conflict, and that transparency is the key factor to

overcome that challenge. “But it is the special challenge in our job that we nevertheless have to find a good access under these conditions. And this works mainly through transparency, the patients must know exactly what is communicated, when and why”.

Transparency when communicating with representatives of the justice system

In line with this dual loyalty conflict, many interviewees highlighted the importance, but also the challenges, of their exchanges with representatives of the justice system: “The exchange, these interface functions between medicine and justice, are a very central part”. Similarly, another participant noted: “We work together with/around the same people […]. So, it is always important to be able to communicate about the situations. It is a skill to communicate about situations without disclosing medical secrecy”.

The interviewed mental health professionals stated that the dual loyalty conflict makes them face difficult decisions when choosing the kind and the amount of information that they share with colleagues from non-medical professions. They reported that a dilemma was created by their obligation to share important information with other professionals while assuring trust and confidentiality towards the patient. This was highlighted by two participants:

> “This is the dilemma which we are facing when we treat mandated patients that we are not allowed to withhold important information.”

> “Our duty as health professionals is to preserve our working instrument, which is trust, which the patients have in us, if we tell everything to the authorities, we will lose their trust.”

Several respondents insisted on the fact that it was hard to decide which content to pass on and in what detail. This poses a challenge when writing the report for the justice system but also in everyday work life: “Basically, we always have to weigh up which things to report, what goes into the report”. Describing the personal decision-making process in securing to ensure confidentiality, a participant stated: “You have to spend time justifying yourself … you have to be well positioned in your role, it's not always easy because you have duties concerning medical confidentiality. What should we say,

what shouldn't we say, what should or shouldn't we share". Furthermore, another participant, noting the dilemma, added that he/she discusses it with the patient:

> "What is of course a recurring topic is this delicate balancing act with regard to confidentiality. So, how much exchange is there, how much may I say, may I not say, which of course also has to be discussed with the patient".

Several respondents considered that there should be an on-going exchange with the prison staff and that transparent communication with all players was crucial: "This sometimes causes great difficulties and requires us to be extremely transparent. Towards everyone". Others agreed that the information should not contain intimate details in order to protect the privacy of the patient, but it should cover the gist of it.

> "There is some exchange, but there are limits. I personally think it needs the possibility that you exchange without going deep into the content. That I do not say anything about the therapy, but that I say: 'At the moment he is not doing so well, you should have an eye on him'".

Discussion

This qualitative interview study is unique as it addresses the insufficiently researched question of how MHPs working in court-mandated treatment settings perceive and resolve their dual loyalty conflict**.** In doing so, we were able to gather new qualitative data about practical ways used to solve this ethical dilemma. Not surprisingly, our study results indicate that mental health professionals differ in the way they perceive their role, obligations, and responsibilities. These different perceptions were expected in light of the diversity in terms of cultural, social and personal background that characterizes our sample. As pointed out by Niveau and Welle (1), forensic psychiatry is a field of dual ethics, which forces mental health professionals to choose a stance.

From a legal point of view, the problem resides in the fact that mental health professionals are simultaneously caring and controlling. The MHP has the obligation to reveal all *significant* information to the authorities, and this overrides medical confidentiality that characterizes a classical

therapeutic relationship. The crucial question is to define which bits of information are *significant*. Some clinicians consider that all the information must be communicated to the authorities, while others think that communicating the conclusions is sufficient and that details are not required. Our study shows that not only this theoretical difference about the level of detail that must be communicated to make a report credible for judicial authorities, but also situational factors influence the positioning of MHPs and drew them at times either closer to the security or the treatment pole. These theoretical and situational factors affect therapeutic practice in relation to medical confidentiality and also in terms of the definition of treatment goals.

Against our expectations, the positioning of participants from the two language regions did not systematically deviate. Moreover, even when participants' personal standpoints were theoretically different (i.e. some practitioners from the German speaking region stated that they worked for the criminal justice system), in their daily clinical practice the majority of participants showed that they work in the interest of the patient's well-being, while trying to integrate security imperatives. The ethical dilemmas resulting from this conflict convene into questions on how to develop a trustful therapeutic alliance while sharing critical information with representatives of the justice system. The one element that all participants consider essential in promoting a high-quality alliance with the patient was transparent communication.

The importance of transparency is in line with major recommendations on how to solve dual role dilemmas such as the guidelines provided by the American Academy of Psychiatry and the Law (5). However, the responses of our participants show, that being transparent about the limits to confidentiality and the conditions of court-mandated treatment, do not resolve the dual role conflict, per se. However, it might facilitate the development of a therapeutic working alliance in spite of the dual loyalty conflicts. Transparency to establish and maintain the alliance could therefore be as a tool to act as a double agent. As highlighted by Stone (31), when a relationship is established, the client might forget that he/she has been warned about possible dual loyalty. Thus, the perceived burden of this dual-role conflict and ethical dilemmas resulting from it must be solved by the clinician. In light of the lack of practical guidelines, questions remain on, for instance, the degree of completeness of the information that the authorities must receive and other prison staff or how to convince the patient that

the predefined goal is in his/her best interest. This suggests, at least indirectly, that there is a need for more detailed practical guidelines as well as training for clinicians working in this field. Nevertheless, as transparency in relation to the therapeutic alliance was put in the spotlight by our participants, we consider it more closely in the following paragraphs by discussing transparency in relation to (a) building therapeutic alliance; (b) truthful exchanges about treatment goals; (c) building trust with patient; and (d) communication with the justice system.

Transparency was considered valuable not only from an ethical point of view regarding the patients' right to receive all the information concerning him/her; but also from a consequentialist point of view concerning the best therapeutic outcome. Indeed, the therapeutic alliance is significantly linked to positive outcome measures of psychotherapy (32). Little is known about the therapeutic alliance in mandatory treatments, as the majority of research is based on general psychotherapy. Nevertheless, it is assumed that results can be mirrored to the coercive setting as it has been shown that alliance ratings are independent of the patient's legal status (33). A further declaration in this respect is the therapeutic alliance being one of the common factors in psychotherapy that are independent of the technique used (34). The widely used concept of the therapeutic alliance was established by Bordin (35). This trans-theoretical construct comprises three dimensions: Goals, Tasks, and Bonds. Meyer, Hachtel (36) state that the three dimensions are affected in court-mandated treatment settings due to aspects such as the therapists' dual role. However, little is known on the therapists' strategies to resolve these influences in daily practice (37).

Transparency, besides its ethical value, is also the prerequisite to truthful exchanges about treatment goals; therefore, it is also associated with improved therapeutic relationships and positive treatment outcomes. Mutual agreement on treatment goals is highlighted as one of the key factors in developing and maintaining a therapeutic relationship between patient and therapist (35). Mandatory treatments add a unique challenge: The majority of the study participants agreed that the involvement of the justice systems brings along a predefined treatment goal: the prevention of recidivism. Hence, the patient is forced into a psychotherapeutic and psychiatric treatment with a goal imposed by a third party. Respondents used two approaches to resolve the conflict of facing a pre-defined treatment goal.

First, realizing that it is not possible to develop treatment objectives jointly between the patient and the therapist without external influence, the strategy privileged by the practitioners of our sample is to try to convince the patient of the benefits of the predefined goal, that is, to see the advantages of not committing another offence. This means that they try to motivate patients to accept the treatment objective in order to resolve their dual loyalty conflict. Some authors have argued that the agreement on therapeutic tasks and objectives is of minor importance in mandatory settings because the main goal of the inmate is to recover his/her freedom (36).

Second, the majority of all respondents stressed their role in caretaking and focused on their patient's well-being. This attitude is in accordance with the recent paradigm shift towards greater integration of strengths-based approaches to increase the effectiveness of treatment (38, 39). In line with this, MHPs' psychotherapeutic techniques emphasize, next to risk management, also the patient's individual needs, protective factors, and personal strengths – thus respecting their autonomy (40). With regard to treatment goals and the therapeutic relationship, although the overall objective is pre-defined, the path to reach this goal is negotiated. Thus, tasks and sub-goals are mutually developed and agreed upon.

Furthermore, transparency is a crucial factor for building trust with the patient. Trustworthiness has been depicted as a therapist characteristic that promotes strong rapport building with clients and that can be complemented through the application of a series of techniques that convey trust (32, 41). Patients' trust in their treating therapist is positively linked to health outcome measures and has therefore been described as one of the foundations of effective treatment in health care (42).

Medical confidentiality ensures trust and protects the patients' private sphere (15). However, confidentiality in court-mandated settings is limited, and that threatens the patient's trust. Mistrust was described as a key issue when working with mandated patients by numerous study participants. They concurred that the main and most important tool to build trust and to develop a therapeutic alliance was transparency. Most participants stated to be very clear, realistic, and open about the conditions of mandated treatments as well as of the limits to medical confidentiality. They emphasized the importance of constant feedback and authentic communication with the patients. Professionals in the

field of forensic psychiatry have underlined the importance of transparency regarding the conditions of limited confidentiality (17, 38, 43) which has also been recommended by "Ethical Guidelines for the Practice of Forensic Psychiatry» provided by the American Academy of Psychiatry and the Law (5). Empirical research substantiates that it is crucial to be open about the MHP's dual role in treatment and control (8, 37). Our findings are therefore in line with previous research and provide further evidence that transparency is a key factor to develop a therapeutic alliance in coercive treatment settings.

Transparency when communicating with representatives of the justice system was also underlined as key element by the study participants. However, in this case the main challenge is to decide whether to share all the information available or only the gist of it, leaving aside the details. Participants argued that it is crucial to protect the privacy of the patient but also to consider security aspects and to prevent risks for prison staff. It was perceived as particularly challenging to decide what piece of information to share while trying to integrate and balance the contradicting demands arising from both objectives, patient health and public safety. This leads to an ethical dilemma that clinicians have to resolve in their daily practice, when they are confronted to situations in which the have to prioritize one over the other. The lack of guidelines on how mental health professionals should breach confidentiality in specific situations has been highlighted previously (44) and our interviews corroborate its importance. It is not surprising to see that the members of our sample perceive this as burdensome and resolve these conflicts differently in the absence of such practical guidelines.

Taken together, our findings suggest that dual role conflicts in court-mandated treatment settings are still a pressing issue for mental health professionals. Based on our findings, it is too early to provide specific recommendations for clinical practice. However, we believe that this bottom-up approach has the potential to identify typical situations that result from the dual-role dilemma, based on which practical guidelines could be developed. On an institutional level, we therefore recommend to follow, for instance, the "moral acquaintance procedure" proposed by Ward and Ward (45). This approach aims at delivering concrete procedures for dealing with dual role conflicts in practice. This way, we could advance our knowledge and awareness on dual loyalty conflicts, stimulate the

discussion on possible strategies to resolve ethical dilemmas, and support the individual practitioner in their decision-making.

Limitations

We applied a qualitative study design that is of an explorative nature and we recruited our sample through convenience sampling. Moreover, the sample comes from a single country (Switzerland) and consists of mental health professionals that work with mandated patients in closed settings, consisting mainly in prisons, forensic, and therapeutic units. These facts threaten the internal and external validity of our results.

In terms of internal validity, a convenience sample means that the stakeholders that were interested in participating might have had a specific set of opinions that influenced the study results. One can never exclude the influence of the institutional regulations and cultural mindsets that prevail in their environment. Similarly, they might have had advanced opinions about what is correct and socially acceptable for a person in their position. Following the classis rules for research of this kind, we tried to limit the influence of social desirability by assuring anonymity and confidentiality.

Further, the mental health professionals interviewed work in different treatment environments including prisons, therapeutic measure centers, and forensic-psychiatric units. The work and treatment conditions therefore vary with the setting, which potentially influence the experiences of dual loyalty conflicts. This might have caused some heterogeneity in the participants' responses. However, the treatment settings within Switzerland differ widely, even for persons living with similar mental health conditions sentenced under the same article. One reasons for this is criminal law being national law but the execution of sentences being under the responsibility of the individual states. The organization of the institutions is consequently very different across the country. For instance, the French speaking language region lacks places in forensic-psychiatric hospitals. Mentally ill persons sentenced to a therapeutic measure are therefore more frequently placed in correctional institutions compared to the German speaking region. Furthermore, the healthcare in prisons of the French speaking region is under the responsibility of the health department while some health services in the German speaking region

are under the responsibility of the justice department. Thus, to capture the variety of experiences on dual loyalty conflicts in Swiss psychotherapeutic treatment settings, we decided to include mental health professionals who work in all different types of settings.

In terms of external validity, the results cannot be directly generalized to other countries and other settings. It must be mentioned, however that the study covers two different linguistic and cultural regions, which pleads for some possibility of generalization. More difficult is to establish whether the findings in the specific setting studied can be transposed to countries where the organization of mental health care and the basic conditions of treatment are diverse, which is often the case even within the same country. However, the ethical dilemmas and the daily clinical decision-making for practitioners working in closed-settings are rather universal, which pleads for at least a limited use of our results for studies conducted in that kind of setting or with involuntary treatment orders in general.

Finally, the mental health professionals' triangular relationship has implications on multiple dimensions. Our study participants elaborated mainly on topics such as therapy goals and limited confidentiality in involuntary treatment orders. However, other situations such as mental health professionals acting as expert witness at court, or being directly involved in the application of punitive measures, have not been addressed by our participants because they were not the subject of this study. Other topics such as the involvement in custodial activities or the use of sedatives for security reasons has not been the focus of our participants' responses. Further research should investigate the clinicians' decision-making processes in other circumstances in which they are affected by dual loyalty conflicts.

Conclusions

Mental health professionals working in court-mandated treatment settings are obliged to resolve ethical dilemmas in their daily practice. Transparency seems to be the crucial factor when communicating with the patient and with representatives of the justice system. More specifically, patients need to be informed from the beginning of therapy about limits to confidentiality. It is also recommended to develop guidelines that define the level of detailed information that should be

disclosed when communicating with the authorities of the justice system. The study findings show that there are certain techniques and approaches that are applied by the majority of mental health professionals working with mandated clients, and that these techniques and approaches are independent of the side taken in the ethical conflict known as dual loyalty within forensic psychiatry. We therefore call for more research on common factors of psychotherapy in court-mandated settings to advance guidelines that support clinicians in their daily decision-making. This would alleviate the burden that is posed on mental health professionals by the dual loyalty conflict and is therefore of utmost importance for clinical practice.

Abbreviations

MHP = mental health professional

Declarations

Ethics approval and consent to participate

The Ethics Commission of Northwest and Central Switzerland (EKNZ) approved this study: Project ID: 2016-01793, Agequake in prisons - second part: Mental health care and forensic evaluation of aging prisoners and persons serving security measures in Switzerland. Prison directors and chief of health services of participating institutions gave permission to our research project. All participants provided written consent before participating in this study.

Consent for publication

Not applicable

Availability of data and materials

The dataset analysed during the current study is not publicly available. Our analysis is based on qualitative interviews with mental health care professionals working in the forensic context. The individual privacy of our study participants would be compromised if we shared the whole transcripts

publicly. However, we can share the parts of the transcripts relevant for this paper upon reasonable request.

Competing interests

The authors declare they have no competing interests.

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Authors' contributions

HM and SH contributed to data collection and analysis. HM further drafted the first version of the manuscript and improved the different draft based on the co-authors comments and suggestions. AE, MA, and EH provided substantial contributions by examining the results presented in draft versions and revised the work. BE provided substantial contributions to the study conception and revision of the work. TW made substantial contributions to the study conception, data analysis, and revision of the work. All authors agree to the final draft of the paper submitted and take responsibility for its content.

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Figures and Tables

Figure1: Elicitation technique

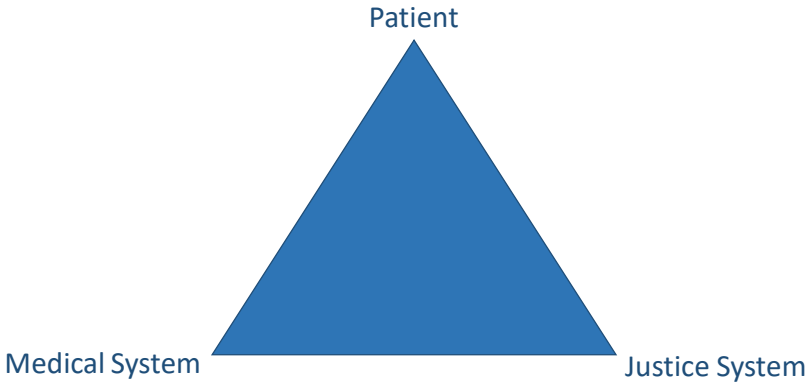

Table1: Participant characteristics

			German speaking language region	French speaking language region	Italian speaking language region	Total
Recruitment scheme	Mental health professionals **invited** for participation		N = 35	N = 31	N = 2	N = 68
	Mental health professionals **declined**		N = 19	N = 18	N = 0	N = 37
	Mental health professionals **participated**		N = 16	N = 13	N = 2	N = 31
						Response Rate: 45.6%
Participant characteristics (N=29; 2 excluded from analysis)	**Sex**	Female	N = 3	N = 4	excluded from analysis	N =7
		Male	N = 13	N = 7		N = 22
	Professional Background	Psychology	N = 5	N = 1		N = 6
		Psychiatry	N = 11	N = 6		N = 17
		Psychiatric nursing	N = 0	N = 6		N = 6
	Institutional Context	Forensic-Psychiatric Institutions	4	1		N = 5
		Psychiatric-Psychological Services	6	3		N = 9

4.2.2. Court-mandated patients' perspectives on the psychotherapist's dual loyalty conflict – between ally and enemy

Full citation:
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Abstract

Background: Mental health professionals working in correctional contexts engage a double role to care and control. This dual loyalty conflict has repeatedly been criticized to impede the development of a high-quality alliance. As therapeutic alliance is a robust predictor of outcome measures of psychotherapy, it is essential to investigate the effects of this ethical dilemma. ***Methods:*** This qualitative interview study investigates patients' perceptions of their therapists' dual role conflict in court-mandated treatment settings. We interviewed 41 older offenders using a semi-structured interview guide, the interviews were subsequently analyzed following thematic analysis. ***Results:*** We first present the patients' perceptions of their treating psychotherapist's dual loyalty conflict, which was linked to their overall treatment experience. In a second step, we outline the study participants' reasons for this judgement, which were most commonly linked to feelings of trust or betrayal. More specifically, they named certain therapist characteristics and activities that enabled them to develop a trustful therapeutic alliance, which we grouped into four topics: 1) Respecting the patient's pace and perceived coercion; 2) Patient health needs to be first priority; 3) Clarity in roles and responsibilities; and 4) The art of communication – between transparency and unchecked information sharing. ***Discussion:*** Developing a high quality alliance in mandatory offender treatment is central due to its relationship with recovery and desistance. Our findings show that some therapists' characteristics and activities attenuate the negative impact of their double role on the development and maintenance of the alliance. To increase the effectiveness of court-mandated treatments, we need to support clinicians in dealing with their dual role to allow the formation of a high quality therapeutic alliance. Our qualitative interview study contributed to this much-needed empirical research on therapist' characteristics promoting a trustful relationship in correctional settings.

Introduction

The goal of court-mandated treatment orders is to reduce the risk of recidivism in mentally ill persons in detention (Dowling et al., 2018). It is therefore crucial to enhance effectiveness of these interventions to protect the society. However, psychological practice in correctional settings is criticized for not meeting the standards of evidence-based practice, amongst others, due to the dual loyalty conflict (Gannon & Ward, 2014; Goulet et al., 2019). The therapists' dual role when treating an incarcerated person, to provide care and at the same time to control, challenges the development of a high-quality therapeutic alliance with the patient (Cervantes & Hanson, 2013; Wittouck & Vander Beken, 2019). As therapeutic alliance is a robust predictor of outcome measures of psychotherapy (Fluckiger et al., 2018; Fluckiger et al., 2015; Horvath et al., 2011; Martin et al., 2000), it is essential to investigate the influence of the therapist's dual role on the alliance to reach the goal of court-mandated treatment orders.

The therapeutic alliance is one of the common factors of psychotherapeutic practice overarching different techniques (Horvath, 2018; Mulder et al., 2017). It can therefore be assumed that this therapeutic element is likewise important in therapy with persons who are incarcerated (Blasko et al., 2018). The greatest differences in the quality of the alliance have been attributed to therapists' contributions (Ackerman & Hilsenroth, 2003; Baldwin et al., 2007; Del Re et al., 2012). For instance, therapists' abilities to display genuineness and empathy are strong moderators of the alliance-outcome relationship (Nienhuis et al., 2018). However, it is unclear how specific circumstances and institutions influence the processes of developing and managing such an alliance (Fluckiger et al., 2015; Horvath, 2018). Correctional settings come with specific challenges and characteristics to treatment (Meyer et al., 2019) such as handling limited confidentiality during interactions with representatives of the justice system (e.g. therapists have to provide a report on a person's treatment progress and the risk of further offending) or being asked to manage risk and restrictions posed on this population (e.g. privileges are granted and revoked by legal authorities, however, these decisions may be based on therapists assessment on the therapy progress) (Dowling et al., 2018). This requiresadditional skills specific to this environment to create a therapeutic alliance with their clients.

Mental health professionals face loyalty conflicts when working in a correctional context (Cervantes & Hanson, 2013; Magaletta et al., 2007). As representatives of the mental health care system working with patients within the justice system, they need to balance individual patient's well-being against others' safety (Goulet et al., 2019). Based on international standards, mental health care in prisons should be under the authority of the ministry/department of health instead of under the ministry/department of justice. This for reasons of improving quality of health care in prisons but also to enhance public health in general (see Coyle, 2014). In reality, this standard is often not implemented and many services are still affiliated with the justice department with the consequence

that it is often under shared responsibility of both the health and the justice system (Salize & Dressing, 2008). Pont et al. (2012) further argue that health care professionals who are directly employed by the justice system face a stronger dual loyalty conflict. Switzerland is a particularly interesting country in this sense, as the French speaking region mainly employs their mental health care professionals through the public health care system while some German speaking region employs these professionals more frequently via the justice system. The strength of the subjectively experienced dual loyalty conflict and pressure put on health personnel by the justice system might therefore differ between the two language regions. Empirical evidence supporting this hypothesis is lacking.

Nevertheless, the tension arising from these differing goals, care versus control, reveals itself in the therapeutic alliance, most dominantly regarding coercion and medical confidentiality (Wittouck & Vander Beken, 2019). Some authors have argued that it is crucial how the client perceives coercion and the exercise of power by the therapist. Studies have shown that perceived coercion is negatively correlated with patient ratings of therapeutic alliance (Manchak et al., 2014; Sheehan & Burns, 2011). At the same time, others noted that legal coercion cannot be equated with perceived coercion as there is different sources of coercion (Hachtel et al., 2019; Urbanoski, 2010). Social pressures can also arise through informal (family and friends) or formal (e.g. employer) influences. Further, the relation between these "objective" measures and perceived coercion to enter and participate in treatment is unclear (Prendergast et al., 2009; Wild, 2006). Suggesting that other factors are intermediary to the way coercion is perceived on patient's side. In the same line, Höfer et al. (2015) revealed that alliance ratings were independent of the patient's legal status (i.e. general psychiatry wards and forensic units). Hachtel et al. (2019) provide an explanation for this phenomenon and argue that the quality of the relationship might be closely linked to the level of perceived coercion. However, it is unclear which and how specific therapist activities influence coercion and alleviate the impact of the dual loyalty conflict on the therapeutic alliance.

Previous research in correctional psychology highlights the importance of transparency regarding the therapist's role in risk management (Dowling et al., 2018; Merkt et al., 2021), perceived coercion (Hotzy & Jaeger, 2016) as well as in relation to limits to confidentiality (Elger et al., 2015a, 2015b; Gannon & Ward, 2014). Others have emphasized that a collaborative but directive style was beneficial (Blasko et al., 2018; Jeglic & Katsman, 2018; Meyer et al., 2019; Ross et al., 2008) while a harsh confrontational and authoritarian style was negatively linked to alliance measures (Marshall & Serran, 2004; Meyer et al., 2019). Wittouck and Vander Beken (2019) proposed that these preliminary findings could be subsumed under the procedural justice theory. According to their approach, therapists who follow the six principles of fairness, voice, validation, respect, motivation (or trust), and information are able to reconcile care and control. However, empirical evidence on the therapeutic alliance in offender therapy that could support this approach is still scant (Blasko et al., 2018; Polaschek & Ross, 2010; Ross et al., 2008; Skeem et al., 2007).

Lastly, the older population is drastically rising within correctional settings (Luallen & Cutler, 2017). They comprise a population of high somatic and mental health needs and therefore considerably impact on health care services (Di Lorito et al., 2018; Fazel & Baillargeon, 2011; Fazel et al., 2006; Fazel & Seewald, 2012). In the Swiss context, the rising number of older persons in forensic settings is mainly fed by persons mandated to treatment. That is, the number of older persons sentenced to mandated treatment (e.g. under Art. 59 Swiss Criminal Code (SCC)) comprised 8.7% in 1999 and rose to 17.8% in 2019 (Bundesamt für Statistik, 2020a). In contrast, within the same time period, the number of persons over the age of 49 sentenced to a custodial sentence rose only from 8 % to 9.5% (Bundesamt für Statistik, 2020b). They are therefore a population that requires intensive resources from the forensic mental health services but the data to guide treatment planning for this specific group is scarce (Williams et al., 2012). Some authors have highlighted that there are particular challenges in the psychotherapeutic practice with this aging population such as the changing perspectives towards past crimes due to the little life time remaining or fear of dying in prison (Avieli, 2020). It is therefore important to shed light into the treatment experiences and needs of older persons who are legally-referred to involuntary treatment. Our qualitative interview study fills an important gap by investigating older patients' perceptions of their therapists' dual role conflict in court-mandated treatment settings and thereby contributes to much-needed alliance research in therapy with incarcerated persons.

Materials and Methods

This qualitative article follows the "Journal article reporting guidelines" for qualitative research by (Levitt et al., 2018), which incorporates qualitative studies reporting guidelines such as COREQ-32 **(Tong et al., 2007)**.

Study Design

This qualitative study is part of a larger Swiss-wide research project on aging experiences and mental health of older persons living in detention ('Agequake in Prisons 2'). As part of the larger project, we not only gathered qualitative data from older persons in prison (described below) but also professional stakeholders, and quantitative information on older persons' mental health condition from medical records and standardized surveys. As older persons in prison are a minority and there is relatively little data on the mental health of this population (Moschetti et al., 2015), the overall goal of the qualitative data collection was to gain insights into their experiences on aging in prison, living with a mental disorders, and their perspectives on prison mental health care. As these are complex social processes that we, to date, know little about, we applied an explorative qualitative approach to capture these social phenomena. Further, as this larger research project covered multiple issues addressing several

specific research questions, only a portion of the results relevant for this paper are presented here. Namely, the participants' perceptions of their therapists' dual role conflict. (Please see our other publications for more findings from our research project (e.g. (Haesen et al., 2021; Merkt et al., 2021).

TW and BE conceptualized the research project. Both have many years of research experience on the topic of older persons living in detention as well as in employing qualitative methodology (Elger et al., 2015a, 2015b; Wangmo, Hauri, et al., 2016; Wangmo et al., 2015; Wangmo, Meyer, et al., 2016). Two research assistants completing their doctoral education conducted the interviews, out of which one was HM. They were trained in qualitative data collection and received supervision throughout the data collection process. Ethics approval was obtained from the regional ethics committee (Ethikkommission Nordwest- und Zentralschweiz) which was followed by other local ethics committees. On the topic of dual loyalty, a manuscript delineating the perspective of stakeholders has been written (Merkt et al., 2021).

Data Collection

Face-to-face interviews were conducted between December 2017 and December 2018 with persons receiving mental health care in Swiss correctional institutions. The inclusion criteria were (1) person sentenced to prison confinement, (2) age 50 years and older, and (3) at least one contact with mental health services. Exclusion criteria were (1) mental state too instable, and (2) prison administration does not allow the person to participate (e.g. due to dangerousness or solitary confinement). The age cut-off 50 was applied for reasons of accelerated aging, that is, persons living in detention tend to depict poorer health status at a younger age when compared to persons of similar age group in the community (Combalbert et al., 2016; Di Lorito et al., 2018; Fazel et al., 2001; Greene et al., 2018; Hayes et al., 2012; Loeb et al., 2008; Merkt et al., 2020).

We included participants from institutions that housed adults sentenced to long-term imprisonment (please see section 2.3 for information on the Swiss legal context and type of settings). We excluded correctional institutions that housed juvenile or remand prisoners exclusively as well as administrative detention centers (centers housing migrants for deportation). Further, psychiatric, therapeutic, and penal institutions from the two major language regions (French and German speaking) were included, the Italian speaking language region was excluded.

All participants were contacted either through the prison administration or the mental health service. We do not know the refusal rates, as participants were recruited through our contact persons in the participating correctional institutions and the internal recruiting processes differed. Study information and informed consent was previously handed out to the participants by our contact person in those settings. At the scheduled time and place of the interview, the researchers explained the purpose of the study, clarified that all data was treated confidentially, and that refusal was possible at all times.

Thereafter, written informed consent was obtained. There was no compensation provided for study participation. When the time of the interview interfered with the participant's work time, the correctional institution organized monetary substitution for the lost work hours.

The interviews with the study participants were semi-structured and followed an interview guide specifically developed for the purpose of this study. The open-ended questions within this interview guide covered topics on (a) personal circumstances and social networks, (b) experience of aging in the prison context (e.g. relationship with younger persons in detention, satisfaction with work and free time activities offered, perception of prison environment, future plans (during and after imprisonment)), (c) access to and quality of mental health care (e.g. types of interventions, frequency and duration of treatments), (d) satisfaction with mental health care (specific aspects of the intervention that helped/impeded therapy progress), (e) mental well-being (e.g. perception of their current mental well-being, questions on possible stigma due to mental health issues), and (f) experiences with risk assessments.

Thoughts on the dual loyalty conflict were encouraged through the use of an elicitation technique. Elicitation techniques are visualisation tasks that are particularly useful to inquire contents and topics that are difficult to inquire with direct explicit interview questions such as abstract concepts or controversial topics. They are used to facilitate the conversation on the topic of interest, to provoke the expression of ideas, views, or values (Barton, 2015; Copeland & Agosto, 2012). We asked participants to position their mental health professional using a coin within a triangle that represented the dual loyalty conflict. More precisely, at a certain stage during the interview, we presented the paper with the triangle graphic (see Figure2 to 4 for examples) and passed a coin to the participant, asking them to position the MHP within it. We used this positioning task as a starting point to facilitate the conversation on their experiences with their MHP's dual role. Thus, we did not explain our understanding of the triangle to the participant but used it to inquire the participants' understanding of the MHP's dual role. Out of the 41 participants, two participants did not complete the elicitation technique for personal reasons.

Interviewer and participant met the first time on the day of the interview, thus, there was no relationship prior to data collection. Only one interview meeting took place with each participant and no repeat interview was done. All interviews were audio-recorded upon the written informed consent of the participant. Field notes were taken after each interview. Interviews were held in the language spoken by the participant, either French, English, German or Swiss German. Thereafter the interviews were transcribed verbatim in the language of the interview, except for Swiss German interviews, which were transcribed in Standard German. Swiss German is a spoken dialect and it is common practice to use Standard German in writing. The interviews were checked for the quality and accuracy

of the transcriptions, during which identifying information were anonymized. Interview transcripts were not returned to the participants for checking.

In total, we conducted 57 interviews, of which seven were excluded mostly due to poor data quality. We based our decision to stop data collection on the principle of data saturation. We identified data saturation when the ability to obtain no additional new information has been attained, further new code is no longer feasible, and there is enough information to replicate the study (Fusch & Ness, 2015). To be able to identify when data saturation was reached for each linguistic region, we conducted data analysis along the on-going data collection and were therefore able to include more participants if needed.

From the total usable data corpus of 50 interviews, 9 interviewees were excluded for the data analysis for this specific manuscript because they were receiving mental health care but were sentenced to a penal sentence (please see further explanation of differences between "measures" and "penalties" in the section 2.3 below). Some regulations in regards to mental health care apply for persons sentenced under measures and penalties. For instance, during the treatment of a persons sentenced to a penalty, the regular medical confidentiality applies while confidentiality is limited in the treatment of a person sentenced to a measure. See table 1 for more details on participants' characteristics.

Context information

The Swiss Criminal Code (SCC) regulates penal law on a national level, sanctions that are imposed for certain crimes are therefore similar across the nation. However, the imposition of sentences is regulated on a federal level. Each state (canton) orchestrates the precise execution of the sentences. Thus, some aspects will vary on a cantonal level such as the settings and placement of mentally ill persons (Fink, 2018). This being said, we will first depict some important differences in the Swiss Criminal Code, which are important in light of our analysis. In a second step, we will briefly outline the characteristics of the settings, in which incarcerated persons are housed, which has implications for the mental health care received.

The Swiss criminal code distinguishes between penalties (Strafen) and measures (Massnahmen). Measures can be imposed when penalty alone is not sufficient to counter the risk of further offending and the offender requires treatment or treatment is required in the interest of public safety (SCC). To impose a measure, the court bases its decision on an expert assessment which comprises estimations of (a) the necessity and the prospects of success of any treatment of the offender; (b) the nature and the probability of possible additional offences; and (c) the ways in which the measure may be implemented. Measures are reassessed at regular time intervals and release is granted based on the fulfillment of the requirements of the parole boards and the risk for further felonies. For all measures,

criminal responsibility can be diminished, however, it is not a *sine qua non* condition for the judge to impose a therapeutic measure.

In our sample, we included persons sentenced to measures under Art. 59 (in-patient therapeutic measures), Art. 63 (out-patient treatment), and Art. 64 (indefinite incarceration). The basic conditions outlined in the previous paragraph concern all measures while certain aspects are specific to each type. For instance, Art. 59 and 63 can be ordered if the person suffers from a severe mental disorder that stands in direct connection with the crime committed and it is expected that the measure will reduce the risk to reoffend. Art. 59 requires the person to be incarcerated while a person sentenced under Art. 63 receives ambulatory mandatory treatment. They can either live in the community or be placed in a correctional institution due to an additional penalty. We included only persons that were incarcerated at the time of data collection.

Art. 64 can be imposed on a person who committed a crime comprising another person's integrity (e.g. sexual offenses, murder). The person suffers from a permanent or long-term mental disorder of considerable gravity that was a factor in the offence and it is seriously expected that the offender will reoffend. In such cases, ordering of a measure in accordance with Article 59 does not promise any success, resulting in sentencing under Article 64 SCC. Persons under indefinite incarceration do not have to undergo psychotherapeutic treatment. However, to have any prospect of release, the person has to receive psychotherapeutic treatment, of which content and progress is also reported to the authorities. The authorities can modify the indefinite incarceration to a measure under Art. 59-61 based on these evaluations. Therefore, if a person sentenced under Art. 64 receives mental health care, MHPs have to report to the authorities if the content is of importance to the authorities decision-making process. In our sample, we included persons sentenced under Art. 64 only if they received mental health care.

Concerning the therapeutic settings, in-patient treatment of a measure should ideally be carried out in a psychiatric or therapeutic institution. However, the person can also be incarcerated in a penal institution given that therapeutic treatment can be provided by specialist staff (e.g. forensic psychotherapists and psychiatrists). The treatment provided will depend on the placement of the person (including the orientation of the institution and the MHP) but also on the type of offense committed and mental health condition. It is therefore not possible to characterise the types of therapies, that our participants received, in detail. However, it can be said, that in practice, most persons sentenced to measures will at a minimum receive individual psychotherapy sessions at a regular interval (e.g. weekly, biweekly, or monthly). Others additionally receive group therapy and some treatment units might foster a therapeutic encounter throughout the day. The type of institution will not give a reliable account of the treatment provided, as for instance, intense therapeutic treatment

units are also available in some penal institutions (see (Brägger, 2014) for an overview on placement options for persons sentenced under a measure).

Data Analysis

The software program MAXQDA was used to support and manage data analysis processes. To build a uniform coding tree for the entire project, eight interviews were first read and coded together by five project members. This allowed the study team to discuss different nuances that are visible in the data and to agree on how to name different codes, and what the codes mean in case of complex code names. Thereafter, three study team members (FP, TW, HM) individually coded all the remaining transcripts and came together to discuss the new codes, solve disagreements, and sorted the final coding tree. During the entire process, the analysis followed thematic analysis (Braun & Clarke, 2006).

In light of the richness of the data and the broad scope of the interviews carried out for the project, coded data related to dual loyalty and the elicitation technique were extracted and examined in-depth for this paper. That is, HM carefully read this sorted data segments in its entirety, re-examined the codes applied to this data extract, and further analyzed them with the study purpose as the focal point. This in-depth analysis on one topic also followed thematic analysis and two major themes were evident "*The perception of the dual loyalty conflict*" and "*Developing a trustful relationship to address dual loyalty conflicts*". Examples of coded quotations were chosen by HM and TW to illustrate the below presented themes. HM translated the codes from the original language into English, the translations were checked by an English native speaker. All authors agreed to the results presented in this paper and its interpretation.

Results

See figure 1 for an overview of the below presented topics.

The perception of the dual loyalty conflict

All study participants positioned their psychotherapist on the triangle indicating that they were aware of the mental health professionals' dual role in this setting. Their experiences with psychotherapeutic treatments were very diverse with responses ranging from being highly dissatisfied resulting in treatment discontinuation to highly satisfied and thereby the wish for more therapy sessions.

> "What I would like most is not just to go to therapy once a week, but preferably twice a week. Or longer, the session". (D414)

> “I consider him very close to me. Anyway, [Name of psychiatrist] that I've had so far, he's/he's very good, yes.” (F446)

> “And I have often discussed this with the woman [name of the therapist]. Where it was about that I would break off my therapy and so on. That I said: How/ I can't understand that she can stand behind the system. Then afterwards she says that this is her job and to bring the people here so far and that simply at the expense of things that shouldn't be.” (D429)

From our data, this variability in treatment satisfaction was mirrored in participants’ positioning of their therapists on the “triangle graphic” and reflected their overall evaluation of the intervention. Participants’ negative experiences were accompanied by therapists’ positioning close to the justice system (see as an example Figure 2). Conversely, their positive experiences were linked to therapists being positioned on the patient side, the medical side, and in the middle of the triangle (see as an example Figure 3, 4, and 5).

It is relevant for our analysis to point out that the respondents’ positioning of their treating mental health professional in the triangle did not systematically deviate between the participants from both language regions or between types of institutions. Treatment satisfaction and the perception of the dual loyalty conflict did not depend on the language region, in which the participants were imprisoned. Responses neither differed based on the participant’s placement in a psychiatric or penal institution.

Developing a trustful relationship to address the dual loyalty conflict

Participants were asked to describe their reasons for the positioning of their therapist and for characterizing the therapy as an overall beneficial or rather as an adverse experience. The reasons provided were based on whether the participants felt that they could trust the therapist or whether they felt betrayed by the therapist. For instance, the following participant (who positioned his therapist close to himself) stated that at that moment he was happy with the progress of his therapy (positive overall evaluation) and shortly thereafter emphasizes that he gained trust in his therapist, which he did not consider as an easy process:

> “I: Close to you? Right now? P: Yes. Because, it's going really well now, (...) I've gained a good, uh yes, trust too, somehow to the therapist, which is not always easy.” (D405)

The majority of participants who positioned the therapist close to themselves mentioned that it was because they trusted their therapist, as succinctly phrased by participant D438**:** “We have a professional distance, indeed, but it is very close in terms of trust.” A few respondents even described their therapist as the only person within prison walls whom they relied on, describing their therapist as their sole safety net during imprisonment. F409 stated: “She's the only person here in the facility that I

can really open up to because there's no one else whatsoever." In contrast, the majority of respondents, who positioned the mental health professional close to the justice system, linked it to a lack of trust:

> "He may not be happy [to hear this] but he's closer to the justice. I: And why do you say he might not be happy? P: No, because it could be a lack of trust but... yes he knows that! (...) Well, I always said he had two hats on, he has the psychiatrist's hat plus the one of justice! So, (…) since he's responsible for the prison thing, I'm a little bit suspicious of him anyway." (F441)

Several other respondents, who positioned their therapist close to the justice system, reasoned that they had the impression the therapist would work against them. For instance, they expressed the feeling that the psychotherapist was searching for reasons to keep them imprisoned and that anything they said might be used against them: "So it actually does worry me that something I say to them will come back and be used against me." (F412).

> "Because he didn't engage with me properly, I consider him an enemy. He was an enemy to me. Who just makes sure that I stay locked up and stay locked up and stay locked up, right?" (D438)

When we asked participants what made them trust or mistrust their therapist, prompting for more specific explanations, they named certain therapist characteristics and strategies that influenced the development of a trustful relationship. These subtopics, that resulted from inquiring on the perception of their therapist's dual loyalty conflict, are all related to the development and maintenance of the therapeutic alliance, which we grouped into four themes: 1) Respecting the patient's pace and perceived coercion; 2) Patient health needs to be first priority; 3) Clarity in roles and responsibilities; and 4) The art of communication – between transparency and unchecked information sharing

Respecting the patient's pace and perceived coercion

Several participants noted that they showed resistance at first and that it took a lot of time to gain trust in their treating therapist. Some said it took a few weeks, others indicated it took three to six months. Overall, many stated that they needed time to get to know each other, as outlined by the following participant:

> "It took about half a year to get there. We had to get to know each other first and uh, yes, have certain conversations, observe, or yes. And also, I had to see, if I/ if I address something now, how does she react? How does she behave?" **(**D438)

Several respondents further elaborated that it was central to have a sense of control over the situation and that they themselves were the pacemakers of therapy progression. One participants described this as the therapist trying to approach him/her – and not the other way around:

> "I was stubborn, so at first. But, she showed a lot of understanding and told me again and again: 'Well, I pave the way', or and I can talk about what I want to talk about. And yes, that/that casual, but nevertheless groundbreaking, she has found the way to me. So she to ME, not me to her." (D428)

A few respondents further depicted trust building as a very slow progression, within which they started to realize that the therapy sessions helped them to feel better. They highlighted that even though they were mandated to therapy sessions, it was key, that the therapist did not pressure them but was merely seeking the conversation:

> "Yeah, you know, you're not really forced to lie down on a 'saltire' [couch], what am I supposed to lie down on a saltire? [Here] they are just looking for the conversation, so first of all you have to build up trust with the psychologist, or, with the person opposite. Just like I said before, openness has developed more and more, to be able to talk about everything." (D404)

> "Because I myself also noticed that it does me good and in a certain way it does me good and [so I told myself] 'so now get involved with the new therapist, you have no choice anyway, so try to find a way.'" (D428)

Patient health needs to be first priority

Several respondents highlighted that they trusted their mental health professional because they developed the impression that the therapist's goal was to enhance their well-being and to help them to get better. They thus felt that the therapists were not focusing on their role to control and monitor the participants, which was appreciated.

> "P: It was more the direction, we are there for you. I: Okay. So the way you position yourself? P: Right. And also say: 'Okay, I'm here to help', independent now/of course the offence plays a role, of course it's first of all about that, but 'We look that it goes forward with you, that you go into a direction. That we can help.'" (F408)

> "They see their role as monitoring me, rather than necessarily trying to assist me." (F412)

This difference in whether the therapist appeared to value control or care for the patient seemed to be linked to feelings of being supported in their individual needs versus following highly structured

treatment plans, ignoring the patient's individuality. More specifically, several respondents who placed their therapist close to themselves stated that the therapist would target their individual needs, fully understand them and their problems, as well as respect them as the person they are. This, they said, enabled them to open up and to share their deepest secrets – to develop a trusting relationship. For instance, two participants depicted that they confided in their treating mental health professional because he/she showed engagement to work on topics that were relevant to the participants: "Precisely because I have faith in her. I can talk about anything, really talk about anything." (D404), or "She addresses the topics in the right way, or what concerns you and they will be dealt with afterwards." (D402). One respondent pointed out that he/she trusted the therapist because he/she could be oneself: **"**Because we trust each other blindly, because we know each other, and because from my side, I can be myself." (D414). Another respondent who positioned his therapist close to him-/herself highlighted that he/she was able to rely on their psychotherapist to support them in any situation: "With all the lows and highs, and he kept carrying me out. And that's my life saver, in plain English. Yes, because without him, as well as without certain other people, I would no longer be here. That's why I want to give him a high value, or in other words, he is close to me." (D419).

In contrast to this, respondents, who positioned their therapist closer to the justice system, stated that their treatment was highly structured and not respecting their individuality. They perceived the structure and goal of the treatment as predefined by the justice system and described it as impersonal.

> "It is much, eh I personally find it more impersonal than it was perhaps ten years ago. It is really more structured and more eh I have to treat this, I have to push that through, I have to do this." (F408)

Clarity in roles and responsibilities

A few respondents highlighted that they confided in their mental health professional when their role within the system was devoted to caretaking only and their affiliations with the justice system clearly communicated. For instance, one respondent underlined that it was crucial that all players involved needed to have clear separation of roles and explicit assignment of responsibilities. Having such clarity was meaningful for the patient to understand the course of events and the measures imposed. He criticized that in his case, nobody wanted to take responsibility for anything but referred to others or the system in general:

> "He is quite far removed from my interests! He is under the cover of his function, but he is at the service of the legal system. Because every... every decision we make at every level is made in consultation with the legal system, and the legal system prevails among all stakeholders! This is the one that prevails. And those who take ... that's my psychotherapist! But there's a

hierarchy above him. So each one covers himself with one, with the other and there's no one who takes a real responsibility, a commitment... it's difficult!" (F445)

Further, participants' responses indicated that his/her relationship with their therapist was impacted negatively when the mental health professional adopted controlling tasks. For instance, the following respondent describes a situation in which the mental health professionals would specify certain therapy goals and link them with benefits such as temporary or escorted leaves:

> "Because the therapists here, they don't have to explain to me - so this is my personal opinion - they don't have to explain to me that they are only interested in us. They have a mandate from the justice system and they have to fulfill it. No matter what it costs. It will simply be fulfilled. It's like a catalogue. These are the expectations tack tack tack tack tack tack tack tack, you have to fulfil them and if you fulfil them, then you can take a step forward and then you can get certain privileges. (...) I can't understand that the people back the system, that exists here, that the psychologists back such a system, I can't understand, simply not. (...) then there are those who pass the order from the justice system - because it is easier. Then they do the job handling the privileges, for example, there are many authorities that give it away. So to speak 'You can deal with the privileges. You can handle the leaves yourself, using our framework.' They give it away like that. (...) He didn't care, the one I got, the guy in charge from the authorities, gave the responsibilities of my privileges to here." (D429)

The art of communication –between transparency and unchecked information sharing

Many participants discussed the importance of well-managed communication. They found communication difficult because as a condition of their mandated psychotherapeutic treatment medical confidentiality is limited. Study participants stated that their therapists would share information with the authorities and other prison and health care staff. They presented three examples, in which transparency was key to build a trustful relationship: 1) breaches to confidentiality, 2) therapist's authenticity and direct feedback, and 3) protecting patient's private details.

First, participants who said that they trusted their treating therapist emphasized that transparency about breaches to confidentiality was key. They stated that they appreciated either knowing under what circumstances their information was shared or being asked to consent to the passing of information before the particular situation occurs. This was highlighted by the following respondents:

> "[My therapist said] 'We're still bound to secrecy, we're still bound to medical confidentiality, but if by chance we see that you're not well, or, that you're telling us something about children or like that, that you have fantasies about children or anything' - well, they told me 'about that we're obliged to notify the authorities [Name of Institution] and then…/ but that's fine." (F450)

> “If he passes more information to / the authorities, he always asks my opinion, 'Can I talk to the authorities about it?', he always asks me.” (F453)

> “Yeah, that's not what I expected from a psychologist, to go telling these things.” (D404)

This was particularly highlighted in relation to the annual report to the justice system. This written report was named as one of the most common breaches to confidentiality, in which the treating psychotherapist would summarize significant information of the therapy content and progress. The report influences the authority’s decision making on the prolongation of the mandated treatment and further security imperatives. It has therefore a high impact on the patient’s future. Most respondents stated that, even though they could not influence the content of the therapy report, they appreciated getting to read it before it was sent out. They further claimed that it would give them an opportunity to discuss discrepancies with their therapist before it was too late. This gave them a certain degree of control over their own situation, as highlighted by a participant:

> “We also read the report first before it goes to the authorities. Of course we have no influence on it but at least we know what goes to the authorities. It's more transparency, it's more openness.” (D403)

Second, many respondents found it crucial that the therapist is transparent, i.e. that he/she was open and honest. They stated that the therapist’s feedback to the patient needed to reflect what they believed about the patient’s mental health and their progress in therapy. If this was the case and the therapist’s behavior during treatment was in accordance to the report written to the authorities – this was perceived as very positive and the dual loyalty conflict did not appear to have a negative impact on the treatment:

> “She is one who says her opinion, often it is in some therapy reports or something, uh it is so that the therapist has an opinion and then the boss writes his opinion in there and then it is changed and she does not allow that for example.” (D403)

> “P: She does not write in my favour but she writes it truthfully, or, and... if she would write it for the justice system, then she would weight it a bit more like, yes, uh, ‘He is so and so far’, but (emphasizes) ... but the "but" that is missing, that is nowhere in it, that is simply - honesty is in it. Nothing else. Yes. I: So it matches with what she tells you directly in therapy P: Exactly, that's also in the report. ... - she gives me this to read, if I agree and so on, and then she sends it off. Yes. Yes. I: That means you have the opportunity to talk about it again? P: Exactly, yes. If you would object to something, that you could still discuss it. But now with the last report, I have to say again - it's one-to-one. (D402)

Respondents further highlighted that feedback needed to be direct and uttered promptly without much time-delay. If participants felt they were not informed in time or even deceived, this would impact their relation to their therapist and they would feel powerless and at the mercy of the system.

> "Afterwards they write a report, then at some point you get the report to read and then it says according to the situation, about me it said, 'she did not participate' and there was not so much to write, because I just did not want to. And afterwards/ you are at their mercy. And they don't have to tell me that they care how you are. They have a mandate from justice and they have to do it." (D429)

> "She just - it/the stuff that she/it has picked up about me, has passed it to other psychosocial support staff and stuff and stories they have twisted that seven times and so on and, yeah. ... That's what takes your trust afterwards, right. (...) And after that I just said: 'If they see something that I have done something that is not fair to the others, then come and tell me', you can't punish a dog two weeks later, he wouldn't remember it anymore either. And not just say 'Yes, the team saw it.'" (D402)

Third, participants did not appreciate when they had the impression that their information was shared with either people that were not directly involved in their health care or in non-structured settings. For instance, one participant highlighted that security personnel was informed about private details with the excuse to create more security.

> "The whole thing is much more transparent under the pretext of security of course, they always say: 'As soon as we know what medication he takes, what problems he has, the more we can react as security officers.', they would then say. In the sense that afterwards of course a lot, a lot, a lot is taken under the hat … secrecy, that the cease/ uh in principle no longer exists." (F408)

Other participants pointed out, with disappointment, that personal information was at times shared at lunch with other staff or in the group room where prisoners and therapists meet all together. Consequently, far more people who were not concerned with their case heard about their details, as indicated by respondent D429: "…if they sometimes discussed things like that over lunch."

Discussion

This interview study is important in that it obtained qualitative data from incarcerated persons receiving court-ordered therapy, in particular concerning patients' perception of the therapist's dual

role in the case of court-mandated treatment. First, our participants' perception of the clinician's involvement with the justice system was linked to their overall treatment experience. Their affiliation with the justice system was mentioned as important factor that affects patient's treatment satisfaction. It is therefore crucial how mental health professionals describe and deal with the influences of the justice system when providing therapy to patients. Second, study findings indicate that for the respondents it is central that therapists take up an exclusively caretaking role and pursue the objective of enhancing the patient's health. To achieve such clarity in roles and responsibilities, mental health professionals must communicate their affiliations with the justice system transparently. This requires therapists to explain upfront and to disclose breaches to confidentiality, to display authentic behavior, and to provide direct feedback to the patient. It is further important for clients that therapists respect patients' individuality and personal needs, and advance in line with the pace of the patient. Participants perceived this as key, not only to build a trustful relationship but also to be motivated to engage in treatment. Our results therefore support previous claims, that "even if the framework of a relationship can be imposed, the trust cannot be forced" (Lagarde & Msellati, 2017, page 5).

Our findings indicate that for patients it is crucial that their individual needs are acknowledged and respected. This is in line with earlier research underlining the importance of therapists' flexibility in responding to client individuality to develop a therapeutic alliance and influence treatment outcome (Blasko et al., 2018; Gannon & Ward, 2014; Jeglic & Katsman, 2018; Marshall & Serran, 2004). However, it stands in contradiction to the use of highly structured manuals that suppress flexibility and neglect client individuality but are common for treatments following the risk-need-responsivity model developed by Andrews and Bonta (2010). Our participants' responses therefore support the recent shift to a greater focus on client individuality that are inherent to strength-based approaches such as the Good Lives Model (see for example Ward & Gannon, 2006). Nevertheless, this does not necessarily stand in contradiction to the risk-need-responsivity model as the responsivity principle emphasizes the importance that the treatment needs to fit the client's ability and learning style. It requires the therapist to adapt a flexible style in order to recognize and respond to topics and goals important to the client (Marshall & Serran, 2004). However, even though our participants' associated highly structured programs with a lack of individuality, it might just show how difficult it can be to balance manual rigidity with patient individuality – and this challenge remains with the psychotherapist.

Our results inform that the therapist's ability to recognize and respond to patient's needs is particularly important during early psychotherapy sessions. Study participants stated that, to overcome initial resistance, it was important to have a sense of control over the content and pace of therapy, to gain trust in their treating therapist. Earlier research has highlighted that in offender therapy it is crucial to take one's time to overcome mistrust to establish an effective alliance (Goulet et al., 2019; Marshall & Serran, 2004). This might be a particularly important aspect in therapy with persons in detention, as research in the community has shown that patients build up comparable alliance levels after three to

five sessions on average (Zimmermann et al., 2019), in contrast, our participants' indicated taking three to six months time. It might be particularly difficult to build a strong alliance with patients suffering from substance use or personality disorders (Meyer et al., 2019; Ross et al., 2008), two highly prevalent disorders within the correctional context (Fazel et al., 2016). However, it still needs to be clarified whether and how the development of a strong alliance might differ between community patients and persons living in detention. Other therapeutic alliance research concludes that therapists and clients need to align their treatment expectations and goals to develop a collaborative working alliance (Fluckiger et al., 2015). The identification of the patient's needs and wishes is therefore a cornerstone of a trusting and collaborative relationship.

Our results provide evidence that mental health professionals working in correctional context should emphasize their role as supportive caretakers to establish a high quality alliance. This is particularly important, as mental health professionals who are able to create a warm, caring, and supporting environment have been shown to be more effective at facilitating change (Blasko et al., 2018; Marshall et al., 2003). It is further crucial, as mental health professionals are frequently even described as the only supporting person within prison walls ((Skeem et al., 2009)). A person's deprivation of freedom is accompanied by a removal of his/her social network. At the same time, it is widely known that positive and strong bonds with others are central for one's well-being (Turner & Brown, 2009). The patient's relationship with the therapist might consequently be of greater meaning to a patient in prison compared to a patient outside the walls. This stresses the importance to facilitate conditions that enable the patient and the mental health professional to form a strong and trusting relationship in correctional contexts.

Further, our study results support previous findings that mental health professionals should not be directly involved in punitive control (Hachtel et al., 2019; Marshall & Serran, 2004; Wittouck & Vander Beken, 2019). To clear doubts related to their association with the justice system, mental health professionals must transparently discuss their role and affiliation with the justice system with their patients. Our study participants appreciated such role clarity and accepted the therapists' duty in sharing information with the authorities. These findings support the procedural justice principle of 'information', which states that patients need to receive information and clarification about procedures (Wittouck & Vander Beken, 2019). However, our study participants underlined that mental health professionals' tasks and responsibilities should concern mental health care only, which would create a rehabilitative environment and the grounds for a trusting relationship. Simultaneously, if the patient knew who was responsible for the "controlling" aspects, it facilitated the perception of the mental health professionals as taking up the "caring" role.

The question remains how to ensure that mental health professionals exclusively carry out caretaking roles. In the mandatory treatment setting, by definition the therapist holds the double role to care and

control. Our findings suggest that all patients need clear information about the roles and obligations of health professionals working in prison: when the different professions working with patients undergoing mandated therapy have clearly and distinctly assigned roles and are at the same time in close contact with the patient, it is possible to build a trusting relationship in spite of the constraints posed by correctional contexts. Thus, as also stated by Strasburger et al. (1997), if there are different roles and responsibilities, then they should be assigned to different players, making each person wearing its own hat.

All our participants reported dual role conflicts of their mental health professionals. This was irrespective of the language region they belonged to or the specific setting they were housed in. This suggests that the fact that a mental health professional works with a patient, who is mandated to psychotherapeutic treatment, might be a reason enough for a patient to doubt his or her independence. The reason that we did not see any strong differences between settings and cultural embedding might, however, also lie in the nature of our qualitative approach. Quantitative analyses might be able to detect differences between specific setting-related factors more precisely and should be the focus of future research.

Trustworthiness has been established as an important therapist characteristic to promote a high quality alliance (Ackerman & Hilsenroth, 2003; Fluckiger et al., 2018; Hilsenroth et al., 2012). In court-mandated treatment orders, trust is at stake due to limited confidentiality. Gannon and Ward (2014, p. 440) highlighted that mental health professionals are frequently asked to share treatment information with the authorities depicting a "common correctional challenge to the therapeutic relationship". Our research supports earlier findings that the conditions of limited confidentiality and its implications for the patient need to be explained transparently (Elger et al., 2015a, 2015b; Gannon & Ward, 2014; Merkt et al., 2021).

Thus, there is an important need to ensure transparency in the therapy context, emphasized in the subtheme on communication. First, transparency requires information sharing with other staff in structured and confidential settings. Patients' private details should be shared exclusively with professionals that are directly involved with the patient care. Second, information that is passed to the authorities (in our study in form of a yearly written report), needs to be previously shared with the patient (Canela et al., 2019). Mental health professionals, who share their report prior to sending it to judicial authorities, allow participatory decision-making to take place. This has been indicated to be linked to less perceived coercion (Hachtel et al., 2019) and reduced violations in involuntary settings (Skeem et al., 2009). In addition, it provides empirical evidence for the 'voice' principle of the procedural justice theory, as sharing the report allows the patient to express their own view (Wittouck & Vander Beken, 2019).

Moreover, the content of the report needs to be in line with the mental health professional's on-going feedback during therapy. When the therapist undertakes such measures, the report does not appear surprising to the patient since the therapist was genuine. That is, he or she was authentic and honest throughout treatment and the report is thereby a reflection of the therapy content. Genuineness is well-established as an important therapist characteristic in general psychotherapy (Nienhuis et al., 2018). Also, sharing the report provides an opportunity to estimate the degree of agreement between the patient and the therapist. Gelso (2014, p. 119) states that the therapeutic relationship is "marked by the extent to which each is genuine with the other and perceives/ experiences the other in ways that befit the other:" This "sharing" procedure could therefore be an opportunity to review and increase the strength of the bond between the mental health professional and the client.

Limitations

Our study followed a qualitative study design, which involves limitations inherent to this methodology. First, our participants' responses might have been influenced by their desire to utter socially accepted opinions. Participants might think that researchers are linked to the justice system, that anonymity is not provided, or that their participation and responses provided during the interviews might alter their chance for release (Dugosh et al., 2010; McDermott, 2013). These perceptions have the potential to alter their responses towards more socially accepted opinions, thereby creating concerns related to validity and reliability (Copes et al., 2013). For these reasons, we also did not collect systematically demographic characteristics such as index offence, time in prison, and psychiatric diagnosis during the interviews unless they were shared voluntarily.

Second, the participants' responses might have differed due to their mental health issues. For instance, patients with problematic personality traits might have more difficulties in establishing an alliance with their treating psychotherapist compared to other patients (Kennealy et al., 2012; Ross et al., 2008). The differences in the perception of the dual loyalty conflict could therefore be linked to the psychiatric diagnosis and could be unassociated with therapists' abilities to deal with the dual loyalty conflict.

Third, older incarcerated participants were recruited through contact persons of the participating correctional institutions thereby raising the issue of potential volunteer as well as selection bias. Therefore, we might have attracted older incarcerated persons with a certain set of opinions and their opinions may vary from younger incarcerated persons.

Fourth, our participants were imprisoned in Swiss correctional institutions. Our results are therefore limited to this specific context and are not generalizable to other contexts. However, we included persons living in detention from two different language regions and different types of correctional institutions and therefore believe that we covered the prevailing notions on the perceived dual role

conflict in this context. Most importantly, our findings are based on participants' own reports identifying a range of experiences with their therapists. These findings were not limited to predefined experiences, as might occur in a survey-based research.

Future Research

Based on our findings and our overall methodology used, we forward the following to improve our understanding on this topic. First, we interviewed persons living in detention in fourteen different institutions from the German and French speaking language regions. Our participants were therefore subject to differing settings and treatment options. This recruiting strategy allowed us to shed light into notions and experiences that are independent of the specific setting. This is particularly important within the Swiss context, as communication between language regions is often hampered. Our research project therefore also aimed at generating knowledge bypassing language barriers and looking at commonalities between the regions. This, however, increased the heterogeneity of our sample, particularly, in regards to types of mental health care received. As for example, some participants received individual sessions only while others were embedded in a more holistic program of a specialized treatment unit. Further research should therefore investigate the impact of certain treatment settings and orientations on the perception of the MHP's dual role.

Second, we did not gather detailed information on the duration and orientation of treatment and conducted only one interview on a single occasion. However, the perception of the alliance can change throughout therapy. As for instance, the development of an alliance will require time in the beginning of therapy and ruptures during on-going therapy need repairing. Thus, the time point within the participant's therapy sequences and the fact that we conducted one interview only might have affected the responses. Future research should therefore explore the link between the perception of the dual role conflict and the development and quality of the alliance over time.

Third, we did not collect data on the MHPs expertise and qualification. A MHP's experience, training and skills has an impact on their ability to build and repair therapeutic relationships (Roos & Werbart, 2013). As we allowed the participants to elaborate on current treatment experiences as well as to draw comparisons with previous treatment experiences, information on the current treating MHPs expertise would have not added any value to our data. Future research should consider assessing the clients' perceptions linking them with demographic and professional characteristics of the MHPs.

Conclusions

Developing a high quality alliance in mandatory treatment with persons in detention is central due to its relationship with recovery and desistance. Our findings show that some therapists' characteristics and activities attenuate the negative impact of their double role on the development and maintenance

of the alliance. Patients valued a well-managed care-control balance that was characterized by (a) prioritizing patients well-being over security aspects, (b) providing transparency in regards to conditions of the court-mandated treatment setting (e.g. limits to confidentiality, MHP's interaction with representatives of the justice system), (c) ascribing the controlling role to a separate person who is tangible (e.g. responsibilities are clearly distributed and every involved person is accessible and known to the patient), and (d) showing some flexibility to take the patient's individuality into account. To increase the effectiveness of court-mandated treatments, we need to support clinicians in dealing with their dual role to allow the formation of a high quality therapeutic alliance. Our qualitative interview study contributed to this much-needed empirical research on therapist' characteristics promoting a trusting relationship in correctional settings.

Declarations

Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Author Contributions

HM contributed to data collection and analysis. She further drafted the first version of the manuscript and improved the different draft based on the co-authors comments and suggestions. TW made substantial contributions to the study conception, data analysis, and revision of the work. FP, ML, and IG provided substantial contributions by examining the results presented in draft versions and revised the work. BE provided substantial contributions to the study conception and revision of the work. All authors agree to the final draft of the paper submitted and take responsibility for its content.

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Data Availability Statement

The dataset analyzed during the current study is not publicly available. Our analysis is based on qualitative interviews with older persons living in detention. The individual privacy of our study participants would be compromised if we shared the whole transcripts publicly. However, we can share the parts of the transcripts relevant for this paper upon reasonable request.

Contribution to the Field Statement

Mentally ill offenders can be mandated to psychotherapeutic treatment in a large number of countries. The treatment conditions differ in comparison to community settings due to, amongst others, the mental health professionals' relationship with the justice system. Mental health professional who work with court-mandated patients act simultaneously as therapist and evaluator and therefore take up a dual role. This dual-role relationship can lead to ethical dilemmas in daily clinical decision-making as the set of norms, that clinicians should adhere to, differ between to two state institutions – the health and the justice system. The debate on which ethical principles should be applied in correctional psychology and psychiatry is on-going. However, dual loyalty issues are commonly subject to discussion but are rarely the focus of empirical research. Our qualitative interview study with incarcerated persons mandated to treatment provides an important contribution to the debate by adding the perspective of the population who is at issue. It could therefore bring new momentum into the discussion on which principles to apply to solve ethical dilemmas in correctional clinical practice.

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Table 1. Participant Characteristics (N=41)

Institutions	Forensic-Psychiatric Institutions	14	participants
	Penal Institutions	27	
Gender	Female	2	participants
	Male	39	
Language Region	French	18	participants
	German	23	
Age	Average	62	years
	Range	50 - 76	
	Standard Deviation	6.92	
Interview Length	Average	69	minutes
	Range	16 - 120	
	Standard Deviation	25.55	

4.2.3. What characterizes a good mental health professional in court-mandated treatment settings? – Findings from a qualitative study with older patients and mental health care professionals

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Abstract

Background: Therapist-related characteristics and activities such as empathy and genuineness are factors that significantly contribute to psychotherapy outcome. As they are amongst the common factors of psychotherapy, it can be expected that they are equally important in the treatment of court-mandated patients. However, these treatment settings come with specific challenges due to coercion and control. Therefore, some therapist characteristics might differ or play a particularly important role. This qualitative interview study therefore sought to investigate service providers' and users' perspectives on therapist characteristics in the context of detention. ***Methods:*** We conducted a qualitative interview study with 41 older incarcerated persons mandated to treatment, and 63 mental health professionals. The data analysis followed thematic analysis. ***Results:*** Patients and experts both emphasized the importance of treating a patient with respect by taking a humanistic approach, that is, condemn the deeds but embrace the person. This, while displaying genuine interest in supporting the patient with any issue or concern that was of relevance to the patient. Further, in light of the coerciveness of the therapy context it was particularly important to incorporate patient's wishes, recognize and respond to the patients' needs, and allow some choice within the given framework. Such inclusive attitude was deemed critical to engage and motivate patients to participate in treatment. In addition, it was emphasized that feedback and advice need to be concrete, detailed and applied to the person's current situation. Lastly, patients questioned the mental health professional's (MHP) qualification when they did not progress in therapy, MHPs should therefore monitor patients' treatment satisfaction carefully to counteract negative feelings towards treatment participation. ***Discussion:*** Our findings indicate that some therapist activities and characteristics are of particular importance in court-mandated settings. These include genuine interest in the patient, a respectful and positive attitude, as well as targeting sensitive issues in a directive but non-confrontational manner. Further research needs to identify specific expressions and behaviors that are linked to the before-

mentioned characteristics in the forensic context. Our study therefore contributes to much-needed empirical research on clinician and patient perspectives on therapist characteristics and activities in the treatment of court-mandated patients.

Background

Therapist-related characteristics and activities are significantly associated with psychotherapy outcome factors (Del Re et al., 2012; Saxon et al., 2017; Webb et al., 2010). They are amongst the common factors of psychotherapy, which shape a "theoretical model about mechanisms of change" overarching different psychotherapeutic methodologies (Mulder et al., 2017; Wampold, 2015). Empathy (Elliott et al., 2018; Soto, 2017), genuineness/congruence (Kolden et al., 2018; Nienhuis et al., 2018), and positive regard (Farber et al., 2018) are the most consistently reported therapist characteristics and activities that are common across all modalities. Evidence suggests that they are equally important in court-mandated treatment contexts, as they were linked to patients responding more positively to psychotherapeutic treatment and enhancing their motivation to change (Blasko et al., 2018; Jeglic & Katsman, 2018; Marshall & Serran, 2004; Polaschek & Ross, 2010; Ross et al., 2008). Even though some central concepts of therapist characteristics might be common to all treatment conditions, others might be specific to the context (Heinonen & Nissen-Lie, 2020; Sandhu & Rose, 2012).

Court-mandated treatment settings come with several specific conditions and requirements for patients and therapists. Persons who are mandated to treatment by a criminal court not only suffer from mental health disorders but have also committed a crime, which is the justification for the official invasion of personal privacy. As a consequence, the overall goal of such mandated treatments is to reduce the risk to reoffend and to protect the public (Brägger, 2014; Pollähne, 2013). Thus, goals of treatment differ considerably from general psychiatry and psychotherapy, where treatment aims to improve psychosocial functioning and ultimately a patient's quality of life (Bonnín et al., 2019; Juckel & Morosini, 2008; Valencia et al., 2013). Therefore, the treatment goals are predefined and only indirectly centered on patient benefit as in other settings. The patient's involvement with the justice system requires the therapist to put additional focus on a person's criminogenic factors. In some jurisdictions, there are even recent efforts to demand so-called "delict-oriented treatments" or "offence-oriented therapy" to be provided by psychotherapists to offenders if no mental disorders can be diagnosed according to DSM or ICD – an approach that is presumably in direct violation of the policies laid out by the World Psychiatric Associations as early as 1977 (Kröber, 2020; WPA General Assembly, 1977).

Further, as the referral by criminal courts guarantee treatment entry and participation, therapists face specific challenges due to the fact that the treatment is not requested by the patient, but imposed, such as resistance and lack of motivation (Snyder & Anderson, 2009). Other important aspects that are

specific to court-mandated treatment are the therapist's dual role to care and control (Pham & Taylor, 2018; Pont et al., 2012; Ward & Ward, 2016; Ward, 2014), limited medical confidentiality (Elger et al., 2015a, 2015b; Merkt et al., 2021; Merkt et al., 2021), as well as coercion (Hachtel et al., 2019; Meyer et al., 2019). The precise impact of these aspects on psychotherapy process and outcome factors is unclear while it is particularly important to understand their influence in light of the mixed evidence of the effectiveness of court-mandated treatments (Werb et al., 2016). These inconsistencies suggest potential intermediary factors such as therapist characteristics.

First of all, as the context of court-mandated treatments is characterized by coercion and control, evidence suggests that it is important to provide some degree of choice to encourage the patient to participate in treatment (Dowling et al., 2018). This is fostered, for instance, by transparent communication regarding treatment planning (Fortune et al., 2010; Livingston et al., 2013; Tapp et al., 2013). Patients want their views to be taken into account, they want to be treated as dignified and active actors, and to be involved in the dialog on unmet needs and future goals (Gault, 2009; Stuen et al., 2015; Wyder et al., 2015).

Further, literature suggests that it is important for therapists to adopt a positive and respectful attitude towards the patient. Feeling stereotyped or labelled by mental health professionals is negatively linked to the development of trust and connectedness with mental health professionals (Epperson et al., 2017; Kras, 2013; Mezey et al., 2010; Skeem et al., 2003; Stuen et al., 2015; Wyder et al., 2015). Wittouck and Vander Beken (2019) described this as *"'us' versus 'them' attitudes",* and emphasized the importance of patients feeling valued and accepted. In the treatment of sex offenders, this seems to be of particular relevance, as they typically experience shame in relation to their offence (Proeve & Howells, 2006). This "*humane attitude"* (Sandhu & Rose, 2012) was further linked to mental health professionals being perceived as caring and supportive (Wittouck & Vander Beken, 2019). That is, the mental health professionals showed genuine and authentic interest in the patient, took the time to talk and listen, took them seriously, and showed willingness to understand (Barnao et al., 2015; Blagden et al., 2016; Epperson et al., 2017; Ferrito et al., 2012; Fortune et al., 2010; Kras, 2013; McIvor, 2009; Skeem et al., 2003).

Two recent reviews have concluded that a directive, authoritative but non-confrontational style is beneficial in the treatment of court-mandated patients (Blasko et al., 2018; Meyer et al., 2019). This should not be confounded with a dominant, authoritarian or confrontational-style, which was highlighted as detrimental in the therapeutic process. For instance, Marshall and Serran (2004) conceptualized confrontation as a derogatory and aggressive communication style (Jeglic & Katsman, 2018; Marshall & Serran, 2004; Polaschek & Ross, 2010; Ross et al., 2008). This is of particular importance when working with persons who committed an offence, as the justice system requires the crime to be targeted as part of treatment and often specifically links facilitation or relaxation of

imprisonment to progress in openness to address past offenses. The way in which a MHP shapes the conversation around these sensitive issues is therefore crucial.

Lastly, worldwide the number of persons mandated to treatment by court-order is rising (Goulet et al., 2019). Among them are older persons, whose proportion is growing faster than any other age group within the criminal justice system (Di Lorito et al., 2018; Williams et al., 2012; Yarnell et al., 2017). Within the Swiss prison context, these two groups overlap, as there has been a drastic increase of older persons sentenced to mandated treatment. For instance, the number of persons over the age of 49 sentenced under article 59 has increased from 8.7 % in 1999 to 17.8 % in 2019 (Bundesamt für Statistik, 2020b) and under article 64 from 35.5% to 74.7% in the same time period (Bundesamt für Statistik, 2020a). Reasons to treat the group of older persons separately are, first, that response and effectiveness of treatments may differ in comparison to younger adults. Second, the higher prevalence of somatic health issues may challenge the application of psychotherapeutic interventions (Woods & Roth, 2005). Particularly with regard to the older prison population it is important to note, that the prevalence rates of physical and mental health problems are higher in comparison to younger persons in detention as well as in contrast to older persons living in the community (Fazel et al., 2001; Wangmo et al., 2015). They are therefore a population of high needs requiring intensive resources, which substantiates the need for research on particular therapy requirements for this age group.

Thus, evidence suggests that there are specific characteristics and activities needed to promote behavioural change in older patients legally-referred to psychotherapeutic treatment. It is therefore crucial to shed further light into the particularities of correctional contexts to increase the effectiveness of mandated treatments. This qualitative interview study contributes to much-needed research on therapist characteristics and activities that facilitate change in patients mandated to treatment by court order.

Methods

This article follows the "Journal article reporting guidelines" for qualitative research by Levitt et al. (2018), which includes the COREQ-32 guidelines by (Tong et al., 2007). With the terminology mandated treatment, we refer to persons sentenced to measures according to the criminal law who are mandated to psychotherapeutic treatment by court-order.

Study Design

This qualitative study is part of a larger research project on mental health of older persons living in detention ('Agequake in Prisons 2', *Swiss National Science Foundation [grant number 166043]*.). As part of the larger project, we not only gathered qualitative data from older persons in prisons and professional stakeholders (described below) but also quantitative information on older persons' mental

health condition from medical records and standardized surveys. As older persons in prison are a minority within the general prison population but growing in certain settings (e.g. persons sentenced to measures), there is little data on the mental health of this population (Moschetti et al., 2015), the overall goal of the qualitative data collection was to gain insights into their aging experiences in prison, living with a mental disorders, and their perspectives on prison mental health care. As these are complex social processes that we, to date, know little about, we applied an explorative qualitative approach to capture these social phenomena. Previously we reported on this group's perceptions of their therapists' dual role conflict in court-mandated treatment settings and these results can be found elsewhere (Merkt et al., under review; Merkt, Wangmo, et al., 2021). TW and BE conceptualized the research project. Both have many years of research experience on the topic of older persons living in detention as well as in employing qualitative methodology (Elger et al., 2015a, 2015b; Wangmo, Hauri, et al., 2016; Wangmo et al., 2015; Wangmo, Meyer, et al., 2016). Two female research assistants (one of them being HS) completing their doctoral education conducted the interviews. They were trained in qualitative data collection and received supervision throughout the data collection process. Ethics approval was obtained from the regional ethics committee (Ethikkommission Nordwest- und Zentralschweiz) which was followed by other local ethics committees. For Canadian expert-participants, approval was given by Correctional Service Canada.

Study sites and participant inclusion criteria

We interviewed MHPs as well as patients receiving care. Patient-participants were recruited from Switzerland exclusively while expert-participants from the two countries Canada and Switzerland were included. Expert-participants were mental health care professionals with work experience with incarcerated patients (psychologists, psychiatrists, psychiatric nurses, social workers, occupational therapists). Canada and Switzerland both have a growing older population. While key characteristics of the older population will be similar, such as high prevalence rates of somatic and psychiatric illnesses, the way MHPs deal with these issues might differ. Thus, including professionals' experiences in handling the older incarcerated population from another country, could shed light into alternative care strategies. At the same time, it can highlight similarities that are common across differing jurisdictions such as MHPs' characteristics that older incarcerated person's value during psychotherapy.

We included correctional institutions and forensic mental health facilities that housed adults, sentenced to long-term imprisonment. We excluded correctional institutions that housed juvenile or remand prisoners exclusively as well as administrative detention centers (centers housing migrants for deportation). In Switzerland, prisons from the two major language regions (French and German speaking) were included, the Italian speaking language region was excluded. Similarly, correctional institutions and forensic mental health facilities from both language regions in Canada (English and French speaking) were included. Staff members of the Correctional Service of Canada recruited

participants from correctional institutions while the research team directly recruited participants from forensic mental health institutions.

We included incarcerated persons who a) were incarcerated in a Swiss psychiatric or penal institution the time of data collection, b) were aged 50 years and older, and c) had at least one contact with mental health services. We excluded participants whose mental state was too instable and/or prison administration did not allow the person to participate for instance due to dangerousness or solitary confinement. Our decision to apply an age cut-off of 50 was due to reasons of "accelerated aging". That is, persons living in detention tend to depict poorer health status, defined as functional impairment as well as burden of illness and disability, at a younger age when compared to persons of similar age groups in the community. This health status is linked to future functional decline, health care utilization, and mortality and is therefore a useful proxy to define an older population of higher needs (Combalbert et al., 2016; Di Lorito et al., 2018; Fazel et al., 2001; Greene et al., 2018; Loeb et al., 2008). Further, studies analyzing data of all age groups show that the rate of somatic and mental health issues, the use of prison health services as well as health care costs in relation to this drastically increase after the age of 50 (Hayes et al., 2012; Thomas et al., 2005). Taken together, this preliminary findings resulted in our decision to depict the age 50 as an age cut-off for our study purposes, see Merkt et al. (2020) for a detailed review on the issue of how to define an age cut-off for older incarcerated persons.

Data Collection Process

We conducted face-to-face interviews with a purposive sample of (a) incarcerated older persons receiving mental health care in Switzerland and (b) mental health professionals working with incarcerated patients in Switzerland and Canada. Incarcerated participants were contacted either through a contact person of the prison administration or the mental health service. Expert participants from participating institutions were directly contacted by the research team via email or telephone.

Study information and informed consent were previously handed out to the incarcerated participants by our contact persons in those settings or sent via email to our expert participants. At the scheduled time and place of the interview, the researchers explained the purpose of the study, clarified that all data was treated confidentially, and that refusal was possible at all times. Thereafter, written informed consent was obtained. There was no compensation provided for study participation. Interviewer and participant met the first time on the day of the interview, thus, there was no relationship prior to data collection.

Only one interview meeting took place with each participant and no repeat interview was done. Interviews with incarcerated persons took place within the institutions and a separate room, in which conversations could not be overheard, was made available for this purpose. Interviews with experts took place mostly in their office or a location of their choosing. All interviews were audio-recorded

upon the consent of the participant. Field notes were taken after each interview. Interviews were held in the language spoken by the participant, either French, English, German or Swiss German. Thereafter the interviews were transcribed verbatim in the language of the interview, except for Swiss German interviews, which were transcribed in Standard German. Swiss German is a spoken dialect and it is common practice to use Standard German in writing. The interviews were checked for the quality and accuracy of the transcriptions, during which identifying information were anonymized. Interview transcripts were not returned to the participants for checking.

Interview Guides

The interviews with the study participants were semi-structured and followed an interview guide specifically developed for the purpose of this study. The open-ended questions within the interview guide with incarcerated persons covered topics on (a) personal circumstances and social networks, (b) experience of aging in the prison context (e.g. relationship with younger persons in detention, satisfaction with work and free time activities offered, perception of prison environment, future plans (during and after imprisonment)), (c) access to and quality of mental health care (e.g. types of interventions, frequency and duration of treatments), (d) satisfaction with mental health care (specific aspects of the intervention that helped/impeded therapy progress), (e) mental well-being (e.g. perception of their current mental well-being, questions on possible stigma due to mental health issues), and (f) experiences with risk assessments.

The interview guide used during the interviews with expert participants covered issues concerning: (a) motivation to work with incarcerated persons, brief description of their work experience and current roles and responsibilities, (b) organization of mental health care, opinion on access to and quality of mental health care services, influence of indefinite release dates on the work with their patients, (c) older patients: exploration of their experiences in working with older patients, their opinion on characteristics of care and interaction with older patients, similarities and differences of care of younger and older patients, prominent therapy topics of older patients, (d) therapist's dual role conflict: use of elicitation technique to provoke responses on their dual loyalty conflict, description of collaboration with other professions and representatives of the justice system, and (e) risk assessment and reporting to the authorities: characteristics, procedures, age as a variable in risk assessments, key criteria in reporting standards, examples.

Study sample

We conducted a qualitative interview study with 41 older incarcerated persons mandated to treatment and 63 mental health professionals with substantial work experience in secure contexts. Please see table 1 for detailed sample characteristics. We based our decision about the number of study participants on the principle of data saturation. As we carried out data analysis alongside on-going data collection, we were able to identify when data saturation was reached for each participant group, and

were able to include more interviewees if needed. We identified data saturation applying the principles presented by Fusch and Ness (2015); the ability to obtain additional new information has been attained, further coding is no longer feasible, there is enough information to replicate the study.

Table1. Sample Characteristics

		Incarcerated older participants	**Expert-participants**	
			Switzerland	Canada
Time period of data collection		December 2017 – December 2018	April 2017 – January 2018	August 2017 – Nov. 2018
Interview length (in minutes)	Average; Range; Standard Deviation	69; 16 – 120; 25.55	71; 48 – 90; 14.16	60; 28-92; 11.49
Number of participants		41	29	34
Participant Characteristics	Gender	2 female 39 male	8 female 21 male	22 female 12 male
	Age	Range: 50-76 Average: 62 Standard Dev.: 6.92	-	-
Language region	German-speaking	23	16	-
	French-speaking	18	13	5
	English-speaking	-	-	29
Number of Participants per type of institution	Correctional institution	27	23	21
	Forensic-Psychiatric Institutions	14	6	13

2.3 Context information

The Swiss Criminal Code (SCC) regulates penal law on a national level, sanctions that are imposed are therefore similar across the nation. However, the imposition of sentences is regulated on a federal level. Each state (canton) is responsible for carrying out the precise execution of the sentences. Thus, some aspects will vary on a cantonal level such as the settings and placement of mentally ill persons (Fink, 2018). This being said, we will first depict some important differences in the Swiss Criminal Code, which are important in light of our analysis. In a second step, we will briefly outline the characteristics of the settings, in which incarcerated persons are confined to, which has implications for the mental health care received.

The Swiss criminal code distinguishes between penalties (in German “Strafen”) and therapeutic as well as safeguarding measures (“Therapeutische und Sichernde Massnahmen”). Measures are imposed when penalty alone is not sufficient to counter the risk of further offending and the offender requires

treatment or treatment is required in the interest of public safety. To impose a measure, the court bases its decision on an expert assessment which comprises estimations of (a) the necessity and the prospects of success of any treatment of the offender; (b) the nature and the probability of possible additional offences; and (c) the ways in which the measure may be implemented. Measures are reassessed at regular time intervals and release is granted based on the fulfillment of the requirements of the parole boards and the risk for further felonies. For all measures, criminal responsibility can be diminished, however, it is not a *sine qua non* condition for the judge to impose a therapeutic measure.

In our sample, we included persons sentenced to measures under Art. 59 (in-patient therapeutic measures for mental disorders with the exception of substance use disorders), Art. 63 (out-patient treatment), and Art. 64 (preventative indefinite incarceration). The basic conditions outlined in the previous paragraph concern all measures while certain aspects are specific to each type. For instance, Art. 59 and 63 can be ordered if the person suffers from a severe mental disorder that stands in direct connection with the crime committed and it is expected that the measure will reduce the risk to reoffend. Art. 59 requires the person to be confined to a correctional institution of a forensic psychiatric clinic, while a person sentenced under Art. 63 receives ambulatory mandatory treatment. They can either live in the community or be placed in a correctional institution due to an additional penalty. We included only persons that were incarcerated at the time of data collection.
Art. 64 can be imposed if an offender is deemed "untreatable". This form of measure is considered a last resort by legal authorities and courts. Persons under preventative indefinite incarceration do not have to undergo psychotherapeutic nor psychiatric treatment. However, one option to have a prospect of release is to ask for deliberate psychotherapeutic treatment. Treatability is re-evaluated on a regular basis and if it is affirmed, a conversion of the safeguarding in a therapeutic measure is being ordered. Therefore, if a person sentenced under Art. 64 receives mental health care, MHPs have to report to the authorities if the content is of importance to the authorities decision-making process. In our sample, we included persons sentenced under Art. 64 only if they received mental health care.
Concerning the therapeutic settings, in-patient treatment of a measure should ideally be carried out in a psychiatric or therapeutic institution. However, the person can also be incarcerated in a penal institution given that therapeutic treatment can be provided by specialist staff (e.g. forensic psychotherapists and psychiatrists). The treatment provided will depend on the placement of the person (including the orientation of the institution and the MHP) but also on the type of offense committed and mental health condition. It is therefore not possible to characterise the types of therapies that our participants received, in detail. However, it can be said, that in practice, most persons sentenced to measures will at a minimum receive individual psychotherapy sessions at a regular interval (e.g. weekly, biweekly, or monthly) accompanied by basic (forensic) psychiatric care. Others additionally receive group therapy and some treatment units might foster a therapeutic encounter throughout the day. The type of institution will not give a reliable account of the treatment provided, as for instance, intense therapeutic treatment units are also available in some penal

institutions (see (Brägger, 2014) for an overview on placement options for persons sentenced under a measure).

2.3. Data Analysis

The software program MAXQDA was used to support and manage data analysis processes. To build a uniform coding tree, four to eight interviews of each participant group were first read and coded together by five project members. This allowed the study team to discuss different nuances that are visible in the data and to agree on how to name different codes, and what the codes mean in case of complex code names. Thereafter, four study team members (TW, HS, and collaborators) individually coded all the remaining transcripts and came together to discuss the new codes, solve disagreements, and sorted the final coding tree. During the entire process, the analysis followed thematic analysis (Braun & Clarke, 2006).

In light of the richness of the data and as a result of the broad scope of the overall interviews, coded data related to therapist characteristics and activities were extracted and examined for this paper. That is, HS carefully read this sorted data segments in its entirety, examined the codes applied to this data extract, and further analyzed them with the study purpose as the focal point. This topic specific in-depth analysis also followed thematic analysis. Examples of coded quotations were chosen by HS and TW to illustrate the below presented themes. Two research assistants fluent in German, French and English, translated the codes from the original language into English. The translations were then checked by a collaborator and HS, and lastly proofread by an English native speaker. All authors agreed to the results presented in this paper and its interpretation.

Results

Using data from both the perspectives of older incarcerated persons undergoing court-mandated treatments and experts mental health care providers, we grouped the results into five topics that all relate to techniques and activities that mental health professionals applied in their work with patients. Not all topics were brought up by both participant groups. Further, Canadian and Swiss expert-participants did not differ systematically in their responses. We therefore do not present them separately. However, we indicate Canadian participants as CXX and Swiss experts as SXX, patient-participants are indicated as PXXX. Please see Table 2 for an overview of the topics. In the following sections, we denote our older study participants as patient-participants.

Table 2. Overview of topics

Themes describing good MHPs	Who described those themes?	Specific characteristics of good MHPs
Treating the patient with respect	Experts and Patient-participants	Avoiding stigmatization
		Humanistic approach
Displaying genuine interest in helping the patient	Experts and Patient-participants	Intrinsic motivation to help
		Take the person and his/her issues seriously
		Providing support that exceeds expectations
Recognizing and responding to patients' needs	Experts and Patient-participants	Incorporating patient's wishes
		Allowing patient some choices
Tackling topics in detail	Patient participants only	Targeting the important issues
		Identifying underlying emotions
		Taking a different perspective
Perceived skillfulness of the therapists	Patient participants only	Having expertise to respond to therapeutic questions
		Emphasizing positive sides
		Good Manners

Treating the patient with respect: Taking a humanistic approach

Expert- and patient-participants emphasized the importance of mental health professionals taking up a respectful attitude towards their patients. This to avoid labelling the person due to the status as an incarcerated person or based on the crime committed:

> "We also have staff in here who think 'You offender, second class, label, no way', this is what we have too. I've already asked myself, why don't they quit? If we are that intolerable and it is no fun at all to work with us? Go away. Yes." (P559)

Some expert-participants described it as a "humanistic idea of man" according to which one condemns the deeds but not the entire person: "And for us it is really, our idea of man / we are humanistically shaped and we condemn the deeds but not the person." (S72). In line with this attitude, treating and helping the patient to improve his/her well-being should be in the center of therapeutic efforts taken. Respondents, who declared following this approach, considered developing an understanding of the factors that contributed to the person committing the crime as a central technique during treatment. This in itself can create some relief for the person. At the same time, it has the potential to illustrate the choices made and to exemplify that there are variations in how one can perceive situations and act upon:

> "And that, that it also…the therapist's, let's say his interest is to help people to get better. It is of course clear from the beginning that the therapist must clearly state that he does not condemn the person as a human being. That he does not agree with the offence, that he does not have to condemn it because that is what the judge already did. But that he cannot approve this in any way and also ... that it is in any way not about finding reasons for exoneration. Well, on the one hand. But an appropriate understanding of the person who has committed the crime is." (S68)

Patient-participants seemed to react positively towards this attitude. For instance, the following respondents described how they felt treated as a "regular human being" and at the same time how strongly supported they felt:

> "So, she helped me a lot, a lot. And each time when I say to her 'Thanks a lot, you are my angel', then she says 'No, no Ms. (own name), it always comes back to you like the way you are. You may have made a mistake, but you're still a good person." (P556)

> "So you are more as a person than a (inc) to the people here um, but they also knew more about you, your situation, your condition. So um yeah that certainly a/a/ at that stage for me it was, was much better, it was far more supportive and you felt the support was there." (P542)

Displaying genuine interest in helping the patient

Another basic attitude that patient-participants appreciated was the impression that the MHP had a genuine interest in helping them. Two aspects seemed to contribute to this distinct feeling: first, receiving support that exceeds expectations and that originates from an intrinsic motivation of the MHP to support the patient and, second, the impression of being taken seriously as person and more specifically perceiving that one's issues and concerns were taken seriously.

Concerning the first subtheme of a humanistic "support" feeling, interviewees specified that the MHP's role to provide therapy was more than just an employment. The patient-participants felt that their MHPs were intrinsically motivated to support them: "With her I do not have the feeling, that she is that kind of a therapist who [is like] 'Yes yes, it is my job, I do therapy, I don't care about the result, I get my salary anyway.'" (P564). Several expert-participants similarly underlined that it was important that MHP's motivation should be to help the person: "And that, that it is … the therapist's, let's say, interest to help the person to get along better with oneself." (S68); and "They are there to work with people and they want to help people" (C37).

This motivation to help consists of a desire to assist the patient in achieving a better future, which goes beyond the mere goal of the justice system for reintegration: "For me, what is important personally, is, in addition to the idea of resocialization, in addition to the protection of victims, also a good future for those affected." (S27). These basic motives were not only important for the health care personnel but also should be the overall attitude of the institution:

> "I know that both the prison management and the people, who supervise that the sentence is carried out in an adequate way, are people with whom I can collaborate and who are in the same direction as me, even if I don't always agree with it, but I hear, uh, I know that they are also there for the patient's good, for I feel." (S55)

MHPs who were described as being genuinely motivated to help a patient were pictured as persons who provided support that exceeded expectations:: "She is a really good woman, she has helped me a lot here, is overly involved, so she really does something, she helps me with problems that come up." (P554) This notion of support was also prominent in several expert-interviews, as outlined by C41:

> "We would often see patients that were admitted here that were in very poor physical condition and when we provided them that physical and mental health care we have seen drastic and marked improvements in their presentation and their quality of life. (…) they um sort of thrive in the supportive environment that we provide and that is very rewarding as well."

This was also exemplified by other patient-participants, who delineated how the MHP provided help and advice to clarify any issue: “No, really great. Also really awesome, gets involved, makes, looks, does, recommends, takes it apart with you.” (P559). They further characterized this genuine interest, in a way that the MHPs would actively listen, which was followed by adequate advice, as succinctly phrased by respondent: “She listens to me, she gives good advice.” (P544); and: “That is the solution here, listening. And I already feel better, I must say.” (P554)

Respondents described this as feeling to be understood and to receive appropriate advice from the MHP. Patient-participants seemed to make a difference between genuine understanding and simple reference to their well-being. For instance, the following respondent depicts, how s/he perceived the MHP’s statements as inappropriate, because the MHP, although concerned about the well-being of the patient, did not fully grasp the patient’s current context and predominant issues:

> “Listen, I saw this psychiatrist again. After a while, he started telling me to take care of myself, to take care of myself. That made me so angry, that I stopped seeing him (...) Oh yes, I got angry. ‘Take care of yourself’, [he said]. But I had a child I had to fight for. How do I take care of myself?” (P560)

Other respondents emphasized that listening alone was not sufficient, as highlighted by participant F542: “And I have had this conversation with them and there is no reaction, nothing has changed, reassuring words yes but, yeah I do not know what we can do with words.” In the same vein, this lack of perceived real help affected another interviewee’s motivation to participate in treatment. According to this respondent therapy lacked a sense of purpose due to the feeling of being left alone to deal with problems: “Sometimes I am not motivated at all, because I sometimes say to myself ‘Why should I talk with them, because yeah, I have to find my own way around, somehow.’” (P535)

Similarly, several respondents highly valued when the MHP’s support would go beyond to sole “listening” but reach into practical life support:

> “She called the doctor because she noticed that I was always limping. (...) And she helped me to get in shared flat four, that I get a bigger room and to be in open prison. So, she helped me a lot, a lot.” (P556)

Concerning the second subtheme, i.e. the genuine interest in the person, interviewees explained that it was reinforced by a distinct feeling of being taken seriously. It was further more specifically described as a sense of one’s concerns and issues being considered, as explained by the following participant: “That’s why I think it’s really good (…) So she takes, she takes the thematic and the problems I have seriously and tries to work on them with me.” (P564) Another respondent specifies it as the willingness to take time to listen to the patient and to care for the patient. This, in the context, of receiving support from all professionals involved, to feel embedded in a team of caretakers:

> “Yes, o/ and uh you know that/ that you are taken seriously, we have/ we have felt from the beginning that they want time/ yes that they want to take time for you and/ and listen and want to help you or, not just ‘Yes, we listen but we will be off work soon anyway, we're leaving". But they, they are there and if there are problems/ it is important that a problem also goes to the therapist. Because it's a trio, it's from the occupational/ from the occupational therapist, uh reference person, therapist, they work together, don’t they.” (P532)

Recognizing and responding to patient needs

One aspect that the majority of participants highlighted was the importance to align therapy content along the patient's interests. Patient-respondents appreciated when they could define the topic of therapy sessions, to address issues that were currently important to them: "It is always only the prisoner who determines the topic of discussion in a therapy session. It is not the therapist who decides 'Today we do it like this.'" (P544). Expert-participants also highlighted the importance of partly shaping the therapy content along the patient's interests:

> "Content has to be something that they find useful to them - independent of their offending - because a lot of offenders will say to you when you interview them to come into to treatment groups "I do not need this group. I have been convicted of this crime. I have solved all my problems now. I will not do this again in the future" right? It is not how life unfolds (laughs) unfortunately because if every one of them was right I would be out of business." (C10)

Allowing patients to participate in decision-making on how to design therapy seemed to have an effect on perceived coercion and patient motivation. For instance, the latter example suggests that by allowing the group to choose the topic of conversation, this person perceived therapy as "less constrained".

> "Then we had a lot of group therapies and they weren't as coercive 'you must, you must', instead Mrs. X sat down, we sat in a circle. And she told us: "Make use of the time." That was her phrase. And then we just started, somebody was talking about something that was bothering him […]. And from these group therapies – [these were] the best conversations." (P555)

Other interviewees linked this degree in co-determination to their motivation to engage in treatment:

> "And then when you are there they say: 'So now we start.' (...) and then I say: 'Yes, but uhm sorry, I've already had two or three days of therapy, therefore.' and then they say: 'What counts for us is from now on. That is how our program works, for three to five years, here you go. Do you want to, do you not want to?' And there the question of motivation is then always a bit, well, okay." (P538)

The following participant described how content and process of treatment was completely against her/his expectations. That is, the MHP did not recognize the person's current situation and did not adapt the treatment to her/his needs and wishes:

> "They started at my birth, so I say "Look, I'm 60, I don't have much time. As soon as there is a place, I have to go to [prison C]. We can't start from childhood on', [therapist:] 'Yes, but we cannot rush it.' 'Yes, but the psychiatrist has already told me that you can give me advice on how to distract myself in the cell.' 'No, we can't do that, [she said]'She had to know why I have claustrophobia … she wanted to talk to my family about why I have this and how they are prepared for the fact that I have to go to prison now. What does that have to do with my claustrophobia? Then I said to her "No, forget it, I'm quitting, I'm not coming back. You can't help me." (P556)

In the same line, numerous expert-participants highlighted the importance to allow some choice within therapy. The conditions of court-mandated treatment within prison is predefined but within this framework, there is a certain degree of choice. They emphasized that it was crucial to provide some power in decision-making to motivate them engage in treatment:

> "And, I think especially, I think if we have choices in our whole life, it gives us the will to continue. If you take away the choices of somebody, which in forensics we are taking away their choices to move freely, to move unmonitored. It's controlled." (C21)

> "You know, talk to them about their options. And then of course if they had you know specific referrals, you know we can make them on their behalf. But it is also you know empowering them also. But you know what kind of care they would like to see." (C35)

Several patient-participants named another reason, why in their opinion the patient should have a say when determining how to develop therapy sessions: the patient knows best their own deficits and strengths. This was also outlined by several expert-participants:

> Above all, I'm going to strengthen the patient in his skills and in everything he knows how to do, and that maybe he forgot that he knows how to do it and how to do it well and probably better than what I could offer him. (S23)

This notion, that the patient knows best, seemed to be particularly true for patients who had previous experience with psychotherapy:

> "I told her what I did in institution X and there, I want to continue. And she said that they have a different kind of therapy, how they do it here, how it's organised and all that. And I'm not/ I just like had no connection to her either. And she didn't want that/ I think as a person I know what I need and what I want. I know it, where I have to make an effort, where I have deficits, what I need." (P555)

Some expert-participant further emphasized that while targeting the goals that were important to the patient, other issues such as criminogenic needs were addressed simultaneously: It used to be that the patient was always last. "And we realized if we start putting their patients' goals first then these other things often also get addressed at the same time." (C16). Further, a few expert-participants highlighted the need to target patients' issues in therapy, in the case of patients' pleading innocence:

> "We are no judges. So, hum, we work on the reason why the patient is here, and, and, and, hum, it will hum be his own way to say things. For the patient who is, who is going to claim his, his, his innocence hum for months and months, we will never tell him that he is wrong, in regards to the conviction because it is not our job, but we are going to work on the reason why he is here, because being in prison is not the same thing as being outside, that's quite clear." (S23)

Tackling topics in detail

The majority of patient-participants appreciated MHP who helped focus the key issues and clarify them in detail. For instance, one patient-respondent, who pictured his/her therapist in a positive light, stated "She certainly goes for the/ the living [key issues], that's for sure" (P535). Participants further emphasized that statements that were too generalized and unspecific were not helpful. The more detailed and specific the MHP focused on their problematic behavior, the more they perceived it as a learning experience. Examples were linked to seeing one's life and committed crimes in a different perspective, learning how to link emotions to specific thoughts and behaviors, identifying possible offending situations, or learning about the effects their acts can have on victims.

For instance, the following respondent explains how the MHP helped to identify underlying emotions: "She could illustrate it really well to me and then point out the things, that there is a feeling underneath." (P555) In a more general way, this participants described how the MHP helped him/her

gain a different perspective on certain crime aspects: "And he teased out certain things and worked them out and he pointed stuff out to me that I could not see from my point of view." (P563). Other patient-participants highlighted that they learned from exercises such as recognizing emotions:

> "You, you have psychologists or psychiatrists who say: 'You harm the child with this, with your behavior'. Yes, I don't have an idea what that means. If you don't break it down for me: Why do I harm [with] this? What does it trigger? They never did this. And now with this therapist that I currently have, we approach this topic, specifically, (…) Yes, we do/ certain/ so we have/ yes, certain offenses that I committed or so, broken down a little. And then [we] also pursued [this matter] a little and looked at: how did the girl react in this moment? What did she look like from her facial expressions? That's something I didn't pay much attention to at that time, because I was in my tunnel, or, uhm yes." (P564)

Moreover, one participant explained how it helped him/her to gain insight into the possible consequences of the crime committed for the victims. To learn about personal life-story of victims helped him/her to understand the impact that a sexual offense can have:

> "And then I still had a uhm therapist who worked with victims and he told their cases. And that really unsettled me, of course, yes. Because I did see, … I never resorted to violence in my offenses. But uhm I still, psychologically, and I manipulated, well, but only I never used any physical violence. And there I naturally uhm thought that it was not as bad or something like that. And the victim would have wanted it too …. Because I got the insight into the victim's situation and the thing with empathy and all, got me a totally different picture and of course I saw all my offenses from a totally different perspective." (P565)

The same respondent explained how s/he learned how to identify situations, in which s/he might reoffend and how this helps to plan free-time activities accordingly: "I know what I am allowed to do, where I go and during holidays: what do I do on vacation? Uhm especially where there are children, if I go to an event where there are children and so forth, that I don't do that anymore" (P565)

Perceived skillfulness of therapist

Last, the skillfulness of a MHP was raised by several patient-participants, the majority of citations were linked to negative treatment experiences. The behaviors that were linked to perceiving them as unqualified were looking for negative sides of a patient only, not being able to respond to therapeutic questions, lacking good manners, or a perceived helplessness of the MHP by not knowing how to help the patient. For instance, one participant named reasons why s/he perceived the MHP as insufficiently qualified: "When I asked something therapeutic or something, then she googled it, then she had to look it up (…) yes just unexperienced, she did not come across like a therapist." (P532) However, a certain degree of reflectiveness and questioning oneself was highly valued:

> "And she can question herself that is maybe also of some importance. I only experienced this very rarely. Do this and your patients will appreciate you! In case you are going into forensics [prison mental health care]. (I laughs) But I also don't think that this is wrong otherwise, when one can question oneself and can say "Oh, I underestimated that", something of importance or anything." (P533)

Other patient-participants pictured an insufficiently qualified MHP as a person who, in their opinion, did not show good manners. For instance, they described the persons as loud and not very eloquent: "When I see employees who express themselves like peasants and Neanderthals and behave like it and stamp and yell through the whole unit, then I wonder how they got this job." (P559). Another

interviewee summarizes his desperation in a way that s/he had the impression, that the MHPs were at the end of their rope, that they seemed overcharged with his case and did not know what to do:

> "P: Yeah, it was it was giving the drugs, it was escalation, I kept saying to, you know, to them that "I am getting worse. I am getting worse. I am getting worse". Ahm and I just do not think they necessarily knew what to do. Hum I think that was the fundamental problem." (P542)

Discussion

Our study findings provide valuable insights into therapist characteristics and activities that facilitate change in correctional contexts. This is, to our knowledge, the first study to combine qualitative data from Swiss and Canadian experts and to integrate those with the experiences of patients in criminal court-mandated treatment. Our study provides therefore an important contribution to psychotherapy process research, specifically targeting court-mandated treatment settings. This is important as this type of research is in large part conducted with general psychiatry patients and we know very little about patients in the correctional and forensic-psychiatric settings. Thus, our results contribute to much-needed empirical evidence to improve patient's adherence in court-mandated treatment orders.

Above all, our results underline the importance of positive and respectful attitude. This attitude was reflected in genuine interest in supporting the patient by taking the time to talk and demonstrating active listening, followed by adequate and tangible advice or help. Second, our findings highlight the significance of the MHP's willingness and ability to understand the patients' particular needs and their overall context. By allowing the patient to raise their personal concerns and therefore granting them some choice and control over the content and course of therapy, they send positive message enabling patients to feel respected, valued and taken seriously. Further, patient-participants highlighted it as central to focus on their issues in detail and link it to very specific and concrete life examples to progress in therapy and to advance their understanding of the crime committed. The more realistic and lifelike the examples were, the more they perceived the therapy as helpful and as a learning experience. Lastly, the MHP's qualification and skillfulness was questioned when they were not able to answer technical questions, displaying bad manners, as well as giving the impression to be at a loss with therapeutic options. These five findings are discussed more in detail below.

Our results support previous claims, that it is crucial to face incarcerated patients with a respectful and genuine attitude (see for example Epperson et al., 2017; Proeve & Howells, 2006). Reasons for the importance of this topic might be due to their status as prisoners. They are frequently subject to labelling attitudes and with self-esteem likely to be low among this group, it makes them susceptible to humiliation (LeBel, 2008; Walker & Bright, 2009). Taking up a respectful attitude is further important due to the relation of low self-esteem with violence (Walker & Bright, 2009) and its potential to impede change (Tangney & Dearing, 2002). Moreover, respect is not exclusive to the

work with persons who offended as studies with general psychiatry patients link therapists' attitude of understanding and respect with drop-out rates and outcome measures (Ackerman & Hilsenroth, 2003). Respectful attitudes can be described as a therapist treating the individual as a person of worth, which is linked to the overarching concept of "positive regard" (Farber et al., 2018). However, what is specific to offender treatment is to show a valuable and accepting attitude by separating the patient as a person from his offensive acts (Marshall et al., 2003, p. 210). This approach was confirmed by our participants, who underlined the value of a *"humane approach".* Further research is needed to identify certain expressions and behaviors that are beneficial in promoting such a respectful encounter.

Along the same lines, displaying genuine interest in treating and helping the patient might contribute to a positive and respectful attitude. Participants delineated positive therapy experiences when therapists took the extra time to talk and to listen actively, provided adequate advice or concrete support, and took the patients and their problems seriously. By doing so, patients perceived them as genuinely concerned about themselves, which could likewise contribute to positive regard. Positive regard is one of the fundamental therapist characteristics, introduced by Rogers (1957). While there is no universally accepted definition, it is frequently described with terms such as support, affirmation, respect, validation, and active listening. As these and similar terms were frequently expressed by our respondents to describe good MHPs, it might therefore implicate that the overall concept of positive regard is vital in the work with incarcerated persons.

The prominence of this concept positive regard, however, also raises the question whether it is particularly difficult for MHPs to display warmth and maintain a positive attitude towards patients who offended. For instance, Harris et al. (2015) showed that patients' crimes elicited fear and disgust in forensic nurses. To cope with their anxiety, the nurses distanced themselves emotionally and held negative attitudes towards their patients. In general, working with people who offended is described as mentally, physically, and emotionally draining (Scheela, 2001). It is difficult to maintain hope, in particular with patients who stay long-term (Völlm et al., 2016). Nevertheless, some MHP described it as a challenging but rewarding work while this "*humane attitude*", described above, also serves as a coping strategy for MHPs to manage their own negative responses towards their patients' offensive acts (Scheela, 2001). Thus, considering the prominence of this topic amongst our respondents, it seems of utmost importance for MHPs to investigate their acceptance and liking for their patients. Further, as Farber et al. (2018) emphasize that one's ability to show positive regard towards a patient should be regular topic of supervision, it seems to be crucial when working with people who offended.

Moreover, it was important to allow a certain choice and control over the topic and content of therapy as by fulfilling patient's needs and wishes, one targets criminogenic factors likewise. The expert opinions seem to mirror current developments in the treatment of incarcerated populations as in the past two decades, the focus from targeting criminogenic factors exclusively shifted towards the incorporation of more resource-oriented approaches into offender treatment (Vandevelde et al., 2017)

such as the Good Live Model (see for example Ward & Gannon, 2006). The patient's perspective showed that they did appreciate some control concerning the therapy content, which they linked to their motivation to participate as well as perceived coercion. Already for reasons of engaging the patient into treatment, it seems valuable to allow the patient to co-determinate therapy content (see for example Dowling et al., 2018; Fortune et al., 2010). Similarly, Hachtel et al. (2019) concluded that patients' want to be respected and participate in the decision-making process. When they are able to do so, they perceive less coercion in involuntary settings. However, the challenge of finding a balance between focusing on issues relevant to the patient while targeting factors that influence the risk of recidivism requires further investigation.

Another therapist technique that was vastly appreciated was the ability to target personal issues. That is, it was not enough to take time to focus on the critical issues but also to support the patient in linking thoughts and feelings with specific behaviors. Respondents valued when therapists helped them break down questions and issues, and provided specific advice and concrete examples while avoiding vague comments and abstract explanations. This can be closely linked to the directiveness concept proposed, for instance, by Marshall and Serran (2004). They revealed that it was beneficial when therapists suggested possible directions or alternatives to patients struggling with issues. It is further striking that our expert-participants did not discuss this topic. Reasons might be that they are either not aware of this issue or that it is self-evident. Nevertheless, this emphasizes the importance that MHPs should adopt the use of detailed and concrete explanations. Our results therefore provide an important contribution, on how MHPs should target sensitive issues, such as past crimes committed.

Lastly, it is questionable in what relation the perceived skillfulness of a MHP stands in connection to their actual qualification. The example, in which a participant explained that one of his former treating therapist was not able to respond to therapeutic questions without using "Google" as a help, could be linked to clinical experience and expertise. Indeed, some studies show a slight positive correlation between psychotherapist's expertise and clinical experience with outcome factors (Owen et al., 2016). As our respondents also linked poor qualification with aspects such as bad manners, issues other than qualification might lead to this overall judgement. For example, it might rather represent a general frustration and dissatisfaction with the mental health care received, which might result in a person describing the MHP as poorly qualified. MHPs should therefore observe a patient's treatment satisfaction carefully to counteract negative feelings towards therapy. This might be particularly important, as our expert-participants did not elaborate on this topic, suggesting that is not in their center of attention. Issues such as a patient's treatment satisfaction as well as MHPs general self-presentation on the treatment unit should therefore be monitored closely.

Limitations

Incarcerated respondents might have participated due to reasons of coercion in a way that participation in our research study might have been encouraged by other players or by a distinct hope (in spite of the information provided by the research assistant during recruitment) that it could increase their chances for release. This potentially impacts reliability and validity of study results as participants might bring an agenda to the interview setting (Copes et al., 2013; McDermott, 2013). We tried to limit the influences coercion and social desirability by conducting the interviews in a private atmosphere (separate room in the correctional institution in which conversations could not be overheard) and by assuring anonymity during the whole process of data analysis. We emphasized the voluntary nature of participation before starting the interviews and explained the purpose and conditions of our research project thoroughly before the interview. They were informed, that they could refuse participation and that information will not be communicated, so they would not face any negative consequences. Since our results contain narratives of positive and negative treatment experiences, we have the impression that participants felt free and safe to talk without constraints.

Moreover, stakeholders that were interested in participating might have had a specific set of opinions that influenced the study results. As with the older incarcerated participants, we assured anonymity and confidentiality to limit the influence of social desirability. Nevertheless, institutional regulations and cultural mindsets that prevail in a certain environment might affect their attitudes towards what is important when working with court-mandated patients. Our participants worked in diverse settings (forensic units and prisons) and in different countries across several language regions (two language regions in Switzerland and Canada) and therefore might have advanced opinions that exist in the respective context. However, our study provides insight into overarching activities that are important in a wide range of court-mandated settings. Future research should consider to investigate the impact of the differing context factors.

Conclusions

Psychotherapeutic encounters in court-mandated treatment settings are challenged by coercion and control. Our findings show that MHPs working with patients legally referred to treatment need to put additional focus on displaying a respectful and positive attitude. A particular strategy to do so was highlighted as the *"humane approach"*, to value the person but to condemn the offensive acts. This makes the patient feel respected and might at the same time contribute to more positive feelings on the MHP's side. Further, in light of the coerciveness of the therapy context, it was of particular importance to grant the patient some choice and control over the content and course of therapy. Doing so will engage and motivate the patient to participate in treatment. In addition, feedback and advice needs to be concrete, detailed and applied to the person's current situation. Vague and general comments need to be avoided. Lastly, patients questioned the MHP's qualification when they did not

progress in therapy, MHPs should therefore monitor a patient's treatment satisfaction carefully to counteract negative feelings towards treatment participation. In sum, while some therapist activities that promote change in psychotherapy might be similar to general psychiatry patients, such as positive regard, the way they are established might differ slightly in a coercive context. Our study therefore contributes to much-needed research on therapist characteristics that are specific to these contexts.

Declarations

List of abbreviations

MHP = mental health professional

Ethics approval and consent to participate

Ethics approval was obtained from the lead ethics committee (Ethikkommission Nordwest- und Zentralschweiz) which was followed by other local ethics committees.

Consent for publication

Not applicable

Availability of data and materials

The dataset analyzed during the current study is not publicly available. Our analysis is based on qualitative interviews with mental health professionals working in secure settings and older persons living in detention. The individual privacy of our study participants would be compromised if we shared the whole transcripts publicly. However, we can share the parts of the transcripts relevant for this paper upon reasonable request.

Competing interests

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Authors' contributions

HS contributed to data collection and analysis. She further drafted the first version of the manuscript and improved the different draft based on the co-authors comments and suggestions. TW made substantial contributions to the study conception, data analysis, and revision of the work. TV, MG, ML, and MEA provided substantial contributions to data collection as well as by examining the results presented in draft versions and revised the work. BE provided substantial contributions to the study conception and revision of the work. All authors agree to the final draft of the paper submitted and take responsibility for its content.

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4.2.4. Incarcerated older persons' motivation to engage in criminal court-mandated treatment: Findings from a qualitative interview study

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Abstract

Background: Motivation to change is a central component of successful psychotherapeutic treatment. It is however unclear how external pressures in court-mandated treatments interfere with a patient's internal motivation. This study sought to investigate service providers' and users' experiences with court-mandated psychotherapeutic treatment and its effects on a patient's motivation. ***Methods:*** We conducted a qualitative interview study with 41 older incarcerated persons receiving involuntary treatment and 63 mental health professionals (MHP) from Canada and Switzerland. Interviews were analyzed using thematic analysis. ***Results:*** MHP participants referred to the difficulties of using internal motivation as selection criterion for treatment participation but emphasized the advantage of the legal-referral as a chance to connect with a person who would otherwise not seek treatment. This allowed the MHPs to build internal motivation throughout the intervention. Further, we delineate certain external and internal factors that influence treatment motivation. For instance, a patient's strategic motivation to engage in treatment to regain freedom; the influence of external decision-makers on treatment motivation; conveying and understanding of psychotherapy to promote active participation. ***Conclusions:*** Our study provides important empirical findings on the effects of the legal-referral on a patient's motivation. Findings suggest that the legal referral in itself does not stand in contradiction to internal motivation. In fact, it facilitates the engagement with a person needing treatment. However, a patient's internal motivation is challenged, if goals set by external decision-makers are unclear, unpredictable, and vague. To increase the effectiveness of court-mandated treatment, institutions should therefore establish clear goals that are communicated clearly and transparently to the patients. By this, a patient's internal motivation can be enhanced, which ultimately affects outcomes of court-mandated treatment orders.

Introduction

Motivation to change is considered a central component of successful psychotherapeutic treatment (Snyder & Anderson, 2009). Persons, who are legally referred to treatment, are commonly thought to lack internal motivation to engage in treatment (Birgden & Vincent, 2000; Laws et al., 2000; Tierney & McCabe, 2002). Despite this belief, court-mandated treatment orders have been effective in reducing recidivism rates (Kelly et al., 2005), suggesting that mandated psychotherapy can bring about changes in people who are seemingly unmotivated to receive treatment voluntarily (McMurran, 2002).

For a person who suffers from a mental health issue, which is causally connected with the crime committed, a legal referral to psychotherapeutic and psychopharmacological care assures his or her treatment entry and participation. The overall goal of such a criminal court-mandated treatment is to reduce the risk of reoffending and to protect the public (Prendergast et al., 2009; Ward, 2013). The effectiveness of involuntary treatment orders is therefore crucial to protect potential future victims. It is further central in light of the infringement of personal rights, as patients are mandated to treatment against their will (Goulet et al., 2019; Ondersma et al., 2010). In order for the psychiatric treatment to be effective, the sole physical participation is not enough. A patient's cognitive and emotional engagement and a certain willingness to change is required (Urbanoski, 2010). Yet to date, it is unclear in what way this external pressure to engage in treatment via court order interferes with a patient's motivation to engage in therapy and to commit to change (Ondersma et al., 2010; Wild et al., 2006).

The concept of motivation represents a complex interplay of environmental, cognitive, emotive, and behavioral variables, and has been described in numerous theories (Tierney & McCabe, 2002). Concerning the treatment of persons involved with the criminal justice system, the Good Lives Model (GLM) provides an organizing framework for offender motivation (please see McMurran & Ward, 2004 for a detailed description of the GLM model). The model underlines that human behavior is rational and goal-directed (Locke & Latham, 2002). According to GLM, the commitment to a goal is influenced by both internal and external factors. Internal motivators can be aspects such values, beliefs, and intrinsic rewards, while external motivators are rather material or social rewards and sanctions. In respect to persons mandated to treatment, internal motivators frequently encompass avoiding shame and guilt, whereas external motivators are the avoidance of sanctions or social disapproval (McMurran, 2002).

Intrinsic motivation is said to be a stronger predictor of change, especially in the maintenance of therapy goals in the long-term (McMurran, 2002; Snyder & Anderson, 2009). Some authors have raised concerns about the effects of external pressures on internal motivation (Klag et al., 2005; Wild et al., 2006) as it might result in greater resistance to therapy and less motivation to change (Snyder & Anderson, 2009). External leverages to seek and participate in treatment are not exclusive to the

involvement of the justice system but can also originate from informal or formal sources (Wild et al., 2006). The referral source (legal or other) further does not predict the level of perceived coercion (Klag et al., 2005; Urbanoski, 2010). Thus, whether a person pursues treatment out of a sense of personal commitment or because it is required is moderated by a variety of factors, that still require clarification.

Moreover, a mandated patient's participation and engagement in therapy is linked to privileges, parole and release dates (Tierney & McCabe, 2002; Urbanoski, 2010). The treating mental health professional has to provide regular assessments to the justice system of the patient's mental health and progress in therapy (Ward, 2013). The mental health professional's perceived therapy performance of the patient will therefore have a great impact on a patient's life. This consequently increases the likelihood of social desirability, meaning that patients participate in therapy but do not genuinely embrace its goals and the need for change (Urbanoski, 2010; Yong et al., 2015). This behavior is frequently called "strategic motivation", which is not only difficult for therapists to gauge when assessing a patient for the justice system but also when using internal motivation as a selection criterion to allow access to treatment. Even if patients are mandated, access to treatment might be restricted and only open to the motivated ones (Parhar et al., 2008). The patient's involvement with the justice system can consequently pose challenges in identifying intrinsic motivation in regards to the assessment of treatment readiness and progress.

Lastly, as the number of persons mandated to treatment has drastically risen in the past two decades, the question of what works in the treatment of persons who are involved with the justice system becomes more pressing (Goulet et al., 2019). Additionally, the number of older persons has risen at a greater speed than any other age group contributing to a demographic shift within the justice system (Kingston et al., 2011; Williams et al., 2010). In the Swiss prison context, the growth of these two groups overlaps, as the number of older persons is rising drastically among persons mandated to treatment (Bundesamt für Statistik, 2020a, 2020b). Despite this exponential growth, there is little empirical data on the specific needs of this older group (Baidawi & Trotter, 2015; Booth, 2016), particularly in relation to treatment motivation. Moreover, the vast majority of previous research has focused on either the service providers' or service users' perspectives only. It is particularly important to incorporate both perspectives in light of the risk of social desirability. This qualitative interview study will therefore contribute to much-needed research on motivation to change amongst older persons legally-referred to treatment, combining insights from both perspectives.

Material and methods

This article follows the "Journal article reporting guidelines" for qualitative research by Levitt et al. (2018).

Study Design

This qualitative study is part of a larger multi-center research project on mental health of older incarcerated persons ('Agequake in Prisons 2'). As part of the larger project, we collected qualitative data from older persons in prison and professional stakeholders (described below), and quantitative information on older persons' mental health condition from medical records and standardized surveys. As older persons in prison are a minority and there is little data on the mental health of this population (Moschetti et al., 2015), the overall goal of the qualitative data collection was to gain insights into their experiences on aging in prison, living with a mental disorders, and their perspectives on prison mental health care. As these are complex social processes that we, to date, know little about, we applied an explorative qualitative approach to capture these social phenomena. The goal of this research project therefore was to understand the reality concerning mental health of older persons living in detention, to evaluate the prevalence of MH problems and to describe different care solutions concerning these MH problems, comparing older and younger incarcerated persons. TW and BE conceptualized the research project. Both have many years of research experience on the topic of older persons living in detention as well as in employing qualitative methodology (Elger et al., 2015a, 2015b; Wangmo, Hauri, et al., 2016; Wangmo et al., 2015; Wangmo, Meyer, et al., 2016). Ethics approval was obtained from the regional ethics committee (Ethikkommission Nordwest- und Zentralschweiz) which was followed by other local ethics committees.

Data Collection

We conducted semi-structured interviews with three participant groups. On the one hand, we interviewed the population at stake, namely incarcerated older persons (patient-participants) receiving mental health care in Swiss secure contexts (forensic-psychiatric institutions and penal institutions). On the other hand, we interviewed mental health professionals (expert-participants) working with incarcerated patients from Switzerland and Canada (psychologists, psychiatrists, psychiatric nurses, social workers, occupational therapists). Through conducting interviews with both, the ones delivering and the ones receiving mental health care, we aimed at obtaining a more holistic view of the present mental health care situation. The purpose of including experts from Canada was to contemplate other health care approaches that could be useful for Switzerland.

Older incarcerated persons were included if they were currently sentenced to prison confinement, were 50 years and older, and had at least one contact with mental health services. They were excluded if their mental state was too instable and/or prison administration did not allow the person to participate

(e.g. due to dangerousness or solitary confinement). Further, as there is no uniform understanding on how to define an older incarcerated person (Williams et al., 2012), we decided to use chronological age as an inclusion criteria and applied an age cut-off 50 for reasons of accelerated aging. That is, persons living in detention tend to depict poorer health status, defined as functional impairment as well as burden of illness and disability, at a younger age when compared to persons of similar age groups in the community. This health status is linked to future functional decline, health care utilization, and mortality and is therefore a useful proxy to define an older population of higher needs (Combalbert et al., 2016; Di Lorito et al., 2018; Fazel et al., 2001; Greene et al., 2018; Loeb et al., 2008). Also, studies analyzing data of all age groups show that the rate of somatic and mental health issues, the use of prison health services as well as health care costs in relation to this drastically increase after the age of 50 (Hayes et al., 2012; Thomas et al., 2005; Wangmo et al., 2015; Wangmo, Meyer, et al., 2016). Taken together, this preliminary findings resulted in our decision to depict the age 50 as an age cut-off for our study purposes, see Merkt et al. (2020) for a detailed review on the issue of how to define an age cut-off for older incarcerated persons.

We applied a purposive sampling method to recruit each participant group. That is, participants who were incarcerated in Swiss institutions were contacted through a contact person of the prison administration or the mental health service. We shared study information and informed consent with the contact person to distribute them to potential participants in advance. On the day of the interview, we made sure that participants had read and understood the informed consent form. We additionally verbally explained the purpose of the study, clarified that all data were treated confidentially, and that refusal was possible at all times. Thereafter, written informed consent was obtained. Swiss expert participants were contacted by the research team directly. We contacted staff of prisons and forensic-psychiatric institutions by phone or email. Informed consent form was previously sent to them via email, they gave their consent on the scheduled time and date of the interview. Experts from Canada were recruited following two strategies: Mental health professionals working in forensic-psychiatric institutions were contacted directly by the research team, while employees of Correctional Service Canada (CSC) were recruited through contact persons within CSC.

We did not compensate any of the participants for their study participation. Two research assistants completing their doctoral education conducted the interviews (of which one was HS). They were trained in qualitative data collection and received supervision throughout the data collection process. Our interviewers and participants met the first time on the day of the interview, thus, there was no relationship prior to data collection. The interviews with the study participants were semi-structured, questions were therefore open-ended and followed an interview guide specifically developed for the purpose of this study (please see table 1 for a brief overview on the topics covered during the interviews).

Table1. Topic guide for semi-structured interviews

Topic	**Patient-participants**	**Expert-participants**
Personal background information	Personal circumstances and social networks (within prison and relationships with outside)	Motivation to work with incarcerated persons, brief description of their work experience and current roles and responsibilities
Aging in the prison context	Relationships with younger persons in detention, satisfaction with work and free time activities offered, perception of prison environment, future plans	Aging in the prison context: exploration of their experiences in working with older patients, prominent therapy topics of older patients
Access to and quality of mental health care	Types of interventions, frequency and duration of treatments, opinion on access to and quality of mental health care, specific aspects of the interventions that helped/impeded therapy progress, perception of their current mental well-being, questions on possible stigma due to mental health issues	Characteristics of care and interaction with older patients, experiences with specific influences due to working in secure contexts (indefinite release dates, dual role conflict (use of elicitation technique), collaboration with other professions and representatives of the justice system)
Risk assessment	Perception of evaluations by forensic experts, experiences with the procedures.	Experiences in reporting to the authorities (characteristics, procedures, age as a variable in risk assessments, key criteria in reporting standards)

We held one interview meeting with each participant and did not conduct any repeat interviews. We audio-recorded all interviews upon the consent of the participant. We took field notes after each interview. The interviewer held the interviews in the language spoken by the participant, either French, English, German or Swiss German. Thereafter, we transcribed the interviews verbatim in the language of the interview, except for Swiss German interviews, which we transcribed into Standard German. Swiss German is a spoken dialect and it is common practice to use Standard German in writing. We checked the interviews for quality and accuracy of the transcriptions, during which we anonymized any identifying information. We did not return any transcripts to the participants for checking.

We based our decision, on the number of study participants on the principle of data saturation. To identify data saturation of our data, we applied the principles presented by Fusch and Ness (2015); the

ability to obtain additional new information has been attained, further coding is no longer feasible, and there is enough information to replicate the study. To be able to identify when data saturation was reached for each participant group, we conducted data analysis along the on-going data collection. Thus, we were able to include more interviewees if needed. Please see Table 2 for detailed sample characteristics.

Table 2. Sample Characteristics

		Patient-participants	**Expert-participants**	
			Switzerland	Canada
Time period of data collection		December 2017 – December 2018	April 2017 – January 2018	August 2017 – Nov. 2018
Interview length (in minutes)	Mean; Range; Standard Deviation	69; 16 – 120; 25.55	71; 48 – 90; 14.16	60; 28-92; 11.49
Number of participants		41	29	34
Participant Characteristics	Gender	2 female 39 male	8 female 21 male	22 female 12 male
	Age	Mean: 62 Range: 50-76 Standard Dev.: 6.92	-	-
Language region	German-speaking	23	16	-
	French-speaking	18	13	5
	English-speaking	-	-	29
Number of Participants per type of institution	Penal institutions	27	23	21
	Forensic-Psychiatric Institutions	14	6	13

Data Analysis

Data analysis followed the steps of thematic analysis by Braun and Clarke (2006). In a first step, we first familiarized ourselves with the data. Meaning that five project members read and coded together four to eight interviews of each participant group to build a uniform coding tree. Throughout this process, we generated initial codes and discussed overarching themes. This approach allowed us to discuss different nuances that are visible in the data and to agree on how to name different codes, and what the codes mean in case of complex code names. Thereafter, three study team members (TW, HS, and other project members) individually coded all the remaining transcripts and came together to discuss the new codes, solve disagreements, and sorted the final coding tree. This allowed us to further

review initial themes, and define and name them more specifically. In light of the richness of the data and the broad scope of the interviews, coded data related to *"patients' motivation to participate in legally-referred treatment"* were extracted and examined for this paper. That is, HS carefully read this sorted data segments in its entirety, examined the codes applied to this data extract, and further analyzed them with the study purpose as the focal point. HS therefore conducted the in-depth analysis on this topic and produced the final report. Examples of coded quotations were chosen by HS and TW to illustrate the below presented themes.

To support and manage all data analysis processes, we used the software program MAXQDA. Finally, analysis took place in the language of the interviews. For the final report, two research assistants, fluent in German, French and English, translated the codes from the original language into English. The translations were then checked by HS and a project member, and lastly proofread by an English native speaker. All authors agreed to the results presented in this paper and its interpretation.

Results

Please see Figure 1 for an overview on themes and topics. We did not see systematic differences in the participant's responses depending on the type of setting (forensic-psychiatric institution or correctional institution) and therefore do not present them separately. Expert-participants are delineated as E followed by a 3 digit number (EXXX), patient-participants as PXXX. There was no systematic difference between the responses of Canadian or Swiss experts, for which reason we do not present them separately.

Perception and description of patient motivation

Motivation as a selection criterion to enter treatment

Expert-participants drew a distinction between motivation as a selection criterion or a treatment need, and very few were in favor of using patient's motivation as a selection criterion for inclusion in treatment. For instance, one respondent pointed out that in his/her institution patients were only allowed to enter the treatment unit when they showed a certain level of willingness to change and engage in therapy. This "motivational pressure" strategy aims at protecting the treatment group atmosphere characterized by a certain hopefulness and willingness to engage in treatment, as outlined by the following participant:

> "So, for us this is the first step, protecting the milieu and not taking in a significant group of refusers and potential dropouts and those without prospects. We take this decision-making liberty. This means that they [some patients] will occasionally have to wait, (…), and will receive the message that they lack prospects, which is actually also taken into consideration in

> the decision-making, and hence, they have to depict some internal willingness to change. That means we also put pressure on them." (E853)

In the same line, an expert-participant delineates how forcing a person who is not ready for treatment might be counterproductive: "Because if you don't want to work on yourself, you're never going to make any progress. So forcing people to work on themselves is counterproductive in my opinion." (E845). A patient-participant highlighted how patients with little motivation might disrupt the group process and impair therapy progress for other participants who are ready and willing to engage in treatment:

> "Yes, because I see that this/that people here are forced to participate in violence therapy, schema therapy, group therapy, other therapies, they are forced and then they are sitting there completely disinterested, they even disturb those who are willing to do something. They are just not ready. But they have been forced to do it." (P948)

An expert-participant outlined that using motivation as a selection criterion also aims at motivating the patient to show some willingness to participate in treatment. According to this notion, it was important to respond correctly to the differing stages of readiness, to communicate that treatment was available only to persons who show some flexibility in their personality as well as willingness to open up and to be reflective about their attitudes and behaviors.

> "Those who cannot be treated at the moment should not be in a treatment facility. This is the wrong message for everyone, for the practitioners, for those who are working seriously on themselves at that moment, but also for the person in question." (E853)

In contrast, the following patient-participant delineates how his/her request for therapy was rejected several times. This destroyed his/her motivation to seek treatment and ultimately lead him/her to lose trust in the service providers:

> "Imagine that, several years I ask for therapy, several years and they have always refused, everything. And they haven't given me any kind of [treatment] plan. (…) I: Now you don't want therapy any more? P: Yes I/ that is actually I don't trust them anymore. They are accusing me of something." (P932)

An expert-participant emphasized that a side-effect of this "motivational pressure" strategy was that about half their patients would not respond to it and refuse to be 'blackmailed' by MHPs:

> "This does not appeal to everyone by far. Well, there are at least 50% of high-risk and chronically ill patients who do not react to it, who rather react with resistance and defiance and refuse to be blackmailed by representatives of the system and psychological sciences. And

then they prefer to accept their absence of prospects rather than engaging in alternatives. So, a very clear 'No'" (E853)

The legal referral facilitates treatment motivation

A majority of expert-participants doubted the use of motivation as a selection criterion. The legal-referral was, in their opinion, the justified pre-requisite to give access to mental health care. This, they emphasized particularly in light of the difficulty to identify true motivation in the context of court-mandated treatment orders:

> "Let's say that we considered that going there was enough, because we didn't want to say if someone is motivated or not, if he or she invests himself or herself into it or not, because it's still very difficult to assess, we never know if the person is really sincere or not but here we say, ok- sometimes it's objective sometimes it's subjective" (E850)

Furthermore, several expert-participants underlined the beneficial aspect of a legal-referral to facilitate treatment entry and participation, which allows building motivation throughout treatment. They nevertheless emphasized that the legal-referral itself was not sufficient to guarantee treatment engagement but could take effect like a "shoehorn", as outlined by participant E858:

> "So, it helps of course if there is a legal referral there, also in terms of the sentence, that one has to do a therapy, that one gets engaged at all. I: Mhm, it helps...? E858: Well, the, uh, pressure is not / so a pressure of expectation or an order is a good thing, also, especially in such an area. But, that alone... (...) Yes, it is a shoehorn. (laughs)"

Some expert-respondents also appreciated the mandatory aspect of treatment entry because it is difficult for a person suffering from a mental health issue to seek help as it comprises multiple steps: the person has to recognize that s/he has a problem, suffers from a mental health issue, and is willing to accept help from a mental health professional. Thus, it requires a certain degree of self-reflection to identify one's own need for support and commitment to ask for help:

> "Many people suffering from mental illness do not recognize the symptoms or do not have the insight to see that you know, they could really benefit from help or assistance. (…) And even the services in the community are entirely voluntary. Um so you do/ you have to recognize the need and you have to want the help and to accept the help." (E733)

Factors linked to the motivation to engage in treatment

Participants frequently described that it was particularly challenging to distinguish a patient's strength and source of motivation. Most participants outlined that they did not perceive the legal-referral as a hindrance to internal motivation. But they emphasized the need for some internal motivators to

facilitate behavior change. They stated that legal-referral guarantees a patient's entry and participation in treatment but not their engagement in treatment and their motivation to change.

> "Treatment is most effective when the participant is motivated to make changes (…). So you have to do things that that help them to see that their participation is actually in their best interest because they typically think that that they are taking treatment to satisfy us, to satisfy the system uh and the parole board and things like that. And the goal of a therapist, I think, is to help the offender to see that it is not that. It is, it is actually in their best interest because the kinds of things that we do in treatment program will help them to live a better life." (E730)

From the different motivations that we could decipher in the data from both patient- and expert-participants, we distinguished external and internal motivators. An external motivator was thus patient participants' willingness to change for goals that they hoped to achieved. Whereas, internal motivators were, for example, one's own desire to engage in therapy to relieve psychological distress.

Strategic motivation to regain freedom

The main external motivator described by the majority of patient- and expert-participants was the goal to regain freedom, while the official goal of the legal mandate is to reduce the recidivism risk to protect the public. A patient's goal to regain freedom might therefore not necessarily include working on dangerous aspects of their personality to avoid reoffending after release. Expert-participants referred to this as lacking internal motivation while participating in treatment: "Or they try to use services for their own um gain. Not necessarily kind of intrinsically motivated but more you know 'what is this going to look like?'" (E756). In addition to treatment participation, some participants mentioned patients performing good deeds such as the entering and participating in psychiatric and psychotherapeutic treatment and contributing towards victim support as a means to obtain their end goal freedom: "Maybe at one point you also pay for victim support or something, so that you appear in a good light." (E866) The risk of patients showing certain behaviors due to social desirability is consequently high in court-mandated treatment settings. Participants frequently referred to this as "strategic motivation":

> "Not only, but the main motivation uhm is/is not, from my point of view/for many isn't…: 'How can I protect my surroundings [other persons] from myself in the future' but 'How do I get out of here?' (...) the social desirability of course, or, their goal is to get out." (E864)

A consequence of a patient being strategically motivated was that patients were only superficially involved in the therapy process. Patient-participants, who stated that they were coerced into treatment and participated only due to social desirability, said that they avoided talking about the crucial aspects, as succinctly phrased by participant P944: "Then I'll just go to this bloody therapy! I'm not interested anyway, I'll just go along with it, then I'll just babble something."; and by participant PD952: ""It just

became a tactical thing, then, right? Tactical, that means I went there, but he didn't get anything out of it/me."

In the same line, most patient-respondents delineated strategic motivation as avoiding to provide topics of conversation relevant to themselves in particular concerning the crime committed: “Mhm, yes, you can't avoid it, but you can avoid talking about it...” (P957). A few respondents further specified the strategies to avoid talking about the crime such as trying to minimalize or trivialize it as well as trying to justify why they committed the crime. These attempts are targeted at not disclosing anything important that the therapist could pick up on, as further explained by the same participant: “Yes because during the first few years, I was trying to rather find arguments to, to, to abscond confinement, to, uh, to, uh, justify myself, minimize, trivialize.” (P957)

Other patient-participants described avoiding to talk about the crime as part of a tactical approach. The next example depicts the difficulty when patients are convinced of their innocence in relation to the identification of strategic motivation:

> “I wasn't "forced" [in quotes]. But I was told that... for the continuation, to be able to have my leave, outings, etc., uh, they decided that I had to go through a psychiatrist because they wanted me to deal with this problem because I NEVER admitted, what I was/what I was accused of. (…) I just wanted to get the message across that I didn't come of my own free will.” (P962)

While some patient-participants provided examples for strategic motivation in the beginning of therapy, others showed, that participation in therapy can be tactical also at a later stage: “So to be honest, after the sixth year, it was of course strategic, very clearly, I have to admit.” (P952) Strategic motivation is consequently not limited to the beginning of therapy but can happen anytime during the progression of therapy, this is especially important, as many imprisoned persons who are legally-mandated to therapy remain in psychotherapeutic treatment for a long time:

> "Is this pure strategy without an inner willingness to change or are they serious about it? Or third way: - and I think this is the most common - probably it is strategy, but through strategy we can still invite them to just get involved and maybe then it will work out.” (E853)

Lastly, a common reason why legally-referred patients attend psychotherapy for strategic reasons might be their understanding that they do not need therapy as they do not suffer from a mental disorder or that they are well enough to take care of themselves. Due to this reasoning, patients might not see any purpose in participating in treatment other than to follow the strategic goal to regain freedom:

> “We have to deal with people who often think that they are not sick that they don't have problems, however, we can see that they do it's - or there are people who want to take care of

their mental problems themselves and who say I don't need psychiatrists but I prefer to smoke cannabis, for example." (E850)

"I just went to therapy and talked about all kinds of things, just not about the crime. (…) I'm a healthy, mentally healthy person who doesn't need this." From this point of view / that is the opinion of most offenders "I don't need that". (...) P: Yeah, yeah, "don't need that", right? And yes, I simply surrendered myself reluctantly to this, that means / they surely noticed that someone is blocking and not cooperating properly, right, they did notice that. And that's why I was in there longer than necessary. (...) P: Yes I resisted of course, I resisted, I was opposed towards it, and then they realised - now we'll just do art therapy then, right." (P952)

Decision-makers hinder treatment motivation

Several expert- and patient-participants outlined that in court-mandated treatment settings, a variety of external factors influence the treatment process. The most common influences named were decisions by review boards affecting the patient's chance of release. As external persons took these decisions, privileges, for example, were not granted in a timely manner, and decisions were often not in line with the patient's therapy progress. This consequently challenged the MHP in maintaining the patient's motivation for treatment despite the lack of positive reinforcement.

"The only thing is you get people ready but what stops things is the entire review board in our case. They, they don't get the, their disposition. It doesn't allow them to go into the community so, they maybe are ready over the past, over the past six months, but they may not be able to leave the hospital for another year. So what do we do in the mean time to maintain that sense of hopefulness, to maintain that hum, desire to recover?" (E741)

In the same line, several participants highlighted that it crushed one's motivation when you yourself see progress, the therapist confirms progress but the authorities deciding on privileges disagree. This would make the situation feel unpredictable and would make them question the purpose of them engaging in treatment.

"For me personally a lot has changed. Yes. In particular, it has changed, I used to take a lot of drugs and the things I haven't done for eight years now, right. Not at all, right, and uh anyway, the whole way of thinking and acting has of course changed a lot, right. Isn't it, and this is also confirmed by the therapists, right. But now it's like this with me, I've been in therapy for eight years now, now the referring authority has come and said: 'Yes, that's of no use, that's nothing.'" (P923)

"When one asks: 'Yes okay, what can I do so that I no longer have this or that it is diagnosed differently or that which way do I have to go, what are the means?', and there the answers then remain quite vague, open, time will bring it, we will see, have to see how it works, eh yes. (...)

> And that also does something, if you, if you eh have perspectives in the future anyway. That is a very big point, too. That means that you are optimistic, have perspectives, have clear goals, clear dates, then you are also more motivated for the therapy and also more motivated to work on yourself" (P927)

> "I've gotten used to it. No one is going to tell me, 'Mr. [Name of prisoner], so, there you go, well done, you did everything right, you can go now.' They're going to tell me 'No, no, we're going to continue' from the/ the/ finally I THINK that the measure is going to be prolonged and uh, well, if it's for another five years, well uh, 75 years and then this is it." (P957)

Some respondents highlighted the risk of a system, which is repressive with unclear to no chance of release. This uncertainty resulted in one participant not entering treatment, consequently decreasing his/her chances of release. The reason for this was the low likelihood of therapy progress helping him/her to achieve the goal to leave prison.

> "Because this is an uncertain future. Because it doesn't mean that when I go to therapy, that I can go into temporary release after three, four, five years. That does not mean that at all. (...) what comes at the end of the tunnel. It could be that in the end they say 'Yes, that's nothing/not working after all, we're transferring you back to Article 64 [indefinite sentence]'." (P933)

Understanding psychotherapy to promote active participation

The majority of patient- and expert-participants agreed that intrinsic motivation is necessary for treatment to be effective. Understanding the value of psychotherapy was deemed as an important internal factor that promotes willingness to actively participate in the treatment. Expert-participants noted that the mental health professional's hands are tied without the patient's willingness to engage: "If they want therapy, I will see them for therapy but they have to want to, right?" (E732); "But that has to come from them as I said before. And that sometimes can be difficult. We can't do things to them." (E741)

Expert-participants depicted this active participation as a willingness to open up, to introspect, and to self-analyse. Patient-participants emphasized the difficulty of facing one's shortcomings and the pain related to this, which was not easy. It was described as contra-intuitive, and hinders their active participation:

> "It's a lot of work, but... it's impossible to do it, but you have to want to do it too! And I think that if we don't do this job... That's when you can start to have problems afterwards. It's as soon as you work on it, well, uh, every time you overcome an obstacle, I can say that, uh, well, it's by doing the work that you get there. It doesn't just happen, right? I: No, no, it's not a miracle." (P969)

> “But you have to put a lot of your own in to make it work! If you don't have that self-investment you can do years, and years and years of therapy and nothing happens, there is no introspection, there is no self-analysis, it's... it's difficult! There are some, they stay a long time in this prison. Because they don't follow this therapy and they don't see any progress, they stay in denial, they put the blame on others all the time. It's always/ it's quite difficult because it's painful to go and look into yourself, where there are weaknesses, where there is pain, where there is trauma, where there/ there are injuries... you/ you try to protect yourself! It's not natural to go and hurt yourself looking for what's wrong!” (P960)

In addition, to get patients to take an active interest in therapy, patients have to go through a learning-process, which frequently takes place at the beginning of therapy. Expert- and patient-participants delineated it as developing an understanding of what to expect from treatment and what they expect from the patient, as outlined by an expert-participant*:* “It then also needs an, so an understanding, what therapy is and can do, what you can expect and what you cannot expect.” (P858); and a patient-participant: “It's true that therapy doesn't do it all, one has to, I myself have to work too.” (P958).

Psychological distress as a reason to engage in treatment

Expert- and patient-respondents delineated psychological strain as the most pressing reason for patients to seek treatment and at the same time, experiencing relieve from psychological strain and feeling better as the main motivator to engage in treatment. They differentiated psychological strain into three broader topics: factors related to (a) imprisonment, (b) crime committed as well as (c) accepting a psychiatric diagnosis.

First, respondents described imprisonment as a stressful experience due to disruptions with the outside world such as losing job positions and relationships with family and friends. Patients have to cope with a new and very different environment, as outlined by two expert participants: “That may be the, the situation that they are facing is not normal, that may, it is not necessarily them, it is a different environment that they are not used to.” (E756); “ Everyone has their own problems, some of them also have family outside, are worried about the children, about the husband or other family members or about the job.” (E864)

Second, the crime committed and the problems related to it would often cause great psychological distress. Patients would commonly strive to resolve this unpleasant condition and intend to understand the reasons that made them commit a crime. They frequently described the crime as an end-point of a long chain of events that were characterized by difficult life circumstances and a range of losses and failures. It stands in contradiction to a positive self-image and is difficult to integrate into one’s life story, as delineated by the following expert-participant:

> “But the suffering is also a topic. Many of these people also suffer because they have done something or got involved in something that they didn't think about beforehand, didn't plan or didn't want to do and where they/ it does something with them again, so - obviously if you have to go to prison, it does something to you when you are torn out of the world. (…) And, um... often, also in a/ this is an expression of a strong life crisis as well. That the offence stands at a/ after a longer phase of failure and problems.” (E858)

Numerous patient respondents further emphasized the need to comprehend the events previous to the crime and the specific triggers that made them commit the offense. Some wanted to tackle their own childhood trauma to relieve their psychological distress. Others outlined their wish to recognize and name thoughts and feelings linked specific situations. The majority of participants repeatedly vocalized the need to answer unresolved questions and the wish to feel better and perceive forgiveness.

> “To understand as well the injuries that also led me to act wrongly, I have molested, uh, children and then ... it was necessary to understand what was in my head for me to act this way! (...) And the therapy allowed me to put all these ideas into words. (...) I realized that it was difficult, and there was an injustice that was superimposed on another injustice and that was too big, so I said, I have to see a therapist to talk about these childhood traumas that prevent me from understanding my daily life calmly and um... and that made me feel good because I stepped on the other side of the wall! …. It did me good!” (P960)

> “I'd like to feel better about myself and then I don't feel good about myself, (…) hard to accept what I've done eh, I can't accept what, I can't forgive myself(…). When you hurt a child, it's / it's painful, it's hard afterwards. And now I can't take it anymore. (Pause) Now I would like my life to take another turn, yes, I would like to see something else in my life than what I have here/ from what I've done, from what's happening now and then eh it seems to me that I haven't done anything very concrete/ very concrete in my life/ that I haven't done anything good, eh (sighs).” (P958)

Other patient-participants additionally highlighted that accepting the fact that one suffers from a mental health issues caused great psychological distress on it’s own: “We have to live with what we have. (...) We have to understand, accept our illness, yes, psychiatric illness. It is not easy, it's not, the flu or something like that.” (P955) This was described as particularly difficult in light of receiving a diagnosis for a severe mental health issues, such as a personality disorder.

> “And then you have to stay, you have to hold on, because psychologically it hurts. … you know, when someone calls you a psychopath, ‘you're severely suffering from psychopathy. We can't cure it, we can't’. So you ask yourself many questions, obviously, and then what

should you believe in? In the end, you don't know anymore where you stand. You're no more than the shadow of your former self." (P935)

Positive treatment effects motivate to continue therapy

In connection with the psychological strain and the need to ease the burden of feeling distressed, a common motivator was described as "starting to feel better" as result of psychotherapy. An aspect that was named by the majority of expert- and patient-participants to motivate patients to engage in treatment was to realize that therapy helped them to gain some relieve.

> "It's clear that to go and explain to a therapist '[talks about how difficult it was to acknowledge that he sexually violated a child]. (…) But two and a half years ago, three years ago, I wouldn't have dared to talk to you the way I'm talking to you [now]. I wouldn't have dared! But now I think it's something that can help me. (…) Yes! Absolutely! So for me it [therapy] helped me a lot, it helped me a lot, it relaxed me, I was more comfortable. And then when I went back to the cell, well I was fine. I didn't burst into tears." (P969)

Another respondent states that for him/her it is important to, at least, try to find solutions even though you might never find specific answers to the unsettled issues. Thus, they might never find full relieve because you cannot undo the offence committed.

> "It's good for me and I like to go. Because, precisely, because I have so many questions inside of me that I have not been able to answer for myself until now. And certainly there are many/ many questions that won't ever be answered. But at least you have tried to find out." (P940)

At its' best, it seems, that psychotherapy can help the patient liberate from the load to carry, which felt to one patient-participant like freedom within prison:

> "I wasn't well! It was bubbling, it was working... and now, it's fine! It's much better! Now I feel... I feel... ah, to a certain extent, liberated... It's funny to talk about freedom when you're in prison (laughs) but it's true eh." (P969)

Discussion

The aim of this study was to shed light on the influence of the legal referral on treatment motivation. This is particularly important since little knowledge is available on how service providers and users experience the involvement of the external pressure to provide and receive therapy (Wild, 2006). Incorporating patient's views could further make treatment more relevant and responsive to their needs

to increase internal motivation (Levenson et al., 2009). However, the majority of literature on motivation of mandated patients is based on clinical experience rather than empirical findings (Tierney & McCabe, 2002). Our study therefore contributes much-needed empirical data on service providers' and users' experience with court-mandated treatment settings.

Our findings show that using motivation as a treatment selection criterion could prove useful to protect therapeutic group atmospheres. As patient's active involvement in group therapy and the overall group cohesion are significant predictors of treatment outcome (Burlingame et al., 2011; Crowe & Grenyer, 2008), it might be important to respect a person's motivation when assigning to treatment units or group therapies. From our results, it is unclear what criteria should be used to identify a motivated patient since only one respondent reported criteria by referring to a person's openness, reflectiveness, and honesty. Other studies suggest that criteria commonly used to identify an adequately motivated patient who offended encompass the expression of regret for offenses committed, a desire to change, and being enthusiastic about the offered treatments (Ward et al., 2004). However, there is no empirical data that shows a link between these aspects and motivation (McMurran, 2002). McMurran (2002) further criticized that the identification of an adequately motivated patient is often reduced to a therapist's expectation of ideal patients who are internally motivated to change, have made robust decisions to change, have beliefs in their ability to change, and to agree with the professional's point of view.

The identification of motivation in court-mandated treatment settings is further complicated by the involvement of external influences that increase the likelihood of social desirability. Meaning that a patient might try to deceive the therapist to increase his/her chance for release. Our findings show that participating in mandated treatment without embracing its utility and goals is a common phenomenon. Patients- and expert-participants confirmed that this behavior was reflected in the patient avoiding to raise critical issues, talking about irrelevant topics as well as minimalizing or trivializing the offense committed. In fact, denial is prevalent in 87% of sex offenders undergoing treatment (Ware & Harkins, 2015). The function and purpose of denial is manifold, though, as we will outline in the following paragraphs.

Some respondents stated that accepting oneself as a person who committed an offense and who suffers from a severe mental illness posed considerable psychological strain on the patient. This is in line with previous findings highlighting the difficulties in admitting to wrongdoing and criminal activity, which contributes to denial (Dietz, 2020). Other reasons for denial raised by our participants were linked to feelings of being coerced into treatment, not considering oneself as mentally ill and/or requiring help. This is an important finding in view of the fact that perceived coercion is inversely linked to motivation (Prendergast et al., 2009). The perceived need of requiring help might further stand in connection with perceived coercion as a person who acknowledges the need for treatment might perceive less coercion in comparison to a person who does not. This is of further importance because a

patient's engagement in treatment is linked to the degree one identifies with the need and goal of therapy, irrespective of being self- or legally-referred (Wild et al., 2006). This link between denial, perceived need of treatment, and perceived coercion needs to be explored by future studies and could partially explain why the referral source does not predict the level of perceived coercion.

Another possibility to interpret this kind of strategic behavior is within the GLM model (McMurran & Ward, 2004), which takes into account the transtheoretical model of change by Prochaska and Levesque (2002). According to this model, people move through different stages of change representing increasing willingness to change one's behavior. When interpreting our results within this framework, expressions of strategic motivation could reflect an early stage of change (e.g. precontemplation stage). Based on this model's assumptions, interventions should be matched to a person's motivation stage. This suggests that patients in denial might require a different type of intervention that focus on the reasons of such behavior (Tierney & McCabe, 2002). As different therapeutic processes and interventions are appropriate at different stages, it is important to adjust the intervention to the current motivational stage of the patient to develop motivation and enhance treatment engagement (Prochaska & Levesque, 2002). A suitable possibility for this could be the implementation of "preparatory groups", which might further depict an opportunity to assess treatment motivation as well as the patient's ability to find his/her way in a group with more scrutiny. This could ultimately facilitate treatment planning and the allocation of resources at an early stage.

Interestingly, our findings indicate that the majority of participants stated that they appreciate the legal referral as a leverage to treatment entry and participation. This external pressure allowed therapists to get involved with a person who might otherwise not seek treatment. Once in treatment, the therapist has the chance to promote an understanding of what to expect from psychotherapy, meaning that, an active participation is required in addition to an internal willingness to embrace the purpose and goals of therapy. Given the patient remains in treatment, one of the strongest internal motivators to continue with therapy is the realization that the psychotherapy helps one feel better. Viewing such progress was of particular importance considering that both participant groups reported strong psychological distress from sudden imprisonment as well as due to the difficulties in understanding and accepting their psychiatric diagnosis and the crime committed. Even though resistance is common in the early phase of court-mandated treatment (Klag et al., 2005), because of the external pressure, patients might remain in treatment long enough to experience some benefit (Prendergast et al., 2009). This is particularly interesting, as Ondersma et al. (2010) found no association between referral source and degree of internal motivation at the end of the intervention. Further, Parhar et al. (2008) showed that three-fourth of the mandated patients wished to remain in treatment, even if the legal referral was removed. Such findings suggests that legal referral does not necessarily negatively interfere with a patient's internal motivation to engage in treatment.

Still, the external influences in court-mandated treatment settings, which emerge from the involvement of the justice system, were under certain conditions perceived as disruptive to the therapy process. In particular, external decision-makers challenged a patient's motivation to engage in treatment when decisions on leaves, privileges, and release dates were not provided in a timely manner. A unique challenge was when knowledge about therapy goals that increase a patient's chance for release, were not aligned between the therapist and authorities. This lack of clear guidance and unpredictability of authorities' decision-making diminished the patient's motivation. This finding is very important as previous studies have shown that mandated patients who score high on both external and internal motivation, have the best treatment outcomes (Wild et al., 2006). It is also in line with our previous research depicting that conditions and expectations of court-mandated treatments need be explained transparently while external decision-makers need to be tangible and responsibilities clearly assigned (Merkt et al., 2021). This might be a particularly difficult endeavor considering the current judicial framework, in which decisions on privileges and release are made by external judicial institutions. The authorities should therefore be encouraged to use their control and decision making power in a way that respects the consequences for a patient's treatment engagement. This is particularly important as enhanced treatment engagement could possibly improve outcomes such as recidivism rates, which are ultimately linked to the overall goal of court-mandated treatments.

Limitations

Our findings are subject to some limitations that are inherent to a qualitative study design. First, our results do not aim at generalizability but represent common notions and thoughts on the influence of the legal referral on treatment motivation (Leung, 2015). As our patient sample consisted of older participants, the results represent the experiences of one age band only and might be different amongst younger participants. For instance, older participants are more likely to have spent a long time in prison and in therapy. Psychological strain due to this very long incarceration might be higher, as for instance psychological distress has previously been linked with long incarceration times amongst older incarcerated persons (Meuschke & Jagsch, 2020; Opitz-Welke et al., 2019). This due to the higher likelihood of fear of death, loneliness, and social isolation of older imprisoned adults (Pageau et al., 2022). Second, our results might have been affected by social desirability, meaning that participants provided responses that they thought might be expected from them. This, in particular, as incarcerated participants have a higher likelihood of perceiving coercion in regards to treatment participation as they might expect advantages of their study participation in regards to increasing their chance of release (Dugosh et al., 2010; McDermott, 2013). However, we tried to limit the influences of social desirability by assuring anonymity and by conducting the interview in a separate room so that conversations could not be overheard. We further emphasized the voluntary nature of the study participation and explained that withdrawal was possible at all times. In regards to expert-participants, MHPs might have forwarded experiences that are socially desirable in their respective institutions, which we tried to limit by

recruiting participants from 14 different institutions in Switzerland and 17 institutions in Canada. We did not collect systematic information on the type of therapies provided or the time point of data collection during the on-going intervention (e.g. beginning or end of the intervention, number of weeks/years since start of intervention). As motivation is not a static condition but might fluctuate over time (Klag et al., 2005), we cannot provide any insight on the development and alteration of motivation in dependence of the different context factors.

Conclusions

Our findings indicate that the legal referral is not necessarily a hindrance to internal motivation. However, external pressures can represent a challenge to the development and maintenance of patient motivation, if they are not in line with a patient's therapy progress. A particular challenge was when the therapist's and patient's perception of therapy objectives and achievements deviated from that of the authorities. External decision-makers need to cooperate with treating therapist to align therapy goals and to communicate them transparently and clearly to the patient. Further, the use of internal motivation as a selection criterion to allow access to treatment is rare, lacks specification and needs further clarification. Instead, internal motivation was predominantly considered a treatment need. In this regard, perceiving a need for help due to psychological strain is a main motivator when a patient perceives treatment as helpful in this regard. Thus, the legal referral serves as leverage to get in contact with a person who would otherwise not seek treatment. If an initial understanding of psychotherapy can be conveyed and resistance overcome, the perception of the beneficial aspects of therapy contribute to the patient remaining in therapy. In sum, external pressures can be used to the advantage of the therapy process, when applied in timely and transparent manner that can be aligned with a patient's internal values and objectives. Future research should therefore investigate the involvement of decision-makers on patient's internal motivation, in particular assessing their impact at different time-points during the intervention.

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4.2.5. Forensic-psychiatric risk evaluations: Perspectives of older incarcerated persons and forensic experts from Switzerland

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Abstract

Background: Forensic-psychiatric risk assessment of persons in prisons aims to provide treatment for their mental health disorder to prevent risk of recidivism. Based on the outcomes of such evaluations, the future of the accused person, for instance, to either be released or further treatment with or without privileges, are decided. Thus, negative assessment means that the person must remain in prison or forensic institutions until the time that their mental health has improved to be safe enough to live in the community. ***Methods:*** Data for this manuscript are gathered using semi-structured one-to-one interviews. The study participants included a purposive sample of 41 older incarcerated persons under measures in Switzerland and 29 expert participants working in Swiss prisons or forensic institutions. We analysed data relevant to forensic risk assessment using thematic analysis. ***Results:*** Study findings within four themes are reported, where we first describe the standard and procedure that expert participants use to carry out adequate risk assessments and conditions under which they refuse to perform such assessments. Thereafter, we present expert participants' concerns associated with predictive risk assessments and highlight the need to be cautious in coming to a conclusion. This theme is followed by the issues associated with the expert and their forensic-psychiatric expertise from the perspective of older incarcerated participants. That is, they report the inconsistencies with the forensic expertise and their belief that these reports tend to be negative towards them. Finally, older participants relayed their experiences of how these evaluations negatively impact their lives and their perspectives of a different future. ***Conclusion:*** The perceptions of the forensic-psychiatric risk assessment point to the need for a clearer communication on how these evaluations and their decisions take place. As incarceration under measures denotes the necessity to continue therapy and reduce dangerousness, it is important that the accused persons understand his or her real progress, feel that the decisions are objective and justified, as well as are aware of the progress that must be made to achieve the goal of eventual release. Such clarity will not only be valuable for those under measures, but also the justice system.

Introduction

Forensic-psychiatric risk assessment of persons in prisons, who are deemed dangerous due to their mental disorder and their crime, is ubiquitous (Singh et al., 2014). Structured instruments are often used to assist in examining risk and making risk management plans (Cornish et al., 2019), which are not without limitations (Cornish et al., 2019; Fazel et al., 2012; Howner et al., 2018). Forensic assessment informs judicial decisions (Helmus, 2018; Moulin et al., 2018) made in the length of incarceration of the person (i.e. sentence vs. measure, prolongation of measures), (further) treatment, privileges, and release from prisons. The forensic mental health system is tasked with the role of balancing risk management to avoid future potential harm to others as well as providing treatment to persons in prisons who suffer from severe mental health illness (Howner et al., 2018; Steinau et al., 2018).

The forensic-psychiatric risk evaluation leads to several ethical dilemmas. Horstead and Cree (2013) discussed how patients in forensic risk assessments are passive actors where the assessments are done to them, affecting their progress. In such situations, the patients believed that the purpose is to punish them further, highlighting the opposing perspectives of patient (i.e. freedom) with that of the expert (i.e. ensuring adequate evaluation). Another concern is that of dual loyalty, that is, the expert performing such assessments may in some rare cases also be the treating therapist (Pham & Taylor, 2018; Pont et al., 2012), or that reports written by the therapists are consulted in the evaluations carried out by the experts. Treating therapists' dual loyalty concerns in the Swiss context have been discussed in recent publications (Merkt et al., 2021; Merkt et al., 2021). Also, studies have reported ethical concerns related to medical confidentiality and how professionals ensure clarity of their role as forensic-psychiatric experts (Appelbaum, 1990; Elger et al., 2015a, 2015b). Since forensic psychiatric assessments are not error-free (Combalbert et al., 2014; Nilsson et al., 2009; Rogers, 2000), there are important ethical concerns of rights of persons deprived of liberty to be freed when their punishments are served and their rights not to be unduly punished for crimes that they may or may not perpetrate in the future.

Brown and Singh (2014) underlined three risk assessment approaches used in different contexts: unstructured clinical judgment, actuarial assessment, and structured judgment. Unstructured clinical judgment is an individual (and possibly subjective) evaluation of a client's likelihood of an adverse outcome without using any assessment tools. Here, clinical skills and experience are the key components. Actuarial assessment includes use of structured instruments that assess protective, risk, static and/or dynamic factors associated with adverse events using statistical methods. Thus, this approach is objective and transparent, but often problematic because validation of the instruments has been done in a few countries (often the US) and thus can only partially be extrapolated to other countries. Finally, structured professional judgment uses risk assessment tools to assess factors (risk, protective, static, dynamic) associated with adverse events (Brown & Singh, 2014). However, the scores help experts to make categorical risk judgments (low, medium, high), which is combined with clinical

experience with the client. This is not as objective as actuarial methods but less subjective and thereby less biased compared to unstructured clinical judgement.

Upon comparing the risk evaluations carried out by forensic experts in Switzerland using unstructured clinical judgment and psychology students using the Ontario Domestic Assault Risk Assessment tool, the latter group was more accurate in assessing long term recidivism among perpetrators of intimate partner violence than the experts (Seewald et al., 2017). The findings point to the subjective nature of unstructured clinical judgement and how experts may not always be the best in judging an outcome. Several other studies on risk assessment from Switzerland describe mostly the validity and use of actuarial tools for the risk assessment process (Dietiker et al., 2007; Endrass et al., 2009; Rossegger et al., 2013; Urbaniok et al., 2007; Urbaniok et al., 2006). A few studies describe the forensic-psychiatric evaluations and their shortcomings (Combalbert et al., 2014; Dahle & Lehmann, 2016; Fazel et al., 2012; Nilsson et al., 2009), but they are not specific to Switzerland.

We are not aware of any study that captures the perspectives of forensic-psychiatric experts and imprisoned persons in Switzerland on how forensic-psychiatric risk assessments are carried out and their consequences as experienced by those affected. Hence, our aim is to highlight the process of these forensic-psychiatric evaluations and the challenges faced by the two parties directly involved in this process: forensic-psychiatric experts and older imprisoned persons under so-called measures, which if renewed several times can be conceived as a form of indefinite incarceration. In doing so, our findings provide nuanced understanding of the process and present ethical concerns that often remain hidden.

The context of measures in Swiss prisons

The Swiss Criminal Code (SCC) distinguishes penalties (imprisonment of a defined duration) from measures. The latter are applied if the penalty alone is not sufficient to reduce the risk of recidivism and requires the offender to undergo treatment. Measures imply regular evaluations of the treatment's effect and of dangerousness. They are often regularly renewed and may thus result in a form of indefinite incarceration (when negatively evaluated and prolonged again) of imprisoned persons to ensure safety of the general public.

Such incarceration is possible under, for example, Article 59 SCC, an in-patient therapeutic measure where the goal is to treat the underlying mental illness associated with the crime. It enables further incarceration until treatment has proven successful. Thus, upon successful treatment, the person can be released. When at the conclusion of the criminal trial it is concluded that the mental health condition could not be improved with the treatments offered and/or if the person is considered very dangerous, the judgement of indefinite incarceration may be pronounced (Art. 64 SCC). In case (s)he is considered treatable at a later time and his or her indefinite incarceration can be converted to Art. 59. In such cases,

(s)he would receive mental health treatment, which theoretically opens the chances of a release in the future.

In the Swiss prison context, forensic-psychiatric assessments are carried out to comply with requests from the court and its authorities before imprisonment by court appointed forensic experts. Forensic-psychiatric evaluation of whether the measure should be prolonged occurs at least every five years. This evaluation is carried out by an external (forensic) psychiatrists. These assessments influence decision-making at different levels (e.g. privileges, continuation of measures). According to Swiss law, forensic-psychiatric assessments require the expert to cover four aspects: (a) diagnosis of mental health disorder, (b) criminal responsibility and related link between psychiatric disorder and crime, (c) risk of recidivism, and (d) the necessity and the prospects of treatment success of the offender. Based on the experts' reports on the above four points, only judges have the normative decisional authority.

Methods

The data included in this paper are part of the larger project "Agequake in Prisons – II" that aimed to capture the situation of older incarcerated persons serving security measures and those receiving mental health care in Swiss psychiatric and penal institutions. The project captured data from two participant groups: expert stakeholders involved in the provision of mental health care; and older persons receiving such care. An older incarcerated person is someone who is 50 years and older (Merkt et al., 2020), and the emphasis on older persons is due to their rising number in prisons worldwide. However, as they still constitute a minority group in prisons, studies that seek their perspectives on the topic are lacking (Haesen et al., 2019; Moschetti et al., 2015). The overall project was approved as part of a multi-center study by the competent cantonal ethics commissions.

Study participants

The inclusion criteria for the older incarcerated participant group were: (1) 50 years and older; and (2) at least one contact with mental health service. These participants were recruited purposively from 11 of the 26 cantons (i.e. states) in Switzerland where data collection took place. From the included cantons, 15 prison and forensic institutions agreed to participate in the project and thereby support recruitment. We excluded correctional institutions that housed juvenile or remand prisoners exclusively as well as deportation centers. The older participants were contacted either through members of the prison administration or the mental health service. These contact persons handed out the study information and informed consent to prospective participants. An interview schedule was set by this contact person in the institutional setting.

The expert participant group was also selected purposively and included those involved in mental health care provision in prisons and psychiatric institutions. The expert participant list was compiled using the Internet. All expert participants were first contacted via email or phone; thereafter they received study information and the informed consent documents by email before the interview.

In total, 57 incarcerated older persons were interviewed and 31 interviews were carried out with expert participants. At the stage of data management, we excluded 7 interviews from the older incarcerated group due to quality reasons, and 2 interviews from the expert group because they were not involved in mental health care of prisoners, but somatic care. Participant characteristics are presented in Table 1.

[Table 1 here]

Data collection process

All interviews were conducted by two female research assistants (one of them HS), who were doctoral students at the time. They received qualitative interview training before starting data collection. Data collection was supervised by two main supervisors of the project, TW and BE, who have led a similar project in Switzerland (Wangmo et al., 2017; Wangmo et al., 2018).

Interviews with older incarcerated participants took place in the institutional settings and those with expert participants mostly in their offices. The language of the interviews was German, French or English, based on the preference of the participants. At the scheduled time of the interview, the researchers explained the purpose of the study, clarified that all data was treated confidentially, and that withdrawal was possible. Thereafter, written informed consent was obtained.

Interviewers and participants met for the first time on the day of the interview; there was no relationship prior to data collection. The research team offered no compensation to either group for their participation. These interviews were carried out between April 2017 to December 2018. All interview discussions with participants took place only once. There were thus no repeat interviews and interview transcriptions were not shared with the participants for further comments. The average duration of interviews was approximately 70 minutes. Please see Table 2 for the topics covered during these interviews.

[Table 2 here]

The number of interviews completed depended on the principle of data saturation (Fusch & Ness, 2015; Guest et al., 2006). We conducted data analysis alongside on-going data collection, during which we were able to identify that the new data being collected were not adding any further themes.

All interviews were tape-recorded upon consent. Project assistants transcribed these recordings into the language of the interview. Each of these transcriptions were checked for accuracy by another project assistant. All identifying information was removed during the transcription process.

Data analysis

For both sets of interviews, the data analysis followed a similar process. In the first stage, five project team members (TW, HM and 3 assistants) met to analyze 8 interviews each from both datasets. This process allowed the team to ensure that there was a common understanding of the coding process and to develop a set of codes and memos. During this process, we discussed the different nuances that are visible in the data and sought to agree on how to name different codes, and what the codes mean in case of complex code names. Thereafter, three study team members (SH/FP, TW, and HS) independently coded all the remaining transcripts.

In light of the broad and explorative nature of the overall project (refer to Table 2, interview guide), further in-depth thematic analysis (Braun & Clarke, 2006) took place at the level of the topic chosen for this paper. This also meant that out of the 50 interviews with older participants, data from 41 were used since they were serving measures and thus have had experience with forensic evaluation.

Specific for this paper, the following steps were taken. All data relevant for forensic-psychiatric evaluation such as coded extracts within themes: “risk assessment”, “measures 59 and 64” and “management and legal issues” were extracted and they formed the data set for this manuscript on risk assessment. TW then re-analyzed this data set and developed themes, which were discussed with two assistants familiar with the data. Modifications were made based on those discussions. The final presented results are the outcome of careful discussions and agreements reached with all co-authors. We agreed on the following four themes relevant for the goal of this paper: (a) Process for an adequate forensic-psychiatric evaluation; (b) Risk of recidivism as the key expectation; (c) Concerns with the expert and the forensic-psychiatric expertise; and (d) Forensic-psychiatric evaluations – hopes crushed. To substantiate our findings, we present quotes from our participants. Longer quotes from participants are provided in the Tables, with one table corresponding to each theme.

Results

Process for an adequate forensic-psychiatric evaluation

All expert participants from both regions discussing the process of forensic-psychiatric evaluations stated that they use written sources of information to carry out their evaluations. The sources of

information included medical/clinical reports and criminal files, that are normally made available to them. Furthermore, they participated in discussion(s) with the person being assessed. As part of their forensic-psychiatric expertise, some also complete question catalogues that contain different tools used to assess dangerousness to provide evidence for possible recidivism (Table 3, EPQ1).

[Table 3 here]

One expert participant reported that s/he refuses to carry out an expertise if s/he has only access to the criminal file, but not to the patient or at least medical/clinical files. The reason for this was that an expert cannot come to a reasonable conclusion if all other sources of information are not available. In such cases (e.g. the refusal of the to be evaluated person to talk to the expert and the lack of a clinical evaluation in a medical record), this interviewee considers it inappropriate to come to any opinion on the diagnosis of possible mental health issue, a key component in their assessment, although the law allows expert reports under such limited conditions. Another expert, who reported completing an expertise with only written information sources revealed that their final report is more conservative since it is based only on available documents and not a combination of written reports and discussions with the imprisoned person. Thus, the lack of opportunity to get an understanding of the incarcerated person with direct contact was viewed as a non-ideal way of making a forensic evaluation since it risks being harsher than normal. See Table 3 (EPQ2 and EPQ3).

In relation to the forensic-psychiatric evaluation procedure, expert participants from the French-speaking region revealed that two experts are involved in the evaluation. The goal is to ensure that the findings are as objective and unbiased as possible. In the German-speaking region, such evaluations are essentially carried out by one expert. Nevertheless, some participants noted having discussions with colleagues (keeping personal details of the prisoner confidential). These expert participants appreciated such informal discussions to ensure that their analysis of the situation is acceptable. See Table 3 (EPQ4 and EPQ5).

Although expert participants reported that while court appointed experts during the trial cannot be treating therapists of the patient, it could be that the expert and the therapist are from the same institution. Such situations may occur when no other expert is available. However, a few expert participants explicitly stated that they refuse to complete an expert report for the evaluation of measures for their own patients. In cases where the forensic psychiatrists carry out expert evaluations at the request of courts during trials, they noted that they ensure that the assessed person knows that there is no therapeutic relationship between them, and they are purely being assessed as agents of the justice system. See Table 3 (EPQ6 - EPQ8).

Risk of recidivism as the key expectation

After the trial, once the measure is pronounced, according the interviewed experts the most important part of the report becomes the question of recidivism. One expert criticized that this is even the case during the trial. Although therapeutic measures were conceived originally for those offenders that are not or only partially responsible for their acts and should thus not be punished but receive treatment, responsibility is neglected: “In the expertise, it is very clear, practically nobody is interested anymore in the question of responsibility. The only thing that people are interested in is the recidivism risk and the measures” (F03).

For many expert participants, highlighting the future dangerousness of a person was a difficult task. They equated it to forecasting and making ‘educated’ guesses based on data that they know of from other studies. Participants underlined that such judgement of dangerousness and thereby the chances of recidivism is a subjective evaluation. Many clearly reported being very cautious in how they communicate this information. That is, they cannot and do not provide any quantified recommendation on recidivism and are only able to relay a sense of whether the risk is low, medium or high. Furthermore, several expert participants concluded that whether someone will recommit a crime depends on many factors such as the type of original crime, their mental health, how the patient works/worked with his own illness during the therapy, and individual factors (e.g. social network). Thus, the expert participants spoke about the conflict between how the justice system wants a precise prognosis of recidivism and their sheer inability to do so. See Table 4 (EPQ1).

[Table 4 here]

The demand for a clear recidivism prognosis is driven by the notion of public safety, which is said to be an omnipresent factor that guides the justice system’s decision making process. Many expert participants wondered about the relationship between the different aspects and the actual effect of measures on recidivism: “did the person have a mental disorder at the time of the event? … is this person dangerous? So, is he likely to reoffend? … Can we reduce recidivism by applying measures?” (F17).

Some expert participants also stated that the questions related to risk assessment need to be interpreted carefully. The reason being that these questions from risk assessment tools may not be validated for persons incarcerated in Switzerland. At the same time, they were aware that these tools could potentially be interpreted differently based on who is reading the results, for what purpose, and the person’s ability to understand the nuances of such tools. Therefore, they voiced that risk communication based on the results of these tools need to be done with much caution. A participant revealed that (s)he finds the tools useful to structure his/her report and not to come to a conclusion. See Table 4 (EPQ2 and EPQ3).

Different from most expert participants, only one expert participant reported that (s)he recommends prolongation of security measures only when it is necessary and serves a particular purpose: “Measures are extended if and only if it makes sense. [...] I have seen that patients were released, where we thought

that this would certainly go wrong […]. Considering that the measure was useless, we had to end it (D15)". Because of this safety imperative, measures are often prolonged and may be perceived as similar to indefinite incarceration.

One older participant stated "Article 59 is a life sentence in disguise, […] an electric chair in disguise" (F85). Similarly, many incarcerated older participants reported that their sentence was prolonged based on the post-trial forensic-psychiatric evaluations and that there was very limited to no hope of being released. These participants thus highlighted repeatedly that it is very difficult to get out of a measure. A few older participants even said that they no longer require therapy, but they still remain in prison and are not released. Their measure has continued with the renewal of Art. 59. In stating so, they underscore the fact that measure (both therapeutic measure and indefinite sentence) practically takes away the real prospect of a release. See Table 4 (OPQ1 – OPQ3).

Concerns with the experts and their expertise

As evident from the results presented above, older incarcerated participants perceived forensic-psychiatric expert reports and the decision that results from them as a hurdle to their freedom. The older participants felt that experts write their reports as if they know the future and spoke critically about the experts. They doubted expert's competence and were bothered by the fact that their future depended on a report. One participant stated that such predictions about the future should not be done by psychiatrists: "Because these are things that are predictive and the prediction should not concern psychiatry. Psychiatry should be based on facts, not predictions. You destroy a lot of people like that" (F57).

The older participants' doubts about expert's quality of work was highlighted with the point that different experts tend to provide different reports. One participant noted, "when I look at this report, the only thing that I realize is that everyone who comes to me and wants to judge me will come up with something new" (D55). Hence, several participants asked how they could trust anyone's evaluation if these evaluations of dangerousness vary based on who is evaluating them. This point further brings forth the lack of standardization across different experts as well as the inherent problem that these evaluations are difficult and subjective (also discussed by the expert participants) and the fact that the decisions are made by the justice system. See Table 5 (OPQ1).

[Table 5 here]

Furthermore, many older incarcerated participants felt that these forensic-psychiatric evaluations are written with considerable hesitation in light of the chances of recidivism and the presence of the public safety imperative. To some of them, this meant that negative reports were generally written that would justify extension of measures. They stated that neither experts nor judges wish to take responsibility for any future crimes that may happen. They also provided national examples of negative events that have

occurred in the recent past when released prisoners have recommitted a crime, which led to reduced chances for everyone in the future. That is, negative event(s) colors everyone's perspectives and affects all persons who are in the process of being evaluated by forensic experts. This also means that the incarcerated persons receive fewer privileges, or rather, fewer chances to prove that they have improved and deserve more privileges and eventual release. See Table 5 (OPQ2 and OPQ3).

Several older participants stated that they find expert reports completely unfair and unacceptable. According to them, the reports are written in such a way that negative points are highlighted and positive points are hidden away, as well as additional unrelated information added. Along the same lines, two older participants stated that even if there is a positive evaluation, it is rejected. Hence, participants felt that the decisions are picked to come to the worst outcome for the incarcerated persons. See Table 5 (OPQ4 – OPQ5)

Other complained about procedural errors and reports being inadequate. They reported that decisions are taken behind their backs since the goal is to keep them imprisoned, thereby raising the issue of whether the entire expertise process is only a formality to confirm the intention to keep them in prison and not a truly open form of procedural justice. Older participants also questioned why experts would ever side with them since the experts are paid well for their work and that they have no interest in the incarcerated persons' future. See Table 5 (OPQ6 – OPQ8).

Forensic-psychiatric evaluations – hopes crushed

The forensic-psychiatric evaluations were viewed by the older participants as an ordeal, as prolongation of measures occurs every five years and in the absence of strong arguments advanced by the expert they continue to remain in prison. This thus results in the eventual building up of hopes and hopes being crushed each time. Some older participants described their situation as that of powerlessness. Despite good therapy progress and many years in prison, their much desired (and earned) release into society is weighed against public safety, where the latter ultimately triumphs since the perception of the justice system is that release is only possible if the risk of recidivism is zero. Therefore, forensic-psychiatric evaluation was a source of disappointment and frustrations. One participant concluded that it would have been better to hand out a life sentence of 40 years than to continuously renew a prison sentence using measures. See Table 6 (OPQ1 - OPQ3).

[Table 6 here]

Finally, a few older incarcerated participants whose measures were renewed suggested that the decisions of the justice system were illogical. That is, even after their measures were prolonged a few times and although they believed they have made continued progress, their risk was not deemed to be diminishing.

To them, the message of these judgements was that the more you stay in prison, the more dangerous you become (Table 6, OPQ4).

Discussion

Unlike other studies that describe forensic-psychiatric risk assessments and their use for judicial decisions (Combalbert et al., 2014; Dahle & Lehmann, 2016; Moulin et al., 2018; Nilsson et al., 2009), our findings provide empirical evidence on this evaluation process from two different participant groups involved in this process. This adds to the Swiss literature, which mostly focuses on the validity of risk evaluation tools in this context (Endrass et al., 2009; Rossegger et al., 2013; Urbaniok et al., 2007; Urbaniok et al., 2006). Overall, our results present important qualitative data that supplements knowledge that we already have from quantitative studies questioning the value of predictive risk assessment (Fazel et al., 2012; Nilsson et al., 2009). At the same time, we identify several important gaps in the process of forensic-psychiatric risk assessment in Switzerland, and in doing so, raise critical concerns.

The legal system has a difficult role to play in forensic-psychiatric evaluations. It is tasked to ensure the safety of the public, while assuring that the rights of the incarcerated persons are not violated and they do not suffer undue harm (Steinau et al., 2018), described in some legislations as cruel and unusual punishment ("Amendment VIII. U.S. Constitution,") or cruel, inhumane and degrading treatment (European Court of Human Rights, 1950). To ensure a fair process, objectivity is sought in these forensic-psychiatric evaluations. The goal of an expert's report is to provide critical information in reaching a legal decision. The role of forensic psychiatry in this evaluation process has been debated on ethical grounds (Appelbaum, 1990; Stone, 2008). These evaluations in essence develop a judgement on, for example, whether an incarcerated person shows improvements in his or her mental health condition that are sufficient to be sure of public safety via reduced risks of recidivism. Our elderly participants complained that creating such a risk assessment is no more than educated guessing and most experts admitted limits of their own evaluations as well. This is a concern that Stone (Stone, 2008) already raised against such evaluations more than three decades ago, and newer research underlines the lacking strength of such predictions (Fazel et al., 2012; Yang et al., 2010). Therefore, it is not surprising that the outcomes of this evaluation are said to be far from fair, with scholars questioning the weight placed on these evaluations in deciding the fate of the person under question by the justice system (Rogers, 2000; Stone, 2008). We note that expert participants cautioned against the use of risk assessment tools for coming to a decision as well, since averaged group values are not necessarily a reliable indicator of one individual person (Nilsson et al., 2009; Skeem & Monahan, 2011).

Our expert participants were aware of the bias associated with interpretation of risk assessment tools and acknowledged that their forensic-psychiatric assessments suffered from several shortcomings

(Brown & Singh, 2014; Howner et al., 2018; Singh et al., 2014). First, the procedure of carrying out this forensic-psychiatric evaluation lacked complete standardization. Most expert participants reported undertaking risk assessment when all sources of information are available in order to make the best judgment, a standard that is necessary to ensure fair process to the accused person. However, a few noted working with less information. These experts reported having to work with reduced information, such as lacking opportunities to meet with the person under evaluation and/or unavailability of relevant files. As noted by one expert, evaluations tend to be harsher than usual when they are written without meeting the person. The lack of access to the accused persons and/or their medical files is often due to their own refusal to allow such access to forensic-experts. The question remains of how to react in situations where the available material is too scarce to permit a professional judgement. Experts seem to use different standards regarding when to refuse the acceptance of an expert mandate. The risk that a few of them might agree to offer recommendations based on (too) limited material raises the ethical concerns of unfairness and undue further punishment as every incarcerated individual should be treated similarly when facing punishment.

Another concern with the post-trial forensic-psychiatric evaluations was that they were not always completed by third party experts with no relationship to the person under examination - thus potentially raising ethical dilemmas related to dual loyalty, which have been discussed extensively in this context (Pham & Taylor, 2018; Pont et al., 2012; Sadoff, 1988). Appelbaum (Appelbaum, 1990) noted that it is acceptable for psychiatrists to be in the position of forensic evaluation when there is no therapeutic relationship. This did not seem to be the case all the time as per the reports of our expert participants, but we cannot exclude that these might be exceptions. Also, since clinical reports written by therapists can also be consulted in building the expert evaluation, irrespective of whether the expert is independent of the accused, the issue of dual loyalty may remain, as the therapists' clinical judgment could potentially influence the legal outcome. We underline that in this paper, we did not include data related to dual loyalty, which is discussed elsewhere (Blinded for Review 1, under peer-review; Blinded for Review ii, In-press).

To address the issue of subjectivity, some expert participants in the German-speaking region stated that they discuss cases with other experts. Although this is a potentially beneficial process, the risk remains that the other expert may be able to identify the person under discussion, raising potential medical confidentiality concerns (Elger et al., 2015a, 2015b). When the risk to confidentiality is evident in such situations, the question arises whether this is a justifiable risk to reach a better outcome for the person under evaluation. In a similar but different manner, expert participants from the French-speaking region discussed how they either conduct the evaluation in pairs to reduce subjectivity and ensuring some level of objectivity (Brown & Singh, 2014; Seewald et al., 2017).

Not surprisingly, subjectivity was also highlighted by the older incarcerated participants. They first stated that the reports differed based on the expert carrying out the evaluation, thus underlining subjectivity at the level of the individual expert. As a consequence, the future of the person under evaluation depends on a luck-factor associated with getting a "nice" evaluator. Inversely, if a person under evaluation receives a "difficult or overly cautious" evaluator, he or she may remain in prison for prolonged periods, as noted by our participants, who reported how difficult it is to get rid of measures. These experiences of the imprisoned older participants concur with what Horstead and Cree (Horstead & Cree, 2013) concluded: that incarcerated patients have lost faith in this forensic risk assessment process and believe that the aim is to further punish them. Moreover, these beliefs of the incarcerated persons that the system is working against them runs parallel to how the forensic reports are interpreted by the justice system, with an inherent presumption against the group under investigation (Nilsson et al., 2009).

The second level of subjectivity reported by the older participants pertained to experts "cherry picking" facts from different available reports on the assessed person, in order to appeal to the public safety argument and zero-risk culture. Such tendencies depict expert evaluators' caution in light of negative events that are independent of the person being evaluated (recidivist events such as rape and murder committed by another imprisoned person) that have been publicized in the media. The experts fear a public backlash and are also wary of the risk of losing their jobs in case their judgment turns out to be wrong. Given that the process of post-trial forensic-psychiatric evaluation occurs every five years, it is natural that the evaluated persons hope for a better outcome each time. But when the outcomes are perceived as not dependent only on their progress but on events unrelated to them, their hopes are crushed each time and they lose any prospect of a different or a better future and possibly also motivation of continuing therapy. That external factors beyond their control at times take precedence in how their cases are handled, that is, one negative case resulting in further punishment for all prisoners, reveals a problematic aspect in the system and points towards a problem of collective punishment, which is inhumane according to international guidelines (International Committee of the Red Cross).

Limitations

The study employed a qualitative methodology where forensic experts and older persons in prisons relayed their perceptions and experiences with the risk assessment process and its outcomes. The participants were chosen purposefully. In light of the research design, we do not claim our findings to be generalizable to all contexts, and they do not depict the experiences or perspectives of all forensic-experts in the country as well as other prisoner groups (e.g. younger prisoners). Our findings are nevertheless informative for others carrying research on the topic. We also cannot exclude social desirability bias, that is, our participants particularly the older persons under measures may have forwarded the worst case picture to fit the general negative perception of the forensic-psychiatric risk

evaluation process. At the same time, we interviewed older incarcerated person under measures, which indicates their generally long prison stays may have an impact on their views. Similarly, our expert participants may also have provided a more neutral account of the process in general and avoided the extreme cases that may ultimately raise more critical ethical concerns.

Conclusions

Our results question the overall quality and value of risk assessment due to its inability to reach a clear, consistent, and objective, hence valid prognosis. Experts themselves see their work as "educated guesses". Indeed, the evaluated persons suffer from problems associated with predictive risk assessment - they are continuously incarcerated and their prospects as well as hopes for a better or different future seem to be taken away with each negative evaluation. Also, the accused are in some cases being punished based on a future that no one knows. That fear of a negative event results in collective punishment is problematic. Expertise thus ought to be objective and standardized to achieve fairness.

These perceptions of the value of predictive risk assessment point to the need for clearer communication of how the forensic-psychiatric evaluations and their decisions transpire. There is also a need to clarify and justify these decisions to the accused person. We recognize that to be clearer when delivering results of their evaluation, experts will have to conduct a more objective evaluation. Since incarceration under measures denotes the necessity to continue the therapy and reduce dangerousness, it is important that the persons understands his or her real progress, and feels that decisions are objective, justified and fair. They also need to be aware of the progress that he or she must relay in order to achieve the goal of eventual release. Such clarity will not only be valuable for the person under measures, but also the justice system, as releasing individuals who have truly improved not only serves justice but is also cost-effective.

DECLARATIONS

Conflict of Interest:

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Author Contributions: BSE and TW designed the project. HS contributed to data collection. HS, TW and FP were engaged in data analysis of the project. Paper specific data analysis was carried out first by TW and validated by all co-authors. TW wrote the manuscript. All co-authors read draft versions of it, provided critical and useful suggestions to improve the quality and precision of our data analysis and thus the quality of the overall manuscript. All authors approved the final version submitted for publication and take responsibility of its content.

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Data Availability Statement

Our entire project dataset, that is, the transcripts of each interview, cannot be made publicly available due to confidentiality concerns. As, our analysis is based on qualitative interviews with older persons in prison and expert participants their privacy could be compromised if we shared the whole transcripts publicly. Our first goal is to protect those participants' privacy. Nevertheless, upon reasonable request, we are willing to share relevant segments of our transcripts that is necessary to confirm and/or challenge our results.

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Table 1: Study participant characteristics

Number of interviews	Incarcerated older participants	50 interviews • 14 Forensic institutions • 36 prisons
	Expert participants	29 interviews
Participant Characteristics	Incarcerated older participants	• 42 male, 8 female • Age range: 50 – 76 years; Average: 61 years • Sentencing: o 41 serving security measures o 9 custodial sentence
	Expert participants	21 male; 8 female
Language region	Incarcerated older participants	31 from German-speaking 19 from French-speaking part
	Expert participants	16 from German-speaking 13 from French-speaking part

Table 2: Interview guide content

Incarcerated older persons	Mental healthcare providers
• Typical activities and personal circumstances in prison and general conditions in prison circumstances • Mental health care received, experiences with access to mental health care, level of care received, satisfaction with treatment, perceived stigma due to MH issues • Perceived dual loyalty issues of the treating therapist • Aging concerns in prisons: aging in prison including serving security measures and their regular experience with risk assessments, relationship with younger prisoners, opinions on work and free time activities offered, what are their future plans	• Motivation to work in this context and work experience • Information on organization of mental health care within the institutions they provide care, treatment characteristics, opinion on current access and provision of mental health care, influence of indefinite sentences on their health care provision and patient motivation • Experience and opinion on the provision of mental health care and forensic expertise for older incarcerated patients • Role conflict associated with providing therapy as well as writing reports for the justice system. • Forensic-psychiatric evaluations

Table 3: Participant Quotes for Theme 'Process of forensic-psychiatric evaluations'

EPQ1	Then uhm it is a matter of studying the files, in the sense of uh collecting information about the alleged offence and in addition gathering all further uh biographical or other information which are available to get a picture first of all. Then the next step would be to talk to the person under evaluation. At the first contact, consent would take place uh and then uh the expert evaluation happens […], then we take the entire anamnesis and also with regard to the alleged offence in order to answer the questions uh the list of questions [obtained from the justice system requesting the expertise] ... And then with regard to the prognosis, there are of course various prognosis instruments that can be used depending on the alleged offence. (D18)
EPQ2	So, on the basis of the medical chart, the criminal file, and other information given by the physician, we have been able to do the expertise. […] But ... **There are situations where I don't really like to give my expertise without meeting the person. Even though, there is a judgment of the federal court which says that it is possible.** … But in cases where there is not even a medical file, we only have the criminal file, which was made available by the justice system, there I tend to refuse, to say that, "no I won't (evaluate this person)". Because I would not do a good job, I would do a job that is not… I do not see on what … how I could make a reliable diagnosis like that ... It's complicated. (F07)
EPQ3	P: Yeah. So I realize that if I rely on just one dossier, I have a tendency to be stricter when it comes to my risk assessment. Because I simply don't have the patient contact, I might not be able to give him the opportunity to show that he has changed, that he might react differently than what is written/portrayed in the files […]. (D24)
EPQ4	We never make an expertise alone – generally speaking. One of the two experts, he will be a bit in first line, if we can say it like that, who will meet the person under examination two three or four times. He will also read the file. And the other expert, he stays a bit in the second line and discusses the development with the first expert. He decides if there is need for other exams, if he is concerned with the progress of things. (F03)
EPQ5	Um, I discuss all my reports with colleagues. Anonymously, of course. But that can sometimes cause a bit of stomach ache, or, because it means, um, if a colleague of mine is on this case, he or she is already aware [of the patient]. [In such cases] would he disclose that he has already discussed it with me or not? So the forensic landscape is a small one and if you go for quality assurance, it also means that you are exchanging

	data and, among other things, you are a little [less] biased. But I do it anyway, because it's important to me (laughs) um, to really be able to exchange with colleagues. (D24)
EPQ6	Her [patient's] court case coming up soon, we will see if there will be a measure or maybe an outpatient measure. In her case, we [the forensic institution of the participant] was involved in both providing expert and treating professionals. This is not without problems, but uh in the end uh it was accepted like that. The forensic expert is one of my senior consultants from the outpatient sector. I supervised the expertise, but at the same time I am also responsible for the uh treatment, but uh not directly involved in the treatment. (D09)
EPQ7	So we get the uhm order [to carry out forensic expertise] from the public prosecutor's office or the court. uhm Then we check if we can accept it, if there are reasons for refusal or reasons why we can't do it, for example, if we know the person personally who is to be explored or examined or if we have treated him before. (D18)
EPQ8	Yeah, I mean creating a relationship should not be an illusion. The only relationship that we create with the person we assess, the person, s/he knows we are there to assess him/her. We know that we're here to assess him/her. So, it's not a therapeutic relationship either […] And then you also don't have to make the person believe that you are a nice doctor who is there to help him/her. Though afterwards you make a report saying that s/he is dangerous. So you need to set things straight from the beginning, that we are experts to answer to the judge's questions or the penal court. (F17)

*EPQ = Expert Participant's Quote

Table 4 Participants Quotes for Theme ‘Risk of recidivism as the key expectation’

EPQ1	And then you have to look, what factors have played a role in the murder. If it was a relationship crime, does it have a connection with a personality structure, where an increased risk of violence is connected with it and so on. Did drug use also played a role? Well, there are a lot of factors that you have to take into account and then you think about, with regard to the individual, which are the favorable and which are the unfavorable factors. ... And the lawyers of course want an assessment that is as exact as possible and uh yes. From a psychiatric point of view, as exact as expected is usually not possible or is not allowed too, yes. (I: That's right, yes, yes) You can then, you can, you can, you just say it is low, it is moderate or it is high or it is very high (D26)
EPQ2	No, well, in fact we use the instruments, only the instruments for which we have been trained specifically, so we have organized sessions, in fact specific trainings for a certain amount of instruments, those that are accepted, … on the aspects of resources, protective factors against risks, so we see that we have been trained for all those scales and then we use them in the framework of our expertise, but we use them in an extremely cautious way here at the center. On one hand because we have no validation points for these tools here in Switzerland, right, these are tools who have all the trouble in the world to be validated for prisoner populations in Switzerland (F03)
EPQ3	Yes [I use risk instruments], but only to structure my decision, my assessment; so, SPJ, if that means anything to you, Structured Professional Judgement - a modern crime prognosis development has understood that in order to achieve the claim of individual assessment, it is of no avail if I, so to speak, only use the results of prognosis instruments, because then I do not take the individual case ... I assign it to a group. That helps the authorities, but it does not help the court, which has to decide how to go forward with the case at hand. Um, and here it is useful to use the instruments, so to speak, to structure the decision-making process, not to overlook anything, to check all the relevant factors again. (D15)
OPQ1	Because we have a lot of “Mr. Little Gods” ["Herrgöttli"] here. The judges are fake and say "The psychiatrist says, there we do nothing else. For God's sake. I want to be re-elected. So let's bust him for something else" (D43)
OPQ2	We call it the “small” measure (i.e. Art. 59, therapeutic measure). I know people who went in there five or six years ago, they never have any freedom, they never set foot outside, because they [the authorities, court] always say "yes this and this and that and" [are needed to be improved for final release]. […] I don't have to receive therapy in the sense of

	offence-oriented, two independent experts have confirmed that already. … And most of all, I want to know what comes at the end of the tunnel. Yes, not that you end up with "Yes, it's nothing, we're transferring you back to Article 64 [security measure]", in other words back to the prison system, I am not taking that risk and my nerves can't take this. (D54)
OPQ3	I'm hoping for this court date, that it goes well so far (coughs). The report of the, Mr. [name of expert] has made an expert opinion, … [stating] "A conditional release is possible ...". And then instead of releasing me or something like that, they put me into measure 59 and there I am now nine years I did that. (D79)

*EPQ = Expert Participant's Quote; OPQ = Older Participant's Quote

Table 5: Quotes for Theme 'Concerns with the experts and their expertise'

OPQ1	When she [the therapist] did it [an evaluation with a scale], she had a score of 8 for me, while the expert had a score of 18 [on the same scale]. So, it is a big difference. Then she [the therapist] filled a report but the commission did not take her report into account ... To minimize things, these people [at the commission] called her, "just a therapist". […] So here they are [at the commission] always minimizing things. They discard certain things. Then as time goes by the people at the commission take the things that are the most serious for them. As time goes by, they accumulate things on you. Then in the end you are not the person that was described anymore. You are described as someone else. (F57)
OPQ2	They [judges] base their decisions on the expertise, on the therapy reports and anyway in the last years anyway extreme [negative case examples], that is what counts, in principle. […] It's not about how the persons behaved in prison, for example, a matter of whether they did their work well or what so on, etcetera. So to speak [these issues are] irrelevant. […] They are very negative now […]. Because everyone protects his own field and because it is also about the responsibility, in case something would happen, that is ... [...] and this is clearly losing your job. Well, I've already been told in no uncertain terms, the authorities told me: "Look, if you go out and something happens, (I: Mmh) there's a big risk that I'll lose my job.". (D48)
OPQ3	Uh, no. This is the procedure I owe to the 2011 incident [when a prison social therapist was murdered by a patient during outside therapy visits]. I told you already, that I was allowed to go out. And today, if you want to get out of here, which is the case since 2011, since 2012, you have to go through an enormous procedure to get the permission to out. (D54)
OPQ4	The expert had written a forensic report, you know, but that's called a file report (I: Yes yes), that means, [his report was based on files made available to him] from the time of the report to the time back uh when the first crimes took place. He just picked out certain things, didn't he? And that [is what he] did afterwards/ so basically he just always/ he just picks out everything negative, you know, from the files, right? And out of that, he wrote the forensic report. (D63)
OPQ5	I had bad luck there, I had a super good assessor [being sarcastic] who would have preferred to do nothing at all. And he pretty much put a crap together in the report [...]. And half of the things were not true, so they did not correspond to the facts. And partly I

	had the feeling that in the report, he has somehow copied things from another person, that did not concern me at all. (D75)
OPQ6	Well you see, I was talking to you about the female doctor [name of a third person]. Well, it's a person I have been seeing for 20 months now. So I saw her many times when I was in preventive detention. She helped criticize the expertise that was done on me, by saying that they were wrong. Though those critics were never retained. Experts never took these [critics] into account. They rejected them. […]. Obviously for him it is a gain to make the expertise. It is a good gain. About 20-30 thousand francs by assessment. He [the expert] won't complain, will he? (F57)
OPQ7	And the public prosecutor then applied to the higher court, that security measure should be applied, you know, and the request was dismissed, right? But now he sits in the expert commission, now there in November, or and demands the same thing again, you know. Demands security measure again, doesn't he, and since the referring authority has just jumped on it, right? So I mean, how can it be that the public prosecutor's office, which is dealing with my case uhm, can place themselves on a commission. I actually think it's weird. (D44)
OPQ8	So the result of the FOTRES, right? And in my case it was said I was actually/ the report said that I was not treatable, um (...) Yes. Repeat offenders and so on. So it's really just the negative, right? And um (clears throat) in the first trial I was also sentenced for the article 64, so to say for indefinite security measure and then I said: "I cannot accept this." […] So, uh, I was held in security measure and normally if somebody is held in security measure, he needs to get two expert opinion. I only had one. So there the judge should have already said: "Wait, excuse me. You want security measure and I only have one expert opinion. Where is the second opinion?" (D63)

***OPQ = Older Participant's Quote**

Table 6: Quotes for theme 'Forensic-psychiatric evaluations – hopes crushed'

OPQ1	[…] S/he considers that there is a moderate/medium, high or other risk of recidivism. It's really decisive. I mean. There is no one who wants to go against the expert […] Listen it's not always easy to receive [the evaluation]. It is not always easy because the expertise doesn't necessarily go in the direction that you have wanted or wished for. Often it is the source of disappointment and frustration. (F82)

OPQ2	... measures Yes. (Breathes heavily) That's just... the curse of this custody. Isn't it? I/ I have thought that back then I, well I still think the same today. So security measure is a torture, it would be smarter/ I would have less trouble if the court said: "40 years imprisonment for the crime you have committed." Right. But somehow like pfft, yes [you are] hanging in the air. (D78)
OPQ3	In the year 2000, there was again an Expert Commission meeting, and then they decided / As I told you I was still going a bit to a psychologist, as an alibi, or, and then they found "Yes, yes, we'll talk again in two years", you know, because of a conditional release, right? And I actually assumed I would be released soon, because I could already go on vacation for one weekend every month and so I always met my son, started making plans there, or, and I actually assumed that I would be released in the next six months. Then there was this commission meeting "Yes, we'll talk again in two years", or, then I thought, for what reason I was going to see the psychologist, you know. (D44)
OPQ4	That [not knowing] is, that is the biggest difficulty with the measure at the moment. (I: Mmh) That is the biggest, biggest difficulty right now. I have now like a time horizon just with eighteen months. In eighteen months I'm going to court again and then we'll see if the judge believes me or if he believes more, the authorities, who think I have an arson risk. After the many years in prison, I'm becoming as well more and more dangerous, [this is] the paradox. (D48)

***OPQ = Older Participant's Quote**

5. Discussion

5.1. Incarcerated older adults: definition and disease burden

Our systematic reviews add to the current literature as we outline prevalence rates of psychiatric diagnoses amongst older incarcerated adults with a particular focus on substance use issues. This addresses a gap in the literature due to substance use disorders being frequently omitted by previous studies. Further, we identified common aspects that hamper the integration of available literature on the topic of older mentally ill persons involved with the justice system and targeted one specific shortcoming in detail, the lack of a shared definition of older incarcerated persons.

Findings confirm that the prevalence of psychiatric disorders are particularly high amongst older incarcerated adults. However, there is a great variety in reported prevalence rates which can partly be explained by the lack of shared age cut-offs applied for the older age group. Applied age cut-offs ranged from 40 to 65, which hampered the integration of literature. Nevertheless, we showed that rates of specific psychiatric diagnoses differed between the age groups with for instance alcohol misuse, affective disorders, and cognitive issues being more common for older adults (Davoren et al., 2015; Gates, Staples-Horne, Walker, & Turney, 2017; Lewis, Fields, & Rainey, 2006; Sodhi-Berry, Knuiman, Alan, Morgan, & Preen, 2015). To plan health care resources on an institutional and national level, we should therefore respect age compositions and changes amongst incarcerated adults.

Preliminary results suggest that the use of age 50 as a cut-off is useful due to studies showing that rates of disorders and health care costs drastically rise with that age (Hayes, Burns, Turnbull, & Shaw, 2012; Thomas, Thomas, & Greenberg, 2005). However, more research is needed to estimate health care needs of differing age bands particularly drawing a more holistic picture including all groups. This to provide sub-analyses of various cohorts on aspects such as changes of cognitive functioning, rates of disorders, and health care costs. Prevalence rates, mortality and life expectancy measures of incarcerated persons in comparison with the general population can provide additional estimates for the impact of mental illness and incarceration on morbidity and mortality.

Regarding the arguments used to back definitions of older adults, our findings confirm previous assumptions that empirical evidence regarding the “accelerated aging” theory of incarcerated adults is scarce and unclear (Gallagher, 2001; Kouyoumdjian, Andreev, Borschmann, Kinner, & McConnon, 2017; Williams, Goodwin, Baillargeon, Ahalt, & Walter, 2012). We identified five studies that compared general and incarcerated populations, showing a difference in health status of 10 to 15 years (Combalbert et al., 2016; Di Lorito, Völlm, & Dening, 2018; Fazel, Hope, O'Donnell, Piper, & Jacoby, 2001; Greene, Ahalt, Stijacic-Cenzer, Metzger, & Williams, 2018; Loeb, Steffensmeier, & Lawrence, 2008). However, some authors have argued that contrasting health status between these two groups is

an oversimplification, does not promote definitions of older incarcerated adults and does not support direct evidence for the assumption that incarcerated adults would age more quickly (Hayes et al., 2012; Kouyoumdjian et al., 2017). To investigate this notion of incarcerated populations aging at a faster rate with more scrutiny, we therefore think that one needs to return to the complex interplay of factors that are thought to impact morbidity and mortality. For incarcerated persons, these were distinguished in unfavourable living conditions before imprisonment (e.g. drug-related issues, low socioeconomic status, stressful life experiences) and the impact of imprisonment on a person's health (e.g. restricted access to treatment, psychological distress due to victimization and isolation) (Davoren et al., 2015; Nowotny, Cepeda, James-Hawkins, & Boardman, 2016; Sodhi-Berry et al., 2015; Wilkinson & Caulfield, 2017).

In sum, the knowledge that mental health issues are particularly common amongst the older incarcerated population is well established. Now, we need to draw a more detailed picture of the needs of incarcerated adults while providing solutions in targeted mental health care. This to increase the public's safety by enhancing the individual's well-being but also the institutional environment. In the following, I will therefore outline some current shortcomings and possible approaches to improve mandated treatment provided to the older incarcerated population.

5.2. Handling limited confidentiality

Medical confidentiality protects a patient's private sphere in a patient-doctor relationship and facilitates trust building (Elger, Handtke, & Wangmo, 2015a, 2015b). Trust is important as it is not only a key factor in the development and maintenance of therapeutic alliance (Fluckiger, Del Re, Wampold, & Horvath, 2018) but also directly linked to health outcome measures (Birkhäuer et al., 2017). However, in court-mandated treatment settings, trust is challenged by limits to confidentiality (Gannon & Ward, 2014). In Switzerland, controversy remains as to how to handle patient confidentiality within court-mandated treatment settings. Practitioners' strategies therefore range from a complete break of confidentiality to no information to be shared without a patient's consent at all (Graf, 2013). Our results showed that in clinical practice, limited confidentiality entails challenges for MHPs in (a) developing a trusting relationship with the patient in spite of restrictions to confidentiality and (b) questions on what information to share with prison staff and representatives of the justice system and to what detail.

In regards to trust building, respondents considered transparency as the critical means to overcome mistrust. Both patient and expert-respondents agreed that patients needed to be informed about breaches to confidentiality before it happens. This confirmed previous empirical evidence suggesting that MHPs and patients appreciated clarity in regards to confidentiality regulations (Elger et al., 2015a, 2015b). Patients accepted different strategies pursued by MHPs, which can be summarized, into two

prevailing scenarios: First, some MHPs asked for written consent at every occasion when information needed to be shared. Our participants' responses indicated that this strategy was advantageous in regards to increasing a patient's perceived control. This strategy could be beneficial in building an alliance as for instance Hotzy and Jaeger (2016) point out that informed consent and shared decision-making affect alliance quality. However, expert-participants predominantly outlined that they explained the possible negative consequences to each patient if they declined consent. Suggesting that true voluntary consent might be compromised nevertheless. Second, other MHPs clarified details to each patient at the beginning of therapy on what information will be shared, under what circumstances, and with whom. An advantage of this strategy seemed to be the coverage of possible unpredictable scenarios, for which health professionals did not have time to gather informed consent (e.g. a threat towards a prison staff from a patient).

Further, yearly therapy reports written by the treating MHPs are mandatory for every patient mandated to treatment (Brägger, 2014). It is the classical example for limited confidentiality in Swiss court-mandated treatment settings, for which reason, the majority of expert-and patient-respondents discussed the difficulties related to confidentiality during report writing. This report contains information on the patient's mental health and progress in therapy, which has implications for the patient's risk of recidivism. The report affects authorities' decision-making on further privileges and release dates and has therefore great influence on a patient's future (Brägger, 2014). Our participants agreed that the report needed to be shared with the patient previously to sending it out. It was considered as an opportunity to allow the patient to be informed and to discuss possible discrepancies. If a therapist was congruent in his/her behavior throughout the therapy process and made sure that feedback and in particular criticism was brought forward in a timely manner, the report was usually characterized by common agreement.

Transparency regarding general conditions of court-mandated treatment as well as specifically regarding confidentiality and reporting was therefore a central issue for MHPs and patients. This confirms previous research indicating that transparency is key in handling limited confidentiality (Gannon & Ward, 2014; Lau & Sachs, 2015; Wittouck & Vander Beken, 2019). However, even though participants agreed that open and transparent communication was crucial in establishing a trusting relationship, MHPs felt challenged in finding the balance between which information to share while assuring confidentiality about very private details that were potentially irrelevant for authorities. Available guidelines, however, are unspecific or focus mainly on forensic risk assessment and do not provide guidance in resolving confidentiality issues for treating MHPs (see for a detailed overview on available guidelines Niveau & Welle, 2018). Our participants indicated that they tried to convey the gist of a message, trying to protect intimate details. Patients further highlighted that they disagreed with sharing information with persons who were not directly involved in their care and, particularly, if this happened in unstructured settings, where conversations could be overheard (e.g. over lunch).

5.3. Integrating the "Control" Role

As stated previously, MHPs treating patients mandated to treatment take up a dual role to care and control (Pollähne, 2013; Ward & Ward, 2016). It is unclear, how to integrate both roles to maximize a patient's benefits from treatment to ultimately reduce psychiatric and criminal recidivism (Gannon & Ward, 2014; Goulet, Pariseau-Legault, Cote, Klein, & Crocker, 2019). Our findings suggest that a MHP's role should be emphasized by their caring role while their involvement with the justice system should be limited to information sharing. To increase alliance quality and treatment satisfaction, the controlling role should be taken up by a different person, who is known and reachable to the patient. This confirms previous research suggesting that the way a MHPs integrates the control role into their work is key to any positive clinical and criminal outcomes (Skeem, Louden, Polaschek, & Camp, 2007).

Previous research on dual role relationships, however, concluded that MHPs who put equal emphasis on both roles, were the most effective in reducing recidivism (Kennealy, Skeem, Manchak, & Louden, 2012; Manchak, Skeem, & Rook, 2014; Skeem et al., 2007). This stands in contradiction with our findings suggesting a greater focus on caring roles. This discrepancy might be explained by two aspects. First, results of previous research projects are based on probationers and parolees living in community settings. Second, these studies are based on officers with a limited background in mental health providing community supervision, they are not specific to psychotherapeutic interventions. Our findings are specific to persons incarcerated and mandated to treatment who received psychotherapeutic interventions by qualified MHPs. The context of data collection therefore differed from patients living in the community vs. in detention. In community settings, such officers might be their only contact person connected with the justice system, possibly creating a greater need for supervision. In an incarceration setting, however, patients are already restricted and controlled by a variety of staff reducing a MHP's need to monitor the patient. Further, our results also showed that MHPs are frequently the only persons left that incarcerated persons confided in and felt understood. In such a restrictive environment, it might be particularly important to receive warm and caring attitudes. Nevertheless, these previous studies showed, that when working with persons mandated to treatment, alliance quality predicts recidivisms rates (Kennealy et al., 2012; Manchak et al., 2014; Skeem et al., 2007). It is therefore central to shed light into the particularities of developing and maintaining a strong alliance in coercive settings to enhance effectiveness of court-mandated interventions.

Our study results are in line, however, with other findings suggesting that positive regard is equally important in coercive settings (Blasko, Serran, & Abracen, 2018; Jeglic & Katsman, 2018; Marshall & Serran, 2004; Polaschek & Ross, 2010; Ross, Polaschek, & Ward, 2008). Positive regard was described for the first time by Rogers (1957) as one of the fundamental conditions of therapeutic change. Even though the concept lacks a coherent definition, it is frequently described as therapists showing support, affirmation, respect, validation, and active listening (Farber, Suzuki, & Lynch, 2018;

Suzuki & Farber, 2016). Similarly, our participants described good MHPs as persons who took time to listen actively, understood and recognized their needs, and provided support characterized by adequate advice or practical life support that ideally exceeded expectations. Further, a MHP's behavior needed to be motivated by a genuine and intrinsic interest in helping the patient to reach a better well-being and personal future.

Even though, these descriptions do not raise specific issues regarding the court-mandated context, it is nevertheless striking that such characteristics were named so frequently. One possible explanation for the importance of positive regard amongst mandated patients might be the frequent lack thereof. The work of a therapist involved with patients, who are deemed as offenders, is commonly described as mentally, physically, and emotionally draining (Scheela, 2001). In particular, therapists who treat sex offenders are confronted with descriptions of sexual and physical violence, as knowledge of these crimes is an integral part of treatment (Ennis & Home, 2003; Newman, Eason, & Kinghorn, 2019). The exposure to such traumatizing content can create psychological distress (Barros et al., 2020; Kadambi & Truscott, 2003) which potentially interferes with a MHP's ability to treat patients effectively (Way, VanDeusen, MartIn, Applegate, & Jandle, 2004). Even though most MHPs experience some negative emotions as a response to the exposures to such descriptions, not all suffer from psychological distress affecting their work. In fact, some MHPs experience their work as challenging but particularly rewarding (Barros et al., 2020). The high likelihood of MHPs dealing with negative emotions towards their clients might, however, interfere with their ability to display positive regard, possibly explaining the high relevance of this topic amongst court-mandated patients.

One approach in dealing with one's negative emotions is to the so-called *"humane approach"*, to condemn the offensive acts but to value the person. This strategy was just as much appreciated by MHPs as by patients. A positive and respectful attitude is beneficial in the treatment of all psychiatric patients but has repeatedly been emphasized when working with patients who offended (Marshall et al., 2003; Stuen, Rugkasa, Landheim, & Wynn, 2015; Wyder, Bland, Blythe, Matarasso, & Crompton, 2015). Incarcerated persons obtain a low status in society and might therefore be frequently subject to labelling attitudes and might be likely to incorporate an anticipated stigma, meaning expecting future discrimination due to being subject to a certain label (Quinn & Chaudoir, 2009; Winnick & Bodkin, 2008). Anticipated stigma is linked to mental health issues and low self-esteem, making them even more susceptible to humiliation (LeBel, 2008; Quinn & Chaudoir, 2009; Walker & Bright, 2009). Sexual offenders might further be particularly prone to feelings of shame in relation to the offense committed (Blasko et al., 2018; Clarke, Lumbard, Sambrook, & Kerr, 2016). Self-respect and the ability to develop a sense of self separate from the "offender identity" is further crucial to enhance treatment engagement (Blasko et al., 2018). The shame linked to those memories can potentially keep patients trapped in emotional distress and decrease their ability to change (Clarke et al., 2016; Tangney & Dearing, 2002).

Our participants confirmed that the offenses committed elicited negative emotions and facing one's shortcomings was a difficult task to face, which also seemed counter-intuitive at first. However, once MHPs would target sensitive issues, patients appreciated when they addressed them in detail. For instance, examples to illustrate other perspectives needed to be concrete and lifelike. The more closely their advice was to the patient's current beliefs and life situation, the more patients experienced it as a learning experience. Such insight into their mental health issues and offending behavior creates a sense of relief (Clarke et al., 2016). Our respondents confirmed this experience that the illustrations of differing perspectives helped them understand alternative ways to act and to understand factors that contributed to them committing the crime. Findings further confirm previous claims that a directive approach is beneficial as long as MHPs address patients without hostility. Harsh confrontational conversation styles characterized by aggressive, critical, sarcastic and hostile expressions increase the likelihood of resistance, denial, and non-compliance (Blasko et al., 2018; Manchak et al., 2014; Marshall & Serran, 2004). Thus, behavior change is affected positively when therapist are caring, warm, and supportive therapists and address sensitive issues in way that is comprehensible to the patient (Marshall & Serran, 2004).

5.4. Flexibility despite predefined therapy conditions and goals

Incarcerated individuals face restrictive conditions with little room for choice and control. Patients mandated to treatment are coerced to participate in treatment to avoid negative consequences in regards to privileges and release dates (Goulet et al., 2019). With such limited possibilities to influence one's living conditions, our findings suggest that it is all the more important to allow patients control wherever possible. Thus, since mandating a person to participate in therapy is in itself a threat to patient autonomy and self-determination (Hachtel, Vogel, & Huber, 2019; Niveau & Welle, 2018), it is important to return some back to the patient. Amongst our respondents, this concerned mainly shared decision-making on treatment goals and topics of individual therapy sessions, by this, allowing to target issues of relevance to the patient. Our results further indicate that it is beneficial when therapists allow patients to determine the pace of trust building, particularly at the beginning of an intervention.

Allowing the patient to define topics and overall goals of therapy requires the therapist to adopt a flexible approach, which is particularly important in establishing a high quality alliance (Blasko et al., 2018; Gannon & Ward, 2014; Jeglic & Katsman, 2018; Marshall & Serran, 2004). This stands in contradiction, however, to highly manualized interventions that are particularly common for RNR-based programs (Schalast, Lebbing, & Völlm, 2018) but speaks in favour for the recent shift towards greater implication of strength-based approaches such as GLM (Vandevelde et al., 2017). One key component of the GLM is the importance of returning the control over treatment processes back to the patient including definition of meaningful therapy goals. According to this notion, one's risk to

reoffend will be reduced by fulfilling a person's primary goods (Ward, Day, Howells, & Birgden, 2004; Ward & Gannon, 2006). Interestingly, all patient-participants endorsed a therapist's flexibility that allowed the focus on topics relevant to the patient. Most MHPs similarly confirmed the need of returning control back to the patient but some also raised the concern of finding a balance between patient wishes and risk needs, considering the balance as a challenging endeavor.

Building an alliance is described as a collaboration between therapist and patient, during which both have to find an agreement regarding tasks and goals (Ross et al., 2008). Suggesting that even though the focus on crime-related topics is predefined in mandated treatments, therapists can allow decision-making on the remaining topics. In particular, during the early stages of an intervention it is key to allow the patient to define the content of therapy session. This, to allow trust building and to foster engagement while sensitive issues can be targeted at later stages, which is line with previous findings (Goulet et al., 2019; Marshall & Serran, 2004). Allowing patients choice and control over topic and content of therapy will further enhance treatment motivation and reduce perceived coercion (Hachtel et al., 2019). Our findings also suggest that by transferring control to the patient, they are less likely to feel at the mercy of the system or to mistrust the MHP to act as a double agent. Considering that no therapy is possible without the patient and the overall aim of risk reduction will not be reached without a patient's involvement, it is key to integrate patient wishes, at least to encourage the patient to remain and engage in therapy (Dowling, Hodge, & Withers, 2018).

5.5. Using external pressures favorably

Internal motivation is a stronger predictor of therapeutic change in comparison to externally motivated behaviors (Lambert, 2008; McMurran, 2002; Prendergast, Greenwell, Farabee, & Hser, 2009; Snyder & Anderson, 2009; Welsh & McGrain, 2008). To date, it is unclear how external pressures interfere with a mandated patient's internal motivation to engage in psychotherapeutic treatment (Klag, O'Callaghan, & Creed, 2005; Ondersma, Winhusen, & Lewis, 2010; Prendergast et al., 2009; Wild, 2006). Our findings indicate, that the involvement of the justice system and the legal referral do not necessarily negatively interfere with patient motivation. However, certain strategies will affect therapeutic work positively or negatively. First, therapeutic goals that are linked to privileges, parole, and release dates need to be clearly and transparently communicated. When a patient's progress in therapy corresponds to such a set goal, decisions need to be made promptly. This to validate a patient's achievements and to maintain patient motivation.

Based on our results, current challenges are that authorities coming to these judgements are frequently unknown and inaccessible to the person in question. Opinions on a patient's mental health status often differ between patients, MHPs, and responsible authorities. Their decision-making is consequently incomprehensible to patients and MHPs likewise suggesting that patients might perceive a lack of

control concerning their progress and future. This is critical considering that the level of autonomy and control over action is linked to a patient's level of engagement in therapy (Wolfe, Kay-Lambkin, Bowman, & Childs, 2013). Clear and transparent goal communication is further important since establishing shared therapy tasks and goals is a major component of developing an alliance (Bordin, 1979; Del Re, Fluckiger, Horvath, Symonds, & Wampold, 2012; Fluckiger et al., 2018; Hotzy & Jaeger, 2016; Ross et al., 2008). Our results indicate that the judicial authorities' definition of therapy goals should therefore ideally respect patient's views. While the overarching goal of reducing the risk to reoffend is not debateable, the sub-goals to reach this target can be negotiated with the patient to potentially increase patient motivation and alliance quality.

It is important to highlight that other studies have shown that regardless of the level of external motivation, low internal motivation predicts poor treatment responses. However, mandated patients who score high on measures of both internal and external motivation show the best treatment retention (Wild, 2006). Even though these are preliminary results, it indicates that if external pressures are applied in a way that they foster internal motivation, we enhance patients' treatment engagement and outcome. In contrast, strong external pressures that do not foster internal motivation possibly increase the risk of patients displaying socially desired behaviors. Amongst our respondents, this so-called "strategic motivation" was depicted as participating in treatment programs merely to show physical presence to increase one's chances for release. Expert-participants indicated that it was a challenging endeavor to distinguish strategic motivation from a patient's genuine wish to engage in treatment, which makes the use of motivation as selection criterion difficult.

Only a minority of expert-participants spoke in favor of using motivation as a selection criterion to control access to treatment programs and units. Reasons for the use of motivation to allocate mental health care resources were to foster internal motivation before treatment entry and to protect group atmosphere on treatment units and during group psychotherapy sessions. Considering that the quality of group cohesion affects treatment outcome, this would indeed speak in favour of selecting patients carefully when assigning to certain interventions (Burlingame, McClendon, & Alonso, 2011; Crowe & Grenyer, 2008). However, selection criteria for patients mandated to treatment were only vaguely expressed amongst our respondents as well as in the scientific literature (McMurran, 2002).

Our interviewees from both participant groups delineated strategic behavior as a patient avoiding to raise critical issues, talking about irrelevant topics as well as minimalizing or trivializing the offense committed. However, such forms of denial can also be signs of an early motivational stage or have other reasons such as feelings of being coerced into treatment or not needing help. This suggests that it is crucial to examine the reasons of any form of denial to elaborate treatment motivation. In addition, this respects the need to inquire patients' needs and wishes and therefore potentially enhances a patient's engagement into treatment.

Moreover, mandated patients' treatment plans, housing allocation, and possibilities for future release are not only affected by their treating therapist's progress report but particularly by external psychiatric evaluations. For a person sentenced to a measure in Switzerland, re-evaluation of their risk happens at least every five years (e.g. Art. 59 SCC). Based on this assessment, the judicial authorities will decide on prolongation or discontinuation of such a measure and initiate certain changes in their placement and treatment. These decisions consequently have important implications for a person's future but also for public safety. Our findings show that these assessments have not only certain shortcomings in their process but also strong impact on the patient's well-being and engagement in therapy.

First, it is alarming that even forensic experts themselves, questioned the quality of psychiatric assessments. Identified problem areas are the lack of standardization between forensic experts, difficulties in exchange with other experts due to confidentiality reasons, and missing validation of a variety of tools amongst the Swiss population. Consequently, forensic experts and incarcerated persons likewise criticized the missing consistency between forensic experts and the great impact of subjectivity on risk assessment results. This partly mirrors the scientific debate on the overall value of risk predictions to the individual case (Hanson & Howard, 2010; Hart, Michie, & Cooke, 2007) due to missing standardization of assessment processes (Doyle & Dolan, 2007) as well as validation of instruments in respective populations (Singh et al., 2014; Singh, Grann, & Fazel, 2011).

These shortcomings are not only relevant for the public's safety but also for the therapy process that the person is forced to undergo. Our findings confirm previous evidence indicating that before-mentioned insufficiencies of these evaluations can lead to a loss of trust in forensic experts and the judicial system (Horstead & Cree, 2013). The unpredictability of such assessments is further challenging in light of their impact on patient's hope, as particularly incarcerated persons stated that their hope was crushed with every new negative prognosis. In light of the effect of hope on symptom severity and psychological distress (Schrank, Stanghellini, & Slade, 2008; Tompkins & Swift), we need to address current shortcomings of forensic-psychiatric assessment and communication of their results to use them in way that is beneficial for treatment process.

Our results therefore not only confirm previous concerns on the applicability of such group-based instruments to the individual case but also raise doubts on their effect on therapy process and outcome. As previously highlighted, if the overall goal of mandating a patient to treatment remains to be the reduction of risk of recidivism, then we need to use all possible resources to increase treatment outcome to protect society. However, current assessment procedures seem to impede therapy process and to hamper therapist's efforts. To increase treatment outcomes, we therefore need to address influencing factors such as the impact of risk assessments on a patient's progress.

5.6. Addressing psychological strain due to imprisonment, crime history, and psychiatric diagnosis

One aspect that motivated patients to remain in mandated therapy were feelings of relief from psychological burden that they carried. This psychological strain, participants summarized into originating from three major sources: coping with imprisonment, dealing with the crime committed as well as accepting a psychiatric diagnosis. When patients remained in treatment long enough to experience progress and some attenuation of their psychological burden, it motivated them to engage in therapy. MHPs knowledge of these common psychological stressors can therefore support them in identifying their patients' needs.

Our findings confirm previous research that imprisonment itself causes psychological strain due to issues such as loss of intimate relationships or the perception of prison environment as threatening (Listwan, Sullivan, Agnew, Cullen, & Colvin, 2013; Shammas, 2017). Our respondents similarly emphasized that they perceived imprisonment as a stressful experience due to disruptions with the outside world such as losing job positions and relationships with family and friends as well as having to cope with a new and very different environment. MHPs further outlined that they were often the only persons left who incarcerated persons confided in. Suggesting that when a trustful relationship is built, therapists are the main contact person with whom incarcerated persons share their struggles of everyday prison life.

Understanding and accepting the crime committed was challenging and burdensome for most respondents. Our findings indicate that patients sought to understand reasons what made them commit a crime and wished to answer unresolved questions. The offense was a contradiction to patients' positive self-image. These difficulties in admitting to wrongdoing and criminal activity contribute to denial (Dietz, 2020). Denial or minimization is common in 60 - 87% of sex and violent offenders undergoing treatment (Craissati, 2015; Henning, Jones, & Holdford, 2005; Ware & Harkins, 2015). As the crimes committed by the person mandated to treatment are a central component targeted during treatment, it can be challenging for MHPs facing patients' denial and minimization.

Some authors argue that patients showing denial are at an early motivational stage requiring specific programs and interventions targeting such behavior (Tierney & McCabe, 2002). Motivational interviewing is an example for such a stage-matched intervention for persons showing denial, to increase treatment motivation (Prendergast et al., 2009; Yong, Williams, Provan, Clarke, & Sinclair, 2015). The development of internal motivation during early treatment phases is crucial in the light of motivation being predictive of treatment participation, completion, and outcome (see Prendergast et al., 2009). Particularly mandated patients are likely to be in an early stage of change and to show resistance with the beginning of therapy (Snyder & Anderson, 2009). Our results therefore provide further evidence to pay particular attention to the struggles that patients face when offense-related issues are targeted during therapy and to identify possible needs regarding their motivational stages.

Further, integrating a definition of oneself as a person who suffers from mental illness can threaten one's self-concept (O'Connor, Kadianaki, Maunder, & McNicholas, 2018). Our findings indicate that patients perceived it challenging to understand and accept a psychiatric diagnosis, in particular when they were characterized as chronic and stable personality traits. One explanation for these difficulties to accept a psychiatric diagnosis is the stigma attached to mental illness and mental health care services (Soroka, Słotwiński, Pawęzka, & Urbańska, 2020). When a person's attitudes held towards mental illness are characterized by negative beliefs and values, it can lead to self-stigmatization. These internalized beliefs about mental illness affect treatment adherence, symptom severity, self-esteem, quality of life, and the development of therapeutic alliance (Kendra, Mohr, & Pollard, 2014; Livingston, Rossiter, & Verdun-Jones, 2011; Owen, Thomas, & Rodolfa, 2013).

Mental health professionals play a critical role in challenging and remodeling these stereotypes (Livingston et al., 2011), which is crucial not only in regards to mental illness but also concerning the integration of an offense committed into one's life story. Creating awareness amongst MHPs to target such issues can therefore help therapists to be more responsive to patient needs and to develop stronger alliances. Relief from psychological burden arising from stigma and pains of imprisonment, motivated respondents to continue with the intervention. It further confirms that when therapists target issues of importance to the patient and respond to them adequately, it motivates patients to remain and engage in therapy.

5.7. Limitations

For our systematic reviews, it is possible that we did not include all relevant literature. This, due to the fact that we considered a limited amount of search engines and keywords. However, our search strategy encompassed the most relevant databases and syntax, suggesting that we covered a large part of the relevant literature (Bramer, Rethlefsen, Kleijnen, & Franco, 2017). Regarding the estimation of prevalence rates of psychiatric diagnoses, our results might be affected by the empirical studies' heterogeneous approaches in collecting their data. Data collection methods varied from self-report to medical records and diagnostic criteria were frequently unclear, potentially explaining the wide range in rates of mental health issues between studies. Further, to define an older incarcerated person, we limited ourselves to chronological age. This, we think is most suitable for research purposes and for planning health resources on national levels. However, since particularly the older age group is amongst the most heterogeneous of all, health care delivered to the individual person requires other classifications then merely age. In regards to older persons, the "frailty syndrome" proposed by Fried et al. (2001) for instance could serve more useful in clinical practice than the sole age of a patient.

Regarding our articles based on qualitative data collection and thematic analysis, certain limitations naturally come with this type of study design. Most importantly, qualitative study designs do not aim

at generalizability of results, as one would expect from quantitative analyses. Instead, we aimed at eliciting in-depth explanations and meanings to derive common notions and thoughts that are predominant regarding the topic of mental health care of incarcerated older adults (Carminati, 2018; Leung, 2015). To reach the objective of gaining detailed explanations from our interviewees, we applied a purposive sampling strategy (Campbell et al., 2020). In qualitative research the sample size may be small but the selected participants should be the most likely to yield appropriate and useful information (Kelly, 2010). However, this sampling technique has certain shortcomings that will be outlined in the following.

First, we might have attracted a group of persons interested in our type of research that share a certain set of opinions on the topic of mental health care of older incarcerated adults. Thus, creating a volunteer selection bias. Second, our participants might have advanced opinions that they thought were socially acceptable. For instance, expert-participants might have represented positions that align with their institution, regional, or cultural mindsets. Incarcerated participants might have participated in our study to display cooperative behavior to increase their chance for release. We tried to limit social desirability by assuring anonymity. We conducted each interview in a confidential setting (separate room in which conversations could not be overheard), emphasized the right to withdraw and the voluntary nature of study participation, and described our independency from authorities and prison representatives. Since our participants' responses contained negative and positive experience with mental health care services, we think that interviewees felt free to talk and that we limited the impact of social desirability.

Further, the objective of our research project was to obtain detailed insights into the experiences of older persons. We were therefore specific in terms of the targeted age band but unspecific in regards to other patient and context characteristics. We included patients aged 50 and over with any psychiatric diagnosis as long as they were detained within a Swiss forensic-psychiatric or correctional institution. Due to this wide range of institutions, included patient-participants were subject to differing treatment settings and detained for differing time lengths. Even though this represents a shortcoming of our study design due to the inability to explain differences in patient or context variables, it simultaneously created the opportunity to identify factors that are important across settings and different patient groups. Thus, using this strategy, we aimed at soliciting aspects that are of particular importance to the older age band.

5.8. Conclusions

The influences of the justice system during mandated treatment orders are omnipresent. Our findings suggest that the way these forces are integrated into treatment delivery and planning affects therapy experiences of MHPs and patients likewise. This qualitative analysis therefore provides an important

contribution to outline current challenges in mental health care of older adults and a starting point to augment treatment recommendations for this drastically rising population.

Our results show that most patients accepted a MHP's involvement with the justice system given their caring role outweighed their controlling responsibilities. More specifically, patients accepted MHPs sharing information with judicial authorities given this followed a transparent and fair procedure. This encompassed for instance outlining therapy conditions and limits to confidentiality at the beginning of therapy and at regular intervals (e.g. yearly written report). MHPs' direct involvement in punitive control was objected and impaired trust building.

Patients perceived an emphasis on therapists' caring role when they displayed a positive, supportive and respectful attitude driven by an intrinsic motivation to help the patient. Patients appreciated therapists who correctly identified their needs and responded with adequate concrete advice and help. This was achieved by allowing patients to determine the specific content of therapy sessions while respecting the overall treatment goal of reducing recidivism. Restrictive therapy conditions of court-mandated treatment orders were approved when there was enough flexibility for the patient to influence content and pace of psychotherapy sessions.

Identifying and responding to patients' needs and wishes is particularly important in a restrictive and coercive prison environment. Therapists, who were able to do so, motivated the patient to engage in therapy. This, not only by displaying a responsive attitude but also through helping them to create relief from psychological burden. The sources of this psychological strain were certainly very individual, however, could be grouped into the three common issues: coping with imprisonment, dealing with crimes committed, as well as accepting psychiatric diagnoses. Knowledge of possible sources of psychological burden can support MHPs in relating to the patient.

Further, judicial authorities taking decisions on patients' treatment requirements, placement options, and release dates affected patients' treatment experiences. Current shortcomings in the lack of clarity of treatment goals and transparent communication of authorities decision-making need to be overcome. Even though, our results indicate that the controlling role should be separated from the caring role, the person representing this monitoring function still needs to be tangible to the patient. By enhancing the influence of these external pressures, we can potentially enhance patients' motivation to engage in treatment.

Last, while therapy should be adjusted according to an individual's personal needs and wishes, an overall definition of older incarcerated persons facilitates research integration and treatment planning. Based on our results, we therefore suggest the use of age 50 to distinguish the older age group from younger incarcerated adults due to analyses of all groups and their impact on rates of disorders and health care usage. However, to investigate the theory of incarcerated persons aging prematurely, we

need to explore the complex interplay between factors of incarceration and lifestyles before imprisonment and their impact on morbidity and mortality.

In sum, our research contributes to a definition of the older incarcerated age group but also sheds light into individual experiences of older adults mandated to psychotherapeutic treatment. We outlined factors influencing care of older adults mandated to treatment and provided insights into therapists' strategies dealing with them. By this, we contribute to enhancing the effectiveness of mental health care provided to older incarcerated and legally referred patients.

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6. Appendix

6.1. Semi-structured interview Guide for incarcerated participants

Part of the interview guide / theme / technique	Interview questions	AIM: What should be dealt with
Introduction	Could you describe a typical day here in [name of the institution]?	• Ice breaker • Getting to know daily life structure in prison
Social Network	How is your relationship with other persons in this institution? • staff • other inmates Do you keep in touch with anybody outside of the institution?	• How are relationships with others within the institution perceived • Less contact is usually available to the outside world – how is this perceived, did they lose relationships, do they keep them?
Transition from introductory to main part	What do you think about the mental health care services in [name of the institution]?	• Get their general (very brief) impression about how mental health services are, how they feel taken care of. • The goal is to ease into questioning them about psychological disorders (since it's a sensitive topic) and the treatments they receive for that.
Diagnoses	What kind of mental health disorders do you have? • How long have you had this disorder for? • Since when have you received treatment for your disorder?	• What is the **subjective disease model** of the patient
Prison Mental Health Care Services	When did you first get in touch with the mental health care service? • How? • Who? • Why?	• Elaborate **access** to mental health care services • How are **decision** taken • How do they approach the staff (through nurses, regular consultations by psychiatric services, security staff…)
Treatments	What **type** of treatments do you receive for your mental disorder? • In the institution • Before imprisonment • Any differences? • Frequency - how often? • Which specialists did you meet? • Duration of a session?	• **Equivalence of care** • Differences between mental health care inside and outside of prison • Any **continuity** given? (same therapist? Contact between prison and outside mental health care staff?) • What is considered as treatment in the view of the patient – what isn't
	Do you think that anything has **changed** about your mental health while being here? • Do you feel any improvement or degradation about your mental health issues? • What treatment helps/has helped you most? • Are you satisfied with these treatments?	• Explore what offender views as most helpful about treatment received • What is seen as most useless?

	• What treatment/activity would you most preferably drop? • Do you think that you're treated differently because of your age?	
	• Do you talk to anybody of the other inmates about being in touch with mental health services? • Has anything changed since you contacted the mental health service/you entered the institution?	• Explore possible threat of **stigma**, mobbing, exclusion
	If you could change anything about the treatment you receive, what would it be? What type of additional mental health care would you need?	• Possible **improvement options** that the persons sees • Their perspective on the **quality** of MH care
	Elicitation Technique Where do you place the mental health professional? Where do you place the person conducting the forensic psychiatric expertise?	• How do they relate to mental health professionals • The MHP's dual role, trust and therapeutic relationship are important aspects in mental health care – use elicitation technique to evoke these issues
Locus of Control	What do you do yourself about the mental health issues that you have? What influences the **progress** of your therapy? Who influences the progress of your therapy?	• How much responsibility do they see on themselves – on others? • What do they see as most important therapeutic effect? • What is the most important facilitator? • Sentencing limitation – **indeterminate** character of the sentence
Risk Assessment		•
Aging	What is it like to be here? What is it like to become older here? What is **most challenging concern** for you in your life right now? • During the stay in your institution, what has changed for you? Do you face different challenges now? • Do you think that aging has an impact on your everyday life in the institution? Is the **prison environment** adapted to people of your age and older? • What would you improve or need?	• What are the **challenges** of the older incarcerated population • The open question shall give room for them to relate to the aspect that is most important to them • How does aging shape their prison experience?
	What **plans** do you have with your life?	• What do they **hope** for • What plans do they have for the future and how does the older age possibly affect this • Do they have any future plans for after imprisonment

Closing up	How would you advise a younger inmate who asks you, how to deal with mental illness?	Enter third person to try to elicit a meta-description of themselves and their life living with a mental disorder within prison.

6.2. Semi-structured interview Guide for incarcerated participants

Part of the interview guide / theme / technique	**Interview questions**	**AIM: What should be dealt with**
Introduction	1. What is/was your **motivation** to work in the field of mental health care for incarcerated persons? 2. What work experience do you have in this field? 3. What involves your current position?	• To get an idea of the general mental model of the mental health professional • To estimate the extent of experience in the field • Following questions will be adapted to the person's personal work experience
	4. In which setting do you mostly work with older persons?	• In which settings did the mental health professional encounter elderly individuals mostly • to prioritize areas brought up by the participant first
Mental Health Care	5. Could you briefly summarize, the way mental health care is **organized** in your institution? a. What are the characteristics of the treatment? b. What is the general frequency of these treatments (per week or month), and how long do they last? c. How is access to a MH professionals guaranteed in case of unexpected episodes?	• Get a general idea on the intervention to establish a shared basis (natural knowledge for the expert, not for the person interviewing) • Very essential problems of the intervention might come up in the beginning (not specific for older offenders, but maybe also relevant for them)
	6. Are the treatments provided for **older** adults the same? a. Does the treatment for the older persons differ in any way? b. Do you notice any change in your attitude towards the elderly? c. If you could change anything about the currently provided interventions to make it most suitable for older detainees, what would you do?	• Specific needs or topics of older incarcerated persons • Noticeable problems in everyday life, in contact with other detainees or staff • Develop a notion on what they consider "old"

	7. Could you name the three most common **needs** that you have noticed treating older incarcerated persons? 8. How do you address these needs?	
Access to Mental Health Care	9. Could you explain the process of how a decision is made that an offender gets in touch with mental health care staff?	• How is access to MH care provided? • Which persons act as gatekeepers? • Are there any regular screenings, during which staff could notice MH issues?
Role Conflict	10. Elicitation Technique: Where do you position yourself?	• Do they experience their professional position as a role conflict? • Does the multidisciplinarity affect them in a way, that they feel liable to different players? • How do they solve this inner conflict? • Who do they feel loyal to? • Does it change depending on different roles within the job?
Risk Assessment	11. Do you conduct risk assessments of your patients? a. Is there a certain procedure that you follow in your institution? b. What instruments do you use? 12. Imagine you would have to explain to a student the concept of risk of relapse. How would you do it?	• Get basic information on how they do risk assessments (it can be expected, that these are handled differently in different institutions and regions) • Interdisciplinarity and transparency : the concept of risk of relapse might be understood differently across disciplines

6.3. Data Extraction Sheet for Medical Records

Agequake in Prison 2 – Medical Records Data Extraction Sheet

DEMOGRAPHIC INFORMATION:

1. Year of birth:

2. Sex: ☐ 1 Male ☐ 2 Female

3. Nationality:
- ☐ 1 Switzerland
- ☐ 2 Western/Eastern Europe
- ☐ 3 Africa
- ☐ 4 Americas
- ☐ 5 Asia/Oceania
- ☐ 111 NA

4. Language:
- ☐ 1 German
- ☐ 2 French
- ☐ 3 Italian
- ☐ 4 English
- ☐ 5 Other (specify)
- ☐ 111 NA

5. Marital Status:
- ☐ 1 Married
- ☐ 2 Divorced
- ☐ 3 Widowed
- ☐ 4 Separated
- ☐ 5 Single
- ☐ 111 NA

6. Number of children: ☐ NA 111

7. Number of grandchildren: ☐ NA 111

8. Number of siblings: ☐ NA 111

9. Mother: ☐ 1 alive ☐ 2 dead ☐ NA 111

10. Father: ☐ 1 alive ☐ 2 dead ☐ NA 111

11. Health insurance: ☐ 1 present ☐ 2 absent ☐ NA 111

12. Education:
- ☐ 1 No Qualification
- ☐ 2 Primarschule (until 6th grade)
- ☐ 3 Sekundarschule (until 8th or 9th grade)
- ☐ 4 Berufsschule/Lehre (vocational training)
- ☐ 5 Gymnasium/Berufsmatura (until 12th grade = High school)
- ☐ 6 University Degree
- ☐ 7 Other (specify)
- ☐ 111 NA

13. Religion:
- ☐ 1 Protestant
- ☐ 2 Catholic
- ☐ 3 Orthodox (Christian)
- ☐ 4 Muslim

☐ 5 No religious denomination
☐ 6 Other, specify
☐ 111 NA

14. If Other, specify Religion:

15. Institution:
☐ 1 Prison, closed
☐ 2 Prison, open/half-open
☐ 3 Measure center
☐ 4 Separate unit for measure sentences
☐ 5 Forensic clinic
☐ 6 Nursing Home
☐ 7 Other, specify
☐ 111 NA

16. If Other, specify Institution:

SENTENCING INFORMATION:

17. Definite/Custodial Sentence ☐ 1 Yes ☐ 0 No ☐ 111 NA
18. Indefinite Sentence (Art. 59 or 64) StGB : ☐ 1 Yes ☐ 0 No ☐ 111 NA

19. Date of entry (of current imprisonment including remand prison):
(If only year available, write 01.07.YYYY. If not available, write 09.09.9999)

20. Is this the first incarceration (in CH): ☐ 1 Yes ☐ 0 No ☐ 111 NA
21. If no, number of times incarcerated (including this one): ☐ 111 NA
22. If no, date of exit (of last imprisonment): ☐ 111 NA
(If only year available, write 01.07.YYYY. If not available, write 09.09.9999)

Offense(s) for which imprisoned (for the current imprisonment):

23. Acts leading to death or intending to cause death
☐ 1 Yes ☐ 0 No ☐ 111 NA
24. Acts leading to harm or intending to cause harm to the person
☐ 1 Yes ☐ 0 No ☐ 111 NA
25. Injurious acts of a sexual nature
☐ 1 Yes ☐ 0 No ☐ 111 NA
26. Acts against property involving violence or threat against a person
☐ 1 Yes ☐ 0 No ☐ 111 NA
27. Acts against property only
☐ 1 Yes ☐ 0 No ☐ 111 NA
28. Acts involving controlled psycho-active substances or other drugs
☐ 1 Yes ☐ 0 No ☐ 111 NA
29. Acts involving fraud, deception or corruption
☐ 1 Yes ☐ 0 No ☐ 111 NA
30. Acts against public order, authority, and provisions of State
☐ 1 Yes ☐ 0 No ☐ 111 NA
31. Acts against public safety and state security
☐ 1 Yes ☐ 0 No ☐ 111 NA
32. Acts against the natural environment
☐ 1 Yes ☐ 0 No ☐ 111 NA
33. Other criminal acts not elsewhere classified
☐ 1 Yes ☐ 0 No ☐ 111 NA

HEALTH INFORMATION:

General physical health information:

34. Chronic somatic conditions and chronic infectious diseases

☐ 1 Yes *if the patient has/ had (a) chronic somatic condition(s) and/or chronic infectious disease(s)*
☐ 0 No *if no chronic disorders are mentioned in the medical record*
☐ 111 NA *if information on somatic disease is completely missing in the medical records (then 34 – 46 should be treated as NA)*

Note: Infection of urinary tract, Pneumonia, Sinusitis, Bronchitis, various viral diseases (also Flu, Cold), Otitis (Ear infection), Digestive Problems (e.g. Diarrhea), Conjunctivitis (Eye infection), Herpes, Sexually Transmitted Diseases etc. **count as <u>acute</u> conditions / diseases and should not be noted.**

35. High Blood Pressure/Cardio(vascular) Disease	☐ 1 Yes ☐ 0 No ☐ 111 NA
36. Tumors	☐ 1 Yes ☐ 0 No ☐ 111 NA
37. Chronic kidney diseases	☐ 1 Yes ☐ 0 No ☐ 111 NA
38. Diabetes	☐ 1 Yes ☐ 0 No ☐ 111 NA
39. COPD (chronic obstructive pulmonary disease)	☐ 1 Yes ☐ 0 No ☐ 111 NA
40. Musculoskeletal disease (Back pain, Osteoporosis, Arthrosis,/Arthritis/Rheumatism)	☐ 1 Yes ☐ 0 No ☐ 111 NA
41. Chronic liver diseases (excluding Hepatitis C)	☐ 1 Yes ☐ 0 No ☐ 111 NA
42. Hepatitis C	☐ 1 Yes ☐ 0 No ☐ 111 NA
43. HIV/AIDS	☐ 1 Yes ☐ 0 No ☐ 111 NA
44. Asthma	☐ 1 Yes ☐ 0 No ☐ 111 NA
45. Allergies	☐ 1 Yes ☐ 0 No ☐ 111 NA
46. Chronic pain	☐ 1 Yes ☐ 0 No ☐ 111 NA
47. Other	☐ 1 Yes ☐ 0 No ☐ 111 NA

Diagnosis Classification (ICD-10 code)

_____

_____

_____

48. Total number of chronic somatic diseases: (0 for none) ☐ 111 = NA

Mental Disorders (ICD-10 categories):

49. 1st Diagnosis ☐ 1 confirmed ☐ 0 tentative ☐ 111 NA

☐ 0=patient diagnosed as normal/none
☐ 1=Organic, including symptomatic, mental disorders
☐ 2=Mental and behavioral disorders due to psychoactive substance use
☐ 3=Schizophrenia, schizotypal and delusional disorders
☐ 4=Mood (affective) disorders
☐ 5=Neurotic, stress-related and somatoform disorders
☐ 6=behavioral syndromes associated with physiological disturbances and physical factors
☐ 7=Disorders of adult personality and behaviour
☐ 8=Mental retardation
☐ 9=Disorders of psychological development
☐ 10=Behavioral and emotional disorders with onset usually occurring in childhood/adolescence
☐ 11=Unspecified mental disorder
☐ 111=NA

50. 2nd Diagnosis ☐ 1 confirmed ☐ 0 tentative ☐ 111 NA

☐ 0=patient diagnosed as normal/none
☐ 1=Organic, including symptomatic, mental disorders
☐ 2=Mental and behavioral disorders due to psychoactive substance use
☐ 3=Schizophrenia, schizotypal and delusional disorders
☐ 4=Mood (affective) disorders
☐ 5=Neurotic, stress-related and somatoform disorders
☐ 6=behavioral syndromes associated with physiological disturbances and physical factors
☐ 7=Disorders of adult personality and behaviour
☐ 8=Mental retardation
☐ 9=Disorders of psychological development
☐ 10=Behavioral and emotional disorders with onset usually occurring in childhood/adolescence
☐ 11=Unspecified mental disorder
☐ 111=NA

51. 3rd Diagnosis ☐ 1 confirmed ☐ 0 tentative ☐ 111 NA

☐ 0=patient diagnosed as normal/none
☐ 1=Organic, including symptomatic, mental disorders
☐ 2=Mental and behavioral disorders due to psychoactive substance use
☐ 3=Schizophrenia, schizotypal and delusional disorders
☐ 4=Mood (affective) disorders
☐ 5=Neurotic, stress-related and somatoform disorders
☐ 6=behavioral syndromes associated with physiological disturbances and physical factors
☐ 7=Disorders of adult personality and behaviour
☐ 8=Mental retardation
☐ 9=Disorders of psychological development
☐ 10=Behavioral and emotional disorders with onset usually occurring in childhood/adolescence
☐ 11=Unspecified mental disorder
☐ 111=NA

Specify below all mental disorders noted in the medical record

Diagnosis Classification (ICD-10 code)

_____

_____

_____

_____

_____

52. Total number of mental disorders: Total count: (0 for none) ☐
111 NA

53. Medication for mental disorders (last 12 months): Total count: (0 for none) ☐
111 NA

Class	Name of Medication	Dosis	Frequency	Date for first Medication Taking	Type of Prescription	Date for last Medication Taking	Compliance with Medication

54. Class

0= None
1= Antidepressant
2= Mood stabilizer
3= Antipsychotic/Neuroleptic
4= Hypnotics/Sedatives
5= Hypnotics/ sedatives for withdrawal
6= Acetylcholinesterase inhibitors (anti-dementives)
7= NMDA-receptor antagonist (anti-dementives)
8= Psychostimulants
9= Hormone Therapy (e.g. Antiandrogen)
10= Antiepileptic/Anticonvulsants
11= Antiparkinsonian/Dopaminergic
12= Pain Medication (Non-opioid)
13= Pain Medication (opioid)
14= Opiods for withdrawal
15= Skeletal muscle relaxant
16= other
111 = NA

55. Name of Medication

Free Text, 0 for none, 111 for NA

56. Dosis

Numeric (eg. 200 mg), 0 for none, 111 for NA

57. Frequency

0 = None
1 = Daily
2 = Weekly
3 = As needed/On Demand
4 = Other (specify)
111 = NA

58. Date for first medication taking

In dd/mm/yyyy – Format If only year available, write 01.07./yyyy If not available/none, write 09.09.9999

59. Type of Prescription

0 = None
1= Fixed Prescription
2= Reserve
3= Only transfer documents (from other institution)
4= Other (specify)
111 = NA

60. Date for last medication taking (day of data collection if not further specified that medication intake has been stopped)

In dd/mm/yyyy – Format If only year available, write 01.07./yyyy If not available/none, write 09.09.9999

61. Compliance with Medication

1=refused
2=not offered
3=complied inconsistently (complied on some occasions and not others or complied with some medications but not others)
4=complied consistently but with limited success noted (e.g., still has delusions, hallucinations)
5=complied consistently with satisfactory success noted (report states good success or if symptoms/mood are controlled).
111= NA
If patient is uncooperative with IM (injected) antipsychotics but still receives it (e.g., due to treatment order, under restraint), count as noncompliant. If symptoms are controlled by DISDATE code as 5.

Code the patient's compliance with medication between START and END dates. Include only medications for psychotic symptoms or mood. Do not include anti-androgens (Provera, CPA) but write a note about these on the coding form. If not on any medications for psychotic symptoms or mood = 2.

Treatment for mental disorders:

Treatment Name	When? Frequency	Participation in therapy and other activities	Date of 1st encounter	Type of Therapy/Activity	Discipline providing the therapy/activity

62. ***Treatment Name***
Free text 0 for none, 111 for NA

63. ***When? Frequency***
0 = none
1= Daily
2 = Weekly
3 = Bi-Weekly
4 = Once a month
5= When necessary
6 = Other
111 = NA

64. ***Participation in therapy and other activities***
0=declined or was not offered
1=occasional participation (irregular attendance or started but dropped out of a structured program)
2=regular participation (consistent attendance or completed a structured program)
111 = NA

65. ***Date of 1st encounter***
In dd/mm/yyyy – Format.
If only year available, write 01.07./yyyy
If not available, write 09.09.9999

66. ***Type of Therapy/Activity***
0 = none
1 = organized, scheduled activities that require or build skills
2 = structured, scheduled group sessions following a manual or prepared curriculum
3 = structured, scheduled individual sessions following a manual or prepared curriculum
4 = unstructured, individual sessions
5 = organized social or group spiritual/session
6 = non-scheduled, occasional or one-time activities with no prepared curriculum
111 = NA

67. ***Discipline providing the therapy/activity***
0 = None
1 = Psychiatrist
2 = Psychologist
3 = Social Worker
4 = Occupational Therapist
5= Nurse
6 = Other
111 = NA

Suicide

68. Suicide attempted (**before** coming to the institution):

☐ 1 Yes ☐ 0 No ☐ 2 More than once ☐ 111 NA

69. If yes, when?

In dd/mm/yyyy – Format, If only year available, write 01.07./yyyy, If not available, write 09.09.9999

70. Suicide attempted (**during** detention):

☐ 1 Yes ☐ 0 No ☐ 2 More than once ☐ 111 NA

71. If yes, when?

In dd/mm/yyyy – Format. If only year available, write 01.07./yyyy, If not available, write 09.09.9999

Substance Use

Tobacco

72. Tobacco smoking (in forensic):

☐ 1 Yes ☐ 0 No ☐ 3 Former smoker ☐ 111 NA

73. If yes, cigarettes smoked in a day: ☐ 111 NA

74. Age of first use: ☐ 111 NA

Alcohol

75. Consumption (before coming to the institution):	☐ 1 Yes	☐ 0 No	☐ 111 NA
76. Alcohol involved in prior offences:	☐ 1 Yes	☐ 0 No	☐ 111 NA
77. Alcohol involved in index offence:	☐ 1 Yes	☐ 0 No	☐ 111 NA

78. Alcohol use age 18 to index incident: ☐ 111 NA

☐ **0** *never drinks (or never uses drugs)*
☐ **1** *no problems: used alcohol (or drugs) but there were no problems associated with his use*
☐ **2** *some problems: some problems occurred as a result of his alcohol (or drug) use but these were not serious enough nor frequent enough to really interfere with his life*
☐ **3** *interference in life: there were serious problems associated with his alcohol (or drug) use, such as major law violations, marital or family problems, employment problems, medical problems, or a diagnosis of alcohol (or drug) dependence or addiction*
☐ **4** *used alcohol (or drugs) but the degree of the problem is unknown*
we use "4" when we are converting the item to "any" problematic use, but remove it when using 0-3 as incremental categories.

Drugs

79. Drugs (before coming to the Forensic unit/institution):

☐ 1 Yes ☐ 0 No ☐ 111 NA

80. If yes, age of first use: ☐ 111 NA

81. Drugs involved in prior offences:	☐ 1 Yes	☐ 0 No	☐ 111 NA
82. Drugs involved in index offence:	☐ 1 Yes	☐ 0 No	☐ 111 NA

83. Drugs use age 18 to index incident (0-4) ☐ 111 NA

☐ **0** *never drinks (or never uses drugs)*
☐ **1** *no problems: used alcohol (or drugs) but there were no problems associated with his use*
☐ **2** *some problems: some problems occurred as a result of his alcohol (or drug) use but these were not serious enough nor frequent enough to really interfere with his life*

☐ **3** *interference in life: there were serious problems associated with his alcohol (or drug) use, such as major law violations, marital or family problems, employment problems, medical problems, or a diagnosis of alcohol (or drug) dependence or addiction*

☐ **4** *used alcohol (or drugs) but the degree of the problem is unknown*

we use "4" when we are converting the item to "any" problematic use, but remove it when using 0-3 as incremental categories.

84.	Cannabis/THC:	☐ 1 Yes	☐ 0 No	☐ 111 NA
85.	Cocaine:	☐ 1 Yes	☐ 0 No	☐ 111 NA
86.	Opioids:	☐ 1 Yes	☐ 0 No	☐ 111 NA
87.	Sedatives:	☐ 1 Yes	☐ 0 No	☐ 111 NA
88.	Stimulants:	☐ 1 Yes	☐ 0 No	☐ 111 NA
89.	Hallucinogens:	☐ 1 Yes	☐ 0 No	☐ 111 NA
90.	Misuse of prescription drugs:	☐ 1 Yes	☐ 0 No	☐ 111 NA
91.	Other drugs:	☐ 1 Yes	☐ 0 No	☐ 111 NA
92.	**If ye**s, name of drug:			☐ 111 NA
93.	Sterile injection material offered?	☐ 1 Yes	☐ 0 No	☐ 111 NA

Daily Living

94. Medical record indicates that the person has difficulties performing basic activities of daily living:
☐ 1 Yes ☐ 0 No ☐ 111 NA

95. Other relevant information noted in the record: e.g. assisted devices used; since when do limitations and disabilities exist, information concerning orientation (space, time, etc.), if injured (as a result of violence), etc.

96. Work capacity: ☐ 1 full ☐ 2 partly ☐ 0 None ☐ 111 NA

97. **If partly**, how much (in %) ☐ 111 NA

RISK ASSESSMENT

98. Tools used ☐ 111 NA

- ☐ 1 = FOTRES (Forensisches Operationalisiertes Therapie-Risiko-Evaluations-System)
- ☐ 2 = HCR-20 (Historical, Clinical, Risk management-20)
- ☐ 3 = LSI-R (Level of Service Inventory-Revised)
- ☐ 4 = PCL-R (Psychopathy Checklist-Revised)
- ☐ 5 = SORAG (Sex Offender Risk Appraisal Guide)
- ☐ 6 = Static-99
- ☐ 7 = VRAG (Violence Risk Appraisal Guide)

- ☐ 8 = VRAG-R (Violence Risk Appraisal Guide - Revised)
- ☐ 9 = SVR-20 (Sexual Violence Risk-20)
- ☐ 10 = SARA (Spousal Assault Risk Assessment)
- ☐ 11 = ODARA (Ontario Domestic Assault Risk Assessment)
- ☐ 12 = LS/CMI (Level of Service / Case Management Inventory)
- ☐ 13 = Risk Matrix 2000 (adult sex offenders)
- ☐ 14 = DyRiAS (Dynamisches Risiko Analyse System)
- ☐ 15 = Other(s), specify
- ☐ 0 = None

If Others, specify Tool(s):

_____

_____

_____

99. Assessment at entry ☐ 1 Yes ☐ 0 No ☐ 111 NA

100. Frequency of Re-assessment

- ☐ 0 = None
- ☐ 1 = Yearly
- ☐ 2 = Other
- ☐ 111 = NA

101. People involved / Responsible Person for Evaluation (Multiple possible)

Psychologists	☐ 1 Yes	☐ 0 No	☐ 111 NA
Psychiatrists	☐ 1 Yes	☐ 0 No	☐ 111 NA
Nurses	☐ 1 Yes	☐ 0 No	☐ 111 NA
Social Workers	☐ 1 Yes	☐ 0 No	☐ 111 NA
Others	☐ 1 Yes	☐ 0 No	☐ 111 NA

Relevant information concerning medical record in general:

6.4. HoNOS-secure

Beurteilungsinstruktionen zum HoNOS-secure-DT, Items 1 bis 12

1. Schliessen Sie keine Information ein, die in einem vorigen Item beurteilt wurde, wenn nicht anders vermerkt.
2. Beurteilen Sie das während der zu beurteilenden Zeitdauer, z.B. in den letzten zwei Wochen, SCHWERSTE Problem
3. Notieren Sie diese Skalen wie folgt:
   0 kein Problem
   1 geringfügiges Problem ohne Handlungsbedarf
   2 leichtes, aber jedenfalls vorhandenes Problem
   3 mittelschweres Problem
   4 schweres bis sehr schweres Problem
   9 keine Informationen verfügbar

1. Überaktives, aggressives, Unruhe stiftendes oder agitiertes Verhalten

Beziehen Sie solche Verhaltensweisen aufgrund jeglicher Ursache ein (z. B. Drogen, Alkohol, Demenz, Psychose, Depression usw.). Beziehen Sie bizarres Verhalten, welches mit dem Item 6 (Probleme im Zusammenhang mit Halluzinationen und Wahnvorstellungen) eingeschätzt wird, nicht mit ein. Beurteilen Sie sexuelle Verhaltensweisen mit Item 8 (I), jede Gewalttätigkeit oder Einschüchterung jedoch hier.

0. Kein Problem dieser Art während des Bewertungszeitraums.
1. Reizbarkeit, Streitigkeiten, Ruhelosigkeit, störendes Verhalten usw.
2. Beinhaltet gelegentliche aggressive Gesten, Schubsen, Belästigen oder Provozieren von Anderen; Drohungen oder verbale Aggression; leichtere Sachbeschädigung (z. B. zerbrochene Tasse, zerbrochenes Fenster, Verbrennung durch Zigaretten); ausgeprägte Hyperaktivität oder Agitiertheit.
3. Körperlich aggressiv gegenüber anderen Personen oder Tieren (im Ausmass Kodierung 4 unterschreitend); anhaltend bedrohliches Auftreten; schwerere Überaktivität oder Zerstörung von Eigentum (beschädigte Türen, geringe Brandstiftung z.B. Mülltonnen/Aschenbecher, etc.).
4. Mindestens ein schwerwiegender körperlicher Angriff gegen andere Personen oder Tiere; Zerstörung von Eigentum (z. B. gefährliche Brandstiftung); Gebrauch von Waffen; anhaltendes schwerwiegendes einschüchterndes Verhalten.

2. Absichtliche Selbstverletzung

Beziehen Sie versehentliche Selbstverletzung (z. B. aufgrund von Demenz oder schwerer Lernbehinderung) nicht mit ein; das kognitive Problem wird mit dem Item 4 und die Verletzung mit dem Item 5 eingeschätzt. Beziehen Sie Erkrankung oder Verletzung als direkte Folge von Drogen-/Alkoholkonsum, die mit Item 3 eingeschätzt werden, nicht mit ein (z.B. Leberzirrhose oder Verletzungen, die durch Trunkenheit am Steuer verursacht werden, werden mit dem Item 5 eingeschätzt)

0. Kein Problem dieser Art während des Bewertungszeitraums.
1. Flüchtige Gedanken über Selbstverletzung, oder Suizid, jedoch geringes Risiko während des Bewertungszeitraums; keine Selbstverletzung.
2. Mäßiges Risiko während des Bewertungszeitraums; schließt ungefährliche Selbstverletzung (z. B. Kratzen der Handgelenke, welches jedoch keiner körperlichen Behandlung bedarf); andauernde oder besorgniserregende/beunruhigende Gedanken über Selbstverletzung ein.
3. Mittleres bis schweres Risiko der absichtlichen Selbstverletzung während des Bewertungszeitraums; schließt vorbereitende Handlungen (z. B. das Sammeln von Tabletten, verbergen von Rasierklingen, anfertigen von Schlingen, Abschiedsbriefe) ein.

4. Schwerer Suizidversuch und/oder schwere absichtliche Selbstverletzung während des Bewertungszeitraums (i.e. Person verletzt sich ernsthaft oder beabsichtigte dies, oder riskiert durch ihre Handlungen ihren Tod).

3. Problematischer Alkoholkonsum oder Drogenkonsum

Beziehen Sie aggressives/destruktives Verhalten aufgrund von Alkohol- oder Drogenkonsum nicht mit ein. Dieses wurde mit dem Item 1 eingeschätzt. Beziehen Sie körperliche Erkrankung oder Behinderung aufgrund von Alkohol- oder Drogenkonsum nicht mit ein. Diese wird mit dem Item 5 eingeschätzt.

0. Kein Problem dieser Art während des Bewertungszeitraums (d.h. Minimaler Cannabiskonsum, Alkoholkonsum im Rahmen von Gesundheitsrichtlinien).
1. Gelegentlich übermäßiger Konsum, jedoch innerhalb der sozialen Norm (z.B. beträchtlicher Cannabiskonsum oder andere Aktivitäten mit geringem Risiko).
2. Verlust der Kontrolle über das Trinken oder den Drogenkonsum, jedoch nicht schwer abhängig (z.B. regelmässiger Cannabiskonsum, Trinken über den Rahmen der Gesundheitsrichtlinien hinaus); (in kontrollierten Settings – gelegentlich positive Urintests, Urlaubsentzug oder verzögerte Entlassung aufgrund von Haltung oder Benehmen hinsichtlich Trinkens und Drogen).
3. Ausgeprägte Abhängigkeit von Alkohol oder Drogen, mit häufigem Verlust der Kontrolle; Trunkenheit am Steuer (in kontrollierten Settings - Schulden aufgrund von Drogen, häufige Versuche, Drogen zu beschaffen; anhaltende Beschäftigung mit Trinken/Drogen; wiederholter Vergiftung oder positive Urintests).
4. Durch das Alkohol-/Drogenproblem handlungsunfähig.

4. Kognitive Probleme

Beziehen Sie Gedächtnis-, Orientierungs- und Auffassungsprobleme die mit irgendeiner Störung assoziiert werden, mit ein: Lernbehinderung, Demenz, Schizophrenie usw. Beziehen Sie vorübergehende Probleme als Folge von Alkohol- / Drogenkonsums (z. B. Kater) nicht mit ein. Diese wurden mit dem Item 3 eingeschätzt.

0. Kein Problem dieser Art während des Bewertungszeitraums.
1. Geringe Probleme mit Gedächtnis oder Verständnis (z. B. vergisst gelegentlich Namen).
2. Leichte, aber eindeutig vorhandene Probleme (z. B. hat sich an einem bekannten Ort verlaufen oder hat eine bekannte Person nicht wiedererkannt); manchmal bei einfachen Entscheidungen verwirrt; erhebliche Beeinträchtigung des Langzeitgedächtnisses.
3. Ausgeprägte Desorientierung hinsichtlich Zeit, Ort oder Person; verunsichert durch Alltagsereignisse; Sprache ist manchmal unzusammenhängend; mentale Verlangsamung.
4. Schwere Desorientierung (z. B. erkennt Verwandte nicht wieder; unfallgefährdet; Sprache unverständlich), Bewusstseinstrübung oder Stupor.

5. Probleme in Zusammenhang mit körperlicher Erkrankung oder Behinderung

Beziehen Sie Erkrankungen oder Behinderungen jeglicher Ursache ein, welche die Bewegung einschränken oder verhindern, das Sehen oder Hören beeinträchtigen oder anderweitig die persönliche Funktionsfähigkeit beeinträchtigen (z.B Schmerz). Beziehen Sie Nebenwirkungen von Medikamenten; Auswirkungen des Alkohol-/Drogenkonsums; körperliche Behinderung als Folge von Unfällen oder Selbstverletzung in Zusammenhang mit kognitiven Problemen, Trunkenheit am Steuer usw. ein. Beziehen Sie psychische oder verhaltensbezogene Probleme, welche mit dem Item 4 eingeschätzt werden, nicht mit ein.

0. Kein körperliches Gesundheitsproblem während des Bewertungszeitraums.
1. geringes Gesundheitsproblem während des Zeitraums (z. B. Erkältung, leichter Sturz usw.).
2. Körperliches Gesundheitsproblem schränkt die Mobilität und Aktivität leicht ein (z.B. verstauchter Knöchel, Kurzatmigkeit).
3. Mittlerer Grad der Aktivitätseinschränkung aufgrund eines körperlichen Gesundheitsproblems (z.B muss Arbeit oder Freizeitbeschäftigung aufgeben).

4. Schwere oder vollständige Funktionsunfähigkeit aufgrund von körperlichen Gesundheitsproblemen.

6. Probleme in Zusammenhang mit Halluzinationen und Wahnvorstellungen

Beziehen Sie Halluzinationen und Wahnvorstellungen ungeachtet der Diagnose ein. Beziehen Sie merkwürdiges und bizarres Verhalten in Zusammenhang mit Halluzinationen oder Wahnvorstellungen, sowie Denkstörungen ein. Beziehen Sie aggressive, destruktive oder überaktive Verhaltensweisen, die auf Halluzinationen oder Wahnvorstellungen zurückzuführen sind, nicht mit ein. Diese wurden mit dem Item 1 eingeschätzt.

0. Kein Anzeichen von Halluzinationen oder Wahnvorstellungen während des Bewertungszeitraums.
1. Etwas merkwürdige oder exzentrische Überzeugungen, die nicht mit den kulturellen Normen übereinstimmen.
2. Wahnvorstellungen oder Halluzinationen (z. B Stimmen, Visionen) sind vorhanden, jedoch besteht geringes Leiden für den Patienten oder eine geringe Manifestation von bizarrem Verhalten, d.h. klinisch vorhanden, aber leicht.
3. Ausgeprägte Beschäftigung mit Wahnvorstellungen oder Halluzinationen, die starkes Leiden verursacht und/oder sich in offensichtlich bizarrem Verhalten manifestiert, d.h. eher mittelschweres klinisches Problem.
4. Psychischer Zustand und Verhalten sind schwer und nachteilig durch Wahnvorstellungen oder Halluzinationen beeinträchtigt, mit schweren Auswirkungen auf den Patienten/andere Personen.

7. Probleme durch gedrückte Stimmung

Beziehen Sie Überaktivität oder Agitiertheit, welche mit dem Item 1 eingeschätzt wurden, nicht mit ein. Beziehen Sie Suizidgedanken oder –versuche, welche mit dem Item 2 eingeschätzt wurden, nicht mit ein. Beziehen Sie Wahnvorstellungen oder Halluzinationen, welche mit dem Item 6 eingeschätzt wurden, nicht mit ein.

0. Kein Problem in Zusammenhang mit gedrückter Stimmung während des Bewertungszeitraums.
1. Bedrückt; oder geringe Stimmungsveränderungen (die nicht als „Depression“ betrachtet werden).
2. Leichte(s), jedoch eindeutig vorhandene(s) Depression und Leiden (z. B. Schuldgefühle; Verlust des Selbstwertgefühls, die jedoch keiner klinischen Episode einer Depression gleichkommen); störende Stimmungsschwankungen.
3. Depression mit unangemessenen Selbstvorwürfen; zwanghaft beschäftigt mit Schuldgefühlen auf einem Niveau, das wahrscheinliche Diagnose und Behandlung nach sich zieht; klinisch problematische Stimmungsschwankungen.
4. Schwere oder sehr schwere Depression mit Schuld oder Selbstanklage.

8. Andere psychische und verhaltensbezogene Probleme

Beurteilen Sie nur das schwerste klinische Problem, welches bei Item 6 und 7 nicht berücksichtigt wurde. Spezifizieren Sie die Art des Problems, indem Sie den entsprechenden Buchstaben notieren: A Phobisch; B Angst; C Zwangsgedanken/ -handlungen; D Stress; E Dissoziativ; F Somatoform; G Essen; H Schlaf; I Sexuell (bei sexuellen Verhaltensproblemen, siehe Anleitung in Klammern); J Andere (spezifizieren).

0. Kein Anzeichen für irgendeines dieser Probleme während des Bewertungszeitraums.
1. Nur klinisch unbedeutende Probleme; (unhöfliche sexuelle Gesten oder Äusserungen).
2. Ein Problem ist klinisch in leichter Ausprägung vorhanden, aber es gibt relativ symptomfreie Intervalle und der Patient hat ein gewisses Ausmaß an Kontrolle (exzessiv fühlbare oder sexuelle Belästigung ohne Kontakt, sehr provokatives Verhalten wie Entblössung, sich fast unbekleidet in der Öffentlichkeit zeigen, in fremde Schlafzimmer spähen, etc.)
3. Konstante Beschäftigung mit dem Problem, Gelegentlich schwerer Anfall oder Leiden, mit Verlust der Kontrolle (z. B. Patient muss sämtliche Angst hervorrufenden Situationen vermeiden, einen Nachbarn als Hilfe hinzuziehen usw.), d.h. mittelschwere Ausprägung des Problems; sexueller Übergriff, z.B. das Berühren von Brüsten/Gesäss/Genitalien über der Kleidung).
4. Schweres andauerndes Problem beherrscht die meisten Aktivitäten; (schwerere sexuelle Übergriff, z.B. Kontakt der Genitalien, sexuelle Berührungen unter der Kleidung.

9. Probleme mit Beziehungen

Beurteilen Sie das schwerste Problem des Patienten in Zusammenhang mit aktivem oder passivem Rückzug aus sozialen Beziehungen und/oder nicht unterstützende, destruktive oder selbstschädigende Beziehungen. Berücksichtigen Sie den begrenzten Zugang zu Beziehungen ausserhalb des gesicherten Settings und schliessen Sie die Beziehungen zu Patienten/ Häftlingen/ Personal ein.

0. Kein bedeutendes Problem während des Bewertungszeitraums.
1. Geringe nicht-klinische Probleme.
2. Deutliches Problem beim Aufbau oder Aufrechterhalten von unterstützenden Beziehungen: Patient beklagt sich und/oder Probleme sind für andere offensichtlich.
3. Persistierende größere Problem aufgrund von aktivem oder passivem Rückzug aus sozialen Beziehungen und/oder Beziehungen, die geringen oder gar keinen Trost oder Unterstützung bieten.
4. Schwere und leidvolle soziale Isolation aufgrund der Unfähigkeit, sozial zu kommunizieren und/oder Rückzug aus sozialen Beziehungen.

10. Probleme mit den Aktivitäten des täglichen Lebens

Beurteilen Sie das allgemeine Funktionsniveau bei den Aktivitäten des täglichen Lebens (ATL) (z. B. Probleme mit grundlegenden Aktivitäten der Selbstpflege, wie Essen, Waschen, Ankleiden, Toilettengang; ebenso komplexe Fähigkeiten wie Haushaltsplanung, Organisieren einer Unterkunft, eines Berufs und der Freizeit, Mobilität und Benutzung von Transportmitteln, Selbstentwicklung usw.). Beziehen Sie jeglichen Mangel an Motivation, Gelegenheiten zur Selbsthilfe zu nutzen, mit ein, da dies zu einem insgesamt niedrigeren Funktionsniveau beiträgt. Beziehen Sie den Mangel an Gelegenheiten, intakte Fähigkeiten und Fertigkeiten (im gesicherten Setting) auszuüben nicht mit ein. Diese werden mit den Items 11-12 eingeschätzt.

0. Kein Problem während des Bewertungszeitraums; gute Funktionsfähigkeit in allen Bereichen.
1. Nur geringe Probleme (z. B. unordentlich, unorganisiert).
2. Angemessene Selbstpflege, jedoch erheblicher Leistungsmangel bei einer oder mehreren komplexen Fertigkeiten (siehe oben); benötigt gelegentliche Aufforderung.
3. Erhebliches Problem in einem oder mehreren Bereichen der Selbstpflege (Essen, Waschen, Ankleidung, Toilettengang) sowie starke Unfähigkeit, mehrere komplexe Fertigkeiten auszuüben. Benötigt konstant Aufforderung oder Beaufsichtigung.
4. Schwere Behinderung oder vollständige Unfähigkeit in allen oder nahezu allen Bereichen der Selbstpflege und komplexen Fertigkeiten.

11. Probleme durch die Wohnbedingungen

Schätzen Sie insgesamt die Schwere von Problemen mit der Qualität der Wohnbedingungen und der täglichen Haushaltsroutine ein. Werden die grundlegenden Lebensnotwendigkeiten erfüllt (Heizung, Licht, Hygiene)? Wenn ja, gibt es Hilfe, die Behinderungen zu bewältigen und eine Auswahl an Möglichkeiten, Fähigkeiten zu verwenden und neue zu entwickeln? Schätzen Sie nicht den Grad der funktionellen Behinderung ein. Dieser wurde mit dem Item 10 eingeschätzt.

Anmerkung: Schätzen Sie die übliche Wohnverhältnisse des Patienten ein, sei dies in einer Gemeinschaft, in offenem oder in gesichertem Setting (Spital oder Gefängnis). Wenn Unterbringung in Akutabteilung/temporärer Betreuung bewerten Sie die Wohnverhältnisse zu Hause.

0. Unterkunft und Wohnbedingungen sind annehmbar; hilfreich, um Behinderung, welche mit dem Item 10 eingeschätzt wurde, auf dem geringstmöglichen Niveau zu halten; und die Selbsthilfe unterstützend.
1. Unterkunft ist einigermaßen akzeptabel, obgleich geringfügige oder vorübergehende Probleme bestehen (z. B. kein optimaler Ort, nicht die bevorzugte Wahl, mag das Essen nicht usw.)
2. Bedeutendes Problem mit einem oder mehreren Aspekten der Unterkunft und/oder der Verwaltung (z. B. beschränkte Entscheidungsfreiheit; Personal oder Personen des Haushalts wissen kaum, wie die Behinderung einzugrenzen ist oder wie der Einsatz oder die Entwicklung neuer oder intakter Fertigkeiten unterstützt werden kann).
3. Zahlreiche belastende Probleme mit der Unterkunft/der Verwaltung (z. B. einige elementare Notwendigkeiten sind nicht vorhanden, Umgebung bietet nur minimale bis gar keine Möglichkeiten, die Unabhängigkeit des Patienten zu verbessern); unnötige restriktive körperliche Sicherheitsmassnahmen (z.B. kein Zugang nach draussen, Warten auf Verlegung in weniger gesicherte Einrichtungen).
4. Die Unterkunft ist inakzeptabel, wodurch die Probleme des Patienten verschlimmert werden, (z. B. elementare Notwendigkeiten sind nicht vorhanden, dem Patienten droht Räumung/willkürliche Verlegung); „Obdachlosigkeit“ oder die stark einschränkenden Wohnbedingungen sind anderweitig nicht tragbar; strenge Gefangenschaft (die meiste Zeit des Tages in einer Zelle eingeschlossen, unnötigerweise in einem abgeschiedenen oder unmöblierten Raum).

12. Probleme mit Beschäftigung und Aktivitäten

Schätzen Sie das Ausmass der Probleme mit der Qualität der Tagesumgebung insgesamt ein. Gibt es Hilfe, die Behinderungen zu bewältigen? Und gibt es Möglichkeiten, die den Beruf und die Freizeit betreffenden Fähigkeiten und Aktivitäten aufrechtzuerhalten oder zu verbessern? Berücksichtigen Sie Faktoren, wie Stigmatisierung, Mangel an angemessen qualifiziertem Personal, Zugang zu unterstützenden Angeboten und Einrichtungen, z.B. Personalausstattung und Ausrüstung von Tageszentren, Werkstätten, sozialen Vereinen, usw. Schätzen Sie nicht das Niveau der funktionellen Behinderung selbst. Dieses wurde mit dem Item 10 eingeschätzt.

Anmerkung: Schätzen Sie die übliche Situation des Patienten ein, sei dies in der Gemeinschaft, in offenem oder gesichertem Setting (Spital oder Gefängnis). Wenn Unterbringung in Akutabteilung/temporärer Betreuung schätzen Sie die Aktivitäten vor der Einweisung ein.

0. Milieu des Patienten ist akzeptabel: hilfreich, um jegliche Behinderung, welche mit dem Item 10 eingeschätzt wurde, auf dem geringst möglichen Niveau zu halten; und die Selbsthilfe unterstützend.
1. Geringfügige oder vorübergehende Probleme (z. B. verspäteter Erhalt von Überweisungen): angemessene Einrichtungen sind verfügbar, jedoch nicht immer zu den gewünschten oder angemessenen Zeiten, usw.
2. Beschränkte Auswahl an Aktivitäten; Mangel an angemessener Toleranz (z. B. zu Unrecht verweigerter Zutritt zu öffentlichen Bibliotheken oder Bädern; Fehlen von Aufenthaltsbereichen usw.); Mangel an Ausstattung in einer grossen Institution; benachteiligt durch Fehlen einer permanenten Adresse; unzureichende Betreuung oder professionelle Unterstützung; hilfreiches Milieu verfügbar, jedoch nur für eine sehr begrenzte Stundenzahl.

3. Ausgeprägter Mangel an verfügbaren qualifizierten Dienstleistungen, die helfen, das Ausmaß der bestehenden Behinderung so gering wie möglich zu halten; keine Möglichkeiten intakte Fertigkeiten einzusetzen oder neue zu entwickeln, unqualifizierte Betreuung, welche schwer zugänglich ist; keine Aktivitätsbereiche verfügbar; von einer kleinen Einrichtung nicht erteilter Urlaub führt zu Einschränkung.
4. Mangel an irgendwelchen Gelegenheiten für Tagesaktivitäten verschlimmert das Problem des Patienten; an jedem Tag lange Zeitspannen erzwungener Inaktivität (z.B. Gefängniszelle).

HONOS-secure-D – Sicherheitsskalen A bis G

Aktualisieren Sie die vollständig verfügbare Krankengeschichte und die Risikobewertung des Patienten.
Verschaffen Sie sich einen Überblick der vergangenen Vorfälle/Verhaltensweisen, Auftreten, aktuellen Fortschritte, etc.
Erfassen Sie das potentiell schwerwiegendste Problem in der näheren Zukunft (Wochen oder Monate).
Sofern relevant, betrachten Sie, ob der Patient ohne Unterstützung in der Gemeinschaft lebt.
`Potentiell´ impliziert dabei eine signifikante Wahrscheinlichkeit. Wenn ein Ereignis unvorhersehbar ist (z.B. Überdosis, Feuer), bewerten Sie im Verhältnis zum Grad des Risikos, das wahrscheinlich eintreten könnte. Anschliessend soll das Fazit der Risikoeinschätzung und des *jetzigen* Bedürfnisses für eine gesicherte Pflege bewertet werden. Diese Bewertung kann, muss aber nicht von der momentan vorgesehenen Pflege abweichen.

A. Beurteilen Sie das Risiko einer Schädigung von Erwachsenen oder Kindern
0. Nicht signifikant.
1. Geringes Risiko, z.B. Auseinandersetzungen; sexuelle Belästigung ohne physischen Kontakt; Sachbeschädigung; Mülltonnenbrand.
2. Signifikante Verletzung; grösserer Brand, sexueller Übergriff.
3. Grosses Risiko – Körperverletzung, lebensbedrohliche Brandstiftung, Vergewaltigung, Behinderung.
4. Schweres Risiko – einschliesslich Homizid, beinahe tödliche Verletzung, tiefgreifendes Trauma.

B. Beurteilen Sie das Risiko einer Selbstschädigung (sei dies absichtlich oder unabsichtlich)
0. Nicht signifikant.
1. Z.B. geringe Selbstbeschädigung/Überdosis; deutliche Vernachlässigung von Hygiene; Unterernährung.
2. Signifikante Verletzung oder Entstellung; stationäre medizinische Behandlung bei Überdosis; Verbrennungen; Hungern, etc.
3. Behinderung durch jegliche Form von Selbstschädigung.
4. Tatsächlicher oder Beinahe-Suizid; Sprung aus der Höhe.

C. Beurteilen Sie die Notwendigkeit für Gebäudesicherheit hinsichtlich Fluchtverhinderung
0. Kein Bedarf - Offener Wohnsitz in der Gemeinschaft.
1. Offene Einrichtung in einer psychiatrischen Klinik.
2. Geringe Sicherheitsmassnahmen; Psychiatrische Intensivstation; hohe Abhängigkeit; eingeschränkter Ausgang mit Sicherheitsmassnahmen.
3. Mittlere Sicherheitsmassnahmen; Luftschleuse; abgesicherte Gebäudearchitektur.
4. Hohe Sicherheitsmassnahmen, Sicherheitsmerkmale vergleichbar mit geschlossenem Gefängnis.

D. Beurteilen Sie die Notwendigkeit eines gesicherten mit Personal ausgestattetem Wohnumfelds

0. Keine Notwendigkeit – unbetreutes Wohnen ist angemessen.
1. Tagespflege; Behandlung Zuhause; 24-Stunden Betreuung/stationär, jedoch mit unbegleitetem Ausgang.
2. 24-Stunden Betreuung/stationäre Pflege ohne unbegleiteten Ausgang.
3. Verstärkte/durchgehende/spezielle Beobachtungsmassnahmen.
4. Gelegentliche oder regelmässige Isolation; mit durchgehend mehr als einem Mitarbeiter.

E. Beurteilen Sie die Notwendigkeit eines begleiteten Ausgangs (ausserhalb des gesicherten Umkreises). ***Dabei ist die Notwendigkeit eines Fahrers nicht mit einzuschliessen***

0. Keine Fluchtneigung; das Individuum verhält sich aufmerksam und angemessen.
1. Eine Begleitperson, wenn das Individuum herumirrt, umfällt, angefahren wird, zu spät kommt oder sich unangemessen verhält.
2. Maximal zwei Begleitpersonen, um das Verhalten zu kontrollieren oder Flucht zu verhindern.
3. Maximal drei Begleitpersonen, um das Verhalten zu kontrollieren oder Flucht zu verhindern.
4. Erfordert besondere Regelungen/Einrichtungen; vier Begleitpersonen; besonderes Fahrzeug; Polizeiassistenz.

F. Beurteilen Sie das Risiko eines Schadens durch andere

0. Nicht signifikant.
1. Mobbing; Entmachtung; unerwünschte Aufmerksamkeit; Benachteiligung.
2. Missbrauch; Übergriff; Betrug; schwerwiegende Belästigung; Prostitution.
3. Schwerwiegende Viktimisierung oder Verletzung; Vergewaltigung; schwere Feindseligkeiten in den Medien.
4. Tod; schwere Behinderung; tiefgreifendes Trauma.

G. Beurteilen Sie die Notwendigkeit von Risikomanagementverfahren

0. Planung der Standardpflege.
1. Laufend klinische Risikoeinschätzung durch das Team.
2. Klinisches Risikomanagement durch Spezialisten; Rückfallprävention oder Sondertherapie.
3. Setzt Pflichtdurchsuchung voraus, Suche oder Test hinsichtlich Drogen; Waffen; Besuchern; Mails/Telefon.
4. Invasive oder intensive Kontrolle, Suche, Tests oder ähnliche Einschränkungen.

Agequake in Prison 2 – Zusätzliche Informationen im Kontext des HoNOS-secure

T1 ☐ Erste Beurteilung T2 ☐ Zweite Beurteilung

DEMOGRAFISCHE INFORMATIONEN:

102. Geburtsjahr (YYYY):

103. Geschlecht: 1 ☐ M 2 ☐ W

104. Information zur Sanktion (Strafe, Massnahme…):

1 ☐ Freiheitsstrafe 2 ☐ Massnahme Art. 59/64b StGB 3 ☐ Massnahme Art. 63 StGB

111 ☐ NA

105. Institution:

1 ☐ Gefängnis (geschlossen) 2 ☐ Gefängnis (offen/halboffen) 3 ☐ Massnahme-Zentrum

4 ☐ Separate Institution für Massnahmen 5 ☐ forensische Abteilung in einer Klinik 6 ☐ Pflegeheim

7 ☐ andere 111 ☐ NA

106. Psychiatrische Diagnosen (ICD-10 Code): F0 ___.___

F1 ___.___

F2 ___.___

F3 ___.___

F4 ___.___

F5 ___.___

F6 ___.___

F7 ___.___

F8 ___.___

F9 ___.___

☐ F99

107. Erstes Eintrittsdatum für die aktuelle Verurteilung (in Gefängnis / forensischer Einrichtung)(DD/MM/YYYY):

108. Erstes Eintrittsdatum für die aktuelle Verurteilung (in derzeitiger Institution) (DD/MM/YYYY):

109. War der Patient schon in psychiatrischer/psychotherapeutischer Behandlung?

1 ☐ Ja 0 ☐ Nein 111 ☐ NA

a. **Wenn ja, seit wann** (DD/MM/YYYY): 111 ☐ NA

b. **Wenn ja**, **wo**:

1 ☐ Gefängnis 2 ☐ Forensische Einrichtung 3 ☐ Allgemeine Psychiatrie 4 ☐ ambulant

111 ☐ NA

110. Psychiatrische/psychotherapeutische Therapie in derzeitiger Einrichtung seit (DD/MM/YYYY):

111.Häufigkeit des therapeutischen Kontakts:

1 ☐ täglich 2 ☐ wöchentlich 3 ☐ zweiwöchentlich 4 ☐ anderes (bitte angeben):

112. Art der Therapie

1 ☐ Einzelsitzung 2 ☐ Gruppensitzung 3 ☐ Milieutherapie

4 ☐ medikamentös (Psychopharmaka) 5 ☐ andere (bitte angeben):

113. Welchem Ansatz folgt die Behandlung?

1 ☐ KVT 2 ☐ AET/AT 3 ☐ CBASP 4 ☐ DBT 5 ☐ Schematherapie

6 ☐ andere (bitte angeben):

114. Gab es in den vergangenen zwei Wochen besondere Vorkommnisse mit psychiatrischer Relevanz?

1 ☐ Ja 0 ☐ Nein 111 ☐ NA

115. Worauf basiert die Einschätzung:

1 ☐ Gespräch mit dem Patienten 2 ☐ direkte Beobachtung 3 ☐ medizinische Unterlagen

4 ☐ Informationen von Kollegen 5 ☐ anderes (bitte angeben):

116. Wie lautet das momentane Behandlungsziel:

1 ☐ Reduktion der Symptombelastung(siehe F-Diagnosen) 2 ☐ Stabilisierung

3 ☐ Deliktspezifisch, z.B. Emotionsregulation 3 ☐ anderes (bitte angeben):

INFORMATIONEN ZUR MACHBARKEIT/NÜTZLICHKEIT DES HONOS-SECURE-DT:

1. Wie lange brauchten Sie, um den HoNOS-Secure auszufüllen:

   1 ☐ 0-10 Minuten 2 ☐ 11-20 Minuten 3 ☐ 21-30 Minuten 4 ☐ anderes (bitte angeben):

2. Wie einfach/schwierig war es, den HoNOS-Secure auszufüllen:

   1 ☐ sehr einfach 2 ☐ eher einfach 3 ☐ eher schwierig 4 ☐ schwierig

3. Wie sehr gibt Ihrer Meinung nach der HoNOS-Secure die tatsächliche Schwere der Symptome (des Patienten) wieder?

   1 ☐ sehr gut 2 ☐ eher gut 3 ☐ eher nicht 4 ☐ gar nicht

4. Gab es Probleme, bestimmte Items zu beurteilen?

1 ☐ Ja, nämlich 0 ☐ Nein 111 ☐ NA

5. Der HoNOS-secure hat uns geholfen bei (jeweils von 1 -4):

a. der Ableitung für die Behandlung:

1 ☐ trifft zu 2 ☐ trifft eher zu 3 ☐ trifft eher nicht zu 4 ☐ trifft nicht zu

b. der Formulierung der Behandlungsziele:

1 ☐ trifft zu 2 ☐ trifft eher zu 3 ☐ trifft eher nicht zu 4 ☐ trifft nicht zu

c. der Interdisziplinären Zusammenarbeit:

1 ☐ trifft zu 2 ☐ trifft eher zu 3 ☐ trifft eher nicht zu 4 ☐ trifft nicht zu

d. der Verlaufsbeurteilung:

1 ☐ trifft zu 2 ☐ trifft eher zu 3 ☐ trifft eher nicht zu 4 ☐ trifft nicht zu

e. der Beurteilung des Behandlungserfolgs:

1 ☐ trifft zu 2 ☐ trifft eher zu 3 ☐ trifft eher nicht zu 4 ☐ trifft nicht zu

6.6. PHQ-9

GESUNDHEITSFRAGEBOGEN FÜR PATIENTEN (PHQ-9)

Wie oft fühlten Sie sich in den letzten 2 Wochen durch die folgenden Beschwerden beeinträchtigt? *(Bitte kreuzen Sie die für Sie passende Antwort an)*	**Über-haupt nicht**	**An einzelnen Tagen**	**An mehr als der Hälfte der Tage**	**Beinahe jeden Tag**
1. Wenig Interesse oder Freude an Ihren Aktivitäten	0	1	2	3
2. Niedergeschlagenheit, Bedrücktheit oder Hoffnungslosigkeit	0	1	2	3
3. Schwierigkeiten, ein- oder durchzuschlafen, oder vermehrter Schlaf	0	1	2	3
4. Müdigkeit oder Gefühl, keine Energie zu haben	0	1	2	3
5. Verminderter Appetit oder übermässiges Bedürfnis zu essen	0	1	2	3
6. Schlechte Meinung von sich selbst; Gefühl, ein Versager zu sein oder die Familie enttäuscht zu haben	0	1	2	3
7. Schwierigkeiten, sich auf etwas zu konzentrieren, z. B. beim Zeitunglesen oder Fernsehen	0	1	2	3
8. Waren Ihre Bewegungen oder Ihre Sprache so verlangsamt, dass es auch anderen aufgefallen sein könnte? Oder waren Sie im Gegenteil eher „zappelig" oder ruhelos und hatten dadurch einen stärkeren Bewegungsdrang als sonst?	0	1	2	3
9. Gedanken, dass Sie lieber tot wären oder sich Leid zufügen möchten	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

Wenn eines oder mehrere der bisher in diesem Fragebogen beschriebenen Probleme bei Ihnen vorliegen, geben Sie bitte an, wie sehr diese Probleme es Ihnen erschwert haben, Ihre Arbeit zu tun, Ihren Haushalt zu regeln oder mit anderen Menschen zurecht zu kommen:

Überhaupt nicht	**Etwas erschwert**	**Relativ stark erschwert**	**Sehr stark erschwert**
☐	☐	☐	☐

M.I.N.I.

Mini International Neuropsychiatric Interview

German Version 5.0.0

DSM-IV

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German version:
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Psychiatrische Universitätsklinik, München - DEUTSCHLAND

NAME DES PATIENTEN:	_____	*PROTOKOLL NUMMER:*	_____
GEBURTSDATUM:	_____	*Beginn des Interviews:*	_____
NAME DES INTERVIEWERS:	_____	*Ende des Interviews:*	_____
DATUM DES INTERVIEWS:	_____	*GESAMTDAUER DES INTERVIEWS:*	_____

M.I.N.I. 5.0.0 / German version / DSM-IV / current

MODULE	ZEITRAUM KRITERIEN ERFÜLLT	
A. EPISODE EINER MAJOR DEPRESSION	Aktuell (2 Wochen)+ lifetime	
A'. MDE MIT MELANCHOLISCHEM ANTEIL	Aktuell (2 Wochen)	Optional
B. DYSTHYMIE	Aktuell (letzte 2 Jahre)	
C. SUIZIDALITÄT	Aktuell (letzter Monat)	
D. (HYPO)MANISCHE EPISODE	Aktuell + lifetime	
E. PANIKSTÖRUNG	Lifetime + im vergangenen Monat	
F. AGORAPHOBIE	Aktuell	
G. SOZIALE PHOBIE (SOZ. ANGSTSTÖRUNG)	Aktuell (letzter Monat)	
H. ZWANGSSTÖRUNG	Aktuell (letzter Monat)	
I. POSTTRAUMATISCHE BELASTUNGSSTÖR	Aktuell (letzter Monat)	Optional
J. ALKOHOLABHÄNGIGKEIT/MISSBRAUCH	Letzte 12 Monate	
K. DROGENABHÄNGIGKEIT/MISSBRAUCH	Letzte 12 Monate	
L. PSYCHOTISCHE STÖRUNGEN	Lifetime + Aktuell	
M. ANOREXIA NERVOSA	Aktuell (letzte 3 Monate)	
N. BULIMIA NERVOSA	Aktuell (letzte 3 Monate)	
O. GENERALISIERTE ANGSTSTÖRUNG	Aktuell (letzte 3 Monate)	
P. ANTISOZIALE PERSÖNLICHKEITSSTÖRUNG	Lifetime	Optional

M.I.N.I. 5.0.0 German version / DSM-IV / current (September 1999 modified November 2005)
Y. Lecrubier, E. Weiller, T. Hergueta, P. Amorim, L.I. Bonora, J.P. Lépine (INSERM-PARIS, FRANCE) / D. Sheehan, J. Janavs, R. Baker, K.H. Sheehan, E. Knapp, M. Sheehan (University of South Florida-TAMPA, USA)
German version: M. Ackenheil, G. Stotz, R. Dietz-Bauer, A. Vossen (Psychiatrische Universitätsklinik, MÜNCHEN, GERMANY)

ALLGEMEINE HINWEISE

Das M.I.N.I wurde konzipiert als ein kurzes strukturiertes Interview zur Erfassung der hauptsächlichen psychiatrischen Achse-IStörungen im DSM-IV und ICD-10. Es wurden Validierungs- und Reliabilitätsstudien durchgeführt, die das M.I.N.I mit dem SCID-P für das DSM-III-R und mit dem CIDI (ein von der WHO entwickeltes strukturiertes Interview für nicht-professionelle Interviewer) für das ICD-10 verglichen. Die Ergebnisse dieser Studien zeigen, daß das M.I.N.I annehmbar hohe Valididierungs- und Reliabilitätswerte hat, daß es aber in einer wesentlichen kürzeren Zeit durchgeführt werden kann (Mittelwert 18.7 □11.6 Minuten, Median 15 Minuten) als die oben angeführten Instrumente. Kliniker können es nach einer kurzen Schulung einsetzen. Nicht-professionelle Interviewer benötigen eine ausführlichere Schulung.

- **Interview :**

Um das Interview so kurz wie möglich zu halten,informieren Sie den Patienten/die Patientin, daß Sie ein klinisches Interview durchführen wollen, das strukturierter ist als üblich und sehr präzise Fragen über psychologische Probleme beeinhaltet, die mit JA oder NEIN zu beantworten sind.

- **Allgemeine Gliederung :**

Das M.I.N.I. Plus ist in Module eingeteilt, die durch Buchstaben gekennzeichnet sind, von denen jeder einer diagnostischen Kategorie entspricht.

– Am Anfang jedes diagnostischen Moduls (mit Ausnahme des Moduls für psychotische Störungen) werden die Screeningfragen, die den Hauptkriterien der Störungen entsprechen, in einem grau-unterlegten Feld aufgeführt.

– Am Ende jedes Moduls kann der Kliniker in den Diagnose-Feldern ankreuzen, welche diagnostischen Kriterien zutreffen.

- **Legende:**

Sätze in "Normalschrift" sollten dem Patienten wörtlich vorgelesen werden, um die Beurteilung der diagnostischen Kriterien standardisieren zu können.

Sätze in "GROSSBUCHSTABEN" sollten dem Patienten nicht vorgelesen werden. Sie sind Anweisungen für den Interviewer und helfen bei der Bewertung der diagnostischen Algorithmen.

Sätze in "**Fettdruck**" geben den zu untersuchenden Zeitraum an. Der Interviewer soll sie so oft wie nötig vorlesen. Nur die Symptome, die innerhalb dieses Zeitrahmens vorlagen, sollten beim Bewerten der Antworten in Betracht gezogen werden.

Antworten mit "darüberstehendem Pfeil" **(➔)** geben an, daß eines von den für die Diagnose notwendigen Kriterien nicht erfüllt ist. In diesem Fall sollte der Interviewer zum Ende des Moduls gehen und in allen Diagnose-Feldern ein NEIN ankreuzen und zum nächsten Modul übergehen.

Wenn verschiedene *Begriffe* mit einem "Schrägstrich /"getrennt aufgeführt werden, sollte der Interviewer nur die Symptome vorlesen, von denen er weiß, daß sie beim Patienten vorliegen (z.B. bei den Fragen A3).

Sätze "(in Klammern)" sind klinische Beispiele für das Symptom. Sie können dem Patienten vorgelesen werden, um die Frage klarer zu machen.

□ Anweisungen für das Rating:

Alle Fragen müssen bearbeitet werden. Die Antwort erfolgt durch Ankreuzen von JA oder NEIN rechts von jeder Frage. Der Kliniker sollte sicherstellen, daß jeder Aspekt der Frage vom Patienten berücksichtigt wurde (z.B. Zeitraum, Häufigkeit, Ausmaß und/oder Alternativen).

Symptome aufgrund einer möglichen organischen Erkrankung oder durch Alkohol- bzw. Drogenmißbrauch sollten im M.I.N.I. nicht mit JA beantwortet werden. Fragen zu diesen Störungen finden Sie im M.I.N.I. Plus.

Wenn Sie Fragen haben, Vorschläge machen, an einem Training teilnehmen oder sich über Aktualisierungen des M.I.N.I. informieren wollen, wenden Sie sich bitte an:

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IV / current (September 1999 modified November 2005)
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➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

A. EPISODE EINER MAJOR DEPRESSION

A1	Fühlten Sie sich in den letzten 2 Wochen beinahe jeden Tag und fast während des ganzen Tages traurig, niedergeschlagen oder deprimiert?	NEIN	JA	1
A2	Hatten Sie in den letzten 2 Wochen fast ständig das Gefühl, zu nichts mehr Lust zu haben und das Interesse und die Freude an Dingen verloren zu haben, die Ihnen gewöhnlich Freude machten?	NEIN	JA	2
	WURDEN **A1** ODER **A2** MIT **JA** BEANTWORTET? ➔	NEIN	JA	

A3 **Während der letzten zwei Wochen, als Sie sich deprimiert oder interesselos fühlten:**

a Hat Ihr Appetit ab,- oder zugenommen und war das an fast jedem Tag der Fall? Oder haben Sie unbeabsichtigt erheblich an Gewicht zu- oder abgenommen (d.h. ± 5 % des Körpergewichts oder ± 3,5 kg bei einem Körpergewicht von 70 kg in einem Monat) NEIN JA 3
WENN EINES HIERVON ZUTRIFFT, KREUZEN SIE **JA** AN

b Hatten Sie fast jede Nacht Schlafprobleme (Einschlafprobleme, nächtliches oder frühmorgendliches Erwachen, übermäßiges Schlafen)? NEIN JA 4

c Haben Sie beinahe täglich langsamer gesprochen oder sich langsamer bewegt als gewöhnlich, oder waren Sie im Gegenteil unruhig und konnten nicht stillsitzen? NEIN JA 5

d Fühlten Sie sich beinahe täglich müde oder energielos? NEIN JA 6

e Fühlten Sie sich beinahe täglich wertlos oder schuldig? NEIN JA 7

f Hatten Sie beinahe täglich Schwierigkeiten, sich zu konzentrieren oder Entscheidungen zu treffen? NEIN JA 8

g Haben Sie wiederholt daran gedacht, sich etwas anzutun, Selbstmord zu begehen oder haben Sie sich gewünscht, tot zu sein? NEIN JA 9

A4 WURDEN **3** ODER MEHR **A3** FRAGEN MIT **JA** BEANTWORTET? (ODER **4 A3** FRAGEN, WENN **A1** ODER **A2** MIT **NEIN** BEANTWORTET WURDEN) **NEIN** ***EPISODE einer MAJOR DEPRESSION*** **JA** ***AKTUELL***

WENN DER PATIENT DIE KRITERIEN EINER AKTUELLEN EPISODE EINER MAJOR DEPRESSION ERFÜLLT:

A5 a Hatten Sie während Ihres Lebens weitere Perioden von zwei Wochen oder länger, in denen Sie sich deprimiert oder interesselos fühlten, und lagen während solcher Perioden bei Ihnen die meisten der gerade angesprochenen ➔ Probleme vor? NEIN JA 10

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

b Lagen mindestens zwei Monate ohne Depression oder Interesseverlust zwischen Ihrer aktuellen und Ihrer letzten depressiven Episode? NEIN JA 11

WURDE **A5b** MIT **JA** bantwortet?

NEIN **JA**

EPISODE einer MAJOR DEPRESSION
FRÜHER

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

A. EPISODE EINER MAJOR DEPRESSION MIT MELANCHOLISCHEN MERKMALEN (optional)

WENN DER PATIENT DIE KRITERIEN FÜR EINE EPISODE EINER MAJOR DEPRESSION ERFÜLLT (**A4 = JA**), KLÄREN SIE DIE FOLGENDEN KRITERIEN WEITER AB:

A6 a	WURDE **A2** MIT **JA** BEANTWORTET ?	NEIN	JA	12
b	Als Ihre aktuelle depressive Episode am schlimmsten war, haben Sie da auch die Fähigkeit verloren, sich über Dinge zu freuen, die Ihnen früher Freude machten oder Sie aufheiterten? **FALLS NEIN**: Wenn etwas Erfreuliches passierte, fühlten Sie sich dann trotzdem, auch vorübergehend, nicht besser?	NEIN	JA	13
	➔ Wurde entweder **A6a** ODER **A6b** mit **JA** beantwortet ?	NEIN	JA	

Während der letzten zwei Wochen, als Sie sich deprimiert oder interesselos fühlten:

A7 a	Haben Sie das Gefühl der Deprimiertheit anders erlebt als das Gefühl von Trauer beim Tod einer nahestehenden Person ?	NEIN	JA	14
b	Fühlten Sie sich morgens regelmäßig und beinahe täglich schlechter als abends?	NEIN	JA	15
c	Wachten Sie beinahe täglich mindestens zwei Stunden früher auf als sonst und hatten Sie dann Schwierigkeiten, wieder einzuschlafen?	NEIN	JA	16
d	Wurde **A3c** mit **JA** beantwortet (PSYCHOMOTORISCHE HEMMUNG ODER AGITIERTHEIT)?	NEIN	JA	17
e	Wurde **A3a** mit **JA** beantwortet (APPETITLOSIGKEIT ODER GEWICHTSVERLUST)?	NEIN	JA	18
f	f Fühlten Sie sich übermäßig oder der Situation unangemessen stark schuldig?	NEIN	JA	19

WURDEN **3** ODER MEHR **A7** FRAGEN MIT **JA** beantwortet ?

NEIN JA

EPISODE EINER MAJOR DEPRESSION Mit Melancholischen Merkmalen AKTUELL

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

B. DYSTHYMIE

DIESEN ABSCHNITT NICHT EXPLORIEREN, WENN DER PATIENT AKTUELL DIE KRITERIEN DER EPISODE EINER MAJOR DEPRESSION ERFÜLLT

B1 Fühlten Sie sich in den vergangenen zwei Jahren überwiegend traurig, niedergeschlagen oder deprimiert? ➔ NEIN JA 20

B2 Kam es in diesem Zeitraum vor, daß Sie sich mehr als zwei Monate gut fühlten? ➔ NEIN JA 21

B3 **Während dieser Zeit, in der Sie sich meistens deprimiert fühlten:**

a Hat sich da Ihr Appetit merklich geändert? NEIN JA 22

b Hatten Sie Schlafprobleme oder schliefen Sie zuviel? NEIN JA 23

c Fühlten Sie sich müde oder energielos? NEIN JA 24

d Haben Sie Ihr Selbstvertrauen verloren ? NEIN JA 25

e Hatten Sie Schwierigkeiten, sich zu konzentrieren oder Entscheidungen zu treffen ? NEIN JA 26

f Fühlten Sie sich hoffnungslos ? NEIN JA 27

WURDEN **2** ODER MEHR **B3** FRAGEN MIT **JA** BEANTWORTET? ➔ NEIN JA

B4 Haben Sie diese Probleme sehr belastet oder erheblich in Ihrer beruflichen Leistungsfähigkeit, Ihren sozialen Beziehungen oder anderen Lebensbereichen beeinträchtigt? ➔ NEIN JA 28

WURDE **B4** MIT **JA** BEANTWORTET ? **NEIN** **JA**

DYSTHYMIE AKTUELL

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

C. SUIZIDALITÄT

Während des vergangenen Monats:

C1	Dachten Sie da, es wäre besser, tot zu sein oder wünschten Sie sich, zu sterben?	NEIN	JA	1
C2	Haben Sie versucht, sich selbst zu verletzen ?	NEIN	JA	2
C3	Dachten Sie daran, Selbstmord zu begehen?	NEIN	JA	3
C4	Machten Sie einen Plan, wie Sie sich das Leben nehmen könnten?	NEIN	JA	4
C5	Haben Sie versucht, Selbstmord zu begehen?	NEIN	JA	5

Während Ihres Lebens

C6	Haben Sie bereits schon einmal versucht, Selbstmord zu begehen ?	NEIN	JA	6

WURDE MINDESTENS **1** DER FRAGEN MIT **JA** beantwortet?

FALLS JA, **SPEZIFIZIEREN** SIE DEN SCHWEREGRAD DES SUIZIDRISIKOS WIE FOLGT:

C1 oder C2 oder C6 = JA: GERING
C3 oder (C2 +C6) = JA: MÄSSIG
C4 oder C5 oder (C3 + C6) = JA: HOCH

NEIN	**JA**
SUIZIDRISIKO AKTUELL	
GERING	☐
MÄSSIG	☐
HOCH	☐

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

D. MANISCHE EPISODE (Hypomanische Episode)

D1 a Gab es bei Ihnen schon **jemals** eine Zeit, in der Sie sich so überschwenglich, aufgedreht und voller Energie fühlten, daß dies für Sie zu Problemen führte oder andere Leute dachten, daß Sie sich außergewöhnlich benehmen würden? WENN SIE NICHT UNTER DROGEN- ODER ALKOHOLEINFLUß STANDEN — NEIN JA — 1

FALLS DER PATIENT NICHT GENAU VERSTEHT, WAS SIE MIT "ÜBERSCHWENGLICH" ODER "AUFGEDREHT" MEINEN, PRÄZISIEREN SIE: Mit "überschwenglich" oder "aufgedreht" meine ich: eine deutlich gehobene Stimmung, vermehrte Energie, geringeres Schlafbedürfnis, Gedankenrasen und Ideenfülle, gesteigerte Betriebsamkeit, Kreativität und Antrieb oder impulsives Verhalten?

FALLS JA :

b Fühlen Sie sich im Moment "überschwenglich", "aufgedreht" oder "voller Energie"? — NEIN JA — 2

D2 a Gab es bei Ihnen schon **jemals** eine Zeit, in der Sie sich andauernd, mehrere Tage lang, so reizbar fühlten, daß Sie in verbale oder körperliche Auseinandersetzungen gerieten oder fremde Personen anschrieen ? — NEIN JA — 3

Haben Sie oder andere bemerkt, daß Sie im Vergleich zu anderen Menschen reizbarer waren oder überreagierten, selbst wenn Sie es in diesem Moment für gerechtfertigt hielten?
WENN SIE NICHT UNTER DROGEN- ODER ALKOHOLEINFLUß STANDEN

FALLS JA :

b Fühlen Sie sich im Moment andauernd reizbar ? — NEIN JA — 4

WURDE **D1a** ODER **D2a** MIT **JA** BEANTWORTET? — ➔ NEIN JA

D3 FALLS D1b ODER D2b = JA : EXPLORIEREN SIE NUR DIE **AKTUELLE** EPISODE
FALLS D1b UND D2b = NEIN : EXPLORIEREN SIE DIE **AUSGEPRÄGTESTE** FRÜHERE EPISODE

Während solcher Zeiten, als Sie sich "überschwenglich", voller Energie oder reizbar fühlten:

a Hatten Sie das Gefühl, Dinge tun zu können, zu denen andere nicht fähig sind, oder eine besonders wichtige Person zu sein? NEIN JA 5

b Brauchten Sie da weniger Schlaf (fühlten Sie sich z.B. nach nur wenigen Stunden Schlaf ausgeruht)? NEIN JA 6

c Redeten Sie ununterbrochen oder so schnell, daß andere Schwierigkeiten hatten, Sie zu verstehen? NEIN JA 7

d Hatten Sie das Gefühl, daß Ihnen die Gedanken durch den Kopf rasten? NEIN JA 8 e

e Waren Sie so zerstreut, daß Sie bereits durch eine kleine Unterbrechung den Faden verloren? NEIN JA 9

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

f Waren Sie derart aktiv oder ständig körperlich in Bewegung, daß sich andere Ihretwegen Sorgen machten? NEIN JA 10

g Erschienen Ihnen bestimmte Aktivitäten derart angenehm und reizvoll, daß Sie die Risiken und Schwierigkeiten, die Ihnen daraus erwachsen würden, nicht beachteten (z.B. unüberlegte Einkäufe, rücksichtsloses Fahren oder leichtsinnige sexuelle Aktivitäten) ? NEIN JA 11

WURDEN **3** ODER MEHR **D3** FRAGEN MIT **JA** BEANTWORTET ODER **4,** FALLS **D1a = NEIN** (FRÜHERE EPISODE) ODER **D1b = NEIN** ➔ (AKTUELLE EPISODE)? NEIN JA

D4 Haben diese Probleme mindestens eine Woche lang angedauert **und** waren sie Anlass für Schwierigkeiten zu Hause, bei der Arbeit oder in der Schule **oder** waren Sie wegen solcher Probleme stationär im Krankenhaus? NEIN JA 12

FALLS BEIDE BEJAHT, BEANTWORTEN SIE DIE FRAGE MIT JA

WURDE **D4** MIT **NEIN** BEANTWORTET ?

FALLS JA, SPEZIFIZIEREN SIE, OB "AKTUELLE EPISODE" ODER "FRÜHERE EPISODE"

NEIN	**JA**
HYPOMANISCHE EPISODE	
AKTUELL	•
FRÜHER	•

WURDE **D4** MIT **JA** BEANTWORTET ?

FALLS JA; SPEZIFIZIEREN SIE, OB "AKTUELLE EPISODE" ODER "FRÜHERE EPISODE"

NEIN	**JA**
MANISCHE EPISODE	
AKTUELL	•
FRÜHER	•

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

F. PANIKSTÖRUNG

E1 Hatten Sie mehr als einmal Zustände oder Anfälle, bei denen Sie sich **plötzlich** voller Angst, beklommen oder unbehaglich fühlten, auch in Situationen, in denen die meisten Leute nicht so reagiert hätten? Erreichten diese Beschwerden innerhalb von 10 Minuten den Höhepunkt? NEIN JA 1

KREUZEN SIE JA NUR DANN AN, WENN DIE BESCHWERDEN INNERHALB VON 10 MINUTEN DEN HÖHEPUNKT ERREICHTEN

FALLS **E1 = NEIN**, BEI E5 NEIN ANKREUZEN UND ZU F1 WEITERGEHEN

E2 Trat irgendeiner dieser Zustände oder Anfälle unerwartet und spontan auf oder war unvorhersehbar und ohne direkten Auslöser? NEIN JA 2

FALLS **E2 = NEIN**, BEI E5 NEIN ANKREUZEN UND ZU F1 WEITERGEHEN

E3 Hatten Sie schon jemals nach einem derartigen Anfall einen Monat oder länger ständig Angst vor einem weiteren Anfall oder machten sich Sorgen über mögliche Folgen eines solchen Anfalls? NEIN JA 3

FALLS **E3 = NEIN**, BEI E5 NEIN ANKREUZEN UND ZU F1 WEITERGEHEN

E4 **Während des schlimmsten Anfalls, an den Sie sich erinnern können:**

a Hatten Sie da Herzrasen oder starkes Herzklopfen? NEIN JA 4

b Schwitzten Sie oder hatten feuchte Hände? NEIN JA 5

c Litten Sie unter Zittern oder Muskelzucken? NEIN JA 6

d Hatten Sie das Gefühl von Kurzatmigkeit oder Atemnot? NEIN JA 7

e Hatten Sie Erstickungsgefühle oder einen Kloß im Hals? NEIN JA 8

f Hatten Sie Schmerzen oder ein Druck,- oder Beklemmungsgefühl in der Brust? NEIN JA 9

g Litten Sie unter Übelkeit oder plötzlich auftretende Magen-Darm- Beschwerden? NEIN JA 10

h Fühlten Sie sich benommen, unsicher, schwindelig oder der Ohnmacht nahe? NEIN JA 11

i Empfanden Sie die Dinge in Ihrer Umgebung eigenartig, unwirklich oder ungewohnt? Oder fühlten Sie sich selbst ganz oder teilweise losgelöst bzw. außerhalb Ihres Körpers? NEIN JA 12

j Hatten Sie Angst, verrückt zu werden oder die Kontrolle über sich zu verlieren? NEIN JA 13

Litten Sie unter Todesangst? NEIN JA 14

Hatten Sie Kribbeln oder Taubheitsgefühle? NEIN JA 15

Litten Sie unter Hitzewallungen oder Kälteschauern? NEIN JA 16

E5 WURDEN SOWOHL **E3** ALS AUCH **4** ODER MEHR **E4** FRAGEN MIT **JA** BEANTWORTET? NEIN JA

FALLS **E5 = NEIN**, WEITERGEHEN ZU **E7** ***Panikstörung"Lifetime"***

E6 Hatten Sie im vergangenen Monat häufiger solche Anfälle (2 oder mehr) und ständig Angst vor einem weiteren Anfall? NEIN JA 17

FALLS **E6 = JA**, WEITERGEHEN ZU **F1** ***PanikstörungAktuell***

E7 WURDEN **1, 2** ODER **3** SYMPTOME IN **E4** MIT **JA** BEANTWORTET NEIN JA 18

_____ _____ ***Panikattacken*** _ ***symptomarm Aktuell***

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

G. AGORAPHOBIE

F1	Fühlen Sie sich ängstlich oder unbehaglich an Orten oder in Situationen, aus denen es im Falle eines Panikanfalls oder der gerade besprochenen panikartigen Symptome schwierig wäre zu fliehen oder keine Hilfe erreichbar wäre, wie z.B. in einer Menschenmenge, einer Warteschlange, fern von zu Hause, wenn Sie allein zuhause sind oder sich auf einer Brücke, im Bus, Zug oder Auto befinden?	NEIN	JA	19

FALLS **F1 = NEIN**, BEI F2 NEIN ANKREUZEN

F2 Fürchten Sie diese Orte/ Situationen so sehr, daß Sie sie vermeiden, sich darin sehr unbehaglich fühlen oder diese nur in Begleitung aufsuchen NEIN JA 20 würden?

Agoraphobie Aktuell

WURDE **F2** (*AKTUELLE* AGORAPHOBIE) **VERNEINT** **NEIN JA** und
WURDE **E6** (*AKTUELLE* PANIKSTÖRUNG) **BEJAHT**? ***PANIKSTÖRUNG ohne Agoraphobie***

WURDE **F2** (*AKTUELLE* AGORAPHOBIE) **BEJAHT** **NEIN JA** und
WURDE **E6** (*AKTUELLE* PANIKSTÖRUNG) **BEJAHT**? ***PANIKSTÖRUNG mit Agoraphobie***

WURDE **F2** (*AKTUELLE* AGORAPHOBIE) **BEJAHT** **NEIN JA** und
WURDE **E5** (PANIKSTÖRUNG „*LIFETIME*“) **VERNEINT**? ***AGORAPHOBIE Ohne frühere Panikstörung***

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

H. SOZIALE PHOBIE (SOZIALE ANGSTSTÖRUNG)

G1	Hatten Sie im vergangenen Monat Angst, die Aufmerksamkeit anderer auf sich zu ziehen oder war Ihnen die Vorstellung peinlich, in bestimmten sozialen Situationen bloßgestellt zu werden, z.B. vor einer Gruppe das Wort zu ergreifen, in Gegenwart anderer zu essen oder zu schreiben oder in anderen sozialen Bereichen beurteilt zu werden?	➔ NEIN	JA	1
G2	Glauben Sie, daß diese Angst übertrieben oder unsinnig ist ?	➔ NEIN	JA	2
G3	Fürchten Sie diese sozialen Situationen so sehr, daß Sie sie vermeiden oder sich darin sehr unwohl fühlen?	➔ NEIN	JA	3
G4	Fühlen Sie sich wegen dieser Angst in der Ausführung Ihrer alltäglichen Arbeiten, Ihren sozialen Aktivitäten oder in Ihrem Wohlbefinden beeinträchtigt?	NEIN	JA	4

WURDE **G4 BEJAHT** ?

NEIN	**JA**
SOZIALE PHOBIE AKTUELL	

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

I. ZWANGSSTÖRUNG

H1 Haben Sie im Verlauf des vergangenen Monats unter aufdringlichen Gedanken oder Vorstellungen gelitten, die unaufhörlich wiederkamen, ohne daß Sie es wollten und die Sie als unangemessen, ängstigend oder belastend erlebten? (Z.B. der Gedanke, daß Sie schmutzig wären oder Keime an sich hätten **oder** Angst davor, andere zu kontaminieren **oder** Angst davor, einer anderen Person Schmerz oder Schaden zuzufügen, obwohl Sie dies nicht wollten **oder** Angst davor, irgendeinen Impuls in die Tat umzusetzen **oder** die Vorstellung, für alle möglichen Dinge, die schief laufen könnten, die Verantwortung zu tragen **oder** aufdringliche sexuelle oder religiöse Vorstellungen oder Impulse)

NEIN JA 1

NICHT ZU BERÜCKSICHTIGEN SIND ÜBERMÄSSIGE BESORGNIS ÜBER PROBLEME DES TÄGLICHEN LEBENS UND IMMER WIEDERKEHRENDE GEDANKEN IM ZUSAMMENHANG MIT ANDEREN STÖRUNGEN (EßSTÖRUNG, SEXUELLE DEVIATION, PATH. ALKOHOL,- ODER DROGENKONSUM, PATH. SPIELEN), WEIL DER PATIENT DANN AN DER AKTIVITÄT SELBST FREUDE FINDEN KÖNNTE UND IHR NUR WEGEN IHRER NEGATIVEN KONSEQUENZEN WIDERSTEHEN WÜRDE.

FALLS **H1** = **NEIN, WEITERGEHEN ZU H4**

H2 Sind Ihnen diese Vorstellungen immer wieder in den Sinn gekommen, selbst wenn Sie versuchten, sie zu ignorieren oder sie loszuwerden? NEIN JA 2

FALLS **H2** = **NEIN, WEITERGEHEN ZU H4**

H3 Glauben Sie, dass diese Vorstellungen Ihre eigenen Gedanken sind und dass sie Ihnen nicht von außen eingegeben wurden? NEIN JA 3

H4 Haben Sie im Verlauf des vergangenen Monats den Drang verspürt, bestimmte Dinge immer wieder zu tun, ohne dem widerstehen zu können, wie z.B. immer wieder Ihre Hände oder andere Dinge zu waschen, immer wieder bestimmte Dinge zu kontrollieren (z.B. Herd, Tür) oder zu ordnen oder Handlungen wie z.B. ständiges Zählen oder Wörterwiederholen ? NEIN JA 4

WURDE **H3** ODER **H4 BEJAHT** ? ➔ NEIN JA

H5 Kamen Ihnen diese immer wiederkehrenden Vorstellungen/ Handlungen übertrieben oder unsinnig vor? ➔ NEIN JA 5

H6 Beeinträchtigen Sie diese immer wiederkehrenden Vorstellungen/ Handlungen bei Ihren alltäglichen Verrichtungen, Ihrer Arbeit, Ihren sozialen Aktivitäten oder Beziehungen oder nahmen mehr als 1 Stunde pro Tag in Anspruch? NEIN JA 6

WIRD **H6 BEJAHT**? **NEIN** **JA**

ZWANGSSTÖRUNG AKTUELL

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

J. POSTTRAUMATISCHE BELASTUNGSSTÖRUNG (optional)

I1 Erlebten Sie jemals selbst oder wurden Sie Zeuge eines traumatischen Ereignisses, das tatsächlichen oder drohenden Tod oder eine ernsthafte Verletzung für Sie oder eine andere Person beinhaltete?
BEISPIELE: LEBENSBEDROHLICHER UNFALL, GEWALTTÄTIGER SEXUELLER ODER KÖRPERLICHER ANGRIFF, TERRORANSCHLAG, GEISELNAHME, ENTFÜHRUNG, BEWAFFNETER RAUBÜBERFALL, BRANDKATASTROPHE, AUFFINDEN EINER LEICHE, UNERWARTETER TOD EINES ANGEHÖRIGEN, KRIEG, NATURKATASTROPHEN)
War dies für Sie mit intensiver Furcht, Hilflosigkeit oder Entsetzen verbunden?

➔ NEIN JA 1

I2 Haben Sie das Ereignis im Verlauf des vergangenen Monats auf belastende Weise wiedererlebt (z.B. durch wiederkehrende Träume, intensiv erlebte Erinnerungen, flashbacks oder körperliche Beschwerden) ?

➔ NEIN JA 2

I3 **Während des vergangenen Monats :**

a Vermieden Sie Gedanken an das Ereignis oder vermieden Sie Situationen oder Dinge, die Sie daran erinnern? NEIN JA 3
b Hatten Sie Schwierigkeiten, sich an einen wichtigen Aspekt des Ereignisses zu erinnern? NEIN JA 4
c Ließ Ihr Interesse an Hobbies oder sozialen Aktivitäten nach? NEIN JA 5
d Fühlten Sie sich von anderen Menschen entfremdet? NEIN JA 6
e Hatten Sie den Eindruck, daß Ihre Gefühle abgestumpft sind? NEIN JA 7
f Hatten Sie das Gefühl, daß Ihre Lebenserwartungen durch das Ereignis eingeschränkt werden? NEIN JA 8

➔

WURDEN **3** OR MEHR **I3** FRAGEN MIT **JA** BEANTWORTET? NEIN JA

I4 **Während des vergangenen Monats:**

a Hatten Sie da Schwierigkeiten, ein- oder durchzuschlafen? NEIN JA 9
b Waren Sie besonders reizbar oder hatten Sie Wutanfälle? NEIN JA 10
c Hatten Sie Schwierigkeiten, sich zu konzentrieren? NEIN JA 11
d Waren Sie unruhig oder ständig “auf dem Sprung”? NEIN JA 12
e Waren Sie übermäßig schreckhaft? NEIN JA 13

➔

WURDEN **2** ODER MEHR **I4** FRAGEN MIT **JA** BEANTWORTET? NEIN JA

I5 Haben Sie diese Probleme während des vergangenen Monats bei Ihrer Arbeit oder Ihren sozialen Aktivitäten beeinträchtigt oder fühlten Sie sich hierdurch sehr belastet? NEIN JA 14

NEIN **JA**

WURDE **I5 BEJAHT** ?

POSTTRAUMATISCHE BELASTUNGS-STÖRUNG AKTUELL

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

J. ALKOHOLABHÄNGIGKEIT/-MISSBRAUCH

J1 Ist es während der vergangenen 12 Monate mehr als dreimal vorgekommen, daß Sie mehr als 3 alkoholische Getränke innerhalb von 3 Stunden getrunken haben? ➔ NEIN JA 1

J2 **Während der vergangenen 12 Monate :**

a Benötigten Sie da mehr Alkohol als früher, um die gleiche Wirkung zu erzielen? NEIN JA 2

b Wenn Sie weniger getrunken haben, zitterten dann Ihre Hände, schwitzten Sie oder fühlten sich erregt? Kam es vor, dass Sie tranken, um derartige Beschwerden oder einen Kater zu vermeiden? NEIN JA 3

WENN EINES HIERVON ZUTRIFFT, KREUZEN SIE **JA** AN

c Kam es vor, daß Sie mehr tranken als ursprünglich beabsichtigt? NEIN JA 4

d Haben Sie bereits erfolglos versucht, Ihren Alkoholkonsum einzuschränken oder gar nicht mehr zu trinken? NEIN JA 5

e Verbrachten Sie an den Tagen, an denen Sie tranken, sehr viel Zeit damit, sich Alkohol zu besorgen, Alkohol zu trinken oder sich von der Alkoholwirkung zu erholen? NEIN JA 6

f Haben Sie Ihre Aktivitäten, wie Arbeit, Freizeit oder soziale Kontakte, aufgrund Ihres Alkoholkonsums eingeschränkt? NEIN JA 7

g Haben Sie weiterhin getrunken, obwohl Sie wußten, daß dies bei Ihnen zu gesundheitlichen oder seelischen Problemen führte? NEIN JA 8

WURDEN **3** ODER MEHR**J2** FRAGEN MIT **JA** BEANTWORTET? **NEIN** **JA**

ALKOHOL-ABHÄNGIGKEIT AKTUELL

➔

ZEIGT DER PATIENT ALKOHOLABHÄNGIGKEIT? NEIN JA

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

J3 **Während der vergangenen 12 Monate:**

a Waren Sie mehrmals betrunken oder verkatert, als Sie Aufgaben zu erledigen hatten in der Schule, bei der Arbeit oder zu Hause? Hat dies zu Schwierigkeiten geführt? NEIN JA 9
KREUZEN SIE NUR DANN JA AN, WENN DIES PROBLEME VERURSACHT HAT

b Kam es vor, daß Sie schon einmal in irgendeiner Situation betrunken waren, in der ein Verletzungsrisiko bestand, z.B. beim Auto,- oder Motorradfahren oder Bedienen von Maschinen etc.)? NEIN JA 10

c Hatten Sie wegen Ihres Trinkens irgendwelche Probleme mit dem Gesetz, z.B. eine Verhaftung oder Anzeige? NEIN JA 11

d Haben Sie weiterhin Alkohol getrunken, obwohl Sie dadurch Probleme mit Ihrer Familie oder anderen Personen bekommen haben? NEIN JA 12

WURDE **1** ODER MEHR **J3** FRAGEN MIT **JA** BEANTWORTET?

NEIN	**JA**
ALKOHOL-MISSBRAUCH AKTUELL	

AMPHETAMIN

CANNABIS

KOKAIN

CODEIN

CRACK

DILAUDID

ECSTASY

AETHER

FREEBASE

BENZIN

KLEBSTOFF

GRAS

HASCHISCH

HEROIN

LSD

MARIHUANA

MESCALIN

METHADON

MORPHINE

OPIUM

PALFIUM

PCP

RITALIN

TEMGESIC

THC

TOLUEN

TRICHLORAETHYLEN

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

K. STÖRUNGEN IM ZUSAMMENHANG MIT PSYCHOTROPEN SUBSTANZEN

K1 Ich werde Ihnen jetzt eine Liste mit verschiedenen Drogen und Arzneimitteln zeigen. Nahmen Sie während der vergangenen 12 Monate irgendeine dieser Substanzen mehrmals ein, um "high" zu werden, sich besser zu fühlen oder Ihre Stimmung zu verändern?

➔ NEIN JA

KREUZEN SIE JEDE SUSTANZ AN, DIE EINGENOMMEN WURDE :

Stimulantien: Amphetamine, "speed", Ritalin, Appetitzügler.

Kokain: Crack, "speedball".

Narkotika: Heroin, Morphine, Dilaudid, Opium, Methadon, Paracodein,

Halluzinogene: LSD ("acid")Trips, Mescalin, Peyott, PCP ("angel dust"), Psilocybin, "Fliegenpilze", Ecstasy, MDA, oder MDMA.

Schnüffelstoffe: Ethylchlorid, Lachgas, Pattex

Marihuana: Haschisch, THC, "pot", "gras", "Sheet" Cannabis

Tranquillantien: Valium, Halcion, Barbiturate, Flunis, Tohyps

Verschiedene: Steroide, rezeptfreie Schlafmittel oder Appetitzügler. Weitere?

NENNEN SIE DIE AM HÄUFIGSTEN KONSUMIERTEN SUBSTANZEN: _____
_____

SPEZIFIZIEREN SIE, AUF WELCHE SUBSTANZEN SICH IHRE WEITERE EXPLORATION BEZIEHT:

JEDE EINZELNE SUBSTANZ (ODER SUBSTANZKLASSE) ☐

NUR DIE AM HÄUFIGSTEN KONSUMIERTE SUBSTANZ (ODER SUBSTANZKLASSE) ☐

BEI GEBRAUCH NUR EINER SUBSTANZ (ODER SUBSTANZKLASSE): ☐

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

K2 **Wenn Sie an Ihren Konsum von [NENNEN SIE DIE SUBSTANZ/ SUBSTANZKLASSE] während der vergangenen 12 Monate denken:**

a Haben Sie bemerkt, daß Sie mehr [NAME DER SUBSTANZ/SUBSTANZKLASSE] einnehmen mußten, um die gleiche Wirkung wie früher zu erzielen? NEIN JA 1

b Hatten Sie Entzugserscheinungen, wenn Sie versuchten, die Einnahme von [SUBSTANZ/ SUBSTANZKLASSE] einzuschränken oder ganz einzustellen (z.B. Schmerzen, Zittern, Fieber, Schwächegefühle, Übelkeit und Durchfall, Schwitzen, Herzklopfen, Schlafstörungen, Unruhe, Ängstlichkeit, Reizbarkeit und deprimierte Stimmung)?
Oder nahmen Sie irgendwelche Substanzen ein, um das Auftreten solcher Beschwerden (Entzugserscheinungen) zu vermeiden oder um sich besser zu fühlen?
WENN EINES HIERVON ZUTRIFFT, KREUZEN SIE **JA** AN NEIN JA 2

c Kam es wiederholt vor, daß Sie mehr [SUBSTANZ/ SUBSTANZKLASSE] konsumierten, als Sie ursprünglich beabsichtigten? NEIN JA 3

d Haben Sie bereits einmal erfolglos versucht, ihren Konsum von [SUBSTANZ/SUBSTANZKLASSE] zu reduzieren oder einzustellen? NEIN JA 4

e Verbrachten Sie an den Tagen, an denen Sie [SUBSTANZ/ SUBSTANZKLASSE] konsumierten, sehr viel Zeit (mehr als 2 Stunden) damit, diese Substanz zu besorgen, sie einzunehmen oder sich von ihrer Wirkung zu erholen?

NEIN JA 5

f Haben Sie ihre Aktivitäten wie Arbeit, Freizeit oder das Zusammensein mit Ihrer Familie oder Freunden aufgrund Ihres Substanzkonsums eingeschränkt?
NEIN JA 6

g Haben Sie weiterhin [SUBSTANZ/ SUBSTANZKLASSE] benutzt, obwohl Sie wußten, daß dies bei Ihnen zu gesundheitlichen oder seelischen Problemen führte? NEIN JA 7

WURDEN **3** ODER MEHR **K2** FRAGEN MIT **JA** BEANTWORTET? **NEIN** **JA**

BENENNEN SIE DIE SUBSTANZ(EN):_____ ***SUBSTANZ-***
_____ ***ABHÄNGIGKEIT***

ZEIGT DER PATIENT ABHÄNGIGKT VON DER (DEN) KONSUMIERTEN DROGEN? ➔ NEIN JA

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

K3 **Während der letzten 12 Monate:**

a Waren Sie durch die Einnahme von [SUBSTANZ/SUBSTANZKLASSE]berauscht oder fühlten sich verkatert oder high, als Sie Aufgaben zu erledigen hatten in der Schule, bei der Arbeit oder zu Hause? Hat dies zu Schwierigkeiten geführt?

NEIN JA 8

KREUZEN SIE NUR DANN **JA** AN, WENN DIES PROBLEME VERURSACHT HAT

b Kam es vor, daß Sie schon einmal in irgendeiner Situation von [SUBSTANZ/ SUBSTANZKLASSE] berauscht oder high waren, in der ein Verletzungsrisiko bestand, z.B. beim Auto,- oder Motorradfahren oder Bedienen von Maschinen etc.)?

NEIN JA 9

c Hatten Sie wegen Ihres Konsums von [SUBSTANZ/ SUBSTANZKLASSE] irgendwelche Probleme mit dem Gesetz, z.B. eine Verhaftung oder Anzeige? NEIN JA 10

d d Haben Sie weiterhin [SUBSTANZ/ SUBSTANZKLASSE] benutzt, obwohl Sie dadurch Probleme mit Ihrer Familie oder anderen Personen bekommen NEIN JA 11 haben?

WURDE **1** ODER MEHR **K3** FRAGEN MIT **JA** BEANTWORTET ?

BENENNEN SIE DIE SUBSTANZ(EN):_____

NEIN **JA**

SUBSTANZ-MISSBRAUCH AKTUELL

L. PSYCHOTISCHE STÖRUNGEN

FRAGEN SIE NACH EINEM BEISPIEL FÜR JEDE MIT JA BEANTWORTETE FRAGE. KREUZEN SIE NUR DANN **JA** AN, WENN DIE BEISPIELE KLAR ZEIGEN, DASS ES SICH UM EINE GEDANKEN,- ODER WAHRNEHMUNGSSTÖRUNG HANDELT ODER SICH DIE BEISPIELE NICHT MIT DER KULTURELLEN ZUGEHÖRIGKEIT DES PATIENTEN ERKLÄREN LASSEN.

BEURTEILEN SIE VOR DEM KODIEREN, OB DIE DENK- UNE WAHRNEHMUNGSSTÖRUNGEN "BIZZAR" SIND.

BIZZARE WAHNVORSTELLUNGEN: DER INHALT IST OFFENSICHTLICH ABSURD, NICHT NACHVOLLZIEHBAR, UNVERSTÄNDLICH UND BASIERT NICHT AUF NORMALEN LEBENSERFAHRUNGEN

BIZZARE HALLUZINATIONEN: EINE STIMME, DIE DIE GEDANKEN UND HANDLUNGEN DER PERSON KOMMENTIERT ODER MEHRERE STIMMEN, DIE MITEINANDER SPRECHEN.

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

Ich werde Ihnen nun einige Fragen zu ungewöhnlichen Erlebnissen stellen, die bei manchen Menschen vorkommen können.

BIZARR

L1 a Hatten Sie jemals den Eindruck, daß jemand Sie ausspionierte, ein Komplott gegen Sie schmiedete oder daß man versuchte, Ihnen etwas anzutun? NEIN JA FRAGEN SIE NACH BEISPIELEN.

b **FALLS JA** : Glauben Sie das gegenwärtig auch? NEIN JA → JA

L2 a Hatten Sie jemals den Eindruck, dass jemand Ihre Gedanken lesen oder hören konnte oder daß Sie die Gedanken anderer lesen oder hören konnten? NEIN b **FALLS JA** : Glauben Sie das gegenwärtig auch? NEIN → JA **L6a**

L3 a Hatten Sie jemals den Eindruck, daß eine aussenstehende Person oder Macht Ihnen Gedanken eingegeben hat, die nicht Ihre eigenen waren oder Sie beeinflusste, Dinge zu tun, die Sie normalerweise nicht tun würden? Hatten Sie jemals den Eindruck, besessen zu sein? NEIN → JA **L6a**

FRAGEN SIE NACH BEISPIELEN. NICHT-PSYCHOTISCHE BEISPIELE NICHT BERÜCKSICHTIGEN.

b **FALLS JA** : Glauben Sie das gegenwärtig auch? NEIN → JA

L4 a Hatten Sie jemals den Eindruck, daß jemand über Fernsehen, Radio oder Zeitung spezielle Botschaften direkt an Sie sandte oder dass eine Ihnen unbekannte Person sich besonders für Sie interessierte? NEIN JA → JA **L6a**

b **FALLS JA** : Glauben Sie das gegenwärtig auch? NEIN JA

L5 a Haben Ihre Verwandten oder Freunde Ihnen jemals gesagt, daß sie Ihre Ideen für merkwürdig oder ungewöhnlich hielten? NEIN JA → JA

FRAGEN SIE NACH BEISPIELEN. KREUZEN SIE JA NUR DANN AN, WENN DIESE EINDEUTIGEN WAHNVORSTELLUNGEN IN L1 BIS L4 NICHT EXPLORIERT WURDEN, Z.B. GRÖSSENWAHN; VERARMUNGSWAHN SCHULD- ODER HYPOCHONDRISCHER WAHN. → JA **L6a**

b **FALLS JA** : Glauben Ihre Angehörigen oder Freunde das gegenwärtig auch? NEIN JA → JA

L6 a Ist es Ihnen jemals passiert, daß Sie etwas hörten, was andere nicht hören konnten, z.B. Stimmen? NEIN JA

HALLUZINATIONEN WERDEN NUR ALS " BIZARR " EINGESTUFT, FALLS DER PATIENT DIE FOLGENDE FRAGE BEJAHT:

Hörten Sie eine Stimme, die Ihre Gedanken oder Ihr Verhalten kommentierte oder hörten Sie zwei oder mehr Stimmen, die sich miteinander unterhielten? → JA

b **FALLS JA** : Hörten Sie derartige Dinge auch während des vergangenen Monats? NEIN JA

L7 a Hatten Sie jemals eine Vision während Sie wach waren oder haben Sie Dinge gesehen, die andere nicht sehen konnten? NEIN JA

KREUZEN SIE NUR DANN JA AN, WENN SICH DIE VISIONEN NICHT MIT DER KULTURELLEN ZUGEHÖRIGKEIT DES PATIENTEN ERKLÄREN LASSEN → JA **L8b**

b **FALLS JA** : Hatten Sie derartige Visionen auch während des vergangenen Monats? NEIN JA

BEURTEILUNG DES UNTERSUCHERS :

L8 b ZEIGT DER PATIENT AKTUELL INKOHÄRENTES DENKEN ODER VERWORRENE SPRACHE ODER AUSGEPRÄGTE ASSOZIATIVE LOCKERUNG? NEIN JA

L9 b WIRKT DER PATIENT AKTUELL ZERFAHREN ODER KATATON? NEIN JA

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

L10b FÄLLT EINE NEGATIV-SYMPTOMATIK WÄHREND DES INTERVIEWS AUF: Z.B. DEUTLICHE AFFEKTVERFLACHUNG, SPRACHVERARMUNG ODER UNFÄHIGKEIT, ZIELGERICHTETE AKTIVITÄTEN ZU BEGINNEN ODER DURCHZUFÜHREN? NEIN JA

L11 **L1 BIS L10** :

WURDEN **1 ODER MEHR** FRAGEN UNTER "**b**" BEANTWORTET MIT **JA BIZARR**?

ODER

- WURDEN **2 ODER MEHR** FRAGEN UNTER "**b**" BEANTWORTET MIT **JA** (NICHT BIZARR) ?

NEIN JA

PSYCHOTISCHE EPISODE AKTUELL

L12 **L1 BIS L7** :

- WURDEN **1 ODER MEHR** FRAGEN UNTER " **a** " BEANTWORTET MIT **JA BIZARR**?

ODER

- WURDEN **2 ODER MEHR** FRAGEN UNTER " **a** " BEANTWORTET MIT **JA** (NICHT BIZARR) ?
  (STELLEN SIE SICHER, DASS DIESE 2 SYMPTOME GLEICHZEITIG AUFTRATEN)

ODER

- WURDE **L11** BEANTWORTET MIT **JA** ?

NEIN JA

PSYCHOTISCHE EPISODE FRÜHER

L13a FALLS **L11 BEJAHT** ODER MINDESTENS EIN **JA** BEI **L1** BIS **L7** ANGEKREUZT

WURDE:

BESTEHT BEI DEM PATIENTEN

EINE EPISODE EINER MAJOR DEPRESSION (AKTUELL ODER FRÜHER) ➔

ODER EINE MANISCHE EPISODE (AKTUELL ODER FRÜHER)? NEIN JA

b WURDE **L13A** MIT **JA** BEANTWORTET? Sie hatten bereits berichtet, daß Sie Zeiten hatten, in denen Sie sich (deprimiert/ überschwenglich/ andauernd reizbar) fühlten. Traten diese Überzeugungen und Erfahrungen, die Sie gerade beschrieben haben (bejahte Symptome L1 bis L7), nur in solchen Zeiten auf, in denen ➔ Sie sich (deprimiert/ überschwenglich/ andauernd reizbar) fühlten? NEIN JA

WIRD **L13b BEJAHT**? **NEIN JA**

AFFEKTIVE STÖRUNG MIT PSYCHOTISCHEN MERKMALEN AKTUELL

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

M. ANOREXIA NERVOSA

M1 a	Wie gross sind Sie?	_____		Cm	☐
b	Was war Ihr niedrigstes Gewicht in den vergangenen 3 Monaten?	_____		Kg	☐
c	LIEGT DAS GEWICHT DES PATIENTEN UNTER DEM KRITISCHEN SCHWELLENWERT? BEACHTEN SIE DIE TABELLE UNTEN	➔ NEIN	JA		1

Während der vergangenen 3 Monate:

M2	Versuchten Sie da trotz Ihres niedrigen Gewichts, nicht zuzunehmen?	➔ NEIN	JA	2
M3	Befürchteten Sie, zuzunehmen oder dick zu werden, obwohl Sie nur so wenig gewogen haben?	➔ NEIN	JA	3
M4a	Fanden Sie sich zu dick oder fanden Sie einen Teil Ihres Körpers zu dick?	NEIN	JA	4
B	Hing Ihr Selbstwertgefühl sehr von Ihrem Gewicht oder Ihrer Figur ab?	NEIN	JA	5
C	Glaubten Sie, normal- oder übergewichtig zu sein?	NEIN	JA	6
M5	WURDE BEI **M4 MINDESTENS EINE FRAGE BEJAHT**?	➔ NEIN	JA	
M6	BEI FRAUEN: Blieb während der vergangenen 3 Monate Ihre Regel aus, obwohl Sie nicht schwanger waren?	➔ NEIN	JA	7

BEI FRAUEN : WURDEN **M5** UND **M6 BEJAHT**? BEI MÄNNERN: WURDE **M5 BEJAHT**?	**NEIN**	**JA**

ANOREXIA NERVOSA AKTUELL

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

N. BULIMIA NERVOSA

N1	Hatten Sie in den vergangenen drei Monaten "Freßanfälle" oder Zeiten, in denen Sie innerhalb kurzer Zeit (z.B. innerhalb von 2 Stunden) übermäßig große Mengen an Nahrung zu sich genommen haben?	➔ NEIN	JA	8
N2	Hatten Sie in den vergangenen drei Monaten mindestens zwei "Freßanfälle" pro Woche?	➔ NEIN	JA	9
N3	Hatten Sie während dieser Freßanfälle das Gefühl, keine Kontrolle über Ihr Eßverhalten zu haben?	➔ NEIN	JA	10
N4	Haben Sie irgend etwas unternommen, um nach solchen "Freßanfällen" einer Gewichtszunahme entgegenzusteuern, wie z.B. Erbrechen, Fasten, übermäßiger Sport, Einläufe oder Einnahme von Abführmitteln, Diuretika oder anderen Medikamenten?	➔ NEIN	JA	11
N5	Hängt Ihr Selbstwertgefühl sehr von Ihrem Gewicht oder Ihrer Figur ab?	➔ NEIN	JA	12
N6	SIND DIE KRITERIEN FÜR EINE ANOREXIA NERVOSA ERFÜLLT? FALLS **N6** = **NEIN**, GEHEN SIE ZU **N8**	NEIN	JA	13
N7	Treten diese Freßanfälle nur auf, wenn Sie weniger wiegen als _____kg *? * VERWENDEN SIE DEN KRITISCHEN SCHWELLENWERT AUS DER TABELLE IM ABSCHNITT ANOREXIA NERVOSA	NEIN	JA	14

N8	WURDE **N5 BEJAHT UND N7 VERNEINT** (ODER ÜBERSPRUNGEN)?	**NEIN**	**JA**

BULIMIA NERVOSA AKTUELL

	WURDE **N7 BEJAHT** ?	**NEIN**	**JA**

ANOREXIA NERVOSA

➔ **BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.**

O. GENERALISIERTE ANGSTSTÖRUNG

O1 a Waren Sie in den vergangenen 6 Monaten oftmals übermäßig ängstlich und besorgt über viele verschiedene Dinge des täglichen Lebens wie z.B. Ihre finanzielle Situation, Ihre Arbeit, Familie oder Ihre Freunde? ➔ NEIN JA 1

KREUZEN SIE BEI O1A JA NUR DANN AN, WENN DIE ANGST NICHT AUF MERKMALE EINER ANDEREN STÖRUNG BESCHRÄNKT IST (Z.B. ANGST BEI PANIKATTACKEN, ANGST VOR ÖFFENTLICHEN SITUATIONEN BEI SOZIALER PHOBIE, ANGST VOR KRANKHEIT BEI ZWANGSSTÖRUNG ODER ANGST VOR GEWICHTSZUNAHME BEI EßSTÖRUNG).

b Beschäftigten Sie diese Sorgen die meiste Zeit? ➔ NEIN JA 2

O2 Fällt es Ihnen schwer, diese sorgenvollen Gedanken zu kontrollieren oder ➔ behindern diese Sorgen Sie in ihrer Konzentration? NEIN JA 3

O3 KODIEREN SIE FÜR O3a BIS O3f NEIN FÜR SOLCHE SYMPTOME, DIE SICH AUF MERKMALE EINER VORHERGEHENDEN STÖRUNG BESCHRÄNKEN

Als Sie sich in den vergangenen 6 Monaten ängstlich oder voller Sorge fühlten, hatten Sie da fast täglich folgende Beschwerden:

a Fühlten Sie sich unruhig, aufgeregt und ständig "auf dem Sprung"? NEIN JA 4
b Fühlten Sie sich angespannt? NEIN JA 5
c Fühlten Sie sich müde, matt oder leicht erschöpfbar? NEIN JA 6
d Hatten Sie Probleme, sich zu konzentrieren oder fühlten Sie sich ganz leer im Kopf? NEIN JA 7
e Fühlten Sie sich oftmals reizbar ? NEIN JA 8
f Hatten Sie Schwierigkeiten zu schlafen (Ein,- oder Durchschlafschwierigkeiten, frühmorgendliches Erwachen oder übermäßiges Schlafen)? NEIN JA 9

WURDEN **3** ODER MEHR **O3** FRAGEN **BEJAHT**? **NEIN** **JA**

GENERALISIERTE ANGSTSTÖRUNG AKTUELL

➔ BEDEUTET: GEHEN SIE ZU DEN DIAGNOSEFELDERN, KREUZEN SIE ÜBERALL NEIN AN UND GEHEN SIE ZUM NÄCHSTEN MODUL ÜBER.

P. ANTISOZIALE PERSÖNLICHKEITSSTÖRUNG (optional)

		NEIN	JA	1
P1	**Bevor Sie 15 Jahre alt waren, haben Sie da:**	NEIN	JA	2
a	Wiederholt Schule geschwänzt oder sind Sie trotz Verbot der Eltern über Nacht von zu Hause weggeblieben?	NEIN	JA	3
b	Wiederholt gelogen, andere "hereingelegt", betrogen oder gestohlen?	NEIN	JA	4
c	Häufig Schlägereien angezettelt oder andere schikaniert, bedroht, oder eingeschüchtert?	NEIN	JA	5
d	Absichtlich Dinge zerstört oder Feuer gelegt?	NEIN	JA	6
e	Absichtlich Tiere oder Menschen verletzt oder gequält?	➔ NEIN	JA	
f	Jemanden zu sexuellen Handlungen gezwungen?			
	WURDEN **2** ODER MEHR **P1** FRAGEN MIT **JA** BEANTWORTET?			
P2	KREUZEN SIE BEI DEN UNTENSTEHENDEN HANDLUNGEN NICHT JA AN, WENN DIESE AUSSCHLIEßLICH POLITISCH ODER RELIGIÖS BEGRÜNDET SIND	NEIN	JA	7
	Haben Sie seit Ihrem 15. Lebensjahr:			
a	Wiederholt Verhaltensweisen gezeigt, die andere als unverantwortlich beurteilen würden, z.B. den finanziellen Verpflichtungen nicht nachzukommen oder keiner dauerhaften Tätigkeit nachzugehen?	NEIN	JA	8
b	Absichtlich Dinge getan, die gegen das Gesetz verstoßen, auch wenn Sie nicht dabei erwischt wurden (z.B. das Eigentum anderer zu beschädigen, Diebstähle zu begehen, Drogen zu verkaufen oder ein Kapitalverbrechen zu begehen)?	NEIN	JA	9
c	Handgreifliche Auseinandersetzungen gehabt (auch mit Ihrem Partner oder Ihren Kindern)?	NEIN	JA	10
d	Häufig gelogen oder andere Leute getäuscht, um sich einen Vorteil zu verschaffen oder einfach nur aus Spaß gelogen?	NEIN	JA	11
e	Andere Leute rücksichtslos in riskante oder gefährliche Situationen gebracht?	NEIN	JA	12
f	Ohne Gewissensbisse jemanden schlecht behandelt, verletzt oder angelogen oder gestohlen oder beschädigt?	**NEIN**	**JA**	
	WURDEN **3 ODER MEHR FRAGEN BEJAHT**?	***ANTISOZIALE PERSÖNLICHKEITSSTÖRUNG "LIFETIME"***		

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Sheehan DV, Lecrubier Y, Harnett Sheehan K, Janavs J, Weiller E, Bonora LI, Keskiner A, Schinka J, Knapp E, Sheehan MF, Dunbar GC. Reliability and validity of the Mini International Neuropsychiatric Interview (M.I.N.I.) according to the SCID-P. *European Psychiatry*, 1997 ; **12** : 232-241.

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The M.I.N.I. was developed simultaneously into French and English. The French and English original versions of the M.I.N.I. for DSM-IV were translated and can be asked to the authors (see page 3). An ICD-10 version is also available into French, English and Danish.

Translations	M.I.N.I. 4.4 or earlier versions	M.I.N.I. 5.0, M.I.N.I. Plus 5.0, M.I.N.I. screen 5.0
Afrikaans		R. Emsley
Arabic		O. Osman, E. Al-Radi
Basque		In preparation
Bengali		H. Banerjee, A. Banerjee
Brazilian	P. Amorim	In preparation
Bulgarian		L.G. Hranov
Catalan		In preparation
Czech	P. Zvolsky	P. Zvolsky
Chinese		L. Caroll, K-d Juang
Croatian		In preparation
Danish	P. Bech	P. Bech, T. Scütze
Dutch/Flemish	E. Griez, K. Schruers, T. Overbeek, K. Demyttenaere	I. van Vliet, H. Leroy, H. van Megen
Estonian		J. Shlik, A. Aluoja, E. Kihl
Farsi/Persian		K. Khooshabi, A. Zomorodi
Finnish	M. Heikkinen, M. Lijeström, O. Tuominen	M. Heikkinen
German	I. van Denffer, M. Ackenheil, R. Dietz-Bauer	M. Ackenheil, G. Stotz, R. Dietz-Bauer
Gujarati		M. Patel, B. Patel
Greek	S. Beratis	T. Calligas, S. Beratis
Hebrew	J. Zohar, Y. Sasson	R. Barda, I. Levinson
Hindi		C. Mittal, K. Batra, S. Gambir
Hungarian	I. Bitter, J. Balazs	I. Bitter, J. Balazs
Icelandic		J. Stefanson
Italian	P. Donda, E. Weiller, I. Bonora	L. Conti, A. Rossi, P. Donda
Japanese		T. Otsobo, H. Watanabe, H. Miyaoka, K. Kamijima, J. Shinoda, K. Tanaka, Y. Okajima
Latvian	V. Janavs, J. Janavs, I. Nagobads	V. Janavs, J. Janavs
Norwegian	G. Pedersen, S. Blomhoff	K. Leiknes, S. Leganger, E. Malt, U. Malt
Polish	M. Masiak, E. Jasiak	M. Masiak, E. Jasiak
Portuguese	P. Amorim, T. Guterres	T. Guterres, P. Levy, P. Amorim
Punjabi		A. Gahunia, S. Gambhir
Romanian		O. Driga
Russian		A. Bystitsky, E. Selivra, M. Bystitsky
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Turkish	T. Örnek, A. Keskiner, I. Vahip	T. Örnek, A. Keskiner
Urdu		A. Taj, S. Gambhir
Welsh		In preparation