

# Summary

## Chronically dangerous forensic patients – numbers and needs

### Background and research questions

Part of the capacity of forensic psychiatric facilities, is occupied by patients who are considered untreatable at present, while the risk of criminal recidivism is such that society needs to be protected from this risk. In this report we use the term 'chronically dangerous patients'.

The occupation of treatment capacity by 'chronically dangerous' patients is seen as problematic, because many other patients who might profit from treatment are on waiting lists (in 2003 for instance, 169 persons waited a mean of 229 days for placement in a TBS-hospital).

Many 'chronically dangerous' patients are in judicial forensic hospitals (maximum security TBS-hospitals), or forensic psychiatric hospitals within the mental health sector (maximum or medium security). Many of them are under mandatory hospital care because of a TBS-order or a penal or civil hospital order.<sup>17</sup>

Within the judicial sector two long stay units for TBS-patients (with 60 places in total) opened in the last five years. These units care for patients at lower financial rates and do not provide treatment aimed at resocialisation.

The purpose of this study is to provide information for (further) development of a policy with respect to 'chronically dangerous' patients who need long term forensic security and/or supervision as well as care. In this report we present estimates by psychologists and psychiatrists of numbers of 'chronically dangerous' patients and of their need of security, supervision and care.

### Research questions:

- 1 How many patients in forensic psychiatric facilities are considered 'chronically dangerous' according to the description provided in this study, by the psychologist or psychiatrist responsible for their case?
- 2 Which level of security and/or supervision do these patients need according to their psychologist or psychiatrist?

<sup>17</sup> The civil hospital order (art 2, 15 Wet BOPZ) is a non-penal measure of mandatory hospital care. The penal hospital order, 'committal to a psychiatric hospital' (art 37 Criminal Code) can be imposed upon offenders who are mentally disordered and are considered by the court to have not been responsible for their acts. The TBS-order (art 37 a, b Criminal Code) can be imposed upon mentally disordered offenders who are considered not responsible or diminished responsible for their offence. The measure of TBS is reserved for offenders who committed serious, almost always violent offences. A condition for both the TBS-order and the civil and penal hospital orders is that the offender is considered by the court to be dangerous to others or to the general safety of persons or goods. The civil and penal hospital orders can also be imposed if the person concerned is a danger to him or herself.

- 3 Which level of care do these patients need according to their psychologist or psychiatrist?
- 4 Do 'chronically dangerous' patients in the judicial TBS-hospitals differ from 'chronically dangerous' patients in mental health care facilities with respect to diagnoses, security need, and need for care?

## Methods

The concept of 'chronic dangerousness' was explored and clarified by means of literature research and expert meetings. 'Chronic dangerousness' was operationalized as follows.

- 1 There is a risk that the patient will commit a serious, violent (sexual or not sexual) offence. The risk of physical damage to others is such that society needs to be protected from this risk.
- 2 Security and/or supervision at the level of a TBS-hospital of a forensic psychiatric facility within the mental health care sector, is needed to prevent the patient from committing offences as mentioned. In addition the patient may need care.
- 3 The risk of offending may be considered long-term, because it is not expected that this risk will be reduced or will be under control within a considerable time span (of at least six years), in such a way that less security and supervision than mentioned under 2 are sufficient.

This operationalisation was chosen to describe a group of patients for research purposes. The criteria are not suitable as a bases for decisions about individual patients.

### *Assessment of numbers of 'chronically dangerous' patients*

The assessment of numbers of 'chronically dangerous' patients took place in the judicial TBS-sector and in the mental health sector. The following facilities were included in the study.

*TBS-sector:* all eight judicial TBS-hospitals

*Mental health sector:* the three forensic psychiatric hospitals, and the nine forensic psychiatric units (within general psychiatric hospitals). The assessment was also done in the three 'Clinics for intensive treatment'. These clinics can be consulted by psychiatric hospitals with respect to patients with extremely problematic behaviour. In addition two closed units for chronic psychiatric patients of a general psychiatric hospital, and a facility for patients with mental retardation and severe behavioural problems took part in the assessment.

A total of 1,673 patients who were inpatients of the facilities mentioned above at the 1st of January 2004 were included in the assessment. Of these patients 1070 were in TBS-hospitals, and 603 in (forensic) mental health care facilities.

In March-July 2004, the psychologists and psychiatrists of these facilities (mentioned as clinicians in the following) screened each of their patients with respect to the question if the patient should be considered 'chronically dangerous' according to the operationalisation provided (see above). In addition they assessed which type of facility the patient judged 'chronically dangerous' would need in the long term. They could choose one of three options: an intramural facility with security and supervision at the level of a TBS-hospital, an intramural facility with security and supervision at the level of a forensic mental health care facility, or a facility where the patient, with supervision of offence related behaviour, can function partly within society (for instance an 'open' long stay unit, or sheltered housing under forensic supervision).

*Characterization of subgroups of 'chronically dangerous' patients: assessment of need for security, supervision, and care*

Six subgroups of 'chronically dangerous' patients were distinguished, based on the sector (TBS or mental health care) they were in at January the 1st 2004, and on the facility clinicians expected them to need in the long term (Table 1).

A sample of 232 patients, spread over the subgroups, was drawn from the total number of patients judged as 'chronically dangerous'.

In April-August 2004 the clinicians filled out a questionnaire with respect to need for security, supervision, and care about their patients in the sample. We received 93% of the questionnaires back in time.

**Results: numbers of 'chronically dangerous' patients and facilities needed in the long term**

In the TBS-sector as well as in the mental health care-sector, a substantial number of patients is judged as 'chronically dangerous' (Table 2).

The clinicians assessed for each of the 'chronically dangerous' patients which type of facility the patient would most likely need in the long term (Table 3).

The number of patients in the TBS-sector, judged by clinicians as 'chronically dangerous' by far exceeds the current number of 'long stay beds' available within the two long stay units in TBS-hospitals. It has to be taken into account however, that according to the clinicians, not every 'chronically dangerous' patient will need the maximum security of a TBS-hospital in the

**Table 1: Subgroups of 'chronically dangerous' patients**

Subgroup	Facility at January 1st 2004	Expected facility needed in the long term
TBS-A	Intramural in TBS-hospital	Intramural in TBS-hospital
TBS-B	Intramural in TBS-hospital	Intramural in forensic mental health care
TBS-C	Intramural in TBS-hospital	Partly in society with supervision on offence-related behaviour
GGz-A	Intramural in (forensic) mental health care	Intramural in TBS-hospital
GGz-B	Intramural in (forensic) mental health care	Intramural in forensic mental health care
GGz-C	Intramural in (forensic) mental health care	Partly in society with supervision on offence-related behaviour

GGz: Mental health care (Geestelijke gezondheidszorg)

**Table 2: Number of 'chronically dangerous' patients related to the sector they were in at January 1st 2004**

Sector at Jan. 1st 2004*	'Chronically dangerous'		Not 'chronically dangerous'		Total number of patients	
	n	%	n	%	n	%
TBS-sector	448	42.8	599	57.2	1,047	100
Mental health-sector	210	34.9	391	65.1	601	100
Total number of patients	658	39.9	990	60.1	1,648**	100

n=number of patients

\* The TBS-sector includes the 8 TBS-hospitals; de Mental health care-sector includes the 3 forensic psychiatric hospitals (FPK's), the 9 forensic psychiatric units (FPA's), the 3 clinics for intensive treatment (KIB's), one facility for mentally retarded patients with severe behavioural problems (SGLVG), and 2 closed units of a general psychiatric hospital.

\*\* No data were provided about 11 patients from the TBS-sector, and with respect to 12 patients from the TBS-sector it was according to the clinician unclear whether they should be judged as 'chronically dangerous'. No data were provided about 2 patients from the mental health-sector. The total number of patients in the table is therefore 1648 instead of 1673.

long term. For a substantial number of patients, an intramural facility of the forensic mental health care-sector is expected to be sufficient in the long term. Furthermore, another substantial number of 'chronically dangerous' patients are expected to be able, with forensic supervision, to function partly within the community.

Based on the assessments by clinicians, there is a considerable need of facilities for 'chronically dangerous' patients. This concerns facilities offering different levels of security, supervision and care.

The overall image is that the more a hospital or unit aims at a population with more serious offences and more complex mental disorders, the higher the proportion of patients judged as 'chronically dangerous', and the higher the proportion of 'chronically dangerous' patients expected to be still needing an intramural facility in the long term.

**Table 3: Expected facilities needed in the long term for 'chronically dangerous' patients**

Sector van verblijf op peildatum*	Intramural TBS		Intramural forensic mental health care		Partly in society with supervision of offence- related behaviour		Total number of patients	
	n	%	n	%	n	%	n	%
TBS-sector	180	42.2	107	25.1	140	32.7	427	100
GGz-sector	24	11.5	79	37.8	106	50.7	209	100
Total number of patients	204	32.1	186	29.2	246	38.7	636**	100

n=number of patients

\* The TBS-sector includes the 8 TBS-hospitals; de Mental health care-sector includes the 3 forensic psychiatric hospitals (FPK's), the 9 forensic psychiatric units (FPA's), the 3 clinics for intensive treatment (KIB's), one facility for mentally retarded patients with severe behavioural problems (SGLVG), and 2 closed units of a general psychiatric hospital.

\*\* No data were provided about 7 patients from the TBS-sector. With respect to 14 of the 448 'chronically dangerous' patients from the TBS-sector, clinicians could not decide about the type of facility needed in the long term. No data were provided about 1 patient from the mental health sector. The total number of 'chronically dangerous' patients in this table is therefore 636 instead of 658.

Both proportions are higher in TBS-hospitals than in facilities within the forensic mental health care sector.

The longer the duration of the TBS-measure, the more likely a patient is to be assessed as 'chronically dangerous'.

### Characterization of subgroups of 'chronically dangerous' patients

In order to characterize (sub)groups of 'chronically dangerous' patients, information was gathered about several aspects, relevant with respect to security, supervision and care.

A number of aspects apply to all six subgroups mentioned above (Table 1). Nearly all 'chronically dangerous' patients committed a violent offence. In most cases there is co-morbidity: most patients are diagnosed with a personality disorder in combination with another psychiatric disorder on Axis I or Axis II of DSM-IV.

Most 'chronically dangerous' patients regularly need a psychiatrist, and a social therapist or a psychiatric nurse. With respect to a large proportion of 'chronically dangerous' patients, 'a lack of awareness of or insight in problems' is considered a factor obstructing a decrease of violence risk.

The aspects assessed differentiated well between subgroups of 'chronically dangerous' patients.

An intramural long stay facility, with security and supervision comparable to a TBS-hospital is considered most suitable for patients of the TBS-A and GGz-A groups. These groups are generally characterized as follows. The

index-offence of a relatively high number of patients is a sex-offence. Many patients in these groups are expected to have a relatively short latency before committing an offence, should the current supervision and security be lost. With many of these patients there is considered to be a (substantial) risk of escape. 'Offending is part of a 'worn' behavioural pattern' is relatively often mentioned with patients in these subgroups as a decisive factor for assessing the patient as 'chronically dangerous'. Furthermore, clinicians more often indicate that they consider the patient to have no realistic treatment perspectives, given the current state of the art. A relatively large number of patients in the A-groups are fifty years or over, a relatively large number have a sexual disorder, and serious problems of social and psychiatric functioning are relatively abundant.

An intramural long stay facility with security and supervision comparable to a facility in the forensic mental health sector is considered by clinicians as most suitable for patients in the TBS-B and GGz-B groups.

Patients in these subgroups are generally characterized by the following aspects. With relatively many patients there is considered to be a (substantial) risk of escape. Discontinuing the use of medication, and/or starting to use alcohol or drugs are considered an immediate cause of increasing violence risk with patients in the B-groups and a lack of reliability in the use of medication is seen as a hindering factor for the reduction of violence risk. Furthermore, relatively many patients are diagnosed with schizophrenia, a lower than average intelligence, and serious problems in social and psychiatric functioning.

A facility with the possibility of partly functioning in the community while under forensic supervision, is considered most suitable in the long term for patients in the TBS-C and GGz-C groups.

Patients in the TBS-C en GGz-C groups are generally characterized by the following aspects. Relatively many patients are diagnosed with abuse or dependence of alcohol or (illicit) drugs. In a relatively large number of patients, substance abuse or dependence is considered a decisive factor in judging the patient as 'chronically dangerous', and use of alcohol or drugs is mentioned as an immediate cause of increase of violence risk. Clinicians indicate that for relatively many patients in the C-groups supervision at the level of a sheltered housing facility would be sufficient. Compared to the other groups, relatively many patients are expected to need probation services.

#### *Differences between patients from the TBS- and mental health care sectors*

Patients in the TBS-sector more often have a sex-offence as an index-offence. They more often have co-morbidity with respect to mental disorders (a diagnoses on both Axis I and Axis II of DSM-IV), and more often have a

(chronic) somatic disorder ( a diagnosis on Axis III). Patients in the TBS-sector are more often diagnosed with a personality disorder, whether or not in combination with a sexual disorder, and without a diagnosis of schizophrenia. Cognitive and interpersonal aspects are with respect to patients in the TBS-sector, more often seen as factors obstructing the reduction of violence risk. Patients in the TBS-sector are more often considered to be able to function in a relatively large group of (more than eight) patients.

Patients in the mental health care-sector are more often diagnosed with schizophrenia, whether or not in combination with a personality disorder. Discontinuation of medication use is more often mentioned as an immediate cause of increase of violence risk. Serious problems in social and psychiatric functioning occur more often in these patients, especially in patients with schizophrenia. More patients in the mental health care-sector than in the TBS-sector need a psychiatrist and psychiatric nurse on a regular basis.

## Conclusions

The main findings are:<sup>18</sup>

- 1 There is a substantial need of facilities for 'chronically dangerous' patients in the TBS-sector as well as the forensic mental health care sector, based on estimates by clinicians (psychologists and psychiatrists).
- 2 There is a need of facilities differentiated according to levels of security, supervision and care. These include: closed (long stay) facilities comparable to the two existing long stay units in TBS-hospitals, intramural (long stay) facilities with a level of security and care comparable to that offered by facilities within the forensic mental health care sector, and facilities where the patient can function partly in the community while under supervision with respect to offence-related behaviour (for instance sheltered housing with forensic supervision).
- 3 The (sub)groups of 'chronically dangerous' patients for whom the facilities mentioned are considered suitable, can be differentiated on the basis of the registered information with respect to security and care. The characterization of these (sub)groups is available for use in the development of facilities.

Clinicians in this study emphasize that differentiation of facilities should go hand in hand with careful risk management. If 'chronically dangerous' patients spend part of their time in the community, this must never lead to a

<sup>18</sup> In this report we draw no conclusions about consequences of the research findings for the development of a policy with respect to (facilities for) 'chronically dangerous' patients. These will be formulated by the department at the ministry of Justice responsible for prevention and sanctions.

decrease in social safety. Another important subject is weighing the pay-offs and costs of different solutions (see for instance Cooke en Philip, 2001; Cohen, 2001).

From an ethical point of view, carefulness in judging a patient as 'chronically dangerous' is warranted, because violence risk can not be assessed without mistakes, neither with clinical judgment nor with actuarial methods.

Furthermore, once a patient is placed in a long stay facility, a vicious circle may occur, especially when little new information is gathered about the patient because no intensive treatment takes place any more.

Developing suitable facilities for patients with a long term violence risk, due to a mental disorder, is one possible solution to protect society. However, another important pathway is to continue investment in development of methods to motivate and treat forensic patients.