

Summary

Serious violent and sexual offenders with a mental disorder

An inventory of legislation and practical experience in the forensic psychiatric systems and the prison systems in England, Germany, Canada, Sweden and Belgium

Introduction and terms of reference

This report describes the results of a study carried out by the Dutch Research and Documentation Centre (*Wetenschappelijk Onderzoek- and Documentatiecentrum* or *WODC*) of the Ministry of Justice, which took inventory of the manner in which various countries – namely England, Germany, Canada, Sweden and Belgium – deal with individuals with a mental disorder who have committed serious violent or sexual offences. The first object of this study is to provide insight into the present situation in these countries in terms of a number of legislative aspects and enforcement of penal measures and sentences imposed upon this group. Secondly, the situation in the Netherlands in regard to these aspects will be compared, along general lines, with that in the countries studied.

The TBS order (art. 37 a, b of The Netherlands Criminal Code) is a penal measure. It can be imposed by the court 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 legally defined condition is further that the offender is considered by the court to be dangerous to others or to the general safety of persons or goods. The main aim of the TBS order is to protect society from serious criminal recidivism by mentally disordered offenders. Two serious offences, committed by TBS patients led to a Parliamentary Inquiry into the execution of the TBS order in 2005.

The commissioning party, the Sanction and Prevention Policy Department of the Ministry of Justice, in liaison with the Parliamentary Committee on TBS orders has formulated five questions for this international study. These questions are:

- 1 Which target groups can be distinguished within the populations of forensic psychiatric patients and perpetrators that can be compared to those against whom a TBS order is made?
- 2 Which statutory and organizational systems of treatment focusing on rehabilitation are in use in other countries?
- 3 How much does the extent to which a person's disorder can be treated influence the decision to admit, treat and discharge someone? To which extent is it possible to determine whether or not a person can be treated in the various stages?
- 4 In which way is supervision of those involved provided for, after the legal reason for hospitalisation or detention has ended?

- 5 What are the working methods and procedural approaches used in decisions regarding treatment strategy, leave and discharge from the system?

Methods

In each country, between 10 and 20 meetings were held with key figures from a set number of fields. For each country, these fields are:

- Ministries of which the portfolio includes policies in terms of forensic psychiatric care and penal institutions and associated legislation.
- Organizations responsible for policy in regard to prison sentences and the enforcement of penal measures.
- Forensic psychiatric institutions.
- Penal institutions.
- Organizations responsible for supervision and after-care of detainees and forensic psychiatric patients.
- Regulatory body that decides on continuation or termination (on conditions) of custodial measures in respect of the population referred to.
- Scientists in fields including forensic psychiatry/psychology or neurosciences.

In addition, library studies were carried out with a focus on legislation and scientific literature, in particular survey studies, policy documents and the like.

The study had to be prepared, carried out and the findings submitted within a limited period of time (October 2005 – March 2006). For that reason, it is a rough inventory of the state of affairs and the strategies selected in the countries concerned. The nature of the study is descriptive and does not pretend to be exhaustive. In addition, part of the forensic psychiatric and penal systems in Germany and Canada is set up at state/provincial level. In each of these countries, two states were selected to serve as an example for the aspects to be discussed. The conclusions regarding those states/provinces therefore do not apply to the country as a whole.

Results

Target groups

All countries included in the study have a forensic psychiatric system which is segregated from the prison system. In Belgium, specific provisions in the forensic psychiatric system have only been marginally developed.

All countries have penal measures or other sanctions in place, which allow for compulsory hospitalisation in the forensic psychiatric system.

The statutory criteria for their application vary from country to country. In the Netherlands, Germany, Belgium and Canada, the legal principle of guilt is the underlying principle. Compulsory hospitalisation (in a forensic psychiatric hospital) may be imposed upon individuals who are not or not fully accountable for the offence committed. In England and Sweden, other criteria are applied. In Sweden, the principle of accountability is not used. The main question is whether or not it is possible to ascertain that the person found guilty of the offence suffered from a serious mental disorder at the time of committing the offence. In England, the question as to whether the person involved needs psychiatric treatment is the guiding principle for the decision to impose a hospital order. In all countries included in the study, a condition for imprisonment in the form of compulsory hospitalisation is the risk of re-offending, from which society must be protected. In Sweden, England and Canada, enforcement (stay, treatment, extension, parole, insofar as applicable) of hospital orders issued by a criminal court is (almost completely) the responsibility of the health care system. In these countries, the separation between the prison system and the forensic psychiatric system therefore seems clearest. The offenders will be placed in either system, a combination of a hospital order and a prison sentence is not possible. In Germany, Belgium and the Netherlands, however, responsibility for forensic psychiatry is shared between the health care system and the judicial authorities. In Sweden, England and Canada, forensic psychiatric patients primarily suffer from serious Axis I disorders and treatment is mainly clinical. Compared to the other countries, the Netherlands in particular has hospitalized a high number of patients with personality disorders.

Statutory instruments for long-term detention

All countries included in the study have one or more penal measures allowing for compulsory hospitalisation in a psychiatric hospital for criminals with a mental disorder. In addition, there are significant differences between the countries in terms of sanctions enabling long-term detention. In England, Canada, Germany and Belgium, for instance, there are special sanctions to protect society from the risk of recidivism of serious violent and sexual offenders. Thanks to these sanctions, it is possible to impose indeterminate prison sentences, or extend the sentence or keep someone detained once his sentence has been served. In Canada, this is called *dangerous and long term offender designation*, in England *life sentence, imprisonment for public protection and extended sentence*, in Germany *Sicherungsverwahrung* and in Belgium *terbeschikkingstelling van de regering*. These sanctions also offer the option of long-term parole or indefinite parole, which in principle gives the possibility of long-term supervision of the person concerned.

Intramural facilities

Apart from Belgium, the countries included in the study have specialized forensic psychiatric institutions (Belgium has a number of small-scale projects in this respect). In addition, patients against whom an order is given are also admitted to general psychiatric hospitals, in forensic psychiatric wards. The level of security of the specialized forensic psychiatric institutions varies significantly. The security level of a *high security forensic psychiatric hospital* in England or Canada is far more sophisticated than that of a similar institution in Sweden or Germany.

The number of detainees per 100,000 inhabitants is between 75 and 142 in the countries included in the study. The number of persons admitted to a psychiatric institution (forensic or otherwise) by virtue of a hospitalisation order varies between five and ten per 100,000 inhabitants. In construing these numbers, one should be non-committal, as difference in the figures for the various countries may be due to differences in inclusion criteria for the various measures, levels of security for the institutions, discharge criteria and discharge practice. As stated before, there are significant differences between countries in terms of the problems of those ending up in the forensic psychiatric system. In some countries, this mainly involves individuals with Axis I disorders, whereas in other countries, the population is more mixed (Axis I and Axis II disorders).

Extent to which disorders are treatable

Every country has serious violent and sexual offenders with mental disorders for whom treatment is not the solution for minimizing the risk of re-offending to an acceptable level. As a rule, the forensic psychiatric system includes wards where individuals stay for a very long time, even though they are not always specifically called 'long stay units'. The extent to which a disorder can be treated in a person is hard to define, as it depends on a multitude of factors, which may also change over time. This includes characteristics of the person involved, the type of problem and level of motivation, the question as to whether treatment exists for the problem in hand and whether, in actual practice, such treatment is available. Among the countries included in the study, we only found one (England) in which this aspect plays a role in access to the forensic psychiatric system.

Treatment in the forensic psychiatric system

In Canada, England and Sweden, clients in the forensic psychiatric system primarily are individuals with serious Axis I disorders, such as schizophrenia. Treatment focuses mainly on clinical therapy of the disorders, and on teaching the persons involved to deal with the related handicaps and getting their day-to-day lives in order (work or other way of spending their time, social contacts and the like). Treatment is less aimed at affecting other criminogenic risk factors. In particular in the Netherlands, but also in Germany and Belgium more individuals with Axis II disorders (personality

disorders) can be found in the forensic psychiatric system. In Belgium, there are very few possibilities of treatment for this group. In the Netherlands and Germany, the forensic psychiatric institutions have a wide range of forms of treatment. However, not every person is given the treatment that seems to be most promising according to literature, and in many cases, the treatment is not given 'according to protocol'.

Treatment in the prison system

It is known from various studies that many people with mental disorders are also held in the prison system. In the countries included in the study, the extent to which treatment aimed at specific mental disorders and reduction of the risk of recidivism is offered within the prison system varies significantly. In Canada and England, the development of treatment programmes within the prison system is the most advanced and most differentiated. These countries have developed various treatment programmes, focusing on serious violent and sexual offenders, in which reducing the risk of recidivism is an important objective. In these countries, the government is a driving force. Thanks to the Home Office in England and the Ministry of Public Safety and Emergency Preparedness in Canada and their respective Prison Services, the same programmes have been implemented in several institutions by order of the central government. In both countries, a number of programmes have a follow-up once the inmate returns to society on parole.

The Dutch government's aim of the *Programma Terugdringen Recidive* (Recidivism Reduction Programme) is to implement a number of programmes in the prison system. Some of those programmes come from England. The programmes are being developed in a number of institutions. Other countries, such as Germany and Sweden, also copy treatment programmes from Canada and/or England. These seem to increasingly replace traditional practices in this respect. In Germany, however, the initiative lies with the governments of the various states.

England and Canada have an accreditation system for their treatment interventions within the prison system. This committee checks whether the programmes are in line with the international meta-analytical literature and whether they are correctly used in practice. Since 2005, the Dutch Ministry of Justice also has had an Accreditation Committee for behavioural interventions. In Canada, where professionals have had experience in this area for quite some time, day-to-day practice has shown that people feel the formal aspects of the accreditation system are too much of a procedural impediment to the implementation of changes in a programme.

Incorporation of structured risk assessment

In each of the countries included in the study, legislation provides for a recidivism risk assessment for individuals who are considered hazards in terms of recidivism. In most cases, the manner in which this has to be done is not defined by law.

All countries included in the study use structured risk assessment tools for serious violent and sexual offenders with a mental disorder; these are usually translations of the well-known Canadian risk assessment tools. In most cases, the use of these tools is optional, and the risk assessment may in principle also be carried out in another way. In a number of situations, risk assessment with the help of such tools is a standard procedure in practice, applied, for instance, to all individuals belonging to a specific group and having arrived at a specific phase in the process, i.e. the stage of diagnosis. Canada is a trendsetter in terms of developing risk assessment tools for violent (sexual) behaviour. It was in Canada that the presently well-known tools for structured risk assessment, such as HCR-20 and SVR-20, were developed. Within the Canadian federal prison system, every detainee is in principle subjected to a structured risk assessment, although it is not mandatory. In England, risk assessment is applied as a standard procedure to specific groups among the serious violent and sexual offenders, such as the group of Dangerous Persons with Severe Personality Disorders. Germany has a mandatory behaviour assessment (to assess the risk of recidivism) with a view to the court deciding on parole, for individuals sentenced to life imprisonment and those sentenced to more than two years of imprisonment for a violent or sexual offence. Usually, structured risk assessment tools are used to that end. In Belgium, the same applies to decisions on releasing individuals who committed a sexual offence with a minor. In Sweden, risk assessment is an obligatory part of the major forensic assessment by order of the court. Moreover, those against whom a hospital order is given (forensic psychiatric care) who are subject to special release terms, must undergo a forensic psychiatric assessment before being released, which includes a recidivism risk assessment. In practice, this has resulted in a significant increase in the use of structured risk assessment tools in Sweden. In the Netherlands, structured risk assessment is mandatory when authorizations for leave are applied for.

Recidivism data and studies of treatment effects

Each of the countries included in the study, apart from Belgium, keeps a national register of recidivism data. However, comparing recidivism data between countries or studies is hampered by the differences in registration of offences and convictions and the different definitions of recidivism. In addition, the population studied is not easy to compare, because different groups of people are placed in different systems in the countries included in the study. Therefore, the recidivism data of the different countries cannot be subjected to an unconditional comparison. Studies based on sound methodology in which the impact of treatment programmes (or statutory measures) on re-offending is investigated are few in the countries included in the study. These include studies in which a group of forensic psychiatric patients or detainees, having followed a certain treatment programme, are compared with a group that is similar

in other respects which was not given the treatment. Both groups must also be followed for a considerable amount of time, so that differences, if any, in recidivism can be established.

With regard to the treatment programmes for serious violent and sexual offenders in the Canadian prison system, some impact studies (each carried out on one site) have been published. The contents of the Canadian programmes are based on international literature on effective interventions. Moreover, programmes are not accredited until a procedural evaluation has taken place, in which the practical feasibility is examined.

One of the reasons why impact studies based on a sound methodology are rare is that it is not easy to carry out such studies within the forensic psychiatric system or the prison system; nor is it easy to designate a suitable control group. Nevertheless, investments in such studies are indispensable for the continued development of the treatment of serious violent and sexual offenders with mental disorders.

Legislation offering a framework for supervision in society

There are large differences between the countries included in the study where it concerns the extent to which they have legislation in place under which long-term supervision in society is possible. In England and Canada, in particular, legislation has been developed in this respect. The long-term or indefinite sentences and orders, on the basis of which the long-term parole discussed above is possible, do in principle offer a framework for long-term supervision of the person involved. This includes *life sentences* and *imprisonment for public protection* in England, and the *dangerous offender designation* in Canada. Canada also has an order for long-term supervision after serving a sentence: the *long-term supervision order*.

The orders mentioned above can only be made against individuals who have committed serious offences. Both Canada and England have short-term measures under which persons must comply with certain conditions and must be supervised if deemed necessary on account of the risk of such person committing a sexual or serious violent offence. These are imposed as a preventative measure, i.e. after the sentence or order has expired; what is more, they may also be imposed upon individuals who are not guilty of any offence. This concerns, in Canada, for example, the so-called *Peace Bonds*. Finally, there are more limited measures, such as the obligation to register, to report change of address and the like.

Under hospital orders, parole is possible in all countries included in the study but Sweden. In Sweden, however, trial leave is possible. In England, Canada and Belgium, the parole period may be extended time and again. In the Netherlands and Germany, it is time-restricted. Germany is considering a bill to make the *Führungsaufsicht* unrestricted in time.

The various countries, in particular Germany, Canada and England, in practice apply different forms of supervision and after-care. In England, the government has developed *Multi Agency Public Protection Arrangements* (MAPPA) in which a number of organizations collaborate in the supervision of serious violent and sexual offenders. The Dutch authorities are becoming more and more interested in supervising individuals discharged from a forensic psychiatric hospital, as can be concluded from the recent initiative of the Forensic Psychiatric Supervision pilot (*Forensisch Psychiatrisch Toezicht*). England and Canada have warning systems with regard to high risk offenders that have been released or are on parole (Multi Agency Public Protection Panels and High Risk Recognizance Advisory Committee respectively). However, there are still very few impact study results on supervision programmes.

Decision-making process on leave and parole

There are quite some differences between the countries included in the study where it comes to the types of institution that may decide on leave outside the institution. The discretionary power usually lies with an external, authoritative body, which seems to indicate that such a decision is highly supervised.

The organization of the discretionary power on release/parole of forensic psychiatric patients varies from country to country. Roughly speaking, there is a dichotomy. In Canada and England, there are boards of lawyers, psychiatrists and laymen who have to reach a joint decision (England: *Mental Health Review Tribunal*; Canada: *Review Board*). In the Netherlands, Germany and Sweden, however, it is generally the courts that make the decision, assisted by behavioural experts.

Detainees in the prison systems in countries including Sweden, England and the Netherlands, are automatically released on parole once they have served a specific part of their sentences. In England and Canada, a parole board decides on the question (and in Germany the court) as to whether those with a longer-term sentence who have served a specific part of their sentences can be released on parole. Canada makes serious investments in the recruitment and training of members of both the Parole Board and the Review Tribunal. Respondents in Canada stated a more positive impression of the professional skills of the members of its Review Board and Parole Board than respondents in England had of the members of its Mental Health Review Tribunals.

The responses from the surveys give the impression that the extent to which compliance with parole terms is monitored vary significantly. In Canada and England, the impression is that parolees in general can expect action (return to prison after obvious and repeated violation of terms) from the Probation Service or other supervisory body. On the other hand, in Sweden, for example, return to prison would appear to occur only rarely.

Implications of incidents for the system

In all countries included in the study, there are examples of serious crimes committed by (former) forensic psychiatric patients or (former) inmates. In a number of cases, such serious incidents have resulted in or have contributed to significant changes in the legal system.

If a serious incident occurs, the institutions responsible for the enforcement of the sentence or order and the institutions responsible for granting leave or (conditional) release, or those recommending on the same, regularly are the object of criticism. In Germany, this may be the minister at state level, or the consultant-psychiatrist. All countries included in the study are familiar with extensive negative coverage in the media on such cases.

Conclusions

In general, the aims to be realised are similar in the various legal systems. In each of the systems discussed herein, value is attached to the protection of society from serious violent or sexual offences. Each country also has a system in place protecting those with a serious mental disorder who have committed a crime, by imposing an order and offering treatment and care rather than a sentence. In each of the systems, the option of rehabilitation (once the sentence has been served or the order has expired) is important. Each of the countries included in the study has a measure implying compulsory hospitalisation in a forensic psychiatric hospital for the purpose of protecting society. Inherent to that order is the possibility of gradually returning into society, whereby the patient is examined regularly to see whether he/she can safely return into society. Each country also has some kind of parole after the prison sentence has been served. Every country has more or less the same groups of people with similar problems, which need to be placed within the various systems. Within this general framework, there are significant differences between the countries:

- The extent to which there are legal instruments focusing on long-term detention of serious violent and sexual offenders.
- The extent to and manner in which statutory instruments have been developed enabling supervision of serious violent and sexual offenders once they are in the community.

In all countries included in the study there seems to be a shift of emphasis, the emphasized principle being protection of society. In several of the countries included in the study, there is a visible trend of additional legislation making long-term detention and/or some other form of supervision following release possible. Others, however, assume that differentiation of statutory tools geared towards detention and

supervision in society could also contribute to rehabilitation. If the law provided for an option of long-term parole, this could serve as a framework for rehabilitation of individuals who could not be released without such leverage because of their risk of re-offending.

In practice, the countries included in the study all experience similar problems. Every country has a problem with forensic psychiatric patients not moving on. That concerns moving on from high-security to low-security institutions, to ordinary psychiatric hospitals and return to society or facilities therein. An institution with several levels of security (from high to low) in place, offering different forms of treatment (from intensive to maintenance) on one site seems promising. This way, individuals can move on at specific moments in their treatment to different wards, and they can be returned directly to the ward with a higher level of security or care, if problems arise.

All countries included in the study have developed or imported treatment programmes aimed at reducing the risk of recidivism of serious violent and sexual offenders. Some countries, and in particular their prison systems, lead the way. In these countries, the government plays an important role in terms of coordinating and controlling the development, facilitation and implementation of treatment programmes. In these countries, the contribution from scientists towards the development and accreditation of treatment programmes is also significant. In any case, all countries attach importance to exchanging know-how and experience regarding serious violent and sexual offenders / forensic psychiatric patients.

The most important issue with regard to the decision-making process on parole/release seems to be whether or not adequate checks and balances (in terms of the rights of those involved) and professional legal and behavioural expertise can be guaranteed, rather than which type of body is in charge of making the decision. In several countries, people believe it is a problem that bodies deciding on release/parole (or members of such bodies) have insufficient specific expertise in forensic psychiatric problems. This emphasizes the importance of education and training courses in this field. Another issue is whether or not involvement from (representatives of) society could offer something extra in such decision. In several countries, trained laymen are involved in the decision-making process on leave and parole. This may be regarded as a fundamental principle that society 'at large' should also have a say in matters that concern its protection from serious offences. In addition, such representatives may also make a positive contribution towards the acceptance of such decisions by society.

For the further development of legislation, treatment and risk management of these individuals, all countries included in the study believe that it is highly important to encourage controlled research and research syntheses in this field. The lack of such research is strongly

felt by those involved in the development of treatment programmes and practical models for supervision in society. As stated above, impact studies based on a sound methodology with regard to treatment programmes for serious violent and sexual offenders with mental disorders are few and far between.

Based on the descriptions of the countries, the conclusion can be made that, to a great extent, they face similar problems regarding serious violent and sexual offenders with mental disorders, and have to make the same types of choices. Which choices are made in actual fact in the short or long term depends largely on the manner in which the relevant system is constructed.