

Summary

Reconviction rates per FPC.

Final report on the feasibility of processing recidivism figures for separate forensic psychiatric centres

The directorate Sanction and Prevention Policy (DSP) from the Dutch Ministry of Security and Justice, and the department of Forensic Care (DFC) of the National Agency of Correctional Institutions (DJI) have requested the WODC to investigate the feasibility of generating reoffending rates per forensic psychiatric centre (FPC). The main concern of this feasibility study, which started early 2013, was how a differentiation of reconviction rates on the institutional level should be attained while accounting for differences between the centres' patient populations. Such a differentiation would allow for a more in depth examination of the outcome of forensic care, which has long been awaited by boards and directors in the forensic psychiatric field. Furthermore, insight into the reoffending behaviour of former patients would stimulate individual FPC's to control the quality of their operations, and provides various departments within the sector with valuable information to be used in policy making.

Recidivism is a distal measure of the quality of forensic care. While, for instance, the maintenance of a safe and proper treatment environment or the development of patients' social skills are directly and exclusively the responsibility of the FPC's personnel, preventing the former patients to relapse into criminal behaviour after release is not. Whether or not a former patient succumbs to criminal reoffending depends on many factors, only one of which is the treatment received within the FPC. Such factors include, but are not limited to, the patient characteristics prior to the mandatory treatment and the socioeconomical circumstances surrounding the former patients after release. FPC's cannot be held accountable for all instances of reoffending behaviour. As a consequence their functioning should not be reduced to a simple figure. In itself a reconviction rate does not say much about the quality of care provided by the institution. It has to be combined with other pieces of information.

Method

The current study adhered to the protocol of the Recidivism Monitor of the WODC, which has been the standard for determining reconviction rates of known offenders in the Netherlands since 2005. The population of known offenders includes individuals who were sentenced to mandatory forensic treatment. As the DJI provides the WODC with release data concerning FPC patients when released, the former patients can be monitored using data from the Dutch Offenders Index (DOI) which is an encrypted version of the official Judicial Documentation System (JDS). This database only concerns (re)offending which has been investigated by the police and prosecuted by the Public Prosecution Service (PPS). In the current study three forms of reoffending are reported: overall reoffending, serious reoffending (i.e., offenses with a maximum penalty of at least four years in prison), and reoffending with the possibility of mandatory forensic treatment (e.g., aggravated violence and sexual offenses), during a follow-up of two years.

Different FPC's treat a different range of patients, which means that the reconviction rates per institution will vary. To provide a more adequate picture of the functioning

of FPC's on the basis of reconviction rates, the current study controls for differences in patient characteristics. Using a statistical model, for each FPC the expected reoffending rates were predicted on basis of these characteristics, and subsequently compared to the actual observed reconviction rate. This comparison provides an indication of the quality of the forensic care provided by the FPC.

The sample consisted of 557 former patients of FPC's who were released in 2004-2010 from one out of ten FPC's functioning in the Netherlands. Out of 13 observed FPC's, these ten institutions handled enough patients to be included on statistical norms. Mid-treatment transfers of patients between FPC's were accounted for by weighting the patient per FPC in accordance to the proportion of the length of stay, compared to the duration of the overall treatment. Furthermore, additional data was obtained from FPC's for 535 patients to maximize control for patient characteristics. Such data mainly concerned historical data, such as prior (un)employment, prior and present psychiatric and addiction disorders, prior mental and physical healthcare, and logistical transfer information.

Results

Within two years after release from a FPC, 22.8% of the 557 former patients were again prosecuted by the PPS as the result of a criminal act (i.e., overall reoffending), 17.9% for a serious offense (i.e., serious reoffending), and 9.3% for reoffending with the possibility of a renewal of the mandatory forensic treatment. Within the current sample, men reoffended more than women, patients with a criminal history prior to hospitalization reoffended more than first offender patients, and patients with mid-treatment transfers reoffended more than patients with no transfers. Also, reconviction was more likely following property offenses, and less likely after sexual or violent offenses.

Moreover, the additional historical information was also associated with (at least one form of) reoffending: more problems within particular life domains were associated with more likely reoffending. More specifically, patients with a history of homelessness and patients who bonded with criminal peers in their early days reoffended more than patients without problems in these realms. Also, the prevalence of substance abuse disorders, prior mandatory forensic treatment, and victimization of strangers was also associated with higher recidivism risks. Furthermore, prior violations of probation conditions were positively related with reoffending, but only with overall and serious reoffending. Minor psychiatric disorders were associated with more likely reoffending compared to major psychiatric disorders. Lastly, personality disorders were not related with reoffending. However, as less than 10% of the observed patients were free from any form of personality disorder, this non-association is likely due to a bias in the sample concerning such disorders.

On the institutional level two FPC's exhibited higher observed reconviction rates than was expected. Four other FPC's showed mixed results: for some forms the observed reoffending topped the expected, while for other forms it was the other way around. Lastly, four FPC's appeared to perform better in terms of reoffending than expected with lower observed reconviction rates than predicted. Overall, the results are mixed and are highly dependent on what form of reoffending is concerned. That being said, due to the limited sample size per FPC, none of these observations of the difference between the 2-year expected and observed reconviction rates were statistically significant. In other words, from a statistical viewpoint all of the observed FPC's performed equally well on preventing reoffending among released patients in 2004-2010.

Conclusion and discussion

A main goal of FPC's is the reduction of the reoffending risk among its patients. Therefore, the reoffending of its patients after release is a logical indicator of how well FPC's perform. The WODC will supply these statistics on yearly basis starting from 2015, with additional differentiation categories and an ongoing process of model quality control. The current study suggests that unadjusted reoffending rates are not appropriate for the purpose of quality assessment, because many other factors besides the treatment at the FPC are associated with reoffending after release. Most of them are beyond the control of FPC's (e.g., a history of homelessness).

Instead, the difference between the expected and observed reconviction rates can be interpreted as an indication of the contribution FPC's have on the level of reoffending. In this vein, the current results suggest that all FPC's perform as expected in regards to what sort of patients they treat. The sample sizes of the FPC's were too limited to adequately determine variation in their performance on a statistical basis. Therefore, the results of the current study should not be interpreted as hard evidence of forensic care quality.

Regardless, FPC boards and directors could use the current results, in combination with other indicators of organisational performance, as an incentive to open up a discussion on how to move forward as an organisation and an industry. Moreover, the study provides the forensic psychiatric field with a preliminary instrument capable of exposing detailed reoffending information among its patients, even if some statistical issues remain. Such issues may be resolved in the near future by utilizing a continuous measure of reoffending instead of a dichotomous one. The WODC is currently developing such an outcome variable.