EVALUATION OBLIGATORY REPORTING PUNISHABLE OFFENCES IN DETENTION UNDER A HOSPITAL ORDER [TBS]

Van Montfoort
Woerden, July 2012

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Summary and conclusions

On 26 June 2008 sections 53 paragraph 2 and 57 paragraph 4 of the Hospital Orders (Care) Regulations [Reglement verpleging terbeschikkinggestelden, Rvt] were amended following an investigation by the Inspectorate for the Implementation of Sanctions [Inspectie voor de Sanctietoepassing] and the Healthcare Inspectorate [Inspectie voor de Gezondheidszorg]. This investigation targeted two instances of detainees absconding from their supervised leave, whereby one detainee was suspected of having committed several serious punishable offences during his escape. In the course of the investigation it transpired that this detainee's leave authorization should have been rescinded by right on the grounds of section 53 paragraph 2 of the Hospital Orders (Care) Regulations since this detainee had had a violent argument with a fellow patient some months before absconding from the supervised leave. The treatment coordinator of the Forensic Psychiatric Centre did not consider this incident a punishable offence, and wrongly so. The Inspectorates pose that the manner in which section 53 paragraph 2 of the Hospital Orders (Care) Regulations has been phrased constitutes a complicated construction, which sometimes renders it difficult to mark a clear point in time at which the leave authorization ought by right to be rescinded. The amendments to sections 53 paragraph 2 and 57 paragraph 4 of the Hospital Orders (Care) Regulations should result in the desired clarity.

As a result of the amendments to the sections 53 paragraph 2 and 57 paragraph 4 of the Hospital Orders (Care) Regulations the head of the institution is required, within 24 hours, to report to a criminal investigator any punishable offences committed by a detainee under a hospital order for which custodial remand is authorized. These punishable offences include serious disturbances of the peace such as arson and acts of vandalism and public disorder but also theft. Thus, the requirement to report such incidents also applies to relatively minor misdemeanours such as shoplifting or the theft of a bike. If the detainee was granted a leave authorization, this should be suspended immediately. The moment the Public Prosecution Service subsequently declares the detainee to be a suspect, the existing leave authorization is rescinded by right. If the Public Prosecution Service declares the detainee not to be a suspect, however, the leave may be renewed.
The field of practitioners working with detainees under a hospital order has identified a number of undesirable side effects expected to come about as a result of these amendments. In order to meet the objections raised by the field the State Secretary has pledged to evaluate the amended regulation.

The data necessary for the evaluation were collected over the period May 2011 – October 2011. In the early part of 2012 some additional interviews were held.
The research questions relate to the following themes:

1. The background of the (tightened) regulations (aims and envisaged side effects)
2. The implementation and realization of the regulations by the clinics
3. The implementation and realization of the regulation by the police and the Public Prosecution Service
4. The quantitative analysis (reporting, completion and turnaround times)
5. The actual observance of the regulations and the actual consequences.

All research questions were answered on the basis of a variety of research sources.

Background	Desk research; interviews representatives Leave Unit [Verlofunit tbs], Advisory College for Leave Testing TBS [Adviescollege Verloftoetsing tbs] and the Directorate Legislation [directie Wetgeving] and consultation with criminal law expert
Implementation and realization by the clinics	Desk research; interviews legal advisors and treatment coordinators in the clinics; interviews representative Leave Unit and Advisory College for Leave Testing TBS; assessment case studies
Implementation and realization by the police and the Public Prosecution Service	Interviews with police officers and public prosecutors
Quantitative analysis	Analysis registration systems of the police and the Public Prosecution Service and central detainee registration of incidents, reports and leave authorizations (MITS)
Observance regulation and actual side effects	All research sources

Background: aims and envisaged side effects
In actual fact, the tightening of the sections 53 paragraph 2 and 57 paragraph 4 of the Hospital Orders (Care) Regulations involves three new instructions for the clinics to follow:

1. They are obliged to report (any offences for which remand in custody is authorized).
2. They must report incidents to the police within 24 hours.
3. They must immediately rescind the leave of the detainee concerned until the Public Prosecutor (being an independent third party) has judged whether the detainee is regarded as a suspect.

That section 53 paragraph 2 of the Hospital Orders (Care) Regulations concerns ‘punishable offences for which remand in custody is authorized’ as well as the fact that ‘the leave authorization is rescinded the moment the detainee is regarded as a suspect’ has already been laid down at a previous amendment of section 53 of the Hospital Orders (Care) Regulations[1]. Yet, these form essential, integral parts of the regulation. The present evaluation therefore relates to the amendments to the regulations as a whole rather than to just the factual amendments / tightening of 2008.

[1] By order of 23 June 2005 (*Official Gazette*, [*Stb*.] 2005, 400).

The primary aim of tightening the regulations as carried out in 2008 was to achieve clarity as to the moment at which the leave authorization is rescinded. Rescindment of the leave authorization was, even after 2005, still subject for discussion in some cases. A tightening of the regulations was to end this.

A number of undesirable side effects had been envisaged in advance by clinics as well as the Council for the Administration of Criminal Justice and Protection of Juveniles [RSJ]; in part these also concern fundamental objections.

- The obligation to report an offence is not in keeping with customized care.
- The obligation to report incidents may, in practice, form a stumbling block: (1) with complaint-based offences, only the person entitled to complain can report the offence (2) the obligation may conflict with the victim's wish not to report the offence (3) the obligation may put pressure on the therapeutic relationship.
- Recognizing offences for which remand in custody is authorized requires a careful legal assessment. An FPC cannot be expected to make this.
- Deeming an individual to be a suspect is not a very workable concept. It does not provide good indications for the existence of a reasonable suspicion (section 67 of the Dutch penal code [Sv]). It is also unclear at what moment the public prosecutor regards someone as a suspect.
- When further verification yields no reasonable suspicion of the person's involvement in punishable offences or unauthorized absence, the leave authorization needs to be applied for anew. This causes a substantial delay in the authorization of the leave and concomitantly in the treatment process. Such delays are hardly acceptable if the care recipient is not at fault.
- Rescindment of the leave authorization by right has no added value over and above the possibilities that the Hospital Orders (Care) Regulations already offers, sc. rescindment of the leave by the head of the institution and rescindment of the leave authorization by the minister.

The Council for the Administration of Criminal Justice and Protection of Juveniles [RSJ] also identifies advantages to the new tightening. It is assumed that the new regulations will offer less space for people's own interpretation on matters and will thus enhance equality before the law.

Implementation by the clinics

All clinics were informed of the tightening of the rules by means of a letter from the ministry, phrased in general terms and addressed to the head of the institution. Often, the legal advisors were consulted next. The subject was discussed in various consultations (such as the sounding board group forensic legal advisors and the LBHIV). Sometimes, the subject was made better known through internal reporting (for instance, through a newsletter). Half of the clinics organized their own ways to inform employees about the amendments to the regulations. Almost half of the clinics informed the detainees under a hospital order about the amendments to the regulations and the consequences for their leave. (According to the interviewees,) these detainees generally have great difficulty accepting such measures touching upon their leave.

The investigation shows that, despite the activities undertaken around the implementation, employees in a number of clinics do not have a correct image of the scope and implications of the regulations. Not everyone in two out of four non-custodial clinics is clear about the fact that the regulation is only applicable if a detainee under a hospital order finds himself outside the institution (i.e. when on leave).Further, almost half of the legal advisors to the custodial institutions is of the opinion that the obligation to report incidents only applies to detainees with a leave authorization. As much is, indeed, stated in the explanatory notes but the actual decision to amend the Hospital Orders (Care) Regulations clearly indicates that the obligation to report refers to all detainees under a hospital order.

Most clinics have a general protocol for reporting incidents; however, the tightened regulations (sections 53 and 57 of the Hospital Orders (Care) Regulations) are only mentioned explicitly in four out of 13 clinics. In general, analysis of the protocols shows there is no consistent reporting of punishable offences for which remand in custody is authorized. Both the specific and the general protocols are more or less torn between two different ideas: on the one hand, the obligation to report incidents and on the other, the space to make one's own assessments. One of the general reporting protocols states, for example, that if physical damage has been inflicted on a patient or an employee, this is always reported unless directly traceable to the disorder or clinical situation.
The clinics' operating procedures for reporting incidents show a certain variety. An incident is always discussed in a wider context but this may be both a multidisciplinary consultation and an incident review committee that includes representatives at board level. The decision may be taken by a treatment coordinator or by the director of the clinic. The role of the legal advisor is often, though by no means always, an advisory one. There are also differences among the clinics as to which staff member actually does the reporting. In short, no two clinics are the same when it comes to the procedural steps that are followed when an incident is reported.

According to the legal advisors, it remains difficult for the therapists to determine which offences do and which do not come under the obligation to report incidents. Therapists may consult the legal advisers of their clinic to this end but we did not get the impression that this happens a lot. And, incidentally, the legal advisors do not always have all the answers to such and other questions. They, in turn, may refer to the Leave Unit TBS but this too does not happen often. Other than what is stated in the explanatory notes (p. 4), no activities have been arranged to equip the clinics so they may recognize the offences for which remand in custody is authorized.

Support within the clinics
The treatment coordinators hold different views on whether the practitioners in their clinics lend their support to the reporting of incidents. Some argue that in general employees rate positively the fact that incidents are reported, also because this constitutes acknowledgement of the injustice done to them. Yet other interviewees emphasize the point that employees often very much dislike reporting an incident as this may disrupt the therapeutic relationship or because they fear retaliation. In general, though, there is support for the reporting of incidents, which should also be considered in the light of a change of culture in the clinics (from tolerating to setting boundaries). However, there is little support for reporting minor incidents (simply because these come under the type of offences for which remand

in custody is authorized). That goes for all parties concerned: thus, not only the treatment coordinators and employees of the clinics but also the interviewees in the Leave Unit TBS and the Advisory College for Leave Testing TBS.
Some treatment coordinators side right away with the present regulations. Most, however, would prefer to retain some space in which to make their own assessment. Even so, a number of them indicate explicitly that in practice they do carry out the rules. They do so acting on the principle 'a rule is a rule' or because it is obligatory for them to do so ('so it has to be done …') or because they were brought to account by the Leave Unit TBS when they had failed to report an incident in a specific situation.

The workability of the regulations
The clinics are faced with tough questions when it comes to the (legal) workability of the regulations. Examples are 'what is to be done in situations where both the clinic and a patient wish to report an offence?' or 'how does the obligation to report relate to professional secrecy?' Moreover, guidelines are felt to be missing with respect to incidents that are only known about through hearsay, in other words, conflicts that occur among the patients, out of sight of the staff. Some clinics do not report in such situations, others make their own assessment of the reliability of the victim's account. More in general, weighing up acts of aggression and verbal violence is mentioned as being tricky. It has been suggested to establish norms in this respect by recording the outcomes of the assessments that are made during the joint consultations in a clinic.

Another area where the regulations prove difficult to implement concerns the fact that the Public Prosecution Service must inform the head of the clinic whether the detainee is regarded as a suspect. As the Council for the Administration of Criminal Justice and Protection of Juveniles [RSJ] had already anticipated, the wording 'regard as a suspect' does not fit in well with existing legal proceedings. The Public Prosecution Service has made no efforts to make this a clearly recognizable moment in the legal proceedings. Instead, another moment was chosen: the moment at which the Public Prosecution Service decides to either dismiss or prosecute a case. As a result, the moment to rescind or renew the leave authorization likewise moves up. As a consequence, a case may be dismissed, with a renewal of the leave authorization while conceivably the detainee is correctly regarded as a suspect (and there was another reason for not prosecuting the detainee). This moment of deciding whether or not to prosecute also has the drawback that it takes longer for the detainee and the clinic to achieve clarity from the Public Prosecution Service as to the consequences of the reporting for the leave.
The moment of the decision whether or not to prosecute has the advantage (for the detainee and the clinic) that it reflects a certain justice. That is to say, it suggests that the fact of the leave authorization being rescinded by right or renewed is linked to the fact that a person is guilty or innocent. However, the Public Prosecution Service rightly points out that a dismissal does not imply that a person is innocent as there are many reasons for dismissing a case; this may even occur in the presence of legal and convincing evidence. It has, moreover, never been the legislator's intention to link the moment of rescinding the leave authorization by right to the question of guilt. From the viewpoint of the safety of society, the fact that a person was regarded as a suspect (by the Public Prosecution Service) sufficed to rescind the leave authorization by right.

The (un)desirable side effects and consequences from the clinics' perspective

At the heart of the difficulties is, as was anticipated, the criticism from the clinics (and the Council for the Administration of Criminal Justice and Protection of Juveniles) that the obligation to report an offence is not in keeping with the principle to 'provide customized care'. Some find the obligation to report the biggest problem. To others, the certain consequences of reporting for the leave constitute an over-simplification. The first group finds the obligation to report an offence an over-simplified approach that does not take into account the severity and nature of the offence. They are also of the opinion that reporting an offence is not always an effective way to deal with offensive conduct; treatment may sometimes work better. The educational value of the legal proceedings is relativized even more because of two other stumbling blocks, the lengthy turnaround times and the limited diversity in settlements: a great number of dismissals and relatively light settlements. The lengthy turnaround time is the more pressing as this contributes to what is an, in effect, existing problem: the long duration of detention. This length of stay was said to contribute to a decrease in the influx of detainees.

The second group especially finds the consequences of reporting an offence for the leave an over-simplification. They would prefer to make their own assessments as to how long a leave should be suspended for. The severity of the offence and the consequences of suspending the 'transmural' leave can then also enter the equation. Presently, one is completely dependent on the Public Prosecution Service on this point. As long as the Public Prosecution Service does not state whether or not they will prosecute[2] the leave will remain suspended, with the patient being unable to go outside. As a result, the patient and the clinic are often kept in ignorance for months as to where they stand and the treatment trajectory grinds to a standstill.

Besides the criticism levelled at the regulations by the clinics, there is also a positive appraisal to be found and positive effects are mentioned as well. These relate to (1) the principle at the heart of the regulations to the effect that a detainee who has been reported and whose case has not been settled yet should not be able to walk freely (2) the external pressure that keeps people sharp and leads to more reporting and (3) the fact that the regulations will lead to greater uniformity in the practice of reporting offences.

Also, there are anticipated undesirable side effects that in practice prove not to play such a big role as had been expected. This concerns 'the fact that reporting an offence may put pressure on the therapeutic relationship', 'the fact that reporting may go against the victim's wishes' and the problems that may arise with complaint-based offences.

One side effect that had been envisaged requires special attention. The clinics as well as the Council for the Administration of Criminal Justice and Protection of Juveniles [RSJ] hold the opinion that should a detainee later prove to have been unjustly suspected of an offence, the leave authorization is still rescinded by right. In that case, a new authorization needs to be requested, which again results in a delay in the treatment process. However, the explanatory notes (p. 5) indicate (succinctly) that in such

[2] In practice, the Public Prosecution Service does not take the moment someone is regarded as a suspect for the moment to provide the clinic with feedback but, rather, the moment it is decided whether or not to prosecute. This then becomes the moment at which the leave authorization may by right be rescinded. We will go into this matter at a later stage in this summary.

situations the leave authorization is renewed. As much is likewise confirmed by the legal advisors who we consulted on the matter. Apparently, this involves a common legal (in civil law) concept: in case of an error or an omission, the assumption is made that the omission or error was not made and that, therefore, the leave authorization still stands. This is only the case if the detainee has been unjustly regarded as a suspect. However, the Public Prosecution Service takes the moment at which the decision to prosecute is made for the moment to provide feedback to the clinic. Thus, the rescindment of the leave authorization is linked to the decision whether or not to prosecute. Yet, if the detainee is subsequently acquitted, this does, in principle, not lead to a renewal of the leave authorization. This only happens if the case is concluded with a code 01 dismissal (unjustly regarded as a suspect). Our conclusion is that the succinct explanation in the explanatory notes has not been conducive to a greater clarity on this point. The Public Prosecution Service's practical translation of the regulations has led to a legal construction that is difficult to explain.

Implementation and realization on the part of the chain partners

Implementation of the regulations on the part of the police and the judiciary has not been sufficiently adequate. Familiarity with the regulations was found to be rather limited, both in the liaisons to the clinics and in the organisation as such. Both the police and the judiciary's contributions to the realization are (still) only limited. Where matters have been laid down in a covenant, things go better but to date there are few of these covenants.

Despite the poor implementation, the police and the Public Prosecution Service are, in principle, positive about the regulations. However, their realization does present a number of (in part fundamental) problems. Realization of the regulations is hampered by a difference in expectations on the part of, on the one hand, the clinics and, on the other, the police and the judiciary. The clinics make their own selection of cases they deem to come under the obligation to report and, in view of their obligation to report, subsequently expect the Public Prosecution Service to impose sanctions. In its turn, the Public Prosecution Service also does its own weighing up, and is under no obligation to prosecute. Serious and grave cases are prosecuted as normal but in many cases it is wondered whether it is feasible to prosecute and if so, what this will yield. The possibilities for settlement are limited. A number of prosecutors believe disciplinary measures from the clinic to be generally preferable to, for instance, imposing a prison sentence. On this matter, the clinics and the Public Prosecution Service hold similar views.

A specific point where the communication between, on the one hand, the clinics and, on the other, the police and the judiciary does not go well concerns the issue of the impact of the disorder on the offence. The clinics include this factor in their deliberations whether or not to report an offence. Because of their professional secrecy, however, they prefer not to impart any information on the subject to the police or the Public Prosecution Service. In their turn, the police and the Public Prosecution Service have expressed the wish to know what views the clinic (being an expert) has on this matter. Further, there is the pertinent idea within the Public Prosecution Service that it is not up to the clinic to decide whether the offence originates in the disorder. According to the Public Prosecution Service, the clinic should not use this as a criterion when deciding whether or not to report the offence.

Are offences reported as required?
Two out of ten interviewed treatment coordinators state they always report punishable offences and therefore do not make their own assessments. The others each mention their own combination of considerations in which certain aspects (almost) always recur. These include the severity and nature of the offence, the damage or injuries inflicted and the nature and severity of the disorder. The majority of the treatment coordinators interviewed does not, then, keep to the (tightened) regulations.
A number of case studies (of offences for which remand in custody is authorized) that were submitted show there is both agreement as to the decision to report an offence in the most serious cases and agreement on the decision not to report in the least serious ones. Thus, we notice once again that the regulations are not always observed as they should. Opinions differ in the wide middle group of cases (3 out of 6 cases). In other words, there is also a grey area where there is no uniformity as to manner of acting. The 'remand in custody may or may not be authorized' factor does not play a role in the way any of the treatment coordinators come to assess the cases.

Numbers of offences reported and comparison characteristics of reports
The approach we adopted of linking and analysing registration systems yielded a total of 89 reports over the two-year period following the 2008 tightening up of the regulations. Our approach found 60 instances of reporting for the two-year period preceding the amendment of the regulations. Our rough estimate is that for both periods half of all the reports have been uncovered. In the post-measurement of the two-year period after 2008, the percentage of offences reported has, thus, risen by 48%. In absolute terms this amounts to a limited increase by 29 reports. The increase does not apply to all clinics. There are also some clinics where the number of reports decreased.

It may be concluded from a comparison of the reports in our measurements for the pre- and post-2008 periods that since the amendment of the regulations more offences have been reported that were committed by patients with a leave authorization and that these more often involved less serious cases that were settled by the police (after consultation with the Public Prosecution Service). The threshold for reporting patients with a leave authorization thus seems to be lower in the measurement for the post-2008 period than in the measurement for the pre-2008 period. Incidentally, the reporting here especially concerns patients with a supervised leave authorization. There was and is hardly any reporting of patients on unsupervised leave, 'transmural' leave or trial leave. The negative effects of the regulations on the re-socialization of the detainees as pictured by the clinics thus remain limited in the current practice of reporting offences.

When incidents are reported, these (presumably) almost always concern offences for which remand in custody is authorized. We cannot commit ourselves fully about this since a quarter of the cases (from the measurement for the post-2008 period) could not be retrieved in the registration of the Public Prosecution Service. Presumably, a large number of these cases were settled by the police (in consultation with the Public Prosecution Service). These often constitute the 'lighter' cases. It is not known whether remand in custody was a possibility in these cases.
A mere quarter of all reporting was done within 24 hours. The fact that the requirement to do so was explicitly laid down in the regulations in 2008 has not (yet) changed actual practice.

The figures corroborate the picture arising from the interviews that cases are frequently dismissed. Cases are usually dismissed because of a patient's disorder or because the person has already been placed under a hospital order.
Turnaround times between reporting an incident and the moment at which a case is settled have decreased from an average 9.5 months to an average of over 7 months according to the measurement for the post-2008 period. Total turnaround times for cases thus seem to be shortening though they are still long. The interviews go to show that turnaround times between reporting an incident and the moment of the Public Prosecution Service deciding whether or not to prosecute are similarly still long.

What implications does implementation of the regulation have for the leave?
We found 29 instances, over a two-year period following the amendment to the regulations, of reported offences committed by patients with a leave authorization. Of these, 14 were probably settled by the police (in consultation with the Public Prosecution Service). Of the 15 remaining reports, 11 were dismissed; four cases were prosecuted. On the assumption that the actual figures are approximately 50% higher, some 30 incidents are reported annually involving patients with a leave authorization whereby the amended leave policy ought to be carried out (rough estimate). The instances which are incorrectly not reported are left out of account here.
We do not know if, in the 29 cases where offences were reported committed by patients with a leave authorization, the clinics immediately rescinded the leave and did not allow the patient to go on leave anymore. We do, however, have indications to that effect. As it is, clinics let the leave authorization expire or have it rescinded and are sometimes stricter than the regulations require them to be.
In the cases under investigation, the clinics may not have known (in time) whether the detainee was to be prosecuted, with the leave authorization then being rescinded by right. Often, the Public Prosecution Service does not (yet) inform the clinics of this. We presume that the clinics at some point in time retrieved this information themselves from the Public Prosecution Service. In the four cases investigated of patients with a leave authorization that were prosecuted, the clinics did not inform the Leave Units TBS that the leave authorization had been rescinded by right. We have drawn this conclusion because the fact of the leave authorization being rescinded by right could not be traced in the registration of leave authorizations. In all four cases, the clinics let the leave authorization expire.

Final conclusions as to observance of the regulations and the direct consequences
Since the amendments to the regulations, offences are more frequently reported, in particular those committed by patients with a leave authorization. The amendments thus have the desired effect, on this score. However, both the considerations mentioned as to whether or not to report an incident and the assessments of the case studies (which all come under the obligation to report) show that there is (as yet) no strict observance of the requirement to report incidents and, therefore, no uniformity in its practical implementation. As long as there are differences between the clinics in their decision whether or not to report incidents there will continue to be differences between the clinics as to their application of the leave rules. Thus, a detainee under a hospital order who has committed a punishable offence for which remand in custody is authorized may have his leave authorization rescinded in clinic A (because the offence has been reported) while he may keep his leave authorization in clinic B (because the offence has not been reported). This does not alter the fact that clinic B can still take measures in view

of the offence that may likewise result in a rescindment of the leave authorization. Besides, a serious incident always needs to be reported to the Ministry of Security &Justice and the Leave Unit TBS will then point out to the clinic that the offence has to be reported. Moreover, the Advisory College for Leave Testing may decide, on the basis of an overview of offences committed, to turn down an application for a new leave authorization for the patient concerned.

As far as observance of the regulations is concerned, the conclusion is drawn that on a number of other points the regulations are not (wholly) observed, either.

- Some of the clinics may report more frequently the offences committed by patients with a leave authorization but they have not changed their own rules with respect to reporting patients without a leave authorization.
- Often, incidents are not reported within 24 hours.
- Reports of incidents are not always forwarded to the Public Prosecution Service; a number of the reports is settled by the police (in consultation with the Public Prosecution Service).
- Often, the Public Prosecution Service does not (yet) adhere to the rule that it ought to inform the head of the clinic. The Public Prosecution Service has chosen for another moment to provide this feedback, sc. the moment it is decided whether or not to prosecute. This also puts off the moment of the leave authorization being rescinded by right.
- The impression has been created that the clinics themselves often enquire of the Public Prosecution Service whether the detainee is prosecuted. They then fail to pass on to the Leave Unit TBS the fact that a leave authorization has by right been rescinded. Thus, this fact is not recorded in the registration of leave authorizations.

The amendments to the regulations aimed to achieve clarity as to the moment the leave authorization is by right rescinded. This clarity has been achieved on paper although not quite as intended since the Public Prosecution Service has chosen a decision moment to offer the clinics this clarity other than is laid down in the regulations. In practice, there is complete clarity only if the clinic consistently reports incidents and the Public Prosecution Service informs the clinic consistently and at the right moment. As to the direct consequences of the obligation to report incidents, the conclusion may be drawn that this obligation may thwart the clinic’s customized care approach. The criminal settlement (with all its shortcomings) replaces the clinic’s own measures that are better able to take into account the nature and the severity of the offence and may have greater educational value. The educational effect of reporting is, an important extent, lost since it frequently takes a long time before clarity is achieved as to the completion of the case and cases are often dismissed (for reasons other than a lack of evidence). The long wait before it is clear whether an offence will be prosecuted also has a delaying effect on the treatment and as a result brings a plan of supervised leave to a standstill, often for a considerable length of time.