The danger of recidivism and its treatment amenability

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The Danger of Recidivism and its Treatment Amenability

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This is a commentary on the text of the paper presented by Th.F. Courtless: *'Commitments of mentally disordered offenders in the State of Maryland (USA); Forensic psychiatric evidence of future dangerousness versus treatment amenability.'*

Professor Courtless talks openly of the fact in the United States – that for some time now – harder sentences (or more severe sanctions) are being imposed on those found guilty of serious offences. Apparently, less consideration is being given to the medical treatment possibilities in these cases, than to the imposition of longer prison sentences. Professor Courtless first of all presents the possibilities open to inmates suffering from severe mental disorders in the 'treatment-prison' known as the 'Patuxent Institution'. He then describes the role this prison (in Maryland) has played since 1955. He talks about the no-limited or long-term, treatment of seriously disturbed psychopaths (defective delinquents) there; these are delinquents who 'juridically' are not regarded as 'insane', but who from a medical viewpoint could be regarded as such.

Courtless then goes on to sketch the recent changes which have taken place in 'Patuxent', which now houses a greater number of adolescents convicted of less serious offences. One of the reasons for this change lies in the fact that the perpetrators of serious offences – such as murder, manslaughter, rape – are either not (or no longer) undergoing treatment, or are only given treatment after a long period in detention (during the parole period). This means, therefore, that rehabilitation only enters the picture at a very late stage. These prisoners are thus denied the desired and necessary treatment, with the result that the danger of recidivism remains. Instead of being able to equip themselves with relevant skills (in 'Patuxent'), they are simply left to languish. All that happens is that they are detained and 'warehoused' in the prison, where they become incapacitated both mentally and physically. The changed population of the 'Patuxent' penitentiary is furthermore the result of the – currently often heard – public call (in the USA) for retribution. There are also signs that the prison population is reaching explosive proportions.

The future of 'Patuxent' appears to be in the balance, partly because of the continuing need for financial cut-backs. Its position was not very strong, anyway, from the point of view of the lack of quality-inspection and supervision there; there were, for instance, no treatment plans or treatment evaluations. The consequence of this, according to Courtless, was a lack of expertise in terms of being able to make valid predictions regarding the effectiveness of the various prison programmes. The fact that the sometimes far from accurate predictions concerning the threat of recidivism/recidive behaviour, often led to heated disagreements among the staff is not a bad thing in itself, but it was extremely difficult to swallow the suggestion that these predictions were partly responsible for the lack of confidence shown both by colleagues in the mental health care services and by the policy-makers in the correctional communities.

The 'treatment prison' as broadly described by Courtless, did not live up to the expectations of those responsible for it (the policy-makers and the treating specialists). The speaker suggests that the most important reason for this was the somewhat ambiguous attitude towards the way in which 'Patuxent' should shape and develop its activities. The task of the prison was, on the one hand, the long-term detention of offenders in order to protect society as a whole, and on the other hand to provide treatment on a voluntary basis. As a 'solution' this was, of course,

doomed to create all kinds of problems, or as Courtless says 'promising a positive regimen was inevitably something of a fantasy'! We can of course always relate the situation to growing commercialisation in society.
These, then, are the main premises of Courtless's paper.

In the Netherlands context, the advice of the forensic behaviour specialist, and the forensic psychiatrist in particular, is of great importance to the presiding judge, when confronted by a defendant who may be mentally disturbed. Accountability for punishable behaviour (guilt) and the imposition of sentence, always depend on the question of whether or not the defendant is, in legal terms, fully accountable for his actions. In other words, is the defendant mentally disturbed or not? Is there any evidence of a morbid disorder in his mental capacities? The viewpoint of the behaviour specialist concerning these questions, appears to constitute a significant guideline for the judge. Nearly all cases in which the judge consults a behaviour specialist, are prompted by the question of whether or not there is any evidence of diminished responsibility, to either a greater or lesser extent.[1] The relevant point in time for the question of whether or not an accused is freely able to determine his own will, *is the actual time of the offence*.[2]
The following formulation is applied in the Pieter Baan Centre, the Prison Service's Psychiatric Observation Clinic in The Netherlands:

> 'On the grounds of the above, it is our opinion that the accused at the time the offence of which he is charged took place, was indeed able to realise the unlawfulness of it, but was also less able than the average normal person – in accordance with such an awareness – to freely determine his actions.
> ... the behaviour specialists conclude, therefore, that the accused at the time the offence of which he is charged took place, was suffering from sub-standard mental development (and/or an aberrant disorder) of his mental capacities to such an extent that this fact – if proved – can be judged to have occurred whilst the balance of his mind was disturbed.'

The forensic psychiatrist's role in the actual judicial process is no less important, indeed he assumes the position of an (extra) expert witness, present whenever necessary to assist the judge. This means that the judge can become convinced that the accused is, or was not, acting as a result of diminished responsibility (at the time of the offence), and that treatment is, or was not, called for.[3]
The judge's need to know if the mentally disturbed defendant is so dangerous that he must be detained for a long(er) period time, is part of the legal task he has to perform. The legal judgement is not only directed to punishment[4]; the judge must also consider the defendant's possible rehabilitation at the end of his sentence. From the point of view of (specific) prevention, the defendant should undergo treatment so that the danger of recidivism is reduced, and thus socially 'acceptable' for rehabilitation. The period in which the accused is detained, must be devoted in particular in developing those skills which will lessen the danger of recidivism. Thoughts usually turn here to the imposition of some 'measure' or other, whereby the accused is committed to a special treatment institute, such as a psychiatric clinic or a clinic for defendants detained under a court restriction order.[5]
In the more 'hopeless' cases, the behaviour specialists can offer little help, and because there seems to be nothing better, the judge apparently opts for the imposition of a long(er) period of detention. And this is clearly unsatisfactory.
It is, therefore, highly desirable that the judge be given a wider choice of treatment possibilities by the mental health care institutions. In this way, society's demand that the danger of recidivism be reduced is met, and collaboration in the field of mental health care between the

Judiciary and Public Health authorities increases. The mentally disturbed 'accused' must, therefore, be given the same opportunities for restoring health, as any other (non-criminal) sick person. Practice has shown that there is more contact nowadays between institutions in the field of general health care and the judicial mental health care authorities than in the past. I commend this development wholeheartedly, and would like to encourage its extension even further. In this respect, I would like to see much more being done to reduce the long waiting lists for the so-called restrictive order detainees.[6]

As a possible solution to the problem, I would suggest an increase in the number of Forensic Psychiatric Clinics and Forensic Psychiatric Departments; aligned to this would be a fast(er) flow of restriction order detainees from Court Restriction Order Clinics to Psychiatric Hospitals on the periphery, plus an increase in probationary and after-care services. And as far as the latter is concerned, I would like to point out that in the near future, the judiciary service will be making more funding available so that the probation and after-care services can be extended.[7]

I make a plea, in respect of the first of my proposed solutions, for every (medium)large Psychiatric Centre, which has a (partial or fully recognized clinical) training programme for prospective psychiatrists, to be given a Forensic Psychiatric Clinic/Forensic Psychiatric Department, with or without government funding.[8,9]

It is in the government's own interests that more places are made available for restriction order detainees, and the institutions must not allow themselves to be turned into detention centres for society's 'hopeless' cases.[10] There is a great need for a minimum availability of treatment places, offering worthwhile prospects for improved mental behaviour.[11] The training programmes for prospective (forensic) psychiatrists will also benefit from (greater) experience in the treatment and care of patients with serious psychiatric disorders.

Would it not be possible then for practical agreements to be made between the Ministeries of Public Health and the Justice Department to brain-storm together on these issues, which are obviously of vital importance to them both? A joint solution would, I feel, meet the needs of both Departments. It would primarily serve the needs of those detained under restriction orders, for whom improvements to their specific problems in particular, would become tangible in reducing the risk of recidivism; and at the end of the day, it is society itself that is calling loudest for substantial improvements in this particular area. This means that specialists and policy-makers are facing a challenge, both here and in the United States – a challenge which as a result of Courtless's dissertation can, in my view, certainly be met.

NOTES

1 The judgement on the mental state of court restriction order detainees, shows, that 47% are sentenced on the grounds of diminished responsibility, 27% on the grounds of seriously diminished responsibility, and 24% on the grounds of their being totally accountable for their deeds. See J.L. van Emmerik, *Kenmerken van ter beschikking gestelden : een follow-up.* (Characteristics of court restriction order detainees : a follow-up). Sancties, 5, 1995, p. 296.

2 The italics are important; see for instance the Netherlands newspaper *NRC Handelsblad* of 18 April 1995, in which Appie A. received a life sentence. The Public Prosecutor called for a 20 year sentence in addition to compulsory treatment in a Court Order Clinic, on the grounds of the accused's diminished responsibility during the attack on 14 May 1990. The judge did not share this opinion. The accused might well at this moment be suffering from diminished responsibility, but was not suffering from it at the time of the attack.

3 The behaviour specialist does not, of course, concern himself with the question of whether or not the indictments solid.

4 And thus on retribution and general prevention by society.

5 See H.J.C. van Marle for details of the clinical treatment of court restriction order detainees : A closed system. A psychoanalytical framework for the care and treatment of court restriction order detainees.

Gouda Quint BV, Arnhem, 1995, the review of the book by T.I. Oei in : *'Delikt en Delinkwent'*, 1995, 25, 10, p. 1099-1110, and the *Medelingenblad van de Nederlandse Vereniging voor Psychoanalyse* (News Journal of the Dutch Psychoanalytical Society), 1995, 10, 10, p. 28-37.

6 Those court restriction order detainees, (more than 140 on 1 April 1995) who because of lack of available places, cannot as yet be treated in a Court Restriction Order Clinic. Apart from the fact that there are too few Court Restriction Order Clinic places, the large number of Court Restriction Order detainees probably arises from the high numbers of Court Orders imposed in the years 1993 and 1994, and at the same time from the considerable drop in the number of completed new legislations. See Note 1, Van Emmerik, o.c., p. 286.

7 A not very large, but nonetheless important, supplement of DFL.15 million will be available in 1996. See *Vrijspraak*, 6, 1995, p. 23.

8 A Forensic Psychiatric Department bed costs DFL.313,70. per day, a figure which hardly differs from that for an average detainee in a prison (DFL. 350,-.) See J.P. Wilken, Grensgang – De plaats van de Forensisch Psychiatrische Afdeling in het veld van de forensische en reguliere psychiatrie Border line – The place of the Forensic Psychiatric Department in the field of forensic and regular psychiatry), NZI, 1994, p.16.

9 This does not mean that there is already a sufficient number of qualified personnel available, on the contrary. There is a lack of forensic-trained behaviour specialists (psychiatrists, psychologists and psychotherapists) as well as sociotherapists and mental nurses. There is, therefore, a greater need to improve staffing and the material infrastructure within the forensic facilities. See also my call for the professionalising of the psychotherapy services in terms of forensic behaviour expertise : T.I. Oei, Functional Method Forensic Psychotherapy, *The European Journal of Psychiatry*, 9, 3, 1995, p. 151-160.

10 The total need is currently estimated at 814 places, increasing to 909 in 1998. The available capacity will reach 647 places at the end of 1995, a shortage therefore of 167 places. There will certainly be a shortage of court restriction order places right up to 1998. See also Note 3, Van Emmerik, o.v., p. 288.

11 During the course of the district psychiatric day in The Hague on 17 November 1995, the need was expressed, in all quarters, for more forensic psychiatric places in general psychiatric hospitals.