Hospital orders

Oei, T.I.

Published in:
European Journal of Psychiatry

Publication date:
1999

Eur. J. Psychiat. Vol. 13, N.° 1, (12-18)
1999

Key words: Forensic Psychiatry, Law, Hospital Court Order.

Hospital Orders, the Danger of Recidivism and Treatment Amenability

T.I. Oei, MD, PhD, FCCP*

* Professor of Forensic Psychiatry
Faculty of Criminal Justice/Law Sciences
Tilburg University of Brabant
5000 IE Tilburg

THE NETHERLANDS

ABSTRACT.– This is the revised commentary on the text of the paper presented by T.F. Courtless, Ph.D., on the occasion of the "First world conference on new trends in clinical investigation and evidence", organized by "The International Network of Research on the Law of Evidence and procedure", in The Hague (NL) on 4 December 1995.

Introduction

The Hospital Court Order principle as applied in The Netherlands, is a criminal law measure imposed by the criminal judge, in the case of a serious offence the offender being severely mentally disturbed, and who without medical treatment, will probably recidivate. An offender on whom a hospital order is imposed, is considered to be so dangerous that in orden to protect society, as a whole, he must be detained for a long(er) period of time. Offences for which the imposition of a hospital order is considered necessary, are those on which a statutory minimum of four years detention can be imposed. Offences which are considered to be serious and unlawful are: murder, manslaughter, rape, arson (with victims), and such like. The problem in The Netherlands at the moment, is that there are too few places for hospital order cases, whilst at the same time an increasing number of hospital orders are curretly being imposed on offenders, in comparison with the situation prevailing just a few years ago. This is a fact known both to the policy-makers (the government) and those responsible for carrying out the required treatment. The same problem, but of a different order (i.e. long[er] prison sentences and greater delays in treatment) is

also evident in the United States of America, where treatment prisons do exist but where there are no hospital order institutions. Professor T.F. Courtless, Professor of Forensic Science and Sociology at the University of Washington D.C., recently gave a paper on his work in treatment prisons at a congress in The Hague (The Netherlands). During the course of that congress, the present author presented a commentary on Professor Courtless's paper; firstly, then, a summary of Courtless's arguments, followed by a look at the situation and problems specific to The Netherlands.

The Patuxent Institution

Courtless refers to the fact that for some time in the USA, harsher sentences (or more severe sanctions) are being imposed on those found guilty of committing serious offences. Apparently, there is less consideration being given to the available medical treatment options than to longer prison sentences. Courtless begins by discussing the possibilities for seriously mentally disturbed offenders in the "Patuxent Institution" treatment prison, and in particular the role played nationally by this prison (in Maryland) since 1955. This institution provides no-limit or long-term treatment for seriously disturbed psychopaths, as well as for delinquents who in judicial terms cannot be regarded as insane, but who from a medical standpoint could well be regarded/categorized as such.

Courtless then goes on to sketch recent changes that have taken place in 'Patuxent', which now has a far greater number of adolescents convicted of less serious offences in its care, than it ever did in the past. One of the reasons for this change, lies in the fact that the perpetrators of serious crimes are either not (or no longer) admitted for treatment, or are only admitted following a long period of normal imprisonment. Rehabilitation, therefore, only enters the picture at a late stage, and this means that the desired and necessary treatment is denied them, with the result that the risk of recidivism is still a reality. What happens in this situation is that detainees languish their time away in prison, instead of being given the opportunity during their stay in "Patuxent", to equip themselves with relevant skills. They are simply held in provisional detention and imprisoned, where they enter a downward spiral of physical and mental deterioration. This population change in the 'Patuxent' is also a result of the current, and often-heard, call of American public opinion for retribution rather than resocialization. There are also signs that the prison population is reaching explosive proportions in the United States. In The Netherlands too, developments such as those occurring in Maryland - i.e. long(er) prison sentences, a higher percentage of adolescent criminals, and a persistent cell shortage (witness the continuing and substantial number of convicted offenders released without having to sit out their sentences), all play a significant role.

There is every reason to fear that financial cut-backs will mean that the '"Patuxent" will not be able to continue its work. Its position was already rather weak as a result of its inadequate quality inspection and supervision facilities; and there were neither treatment plans nor treatment evaluations, leading Courtless to feel in consequence that there was also a shortage of essential expertise, in terms of being able to make valid preditions as to the effectiveness of the various prison programmes. The sometimes far from accurate recidivism

risk, or nonrisk, predictions often led to serious disagreement among the staff members. It was difficult to accept, however, that part of the blame for this lay in the degree of mistrust which had developed between the policy-makers and mental health care colleagues among themselves.

The '"treatment prison" as sketched by Courtless, appears not to have been as successful as the policy-makers and treating specialists had expected. Courtless suggests a significant reason for this, i.e. the ambiguous conception on which '"Patuxent" was expected to develop its activities. On the one hand, '"Patuxent" was responsible for the long-term detention of offenders in the interests of public safety, and on the other hand for the provision of voluntary treatment aimed ultimately at resocialization. A highly problematical "solution", as indeed ti me would tell! And as Courtless says, there is good reason to equate its failure to the current and growing public trend to want to see all organizations (penal institutions included), run as commercial businesses.

Although the Maryland developments mentioned here are certainly familiar in the Netherlands situation –bearing in mind that we have no treatment prisons, but opt instead for hospital order institution– they are nonetheless of a somewhat different order. They are clearly evident in the number of efficiency and effect studies which have been carried out. Take, for instance, the reorganization of the Dutch rehabilitation programmes, the building of new cells, and the shortage of hospital order places. Of quite another order too when looked at from the point of view of the role played by the reporting psychiatrist and psychologist, or from the point of view of the significance given to resocialization in the human conceptions of the Dutch criminal law code. Anyone convicted of a serious offence in The Netherlands, has the right to change his personality/behaviour pattern, or at any rate the right to be given the opportunity to acquire, through proper care and treatment, that which will lessen the risks of recidivism in him.

Forensic behaviour specialists

In The Netherlands situation, the advice given by the forensic behaviour specialist (psychiatrist/psychologist), is of importance to the judge when confronted with a justiciable/defendant who may be mantally disturbed. Accountability for punishable behaviour (guilt) and the imposition of a sentence, are always dependent on the question of whether or not the (suspected) justiciable/defendant is fully accountable for his actions. In other words, is the defendant/ suspect mentally disturbed/the victim of poor mental development, or not? Is there any evidence of a morbid disorder of his mental capacities? The view held by the behaviour specialist with regard to these questions, appears to constitute a very significant/valuable guideline for the judge. It seems in nearly all cases in which the judge consults a behaviour specialist, that there is some degree of accountability, either to a lesser or greater degree[1]. 'The relevant

1. The judgement of accountability in the case of hospital order detainees shows that 47% is judged to be "less accountable", 27% as 'seriously limited accountability', and 24% as 'unaccountable' (Van Emmerik, 1995).

point in time for asking the question of whether or not the defendant is freely able to determine his own will, is the actual time of the offence"[2].

This is formulated at the Pieter Baan Centre, the Dutch Prison Service's Psychiatric Observation Clinic, as follows:

"On the grounds of the above, it is our considered opinion that the defendant we have examined was indeed able, at the time the offence of which he is charged was committed, to understand its unlawfulness, but was less able than the average normal person –in accordance with such an awareness– to freely determine his own will.

... the... (behaviour specialists) conclude (therefore), that the defendant examined by them was suffering, at the time the offence of which he is accused was committed, from the consequences of sub-standard development (and/or mental/aberrant disorder) of his mental capacities/whilst the balance of his mind was disturbed, to such an extent that this fact, if proved, can be judged to have been, to a lesser degree, accountable for his actions".

The forensic psychiatrist's role in the actual judifical process, is by no means a minor one. More often than not, he assumes the position of an (extra) expert witness, who –whenever necessary– assists the judge. The judge might become convinced that the accused was, or was not, ill/disturbed (at the time of the offence), and is therefore (not) in need of treatment. The behaviour specialist does not, of course, concern himself with the question of whether or not the prosecution's case is sound.

The judge's need to know whether the mentally disturbed defendant is dangerous to such an extent that the must detained/held in custody' for a long(er) time, is inherent in his judicial task. The court's decision is aimed not only at punishement[3]. The judge also needs to bear the defendant's possible resocialization in mind, should he be released. From the point of view of (specific) prevention, the justiciable should be treated, so that the danger of recidivism is reduced, i.e. socially "acceptable".

It is important, therefore, to ensure that the defendant's period of detention is used in the interests of developing skills, so that the danger of recidivism is lessened. In most instances, this becomes a question of imposing "some" "measure" whereby the offender is commited for treatment to a special treatment institution, such as a psychiatric clinic or hospital order institution (Van Marle, 1995; Oei, 1995).

In the case of the more or less "hopeless" cases, the behaviour specialist can be of little help as a carer. When aggressive sex offenders, such as "core paedophiles", who recidivate (repeatedly or not) are brought to court, for instance, the behaviour usually advises the judge to impose (further) period of mandatory psychiatric treatment. The risk of recidivism in this case, is too great and thus socially unacceptable. The same is

---

2. The italics are very important here. See, for instance, NRC Handelsblad (daily newspaper), 18 April 1995, which reports on the life-sentence given to Appie A. The Public prosecutor demanded a 20 year sentence with a hospital order and compulsory treatment, on the grounds that the accused was not wholly accountable for his actions during the attack on 14 May 1990. The district court, however, did not share this view. The accused might not, at this moment, be wholly accountable for his actions, but at the time of the attack he was.

3. And is thus intent on retribution and overall protection for society.

also true of offenders who are so seriously mentally disturbed that effective treatment is hardly possible, but who could perhaps be be helped to function reasonably well under supervisión. So too in the case of an offender not presenting an immediate danger to himself or others, but who, it is felt, might well do so in the long(er)-term. In cases of this kind, the hospital order institution, in the event of the judge (respeatedly) extending the compulsory treatment order, will proceed to prolong the detention order (for a very long period, if not for life) of such a person. And this raises the question of whether such an institution is actually equipped for the task, and perhaps more fundamentally, whether that should be its task at all. In cases in which mentally handicapped people repeat a serious sex offence, the treatment prognosis will be extremely difficult, if not hopeless. In the face of nothing better, the judge often resorts to the imposition of a long(er) "punishment" term– an ultimately far from satisfactory "solution".

Collaboration in mental health care?

It is very much to be desired, therefore, that the judge be given a wider choice of treatment options in mental health care institutions[4]. The social demand for fewer recidivism risks is met to the extent that collaboration between the Justice and Public Health authorities in the field of mental health care is extended and improved. This means that the mentally disturbed justiciable must be accorded the same opportunities as any other (non-criminal) person. We see at present that there is more contact between general health care and judicial mental health care institutions –a development well worthy of encouragement–. I would however, like to see this extended even further, particularly with regard to reducing the long waiting lists for the so-called restrictive order detainees[5].

A possible solution might lie in expanding the number of Forensinc Psychiatric Clinics (FPC) and Forensinc Psychiatric Departments (FPD), in addition to subsequent fast(er) transfer of hospital order justiciables from hospital order institutions to Psychiatric Hospitals on the periphery, plus an increase in the after-care capacities for those on probation. With regard to the latter, it appears that the Justice Department has deployed extra funds to extendind aftercare activities within the Probation Service[6].

As far as the first solution is concerned, I/advocates that every (medium) large Psychiatric Centre, where (a partially or fully recognized clinical) training schedule

4. The term 'treatment' is understood here to mean all forms of mental and medical psychiatric care and supervision, available in the fields of general psychiatry and mental health care. In the 'Volkskrant' (daily newspaper) of 10 February 1995, the present author commented on the different treatments for hospital order detainees.

5. On the 1st April 1995, there were more than 140 hospital order detaines still waiting for a treatment place in a hospital order institution. Apart from the shortage of hospital order places, this high number of hospital order transients is probably the result of the high number of hospital orders imposed in 1993 and 1994, and at the same time, to the sharp drop in the number of completed measures/legislations/orders. See Note 2, Van Emmerik, op. cit., 286.

6. As not very large, but nonetheless important financial supplement of 15 million guilders has been made available for 1996. See Vrijspraak (Acquittal), 6: 23, 1995.

exists for prospective psychiatrists, be given PFC/FPD status, with or without government funding[7,8].

It is in the interest of the government too, that more places are created for hospital order detainees. The "institutions" must not become detention centres for the '"hopeless"[9].

There is a need for a minimum availability of treatment and caring facilities, offering prospects of improved mental behaviour[10].

The training of prospective (forensic) psychiatrists will also be served in providing (more) experience in the treatment and care of patients with serious psychiatric problems.

Would it not be possible, therefore, for the Public Health and Justice Departments to work together in tackling these extremely important issues? A joint solution would surely be of equal advantage to both departments. Such a solution, however, primarily addresses firstly the needs of the hospital order detainees themselves, and for whom improvement of their specific problems especially, would become tangible in the subsequent and substantial lessening of the dangers of recidivism[11].

In the final analysis, it is society as a whole wich wants to see law and order protected. Here again, policy-makers and psychiatric carers in both The Netherlands and the United States are facing the same challenges. And in Courtless's discourse lies the promise that this challenge can indeed be met.

References

T.F. COURTLESS. *Commitments of mentally disordered offenders in the Stat of Maryland (USA) - forensic psychiatric evidence of future dangerousness versus treatment amenability.* Paper, The Hague 1995.

---

7. An FPD bed costs DFL 313.70 per day, a figure differing only very slightly from the average detention place in a remand prison (DFL. 350). See J.P. Wilken, Grensgang – De plaats van de Forensisch Psychiatrische Afdeling in het veld van de forensische en reguliere psychiatrie (The place of the Forensic Psychiatric Department in the field of forensic and regular psychiatry), NZI, 16, 1994.

8. This does not mean that there are already sufficient numbers of qualified personnell – on the contrary. There is a shortage of forensic-trained behaviour specialists (psychiatrists, psychologists and psychotherapists), as well as sociotherapists and psychiatric nurses. There is an even greater need to improve the personnel and material infrastructures whithin the field of forensic medicine. See also the present author's call for more professionalism in the psychotherapy services, with regard to the science of forensic behaviour. T.I. Oei: Functional Method Forensic Psychotherapy, European Journal of Psychiatry, 9, 3: 151-160, 1995.

9. The current need is estimated to be 814 places, rising to 909 in 1998. The available capacity at the end of 1995 was 647, a shortage therefore of 167 places. Until 1998 there will certainly be an actual lack of hospital order places. See Note 2, Van Emmerik, op. cit., 288.

10. During the course of the District Psychiatric Day held in The Hague (NL) on 17 November 1995, there was a general feeling that more forensic psychiatric places were needed in general psychiatric hospitals.

11. It is interesting that the Report 'Doelmatig behandelen' (Effective Treatment) struck a chord in, in its support of the recommentations for on-going collaborative efforts between hospital order clinics and Psychiatric Centres. See NRC Handelsblad (daily newspaper), 8 January 1996.

J.L. VAN EMMERIK. Kemmerken van ter beschikking gestelden: een follow-up (Features of hospital order detainess: a follow-up). *Sancties (Sanctions)*, 5, 286-296, 1995,.

H.J.C. VAN MARLE. *Een gesloten systeen. Een psychoanalystisch kader voor de verpleging en behandeling van TBS-gestelden (A closed system. A psychoanalytical framework for the case and treatment of hospital order detainess)*. Gouda Quint BV, Arnhem 1995.

T.I. OEI. Boekbespreking van "Een gesloten systeem", in: *"Delikt en Delinkwent" (Offence and Offender)*, 25, 10, 1.099-1.110, 1995.

T.I. OEI. Functional Method Forensic Psychotherapy, *Eur. J. Psychiatry*, 9, 3, 151-160, 1995.

J.P. WILKEN. Grensgang - De plaats van de Forensisch Psychiatrische Afdeling in het veld van de forensische en reguliere psychiatrie (The place of the Forensic Psychiatric Department in the field of forensic and regular psychiatry), NZI, 16, 1994.

Address of author:
T.I. Oei
Professor of Forensic Psychiatry
Faculty of Criminal Justice Law Sciences
Tilburg University of Brabant
5000 IE Tilburg
THE NETHERLANDS