Chapter 6

Mentally ill offenders

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Mentally ill offenders clearly require specialized behavioural interventions inside as well as outside the prison system. The tbs measure for the mentally disturbed is an arrangement that can be deemed specifically Dutch in its design, implementation and attributed significance. In most countries it is not unusual that there is some arrangement pertaining to the care and if possible treatment of mentally ill offenders if the mental disorder is related to the most severe form, i.e. a psychotic disorder.[1] If penal liability can be judged as waived, the detainee can be committed to a psychiatric or a special hospital. With the notable exception of Germany and in a certain sense the United Kingdom, most countries do not have an arrangement pertaining to less severe psychiatric disorders classified as personality disorders or those whereby penal liability has not been completely but only partially waived or deemed to be.

This chapter compares the Dutch tbs measure for the mentally disturbed to other forensic mental health care arrangements for psychologically disturbed detainees. The background of the tbs measure is described. The legal responsibility and estimated risk are discussed as essential components of the individualizing assessment. The population subject to the tbs measure and the implementation of the measure are surveyed. Special attention is devoted to a new phenomenon, i.e. placement at a long-stay ward. The chapter concludes with an account of the penal detention facilities for the mentally disturbed and the prison system as a comprehensive system of facilities for mentally ill offenders.

1 Mentally ill offenders in the criminal law system

The mental problems of detainees in the Dutch criminal law system are the concern of the prison system, the system of tbs measures, and the mental health care system. The District Forensic Psychiatric Services play a crucial role in Dutch forensic mental health. Every court district has an office of this

1 Bal & Koenraadt, 2000; Blaauw, Hoeve, Van Marle & Sheridan, 2002.

service. Employees of this service do pre-trial consultations with suspects and submit recommendations to the judge on whether, and if so, what type of forensic mental health report should be drawn up.

District forensic psychiatrists and psychologists are also consulted by other penitentiary workers, particularly the Psycho-Medical Team and medical services. They advise the management, the law courts and the Ministry of Justice on the mental state of detainees. They are involved in the transfer of mentally ill detainees and their treatment after the transfer. They play a liaison role among forensic mental health care institutions, the criminal law system, the probation system and the prison system.

Every prison has a psychomedical team to safeguard and monitor the mental state of the detainees. A prison physician, nurse, psychiatrist, and psychologist are members of this team.[2]

Often at an early stage of the criminal law procedures, detainees with mental problems have dealings with forensic mental health assessment, either on an out-patient basis or on an in-patient basis in the Pieter Baan Centre,[3] after mediation by the District Forensic Psychiatric Service.[4] In a small number of cases, about 200 a year, if the conditions described above have been met with, in the legal process this can lead to the enforcement of a tbs measure.

With the expansion of the capacity of the prison system including remand prisons, open and semi-open prisons and youth prisons, the mental problems among detainees have increased in an absolute sense in recent years as a result of the growth of the number of mentally ill detainees. The severity of the disorders has also increased and become more complex than in the past, since there are now multiple problems such as addiction, mental disorders, mental handicaps and problems related to ethnic minorities.

In the prison system as well as the mental health care system, mentally ill offenders constitute a problem group that is a cause for concern and that the sectors are not adequately equipped to deal with. Detainees with mental problems are the exception in the prison system, but the mental health care system is very well equipped to hospitalize or treat them after they have served their sentence. Despite the obligation to provide care for them, prisons do not have a proper treatment climate. The incarceration, the element of retaliation, the punishment aspect are only a few of the punitive aspects that are certainly not designed to further their well-being.

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2 See for more details Van Marle, 2000.

3 See for the forensic assessment in a residential setting Koenraadt, Mooij & Van Mulbregt, 2006.

4 In 2006 the District Forensic Psychiatric Services and the Pieter Baan Centre merged into one organization: the Dutch Institute for Forensic Psychiatry and Psychology.

Detainees with mental problems are primarily treated or counselled within the prison system however, be it that the possibilities for real treatment are limited. Each prison, even if it is mainly designed to punish, has primary health care (prison physician, medical service) and secondary health care (psychiatrist, psychologist) facilities available. In addition, the Dutch prison system has ample specialized and differentiated facilities, such as individual guidance departments, special care departments, addiction guidance departments, safe individual guidance departments, the Amsterdam Forensic Observation and Guidance Department, the Penitentiary Selection Centre in The Hague and the National Isolation Ward. Mental needs are often so severe however that it is impossible to provide adequate assistance within the prison system and it is necessary to transfer individuals to facilities designed for the tbs measure or to the mental health care system.[5]

Since regular psychiatric hospitals often fail to respond affirmatively to requests to hospitalize detainees, the Forensic Observation and Guidance Department was set up in 1981 within the Amsterdam prison system as a facility for crisis intervention with severely mentally disturbed (mainly psychotic) detainees who need psychiatric treatment and cannot be treated and adequately coped with at a penitentiary. The Forensic Observation and Guidance Department serves a national function. In 2006 it had a capacity of sixty-six beds.

Mental health care facilities are not only needed for prison detainees deemed unsuitable for detention, mainly because a judge rules that placement at a facility of this type is called for. The judge can also authorize placement at a mental institution.[6] The important institutions forensic psychiatric patients are admitted to in the general mental health care system include three forensic psychiatric hospitals and ten forensic psychiatric wards. There are also two special institutions, Hoeve Boschoord in Vledder for mentally handicapped patients and Groot Batelaar in Lunteren, a forensic psychotherapeutic centre. At these institutions, sometimes detainees subject to a tbs measure are placed for treatment or in the framework of a trial leave or a special condition of the sentence.

5 Groen & Drost, 2003; Van Marle, 1997; 2000.

6 Research has shown that no fewer than seventeen legal terms are now feasible, on the grounds of which a mentally disturbed detainee can be placed at a psychiatric hospital in accordance with the Special Admissions to Psychiatric Hospitals (BOPZ) Act. The Special Admissions to Psychiatric Hospitals Act arranges the internal and, more importantly, the external legal position of patients who are involuntarily admitted to a psychiatric hospital. Beekman & Koenraadt, 2002.

2 Criminal law measures for mentally ill offenders

In Dutch criminal law, the *measure* occupies a separate position as regards the *punishment* (see also table 1).

From a Dutch perspective, punishment is retaliatory, even though it also has a preventive effect, as in a general sense, it can keep people from committing offences and in a specific sense, the actual enforcement of the punishment for the duration of the sentence keeps the detainee from committing offences. However, a measure should not serve as retaliation but as a way to avert risk. In addition to the measure that makes it possible to place psychotic detainees at a psychiatric hospital, the tbs measure is the important measure in this field. It is widely feared because in principle it can be enforced for an unlimited period of time. This makes it clear that the tbs measure is not and indeed cannot be embedded in the Classical School of criminal law thought, where the principle of the punishment fitting the crime or *proportionality* occupies a central position. It is precisely this notion of retribution that restricts criminal law to solely reactive responses to crimes that have already been committed, and does not provide grounds for prospective intervention as regards crimes that might some day be committed. The New School does not primarily view guilt that requires retribution as grounds for punishment, but instead focuses on the risk presented by the criminal. It was conceivable on this basis to dissociate from the retrospective approach of the Classical School and allow ample space for a policy on crime that uses the tbs measure as an important instrument.[7] The development of the social sciences and psychiatry have made this approach quite feasible.

Table 1 Various criminal law sanctions

Punishment	Measures
Retribution	For general protection
To make the person suffer	Not proportional
In principle limited	Possibly unlimited
Proportional to the severity of the offence and the guilt of the perpetrator	For specific prevention
For general and specific prevention	

After a legislation process of a quarter of a century, the relevant act[8] was passed in 1925 and went into effect in 1928. Significant amendments were introduced in 1988 designed to improve the external legal position of

7 Kelk, 1994.

8 The Psychopaths Act, 25 May 1925, Statute Book 221.

detainees subject to a tbs measure. One important point, the requirement that an expert report be drawn up prior to the tbs measure for the mentally disturbed, was later withdrawn.

The tbs measure has always been subject to debate in society and in the academic world.[9] Sometimes criticism focuses on its unspecified duration and sometimes on the intensity of the care. Other controversial issues have been the sequence in which the punishment and the penal measure are put into effect, the proportionality between the severity of the offence and the unlimited duration of the measure, and the increasing costs involved. Differing opinions have also been expressed by officials involved in the administration of justice. In the 1970s and 1980s, there were doubts as to whether the tbs measure would indeed make society safer,[10] but the measure itself was never fundamentally a point of discussion and ever since the mid-1990s it has even been increasingly imposed.

3 Specific rules and regulations

The tbs measure can be enforced in addition to a prison sentence. The prison sentence can be waived, though this does not usually occur, and the combination of a lengthy prison sentence and a tbs measure for the mentally disturbed has become quite common. It is enforced for a period of two years, and goes into effect as soon as the sentence is pronounced. The measure can be extended for a period of one or two years. A request is submitted by the Office of the Public Prosecutor to the Court where the measure has been pronounced simultaneously with a recommendation by the hospital or independent behavioural specialists to either extend the penal measure or not to do. In principle, the termination of the measure goes into effect if no such request is submitted or as soon as it has been rejected.

The tbs measure can also be provisionally enforced, in which case it is not implemented if the detainee adheres to the conditions, for example if he undergoes treatment.[11]

There are at least three conditions for a tbs measure to be enforced. 1. The individual has committed a serious offence punishable by at least four years in prison (or any of a number of other stipulated offences). 2. There is evidence of a mental disorder at the time of the offence and bearing some relation to it. 3. There is the expectation that other offences will be committed in the future due to the same disorder. The point of departure is that as regards offences committed in the past as well as those expected to be committed in the future, the safety of other individuals or the general safety

9 Hofstee, 1987; 2003; Kooijmans, 2002.
10 Van Emmerik, 1984.
11 Van den Berg & Harte, 2001.

of the population or property are endangered.

The behavioural conditions consist of the second and third aspects, i.e. a mental disorder and its effect on the person committing an offence and the same estimated causal relation as regards possible offences in the future. The Court can assume these aspects on its own authority, but this very rarely occurs. In actuality, a psychiatric or psychological assessment focuses on whether there is such a disorder, whether there is a relevant causal relation and if so, what it is. In practice, the procedure is that in the framework of the preliminary inquiry, the examining magistrate calls for an assessment of the individual's mental state if he suspects that the question of a tbs measure is likely to arise in the course of the criminal case.

The observation or assumption (preferably in the framework of a psychiatric or a psychological assessment) of a disorder at the time of the offence and its possible effect on the offence as well as the possible prevention of a similar type of causal relation in the future, is essential for the imposition of a tbs measure for the mentally disturbed.

4 Legal responsibility

It is a very basic notion that it is not reasonable to punish a suspect who, on the grounds of his mental disorder, was unable to act in any other manner, since in his case there was no freedom of choice or freedom of intention underlying the offence. This is based in turn on the general idea that it is not reasonable to hold a person responsable if he has no freedom at all to act and if he is unable to refrain from committing a certain act.[12]

Legal responsibility for certain acts assumes that the perpetrator is of sound mind. His responsibility is non-existent or restricted in the event of a mental disorder that affects his freedom to act and has proved to have an essential effect on the offence. In this case, the conclusion can be drawn that the suspect cannot be held legally responsible. It is conceivable in the Dutch situation for a certain extent of reduced legal responsibility to be assumed. In this sense the Dutch system differs from most criminal law systems,[13] where no gradations are allowed and only a judgement of either a legally sound mind or a legally unsound mind is allowed. In the Netherlands, subsequent to the introduction of the tbs measure, a criminal law practice emerged in which the following five gradations have come to be accepted: complete responsibility, slightly diminished responsibility, diminished responsibility, severely diminished responsibility, and complete non-responsibility. If there is no legal responsibility and a considerable risk that

12 Mooij, 2004.

13 Germany also has a distinction in three degrees of responsibility.

the same kind of offence will be repeated in the future, a criminal law placement at a forensic psychiatric hospital is a definite possibility. The tbs measure is primarily an option if there is assumed to be (severely) diminished responsibility or complete irresponsibility. This tbs measure is not considered in cases of slightly diminished responsibility (see table 2). In cases of slightly diminished responsibility, the role of the person's freedom of choice is felt to be too large to impose a tbs measure on these grounds.

Table 2 Possible sanction based on extent of responsibility

Extent of responsibility	Possible sanction
Fully responsible	Punishment
Slightly diminished responsible	Punishment
Diminished responsible	Punishment and/or tbs measure
Strongly diminished responsible	Punishment and/or tbs measure
Fully irresponsible	Placement at psychiatric hospital or tbs measure

Due to the complexity of the question, the psychiatric and psychological assessment prior to a possible tbs measure should be extremely intensive and extensive. The issue should be addressed whether there was a mental disorder at the time of the offence of a kind that affects the freedom of choice to a considerable extent or even eliminates it altogether, and whether it influenced the offence or acts in the past and will influence possible offences in the future. The issue should also be addressed whether, and if so to what extent the suspect himself should be blamed for the disorder because he 'chose to be that way' to a certain extent.

5 Drawing up the report: individualizing approach

In determining a suspect's responsibility, the internal relation is assessed between the offence or the act he is being charged with and the underlying disorder, and the extent is assessed to which the disorder affects his freedom of intention. Relations of this kind can only be revealed in an individualizing assessment. Firstly, the nature and severity of the mental disorder are described and the way and extent to which the disorder affects the capacity for careful consideration (freedom of intention). Secondly, the way and extent of the thematic influence of the disorder on the act the person is being charged with is assessed. Of course this does not always have to be done explicitly, it can also become implicitly evident from the description of the behavioural or psychopathological background of the offence.[14]

14 Mooij, 2006.

There are various possibilities connected to this. The nature of the disorder can be severe and lead to a strong restriction of the person's freedom of intention and its influence on the offence can also be sizable, as in the event of a mental disorder whereby the offence is committed under the direct influence of command hallucinations. In view of its nature, the disorder can be severe in relation to the individual's freedom of intention, even though the thematic connection to the offence may be negligible, as in the case of a psychotic person who commits an opportunist act such as shoplifting. In view of its nature, the disorder can be less severe in relation to the freedom of intention in combination with a considerable thematic connection, as in an offence where having been narcissistically hurt plays a role in a narcissistic individual. Lastly, in view of its nature, the disorder can be less severe in relation to the freedom of intention even if the connection is limited, as in a culturally determined offence such as an act of revenge as a matter of family honour committed by an individual with a dependent personality disorder. Given this state of affairs, an individualizing description is called for that is focused on the individual problems of the person involved.

Various aspects should be taken into consideration. They include the functioning of the conscience, the capacity for empathy, ways of coping with aggressive feelings, the use of defence mechanisms such as suppression or splitting, sensitivity to humiliation, abandonment and emptiness, power and a lack of power, and the nature of the personal relationships involved. Since it is not a matter of independent variables but of a structural whole, the various aspects are considered collectively as a whole with separate components that are interwoven. A certain functioning of the conscience is reflected in a capacity for empathy and this in turn affects the personal relationships involved.

The various aspects pertain to the interconnected components of a structure and cannot be viewed as separate functions, each shaping its own relation to the freedom of intention and exerting its own effect on the offence an individual is charged with. An isolating and externalizing approach is certainly conceivable, but it makes it easy to lose oneself in a relatively artificial distinction of functions that are in reality non-independent parts of the same structural whole. The evidence-based approach, also practiced in psychiatry as in general medicine, and ideally based on the presence of systematic or statistical correlations between phenomena at a collective or group level, is of the same significance – useful but of limited importance – even though less stringent demands are also sometimes made of the probative value (best available evidence). The fact that people with a certain disorder such as an anti-social personality disorder have a tendency towards criminal conduct could imply that whoever meets with the criteria

of the collective aspects exhibits a heightened risk profile, which serves as a point of departure for a line of reasoning pertaining to legal responsibility.

The same consideration holds true in a more general sense for the classifying approach, now mainly based upon DSM-IV, the most commonly accepted classification system and one that includes an extremely large number of disorders. The existence of a disorder that can be classified according to the DSM-IV is not necessary and not enough to arrive at a qualification of a 'disorder in a legal sense'. This is not necessary as there is no reason why a disorder that affects the capacity for careful consideration but is not classifiable be viewed as a disorder in the sense of the law. It is not adequate because the DSM-IV classifications, certainly in the field of personality disorders, predominantly describe interaction strategies stipulated on the basis of external behavioural criteria. In that case, a DSM-IV category should be rewritten in a structural sense, sketching the structure of the individual in interpersonal relationships and consequently evaluating his capacity for creating distance. Strictly speaking, the assumption of diminished responsibility is not based on the existence of a classifiable disorder, but on a structurally explained variant of it that is perhaps only very loosely connected to the classifiable disorder. So in this perspective, a strong reliance on classifiability is not necessarily called for, since this strongly external form of diagnostics can only partially cope with the limitations related to structural diagnostics.

In view of this specific relation, a concrete proposal pertaining to responsibility will always contain something of a construction that, though highly plausible if it is to be acceptable, is nonetheless of the category of 'plausibility'. In weighing the severity of the disorder and its effect on the offence, ample caution and care are thus required and prudence is called for. The findings leading to the assumption of a disorder should be objectified as much as possible and the description of the effect on the offence should be transparent and coherent. The prudence is measured by the criteria of objectifiability, clarity and coherence. The required form of prudence thus leads to a unique form of evidence that differs from the evidence presented via the stipulation of an encipherable disorder or a statistical relation. In addition to a form of evidence based upon statistics (evidence-based medicine), there is also a 'prudential form of evidence'. This is in keeping with the conceptual diagram used in legal practice, which includes the concepts of action, responsibility and freedom. The prudence that leads to a proposal as regards legal responsibility is a component in this manner of criminal law prudence or jurisprudence. The required certainty does not lie in the order of strict evidence, as in the case of the judicial finding of a charged fact, but in the order of plausibility, taking into consideration the criteria of objectifiability, clarity and coherence. This prudence does not alter the fact that before imposing a tbs measure, there has to be a clear statement about the individ-

ual's responsibility that at least makes a diminished level of responsibility plausible.

6 Estimating the risk

Before a tbs measure is imposed, not only is diminished responsibility required, there should also be a considerable chance of similar offences being committed in the future, to the extent that this chance of recidivism is based on the mental disorder. The future danger of the suspect committing these offences should not be based on his free choice but on a limitation of his freedom of intention due to the mental disorder, and the effect of the disorder on the future offences should be made plausible. The required estimated risk is thus derived from the responsibility requirement. This implies that in the Dutch system, as regards this point as well, one can only rely in part on standardized decision-making procedures, classifying approaches and statistical insights.

This does not mean statistical data are not important. A certain type of crime has a certain chance of being repeated. Relevant aspects include belonging to a certain ethnic group, educational level, residential environment, earlier acts of violence, and the statistical chance of recidivism of certain types of behaviour.[15] A probability calculation of this kind however cannot replace the required estimate of risk. Firstly, a statement about an individual as a member of one or more classes still does not justify drawing a conclusion about him. Secondly, it is not the probability of a recidivism as such that is required, but the probability of a recidivism determined by the disorder. Here again, the disorder plays a crucial and decisive role. This leads to an essentially different question than the one about the probability of a recidivism of the actual behaviour. It pertains to a chance of recidivism of behaviour as far as this chance is due to a mental disorder. This means that statistical or actuarial predictions can at most be supportive and can never replace the independent behavioural evaluation. This does not make them any less significant, but it does put their significance in a certain perspective. The same holds true as regards the impure actuarial instruments that use a standardized clinical weighing system such as the HCR-20 and to a certain extent the PCL-R.[16] They too can support the behavioural evaluation, but cannot replace it. In estimating the probability of recidivism that is relevant in criminal law in the implementation of a tbs measure, the chance of the recidivism of purely factual conduct is not the issue. The issue is the chance of recidivism as far as this recidivism is due to a specific disorder

15 Philipse, 2005.

16 The PCL-R is not a risk-assessment instrument in strict sense. It is a diagnostic instrument, that has predictive power as far as risk of relapse is concerned.

that affects the freedom of intention and exerts a thematic influence on the offences.

The restriction of 'danger' to 'danger as far as it is due to the disorder' is of practical importance in the actual implementation of a tbs measure. A purely actuarial estimate prior to submitting a recommendation as regards the tbs measure would not take into consideration a disorder relevant to criminal law, so that detainees without a disorder could also qualify for the same measure. It serves a shielding function. It also serves a protective function, so that the distinction is not only of practical use but is also of essential significance because it provides legitimacy for the tbs measure as a whole. It draws a distinction, after all, between cases where the relation between the disorder and the offence does not play a role and cases where it does. It is only on the basis of this distinction that it is possible to conceive a measure treating the disorder in such a way as to limit and eliminate the risk emanating from it, which is after all the aim of the tbs measure for the mentally disturbed.

7 Implementation of the tbs measure

For the following reasons, the tbs measure is more feared by suspects awaiting trial than any other legal sanction: 1. A detainee sentenced to a certain amount of time in prison knows how long it will last at most, but if a tbs measure is imposed, he has no way of knowing when, if ever, the measure will be terminated. 2. An detainee sentenced to a certain amount of time in prison can simply serve his time, but if a tbs measure is imposed, certain efforts on his part will be required in the course of the treatment, otherwise he will run all the more risk of having the measure extended. 3. If the treatment proves to be inadequately effective or not effective at all, there is a chance that the detainee will be placed at a long-stay ward where there is even less of a chance of ever being released.

Once a tbs measure has been imposed, it serves as an implicit point of departure for the parties involved. If a detainee is sentenced to a certain amount of time in prison to be followed by a tbs measure with mandatory treatment, then after one third of the prison sentence is completed, the tbs measure will be implemented at a specially equipped forensic psychiatric hospital. Detainees subject to this criminal law measure are randomly placed at one of the available forensic psychiatric hospitals.[17] As an exception to the random placement, the following criteria nonetheless play a role: sex, IQ higher/lower than 80, escape risk/no escape risk, and the nature of the mental disorder. As noted above, an important bottleneck is the availability

17 See table 3.

of beds at the forensic psychiatric hospitals. The history of the tbs measure includes a long list of problems related to capacity of tbs hospitals and their waiting lists. The mentally disturbed detainee at a remand prison awaiting placement at a forensic psychiatric hospital is no longer a suitable detainee at the remand prison.[18] Sometimes, however, the waiting period can even be over a year.

Sociotherapy, psychotherapy (mainly cognitive therapy and behavioural therapy), psycho- pharmaceutic treatment, occupational therapy, systematic analysis, educational training, sports and mental care are important components in the treatment. Most of the treatment takes place in groups. There are separate treatment programmes for psychotics, patients with a personality disorder, patients with a sexual disorder, the mentally handicapped, and detainees who represent an extreme escape risk.

Under the influence of the social trend towards a risk society with increased ministry control, attention has increasingly been focused in the penal sector for mentally ill offenders during the treatment and counselling period on risk prevention.[19] An important instrument is the offence script procedure, which is derived from cognitive therapy and is especially used in coping with sexual offenders.[20] Another important instrument is the increasingly widely used psychometric risk estimate. In the tbs sector for the mentally disturbed, it is mainly used as a risk management instrument in making decisions on leaves.

A chance to be able to expand one's own freedom of movement or to have it limited if the results are disappointing is an essential part of the treatment at forensic psychiatric hospitals. As a result of a policy of internal differentiation, this is why each hospital has a wide range of ways to limit the detainees' freedom of movement. This also holds true at the ward level (very intensive care ward, intensive care ward, closed ward, accommodation

18 Boone & Dane, 1999.

19 After the social and political indignation caused by a number of serious offences committed by detainees subject to penal detention for the mentally disturbed, who were on unwarranted leave. This led to the appointment of the temporary parliamentary inquiry committee on tbs measures for the mentally disturbed, which submitted its report to the Lower Chamber of Parliament on 16 May 2006. The committee was appointed in response to a motion by Members of Parliament Wolfsen and Weekers on 16 June 2005. The inquiry was to result in proposals that would lead to an improved system for penal detention for the mentally disturbed and adequate regulations and policy in this field. The committee report is a descriptive account and inventory as an analysis of the committee findings. The report is titled *Tbs measure for the mentally disturbed today on yesterday and tomorrow* and concludes with seventeen recommendations.

20 The offence script procedure is used in the forensic mental health reports as well as later when the matter of a possible tbs measure for the mentally disturbed is addressed (Van Beek & Mulder, 1992).

and resocialization ward and clinic outside the hospital). In addition to the variation in the extent to which the wards are closed, there are multifarious leave options. Leave is a first step in the gradual, staged return to society. The aim of the leave is to improve the patient's embeddedness in society and test the progress made in the treatment. There are various leave modalities: accompanied leave, unaccompanied leave, residential leave and trial leave. The kinds of leave may vary as regards the duration, the territory and the nature of the supervision. The treatment policy is designed to be able to expand the freedom of movement in a responsible fashion.

A few decades ago, a forensic psychiatric hospital was a kind of fortress for the mentally disturbed in the criminal justice system.[21] Nowadays there are numerous treatment and supervision options outside the hospital framework. Most forensic psychiatric hospitals now have out-patient facilities, clinical facilities, and day hospital facilities for treatment, supervision and/or aftercare.

8 Population subject to the tbs measure

In the first years of the tbs measure in the first half of the twentieth century, the population subject to it mainly consisted of detainees who had committed property or sexual offences. There were only very few detainees who had committed violent offences. Ever since the Stop Act was passed in 1933, designed to restrict the mushrooming numbers of mentally ill offenders subject to the tbs measure, the number of detainees in the sector who had committed property offences had gradually decreased. After the Stop Act was repealed, the number of detainees who had committed property offences increased again.

In the 1970s and 1980s, there was a change in this pattern of offences subject to the tbs measure. In 1971 the percentage of aggressive offences or offences with an aggressive component, whereby the offenders were subject to a tbs measure for the mentally disturbed, was 38%, but by 1983 the percentage detained for this type of index offence had risen to 89%. At the moment it is even as high as 98%. In other words, the tbs measure with mandatory treatment is now mainly imposed by the courts for aggressive and/or sexual offences. Nowadays, property offences without an aggressive component basically no longer lead to tbs measures. The percentage of female detainees subject to the tbs measure is now 6%. The average age of the population subject to the tbs measure is 31. Most of them had contact

21 Weijers & Koenraadt, 2007.

with institutions of some kind before: 70% were sentenced before and 72% were treated in the mental health care system.[22]

The most common disorders among the detainees subject to the tbs measure are personality disorders. There are also psychotic disorders, which are sometimes co-morbid. Multiple problems are also often observed.

In the past few decades, the population subject to the tbs measure has become more diverse. Many of them are of non-Dutch descent. This trend is immediately clear in any number of ways. Differences in religious customs, eating habits, languages and social conventions are only a few examples of how this diversity manifests itself in day-to-day life.

In November 2006 1699 tbs detainees occupied forensic psychiatric hospitals, 151 of whom were at long-stay wards and 103 on trial leave. There was an extremely high occupation percentage of 99%, representing the degree of agreement between the formal capacity and the actual occupation.

The increase in the number of detainees subject to the tbs measure, and thus the growing need for capacity at the forensic psychiatric hospitals, has been a result of several trends. Ever since the end of the twentieth century, there has been a sharp rise in the number of detainees subject to the tbs measure[23] and in the length of time the penal measure is imposed for. The residential duration of the tbs measure treatment was 59 months in 1995, which had increased to 89 months by 2005. What is more, in the past two decades the number of tbs measures that were terminated lagged far behind the number that were imposed. In 1995 the tbs measure was imposed 180 times and terminated 73 times, and in 2003 it was imposed 217 times and terminated 83 times. For this reason alone, there was an annual rise in the demand for capacity of an average of 100 beds. The rise in the number of tbs measure beds[24] as a result of the expansion of the capacity at the existing hospitals and the construction of new hospitals lagged behind the rising demand, so that the number of detainees on the waiting list for placement at forensic psychiatric hospitals is sizable and increased from 138 in 2000 to 225 in 2005.

There are three types of forensic psychiatric hospitals, i. e. three national forensic psychiatric hospitals that reside under the Ministry of Justice, five private forensic psychiatric hospitals that reside under the Ministry of Justice and four forensic psychiatric hospitals that reside under the Ministry

22 Van Emmerik, 2004.

23 It was imposed 180 times in 1995 and 210 times in 2004.

24 The formal capacity at the forensic psychiatric clinics was 650 at the end of 1995 and 1637 at the end of 2005.

of Public Health, Welfare and Sports.[25] The nursing is preferably done at private forensic psychiatric hospitals.[26]

Table 3 Exiting forensic psychiatric hospitals and their capacity

Hospital and location	Year founded	# of detainees Nov. 2006	Gender of population
Ministry of Justice national hospitals			
Veldzicht (Avereest) in Balkbrug	1933	231	m f
Dr. S. van Mesdag Hospital, Groningen	1952	203	m
Oostvaarders Hospital, Utrecht/Amsterdam	1951	129	m
Ministry of Justice private hospitals			
Oldenkotte, Rekken	1929	134	m f
Dr. H. van der Hoeven Hospital	1955	154	m f
Prof. W.P.J. Pompe Hospital, Nijmegen	1967	271	m
De Kijvelanden, Poortugaal	1996	161	m
De Rooyse Wissel, Venray	2000	181	m
Non-Ministry of Justice hospitals			
Hoeve Boschoord, Vledder	1950	96	m f
Forensic Psychiatric Hospital, Eindhoven	1918	81	m f
Forensic Psychiatric Hospital, Assen	1994	20	m
FPC 'de Meren', Amsterdam	2001	38	m f

9 Placement at a long-stay ward

Around 1995 it became increasingly clear that a lengthy stay at a forensic psychiatric hospital was the fate that lay in store for detainees who fell under the tbs measure for the mentally disturbed and were not expected to exhibit any treatment success. They exerted a negative influence on the average duration of the intramural treatment. There were two sides to the need for long-stay wards. On the one hand, the founding of long-stay wards made room for mentally ill offenders who still hopefully had a positive treatment perspective, and the daily costs at the long-stay wards was lower.
On the other hand, there was an awareness at the forensic psychiatric hospitals that for a growing group of detainees, no longer any treatments were available at the regular wards and they needed separate care and nursing. The founding of the long-stay wards was thus an effective, efficient and economically attractive solution to the capacity problem at the forensic

25 See table 3.
26 Section 37d, Code of Penal Law.

psychiatric hospitals. There are now two forensic psychiatric hospitals with formally instituted long-stay wards, FPC Veldzicht in Balkbrug, long-stay ward opened in 1999, and the Pompe Hospital in Nijmegen, long-stay ward opened in 2003.

To qualify for placement at a long-stay ward, a detainee has to meet several general and specific requirements. He has to have had residential treatment for at least six years.[27] He has to have been treated at at least two different hospitals. It has to be plausible that the treatment has not led to a substantial reduction of the risk of the offence recurring because the disorder the mentally disturbed detainee had at the time of the offence is still in evidence. In view of the extent of the risk to society presented by the mentally disturbed detainee, and because there is little or no prospect of improvement, he does not qualify for placement at a mental health care facility that is not run by the Ministry of Justice, and he has to remain at a forensic psychiatric hospital. Two independent experts must assess the behavioural mental need for placement at a long-stay ward. The decision to place someone at a long-stay ward with the Council for Criminal Law Administration and Protection of Juveniles is subject to appeal.

At the long-stay ward, detainees are no longer treated to prepare them to return to society. The low-intensity treatment at the long-stay ward is simply designed to stabilize their mental functioning and to prevent relapses.

The average long-stay patient is a man of subnormal to average intelligence at an average age in the late forties with a mental or a personality disorder or a combination of the two. The offences that led to the tbs measures being imposed are violent, fatal and sexual offences. For most of these detainees, the present-day tbs measure lasts more than ten years, and for some a lot longer.[28]

The detainees remain at the long-stay ward for an indefinite period. In view of the severity of their disorder, most of them will stay there for a very long time or for the rest of their lives. The fact that for some detainees, the tbs measure lasts for the rest of their lives is nothing new, as this has also been the case before the long-stay wards were opened. The fact though that these wards exist has focused attention on the cases and the size of the group of patients who might need to be incarcerated for the rest of their lives.[29]

There are certain conditions in which it is conceivable that a detainee's institutionalization at a long-stay ward will be terminated. In other words, the door is not totally shut. In the first instance, the tbs measure can be

27 Idem, p. 35. It is possible to count mental health care treatment in the framework of involuntary hospitalization under the Special Admissions to Psychiatric Hospitals (BOPZ) Act for a maximum of two years.

28 Koenraadt & Dijs, 2005.

29 Bleichrodt, 2006.

terminated (or not continued) by the judge. There can also be developments in the field of treatment.

10 In closing: the forensic psychiatric hospital and prison as parts of a comprehensive system for mentally ill offenders

The tbs measure was introduced at the beginning of the twentieth century because there was too great a gap for mentally ill offenders between placement in the prison system and placement at a psychiatric hospital. Placement at a forensic psychiatric hospital was an adequate intermediary solution.

Nowadays there are still large numbers of mentally ill offenders in the prison system, not just at forensic psychiatric hospitals. In their cases, the relation between their mental disorder and the offence they have committed is evaluated by the experts and the judge in such a way that placement at a separate treatment facility is called for. What is more, Dutch legislation and regulations make it possible to transfer mentally ill offenders from a prison to a forensic psychiatric hospital for treatment. In the 1980s and 1990s, ample use was made of this possibility. In recent years, however, as a result of the increased scarcity of beds at forensic psychiatric hospitals, little or no use is made of this option. Even though the capacity of the forensic psychiatric hospitals has been greatly expanded,[30] and in the 1990s the capacity even increased by almost 300%,[31] the scarcity of beds at forensic psychiatric hospitals now means that individuals under a tbs measure for the mentally disturbed have to wait in a prison for a long time before they can be placed at a forensic psychiatric hospital. Efforts are now being made at prison facilities to conduct preliminary interventions by way of a pre-clinical intervention. What is more, at several prison facilities, certain divisions are

30 Three new forensic psychiatric clinics have opened in the past decade.

31 It is noted in the 2006 Ministry of Justice Budget that 'The number of beds for mentally ill offenders will be rising sharply in the years to come. Funding has been reserved in the Ministry of Justice Budget for the extra treatment of 120 mentally ill offenders starting in 2006. This increase is in addition to the expansion of the number of long-stay beds, which is also to provide extra treatment capacity. In the next two years, there are going to be an additional 140 long-stay beds. They are for the growing number of mentally ill offenders in whose cases the treatment of their disorder failed to be effective and who thus remain a risk to society. As a result of this expansion, the total number of long-stay beds will be 200 in 2007. Since mentally ill offenders for whom treatment has proved ineffective will be able to be transferred to the long-stay wards with less delay, another 140 extra treatment beds will be available. With this expansion of a total of 260 treatment beds, Minister Donner expects there to be a better outflow of mentally ill offenders from the prison system. More than a million euros are to be made available starting this year, for the intended improvement of the leave system for mentally ill offenders, including the expansion of the work of the Forensic Psychiatric Service and the start of a Central Coordination Point at the Office of the Public Prosecutor.'

being converted into special divisions for mentally ill offenders.

Despite the capacity expansions, the scarcity of beds for mentally ill offenders has gradually resulted in a virtual cessation of transfers from the prison system to forensic psychiatric hospitals. Nowadays many mentally ill offenders remain in the prison system, even though by virtue of their legal sentence, that is not where they belong.

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