# Victim-Offender Contact in Forensic Mental Health

## Resocialisation and Victim Acknowledgement During the Execution of the Dutch TBS Order

**Lydia Dalhuisen & Alice Kirsten Bosma***

**Abstract**

Crime victims have gained a stronger position in all phases of the criminal procedure, including the post-sentencing phase. It is in this phase specifically that victims' needs and interests relating to acknowledgement interplay with the offenders' needs and interests relating to resocialisation. In the Netherlands, offenders who suffer from a mental disorder at the time of the offence limiting their criminal accountability and pose a significant safety threat, can be given a TBS order. This means that they are placed in a forensic psychiatric hospital to prevent further crimes and receive treatment aimed at resocialisation. As resocialisation requires the offender to return to society, contact with the victim might be a necessary step. This article focuses on victim-offender contact during the execution of this TBS order, and looks at risks and opportunities of victim-offender contact in this context, given the particular offender population. Offenders are divided into three groups: those with primarily psychotic disorders, those suffering from personality disorders and those with comorbidity, especially substance abuse disorders. The TBS population is atypical compared to offenders without a mental disorder. Their disorders can heighten the risks of unsuccessful or even counterproductive victim-offender contact. Yet, carefully executed victim-offender contact which includes thorough preparation, managing expectations and choosing the right type of contact can contribute to both successful resocialisation as well as victim acknowledgement.

**Keywords:** victim-offender contact, resocialisation, victim acknowledgement, forensic psychiatry, mentally disordered offenders.



## 1 Introduction

In recent years, the objective of resocialisation of detained people has gained considerable attention in European countries. The European Court of Human Rights has stressed that Member States should facilitate reintegration of prisoners in society.[1] Reintegration in society includes, but is not limited to reducing recidivism. It also requires resocialisation: the preparation of return to life in society, whereby the former offender adjusts to the social surroundings.[2] This is not only the case for offenders sentenced to a short, fixed-term imprisonment, but even more so for long-term prisoners, including those sentenced to life imprisonment and those treated in forensic psychiatric hospitals.[3] While retribution may be the most prominent aim of detention, the longer a sentence lasts, the more the balance will shift to emphasise other aims such as prevention and resocialisation as well.[4]

A specific measure aimed at reintegration is the Dutch so-called TBS order: compulsory treatment of dangerous offenders suffering from a mental disorder in a forensic psychiatric hospital. The TBS system is quite effective in resocialisation of the offender,[5] yet public sentiments are rather negative.[6] The public view is based on a small number of (very) serious incidents with (former) TBS patients, contributing to feelings of fear and concern.[7] This negative attitude seems to create a hard contrast between the interests of the offender – namely resocialisation, rehabilitation and human dignity[8] – on

* Lydia Dalhuisen, PhD, is Assistant Professor at the Utrecht University, the Netherlands. Alice Kirsten Bosma is Assistant Professor at the Faculty of Law of Tilburg University, the Netherlands.

1 *Vinter and others* v. *United Kingdom*, ECHR (2013), 66069/09, 130/10 and 3896/10; *Harakchiev and Tolumov* v. *Bulgaria*, ECHR (2014), 15018/11.

2 S. Meijer, 'De opmars en evolutie van het resocialisatiebegrip', 45 *Delikt en Delinkwent* 688 (2015).

3 *Murray* v. *Netherlands*, ECHR (2016) 10511/10; S. Ligthart, G. Meynen, N. Biller-Andorno, T. Kooijmans & P. Kellemeyer, 'Is Virtually Everything Possible? The Relevance of Ethics and Human Rights for Introducing Extended Reality in Forensic Psychiatry', *AJOB Neuroscience* (2021).

4 *Dickson* v. *the United Kingdom*, ECHR (2007), 44362/04, at § 75: 'However, and while accepting that punishment remains one of the aims of imprisonment, the Court would also underline the evolution in European penal policy towards the increasing relative importance of the rehabilitative aim of imprisonment, particularly towards the end of a long prison sentence.'

5 J.A.W. Knoester and J. Boksem, 'Zorgen rondom het strafrecht: TBS', 5 *Boom Strafblad* 241 (2020).

6 M.Y. van Denderen and M.J.F. van der Wolf, '"In mijn beleving was hij een monster, dat stukje is nu weg." Aandacht voor slachtoffers in de tenuitvoerlegging van de tbs', 5 *Sancties* 29 (2021); J. van Emmerik and O. Maathuis, 'TBS en het beeld hiervan bij de Nederlandse bevolking', 22 *Sancties* 178 (2017).

7 However, in practice the chance that a serious incident occurs is very small, see J. Feldbrugge, *Wat iedere Nederlander zou moeten weten over de tbs* (2009).

8 R. van Spaendonck, *Meer dan een kwestie van tijd. De verlenging van de tbs-maatregel* (2021), at 289.



doi: 10.5553/ELR.000200

the one hand, and the interests of victims and society as a whole – namely protection and acknowledgement – on the other.[9]

The negative perception with regard to the dangers of resocialisation have steered not only public sentiment, but influenced the Dutch legislator as well. For example, recently, several restrictions to existing possibilities for resocialisation of (mentally sound) prisoners in the name of 'justice for victims' were introduced.[10] Despite a fair amount of criticism in the academic – including victimological – literature,[11] conditional release from prison has been limited to two years maximum per the first of July, 2021,[12] based on this so-called victim-oriented argument.[13]

However, the apparent yet false dichotomy between protection and resocialisation ignores the fact that resocialisation and rehabilitation can also contribute to the fulfilment of victims' and societal needs.[14] What is more, too much focus on risk management can paradoxically heighten the risk of recidivism.[15] Failing to consider the rehabilitative goal of detention may thus put society, including the direct victim, in more danger than bridging the gap between them.

The question is how contact between the victim and the offender can be realised. Over the years, various avenues for victim participation in the criminal justice procedure have been introduced in Dutch law.[16] However, the TBS population is different from the regular offender population, prompting the question to what extent contact should be shaped differently. By definition, criminal responsibility is diminished or absent, limiting the possibilities for punishment. Unfulfilled needs for retribution may hamper subsequent restorative approaches.[17] In addition, the population comprises of dangerous offenders who have committed serious crimes resulting in corresponding suffering for either survivors or next of kin. A complicating factor in this respect is the finding that many offenders know their victims.[18] What is more, the various mental disorders that are present within this population can make offenders in TBS hospitals more vulnerable in contact with others or limit the possibilities of interaction. Characteristics of various types of disorders call for specific considerations with regard to victim-offender contact.

In this article, we focus on contact between victims and offenders suffering from various types of mental disorders, aiming to answer the following question: what are risks and opportunities in victims' contact with dangerous offenders suffering from a mental disorder. In this respect, we adopt a broad definition of the term 'contact', referring to either direct or indirect exchanges of interests between victims and offenders. To answer the central question, a multidisciplinary literature study is conducted, looking at victimological, legal and forensic psychiatric literature. Although we focus on the Dutch context of the TBS order specifically, the considerations might be of value for other systems as well. Many jurisdictions have specific provisions for dealing with dangerous offenders with mental disorders limiting criminal accountability that bear resemblance to the Dutch TBS.[19] Moreover, the question on how to deal with victim-offender contact and rehabilitation within this specific offender population is of relevance regardless of the legal framework.

In Section 2, we will first explain the TBS order and discuss possibilities that victims have within this forensic psychiatric context to exchange views, either directly or indirectly, with the offenders. In Section 3, we will describe the particular forensic psychiatric offender population. In Section 4, specific risks and opportunities of contact with offenders suffering from various mental disorders are discussed. In Section 5 we will present our closing remarks and answer the general question on the implementation of victims' rights within a forensic psychiatric context.



9 F. Koenraadt and R. Kool, 'Een herstelgerichte benadering van delinquenten met een psychische stoornis', 5 *Proces* 304 (2013).

10 *Kamerstukken II* 2018/19, 35122, no. 3, 6-7.

11 For example A.K. Bosma, M.S. Groenhuijsen & G.M. de Vries, 'Victims' Participation Rights in the Post-sentencing Phase: The Netherlands in Comparative Perspective', 12 *New Journal of European Criminal Law* 128 (2021); P. Schuyt, 'Voorwaardelijke invrijheidstelling: het beeld en de werkelijkheid', 2 *Sancties* 5 (2019); S. Struijk, 'Wetsvoorstel Straffen en beschermen: wordt het kind met het badwater weggegooid?', 13 *Sancties* 56 (2020).

12 Art. 6:2:10 Dutch Criminal Code of Procedure.

13 That victim-image may be used for political gain in this context has also been recognised abroad, see Y. Mehozay, 'From Offender Rehabilitation to the Aesthetic of the Victim', 27 *Social & Legal Studies* 97, at 98 (2018).

14 Compare D. Gromet and J. Darley, 'Punishment and Beyond: Achieving Justice through the Satisfaction of Multiple Goals', 43 *Law and Society Review* 1 (2009); and P. Mascini and D. Houtman, 'Rehabilitation and Repression. Reassessing Their Ideological Embeddedness', 46 *British Journal of Criminology* 822 (2006). Also evidenced by the success of reparative and restorative justice, J.A. Wemmers, 'Restitution: Helping Victims or Offenders?', in J. Joseph and S. Jergenson (eds.), *An International Perspective on Contemporary Developments in Victimology* (2020) 283, at 291.

15 P. Nelissen, 'Re-integratie van ex-justitiabelen als speerpunt voor een herstelgerichte reclasseringspraktijk', *19 Tijdschrift voor Herstelrecht* 13, at 20 (2019).

16 Bosma, Groenhuijsen & de Vries 2021, above n. 11.

17 K. Daly, 'Revisiting the Relationship between Retributive and Restorative Justice', in H. Strang and J. Braithwaite (eds.), *Restorative Justice* (2000) 33, at 41; P. Strelan and J.W. van Prooijen, 'Retribution and Forgiveness: The Healing Effects of Punishing for Just Deserts', 43 *European Journal of Social Psychology* 544 (2013). Note that there is an ongoing discussion on the weight of the retributive vs. restorative justice needs. See additionally: A. Ten Boom and K.F. Kuijpers, 'Victims' Needs as Basic Human Needs', 18 *International Review of Victimology* 155 (2012); W. Veraart, 'Vergelding of herstel? Een reflectie op de rol van het slachtoffer in de executiefase', 60 *Sancties* 280 (2019).

18 A study on Dutch forensic psychiatric patients comparing women to men found that 72% of women and 60% of men know their victim, V. de Vogel and E. de Spa, 'Gender Differences in Violent Offending: Results from a Multicentre Comparison Study in Dutch Forensic Psychiatry', 25 *Psychology, Crime & Law* 739 (2019). Similar percentages are found abroad regarding victims of offenders who were found not guilty by reason of insanity, see I. Jeandarme, L. Vandenbosch, M. Groenhuijsen, T.I. Oei & S. Bogaerts, 'Who Are the Victims of NGRI Acquittees? A Study of Belgian Internees', 34 *Violence and Victims* 434 (2019).

19 H.J. Salize and H. Dressing, *Placement and Treatment of Mentally-ill Offenders. Legislation and Practice in Member States* (2005), at 225; J.M. Jehle, C. Lewis, M. Nagtegaal, N. Palmowski, M. Pyrcak-Górowska, M. van der Wolf & J. Zila, 'Dealing with Dangerous Offenders in Europe. A Comparative Study of Provisions in England and Wales, Germany, the Netherlands, Poland and Sweden', 32 *Criminal Law Forum* 181 (2021); J. Tomlin, I. Lega, T. Braun, H.G. Kennedy, V.T. Herrando, R. Barroso, L. Castelletti, F. Mirabella, F. Scarpa & B. Völlm, 'Forensic Mental Health in Europe: Some Key Figures', 56 *Social Psychiatry and Psychiatric Epidemiology* 109 (2021).

# 2 Legal Framework

When reviewing victim-offender contact within the TBS context, the particularities of this context, most notably the forensic mental health hospital and the particular vulnerabilities of the offender population, need to be taken into account. In this section, we will present an overview of the Dutch TBS order. We will then explore the possibilities for victims to share their needs and views within this context, which may guide the offenders' resocialisation plan.

## 2.1 The Dutch TBS Order

Inpatient forensic psychiatric care differs from most other forms of psychiatric treatment because of its dual aim. Apart from treatment of an individual suffering from a psychiatric disorder, forensic psychiatry aims to protect society from future harm that such individuals might cause.[20] Many jurisdictions have specific provisions for dealing with dangerous offenders;[21] however, the Netherlands is known for having high security forensic psychiatric centres as part of the criminal rather than the mental health system.[22] In our analysis, we will focus in particular on the Dutch TBS order imposed on dangerous offenders with mental disorders resulting in limited or no criminal accountability.

Dutch criminal law distinguishes punishment and measures, with the first being retributive and the second reparative and preventive.[23] According to Article 39 of the Dutch Criminal Code, an offender who commits a crime but cannot be held responsible due to a mental disorder, psychogeriatric disorder, or intellectual disability, cannot be punished.[24] However, in such instances it is possible to impose a treatment measure. In addition, the possibility of diminished responsibility is recognised, enabling the imposition of punishment dependent on the attributable part of the offence, followed by treatment for the part of the offence for which the offender was not accountable.[25] The most extensive and invasive treatment measure that can be imposed is the TBS order.

TBS or *terbeschikkingstelling* can be translated as 'at the discretion of the state'. It entails compulsory treatment[26] of dangerous offenders, which can only be imposed when a mental disorder was present at the time of the offence and risk of reoffending exists.[27] In addition, the offence must be serious; a notion operationalised through the requirement that the maximum penalty carried by the offence is at least four years imprisonment.[28] If an offence did not result in (a threat of) bodily harm, the TBS order cannot exceed the duration of four years.[29] In other cases, the measure is reviewed every one or two years (depending on the original decision), resulting in either an extension or (conditional) termination of the TBS order. The mental health issue, the risk of recidivism and the course of treatment are the most important factors that determine the outcome of the review. Unconditional termination is only possible after a conditional termination of at least one year.[30] The main objective of the TBS order is to protect society from dangerous offenders. Forensic psychiatric treatment is directed at recovery resulting in a reduced risk of recidivism.[31] The need for resocialisation is thus framed in the light of protection of the victim of the crime and of society as a whole.

## 2.2 Possibilities for Victim-Offender Contact

Some people worry that a victim's only desire is to restrict freedoms of the offender.[32] However, we argue that this view, which strictly opposes rehabilitation to repression, takes too pessimistic a stance on victims' punitiveness.[33] Recovery of the victim and resocialisation of the offender do not have to be contradictory. We believe victims sharing their views and interests might provide opportunities to enhance both resocialisation and victim acknowledgement at the same time, if the victim can successfully inform how to shape conditions for further resocialisation possibilities.[34] In this section, we discuss the possibilities for victims to give input either via direct contact or indirectly through other agencies.



20 A. Buchanan and A. Grounds, 'Forensic Psychiatric and Public Protection', 198 *The British Journal of Psychiatry* 420 (2011).

21 See for overviews of European legislation: F. Dünkel, J. Jesse, I. Pruin & M. Von der Wense, *European Treatment, Transition Management, and Re-integration of High Risk Offenders* (2016); R. Edworthy, S. Sampson & B. Völlm, 'Inpatient Forensic-Psychiatric Care: Legal Frameworks and Service Provision in Three European Countries', 47 *International Journal of Law and Psychiatry* 18 (2016); Jehle et al., above n. 19.

22 Jehle et al., above n. 19, at 197.

23 F. Koenraadt and A. Mooij, 'Mentally Ill Offenders', in M. Boone and M. Moerings (eds.), *Dutch Prisons* (2007) 167, at 170.

24 See for information about the establishment of the mental disorder: T. Kooijmans and G. Meynen, 'Who Establishes the Presence of a Mental Disorder in Defendants? Medicolegal Considerations on a European Court of Human Rights Case', 8 *Frontiers in Psychiatry* 199 (2017).

25 A so-called combined sentence (*combinatievonnis*). It has been recommended to start treatment earlier, see Knoester and Boksem, above n. 5, at 242.

26 A discussion of the conditional TBS order – in which the actual measure will not be executed if certain conditions are met – is beyond the scope of this article.

27 Art. 37a(1)(1) Dutch Criminal Code; J. Bijlsma, E. Nauta, T. Kooijmans, F. de Jong, L. Dalhuisen & G. Meynen, 'Stoornis en gevaar. Een aanzet tot onderzoek naar een alternatief voor tbs', 25 *Delikt en Delinkwent* 357 (2020).

28 Or one of the offences explicitly added, such as reckless driving and stalking, see Art. 37a(1)(2°) Dutch Criminal Code.

29 Art. 38e(1) Dutch Criminal Code; this is the so-called maximised TBS (*gemaximeerde tbs*).

30 Art. 6:6:10(4) Dutch Criminal Code of Procedure.

31 See also Forensic Care Act (*Wet forensische zorg*), especially Art. 2.

32 Eg., J.J. Serrarens, 'Invoering spreekrecht slachtoffers bij tbs-verlengingszittingen: geen wenselijke ontwikkeling', 4 *Sancties* 24 (2021).

33 Mascini and Houtman, above n. 14.

34 Similarly, in clemency law: D. Pascoe and M. Manikis, 'Making Sense of the Victim's Role in Clemency Decision Making' 26 *International Review of Victimology* 3 (2020). Additionally, see the framework of Therapeutic Jurisprudence (TJ). P.H.P.H.M.C. van Kempen, 'Conflictoplossing, therapeutic jurisprudence en de modernisering van het Wetboek van Strafvordering', 50 *Delikt en Delinkwent* 409 (2020) describes TJ in relation to the Dutch code of criminal procedure.


doi: 10.5553/ELR.000200

*2.2.1 Indirect Victim-Offender Contact*

Victims have a right to be informed about the progress of the detention of the offender, as well as about the offender's (temporary and/or conditional) leave and release. The *Informatiepunt Dententieverloop* (IDV) is responsible for providing this information to the victim.[35] In addition to receiving information, in case of a TBS order, victims could also contact the ministry of Justice and Security to express their views on possible leave for the offender.[36] When leave is considered, a victim impact analysis must be conducted.[37] The *Adviescollege Verloftoetsing tbs* (AVT) advises the minister about leave and may include victims' needs in their assessment.[38] In this way, victims may indirectly provide input for specific protective measures which allow for leave but at the same time protect victims, such as protection orders.[39]

When the court reviews the conditional termination of the TBS order, the Dutch probation service may advise the court about the conditions of the termination, which happens in a procedure similar to the AVT-assessment described earlier.[40] Additionally, staff of the forensic psychiatric hospital may advise the court on the offenders 'environmental sensitivity', which includes sensitivity to the victims needs and views.[41] Research has shown that the clinic's advice carries much weight in the judge's risk assessment.[42]

Not all TBS treatment trajectories are successful in the sense that they reach the stage of conditional release, or even leave. From 2014, so-called *zorgconferenties* (translated as care conferences) have been developed. Identifying a need for a multidisciplinary intervention in cases in which the TBS order is frequently extended, *zorgconferenties* aim to tackle the main problems that arise in the treatment. The z*orgconferentie* may result in recommendations for the forensic psychiatric hospital for further treatment.[43] Victims do not play a direct role in the *zorgconferenties*, because there are no conditions that relate to their possible interaction with the offender at stake. It is, however, reasonable to assume that the experts in the *zorgconferentie* (e.g., direct caregivers, representatives of the ministry of Justice and Security) take into account victim sensitivity in these meetings.[44] Several authors have expressed their worries about current shortcomings in the information flow from the authorities to the victim and the opportunities for victims to express their views.[45] Indirect contact through agencies such as the IDV and the ministry of Justice and Security is dependent on regular contact between the victim and the agencies, high levels of involvement of agencies and careful 'translation' and management of the information.[46] Van Denderen and Van der Wolf warn that deficient communication may elicit defensive attitudes in victims resulting in alienation rather than reintegration,[47] which may explain the worries of authors emphasising victims' punitiveness.

*2.2.2 Direct Victim-Offender Contact*

There are various ways in which victims can directly have contact with an offender. Recently, the Extension of Victims' Rights Act was adopted by the Dutch Senate.[48] In the near future, victims will become eligible to give a Victim Impact Statement when the conditional termination of the TBS order is discussed in court. This statement can only refer to the desired conditions of the termination.[49] This new opportunity for victim participation has sparked a sharp debate in the literature about the extent to which victims' voices should play a role in the termination of the order.[50] Opponents refer to victims' punitiveness hindering the possibilities for offenders to reintegrate into society, while proponents emphasise that successful reintegration requires a safe environment for both victim and offender, as well as possibilities for communication about safety between the two.

An even more direct way for the victim and offender to interact is through mediation.[51] There are different forms of mediation. In earlier phases of the criminal proceedings, formal mediation is an option. In this respect *mediation* is defined as direct victim-offender contact in the presence of a *certified* mediator aimed at *making legally relevant agreements*, for example about compensation or contact after the proceedings. In the TBS

35 A.S. Koek, 'Recht doen aan slachtoffers, recht doen aan de TBS-behandeling', 31 *Sancties* 218 (2015).

36 Serrarens, above n. 32, at 25. Victim Support may assist the victims in communicating their needs, see F.J.H. Hovens, 'Inspraak over voorwaarden bij tbs; spreekrecht om het spreekrecht?', 3 *Sancties* 17 (2021).

37 Art. 1(f) Leave rules Tbs (*Verlofregeling Tbs*); S. Leferink and D. Peterse, 'De positie van het slachtoffer in de executiefase', 29 *Sancties* 193 (2015), at 203; Van Denderen and Van der Wolf, above n. 6. Prior to implementation of this instrument, some forensic hospitals had a tradition of contacting the victims or their general practitioner to consider their protection needs in case of leave, see: A. Goosensen, I. Jeandarme, J. van Vliet & K. Oei, 'Het slachtoffer: centraal voor het wetenschappelijk werk van Marc Groenhuijsen?', in T. Kooijmans, J. Ouwerkerk, C. Rijken & J. Simmelink (eds.), *Op zoek naar evenwicht. Liber Amicorum Marc Groenhuijsen* (2021) 267, at 268.

38 Serrarens, above n. 32, at 25.

39 See for the effectiveness of protection orders: I. Cleven, T. Fischer & S. Struijk, 'In het belang van het slachtoffer. De bijdrage van strafrechtelijke contact-locatie- en gebiedsverboden aan de veiligheidsbeleving van slachtoffers van geweldsdelicten en stalking', 62 *Tijdschrift voor Criminologie* 11 (2020).

40 Serrarens, above n. 32, at 25.

41 Hovens, above n. 36.

42 Van Spaendonck, above n. 8, at 206.

43 Knoester and Boksem, above n. 5, at 245; P. Oosterom, B. Bezemer & J.A.W. Knoester, 'Zorgconferenties in de tbs – ervaringen opgedaan in het project 15-plus', 2 *Strafblad* 32 (2019); RSJ, *Langdurig in de tbs. Stagnatie in de door- en uitstroom van de ter beschikking gestelden* (2020).

44 Van Denderen and Van der Wolf, above n. 6, at 29 state that when victims may play a role in the resocialisation of the offender, they will be taken into account in the treatment.

45 Bosma, Groenhuijsen & De Vries, above n. 11, at 17 and Van Denderen and Van der Wolf, above n. 6, at 31.

46 Van Kempen, above n. 34.

47 Van Denderen and Van der Wolf, above n. 6.

48 *Stb.* 2021, 220, *Wet uitbreiding slachtofferrechten.*

49 Art. 6:6:13(4) Dutch Criminal Code of Procedure (new).

50 See for example Bosma, Groenhuijsen & De Vries, above n. 11; J. Claessen, A.P.L. Pinkster & G.J. Slump, 'De mogelijke meerwaarde van mediation in de tenuitvoerleggingsfase', 2 *Sancties* 5 (2021); Hovens, above n. 36; A. Pemberton, 'Een victimologisch fundament voor het strafrecht: vergelden, verbinden, verhalen', 51 *Delikt en Delinkwent* 604, at 616-617 (2021); Serrarens, above n. 32; Van Spaendonck, above n. 8, at 125.

51 G.J. Slump, 'Herstelgerichte detentie in Nederland 2017', 3 *Tijdschrift voor Herstelrecht* 54 (2017), Van Denderen and Van der Wolf, above n. 6.



doi: 10.5553/ELR.000200

phase, only a more informal type of mediation (in Dutch: *bemiddeling*) is available. *Bemiddeling*, like mediation, entails direct victim-offender contact in the presence of a mediator, but this mediator does not have to be certified and the parties cannot make legally relevant agreements. Claessen and colleagues argue for the implementation of formal mediation in the TBS setting, because there are still relevant opportunities for making agreements, which could be considered in, for example the conditional termination of the TBS order.[52] In the literature, the importance of tailor-made arrangements for this type of contact is underlined. Participation in mediation should be entirely voluntary, and victims should also be able to determine when and how this contact should take place.[53] This attention for an individualised approach can also be seen in the recently developed guideline on victim awareness for forensic social workers (*Handreiking slachtofferbewust werken*).[54] This guideline is developed within the forensic psychiatric field of work and aims to raise professional awareness for the needs of victims in the context of forensic mental health care underlining the importance of victim-offender contact. There are three phases to accommodate this contact: first the assessment of victims' risks and needs, second, the preparation of the contact, and finally the execution and finalisation of the contact.

In sum, the opportunities for victims to express their views and interests in the context of the TBS order, whether direct or indirect via the IDV or law enforcement agencies, almost exclusively relate to the conditions that may be imposed when extending the freedom of the offender. Extending the freedom of the offender in small steps through conditional leave and in bigger steps when the conditional termination of the TBS order is granted is important for resocialisation. Indeed, an important aim of the TBS order is to prepare for a return of the offender to society when recovered. At the same time, protection of the victim and of society is still required. In the next section, we will discuss the vulnerabilities of the TBS population, which impacts possibilities for resocialisation and victim-offender contact.



# 3 Offenders With Mental Disorders

Various mental health disorders demand different approaches when it comes to victim-offender contact and have their own risks and opportunities. These risks and opportunities are (co)dependent on the characteristics of the offender population. In this paragraph, we will outline the most commonly found offender types or subgroups and their characteristics to give more insight into the specific disorders.

## 3.1 Typology

The group of dangerous offenders suffering from mental disorders residing in forensic mental health facilities in the Netherlands is not homogeneous. Various studies on TBS found clear differences in the patient population regarding diagnoses and offences.[55] These studies aimed at shedding light on the specific subgroups that can be found within the TBS population. Table 1 gives a brief overview of their findings and the parallels that can be seen.

52 Claessen, Pinkster & Slump, above n. 50.

53 M. Wouters, 'Herstelbemiddeling: het belang van maatwerk bij contact tussen slachtoffer en dader', 6 *Sancties* 39 (2021).

54 M. van Denderen, N. Verstegen, V. de Vogel & L. Feringa, *Handreiking Slachtofferbewust Werken voor Forensisch Maatschappelijk Werkers* (2019). www.kfz.nl/projecten/call-2016-60, last accessed 14 March 2022..

55 S. Bogaerts and M. Spreen, *Persoonlijkheidspathologie, slachtofferschap vóór het 18e levensjaar, huiselijk geweld en delictinformatie in een klinische groep terbeschikkinggestelden* (2011); C.H. van Nieuwenhuizen, S. Bogaerts, E.A.W. de Ruijter, I.L. Bongers, M. Coppens & R.A.A.C. Meijers, *TBS-behandeling geprofileerd. Een gestructureerde casussenanalyse* (2011); F.C.A. van der Veeken, S. Bogaerts & J. Lucieer, 'Patient Profiles in Dutch Forensic Psychiatry Based on Risk Factors, Pathology, and Offense', 61 I*nternational Journal of Offender Therapy and Comparative Criminology* 1369 (2015).



doi: 10.5553/ELR.000200

*Table 1 Subgroups of Offenders Found Within Dutch TBS Hospitals*

| **Study** | **Van Nieuwenhuizen et al. (2011)** | **Bogaerts and Spreen (2011)** | | **Van der Veeken et al. (2015)** |
|---|---|---|---|---|
| | | **Study 1** | **Study 2** | |
| **Grouping based on** | Primary diagnoses and index offence | Risk and protective factors | | Diagnoses, crimes committed, risk factors |
| **Partici-pants** | Patients residing in 13 TBS hospitals (N=176) | Psychotic patients residing in 5 TBS hospitals (N=234) | Personality disordered patients residing in 5 TBS hospitals (N=348) | Patients residing in 2 TBS hospitals (N=244) |
| **Groups found** | 1)* **Psychotic** patients with **multiple problems**; some types of psychotic disorders are combined with a **personality disorder**. Offences are diverse, but the use of (sexual) violence is striking | 3)* Patients with **psychotic symptoms**, severe mental illness and **personality disorders** | - | 2)* **Mixed profile** patients with multiple problems, with both cluster B** **personality disorders** and comorbid **psychotic disorders** or **substance use** disorders |
| | 2)* **Antisocial** patients; in whom antisocial behaviour combined with severe substance abuse is dominant and a **personality disorder in cluster B**** is mostly present. Offences are diverse but most patients have committed murder/ homicide | - | 4)* **Antisocial** patients with a **cluster B**** **personality disorder**, high impulsivity and hostility | 1)* **Antisocial** patients mostly with a **cluster B**** **personality disorder** |
| | 3)* **Prototypical psychotic** patients; in whom the psychotic disorder is dominant, personality disorders are less often found and offences are mostly very serious | 1)* **Pure psychotic patients** with low risks on other factors | - | 4)* **Psychotic** first offenders |
| | 4)* Patients with **sexual problems** and sexual offending | - | - | 3)* Maladaptive affective disordered patients, suffering mostly from **paedophilia or pervasive developmental disorders** and/or a **personality disorder not otherwise specified** |
| | 5)* Patients with **substance use** related disorders in combination with a **personality disorder** not otherwise specified with a diverse pattern of offending | 2)* **Psychotic patients** with high historical risk factors and **comorbidity** | 5)* **Mixed profile** with high **comorbidity** and current and past **psychotic symptoms** | 2)* **Mixed profile** patients with multiple problems, with both **cluster B**** **personality disorders** and **comorbid psychotic disorders** or **substance use disorders** |
| | - | - | 6)* **Lower risk personality disordered** patients with no psychotic disorders at present or in the past | - |

* Numbering in this table corresponds to the labels given to the classes/clusters in the original studies.
** See Section 3.3 for a description of the various clusters in which personality disorders can be divided.

Some distinct offender groups or clusters residing within Dutch TBS hospitals can be found. First, the 'purely' psychotic patients without a very disturbed past and second, the patients with personality disorders, in particular those with antisocial traits. It should be noted that until 2013, the *Dienst Justitiële Inrichtingen* (DJI;



doi: 10.5553/ELR.000200

Custodial Institutions Agency), an agency under the responsibility of the Dutch Ministry of Justice and Security that is primarily tasked with the realisation of detention of convicted offenders,[56] defined the TBS population based on comparable diagnostic groups, namely psychotic disorders (about 67% of the population) and personality disorders (about 33% of the population).[57] However, based on the academic literature, a third group can be discerned, namely the patients with a more mixed profile, with high levels of comorbidity including addictive disorders.

Even though we focus on the Dutch population, evidence suggests that populations in forensic psychiatric hospitals are similar across countries. Studies conducted in Canada, New Zealand, the United States and Austria show psychotic disorders as most common, followed by personality disorders, and high rates of comorbid substance abuse.[58] However, in the Dutch population personality disorders are more prevalent in patients residing in forensic psychiatric hospitals than in most other European countries.[59]

So, although the group of forensic psychiatric patients is heterogeneous, certain profiles can be discerned. The next sections will pay specific attention to offenders suffering from the most prevalent disorders found in forensic mental health hospitals: (1) patients with psychotic disorders, (2) patients with (antisocial) personality disorders and (3) those suffering from comorbidity including substance abuse disorders.[60] Although the third group is far less clear-cut than the first two, and a description is much more difficult to provide, we will include this third diffuse group in our article because of its practical and clinical relevance.[61] Per group a brief description of relevant characteristics of the disorders is provided.



### 3.2 Patients With Psychotic Disorders

Patients with psychotic disorders[62] suffer from a mental condition that affects the way they perceive reality, the way they think and the way they feel.[63] They experience various symptoms that are grouped into four clusters. Symptoms from the first cluster, labelled psychotic symptoms, are always present and are often combined with one or more symptoms from the following clusters: negative symptoms, cognitive symptoms and affective symptoms.[64] We will discuss these four symptom clusters in more detail to give more insight to the main characteristics of this patient population.

*Psychotic symptoms* comprise delusions, hallucinations, disorganised speech, and disorganised behaviour or catatonia.[65] Delusions relate to the content of thought; the patient has false beliefs about reality which are unlogic and unfounded, yet the patient cannot be convinced that the belief is faulty even when presented with clear conflicting evidence.[66] Examples are persecutory delusions, in which a patient thinks that he is being haunted by for instance the secret service, or delusions of grandiosity, where a patient believes to be 'special' or 'chosen' (e.g. the saviour of the world). Hallucinations relate to false sensory perceptions, so hearing, feeling, seeing, smelling or tasting things that are not actually present. Hearing voices is a clear example and also the most frequently found type of hallucination.[67] When patients experience disorganised speech, they are incoherent in their communication and difficult to follow, often associatively changing from one theme to another. Disorganised behaviour can be displayed by being very hyperactive, or the complete opposite with no movement at all or a cramped posture (catatonia). Apart from psychotic symptoms, patients can experience symptoms from other clusters. *Negative symptoms*, such as diminished emotional expression and a lack of motivation and initiative mean that normal functions are lost or greatly diminished, hence the label 'negative'.[68] Patients often also experience *cognitive symptoms*, relating to attention, memory, problem solving, concentration and planning. Finally, a psychotic episode can cause emotional disturbance, resulting in feelings of anxiety, depressed mood, or a more general emotional disbalance (*affective symptoms*).

In short, patients with psychotic disorders perceive reality in a different manner and interpret their perceptions differently. This makes it difficult to level and interact

56 www.dji.nl/english.

57 DJI. *Forensische zorg in getal. 2009-2013*. Den Haag: DJI (2014); M.H. Nagtegaal, K. Goethals & G. Meynen, 'De tbs-maatregel: kosten en baten in perspectief', 58 *Tijdschrift voor Psychiatrie* 739 (2016).

58 E.M. Jansman-Hart, M.C. Seto, A.G. Crocker, T.L. Nicholls & G. Côté, 'International Trends in demand for Forensic Mental Health Services', 10 *International Journal of Forensic Mental Health* 326, at 328 (2011).

59 With the exception of Germany; C.H. de Kogel, M.H. Nagtegaal, E. Neven & G. Vervaeke, *Gewelds- en zedendelinquenten met een psychische stoornis. Wetgeving en praktijk in Engeland, Duitsland, Canada, Zweden en België* (2006), at 20-21; H.J. Salize and H. Dressing, *Placement and Treatment of Mentally-ill Offenders. Legislation and Practice in Member States* (2005), at 236.

60 These are the most commonly found disorders, but the list is not exhaustive. Apart from these three groups, offenders suffering from other disorders such as pervasive developmental disorders (e.g. autism) or mood disorders (e.g. depression) and distinct groups based on type of offence (e.g. sexual offenders, fire setters) can be identified.

61 Most violent offenders have multiple psychiatric diagnoses and studies describe comorbid substance abuse in 50-80% of forensic psychiatric patients; T.Z. Palijan, L. Mužinić & S. Radeljak, 'Psychiatric Comorbidity in Forensic Psychiatry', 21 *Psychiatria Danubina* 429 (2009).

62 In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a manual used worldwide with diagnostic criteria for psychiatric illnesses, psychotic disorders are grouped together in the category 'Schizophrenia spectrum and other psychotic disorders' comprising schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, psychotic disorder due to another medical condition, substance/medication-induced psychotic disorder, unspecified schizophrenia spectrum and other psychotic disorder, and other specified schizophrenia spectrum and other psychotic disorder; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (2013).

63 www.ggzstandaarden.nl/zorgstandaarden/psychose/over-psychotische-stoornissen/over-psychotische-stoornissen.

64 J.S. Nevid, S.A. Rathus & B. Greene, *Psychiatrie een inleiding* (2021), at 368.

65 www.ggzstandaarden.nl/zorgstandaarden/psychose/over-psychotische-stoornissen/over-psychotische-stoornissen.

66 American Psychiatric Association, above n. 62.

67 S. McCarthy-Jones, et al., 'Occurrence and Co-occurrence of Hallucinations by Modality in Schizophrenia-Spectrum Disorders', 252 *Psychiatry Research* 154 (2017).

68 www.ggzstandaarden.nl/zorgstandaarden/psychose/over-psychotische-stoornissen/over-psychotische-stoornissen.


doi: 10.5553/ELR.000200

with them. However, it must be noted that patients are not psychotic all the time. Acute episodes are often interspersed with episodes in which psychotic symptoms are less obvious or even absent. Yet, cognitive, social and emotional problems remain present and hamper the patient significantly.[69]

### 3.3 Patients With Personality Disorders

Every person is a unique mix of various personality characteristics or personality traits, such as courage, jealousy, impulsiveness, extraversion and so forth, which make up who we are. These traits can be described as 'enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts'.[70] Normally, we function quite well with them. However, when these personality traits are inflexible and maladaptive, resulting in functional impairment or personal distress, it constitutes a personality disorder. So, a person with a healthy personality is able to adapt his behaviour to specific circumstances or a specific situation, allowing that person to function well and feel good about himself. However, persons with personality disorders cannot adapt to specific situations because they have a maladaptive enduring pattern of inner experience and behaviour involving how they think, feel, interact and/or control their impulses that is rigid and pervasive across a broad range of various situations.[71]

There are ten specific personality disorders that can be discerned, divided into three clusters based on descriptive similarities.[72] Cluster A comprises the paranoid, schizoid and schizotypical personality disorders. These three personality disorders are grouped together because patients with these disorders often show strange or eccentric behaviour.[73] The paranoid personality disorder is best characterised by a deep-felt mistrust and suspiciousness towards others, who are seen as malicious. Patients with a schizoid personality disorder generally lack interest in social contact and are emotionally aloof. Rather than a disinterest in social relationships, close relationships result in acute discomfort for persons with a schizotypical personality disorder, they also show eccentric behaviour and have cognitive or perceptual distortions.

Cluster B personality disorders are characterised by dramatic, emotional or whimsical behaviour and persons with these types of personality disorders can be described as troublemakers.[74] The antisocial personality disorder is described as 'a pattern of disregard for, and violation of, the rights of others'.[75] Patients with borderline personality disorder are unstable in their relationships, their self-image and their emotions, and can be very impulsive. The histrionic (theatrical) personality disorder is characterised by attention seeking behaviour and extreme emotionality. Finally, feeling grandiose, needing admiration and lacking empathy are characteristics for the narcissistic personality disorder.

Cluster C personality disorders are grouped together because they all involve nervous and anxious behaviour. The avoidant personality disorder results in social withdrawal, out of fear of rejection and a feeling of inadequacy. Patients with a dependent personality disorder have an excessive need to be taken care of by a significant other, towards whom they show submissive and clinging behaviour. Patients with an obsessive-compulsive personality are preoccupied with orderliness, perfectionism and control.[76]

Although most patients with personality disorders do not commit offences, patients with a personality disorder in cluster B, especially those with a borderline or antisocial personality disorder, are most at risk of offending. In these disorders, symptoms like poor impulse control and dysregulated mood states heighten the risk of violence.[77] This risk increases even more when there is a comorbid disorder present, like schizophrenia or substance abuse, that are in themselves also associated with violence.[78] These more complex cases of patients are discussed in the next section.

### 3.4 Patients With Comorbidity Including Addictive Disorders

Comorbidity can be defined as 'the presence of more than one specific disorder in a person in a defined period of time'.[79] In the context of forensic psychiatry, comorbidity refers to the co-occurrence of two or more psychiatric disorders. Comorbidity is a common phenomenon in forensic psychiatry, with the majority of violent offenders having multiple psychiatric diagnoses.[80] Of these diagnoses, the co-occurrence with addictive disorders is of particular interest, with studies showing high rates of comorbidity between substance abuse and psychotic disorders, and substance abuse and personality disorders, in particular the antisocial personality disorder.[81] In the various studies looking at the TBS population in the Netherlands, this mixed patient category was indeed also found. These studies show that comorbidity is related to a multitude of problems, such as an early onset of antisocial behaviour and other historical risk



69 Nevid, Rathus & Greene, above n. 64, at 366.
70 American Psychiatric Association, above n. 62, at 647.
71 American Psychiatric Association, above n. 62.
72 Interested readers are referred to the DSM-5 for a more detailed description of all ten personality disorders; American Psychiatric Association, above n. 62.
73 Nevid, Rathus & Greene, above n. 64, at 403.
74 Nevid, Rathus & Greene, above n. 64, at 407.
75 American Psychiatric Association, above n. 62, at 645.
76 *Ibid.*
77 N. Eastman, G. Adshead, S. Fox, R. Latham & S. Whyte, *Forensic Psychiatry* (2012), at 58-59.
78 *Ibid.*, at 59.
79 H.U. Wittchen, 'Critical Issues in the Evaluation of Comorbidity of Psychiatric Disorders', 168 *British Journal of Psychiatry* 9, at 9 (1996).
80 Palijan, Mužinić & Radeljak, above n. 61.
81 J.R.P. Ogloff, D. Talevski, A. Lemphers, M. Wood & M. Simmons, 'Co-occurring Mental Illness, Substance Use Disorders, and Antisocial Personality Disorder Among Clients of Forensic Mental Health Services', 38 *Psychiatric Rehabilitation Journal* 16 (2015).

factors, and high dynamic risk factors such as lack of empathy and stressful circumstances.[82]

Although we did not describe specific characteristics of a particular diagnostic category in this section, we want to draw attention to the complex reality of patients suffering from a combination of disorders. In practice, sayings like *double trouble* or *triple cripple* are well-known and refer to the more problematic treatability of patients with multiple and mutually interfering diagnoses.[83] The complexity of this particular group of patients is something that must be taken into account when thinking about victim-offender contact.

# 4 Risks and Opportunities

Now that we have discussed the characteristics of the specific offender population from a forensic mental health perspective,[84] we will discuss the possible consequences of these characteristics for victim-offender contact within the framework of resocialisation. We will first outline general considerations for victim-offender contact from a victimological perspective. Subsequently, we will discuss the specific risks and opportunities in contact with specific offender groups, also paying attention to the specific category of related victims.

## 4.1 General Considerations in Victim-Offender Contact



Over the last decades, the victims' position in the criminal justice procedure has been gradually extended. In the Netherlands, victims have gained more agency in the criminal proceedings, including the post-trial phase.[85] The number of opportunities to, either directly or indirectly, interact with the offender has increased. The purpose of the extension of victims' rights is to enhance victims' acknowledgement and safety, and to avoid secondary victimisation. Successful acknowledgement depends on feedback: the victim should be aware that his or her input was heard and understood,[86] highlighting the need for communication back and forth – either directly or indirectly.

Victims' rights have been developed and shaped towards a specific type of victim interacting with a specific type of defendant or offender. The prototypical victim is passive, disempowered and vulnerable – hence in need of protection – but also compassionate and willing to forgive.[87] In restorative justice settings, the willingness and ability to communicate with the offender is stressed even more.[88] This type of 'ideal' victim is to interact with an offender who takes direct responsibility and subsequently is willing and able to show remorse, heal and avoid reoffending.[89] It is thus expected that victim-offender contact poses opportunities for reliable information, dialogue, restoration (e.g. compensation, apology and forgiveness, etc.), and ultimately resocialisation.

There are, of course, also risks: victim-offender contact that does not result in acknowledgement may on the contrary result in secondary victimisation.[90] And for the offender, a disbalanced focus on victims' needs combined with a victim who is not open to rapprochement can prioritise restrictions and negatively influence resocialisation. As noted, this may in turn heighten the risk of reoffending.[91]

In sum, victim-offender contact may result in acknowledgement and facilitate resocialisation, but victim-offender contact also poses risks for the well-being of both victims and offenders. The latter is especially true when the contact involves offenders with mental disorders.

## 4.2 Specific Considerations Regarding Offenders in Forensic Mental Health Hospitals

Offenders suffering from a mental disorder do not conform to the ideal offender stereotype. By definition, the TBS order is imposed on an offender who cannot take full responsibility for the crime committed. However, symptoms of disorders such as difficulties in social and emotional processing do not necessarily provide contra indications for victim-offender contact.[92] Practice-based evidence has shown that even direct victim-offender contact can successfully take place within the context of a secure hospital environment.[93] To ensure successful victim-offender contact, it is paramount that the specific characteristics of this offender population are taken into account. According to Van Denderen and colleagues the most important considerations are: the often-limit-

82 Bogaerts and Spreen, above n. 55; Van Nieuwenhuizen et al., above n. 55; Van der Veeken, Bogaerts & Lucieer, above n. 55.

83 J. van Mulbregt and F. Koenraadt, 'Het bereik van zelfintoxicatie: allesbehalve een vrijbrief', 62 *Ars Aequi* 750 (2013).

84 Note that it goes beyond the scope of this paper to also address specific mental health challenges of victims. It is worthwhile for future research to investigate the victim population in more detail, including mental health challenges like PTSS, which could also impact victim-offender contact.

85 Bosma, Groenhuijsen & De Vries, above n. 11.

86 T. Booth, A.K. Bosma & K.M.E. Lens, 'Accommodating the Expressive Function of Victim Impact Statements: The Scope for Victims' Voices in Dutch Courtrooms', 58 *British Journal of Criminology* 1480 (2018).

87 G. Maglione, 'Embodied Victims: An Archaeology of the 'Ideal Victim' of Restorative Justice', 17 *Criminology & Criminal Justice* 401, at 403 (2017); J. van Dijk, 'Free the Victim: A Critique of the Western Conception of Victimhood', 16 *International Review of Victimology* 1, at 22 (2009).

88 I. Aertsen, 'Recalibrating Victimhood through Restorative Justice: Perspectives from Europe', 5 *Restorative Justice* 352, at 357 (2017).

89 G. Maglione, 'Immature Offenders. A Critical History of the Representations of the Offender in Restorative Justice', 21 *Contemporary Justice Review* 44 (2018).

90 U. Orth, 'Secondary Victimization of Crime Victims by Criminal Proceedings', 15 *Social Justice Research* 313, at 316 (2002).

91 United Nations Office on Drugs and Crime (UNODC), *Introductory Handbook on the Prevention of Recidivism and the Social Reintegration of Offenders* (2012).

92 J. Tapp, E. Moor, M. Stephenson & D. Cull, "The Image Has Been Changed in My Mind': A Case of Restorative Justice in a Forensic Mental Health Setting', 22 *The Journal of Forensic Practices* 213 (2020).

93 A. Cook, G. Drennan & M. Callanan, 'A Qualitative Exploration of the Experience of Restorative Approaches in a Forensic Mental Health Setting', 26 *The Journal of Forensic Psychiatry & Psychology* 510 (2015); M. van Denderen, N. Verstegen, V. de Vogel & L. Feringa, 'Contact between Victims and Offenders in Forensic Mental Health Settings: An Exploratory Study', 73 *International Journal of Law and Psychiatry* 1 (2020).


doi: 10.5553/ELR.000200

ed problem awareness and lack of reflective abilities; the unstable psychiatric or physical conditions of mentally disordered offenders; and their (in)capacity to keep agreements.[94]

When these considerations are kept in mind, it is then paramount to promote engagement from all parties involved. Motivation to repair the relationship combined with trust in the facilitator and in the process are important factors in this respect. This trust can be enhanced by providing accurate information and designing the contact in a structured manner.[95] This corresponds to the first of three ways in which difficulties in victim-offender contact can be counteracted, according to Van Denderen and colleagues, namely detailed preparation and managing the expectations of victims and offenders. Second, practitioners must make sure that the type of contact is appropriate. Practitioners may find a letter preferable over direct face-to-face contact because it allows for more careful monitoring of the content. Third, practitioners must not be afraid to forbid contact when necessary to protect victim and/or offender, for example when there are restraining orders in place or when further harm is expected for the victim because of insincere offenders.[96] In the following subsections, per group of offenders, relevant offender characteristics and corresponding risks and opportunities for victim-offender contact are discussed.

#### *4.2.1 Psychotic Disorders and Victim-Offender Contact*

Offenders suffering from psychotic disorders may have unstable emotions and perceptions. The extent to which victim-offender contact is possible depends on the state of the offender, requiring a flexible attitude of the victim. Especially during an acute psychotic episode, direct victim-offender contact is not desirable. A complete lack of reason combined with hyperactive behaviour or catatonia does not reflect an adequate attitude to engage in victim-offender contact. Psychotic symptoms may complicate communicative abilities and hamper the ability of offenders to comprehend the harm caused and the demands made by their victims, making restoration via more indirect manners such as a letter also difficult.[97] When an offender does not comprehend the harm caused, it is likely that a response to a Victim Impact Statement would not be favourable either, as research has highlighted the start of a dialogue as the factor which makes such a statement effective.[98] If an offender stabilises over time, the victim-offender contact can be started or resumed. This requires flexibility on the side of the victim, who may have to wait for an unknown period of time to start or resume contact, and may have to reschedule on short notice.

If victim-offender contact is established, it is important to take into account the nature of the psychotic symptoms. Often, patients are very distrustful of others. It is then useful to design the contact in such a manner that not only the victim, but also the offender feels reassured and heard, increasing the chance of acceptance of responsibility and the expression of remorse. When the mental condition stabilises, remorse can be genuine and apologies sincere. However, psychotic offenders often lack insight in their mental condition and its relationship to their offence,[99] and may therefore be unable to give (full) insight in the by victims often sought-after information on why they were victimised.[100] However, giving the offender a voice can enhance victims' knowledge about the mental disorder and its symptoms.[101] Managing the expectations of victims beforehand and explaining the mental disorder to them is also significant in this respect.[102] As the mental state of the offender may fluctuate in psychotic patients, indirect information exchange and expectation management via the IDV can only be successful if the IDV is in close contact with both the victim and the forensic mental health hospital.

#### *4.2.2 Personality Disorders and Victim-Offender Contact*

In the personality disordered offender group, limited problem awareness and reduced reflective abilities are most notable. Especially offenders with a more antisocial personality generally lack problem awareness.[103] They do not feel that they did something wrong or blame the victim out of general contempt for others and have a persistent lack of empathy.[104] In offenders who lack empathy and problem awareness, it is paramount to carefully manage victims' expectations beforehand and explain the continuous nature of the challenges of victim-offender contact. Unlike psychosis, a personality disorder is not episodic but a stable condition. What is more, personality disorders are often difficult to treat, although some progress can be made.[105]

Victims must be informed about the possibility that an apology or expression of remorse is instrumental and not sincere.[106] However, receiving an apology is not the only goal of victim-offender contact. In a preparatory

94 Van Denderen, Verstegen, De Vogel & Feringa, above n. 93.
95 Cook, Drennan & Callanan, above n. 93, at 517.
96 In the Guideline victim awareness, the type of contact is made dependent on the mental disorder of the offender (Guideline at 31); Van Denderen, Verstegen, De Vogel & Feringa, above n. 93, at 5.
97 Van Denderen, Verstegen, De Vogel & Feringa, above n. 93, at 4.
98 Booth, Bosma & Lens, above n. 86.
99 M. Garrett and M. Lerman, 'CBT for Psychosis for Long-term Inpatients with a Forensic History', 58 *Psychiatric Services* 712 (2007); H. Walker, L. Tulloch, M. Ramm, E. Drysdale, A. Steel, C. Martin, G. MacPherson & J. Connaughton, 'A Randomised Controlled Trial to Explore Insight into Psychosis; Effects of a Psycho-education Programme on Insight in a Forensic Population', 24 *The Journal of Forensic Psychiatry & Psychology* 756 (2013).
100 R. Morris, 'Two Kinds of Victims: Meeting their Needs', 9 *Journal of Prisoners on Prisons* 93 (1998); A. Pemberton, P.G.M. Aarten & E. Mulder, 'Stories as Property: Narrative Ownership as a Key Concept in Victims' Experiences with Criminal Justice', 19 *Criminology & Criminal Justice* 404, at 414 (2019).
101 T.L. Hafemeister, S.G. Garner & V.E. Bath, 'Forging Links and Renewing Ties: Applying the Principles of Restorative and Procedural Justice to Better Respond to Criminal Offenders with Mental Disorder', 60 *Buffalo Law Review* 147, at 204 (2012)
102 Van Denderen, Verstegen, De Vogel & Feringa, above n. 93.
103 *Ibid.*
104 Eastman et al., above n. 77, at 61.
105 A.W. Bateman, J. Gunderson & R. Mulder, 'Treatment of Personality Disorder', 385 *The Lancet* 735 (2015).
106 Van Denderen, Verstegen, De Vogel & Feringa, above n. 93.



doi: 10.5553/ELR.000200

conversation prior to direct (face-to-face) contact like mediation, it can be useful that the mediator discusses with victims what they can expect. Even if (sincere) apologies are not to be expected, victims can still benefit from a conversation, for example by receiving information and answers to some of their questions related to their victimisation. In some cases, it may be necessary to adjust the type of contact (e.g., change face-to-face contact in an exchange of letters), to prevent secondary victimisation.[107] For instance, when a reaction of an offender cannot be predicted or controlled, and an offender may act aggressively. It might also be necessary to limit victim-offender contact during leave or conditional release. This can be done via protection orders, for which victims can express their needs via the ministry of Justice and Security or IDV.

#### *4.2.3 Mixed Problems and Victim-Offender Contact*

In the more complex cases characterised by comorbidity, closely monitoring the victim-offender contact from the start to the evaluation is of importance. Especially high comorbidity with substance use is relevant in this respect, as it contributes to several circumstances that are less desirable when thinking about victim-offender contact. In general, compared to patients with a single disorder, patients with comorbidity show 'a more severe course of illness, more severe health and social consequences, more difficulties in treatment, and worse treatment outcomes'.[108] In offenders with personality disorders, comorbid addiction is also associated with a worse treatment outcome, more provocative behaviours during treatment, higher levels of treatment resistance and more difficulty forming interpersonal bonds (including with the therapist).[109] And in offenders with schizophrenia, addictive disorders are also related to poorer clinical outcomes, including violent behaviour.[110]

These less favourable circumstances are relevant when looking at the victim-offender contact from a resocialisation perspective. However, the notion of 'double trouble, triple cripple' does not automatically mean that victim-offender contact is not possible and could not promote the resocialisation of offenders. Nonetheless, it does demand extra effort from the practitioners facilitating the contact.[111] Parallel to treatment needs in this demanding group, this entails providing more structure and support.[112] Particularly in direct victim-offender contact such as mediation, the level of skill a practitioner has, can have an important effect on the outcome of the contact.[113] But also when only indirect contact is indicated, this offender group is most demanding, and one should always proceed with care to make sure the outcome of the interaction furthers resocialisation and does not result in secondary victimisation.[114] Adverse outcomes can have serious implications for this vulnerable offender group. Not only damaging ongoing treatment, but even increasing future risk and thereby lowering the chances of successful resocialisation.[115]

#### *4.2.4 Specific Considerations With Familiar Victims*

A complicating factor in victim-offender contact is the fact that a significant part of victims is known to the offender, with percentages of known victims ranging from 53% to 65%, and even 72% in female offenders.[116] Of particular interest are victims in the direct family such as (ex)partners, children, parents, and close family members, because they remain part of the offenders' social network. This group is smaller with percentages ranging from 21% to 37%,[117] but still relevant because these familial victims can play a direct role in therapy or risk management, as support from the social network is an important factor in resocialisation.[118] In case of familial victims the victim-offender contact can be beneficial for both the offender and the victim because of the restoration of family relationships and contact.[119] However, the family dynamics can also result in a more complicated victim-offender contact demanding a careful approach.

## 5 Closing Remarks

Resocialisation has gained considerable attention as an important aim of criminal sanctions. In a time in which victims' rights spread to all phases of the criminal procedure including the post-sentencing phase, this asks for a careful balancing of needs and interests of both victims and offenders. In this article, risks and opportunities for victims in contact with a particular and atypical offender population at this post-sentencing phase are discussed. There are various ways in which victims can have contact with offenders in the context of a TBS order, either directly or indirectly, such as a right to in-

107 A. Pemberton, F.W. Winkel & M.S. Groenhuijsen, 'Taking Victims Seriously in Restorative Justice', 3 *International Perspectives in Victimology* 4 (2007).
108 D. Morisano, T.F. Babor & K.A. Robaina, 'Co-occurrence of Substance Use Disorders with Other Psychiatric Disorders: Implications for Treatment Services', 31 *Nordic Studies on Alcohol and Drugs* 5, at 5 (2018).
109 T.J. Trull, M.B. Solhan, W.C. Brown, R.L. Tomko, L. Schaefer, K.D. McLaughlin & S. Jahng, 'Substance Use Disorders and Personality Disorders', in K.J. Sher (ed.), *The Oxford Handbook of Substance Use and Substance Use Disorders* (2016) 116, at 142.
110 K. Kivimies, E. Repo-Tiihonen, H. Kautiainen & J. Tiihonen, 'Comorbid Opioid Use Is Undertreated among Forensic Patients with Schizophrenia', 13 *Substance Abuse Treatment, Prevention, and Policy* 1 (2018).
111 Cook, Drennan & Callanan, above n. 93.
112 Trull et al., above n. 109.
113 J.S. Kenney and D. Clairmont, 'Using the Victim Role as Both Sword and Shield: The Interactional Dynamics of Restorative Justice Sessions', 38 *Journal of Contemporary Ethnography* 279 (2009).
114 Pemberton, Winkel & Groenhuijsen, above n. 107.
115 Cook, Drennan & Callanan, above n. 93, at 525,
116 De Vogel and De Spa, above n. 18; K.R. Goethals, W.J.P. Gaertner, J.K. Buitelaar & H.J.C. van Marle, 'Targets of Violence and Psychosocial Problems in Psychotic Offenders Detained under the Dutch Entrustment Act', 19 *The Journal of Forensic Psychiatry & Psychology* 561 (2008); H. Nijman, M. Cima & H. Merckelbach, 'Nature and Antecedents of Psychotic Patients' Crimes', 14 *The Journal of Forensic Psychiatry & Psychology* 542 (2003).
117 De Vogel and De Spa, above n. 18; Goethals et al., above n. 116.
118 Y.H. Bouman, M. van der Logt & B.H. Bulten, 'Desistance by Social Context in Forensic Psychiatry' in T.I. Oei and M.S. Groenhuijsen (eds.), *Progression in Forensic Psychiatry* (2012) 397.
119 Van Denderen, Verstegen, De Vogel & Feringa, above n. 93.




doi: 10.5553/ELR.000200

formation about leaves and release, and the upcoming possibility to give a Victim Impact Statement when the conditional termination of the TBS order is discussed in court.

However, in the implementation of the possibilities that victims have to interact with an offender within a forensic psychiatric context, the specific offender population must be taken into account. Offenders residing in TBS hospitals are classified as dangerous, diagnosed with one or more mental disorders and lack (full) criminal responsibility. These characteristics can heighten the risk of unsuccessful or even counterproductive victim-offender contact. However, when these risks are counterbalanced by careful preparation, the management of expectations and choosing the right type of contact, much is possible.[120]

At first glance it may seem that resocialisation of the offender and respecting the rights of the victim are two opposing objectives. Yet, keeping in mind the states' obligation to prepare the offender for a safe return in society, successful resocialisation is key. Carefully executed victim-offender contact, mindful of the particularities of the specific type of offender, can contribute to this, also within the context of a forensic mental health hospital.



120 Cook, Drennan & Callanan, above n. 93, at 517; Van Denderen, Versteegen, De Vogel & Feringa, above n. 93, at 5.