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# RECIDIVISM

among psychiatric offenders

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# RECIDIVISM AMONG PSYCHIATRIC OFFENDERS DETAINED AT THE GOVERNMENT'S PLEASURE (‘TBR’)

A Summary of a survey of persons who were discharged between  
1974 and 1979

by Drs. Jos van Emmerik

## 1. Subject and purpose of survey

One of the ways in which the Dutch criminal courts can deal with an offender is by detaining him (her) at the government's pleasure (‘TBR’); the other options include imposing a prison sentence. A TBR may be made in cases where:

(a) a person has committed a certain offense\* but is not liable to punishment or to full punishment, as a result of retardation or pathological impairment of the mental faculties;

(b) it is necessary to protect the community against further serious offenses which this person may be expected to commit as a result of these disorders.\*\*

In the short term the TBR attempts to achieve its purpose – to obviate, restrict, neutralize or reduce the danger of further offenses being committed – by the confinement of the offender. In the longer term the idea is to improve the security of the community by attempting to exert a beneficial influence on the cause of the danger. Thus TBR's are particularly designed as specific preventive measures aimed at specific individuals.

The present survey looks at the extent to which the primary goal of TBR, to protect the community, is achieved. To assess this, data on recidivism among offenders placed under TBR are required. The follow-up survey at the Van der Hoeven Clinic<sup>o</sup> gives data on subsequent offenses committed by psychiatric offenders detained at the government's pleasure and other patients referred to the Clinic by the courts. These data cannot be assumed to apply in general to all psychiatric offenders, however, since this Clinic receives a particular selection of them.

\* Unless stated otherwise, the term ‘offense’ throughout this article refers to the more serious category of crime (‘indictable offenses’). (Translator's note)

\*\* A TBR is made for an initial period of two years; the court may subsequently renew it for a period of one or two years. Parliament has recently passed an Act restricting the total duration of a TBR to four years in the case of non-violent offenses.

<sup>o</sup>See Chapter IX of this reader.

It is known, furthermore, that the population of offenders subject to TBR has gradually come to consist mainly of persons convicted for offenses involving violence. The present survey aims to provide more general figures for recidivism among former psychiatric offenders.

Detention at the government's pleasure and prison sentences are two different ways of reacting to crime. From time to time questions are asked about the relative effectiveness of TBR in comparison with other measures, particularly long prison sentences. It is illuminating in this respect to look at figures for recidivism among long-term prisoners collected in a similar way and such figures have therefore been included in this survey. It should however be realized that it is difficult to compare the two categories; we shall return to this problem later.

Given these two objectives the survey was designed to answer the following questions:

1. How many subsequent offenses, and of what kind, are committed by persons placed under TBR while they are serving their sentences?
2. How many offenses, and of what kind, are committed by persons placed under TBR after they have completed their sentences?
3. Is there any connection between offenses committed after they have completed their sentences and factors in their criminal records and length of sentence?
4. How many subsequent offenses, and of what kind, are committed by long-term prisoners?

All psychiatric offenders who completed their sentences during the period from 1 July 1974 to 30 June 1979 were selected for the survey: a total of 589. Only a small number (about 50) were excluded from the survey because the data required could not be obtained. Women and aliens were also excluded because of the small numbers. Also included in the survey were those long-term prisoners who had been sentenced to a total of no less than 2½ years imprisonment (not suspended) and released during the same period as the psychiatric offenders: a total of 373. To ensure comparability, female and alien long-term prisoners were excluded. A recidivism period of no less than three and no more than eight years applied to both groups.

## 2. Criminal records of psychiatric offenders

The majority of the offenders included in the survey were placed under TBR for a violent crime (5% + 4% + 25%) or a property-related or sexual offense (28% + 21%) involving violence (see Table 1).

During the period under consideration a marked increase was found in the

Table 1. Proportions of psychiatric offenders sentenced for particular types of offence

Type of offence	Frequency	%
Property-related, without violence (embezzlement, theft)	98	17
Property-related, with violence (robbery with violence/burglary)*	165	28
Crimes of aggression		
offenses against property (e.g. arson)	28	5
assault with slight personal injury	21	4
assault with serious personal injury, including death	148	25
Sexual offense**	122	21
Other	7	1
Total	(n = 589)	101

\* This category is made up of 19% burglary and 9% property-related offenses involving violence to persons.

\*\* All except three of the sexual offenses were crimes of violence.

number of violent crimes. According to recent data on the population mix of psychiatric offenders provided by the Ministry of Justice this trend has continued to date. Only in sporadic cases (about 14% in 1982) are TBR's made for other than crimes of violence. Usually a custodial sentence of a specified length is imposed in addition to the TBR; this exceeded 12 months in the case of only 12% of the offenders in the survey. In the case of 16% of the offenders the conviction resulting in the TBR was also their first; it was at least their fifth, however, in half of the cases.

### 3. Period of execution of the measure of TBR

The median duration of in-patient treatment was 40 months; in terms of overall distribution, an in-patient term of no more than 24 months can be regarded as short and one of no less than 60 months as long. The median total length of treatment, in-patient and out-patient treatment included, was 50 months; in terms of overall distribution, a total term of no more than 36 months can be regarded as short and one of no less than 80 months as long. The total length of treatment dropped during the period under review; the arithmetical average fell from 82 months in 1974 to 58 months in 1979; over the entire period it was 72 months. This was due to the reduction in the number

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of out-patients treated for longer than a year. The length of sentence does not include time spent in custody in a House of Detention or prison.

Almost two-thirds (64%) of the offenders in the survey were discharged after a period of parole, whereas one third (33%) were discharged before parole because the period of validity of the TBR had come to an end and it was not renewed.

Three-quarters (74%) of the offenders were discharged on the recommendation of the hospital, as against 19% discharged against its advice (7% otherwise or unknown); the latter figure rose from 14% in 1974 to 37% in 1979! Two-thirds of those discharged against the hospital's advice were still inmates at the time.

The majority of the offenders (58%) were placed in a TBR institute (hospitals for psychiatric offenders detained at the government's pleasure) directly or through the Selection Institute and were not recommitted during their sentence. About 1/4 were recommitted to the same or another hospital once or twice. Under 20% were recommitted three or more times.

A third of the offenders committed at least one offense without violence during their in-patient period, as against 11% who committed at least one violent crime\* (the figures relate to officially recorded crime). Since offenders are often not prosecuted for minor offenses because their TBR is still running, the criterion for recidivism is broadly defined as 'any offense committed irrespective of the judicial outcome'.

Sixty-two percent of the offenders were recorded as absent without leave (AWOL) at least once for a day or longer; a quarter of the offenders were AWOL at least four times. No distinction was made between absences from supervised or unsupervised leave and from the hospital.

Seventy-eight percent of the offenders were released on parole one or more times\*\*; a quarter of these were convicted for an offense committed while on parole. The facility had to be withdrawn from a somewhat larger proportion, viz. one third; not every such case was connected with a conviction; convictions occurred in about 60% of these cases.

There are various relationships between personal circumstances, criminal records and length of sentence. Those placed under a TBR at an earlier age,

\* Some psychiatric offenders committed offenses both with and without violence. A total of 39% committed at least one offense.

\*\* A patient granted parole is in fact discharged from the hospital while officially remaining on the hospital roll. Most of the actual supervision work is entrusted to the probation and after-care service. Parole is intended to be the last phase, or one of the last phases, of the TBR; it may however be suspended in the event of irregularities. There are also other forms of leave.

for instance, were committed to more hospitals and were more frequently AWOL than those detained at an older age.

Those detained for a sexual offense serve a markedly longer period as in-patients: an arithmetical average of 6½ years as against 3½–4½ in the case of other offenders. The former also served significantly longer overall sentences.

Those convicted for property-related offenses more often went AWOL and committed significantly more offenses serving their sentences than the other offenders. The percentage of offenders in this category discharged against the hospital's advice was about twice as high as that of those detained for sexual offenses or crimes of aggression.

#### 4. Recidivism following completion of TBR

Various criteria can be used to assess the degree of recidivism. Table 2 shows percentages for recidivism following final discharge according to four different criteria, which yield highly differing results.

*Table 2. Recidivism percentages for psychiatric offenders following discharge, according to different criteria*

Criterion	%
Any offense committed	63
Reconvicted	51
Reconvicted: custodial sentence and/or TBR (not suspended)	33
Reconvicted: custodial sentence of over six months and/or TBR (not suspended)	16
Total	(n = 589)

The criteria given in Table 2 relate to general recidivism among psychiatric offenders, i.e. the commission of any type of offense. A distinction may also be made between special recidivism (the commission of the same category of offense) and specific recidivism (the commission of the same offense). Table 2 shows that 51% of the offenders were reconvicted (general recidivism); special recidivism was 29% and specific recidivism 18%. Thirteen percent of the offenders were reconvicted for a crime involving violence. The figure for those detained for burglary, property-related crime involving violence to persons and

rape/sexual assault was somewhat higher than for those detained for property-related crime without violence, offenses against property, offenses resulting in slight injury or serious injury and murder or manslaughter. If we define recidivists as those on whom a custodial sentence of over six months and/or TBR (not suspended) is imposed, we find that 9% were sentenced again for an offense involving violence.

There are various relationships between features of offenders' criminal records and length of sentence and whether or not they commit subsequent offenses. Without going into detail, the recidivism figure is higher for those placed under TBR at an earlier age, those convicted for property-related offenses and those with a relatively large number of convictions behind them before being placed under an order. The recidivists also more often go AWOL while serving their sentence, commit more offenses and are more often transferred.

In connection with the sharp increase in the number of discharges against the hospital's advice, it is informative to look at recidivism with regard to different combinations of final discharge as recommended by the hospital, discharge against its advice and type of treatment. Table 3 shows that fewer subsequent offenses were committed by those who had already been on parole and were discharged against the hospital's advice than in the case of the other combinations. More offenses were committed following discharge, on the other hand,

Table 3. Recidivism according to two criteria in relation to mode of discharge

Recidivism ↕ following final discharge	Discharge:				
	while on parole, as recom- mended	while on parole, against advice	from hospital, as recom- mended	from hospital, against advice	total*
	%	%	%	%	%
Reconvicted	48	36	53	69	51
Ditto with custodial sentence/TBR	28	21	38	55	33
Total	(n = 326)	(n = 39)	(n = 104)	(n = 75)	(n = 589)

\* This does not include all the combinations which actually occur: this is why the total of the categories does not add up to 589.



by those discharged against the hospital's advice while still inmates than in the case of one of the other combinations.

A certain pattern can in fact be discerned in the situations where the judicial authorities order final discharge against the hospital's advice. For instance, 73% in the category 'while on parole, as recommended' were among those who had been detained for a violent crime as against only 39% in the category 'from hospital, against advice'. The percentage in the categories 'while on parole, against advice' and 'from hospital, as recommended' were 67 and 50 respectively. In other words, discharges from the hospital against its advice take place relatively rarely in the case of violent crimes and relatively often in the case of property-related offenses.

## 5. Long-term prisoners

This category is generally similar to psychiatric offenders in terms of age on conviction and number of previous convictions. There are major differences, however, in the type of offense for which the convictions occur: the proportion of property-related offenses involving violence, for instance, is over double that among psychiatric offenders. It is notable that sexual offenses are few and far between among long-term prisoners, whereas drug traffickers are virtually absent among psychiatric offenders.

The execution of prison sentences differs considerably, of course, from that of TBR's. It need come as no surprise, therefore, that the proportions of prisoners AWOL (18%) and of those committing an offense while serving their sentence (7%) are lower than among psychiatric offenders. These figures are shown in a different light, moreover, by the differences in time spent as inmates. The arithmetical average length of imprisonment in the case of the long-term prisoners in the survey was about half that of the psychiatric offenders' in-patient treatment. All in all, then, the period in detention was much longer for the psychiatric offenders than for the long-term prisoners.

The figures for recidivism, especially in respect of the more serious offenses, were somewhat higher among the long-term prisoners than among the psychiatric offenders, as shown by Table 4. The figures for special and specific recidivism among the long-term prisoners and for subsequent serious crimes of violence were generally comparable with those among the psychiatric offenders; thus no discussion is called for here.

**Table 4.** Recidivism according to three criteria among long-term prisoners and psychiatric offenders on the basis of type of offense for which convicted\*  
(LTP = long-term prisoners, TBR = psychiatric offenders)

Type of offense (original conviction)	Recidivism (%)					
	reconvicted		custodial sentence (including TBR)		custodial sentence > 6 months (including TBR)	
	LTP %	TBR %	LTP %	TBR %	LTP %	TBR %
Property-related, without violence	56	57	48	43	39	22
Property-related, with violence	67	66	51	47	33	25
Crime of violence	45	40	32	19	14	7
Total	60 (n = 373)	51 (n = 373)	44 (n = 589)	33 (n = 373)	28 (n = 589)	16

\* Sexual offenses and drug traffickers are not separately identified since these categories are virtually absent among long-term prisoners and psychiatric offenders, respectively.

## 6. Conclusions

It may be concluded from the findings regarding the in-patient period that it is not unusual for psychiatric offenders to go absent without leave, i.e., not to return on time from leave, to evade supervision when on supervised leave or to escape from the hospital; about 60% of the offenders went AWOL at least once and 25% no less than four times. Whether this creates unacceptable risks is another matter. It is true that 39% of them are found to have committed an offense, but so far as is known no more than 11% of the offenders committed an offense involving violence while absent without leave (this includes minor offenses such as common assault).

The findings regarding the period offenders spent living outside the hospital on parole reveal that the parole facility had to be withdrawn in the case of about one third of them, in about 60% of these cases presumably owing to a conviction. Of all offenders to whom parole was granted 24% were convicted for an offense committed while on parole. Not all these convictions caused the parole facility to be withdrawn, however. Parole is of course an experiment in every case, and failures are only to be expected. It may be concluded from the

findings that there is clearly no reason to withdraw the facility in the large majority of cases.

Different criteria for recidivism were applied in the study, giving widely varying figures. Since about half the offenders were reconvicted at least once after being discharged, it can scarcely be said that recidivism is the exception. It can however be concluded that those who go on to commit more or less serious crimes constitute a small group: no more than 16% of the offenders were sentenced to a total of more than six months' imprisonment (not suspended) after being discharged.\*

The figures for recidivism among the populations of the various hospitals vary only slightly from the overall figure, and those differences that do exist can be traced back to the differences found in the criminal records of the patients in different hospitals.

Nor are there particularly large differences in recidivism between the psychiatric offenders and the long-term prisoners, albeit the subsequent offenses committed by the latter are rather more serious. It should not be concluded from this that it makes no difference whether a person is placed under a TBR or given a term of imprisonment. It is quite conceivable — and this is a *raison d'être* of TBR — that the recidivism and/or psychosocial state of people detained at the government's pleasure might have been worse if they had served a term of imprisonment: the two categories cannot be regarded as comparable in terms of their psychosocial background. Of course there are long-term prisoners who suffer from mental disorders, serious or otherwise; this is apparent from a report by a Committee on Psychotherapeutic Facilities in Prisons. Even here, however, it may be concluded that this is a small group. It should also be noted that the idea of the judicial process as a lottery in which long prison sentences and hospital orders are issued at random is not supported by the facts: the difference in the composition of the two categories is too great (notably in respect of drug offenses and sexual offences).\*\* A corresponding argument explains the overall lack of differences in recidivism between the various hospitals.

## 7. Discussion

Recent research indicates that a large proportion of the members of the judiciary have fairly pronounced opinions on the security provided by the

\* Including any TBR (not suspended).

\*\* Mulder (1982) suggests that there is considerable similarity between the populations of prisons and TBR institutes. See also the reaction of (among others) Blankstein (1983).

measure of TBR.\* The question is, <sup>10</sup> what criteria and standards do they apply, and on what facts do they base their opinions? To answer such questions a more differentiated approach is needed than was originally regarded as necessary for this survey. It will be found, first of all, that the distinction between 'short-term' and 'long-term objectives' is too simple: at least three phases can be distinguished in the short-term period. The sentence begins with a phase in which the offenders are expected to remain within the hospital; at most they will be permitted to leave for a specified period under adequate supervision. In the second phase the offenders are given increasing freedom of movement to visit their families and take part in recreation, employment, etc., but are still regarded as inmates of the hospital. The third phase is parole, where offenders live outside the hospital under the supervision of the probation and after-care service. These phases vary in length, and do not all occur in every case: the parole phase in particular is sometimes omitted. Absence without leave is not a meaningful concept during the parole phase, and it takes different forms in the first and second phases, viz. escape and failure to return on time from leave, respectively. Not every absence without leave need have serious consequences, i.e., involve the commission of more or less serious offenses.

The meaning of the term 'security' is different in each of the phases identified here. A successful escape and certainly an offense committed during the first phase can be regarded as essentially violating the security intended; confinement is deemed to provide a certain degree of protection against this. Little by little, however, reasonable risks are incorporated (with the approval of the Ministry of Justice): more freedom of movement is given, with the risk that this will not be used constructively. If this concession proves unsuccessful, not only the security aspect but also the judgement of the individual's progress under treatment is brought into question. This also applies, of course, to discharge. We find, moreover, that the judicial authorities are increasingly ordering discharge against the hospital's advice; there is no reason to hold the hospitals automatically responsible for the resultant failures here. Before a balanced assessment can be made of the short-term security provided, standards for acceptable and unacceptable levels of security are needed. These must take into consideration the nature of any absence without leave (escape, evasion of supervision, failure to return from leave), in which phase it occurs, the consequences if any, and so on.

During the parole phase a further increase in freedom of movement is considered justified. Since by definition there can be no absence without leave during this phase, the figures available for recidivism must be used to judge

\* See Van Emmerik (1984): *Opinions on TBR*.

whether this measure is indeed justified and how much security is actually provided. The situation following discharge must of course be assessed in the same way. One problem here is how to measure recidivism, and above all what allowance to make for the nature and extent of the person's previous criminal record and the length of the sanction. A few examples will illustrate this. Is it right to apply the same definition of recidivism to someone convicted countless times of property-related offenses as to a person convicted for the first time of homicide? Should a certain degree of recidivism be assessed differently according to whether the period of treatment is short or long? Or is the mere fact that someone has committed another offense the important thing, more or less irrespective of the seriousness of the crime? Given the many options and in view of the objective of TBR, a practical guideline might be to regard recidivism as the commission within a specified period of an offense of a nature and seriousness such that a fresh TBR could be considered appropriate.

Treatment under psychiatric supervision is the means used to try to achieve the long-term objective of TBR, to reduce or prevent recidivism; this is the form which the 'care' takes. The argument here is roughly as follows: a complex set of factors, including above all mental disorders or retardation, is regarded as being responsible for the patient's criminal behavior. If we are to obviate the need of incarcerating him, for the rest of his life if necessary, for security reasons, we must try to reactivate the interrupted development and guide it into the right direction. This is not just a question of law and economics, it is a matter of civilization, of humanity. Cure, or at least improvement, of the development disorder is thus regarded as a precondition for reducing or preventing recidivism. Obviously, then, the recidivism figures are the ultimate indication of whether particular efforts have been successful. At the same time it must be recognized that they cannot be regarded as more than partial indicators of the success achieved. The extent to which a particular psychological or social development can be initiated is another factor in the success or failure of the treatment.

Can the same degree of success be expected, however, with every detainee? If treatment is regarded as a process designed to enable the patient to take charge of his own development again without the occurrence of unacceptable clashes with other people, it must be realized that 'care' cannot always have this effect. In some situations care will amount to looking after the patient without any immediate prospects of recovery being apparent. In other cases we shall have to be content with developing to a limited extent faculties which are otherwise damaged: a cure, in the sense of enabling the patient to take charge of his own development in future, is not something that can be expected here.

Apart from the fact that a cure is not always possible, there are humanitarian

and economic reasons for not seeking a cure at all costs, however much importance is attached to the security of the community. It is not just a question of the cost involved in material terms, but also of protecting the legal status of individuals. A balance must be sought between the invasion the offender has made into the freedom of members of the community and the community's consequent invasion of his freedom.

Any assessment of the results of a TBR must therefore begin with realistic expectations. What methods are available for such assessments? Criminology has a long tradition of research into the predictability of criminal behavior on the basis of the personal details and history of offenders. It is still the case, however, that neither the clinical method (as practiced by psychologists and psychiatrists) nor the statistical method (based on criminal records) is accurate. The clinical method tends towards caution: incorrect predictions mainly concern persons who are later found to have been unnecessarily labelled as dangerous. The statistical method is particularly unreliable: only a small number of offenders, those who fall into one or other extreme and present either a high or low risk of recidivism, can be divided reliably into recidivists and non-recidivists. A large proportion of psychiatric offenders undoubtedly belong in the high-risk category at the time the order is made. At present there are however no prediction tables for the Dutch situation, and there is thus no short-term yardstick by which the results of TBR's can be assessed.

In addition, it is now customary to compare the results of one type of sanction with another and to assess which is likely to have the greatest effect by means of experimental or quasi-experimental studies. In the case of TBR's this could take the form of:

- (a) comparing different types of treatment in the various hospitals;
- (b) comparing psychiatric offenders with other categories of inmates, e.g., long-term prisoners.

These comparisons are thus concerned with the relative effectiveness of one sanction in relation to others. The main idea of these (quasi-)experimental studies is to provide as much certainty as possible on the effect of a sanction on recidivism, excluding other influences. It is likely that experiments of this kind have limited applications. It will be found in practice when trying to compare TBR institutes that the subgroups are often too small or — because of the selection process! — occur in only one or a small number of hospitals, thus making comparison difficult or bringing the reliability of the comparison into question.

There are problems in comparing long-term prisoners with psychiatric offenders, as mentioned above. Only if the same regime were applied to psychiatric offenders as is now customary with long-term prisoners would it be

possible to say what the relative effectiveness of the two systems would be. There might well be doubts, in fact, as to the feasibility of such a regime for psychiatric offenders, given (a) the problems already raised in the prison system by long-term prisoners with mental disorders and (b) the facilities it is urged they should have, even leaving aside the fundamental legal objections which could be made.

The findings, then, fit the popular conception that the effects of treatment programs are often difficult or impossible to prove. This is not only the case with rehabilitation efforts in the prison system, TBR institutes and the probation and after-care service, however. A recent survey of evaluation research by Rossi and Wright\* makes it clear that it is virtually impossible to establish what the effects of programs instituted in the sixties and seventies to change attitudes or behavior have been: neither in the education nor in the health, housing, policing fields, etc. have the results been impressive. They seek the causes first of all in the limited applications of experiments to *existing* programs: it is out of the question, as a rule, that people are selected at random for a particular type of treatment (e.g., TBR or prison sentence). They also conclude that it is difficult to bring services performed for people, e.g., treatment, under experimental control. This is not the case, for instance, with measuring the effects of income supplements. It has been found, furthermore, that it is extremely difficult to keep the experiment going unaltered over a relatively long period. The non-experimental types of research offer only a limited solution to this problem, especially since the results are an easy target for anyone wishing to criticize the limitations of the research method.

Rossi and Wright see the enlarged scope of modern evaluation research as a general step towards solving these problems. In particular they point to:

- (a) the increased preference accorded to 'qualitative research' which is able to react to a changing reality with more flexibility than experimental research with its strict control requirements;
- (b) greater interest in what is in the 'black box', what takes place during treatment, what this consists of, why effects are expected of certain components, and what these effects are;
- (c) greater interest in organizing programs in accordance with the underlying ideas, with particular considerations being given to problems which jeopardize the achievement of the original purpose.

These developments could also be encouraged in The Netherlands. Their advantage is that they can assist in the search for better forms of treatment in a more direct and constructive way. In addition, research efforts could then

\* See Rossi and Wright (1984) and Van Emmerik (1983).

achieve a better balance between evaluation and development research.

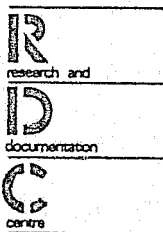
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