

# **Detention under a hospital order (TBS) and the functioning of the Mental Health Service in The Netherlands.**

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## **Introduction about ‘detention under a hospital order’: TBS**

TBS is a special measure judges can impose on people who suffer from a personality disorder and/or a serious mental health problem and have committed a serious crime. They are therefore not completely responsible for the crime. The mental health problems must have contributed to them committing the crime and increase the risk of them committing another crime.

Internationally, TBS is a unique combination of prison and psychiatric care. In other countries, people *either* go to prison *or* into psychiatric care. Legally, TBS is called a measure rather than a verdict.

The Dutch courts decide on agreed dates as to whether or not a TBS measure needs to be extended. They do this each year or every two years. The TBS measure can only be extended if there is an unacceptably high risk that the convicted person will commit another serious offence. Behavioural expertise is required in assessing this risk. The court receives advice from the treating clinic, a psychiatrist and the probation and after-care service respectively. Contrary termination is defined as the non-extension of the TBS measure, contrary to the opinion of the advisory body, by the court or, in appeal cases, by the Parole Appeals Section of the Arnhem Court of Appeal.

## **History**

At the beginning of the 20th century, developments in justice and psychiatry made it possible to section (detain) people who had committed a crime and were very disturbed and a danger to their environment. This happened either completely within or partially outside the forensic institutions. Originally, this was only applicable to those who were fully incapable, who were admitted to a psychiatric hospital. Later, this possibility also became available to those who were only to some extent ‘crazy and bad’.

The Psychopaths Law and the introduction of the so-called TBS made it possible to treat these people in secure units. In that sense, one can argue that TBS, mental health care and forensics form

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one communal domain in which regular transfers of patients within the different parts should be possible.

However, in recent decades, these sectors have grown apart and there has hardly been any interaction. During the 90s, the number of TBS verdicts has increased, which has made it necessary for the TBS-sector, forensic psychiatry and the Department of Justice to have better access to the general mental health care sector. Much has been invested in schemes to encourage co-operation and communication between these sectors in order to improve the transfers of patients.

In practice, it has proven difficult to balance supply and demand in this way. Communication and co-operation were already identified in 1990 as two important factors to improve the transfer of patients, but they have not been as successful as was hoped for. In my study, there is strong evidence that communication between services (in professional networks) for people who leave TBS or prison are not effective enough. The question is whether there is enough goal-oriented governance.

### **The research**

The direct motive for the research was the question asked by the vice-president of Penal Chamber of the Court in Arnhem, “*Are we imposing more TBS verdicts because mental health care is not functioning?*”

My study investigated what type of mental health care is available to people before a TBS is imposed. The hypothesis of my research was that most people who receive a TBS, have already been in contact with or treated by a mental health service and they have been ‘lost’ by these organisations. I conducted a literature research, as well as case studies at the Court and at the dedicated penal chamber of the Court in Arnhem.

Some conclusions:

- There is not enough sharing of information between youth, addiction and mental health services to create a consistent, holistic and meaningful supply of care.
- Health institutions find it difficult to deal with people who do not fit the image of autonomous, self-sufficient people who are able to make their own choices.
- The patients have to continuously adapt to the organisation of care.
- Care professionals may have ‘avoidance behaviour’ to their patients.
- So called care-avoiders have contact with care providers...
- But the question is do they get enough and suitable care?

- A fragmented organisation of care increases the risk of cutting off care and (subsequently) a higher risk of crime.

### **Prevention of TBS**

Many TBS patients are found to have been in long and intensive contact with general mental health care institutions before a TBS verdict is actually imposed. The question is if this was the right care and treatment. It seems supply and demand do not fit and patients are thus allowed to 'grow towards' the serious crime that eventually leads them into TBS. There is, in short, not enough attention for prevention.

My literature study shows that many TBS patients have often had years of contact with the mental health care system before they commit the crime. This was in part already known from previous research. However, many TBS patients have also been admitted to youth institutions, voluntary or forced admittance to mental health care institutions, or have had outpatient contact with them. There seems to be little or no follow up at all when these treatments are ended, albeit by the patient or the care institutions. Relationships can last for years, diagnoses are made, medication is given and the judicial history is known, but patients are not being actively contacted once they have ended treatment.

The reason to end treatment could be that patients are expected to adapt to the organisation of care and health professionals display 'avoidance behaviour' if patients do not comply with the expectations of mental health care organisations. As a result, the organisations break off the contact. Sometimes it is the patient himself who ends the contact, and if that happens, the mental health care organisation do not seem to make a forceful effort to get the patient back into care or to identify possible problems for the future.

### **TBS and Substance Abuse**

Until recently, addiction was not recognized as a mental illness (or disorder) and special treatment of addiction within the TBS service was hardly developed. In the past few years, more research findings have given more insight into the influence of addiction to TBS patients, both before and during the crime, as well as the rate of re-offending.

Amongst TBS patients, addiction usually develops at an early age. The most prevalent form of abuse or addiction is alcohol, followed by cannabis and hashish. More than 25% of the TBS population have used hard drugs or are addicted to them. Gambling or addictions to prescribed medications are relatively limited. Over two thirds of the population is addicted to one or more

substances, or is a heavy user. There is a strong link between substance abuse in the history, and having been under the influence of that substance whilst committing the crime.

Additionally, the use of alcohol during the TBS period significantly increases the risk of re-offending when patients are on leave.

### **After the TBS**

Once the judicial sentence has been completed, experience shows there is a need to continue treating patients and clients. It may be necessary to provide an intensive care programme for long-term treatment and to develop services to reduce the risk of patients who have nowhere to go. At the moment, it seems questionable whether or not mental health care services are willing to treat patients once they have been given a TBS, i.e. after they have committed a serious crime and have been sectioned.

### **Conclusion and Recommendations**

The hypothesis that most people who are given TBS, have already been in contact with or treated by a mental health care institution and have been 'lost' by these organisations, has been proven. Previously there has not been research into the link between care and treatment, and committing a serious TBS crime. There is a correlation between care history and crime behaviour, but no proof as yet of causality. This research makes it possible to look further into the relation between the nature of the contact between the TBS patient and mental health services before the crime is committed.

It has also highlighted the important role of usage of alcohol and drugs, both before and during committing the crime.

The impact of substance abuse and care history, emphasizes the need to share information between youth, addiction and mental health care services to create a consistent, holistic and meaningful supply of care and treatment.

To respond to the problem of lack of follow-up care once the TBS has ended, I propose the introduction of a 'civil penal order' as an interim-measure. This could be enforced and executed by the Public Prosecution Service, the Probation service and forensic organisations.

Additionally, as a precautionary measure, we recommend that employees in mental health care services will have a duty to inform authorities when care of a patient is ended, or when patients with a criminal record repeatedly show aggressive behaviour. These patients have a high risk of ending in a vacuum of care, during which they could commit a serious crime that leads to TBS.

Finally, building upon the previous research, it is important to conduct further investigation into the question of “to what extent TBS patients differ from those who are cared for within the mental health care system?” This could lead to a preventive approach where people at risk of committing a serious TBS crime could be identified at an earlier stage.

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