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Inpatient forensic-psychiatric care: Legal frameworks and service provision in three European countries

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Abstract

Laws governing the detention and treatment of mentally disordered offenders (MDOs) vary widely across Europe, yet little information is available about the features of these laws and their comparative advantages and disadvantages. The purpose of this article is to compare the legal framework governing detention in forensic psychiatric care in three European countries with long-established services for MDOs, England, Germany and the Netherlands. A literature review was conducted alongside consultation with experts from each country. We found that the three countries differ in several areas, including criteria for admission, review of detention, discharge process, the concept of criminal responsibility, service provision and treatment philosophy. Our findings suggest a profound difference in how each country relates to MDOs, with each approach contributing to different pathways and potentially different outcomes for the individual. Hopefully making these comparisons will stimulate debate and knowledge exchange on an international level to aid future research and the development of best practice in managing this population.

Keywords: Forensic psychiatry; Mental health law; England; Germany; Netherlands

~~1.~~1 Introduction

Forensic psychiatric care differs from other psychiatric specialties in a number of ways. Detention in a secure psychiatric setting can be both restrictive for the individual and expensive for society (Adshead, 2000; Centre for Mental Health, 2011; Farnworth, Nikitin, & Fossey, 2004; Meehan, McIntosh, & Bergen, 2006). Furthermore, detention is almost exclusively involuntary which raises additional ethical questions, particularly as length of stay may be high and often indefinite (Dell, Robertson, & Parker, 1987; Gunn & Taylor, 2014; Mason, 1999). Unlike other areas of psychiatry, detention and treatment in forensic settings is not only for the benefit of the individual but also for the protection of others (Buchanan & Grounds, 2011). In fact, in times of increasing moral panic and societal fears regarding the dangerousness of mentally disordered offenders (MDOs), this balance may be uncomfortably skewed towards public protection (Boyd-Caine, 2012; Carrol, Lyall, & Forrester, 2004; Forrester, 2002). To make matters worse, evidence for the effective treatment of MDOs is limited and long-term outcomes are poor (Davies, Clarke, Hollin, & Duggan, 2007). Ongoing research into the effectiveness and efficacy of inpatient forensic psychiatric services is therefore paramount.

Few papers have been published describing forensic psychiatric care in individual countries (de Boer & Gerrits, 2007; Harty et al., 2004; Müller-Isberner, Freese, Jöckel, & Gonzalez Cabeza, 2000; Ogloff, Roesch, & Eaves, 2000) and the literature on international comparisons of such care is scarce. However, these comparisons are important, in particular as discussions regarding service reorganisation and cost improvements become more commonplace worldwide (Priebe et al., 2005). In England and Wales, for example, debates are currently underway regarding the provision of care for personality disordered offenders, with suggestions being made that such individuals should be primarily treated within the criminal justice system as opposed to the healthcare system (Department of Health, 2011a). In addition, discussions surrounding patients who need longer term secure care are being had in several countries (Expertisenentrum Forensische Psychiatrie, 2014; see also the special interest group of The International Association of Forensic Mental Health Services at http://www.iafmhs.org). International comparisons may stimulate national debate and ultimately improve the development of best

practice. A number of EU-funded projects by Salize, Dressing, and Peitz (2002) and Salize and Dressing (2005) have begun to compare the legal frameworks and service provisions in psychiatry, forensic psychiatry and prisons in a number of EU member states. These studies concluded that legal provisions are heterogeneous and future efforts should be made to harmonise legal frameworks.

In this paper we continue this process by comparing, in more detail, the inpatient forensic psychiatric system in England and Wales with that of Germany and the Netherlands (where we will focus on the TBS system). We focus here on inpatient services in order to make the material included manageable though it is important to note the impact the broader context of forensic psychiatric care, including management in police custody, prison in-reach services, community forensic mental health-care and compulsory community treatment and supervision, is likely to have on those services. Taking England and Wales as an example, the prison population is currently 85,741 (GOV.UK, 2015) or 148/100,000 inhabitants, the highest in Western Europe. Over 70% of these prisoners are thought to suffer from at least one mental disorder (Singleton, Meltzer, Gatward, Coid, & Deasy, 1998). Policies regarding the treatment of these mentally disordered prisoners will impact on patient numbers in secure forensic-psychiatric hospitals. The management of prison in-reach services was transferred from the Ministry of Justice to the Department of Health in 2006 (Kaul & Völlm, 2013). This move has resulted in a more standardised approach to prison mental healthcare though bed numbers in forensic-psychiatric care have not decreased as a result (Centre for Mental Health, 2014). The UK government has also begun to implement plans to provide treatment for personality disorder primarily in prison rather than hospital (Department of Health, 2011b). This is likely to have an impact on the numbers of patients in forensic psychiatric hospitals; however, the effect of this new policy is as yet unknown. Community forensic care across Western Europe is often inconsistent, rudimentary or non-existent with great variations between areas and isolation from general psychiatric services (Mullen, 2000). However, with decreased beds in general psychiatric services there is now a much larger need for community forensic services as well as possibly compulsory community supervision and treatment. In England & Wales such community compulsion has been available since 2007, though recent research on these new community treatment orders has found that is doesn't reduce the rate of readmission (Burns et al., 2013).

England has a long tradition of forensic psychiatric care with the opening of the first secure hospital, Broadmoor High Secure Hospital, in 1863. Legal frameworks and care provision have continued to evolve with the 1975 Butler Report and subsequent introduction of regional (medium) secure units marking one of the milestones in this journey. More recently, low secure and community forensic psychiatric services have been developed (Department of Health, 2002; National Health Service, 2014a). England and Wales now detains more MDOs than ever before in secure forensic psychiatric hospitals, a trend that has continued over the last decade (Home Office, 2010). Although the comparator countries, Germany and ~~T~~the Netherlands, operate under Roman law (as opposed to common law as seen in England and Wales), they were chosen due to their similarly long tradition and well-developed forensic psychiatric system, as well as the common bond the countries share under the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (ECHR) (Council of Europe, 1950). In this paper we focus on legal frameworks, the role of criminal responsibility in decisions about detention and criteria for admission to and discharge from forensic psychiatric care. Finally we will discuss service provisions and the treatment philosophies that underpin them, with recent developments in each comparator country also detailed.

~~2.~~2 Methods

A literature search was conducted using PsycINFO with a timeframe 2003 to 2013. Due to ongoing changes in legal frameworks and ever-evolving service provision we originally discounted literature dating back more than 10 years; however, we found that for some areas it was helpful to use more historical research and so this was included if deemed valuable for our purposes. Search terms included [('Dutch') OR ('TBS')] AND ('forensic') AND ('law'), [('German') OR ('Maßregelvollzug')] AND ('forensic') AND ('law') and [('United Kingdom') OR ('England')] AND ('forensic') AND ('law'). Articles were reviewed for relevance by one of the authors. The literature review was complemented by information gathered from experts in the field. These experts were the representatives of the three countries of interest (two per country) on the EU funded COST action (Cooperation in Science and Technology) 'Towards an EU research framework on Forensic psychiatric care' (see http://www.cost.eu/COST_Actions/isch/Actions/IS1302).

~~3.~~3 Results

~~3.1.~~3.1 Legal framework

Each of the three countries has developed legislation that governs the detention and treatment of MDOs. In England and Wales, most of the relevant provisions are dealt with under specific mental health legislation, namely the Mental Health Act 1983 (MHA) (amended in 2007), which covers both civil and criminal patients. Provisions for criminal responsibility (diminished responsibility and insanity) are, however, dealt with in criminal law, specifically the Homicide Act 1957 (as amended under S52 Coroners and Justice Act 2009) and the Criminal Procedure (Insanity and Unfitness to Plead) Act 1964 (as amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004).

Whilst England and Wales provide a framework for the detention of MDOs under specific mental health legislation, in both Germany and the Netherlands the legislation relevant to mentally disordered offenders is incorporated into criminal law. In Germany, this is the German Criminal Code (Strafgesetzbuch, StGB). Under Section 63 of this code, if someone commits an unlawful act either with absent criminal responsibility or with diminished responsibility (see ~~part~~ Section 3.2), the court may order them to be placed in a psychiatric hospital if they are at risk of committing further serious unlawful acts.

Similarly to the legal framework in Germany, the Dutch framework incorporates legal provisions for MDOs into their criminal law. For the purpose of this paper, we will focus on the options for disposal related to levels of criminal responsibility as governed by the measure of Terbeschikking Stelling (TBS). This was introduced to the Dutch Penal Code in 1928 and can be loosely translated as 'at the disposal of the government', found under Article 37a of The Netherlands Criminal Code. What is relevant here (as

with Germany) is the offender's mental state at the time of the offence, as opposed to at the time of trial or time of assessment in prison for transfers of MDOs to the hospital system (as in England and Wales).

Whilst discussing legal frameworks, it is relevant to examine what procedures are in place if someone is deemed unfit to plead. This concept reflects consideration of reduced capacity at the time of the court process rather than when the crime was committed. In England and Wales, the common law test for fitness to plead is laid out in the Pritchard criteria (R v Pritchard, 1836, 7 C & P 303). These criteria state a person is unfit to plead if they don't understand the charge, can't decide whether to plead guilty or not, can't exercise their right to challenge jurors, can't instruct legal representatives, can't follow court proceedings or can't give evidence in their defence. These criteria have been criticised for a number of reasons including being inconsistent with the modern trial process, setting the threshold too high and having no consideration for decision-making capacity. For these reasons, the Law Commission are developing a new set of criteria for fitness to plead in England and Wales (Law Commission, 2014). In the Netherlands the criteria are similar including if a person is unable to respond to the charges or to matters arising during court proceedings and if they are unable to instruct or respond to the counsel (Van den Anker, Dalhuisen, & Stokkel, 2011). In Germany the term 'Verfahrensunfähigkeit' (competence to participate in the trial) is used. This refers to a situation where the defendant is unable to represent themselves, i.e. defend themselves, follow proceedings, file and understand procedural declarations or ~~or~~ instruct representatives to do so on their behalf. In civil matters a guardian can act on behalf of the incompetent individual; in criminal matters a guardian can also participate on behalf of the ~~defedant~~defendant to some extent (e.g. request legal representation). In addition, the proceedings can be adapted to enable the defendant to participate (e.g. through the presence of a psychologist, longer breaks~~, etc.~~) (Rothschild, Erdmann, & Parzeller, 2007).

~~3.2.~~3.2 Criminal responsibility

The concept of criminal responsibility is covered in criminal law for all three countries. It is important to examine and understand how criminal responsibility is assessed and applied as these provisions have significant implications for conviction and sentencing. Importantly, all three countries recognise the significance of criminal responsibility in the determination of guilt and subsequent punishment. Individuals who lack criminal responsibility cannot be held responsible for their actions and can therefore not be punished for their offences. The main differences between the countries of interest here are in the definition of criminal responsibility and its role in determining admission to a forensic psychiatric institution.

In England and Wales, the Criminal Procedure (Insanity and Unfitness to Plead) Act 1964 is relevant where a defence of insanity is sought. Under the *M'Naghten* rules, a plea of insanity may be sought where it is proven that '*at the time of the committing of the act, the party accused was labouring under such a* [*1*] *defect of reason, from* [*2*] *a disease of the mind, as* [*3*] *not to know the nature and quality of the act he was doing; or, if he did know it, that* [*4*] *he did not know what he was doing was wrong*'. These four criteria need substantiating and are interpreted in the light of case law that has developed since the original *M'Naghten* case was heard in 1843. The rules have subsequently been criticised, namely in the Butler Report (1975), for not providing a satisfactory test of criminal responsibility due to outdated language and understanding regarding mental disorder. More recently, the Law Commission published a discussion paper on the insanity defence which highlighted a number of criticisms of the current criteria (Law Commission, 2013). They found it lags behind current psychiatric understanding and practice, leading to it being underused. This underuse means it does not fairly identify those not criminally responsible, leading to some vulnerable individuals being at greater risk of self-harm and suicide in the prison system. They therefore argue that the current law is at risk of breaching the European Convention of Human Rights. They also found that the current criteria disregards the potential inability to control emotions and resist compulsions, provides an unusually narrow definition of what 'wrong' means (i.e. if a person simply knows that something was against the law then the insanity defence wouldn't apply) and that the label of 'insanity' is both stigmatising and inaccurate. They have developed a number of provisional proposals for change, including a lack of capacity defence and a new defence of not criminally responsible by reason of recognised medical condition.

A plea of diminished responsibility can only be sought as a partial defence to murder in England and Wales which, if successful, will reduce the liability of murder to manslaughter and as a result the disposals available range from life imprisonment to absolute discharge (Wrench & Dolan, 2010), while murder carries a mandatory life sentence. In order for a plea of 'diminished responsibility' to be successful, the claimant has to satisfy a four-stage test set out under the Homicide Act 1957, as amended by Section 52 of the Coroners and Justice Act 2009: [1] the individual was suffering from an '*abnormality of mental* functioning', [2] which had arisen from a medical condition [3] which substantially impaired their ability to [4] understand their actions, make rational judgements or exercise self-control at the time of the offence. In other words, there must be some level of causation between the abnormality of mental functioning and the defendant's actions so that it becomes a '*significant contributory factor*' (Ministry of Justice, 2010). It is the duty of the defence to provide evidence to prove the individual was not wholly responsible, but it is the jury that decides whether or not the plea is to be accepted on the balance of probabilities.

The German Criminal Code incorporates three levels of responsibility; full, diminished and absent; however, these can be applied to *any* type of criminal offence. Although the assessment of criminal responsibility and admission and discharge from psychiatric hospitals are governed by criminal laws, the laws regarding patients' rights and treatment are governed by 16 different state laws (of the 16 German states or 'Länder') and therefore differ across the country (Müller-Isberner et al., 2000). For those found to have no responsibility for their actions due to a '*pathological mental disorder, a profound disturbance in consciousness, a mental deficiency or any other serious mental abnormality*' (Section 20, German Criminal Code) a person can be detained (potentially) indefinitely in a psychiatric hospital for treatment if they pose a risk to others (Section 63, German Criminal Code). If they do not pose such a risk, they will be acquitted. For those thought to have diminished (rather than a total absence of) responsibility at the time of the crime under Section 21 German Criminal Code, the court gives an additional prison sentence. The time spent in the forensic hospital is set against this prison sentence (Salize & Dressing, 2005).

The Netherlands operate a 'sliding scale' model to judge criminal responsibility. There are five stages; total absence of responsibility, severely diminished responsibility, diminished responsibility, slightly diminished responsibility and complete responsibility (Van der Leij, Jackson, & Nijboer, 2001). As with the German concept of criminal responsibility, this scale can be applied to *any* criminal offence if a panel of at least two psychiatric experts assesses the individual as having diminished responsibility. The critical component is whether the mental disorder was deemed to be serious enough at the time of the offence to impair the offender's responsibility for their actions (Van Hoecek, 2010). If a defendant is found to be lacking responsibility for their actions at the time of the offence they are not culpable for the crime and therefore not considered punishable. In such cases, the TBS measure can be imposed and the individual will be sent to a psychiatric hospital. However, if a person is found to have diminished

responsibility and culpability is not totally absent, a prison sentence can be imposed (to be served first) as well as a TBS measure for treatment in a psychiatric hospital.

~~3.3.~~3.3 Criteria for admission

In England and Wales there appears to have been a shift in legislative philosophy from the traditional welfare model, based on patient care, to a more justice-focused model concerned with public protection (Cohen & Eastman, 2000; Hall & Ali, 2009). Under Section 37 of the current Mental Health Act 2007, a judge has the power to sentence an offender (charged with an offence punishable with imprisonment) suffering from a mental disorder, who poses a risk to themselves or others, to detention in a secure psychiatric hospital though the risk need not be 'high' or 'immediate'. For this disposal an opinion is required from two registered medical practitioners to demonstrate that the offender is suffering from a mental disorder '*of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him*' (s37(2)). 'Mental disorder' is not further defined, though sole dependence on alcohol or drugs is specifically excluded from the definition. The term '*appropriate medical treatment*' is broadly defined and includes psychological interventions, nursing and specialist mental health care; these only have to be 'available', in other words, conditions for detention are fulfilled even if the patient chooses not to engage with the interventions provided or does not benefit from them. In England and Wales, confirmation has to be obtained from a hospital that arrangements for admission can be made within 28 days of the order being given. If oral evidence from the experts suggests that the person poses a risk of serious harm to others if released from hospital, under Section 41 of the Mental Health Act 2007 the judge can impose a restriction order on the individual which means they are subject to a number of restrictions before they can be given leave, transferred or discharged. Prisoners who have been sentenced and are subsequently found to have symptoms of mental disorder can also be transferred to psychiatric hospitals for treatment under Section 47 of the Mental Health Act 2007. This is the case even for short-term sentenced prisoners, which may have the effect of keeping a person detained for a longer time in hospital than they would have been in prison as they can be detained in hospital beyond their sentence, potentially indefinitely. There is a so-called hybrid order under Section 45a hospital and limitation direction of the Mental Health Act 2007 which directs a person to hospital for treatment, but where the Ministry of Justice can direct them back to prison to serve any remaining part of their sentence if treatment in hospital is deemed no longer necessary. This reflects some of the features of disposals available in Germany and the Netherlands, however very few of these orders have ever been made (Peay, 2015). Unlike in other countries, non-offending patients can also be admitted to forensic psychiatric hospitals if their behaviour cannot be managed in general psychiatric care.

In Germany, under Section 63 of the German Criminal Code, if a person is found to be lacking responsibility (Section 20, German Criminal Code) or have diminished responsibility (Section 21, German Criminal Code) as a result of a '*pathological mental disorder*, *a profound disturbance in consciousness*, *a mental deficiency or any other serious mental abnormality*' the court will order their involuntary admission to a forensic psychiatric hospital for treatment. Personality disorders, neuroses, and sexual deviations can all be included (Felthous & Saß, 2007), and '*profound consciousness disorder*' refers to extreme affective states of emotional arousal in otherwise 'normal' people. Offenders judged to be guilty but with severely diminished responsibility can be sentenced to time in prison and their time spent in hospital will be subtracted from their sentence (Müller-Isberner et al., 2000). A prisoner can also be transferred to a psychiatric hospital for treatment if they become mentally ill in prison. However, unlike in England and Wales, this wouldn't change their status as a serving prisoner and their stay in hospital could not be for longer than their original prison sentence. Under Section 64 of the German Criminal Code, individuals with substance misuse disorders can also be detained in hospital for treatment if they were intoxicated at the time of the offence or are judged to have diminished responsibility as a result of substance misuse. Detention under this section can only be for two years and will only be imposed if there appears a reasonable chance that treatment will be successful. Though not aimed at MDOs, the issue of preventive detention under Section 66 of the German Criminal Code warrants a brief mention as challenges to this provision (see ~~part~~ Section 3.8.2) have also impacted service organisation for MDOs. Under Section 66, preventive detention ('*Sicherheitsverwahrung*') can be imposed for individuals who have committed a grave offence and are considered a danger to the public. This detention is indefinite and is served within prison.

In ~~T~~the Netherlands, in order for a judge to impose a TBS order the following criteria must be met: the offender must have been suffering from a mental disorder at the time of the offence; this mental disorder diminished his responsibility for his actions in part or wholly; the offence must hold a prison tariff of at least 4 years and the individual must pose a risk to society (de Ruiter & Hildebrand, 2003). However, there is currently no definition of 'mental disorder' leaving it open to interpretation (Salize et al., 2002). The courts in the Netherlands can impose a prison sentence based on the seriousness of the offence and the degree to which the offender is considered responsible for their actions, followed by a TBS measure under which they will be admitted to a hospital for psychiatric treatment and rehabilitation. The prison sentence is served first to reflect the need to be held accountable for their actions (de Boer & Gerrits, 2007).

~~3.4.~~3.4 Review of detention

In England and Wales, all patients detained under the Mental Health Act can apply annually to a Mental Health Tribunal (MHT) for a review of their detention. If no application is made by the patient for three years, they will be automatically referred. MHTs consist of three members: a judge, an independent psychiatrist and a specialist (lay) member. The treating '*responsible clinician*' (usually a consultant forensic psychiatrist) has to submit a report on the patient outlining why they continue to warrant detention. The hearing of MHTs may be held privately or publicly (at the patients' request). MHTs may order the discharge of a patient (unrestricted or restricted) or make recommendations, e.g. for their transfer to another hospital or a Community Treatment Order (CTO). These recommendations, however, are not binding.

When committed to a psychiatric hospital in Germany, this is for a potentially '*indefinite period of time*', with judicial checks at least every year (or 6 monthly for those detained under Section 64) in order to ascertain the suitability of continued commitment (Konrad & Lau, 2010). This is done by the 'court of the execution of the sentence' (Strafvollstreckungskammer) as there are no separate tribunals.

In the Netherlands, decisions as to continued detention also remain with the sentencing court for all TBS measures (Salize & Dressing, 2005). A TBS measure is imposed for two years initially and will then be reviewed every two years by the court, alongside advice from the clinical team. A TBS measure can be extended for as long as the court feels is necessary in order to protect society, but proportionality related to the severity of the offence will also be considered by the judge. An external expert opinion

is required every six years to give an assessment of the TBS patient's progress and prognosis.

~~3.5.~~3.5 Discharge

For someone on a Section 37 hospital order in England and Wales, decisions about transfer and discharge are the responsibility of the responsible clinician or the hospital managers – in addition patients can be discharged by a MHT (Ministry of Justice, 2014). However, a Section 41 restriction order can be added to the hospital order meaning that discharge can only be granted by a MHT or the Ministry of Justice (but not the responsible clinician alone) and any transfer and leave also has to be agreed by the Ministry of Justice. For restricted patients there are different forms of discharge: absolute discharge, conditional discharge (discharge with certain conditions and recall to hospital if they are breached), and deferred conditional discharge (conditional discharge at a later point when certain specified arrangements are in place). For those transferred from prison for treatment under Section 47 of the Mental Health Act 1983, this almost always comes with an accompanying restriction direction (Section 49). When a person's sentence of imprisonment expires, a Section 49 restriction direction ceases to have effect leaving discharge in the hands of the medical care team (or hospital managers or a MHT) as opposed to the Ministry of Justice, similar to patients on a Section 37 hospital order. Before the expiry of their prison sentence, discharge can only be back to prison as opposed to the community. Similarly with decisions about transfer or leave, the responsible clinician can make these decisions for unrestricted patients while for restricted patients the Ministry of Justice has to agree.

In Germany, Section 67d paragraph 2 provides that the patient is discharged when '*no further criminal acts can be expected*'. Section 67d paragraph 6 provides that forensic detention shall be terminated when '*the court finds that the conditions for the measure no longer exist or that the continued enforcement of the measure would be disproportionate*'. While admission to hospital is potentially life-long, the Federal Constitutional Court (Bundesverfassunsgericht) has stated that the length of involuntary hospitalisation must be directly related to the severity of the index offence as well as the risk of recidivism. The longer the patient spends detained in hospital, the more their right to freedom begins to outweigh the public's right to protection (Müller-Isberner et al., 2000). Individuals may be subject to supervision in the community after discharge if the court deems it necessary to prevent further offending. Supervision can be ordered for a minimum of two and a maximum of five years, though it can be indefinite if the patient is repeatedly non-compliant with supervision arrangements. Breaching of conditions can also result in a further custodial sentence.

In the Netherlands, decisions to discharge also remain with the sentencing court for all TBS patients; a judge can over-rule any proposal from the clinical team regarding the patient's release or continued hospitalisation. The Ministry of Justice appoints two independent experts (a psychiatrist and a psychologist) to give evidence, however the final decision is with the court. Similar questions are asked in this process to those at the pre-trial assessment, although degree of responsibility is no longer relevant. Instead, treatment outcomes and prognosis become more important (Drost, 2006).

~~3.6.~~3.6 Service provision

Forensic psychiatric services in England and Wales are provided by either the National Health Service (NHS) or the independent sector and are organised according to three different levels of security to cater for different levels of risk posed by patients. High secure services are provided in three NHS hospitals, Broadmoor in Berkshire, Rampton in Nottinghamshire and Ashworth in Merseyside, with a total of around 750 beds (Rutherford & Duggan, 2007). They cater for individuals who present a 'grave and immediate' danger to the public. In recent times there has been a drastic reduction in high secure beds; however, an even bigger increase in medium secure beds. There are around 3,500 medium secure beds in total, just under half provided by the independent sector. In addition there are about 2,500 low secure beds (both NHS and independent) (National Health Service, 2014b). As each secure hospital has their own referral system and gatekeeping process to assess risk and clinical suitability, transfers between levels of security and from prison to hospital can be cumbersome. This may lead to patients being placed in inappropriately high levels of security for longer than is necessary (Shaw, Davies, & Morey, 2001). De Boer and Gerrits (2007) echo~~es~~ this finding, stating that England and Wales lacks a straightforward and easily applicable care pathway from high security back into the community for forensic patients.

The situation in Germany also lacks consistency as different German states have different processes and service provisions. According to Müller-Isberner et al. (2000), hospital treatment orders are carried out in forensic psychiatric hospitals with around 250–350 beds or in smaller forensic departments of general psychiatric hospitals, each funded and supervised by the State's Ministry of Health. However, due to increasing patient numbers, more patients are treated in general psychiatric hospitals which can cause severe security problems, in addition to the non-separation of voluntary and involuntary patients and a lack of appropriate treatment provision (Salize et al., 2002). Furthermore, service provision for patients on a hospital treatment order varies greatly between the sixteen German states. Unlike in England and Wales, in most German states the differing levels of security are encapsulated in 'one single service', in which transfers from higher to lower security levels can be completed 'within hours' (Müller-Isberner R, personal communication, 2015). Over the last two decades, forensic psychiatric bed numbers have increased by 389% in East Germany alone (Mundt et al., 2012). Figures published by the German National Office for Statistics confirm this trend with an increase in forensic patient numbers by about 100% between 1998 and 2013. By the end of March 2013, there were 6652 patients detained under Section 63 and 3819 under Section 64 (i.e. those treated for substance related disorders) (Statistisches Bundesamt Maßregelvollzugsstatistik, 2014).

According to research conducted by Petrila and de Ruiter (2011), there were 650 TBS beds in the Netherlands in 2001 compared with more recent figures which show a dramatic increase to 2,008 TBS beds in 2009. This dropped slightly to 1867 beds in 2013 and in 2018 it is expected the capacity will be 1339 for high secure inpatient care (Bulten E, personal communication, 2015). There are many reasons for this recent decline in capacity. For example, the courts are more cautious in giving TBS orders due to increasing lengths of stay, individuals are refusing pre-trial assessments making it very complicated to give a TBS order, the overall crime rate is dropping and the population is ageing (Bulten E, personal communication, 2015). Similar to Germany, TBS clinics in the Netherlands provide all levels of security within one hospital from maximum security down to pre-discharge and community supervision. This means that patients can be transferred between security levels easily and movement along the care pathway

becomes much more fluid (de Boer & Gerrits, 2007). Once assessed as being ready for discharge, patients can go on to 'transmural' treatment, which means they live in accommodation outside of the hospital but remain under supervision by the hospital and clinical team. They can be recalled immediately if conditions of this treatment are breached. Most patients will spend several years in transmural treatment before being absolutely or conditionally discharged from their TBS order. Probation services are responsible for monitoring the individual following conditional discharge (de Boer & Gerrits, 2007). TBS clinics were once greatly assisted in the discharge of patients by the cooperation of local businesses, which provided opportunities for work experience to current patients allowing them leave into the community and a chance to provide evidence of their progress (McInerny, 2000). Unfortunately, due to a current crisis of unemployment and an increasing stigma towards sex offenders (those with convictions against children in particular) this is becoming increasingly difficult (Bulten E, personal communication, 2015).

~~3.7.~~3.7 Treatment

In comparing the Dutch and UK models of forensic psychiatric care, De Boer and Gerrits (2007) observed that the medical model is dominant in England and Wales placing the patient as a passive recipient of medical treatment, '*in need of care*' for their mental illness. This philosophy is also apparent in the legal framework where mental health legislation – rather than criminal legislation – governs the provision for MDOs. Those who receive a hospital order receive no formal punishment for the offence they have committed and their ongoing detention, even if for longer than would have been the case had they received a prison sentence, is at the discretion of the clinical team rather than a judge. As forensic psychiatric care is therefore firmly grounded within the NHS, it is subject to a number of complex regulations to ensure high standards of care and is monitored by the Care Quality Commission (CQC, www.cqc.org.uk) as well as on a voluntary basis through the Royal College of Psychiatrists' Quality Improvement Network (Royal College of Psychiatrists, ~~RCP,~~ 2011). In terms of medical treatment, England and Wales adopt~~s~~ a paternalistic model of decision making which allows professionals to override a detained patient's refusal to consent even if they have capacity to make decisions. Psychological interventions are provided for the purpose of risk reduction ~~–~~ typically, following the stabilisation of any underlying mental disorder delivered on a 1:1 and/or group basis in manualised form. English healthcare places much emphasis on evidence based medicine as evidenced through the guidelines published by the National Institute for Health and Care Excellence (NICE, www.nice.org.uk) which are often cited beyond UK borders. Unfortunately, the evidence base for effective interventions in the treatment for MDOs remains limited (Knabb, Welsh, & Graham-Howard, 2011) leading to ethical challenges in a situation where the patient has to demonstrate a reduction of risk in order to be discharged.

For patients who are assessed to have diminished responsibility and receive a hospital order plus a prison sentence in Germany, time spent in a forensic psychiatric hospital is subtracted from the total time they had originally been sentenced to for the crime committed thereby emphasizing the individual as an agent able to make responsible decisions (Müller-Isberner et al., 2000). Personal autonomy and an individual's right to self-determination are highly regarded and must be respected, even if the patient lacks capacity or makes unwise decisions. This was first confirmed – and has since been reaffirmed – by the Federal Constitutional Court in 1996 that found a person's 'right to be ill' and to maintain mental illness (*BVerfGE 58*, *208*, *226ff*, *BVerfG 2 BvR 2270/96*; Rottgers & Lepping, 1999) outweighed society's responsibility for 'improving' the person's condition, as this would infringe on their personal freedom (Salize et al., 2002). Patients must not be restricted more than necessary within the institution, hence it would not be possible to blanket ban e.g. contact with family and spouses (including sexual), smoking and other activities commonly prohibited in the UK. In terms of actual treatment, due to a lack of national guidance and a very strong tradition of 'therapeutic freedom' on behalf of the therapists, an evidence base and research into the effectiveness of treatments is only slowly emerging in Germany (Müller-Isberner et al., 2000). Furthermore, the German Psychiatric Society Association has started to initiate discussions in order to implement minimum legally enforceable standards to govern services that patients receive in forensic hospitals and prison systems within Germany. These discussions are ongoing and the development is currently in its infancy (Müller-Isberner R, personal communication, 2015).

In the Netherlands, a MDO with diminished responsibility is first seen as an offender and is punished for their crime (with a prison sentence) before receiving treatment for their illness in hospital, with the main aims of a TBS order being for the protection of society with rehabilitation secondary, or 'if possible' (de Boer & Gerrits, 2007). However, if individuals are found to be completely criminally irresponsible they will not be punished but instead sent to hospital for treatment. Even then the onus is on the patient to not only take responsibility for their actions that have caused harm but to also take advantage of the treatment offered to them in order to reduce their future risk (de Boer & Gerrits, 2007). Once detained, the philosophy of treatment in TBS units is based on the principles of the Risk-Need-Responsivity and Good Lives model. Treatment is often organised incorporating Therapeutic Community approaches. Protective factors and quality of life are important concepts that are regularly assessed so that the patient is seen in a holistic way (rather than just 'a risk') (Bulten E, personal communication, 2015). This holistic approach is further reflected in that all patients, once able, are expected to work within the hospital for which they receive a salary. Links to the community are established early and hospitals are punished financially if patients do not achieve community leave within one year of admission.

Please see Table 1 below for a comparative summary of ~~parts~~ Sections 3.3–3.7~~—~~.

~~Table 1.~~Table 1

alt-text: Table 1.

Country	Criteria for admission	Review of detention	Discharge	Service provision	Treatment
England	- Section 37 Mental Health Act 1983 (risk to self or others)	- Mental Health Review Tribunal (annual by	- Section 37 (unrestricted patients) responsible	- National Health Service (public) and	- Those with hospital order

	- Opinion required from two registered medical practitioners - Mental disorder of *nature and degree making it appropriate* to be detained in hospital and *appropriate medical treatment* is available - Diversion from prison to hospital (Section 47 Mental Health Act 1983) - Non-offenders accepted	patient; automatic referral every 3 years) - 'Responsible clinician' - Restricted or unrestricted discharge	clinician/hospital managers - Section 41 (restricted patients) Ministry of Justice: absolute, conditional or deferred conditional - Section 49 restriction order: once expired, responsible clinician/hospital managers	private - Separate high, medium, low secure - 750 high-secure - 3,500 medium secure	receive no punishment - Regulated by Care Quality Commission (CQC) - No right to refuse treatment - Medical and psychological treatment - Focus on evidence-based model of care
Germany	- Section 63 German Criminal Code - Lacking responsibility (Section 20 German Criminal Code) or diminished responsibility (Section 20 German Criminal Code) - 'Preventative detention' for those of grave danger to the public (Section 66 German Criminal Code) - Diversion from prison to hospital possible, however does not change status as 'prisoner' - Non-offenders not accepted	- Judicial checks (annual) - Section 64 German Criminal Code (6 monthly review)	- Section 67d (para 2): discharge when 'no further criminal acts expected' - Section 67d (para 6): discharge determined by courts	- Ministry of Health funded (approx. 250–350 beds) forensic departments - Different between Germany's 16 states - 'One single service' (high to low secure)	- Time spent in hospital subtracted from original prison sentence - 'Right to be ill' and maintain mental illness - Limited restriction - Focus on 'therapeutic freedom' for physicians
Netherlands	- Terbeschikkingstelling (TBS) order - Diminished responsibility for actions in part or wholly; the offence must hold a prison tariff of at least 4 years; individual must pose a risk to society - Diversion from prison to hospital not possible - Non-offenders not accepted	- TBS imposed for 2 years initially (reviewed every 2 years) - Expert opinion required every 6 years	- Decision to discharge with sentencing court - Ministry of Justice: two appointed experts	- 1,867 TBS beds (in 2013) - All levels of security in one hospital	- Prison sentence received before treatment - Treatment to reduce future risk - Risk-need-responsivity and Good Lives model

					- Therapeutic Community and Quality of Life - Holistic treatment approach

~~3.8.~~3.8 Recent developments

~~3.8.1.~~3.8.1 *England and Wales*

There have been a number of changes to mental health legislation and service organisation in the UK in recent years which some (e.g. Pickersgill, 2013) have argued were designed to give authorities the right to detain more individuals indefinitely, with little regard for their treatment needs. Some of the changes were prompted by two high-profile murders committed by Michael Stone in 1996. Michael Stone had been diagnosed with a severe personality disorder (psychopathy) but was not deemed treatable and therefore not admitted to psychiatric care despite his known dangerousness. In the MHA (up to the changes in 2007), the '*treatability test*' applied to certain groups of patients requiring that treatment was "*likely to alleviate or prevent a deterioration of his condition*". This clause frequently led to the exclusion of individuals with psychopathy from psychiatric care and the government to accuse the psychiatric profession of not taking enough responsibility for the protection of the public. Plans were therefore made for specific legislation to allow the detention of psychopathic individuals and for investment in the treatment of personality disorders generally and of those with 'dangerous and severe personality disorders' (DSPD) in particular. Plans for separate legislation were abandoned – following widespread opposition – and changes made instead to existing mental health legislation and service delivery.

Under the MHA 1983, up to the changes in 2007, the definition of mental disorder was previously broken down into four categories: mental illness, psychopathic disorder, mental impairment and severe mental impairment. Since 2007 a 'simplified' definition is used '*any disorder or disability of the mind*', broadening the group of people the Act could apply to. Certain disorders remain excluded: '*Dependence on alcohol or drugs* [*not to be considered*] *a disorder or disability of the mind*'; however, sexual deviancy is no longer excluded, now permitting the detention of individuals with, e.g., paedophilia under the MHA. Another key amendment came in the replacement of the '*treatability test*' with the '*availability of appropriate treatment*' test. With this amendment a patient therefore no longer has to be deemed 'treatable', but '*appropriate medical treatment*' must merely be available (as opposed to the individual benefitting from such treatment) in the hospital in which a person is to be detained (Department of Health, 2012).

In terms of service provision, services for those with 'dangerous and severe personality disorders' (DSPD — a purely 'political' as opposed to clinical diagnosis) were commissioned from around 2003 onwards in two prisons and two high secure hospitals, catering for a~~bou~~round 300 patients in total. These units were available mainly for individuals with high psychopathy scores previously deemed untreatable. While the intention of the ~~g~~Government was to allow the detention of these individuals mainly for protection of the public, DSPD services did also allow for the development and evaluation of treatments for this challenging patient group (For a review of DSPD services and their successes and failures see Tyrer et al., 2010 and Völlm & Konappa, 2012). Unfortunately, these efforts have now been curbed with the announcement of the decommissioning of the DSPD programme. Instead, a new '*Offender personality disorder pathway*' is being implemented to treat personality disordered MDOs within the criminal justice system rather than the health system (Department of Health, 2011c).

~~3.8.2.~~3.8.2 *Germany*

Within the last few years, forensic psychiatric services in Germany have faced significant challenges due to a number of legal cases brought by detainees to the Federal Constitutional Court of Germany as well as the European Court of Human Rights. As a result, the German Therapy Detention Act came into force in 2011. It only applies to individuals who would otherwise be discharged due to the rulings as described above and can only be applied to individuals suffering from a mental disorder who present a serious risk to others. These individuals can be detained in an institution which must be able to offer adequate treatment for their mental disorder and a therapeutic environment that places the least burden possible on the detained individual. This sanction is imposed by a civil rather than criminal court. In addition, Section 66 of the German Criminal Code was amended in 2013 to emphasise the therapeutic nature of the measure. Another appeal heard by the European Court of Human Rights was *Glien v. German Government*. In this case the applicant claimed that his preventive detention under Section 66 was disproportionately long as at the time of his original sentencing in 1997 preventive detention could only be imposed for a maximum of 10 years. The Court found in 2013 that Glien's detention breached his right to liberty under Article 5 of the European Convention on Human Rights; in addition in the view of the Court, the preventive detention was to be classed as a 'penalty' and as such breached his right not to have a heavier penalty imposed than the one applicable at the time of offences. The Court further criticised that as the applicant was detained in a prison wing that, while designed for those in preventive detention, did not provide the treatment or therapeutic environment required under the Therapy Detention Act. In addition the Court made clear that a narrow definition of mental disorder was to be applied and that the disorder warranting detention under the new Act needed to be serious and suggested that the pure diagnosis of an antisocial personality disorder may not be sufficient. Mr Glien and others were awarded damages for their prolonged detention. These successful legal challenges to forensic detention in Germany once again highlight the need for both national and international comparison and review of the legal provisions in place to sanction MDOs.

~~3.8.3.~~3.8.3 *The Netherlands*

In recent years length of stay in the TBS system has slowly increased from 6 years to 10 years, partly due to Government policies on patient leave becoming stricter, restricting the options for clinical teams to support rehabilitation. A task force (including the Ministries of Justice and Health) was put together with the objective of reducing length of stay. This has been successful and length of stay has decreased back down to 8 years as a result of further changes in Government policy on patient leave. Hospitals must now apply for escorted leave for every TBS patient within 1 year of admission, unescorted leave within 4 years and transmural leave within 6 years enabling patients to move through the system quicker. This is currently a voluntary agreement between the Government and hospitals, but financial penalties may be put in place if targets aren't met in a reasonable amount of time. The task force also put arrangements in place to ensure all TBS patients can be discharged from forensic mental health hospitals once treatment is complete and further treatment should be made available to them in general mental health services where necessary. This is mainly targeted towards sex offenders who are the most difficult patients to get back into general health services and the community. However, it is important to remember that there may be a group of patients whose response to treatment is slower and for whom a system designed for faster throughput is not appropriate. These patients may be accommodated in specific long-stay services, established in the Netherlands in 1999, where they have been cared for in two separate TBS hospitals for a total of at least 6 years but who do not have a prospect of discharge in the short or medium term. These units, instead of focusing on risk reducing interventions, concentrate on quality of life. However recently, the Dutch Government has altered the leave policy for long-stay TBS patients (following a serious incident) so that they are no longer allowed unescorted community leave. This could have severe implications for their human rights and quality of life (Bulten E, personal communication, 2015).

~~4.~~4 Discussion

The purpose of this study was to build upon recent research and compare the forensic psychiatric system in England and Wales with that in Germany and the Netherlands. This was achieved by assimilating the results of a literature search and key information from personal communication with international experts from the comparator countries. Significant differences in the legal and policy context between the three countries emerged in terms of key concepts (e.g. of criminal responsibility) and the organisation, philosophy and incentivisation of forensic psychiatric care. For example in England and Wales, forensic psychiatric hospitals are divided into separate security levels, whereas those in the comparator countries incorporate all levels of security into one institution lending itself to a faster and more coherent throughput. A similar division can be seen in treatment philosophies, where patients in England and Wales have almost all responsibility for their recovery removed and placed onto their responsible clinician, but yet in Germany and the Netherlands patients retain a significant level of responsibility to partake in treatment and retain autonomy where possible. Clearly, all three countries are in the process of significant challenges and changes in care provision reflecting the tensions between the two key values of forensic psychiatry: Care for the individual and protection of the public, "*Respect for justice usually requires that we treat similar people in similar ways. However, forensic patients are vulnerable to exploitation and injustice… the patient's claim to justice is set against another's claim in an adversarial way*" (Adshead, 2000, p.302).

As the differences show, the way in which criminal responsibility is judged and applied within the legal framework can have significant implications for individuals who are considered to have had a mental disorder at the time of their offence. If the only options are to be wholly responsible or wholly irresponsible, only those with severe mental disorders can benefit from the regulations as is the case in England and Wales, where in addition the defence of diminished responsibility is only applicable for those charged with murder – an arrangement that lacks rationale coherence. Therefore, various suggestions have been made to reform the current diminished responsibility plea in England and Wales to either base it on lack of capacity (Law Commission, 2013), abolish it or extend it to incorporate all criminal offences (Mackay & Mitchell, 2003). This would bring it more in line with the varying levels of responsibility available in Germany and the Netherlands which can be applied to any offence, meaning that many more people experiencing mental health issues can be recognised and dealt with more appropriately.

Unlike the two comparator countries, in England and Wales the consideration of criminal responsibility is irrelevant to whether or not an individual is committed to forensic psychiatric care as opposed to receiving a prison sentence. Criteria for admission to forensic psychiatric care are largely the same as those applied to non-offending psychiatric patients, and these criteria are set out in mental health rather than criminal law. Both approaches have ethical implications. Restricting forensic psychiatric care to those with some level of diminished responsibility (as in Germany and the Netherlands) emphasises the importance of the likely mental state at the time of the offence but might neglect disorders developing subsequent to this, potentially hindering service provision to those who become unwell in prison. Admission to forensic psychiatric care based on current need (as in England and Wales) has the advantage of potentially delivering treatment to all those who require it. However, given the often lengthy stay in forensic psychiatric care, MDOs without diminished responsibility might find themselves incarcerated for significantly longer periods than if they had received a prison sentence in England and Wales, whereas in Germany time spent in hospital is deducted from their prison sentence and in the Netherlands the prison sentence is served first.

One unanswered question when considering the legislative frameworks for the detention of MDOs is whether differences in these frameworks actually result in or are at least associated with variations in numbers of detainees. Examining the criteria for detention in the three countries of interest here, one might expect that England and Wales would have the largest number of detainees as criteria for detention are vague in terms of immediacy and severity of risk; in addition there is no requirement for an impairment of criminal responsibility. However, rates of psychiatric detention (per 100,000) for the three countries are as follows; 74.8 for England and Wales (Hewlett & Horner, 2015), 171.9 for Germany (Valdes-Stauber, Deinert, & Kilian, 2012) and 136 for the Netherlands (Ministerie van Justitie, 2013). The higher rates in Germany and the Netherlands may reflect the differences in admission criteria (i.e. relating to criminal responsibility), different interpretations of the legal framework of each country and the exclusion of substance misuse disorders, but may also confirm Appelbaum's hypothesis that clinicians apply intuitive criteria for compulsion resulting in a relatively stable population of detained individuals over time almost regardless of any changes in law (Appelbaum, 1994). In addition there are, of course, other factors at play that affect detention figures and are more subtle, such as attitudes towards MDOs in society as a whole and bed availability. The number of psychiatric beds available in hospitals in the Netherlands (per 100,000) is 140, which is much higher than in Germany with 49 and England with 61 (European Commission, 2013). This will

have some bearing on what services are available for MDOs and the rates of psychiatric detention.

Outcomes are important indicators of how effective a system is. A follow-up study of patients discharged from a medium secure hospital in England over a twenty year period shows relatively poor outcomes, with 49% being reconvicted, 38% being readmitted to secure care and a risk of death six times greater than that of the general population (Davies et al., 2007). In the Netherlands, however, recidivism rates for discharged TBS patients have been steadily falling from 52% between 1974 and 1978 to 23% between 1994 and 1998 (de Boer & Gerrits, 2007) and in Germany between 1984 and 2003 readmission rates have fallen by 46% and recidivism by 74% (Müller-Isberner, 2012). The apparently poorer outcomes for patients in England and Wales may be due to ineffective treatments, but a potentially more likely explanation concerns their reintegration into society. UK policies are highly restrictive, for example the sex offender register prolongs stigma, criminal record checks greatly reduce employment opportunities and public opinion on offenders limits successful reintegration.

A shift towards greater concern for public protection as opposed to the individual offender's right to freedom has been identified in England and Wales and in the Netherlands, leading to increasing lengths of stay (Rutherford & Duggan, 2007) and a vast increase in forensic psychiatric beds (Priebe et al., 2005). In England & Wales concerns have also been expressed regarding the inappropriate use of the powers of detention under the Mental Health Act in order to secure necessary care, as there is also a severe lack of resources in general psychiatric care (see BBC, 2013 and BBC, 2014). Different approaches have been adopted by the two countries to deal with this situation. While the Netherlands have introduced a number of measures to reduce length of stay within the forensic psychiatric system as well as developing specific services for those for whom this is not successful (long-stay services), the UK government has focused resources in the prison system as opposed to the hospital system to reduce costs without reducing – and one might argue running the risk of increasing – length of stay or overall patient numbers. Germany has witnessed a very different trend where the pendulum appears to have swung back to an interest in individuals' rights with a significant overhaul of the forensic psychiatric system.

~~5.~~5 Conclusion

There are profound differences in the basic philosophy relating to the mentally disordered offender – are they treated first and foremost as a patient, or punished as a criminal? Unlike in Germany and the Netherlands, in England and Wales the regulations regarding detention of MDOs are largely removed from the criminal justice system – the individual is admitted to hospital care on the basis of clinical need rather than due to considerations regarding their criminal responsibility. While this may have been well intentioned at the time of inception, long-term detention in hospital – while not formally a punishment – may well feel just that by the recipient of such an order as a significant amount of personal autonomy and freedom is removed, as it would be in prison, and the time spent in hospital is potentially indefinite. Leaving decisions to admit and discharge with the medical profession and the Executive, rather than the Judiciary, may leave MDOs vulnerable to fall victim of changing societal attitudes.

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