

THE COMPETING FACES OF MENTAL HEALTH LAW: RECOVERY AND ACCESS VERSUS THE EXPANDING USE OF PREVENTIVE CONFINEMENT

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Introduction

Mental illnesses are the leading cause among all illnesses of disability in the United States, Canada, and Europe.¹ Mental illness and physical health are interrelated, with individuals with chronic disorders often suffering depression, and suicide ranking as the leading cause of violent death in the world.² In countries with established market economies, mental illnesses, including suicide, account for more than 15 percent of the burden of disease, and depressive disorders are the top cause of years of healthy life lost to illness in both high and low income countries.³ On October 10, 2010, the UN Secretary General launched its Mental Health Gap Intervention Guide, and asserted:

The vast majority of people with mental, neurological and substance use disorders do not receive even the most basic care. Yet such services are essential if we are to offer hope to some of the most marginalised people in the world, especially in developing countries, to live their lives in dignity.⁴

Few countries have sufficient treatment capacity and as public health budgets are cut in response to economic pressures, untreated mental illnesses threaten to become an even larger individual, family and social problem.⁵ Despite these problems,

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¹ *The World Health Report 2001—Mental Health: New Understanding, New Hope*, Geneva: World Health Organisation 2001.

² *Idem*, p. 21.

³ *Global Burden of Disease and Risk Factors*, Geneva: World Health Organisation 2001.

⁴ *mhGAP Mental Health Gap Action Programme: Scaling up Care for Mental, Neurological, and Substance Use Disorders*, Geneva: World Health Organisation 2010.

⁵ In the United States, less than one third of adults with a diagnosable mental illness receive treatment in a given year. See: United States Surgeon General, *Mental Health: A Report of the Surgeon General*, Washington D.C.: United States Department of Health and Human Services 1997, Chapter 2. A recent study in six European countries, including the Netherlands, found that use of health services by people with mental disorders is limited as well. J. Alonso, *et al.*, 'Use of mental health services in Europe: Results from the European study of the epidemiology of mental

there have been significant advances in treatment modalities and philosophy over the last two decades that have advanced the 'state of the art' in treatment. Biopsychosocial treatments that integrate medical, case management and support services result in increased contact with patients who otherwise might be lost to the care system.⁶ Recovery from mental illnesses is now the goal in treating even the most serious illnesses, a dramatic change from the traditional view that only symptom relief was possible.⁷ Finally, international conventions speak strongly about the rights of people with mental illnesses, including rights to be free from discrimination, to exercise autonomy, and to receive adequate care.⁸

These are important developments. An emphasis on recovery and patient-centred treatment enhances respect for the individual's dignity and autonomy. The codification of mental illness as a human rights issue provides a reminder that mental illness continues to be a cause for discrimination and differential treatment, and illustrates how policymakers have elevated mental illness to equal status among other disabilities. These salutary changes provide a foundation for reforming mental health care in many nations, even if they do not directly resolve questions of inadequate treatment capacity and access.⁹

disorders (ESEMeD) project', *Acta Psychiatrica Scandinavica* 2004-109 Supp.420, pp. 47-54.

⁶ S. Sytema, *et al.*, 'Assertive community treatment in the Netherlands: a randomised controlled trial', *Acta Psychiatrica Scandinavica* 2008-116, pp. 76-77.

⁷ Recovery has become an organising principle for policymakers and caregivers in many places, including but not limited to Canada (M. Piat, J. Sabetti, & D. Bloom, 'The transformation of mental health services to a recovery-oriented system of care: Canadian decision maker perspectives', *International Journal of Social Psychiatry* 2010-56, pp. 168-177); Slovenia (J.K. Hyun, *et al.*, 'Recovery and community based mental health services in the Slovak Republic: A pilot study on the implications for hospitalisation and inpatient length of stay for individuals with severe and persistent mental illness', *International Journal of Psychosocial Rehabilitation* 2008-13, pp. 67-80); Norway (M. Borg & K. Kristiansen, 'Recovery-oriented professionals: Helping relationships in mental health services', *Journal of Mental Health* 2004-13, pp. 493-505); the United Kingdom and Australia (B. Healy & N. Renouf, 'Recovery from mental illness as an emergent concept and practice in Australia and the UK', *International Journal of Social Psychiatry* 2007-53, pp. 108-122); and the Netherlands (H. Van Gestel-Timmermans, *et al.*, 'Hope as a determinant of mental health recovery: A psychometric evaluation of the Herth Hope Index-Dutch version', *Scandinavian Journal of Caring Sciences* 2010-24 S.1, pp. 67-74.

⁸ See: L. Gostin, 'Human rights of persons with mental disabilities: the European convention of human rights', *International Journal of Law and Psychiatry* 2000-23, pp. 125-159. Also, United Nations, *Convention on the Rights of Persons with Disabilities and Optional Protocol*. United Nations 2008.

⁹ For an analogy illustrating the potential impact of international conventions, one might examine the impact of United Nations' guidelines on juvenile justice. The guidelines have had considerable influence in countries trying to create non-punitive juvenile justice systems, rather than the more punitive systems that have developed over the last two decades in some Western countries. See: J. Petrila, 'An international perspective on juvenile justice issues', in B.L. Bottoms, C.J. Najdowski, & G. Goodman (eds) *Children as Victims, Witnesses, and Offenders*, New York: Guilford 2009, chapter 19 pp. 369-384.

I. The Continuing Problem of Coercion

Coercion of one sort or another has been used to segregate or forcibly treat people with mental illnesses for centuries. For example, in the Middle Ages, people thought to be mentally ill were kept in towers, burned, immersed in water, or otherwise tortured in some circumstances. The burnings associated with allegations of witchcraft often killed people who in fact were mentally ill.¹⁰ In the United States, in the 18th century, Dr. Benjamin Rush, the 'father of American psychiatry', urged, for therapeutic reasons, the use of 'swinging'. This process involved strapping people with mental illnesses into gyration devices suspended by chains from a ceiling and spinning them for as long as several hours.¹¹ The horrors of the institutional 'cuckoo's nest' were not revealed until the 1960s and 1970s when the overcrowding, understaffing, and overmedicating in United States psychiatric facilities was first exposed in books and film.¹²

Today, institutional conditions in many countries have markedly improved, though egregious practices, including the misuse of psychiatric care as a tool against political dissidence, have not disappeared.¹³ Coercion is still used, particularly with involuntary civil commitment. While substantive and procedural protections differ from nation to nation, in general these statutes provide that an involuntary treatment order can be entered if the person has a mental illness, is unwilling or lacks the capacity to seek care voluntarily, and presents some type of danger to themselves or others, through active behaviour or

¹⁰ For an excellent review, see: M. Foucault, *Madness and Civilization: A history of insanity in the age of reason*, London: Tavistock 1982.

¹¹ Benjamin Rush, *Medical Inquiries and Observations Upon the Diseases of the Mind*, Philadelphia: John Grigg 1830. Rush acted from a belief that these and other treatments that would now be considered inhumane had a therapeutic impact. As has often been the case in the treatment of mental illness, there was a chasm between therapeutic intent and scientific evidence for a treatment's efficacy.

¹² Ken Kesey's book, *One Flew Over the Cuckoo's Nest*, Signet 1963, based on his experiences as an aide in a psychiatric hospital in the 1950s, had enormous influence in exposing the inhuman conditions that existed in many psychiatric institutions. When the book was turned into a very popular film, its influence expanded considerably. It should be noted, however, that some of the images in the film (e.g., of Jack Nicholson receiving electroshock treatment) were overly dramatised and medically incorrect.

¹³ Forced psychiatric hospitalisation for political dissidents was a common practice in Soviet bloc countries and reportedly continues today in some countries, for example, China. See: Human Rights Watch and Geneva Initiative on Psychiatry, *Political Psychiatry in China Today and its Origins in the Mao Era*, New York: Human Rights Watch 2002; J. Amon, 'Abusing patients: Health providers' complicity in torture and cruel, inhuman or degrading treatment', January 21, 2010, at: <http://www.hrw.org/en/node/87624> (2 December 2010).

neglect.¹⁴ Several nations also permit the involuntary commitment of an individual to outpatient care, with substantive and procedural criteria sometimes different than those for inpatient commitment. This practice is called outpatient commitment or assisted treatment in the United States; in other countries, it is more commonly referred to as community treatment orders.¹⁵ Community treatment orders have been used most frequently in North America, Australasia, the United Kingdom, and Israel. In The Netherlands, patients can be released from hospital with a judicial order authorising outpatient treatment for a maximum of six months, during which the patient agrees to comply with a treatment plan. If the patient does not comply with the treatment plan, he or she can be involuntarily admitted.¹⁶ While the implementation of outpatient commitment in some jurisdictions has been hampered by a lack of adequate treatment resources and cumbersome statutory procedures,¹⁷ research conducted in the U.S. and elsewhere suggests that an outpatient treatment order of at least six months duration, combined with adequate treatment over that period, can reduce hospitalisations and criminal offending among some individuals with serious mental illnesses.¹⁸

¹⁴ For an interesting comparison of civil commitment statutes across former British Commonwealth countries, see: E.C. Fistein, *et al.*, 'A comparison of mental health legislation from diverse Commonwealth jurisdictions', *International Journal of Law and Psychiatry* 2009-32, pp. 147-155. Commitment rates vary dramatically across Europe, from 6 per 100,000 citizens in Portugal to 218 per 1000,000 in Finland. See: H.J. Salize & H. Dressing, 'Epidemiology of involuntary placement of mentally ill people across the European Union', *British Journal of Psychiatry* 2004-184, pp. 163-168.

¹⁵ The United Kingdom adopted legislation permitting the use of community treatment orders beginning in 2008. See: K. Jethwa & N. Galappathie, 'Editorial: Community treatment orders', *British Medical Journal* 2008-337, p. 613. Australia and New Zealand also permit the use of community treatment orders. For a review, see: J. Dawson & S. Romain, 'Use of community treatment orders in New Zealand: early findings', *Australian and New Zealand Journal of Psychiatry* 2001-35, pp. 190-195.

¹⁶ H.E. Kortrijk, *et al.*, 'Involuntary admission may support treatment outcome and motivation in patients receiving assertive community treatment' *Social Psychiatry and Psychiatric Epidemiology* 2009-45, pp. 245-252.

¹⁷ M. Gould, 'Hazards of a health safeguard', *The Guardian*, 13 May 2009, p. 3, reporting that CTO orders were delayed because of the shortage of independent physicians required to provide a second opinion on the person's suitability for an order; J. Petrila & A. Christy, 'Law & psychiatry: Florida's outpatient commitment law: a lesson in failed statutory reform?', *Psychiatric Services* 2008-59, pp. 21-23, reporting that Florida's outpatient commitment law had been used only 71 times in 3 years, despite that fact that more than 40,000 individuals potentially met statutory criteria.

¹⁸ There is an extensive literature on this topic, primarily from studies conducted in New York and North Carolina. For one recent example, see: M. Swartz, *et al.*, *New York State Assisted Outpatient Treatment Program Evaluation*, Durham NC: Duke University School of Medicine 2009.

II. Preventive Detainment Under the Guise of Treatment

Though involuntary treatment is still controversial, statutory frameworks assure periodic judicial and medical review. In addition, reductions in hospital stays¹⁹ and the development of new treatment modalities such as Assertive Community Treatment (ACT) provide new models for treating difficult-to-engage patients with severe mental illness and may have an impact on the use of commitment.²⁰ However, for some individuals, judicial commitment to an inpatient treatment facility can effectively be a life-sentence, based on flawed expert testimony, empty legislative promises of treatment, and legal processes that are more likely to assure the person stays confined indefinitely. Two populations, those committed in some countries as sexually violent predators (SVP) and those committed for an indefinite period in the Netherlands for mental health care after serving a criminal sentence under TBS legislation, illustrate a practice with broad ramifications for individual liberties, clinical practice, and public mental health systems.

II.1 Sexually Violent Predator Statutes

Since the 1980s, nearly 20 states in the U.S. have amended involuntary civil commitment statutes to permit the indeterminate confinement of 'sexually violent predators'. More than 3,000 people are confined in the U.S. under these statutes.²¹ Several states in Australia have similar laws²² as does Canada.²³ Civil law statutes are used because indefinite

¹⁹ The best discussion of this phenomenon can be found in: J. Bloom, 'Civil commitment is disappearing in Oregon', *Journal of the American Academy of Psychiatry and Law* 2006-34, pp. 534-537.

²⁰ M. Fiander, *et al.*, 'Assertive community treatment across the Atlantic: A comparison of model fidelity in the UK and USA', *British Journal of Psychiatry* 2003-182, pp. 248-254; S. Priebe, *et al.*, 'Processes of disengagement and engagement in assertive outreach patients: Qualitative study', *British Journal of Psychiatry* 2005-187, pp. 438-443.

²¹ M. Davey & A. Goodnough, 'Doubts rise as states hold sex offenders after prison', *New York Times*, 4 March 2007. More than 700,000 people are registered as sex offenders in the United States. National Center for Missing and Exploited Children, 'Map of registered sex offenders in the United States', 8 December 2009, at: http://www.missingkids.com/en_US/documents/sex-offender-map.pdf. Mandatory registration of sex offenders occurs in a number of countries, for example, Germany. See: A. Hammel, 'Preventive detention in comparative perspective', in: R. Miller & P. Zumbansen (eds) *Annual of German & European Law Volume II & III*, Oxford: Berghahn Books 2006, pp. 89-105.

²² P. Keyzer, 'The 'preventive detention' of serious sex offenders: further consideration of the international human rights dimensions', *Psychiatry, Psychology, and Law* 2009-16, pp. 262-270.

²³ For a comparison of United States and Canadian laws, see: M. Petrunik, L. Murphy & J.P. Federoff, 'American and Canadian approaches to sex offenders: a study of the politics of dangerousness', *Federal Sentencing Reporter* 2008-21, pp. 111-123.

confinement as a sexual offender typically occurs *after* a prison term ends; in countries where individuals cannot be punished twice for the same offense, a non-criminal approach is necessary to avoid constitutional problems that would arise if a person was confined under criminal law at the expiration of a sentence for the same offense.²⁴ Indeed, the constitutionality of these laws has been affirmed by high courts that have rejected arguments that these statutes impose criminal sanctions in the guise of civil law.²⁵

There is no question that many of the people who are confined under SVP statutes have committed heinous and often repeated offenses. Why and how, then, do these statutes offend core legal and ethical values?

First, they blur the line between civil and criminal law and provide an example of the growing use of preventive confinement.²⁶ While treatment is often promised, it is rarely delivered, resulting in what John LaFond characterises as “preventive detention masquerading as involuntary treatment”.²⁷ Individuals seldom can prove they will not be dangerous in the future, and so confinement continues, with life-long confinement a real possibility.²⁸

Second, the laws contaminate mental health clinical practice, particularly in diagnosis and risk assessment. SVP statutes do not typically use definitions of ‘mental illness’ rooted in psychiatric nomenclature. Rather, ‘mental abnormality’ is used, with a definition quite different than the ‘mental illnesses’ more commonly used in involuntary civil commitment laws. For example, the state of Kansas defines a ‘mental abnormality’ as

²⁴ For one of the best of many discussions of the constitutional issues, see: E.S. Janus & B. Bolin, ‘An end-game for sexually violent predator laws: As-applied invalidation’, *Ohio State Journal of Criminal Law* 2008-25, pp. 25-49.

²⁵ The key US Supreme Court decision is *Kansas v. Hendricks*, 521 U.S. 346, 1997. The Court ruled recently that the United States Congress has authority under federal law to create a federal sexual offender statute. *United States v. Comstock*, No. 08-1224, May 17, 2010. In Australia, the key case is *Fardon v. Attorney-General (QLD)* (2004) 223 CLR 575, critiqued in: P. Keyzer, ‘Preserving due process or warehousing the undesirables: to what end the separation of judicial power of the commonwealth?’, *Sydney Law Review* 2008-30, pp. 101-114.

²⁶ For a comprehensive discussion, see: B. McSherry & P. Keyzer, *Sex Offenders and Preventive Detention*, Annandale, NSW: The Federation Press 2009.

²⁷ J. LaFond, ‘Sexually violent predator laws and the liberal state: an ominous threat to individual liberty’, *International Journal of Law and Psychiatry* 2008-31, pp. 158-171, at p. 169.

²⁸ Courts in the United States at least have been clear that people committed under the SVP provisions of an involuntary civil commitment law can be treated differently, to their detriment, than other civil committees. Equal protection claims generally have been rejected. For a discussion, see: J. Petrila, ‘Because they do horrible things: fear, science, and the erosion of civil liberties in sexually violent proceedings’, *Journal of Psychiatry & Law* 2008-36, pp. 359-387.

a "congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses in a degree constituting such person as a menace to the health and safety of others".²⁹ There are no real diagnostic correlates to this definition and, as a result psychiatrists have asserted that individuals with various sexual paraphilias lack volition as required by the definition of 'mental abnormality' when in fact there is little evidence that this is true in most cases of paraphilia.³⁰ A finding that a person is a sexually violent predator and warrants indefinite confinement also requires a finding that the person is a future risk to re-offend. In several reported cases, mental health professionals exaggerated the reliability and validity of risk assessment instruments. In other cases they asserted that the *individual* would offend again when risk assessment instruments at best present a probabilistic assessment of future risk based on group statistics.³¹ As a result, the American Psychiatric Association has concluded:

Sexual predator laws represent a serious assault on the integrity of psychiatry (...) By bending civil commitment to serve essentially non-medical purposes, sexual predator statutes threaten to undermine the legitimacy of the medical model of commitment.³²

Third, SVP statutes erode due process guarantees because courts do not always exercise their discretion in barring often unsubstantiated testimony on future risk and diagnosis.³³ The use of civil law without adequate judicial oversight to advance

²⁹ Kansas Statutes Annotated, 59-29102(b).

³⁰ M.B. First & R.L. Halon, 'Use of DSM paraphilia diagnoses in sexually violent predator commitment cases', *Journal of the American Academy of Psychiatry and Law* 2008-36, pp. 443-454. First and Halon also point out that diagnoses are often incorrect in SVP proceedings, and that diagnoses of paraphilias often significantly exceed base rates found in treatment programs for sex offenders.

³¹ Risk assessment is a complex issue and controversy regarding the reliability of clinical testimony related to the risk of future offenses by someone with a mental illness is not entirely new. Nowadays there are tools to structure the inquiry into future risk by pointing the mental health professional towards the domains of information that research has shown are relevant in determining the probability for repeated offending. However, these instruments cannot be used to predict accurately whether a particular individual will re-offend. Space does not permit a full discussion of these issues here. The reader interested in the misapplication of risk assessment testimony in SVP proceedings might begin with: R.A. Prentky, *et al.*, 'Sexually violent predators in the courtroom: science on trial', *Psychology, Public Policy, and Law* 2006-12, pp. 357-386; S.D. Hart, C. Michie & D.J. Cooke, 'Precision of actuarial risk assessment instruments: Evaluating the 'margins of error' of group v. individual predictions of violence', *British Journal of Psychiatry* 2007-190, pp. 60-65.

³² *Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association*, Washington, D.C.: American Psychiatric Association 1999, pp. 173-174; T.W. Campbell, *Assessing Sex Offenders: Problems and Pitfalls*, Springfield Illinois: Charles Thomas 2005.

³³ Petrila, *supra*, note 27.

deterrence and incapacitation goals more commonly associated with criminal law, this can have broader implications for the use of preventive detention in liberal democracies that depend on clarity and transparency in articulating the uses of law against citizens.

Finally, legislative and professional beliefs that sexual offenders are inherently untreatable are uninformed at best, and cynical and therapeutically nihilistic at worse. Consider this passage from the Kansas legislation, a legislative model in the U.S.:

The legislature finds that a small but extremely dangerous group of sexually violent predators exist who *do not have a mental disease or defect that renders them appropriate for involuntary treatment* pursuant to the treatment act for mentally ill persons (...) sexually violent predators generally have antisocial personality features which are *unamenable to existing mental illness treatment modalities* and those features render them likely to engage in sexually violent behaviour. The legislature further finds that sexually violent predators likelihood of engaging in repeat acts of predatory sexual violence is high (...).³⁴ (italics added)

This assumption of untreatability ignores important developing evidence that some types of treatment actually can be effective.³⁵ However, because it is virtually impossible for detainees to obtain release once committed under an SVP statute, it is difficult to test the effectiveness of treatments on recidivism. Many individuals in these facilities also refuse treatment.³⁶ The result has been characterised as the return of the psychiatric warehouse, a phenomenon that threatens to undermine the hard won reforms in public mental health care that have occurred in the last four decades.³⁷

³⁴ KS LEGIS (1994). Chapter 316, section 1.

³⁵ R. Mann & W.L. Marshall. 'Advances in the treatment of adult incarcerated sex offenders', in: A.R. Beech, L.A. Craig & K.D. Browne (eds), *Assessment and treatment of sex offenders: A handbook*, New York: Wiley 2009, pp. 329-347; P. Briken & M. P. Kafka, 'Pharmacological treatment for paraphilic patients and sexual offenders', *Current Opinion in Psychiatry* 2007-20, pp. 609-613.

³⁶ Only 17% of 283 detainees (those awaiting the outcome of the civil trial that would determine whether they met the Florida SVP statutory criteria) were participating in treatment, while 46% of the 322 committed as SVPs after hearing were in treatment. Florida Office of Program Policy Analysis & Government Accountability *The Delays in Screening Sexually Violent Predators Increase Costs: Treatment Facility Security Enhanced*; Tallahassee, Florida, 2008. The review also found that the large number of detainees at the facility exacerbated both safety and therapeutic concerns, and drove up costs.

³⁷ Petriola, *supra*, note 27.

II.2 TBS Legislation and the Confinement of the 'Personality Disordered'

The U.S. and Australasia are not the only countries who indefinitely confine classes of 'mentally disordered offenders'. For nearly two decades, the U.K. has permitted the indefinite confinement of sexual and persistent violent offenders and debates over expanding the use of compulsion have raged for more than a decade.³⁸

More pertinent here, Dutch criminal law has permitted the indefinite confinement of individuals with mental disorders since 1928.³⁹ A person confined under the TBS legislation serves his or her prison sentence first and then, if determined to be "a danger to others and/or to the general safety of persons and property", he or she is remanded to one of 13 Dutch forensic psychiatric facilities permitted to hold and treat such individuals.⁴⁰ The legislation is designed to provide confinement of individuals whose criminal act was affected by a mental disorder with responsibility diminished or absent.⁴¹ Forensic patients detained under TBS legislation generally have been

³⁸ In the UK, the numbers of those indefinitely detained or monitored has grown from 2,677 (or 8.7% of sentenced offenders) in 1989 to 7,274 (or 11.5%) in 2006. See: J. de Boer, S. Whyte & T. Maden, 'Compulsory treatment of dangerous offenders with severe personality disorders: a comparison of the English DSPD and Dutch TBS systems', *The Journal of Forensic Psychiatry & Psychology* 2008-19, pp. 148-163. For one of many examples of the debate over treatment orders, see: S. Lawton-Smith, J. Dawson & T. Burns, 'In debate: community treatment orders are not a good thing', *The British Journal of Psychiatry* 2008-193, pp. 96-100; H.R. Steinbock, 'New developments in preventive detention in Germany', *Current Opinion in Psychiatry* 2009-22, pp. 488-491.

³⁹ The Dutch entrustment Act, or Terbeschikkingstelling van de staat (TBS) was enacted in 1928 to protect society from individuals who had committed a serious crime on account of a serious mental disorder or defective development (including personality disorder) who were believed to constitute a continuing danger to society. See; C. de Ruiter. & M. Hildebrand, 'The dual nature of forensic psychiatric practice: Risk assessment and management under the Dutch TBS-order', in: P.J. van Koppen & S.D. Penrod (eds), *Adversarial vs. Inquisitorial Justice: Psychological Perspectives on Criminal Justice Systems*, New York: Plenum Press 2003, pp. 91-106.

⁴⁰ A general overview can be found in: H.J.C. van Marle, 'The Dutch entrustment act (TBS): its principles and innovations', *International Journal of Forensic Mental Health* 2002-1, pp. 83-92.

⁴¹ There are several statutory criteria that must be met. The person must have suffered from a mental disorder and/or defective development (including intellectual disabilities and personality disorders) at the time of the offense; there must have been a link between the disorder and the offense; the offense carries a prison sentence of at least 4 years' duration according to the Criminal Code; there is a high risk of reoffending; and the offender cannot be held fully accountable for the offense because of the disorder. See: J. de Boer, S. Whyte & T. Maden, 'Compulsory treatment of dangerous offenders with severe personality disorders: a comparison of the English DSPD and Dutch TBS systems', *The Journal of Forensic Psychiatry* 2008-19, pp. 148-163; De Ruiter & Hildebrand, *supra*, note 39.

convicted for serious violent and sexual offenses.⁴² TBS is part of Dutch criminal law. As is the case with SVP laws, the number of people confined continues to increase, stretching the resources necessary to implement the statute.⁴³ There were 650 TBS beds in 2001, but the latest figures provided by the Dutch Correctional Service in September 2009 reveal the number of TBS-detainees has since then increased to 2,008.⁴⁴

Recidivism rates of those confined to TBS hospitals appear to be politically and socially acceptable, particularly given the legislative goal of protecting public safety.⁴⁵ However, many of the criticisms of SVP legislation are applicable to the TBS system. First, the statute permits indefinite confinement based on risk assessment techniques that cannot accurately predict over the long term whether *an individual* will reoffend. The use of structured risk assessment tools has improved the replicability and predictive accuracy of risk assessment markedly over the years⁴⁶, but predicting long term risk is inexact and in an era in which preventive confinement is increasingly turned to in the interest of public safety, there

⁴² M. Hildebrand & C. de Ruiter, 'PCL-R psychopathy and its relation to DSM-IV Axis I and Axis II disorders in a sample of male forensic psychiatric patients in the Netherlands', *International Journal of Law and Psychiatry* 2004-27, pp. 233-248.

⁴³ A court reviews whether the person continues to meet criteria for confinement every one or two years. A mandatory independent clinical review must occur every six years, and as the number of detainees increases, it has become increasingly difficult to conduct the independent reviews in a timely manner. There have also been delays in transferring people from prison to hospitals because of waiting lists. Van Marle, *supra*, note 40.

⁴⁴ TBS in getal (2005-2009), Dienst Justitiele Inrichtingen, Netherlands Ministry of Justice, at: <http://www.dji.nl/Organisatie/Feiten-en-cijfers/index.aspx> (16 December 2010).

⁴⁵ A multiple cohort study of people held under TBS orders from 1974-1998 found that the rate of recidivism had declined over time. Approximately 20% of those released to the community committed a new violent offense within five years. See: B.S.J. Wartna, S. Harbachi & L.M. van der Knaap, 'Recidivism following treatment: a statistical review of criminal recidivism of former offenders under an entrustment order in the Netherlands', in: *Series Onderzoek en beleid*, The Hague: Boom Juridische uitgevers, at: <http://english.wodc.nl/onderzoeksdatabase/01.092a3---recidive-tbs.aspx>

⁴⁶ Several studies on the predictive accuracy of structured instruments for violence risk assessment have been conducted in samples of TBS patients who were released. All of these studies have demonstrated good to excellent predictive validity for general and sexual violence over follow-up periods up to six years after release. See for instance: V. de Vogel, *et al.*, 'Type of discharge and risk of recidivism measured by the HCR-20: A retrospective study in a Dutch sample of treated forensic psychiatric patients', *International Journal of Forensic Mental Health*, 2004-3, pp. 149-165; V. de Vogel, *et al.*, 'Predictive validity of the SVR-20- and Static-99 in a Dutch sample of treated sex offenders', *Law and Human Behavior* 2004-28, pp. 235-251; V. de Vogel & C. de Ruiter, 'The HCR-20 in personality disordered female offenders: A comparison with a matched sample of males', *Clinical Psychology and Psychotherapy* 2005-12, pp. 226-240.

certainly will be individuals who spend years in confinement who would not have offended again.⁴⁷

Second, it appears that treatment can have a positive effect for some committed under TBS laws.⁴⁸ However, as the population of detainees grows, scarce treatment resources may be drawn away from people with serious mental illnesses in other settings in favour of those entering care through the criminal justice system. This can have the effect of altering the mission of a public mental health system, from a focus on recovery and long-term care for people with serious mental illnesses to providing services to a comparatively small group of people where the emphasis is on managing public risk rather than recovery from mental illness.

Finally, TBS laws, like SVP laws, raise human rights concerns. Even if one grants the basic legal legitimacy of such statutory schemes, inefficiencies in administration and a lack of necessary resources can significantly extend the amount of time a person is confined, with no treatment and no opportunity for release. The increase in the number of TBS patients transferred to secure long stay and long care facilities in recent years is alarming, according to the Dutch Council for the Administration of Justice and Juvenile Protection.⁴⁹ Resulting delays in access to care is a human rights issue, and the European Court of Human Rights awarded monetary damages to an individual

⁴⁷ While it is difficult to predict which individuals will commit an offence again in the long-term, it is of course also difficult to predict who will not. Legislation like SVP statutes and the TBS law draw from a population of previous offenders, and so, to some degree, ameliorate the potential threat to civil liberties to the population at large, given that previous offenses are the best predictor of future offending. However, when preventive confinement is used more and more broadly, the risk of 'false-positives' (wrongly identifying individuals as threats to commit an offence who would not have done so) increases. A recent case study (in Dutch) by De Ruiter revealed that even an individual with a low base rate of recidivism in the long term, as was demonstrated in large cohort studies, may inadvertently end up in a TBS long stay facility and was only released under conditions because a counter-expert alerted the deciding judge that the risk assessment performed by the detaining hospital was inaccurate. See: C. de Ruiter, 'Eenbrandstichter op de longstay: Waarom contra-expertises hard nodig zijn', *GZ-Psychologie* 2010-2 (3), pp. 18-23.

⁴⁸ C. de Ruiter & R.L. Trestman, 'Prevalence and treatment of personality disorders in Dutch forensic mental health services', *Journal of the American Academy of Psychiatry and Law* 2007-35, pp. 92-97; P.G.J. Greeven & C. de Ruiter, 'Personality disorders in a Dutch forensic psychiatric sample: Changes with treatment', *Criminal Behaviour and Mental Health* 2004-14, pp. 280-290.

⁴⁹ 'Longstay in the context of a hospital order (tbs)', advice to the Minister of Justice, 1 February 2008, at: http://www.rsj.nl/english/Summaries_of_recommendations/ (16 December 2010). Furthermore, government regulations require tri-annual reviews of the patients in long stay, as of 1 June 2009. In a letter dated 18 November 2009, the Council for the Administration of Justice and Juvenile Protection, raised concern about the lack of transparent criteria for long stay/long care and the delay in the implementation of the tri-annual reviews of these cases.

committed under TBS law whose transfer from prison to treatment was delayed for 14 months.⁵⁰

Conclusion

There have been great advances in treatment of mental illnesses in the last two decades, and the emergence of recovery as the goal of treatment, even in the most serious cases, raises hope that individuals with serious mental illnesses can return in greater numbers to productive participation in society. However, the growing use of preventive detention in which mental health professionals play an active role, stands in contrast to this more hopeful vision of mental health treatment. In an era of scarce resources, with no foreseeable improvement in national economies, political decisions to focus resources on the putatively dangerous can only further postpone the implementation of effective community focused public mental health systems while potentially contributing to the erosion of broader due process protections and basic rights.

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⁵⁰ Brand v. The Netherlands 49902/99 (2004) ECHR 196.