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

Rachel Edworthy [a], Stephanie Sampson [b], Birgit Völlm [c,*]

[a] School of Medicine Division of Psychiatry and Applied Psychology, Section of Forensic Mental Health, Institute of Mental Health, University of Nottingham Innovation Park, Triumph Road, Nottingham NG7 2TU, United Kingdom
[b] Institute of Mental Health, University of Nottingham Innovation Park, Triumph Road, Nottingham NG7 2TU, United Kingdom
[c] Head of Section Forensic Mental Health, School of Medicine Division of Psychiatry and Applied Psychology, Institute of Mental Health, University of Nottingham Innovation Park, Triumph Road, Nottingham NG7 2TU, United Kingdom

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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.

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

* Corresponding author. Tel.: +44 1158 231266.
E-mail addresses: rachel.edworthy@nottinghamcity.nhs.uk (R. Edworthy), stephanie.sampson@nottingham.ac.uk (S. Sampson), birgit.vollm@nottingham.ac.uk (B. Völlm).

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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 healthcare 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 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. 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. Results

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 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

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