

Summary

Reoffending following forensic care trajectories ending in 2013-2015

Introduction

Forensic care refers to mental health care, addiction treatment, and care for people with mild or borderline intellectual disabilities, provided within the criminal justice system. The primary aim of forensic care is to prevent perpetrators with mental health disorders from reoffending.

The Dutch Research and Documentation Centre (WODC) is carrying out a five-year research programme into reconviction and forensic care (2016-2021), at the request of the Department of Corrections and Youth and the Department of Custodial Institutions from the Ministry of Justice and Security. Previous research within this programme provided reconviction rates broken down according to the different kinds of forensic care orders that can be imposed (Drieschner, Hill & Weijters, 2018). Rates were calculated for offenders released in 2013 and 2014. However, there is no direct relationship between forensic care orders and the type of care provided in the name of reducing the risk of reconviction. Hence, in this study, reconviction rates are linked to the type of care received, rather than the forensic care order imposed. Rates are presented for offenders released between 2013 and 2015.

The Dutch forensic care system is made up of many different types of care. These include outpatient and inpatient treatment with different security levels, specialized treatment for people with addiction problems and intellectual disabilities, forensic care within the prison system, and forensic care in assisted living facilities. Several types of forensic care can be provided during a single period within the criminal justice system, referred to in this report as a forensic care trajectory. In this study we differentiate between tbs trajectories (*terbeschikkingstelling*: disposal to be treated in a forensic hospital on behalf of the state) and trajectories encompassing all other forensic care. These other forensic care trajectories are differentiated according to the presence of a period in prison or in assisted living facilities during the forensic care trajectory, as well as the provision of outpatient or inpatient treatment. Using these criteria the forensic care trajectories are classified into ten trajectory types (see table S1).

Table S1 Classification of ten types of forensic care trajectories

Trajectories	
<i>Other forensic care trajectories</i>	
Entirely outpatient treatment	1 All FC is provided by one or more forensic psychiatric outpatient facilities
	2 All FC is provided by one or more forensic addiction facilities
	3 All FC is provided by other or unspecified types of outpatient facilities
Including inpatient treatment	4 At least some of FC consists of inpatient treatment (excluding assisted living)
	5 At least some of FC consists of assisted living care
Including a prison period	6 All FC is provided in prison, including penitentiary psychiatric centres
	7 FC outside prison (excluding assisted living) alongside one or more periods of imprisonment
	8 Assisted living care (with or without other FC) alongside one or more periods of imprisonment
<i>Tbs trajectories</i>	
	9 FC within the tbs order
	10 FC within the conditional tbs order

Note: FC=forensic care

The following research questions are answered for the ten different forensic care trajectories:

- 1 What types of forensic care trajectories can be distinguished, and what proportion of ex-offenders is released from each type of trajectory?
- 2 Per type of forensic care trajectory, what are the demographic and criminal history characteristics of ex-offenders released between 2013 and 2015?
- 3 Examining a range of different time points following release, what are the reconviction rates for the different types of forensic care trajectories?
- 4 What are the reconviction percentages?
- 5 What is the average number of new criminal cases per reoffender?
- 6 Which offender characteristics and features of the forensic care provided are associated with reconviction following release?

Method

The research population includes all recipients of forensic care who were released in 2013, 2014 or 2015.

The research sample was based on data from seven national registration systems: the Information Monitoring System for the tbs group (MITS), the prison registration system Execution of Personal Penalties (TULP), the Forensic Care Information System (IFZO), the Billing Control System (FCS), the billing system Discharges and Patient Flow within Forensic Care (RePaD) (all managed by the Department for Judicial Interventions; DJI); the WODC's Research and Policy Database for Judicial Documentation (OBJD); and registration of conditional orders by the Central Judicial Collection Service (CJIB). Data from these systems were matched and processed in order to put together the final research file. This file contains the following data on each offender: start and end data of the forensic care trajectory, type of forensic care received, with details of each period of care within a single trajectory, criminal order under which the care was imposed, classification of psychopathology, demographic characteristics, and finally details on criminal cases, divided into reconviction cases, the index case for the forensic care, and criminal history.

In line with the standard method of the Dutch Recidivism Monitor, in this study reconviction is operationalised as a criminal case resulting from a crime committed following release from a forensic care trajectory, which ends in either a guilty verdict by the judge or a settlement by the public prosecution service. Three reconviction categories are examined: general reconviction (includes all offences that lead to a reconviction), very serious reconviction (conviction based on a law article with treat of a custodial sentence of eight years or more), and reconvictions for offences for which a tbs order can be imposed. In addition, reconviction rates are reported for violent offences, sex offences, property offences and drug offences.

For each of the ten forensic care trajectories, survival analysis is used to calculate the percentage of offenders reconvicted within two years of release from a forensic care trajectory, as well as the average number of reconvictions per reoffender. In addition, the percentage of offenders reconvicted throughout the first four years following release are computed. The rates for general and very serious reconvictions for the ten trajectories are further broken down by demographic characteristics, criminal history, type of offence in the index case, criminal order, and psychopathology. Finally, Cox regression analysis is used to determine which combination of individual characteristics (demographics, criminal history, psychopathology), criminal order, and characteristics of the forensic care (trajectory type, trajectory length, and security level) explain general and very serious reconviction.

Main findings

Between 2013 and 2015 roughly 17,500 offenders were released from a forensic care trajectory. Of these, 50% were trajectories consisting entirely of outpatient forensic care (trajectory types 1-3), 40% were trajectories that included an imprisonment period (trajectory types 6-8), 6% were trajectories with inpatient forensic care or assisted living, and 4% were tbs trajectories.

The groups based on the ten forensic care trajectories differ in terms of demographic characteristics and criminal histories. Fewer females are found in the trajectories with an imprisonment period, and in the tbs trajectories, than in the other trajectories. Furthermore, in the trajectories with an imprisonment period, the percentage of offenders born outside the Netherlands is higher than in the other trajectories. For the tbs trajectories, and above all the tbs with compulsory care rather than the conditional tbs, average age at release is considerably higher than for the other trajectories. This is due to the longer length of the tbs trajectories.

Table S2 Demographic characteristics and criminal history of the research groups for ten forensic care trajectories

FC trajectory		Demographics of the group			Criminal history	
		% female	% born in the Netherlands	Average release age	Average number criminal cases	Average number of imprisonments
Outpatient trajectories	1 Exclusively forensic psychiatric facilities	9-14%	73-84%	36-39	6-10	1-2
	2 Exclusively forensic addiction facilities					
	3 Other/unspecified outpatient FC					
Trajectories with inpatient treatment or assisted living	4 Inpatient with possible outpatient treatment	6-7%	59-72%	40-44	7-10	2
	5 Inpatient and/or outpatient treatment and assisted living					
Trajectories with prison periods	6 Exclusively FC in prison	6-7%	59-72%	40-44	7-10	2
	7 Outpatient treatment alongside prison					
Tbs trajectories	8 Assisted living, prison and possible outpatient treatment	6-7%	59-72%	40-44	7-10	2
	9 Tbs order with treatment in forensic hospital					
	10 Conditional tbs order					

With the exception of the tbs trajectories, the extent of the criminal history is related to the type of forensic care received. The groups who have completed a trajectory with an imprisonment period, have the highest numbers of previous convictions and previous unconditional imprisonments. The groups who completed trajectories with outpatient forensic care, have the least extensive criminal history. In the middle, we find the forensic care trajectories with inpatient forensic care or assisted living. For the tbs trajectories, the link between the index case offence and having a tbs order imposed, is stronger than the link with criminal history.

The results presented in table S3 indicate that 51-53% of those released from a forensic care trajectory that includes a period in prison, are reconvicted within two years of release. In 9-11% of cases, the reconviction is for a very serious offence. For this group, the percentage of reoffenders is twice as high, and for those with reconvictions for very serious offences four times as high, as that of the groups who followed trajectories with solely outpatient treatment. These groups have reconviction rates of 26-27% and 2-3% respectively. The trajectories which include inpatient treatment or assisted living (types 4 and 5) and outpatient addiction treatment (type 2), fall in the middle of the imprisonment and outpatient trajectories, with reconviction rates of 34-37% and 3-6% for very serious offences. Regarding general reconviction, the percentages of reoffenders are the lowest for the tbs trajectories, namely 18-20%. However, the percentage of ex-tbs offenders reconvicted for a very serious offence is 4-7%, and thus relatively high compared to general reconviction for this group.

Table S3 Reconvection percentages and average number of reconctions per reoffender within two years per forensic care trajectory

	Percentage reoffenders		Average number of reconctions per reoffender	
	General reconctions	Very serious reconctions	General reconctions	Very serious reconctions
<i>Outpatient trajectories</i>				
1 Exclusively forensic psychiatric facilities	26.6	3.0	1.8	1.1
2 Exclusively forensic addiction facilities	33.9	2.3	2.3	1.0
3 Other/unspecified outpatient FC	26.3	2.3	1.8	1.1
<i>Trajectories with inpatient treatment or assisted living</i>				
4 Inpatient with possible outpatient treatment	35.6	5.5	2.4	1.0
5 Inpatient and/or outpatient treatment and assisted living	36.9	2.8	2.3	1.2
<i>Trajectories with prison periods</i>				
6 Exclusively FC in prison	51.7	11.0	3.3	1.1
7 Outpatient treatment alongside prison	53.1	9.2	2.8	1.2
8 Assisted living, prison and possible outpatient treatment	51.2	10.6	3.3	1.3
<i>Tbs trajectories</i>				
9 Tbs order with treatment in forensic hospital	18.2	4.2	1.7	1.1
10 Conditional tbs order	20.0	6.7	2.2	1.3

A similar pattern emerges for the number of reconctions per reoffender. This is highest for forensic care trajectories with a period in prison (on average 2.8-3.3 cases), followed by the trajectories with inpatient treatment or assisted living and the outpatient addiction treatment trajectories (2.3-2.4 cases), the remaining outpatient trajectories (1.8 cases), and the tbs trajectories (1.7-2.2 cases).

An important question is, which variables are associated with the risk of reconction. This is investigated separately for the two types of tbs-trajectories (types 9 and 10) and the other eight trajectories. In the case of the tbs-trajectories, associations of reconction with demographic characteristics, criminal history, and psychopathology are investigated. In the case of the other types of trajectories, we also looked at characteristics of the forensics care that was delivered. In all cases, the focus was on the question, which variables are associated with reconction after controlling for the influence of all other variables.

After release from tbs-trajectories, a higher risk of reoffending is associated with younger age at the time of the first offence, and with a higher number of previous convictions. In addition, the risk of very serious reoffending is higher for those born outside the Netherlands.

After release from the other types of trajectories, the following variables make a unique contribution to the statistical explanation of reconction, after controlling for all other variables. With respect to demographic characteristics, males have a higher risk of reconction than females, and those born outside of the Netherlands have a higher risk of reconction than those born in the Netherlands. The risk of very serious reconctions for these two groups is even higher than for general reconctions. The risk of reconction decreases as age increases.

Criminal history is also correlated with risk of reconviction. The risk increases as the number of previous convictions increases and as the number of previous unconditional custodial sentences increases. Furthermore, the younger an offender was at the time of their first conviction, the higher the chance of being reconvicted. If forensic care was imposed as a result of a violent or sex offence, the risk of reconviction is lower. If it was imposed as the result of a property offence not involving violence, the risk of reconviction is higher.

Examining the type of disorder treated, the group with a substance-related disorder has the highest risk of reconviction. Those with a sexual disorder the lowest risk of reconviction.

With the exception of the tbs trajectories, the relationship between type of trajectory and reconviction was examined. Even having controlled for all characteristics named above, this relationship remained statistically significant. Compared to outpatient trajectories, the group released from trajectories with an imprisonment period has a substantially higher risk of reconviction. In the period immediately following release, their risk of general reconviction is twice as high and their risk of reconviction for a very serious offence is between two and a half and four times as high. With each additional year, however, the difference in reconviction risk between outpatient trajectories and trajectories with an imprisonment period decreases. For trajectories without an imprisonment period, but with inpatient treatment, the risk of reconviction for a very serious offence is also nearly twice as high as that for outpatient trajectories. For all trajectory types, the risk of reconviction decreases slightly as the duration of the trajectory increases.

The criminal order under which the forensic care was imposed, is not related to the risk of either general or very serious reconviction.

Conclusion

In this study, reconviction following release from forensic care between 2013 and 2015 has been investigated. Ten different types of forensic care trajectories are examined.

Over half of those released from forensic care followed a trajectory exclusively involving outpatient treatment. The second largest group concerns the forensic care trajectories with a period in prison, where either the trajectory began with a period of unconditional imprisonment or a conditional order with forensic care was converted to unconditional imprisonment. Just ten percent of the forensic care population is released from tbs trajectories or from other trajectories with inpatient care and or assisted living.

Offenders from outpatient trajectories have on average a less serious criminal history than offenders from the other trajectories, and in particular than those in the trajectories which include a period of imprisonment. This indicates that the imposition and allocation of forensic care is broadly in accordance with the scientifically supported core principle of effective offender treatment, i.e., that the more intensive interventions are reserved for the offenders with the highest risk of reconviction.

The reconviction rate of 50% within two years after release is twice as high for forensic care trajectories with a period of imprisonment than for outpatient trajectories. With 10%, the reconviction rate for very serious offences is about four times higher. The forensic care trajectories with inpatient treatment or assisted living fall in the middle of these, as do the tbs trajectories with regard to reconvictions for very serious offences. Regarding general reconvictions, the rate is lower for the tbs trajectories than for the outpatient trajectories.

An important question is whether the higher reconviction rates for offenders not released from an outpatient trajectory, and particularly for those with an imprisonment period, can be explained by a more serious criminal history, by demographic differences, or by psychopathology. This appears to be only partly the case. Even after adjusting for these differences, those released from a trajectory with an imprisonment period have a much higher risk of reconviction than those released from an outpatient trajectory, in particular for the period immediately following release.

However, despite the fact that differences in reconviction rates between the forensic care trajectories cannot entirely be attributed to criminal history, demographic, or diagnostic differences between the groups concerned, conclusions as to the effectiveness of the trajectory types for reducing reoffending cannot be drawn. It is possible that the groups differ on characteristics not included in this study. These might include risk factors, such as, motivation and commitment to treatment or willingness to adhere to conditions imposed.

Contrary to the previous study on reconviction following forensic care, reconviction rates were examined for different types of forensic care provided, rather than the type of criminal order under which the forensic care was imposed. Two results support the importance of this approach. First, the reconviction rate within the same criminal order was found to vary widely, depending on the type of forensic care provided. Secondly, a relationship between the type of forensic care trajectory and reconviction was found after controlling for the influence of all other variables included in the model. This was not the case for the type of criminal order imposed. In order to obtain an even more complete picture of reconviction and forensic care, future research needs to examine reconvictions during forensic care trajectories, as well as the role of regular care following release from forensic care trajectories. This research is planned within the WODC programme Recidivism and Forensic Care, 2016-2021.

When considering the implications of this research, misinterpretation of the results in terms of the effectiveness of certain types of forensic care must be guarded against. Further investigation is needed regarding three striking findings: the high reconviction rates for forensic care trajectories with an imprisonment period; the fact that forensic care is scaled down relatively infrequently in the run-up to release; and the remarkably high percentage of reoffenders in subgroups, with certain combinations of criminal order and type of forensic care trajectory. Furthermore, prior to conducting research into the effectiveness of forensic care, an investigation of the factors that determine which individuals receive forensic care, or receive a specific type of forensic care, is necessary.