

Prolonging the court-ordered detention of offenders: the contribution of forensic psychiatric expert testimonies

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Abstract

In Germany, the average duration of court-ordered detention of offenders has more than doubled during the past twenty years. The paper investigates the contribution of psychiatric experts to this development, thus shifting the focus away from offenders to psychiatrists and to their assessments of the offenders' future risks. First, the various modes of detention of sexual as well as other offenders in Germany will be explained. Second, the legal role of forensic psychiatric experts in assessing future risks of offenders will be described. Third, the question is raised if it is worthwhile to include psychiatric experts in prognostic decisions relating to detainees, and it will be discussed who benefits from forensic psychiatric reports, in particular, it will be explored whether it is the experts themselves and/or the public who benefit most from these reports. Forth, an example will be given how the involvement of psychiatric experts contributes to the prolongation of detention. Finally, a provocative recommendation for the future use of forensic psychiatric reports in the context of release decisions will be given.

Key words: Criminal detention, psychiatric experts, risk assessment

(1) Detention of offenders with mental disorders in Germany

The German Penal Code provides for different modes of detention for convicted offenders depending on their degree of criminal responsibility and whether they suffer from a psychiatric disorder. (1) If an offender has committed a serious crime, for which he is fully responsible, he will be sent to a normal prison. (2) If they are fully responsible and have (a) committed very serious crimes or (b) repeatedly offended, they may also get, in addition to their prison sentence, a period of preventive detention according to section 66 of the Penal Code. They will have to serve this after they have served their full prison sentence. Such preventive detention is comparable to American sexually violent predator laws that operate in some states in the U.S. (although the mechanism by which such detention is applied differs greatly from the American practice and is not restricted to sex offenders). (3) Under section 64 of the Penal Code perpetrators whose crimes were mainly triggered by drug- and alcohol abuse may get both a prison sentence and a time-limited commitment to a high secure psychiatric hospital that specialized in treating addicts. (4) Section 63 of the Penal Code allows for the indefinite detention of offenders who are found to lack criminal responsibility on the grounds of mental illness; typically in a high secure hospital. The same provisions apply for offenders whose responsibility was severely impaired when committing the crime. Although they will get a prison sentence, they usually will be sent directly to a high secure hospital, and their detention is reviewed annually by the court. It is that last group that is the focus of this paper because forensic psychiatric expertise is regularly sought by the courts before the imposition of indefinite detention; and is also sought in relation to reviews of detention and release.

(2) The role of the psychiatric expert in decisions about detention

Unlike some jurisdictions, where psychiatric experts are instructed by either the prosecution or the defense, in Germany, the role of the expert is conceptualized as an independent role in the service of the neutral court. In relation to evaluations of mentally abnormal offenders (Section 63), offenders with addiction (Section 64) and fully responsible offenders with an additional preventive detention (Section 66) with regard to discharge, experts are instructed by the court involved in the review of risk. The choice of expert is usually made with the agreement of all parties involved (similar to the Single Joint Expert practice in the UK family courts).

The German Penal Code underwent significant reform in the early 1970s particularly in relation to sex offenders. The reform took place in the context of more general challenge to a reform of traditional psychiatric services across Europe, under the influence of radical psychiatrists as Franco Basaglia in Italy, Ronald D. Laing and David Cooper in the United Kingdom, and Klaus Dörner, Erich Wulff amongst many others in Germany. At that time, high secure forensic psychiatric hospitals were overcrowded institutions that offered lengthy detention with limited treatment opportunities to patients.

In the early 1980s, a group of lawyers, judges, psychiatrists and social workers founded an academic journal *Recht & Psychiatrie* (Law and Psychiatry) specifically addressing some of the medico-legal and ethical issues associated with detention of mentally ill offenders in high secure hospitals. The third issue contained a case study of a patient with schizophrenia, Mr. Stone, who had been detained under court order in a high secure psychiatric facility for ten years after he had stolen a fur coat. The authors of the article, the psychiatrist Erich Wulff and the jurist Dirk Fabricius, nicely demonstrated that any rebellious behavior of the patient during his stay in the hospital was attributed to his schizophrenic disorder and this 'evidence' of mental illness was then used at the annual court reviews to argue that he was dangerous to others, until Wulff, as independent psychiatrist, exposed this 'evidence' as prejudice by the hospital doctors, and the patient was finally discharged (Fabricius & Wulff, 1984).

This case clearly demonstrated that independent external psychiatric evaluations were needed to challenge fixed ideas about mental illness, offending and risk that were then characteristic of European forensic psychiatry; and which led to lengthy and unjust detention in hospital. The discussion of Mr. Stone's case resulted in a new law coming in force in 1985 in the Federal State of Northrhine-Westfalia, which ruled that every patient detained under the order of the criminal court in forensic psychiatry had to be evaluated every three years by an independent external psychiatric expert who never before had been involved in his diagnosis or treatment. In the decade after the law was passed, there were two waves of discharge of forensic patients in Northrhine-Westfalia (personal communication Prof. Sabine Nowara), demonstrating how many people had been detained unnecessarily; and how effective this change of policy was in terms of justice.

(3) Is prognostic psychiatric expert evaluation worthwhile?

For Mr. Stone and quite a few of his contemporaries, the external expert opinion had been worthwhile. When presently asking, if external expert opinions pay off, the question has to be differentiated: Do they pay off for the detainees, so that they may be discharged more rapidly; do they pay off for society's safety; do they pay off for the experts; and, finally, do they pay off for the hospitals?

Before discussing these questions, it may be helpful to examine relevant statistics. Fig. 1 shows the rates of three forms of commitments to detention in Germany between the years 1970 and 2010.

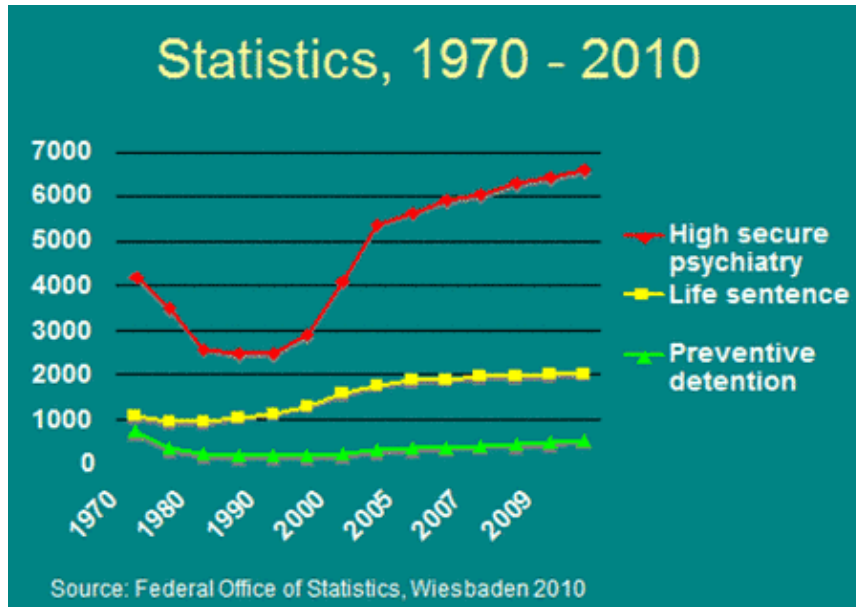


Fig. 1: Three forms of detention in Germany, 1970-2010

The red line shows the detentions in high secure forensic psychiatric hospitals according to section 63 of the Penal Code. One sees the steady decline in the 1970s until it reaches the low in the mid-1980s due to the reform of the Penal Code as well as to the criticism voiced by social psychiatrists, mentioned above. From the mid-1990s, one can observe a steady and, initially, steep increase of the numbers of detained patients, which will be commented on below. The yellow line describes the number of prisoners serving a life sentence; comparing these numbers in the years 1970 and 2010, this number has doubled. This also applies for the green line, although it may look rather flat because the numbers are smaller: the green line shows fully responsible perpetrators who, in addition to their prison sentence, got a sentence for preventive detention. Their number has also more than doubled in the past twenty years, reflecting a development which is also observed in other countries.

When now focusing on the numbers of offenders committed to high secure forensic hospitals in more detail one can see that the numbers of new admissions - red line at the bottom of the following graph - as well as the numbers of discharges - black line at the bottom of the graph - appear steady and balanced. However, this masks a steep increase in the total number of forensic patients starting in the mid-1990s, amounting to an almost 150% increase during the past 20 years. This steep rise results predominantly from the fact that patients are kept in detention for longer times.

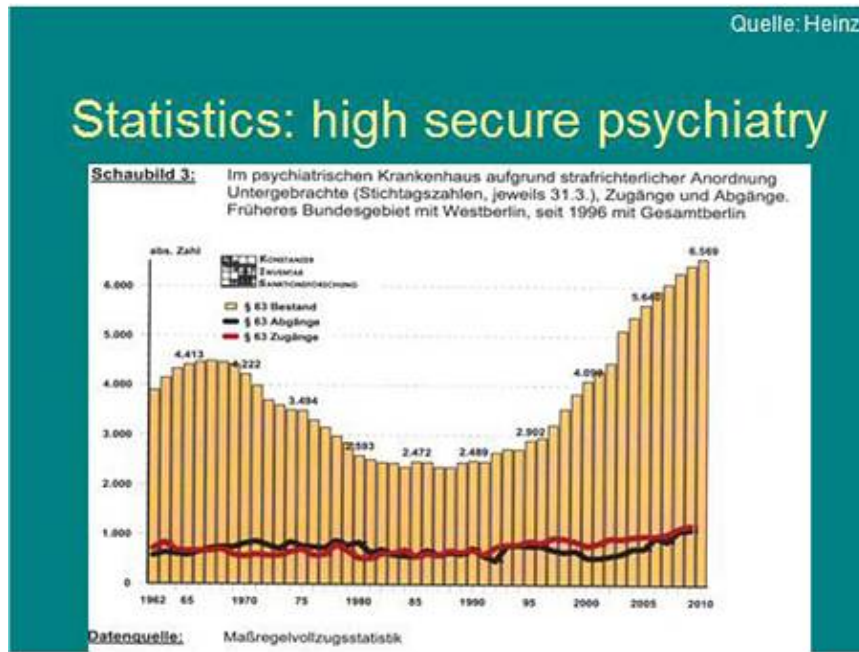


Fig. 2: Detention in high secure forensic hospitals in Germany, 1962-2010 (source: Heinz, W. [2011]. *Wie weiland Phönix aus der Asche - die Renaissance der freiheitsentziehenden Maßregeln der Besserung und Sicherung in rechtstatsächlicher Betrachtung.* In: *Recht & Psychiatrie* 29: 63-87).

There are many possible factors to explain this enormous increase. One possible influence is the effect of lost war against Vietnam on US psychiatry in the 1970s. A post-war lack of an external enemy combined with the return of many disordered Vietnam veterans (Burns, 2013) acted as a stimulus to expand the concept of Posttraumatic Stress Disorders now encompassing all kinds of traumatization and victimization, including victims of sexual abuse (cp. Taub, 1999). After the usual delay of about a decade this debate also started in European countries.

Another possible reason for the increase in detained patients might be a politically driven focus of public attention on public risk from offenders, especially sexual offenders. Such a focus neatly distracts public attention from other important problems in society (for instance high rates of unemployment). Such a political process may similarly operate at regional and local levels, for instance elections for the national parliament and for the parliaments of the sixteen individual German Federal States, activating politicians to plead for stricter interventions against crimes. National and local political pressure influenced the legislation in the 1990s in respect to longer prison sentences for certain crimes and higher thresholds for discharge of high secure patients, and they may influence psychiatrists as regards their risk assessments, making them more risk averse.

Some evidence of the influence of such political processes may be demonstrated by the great regional differences in the average duration of court ordered detention in psychiatry across the sixteen federal states of Germany. Fig. 3 compares duration of detention in high secure hospitals in six of the sixteen Federal States of Germany between 2006 and 2009. In 2009, the Federal State of Hesse (the area around Frankfurt a. M.) had the shortest duration of detention; especially compared to the Federal State of Schleswig-Holstein in the North of Germany which had durations almost twice as long as in Hesse. In the year 2006, the durations in the Federal State of Hamburg and the Federal State of Saarland also were comparatively short, but had greatly increased by 2009.

Duration of psychiatric detention

in days, qualifying date Dec. 31st

	2006	2009
Hesse	k.A.	1.885
Hamburg	1.734	2.475
NRW	2.188	2.429
Rhl.-Palatine	2.241	2.623
Saarland	1.734	2.595
Schl.-Holst.	3.390	3.441

Fig. 3: High secure psychiatric detention in 6 selected States of the 16 Federal States of Germany, comparison of days of detention in the years 2006 and 2009.

Even within individual German states, there are great differences of the average duration of detentions in high secure psychiatric hospitals, as demonstrated by Köpke (2010). The author compared detention duration in three high secure psychiatric hospitals in one German Federal State, Mecklenburg-West Pomerania; and demonstrated that the differences of the duration of the detentions were not due to different patient populations as regards crimes and diagnoses but to the different attitudes of the staff and the directors running the hospitals.

The Federal State of Northrhine-Westfalia was the first German federal state to introduce, in 1985, regular external prognostic evaluations of the detained patients, it is therefore of interest, to compare the average duration of detention in this state with data from all German Federal States. Although there are some federal states that have very long durations of detention (Fig. 3: e.g. Schleswig-Holstein, Rhineland-Palatine, Saarland), during the last seven years Northrhine-Westfalia almost always had longer durations than the average in Germany at large (see Fig. 4).

High secure psychiatric detention								
Comparing Germany with Northrhine-Westfalia; duration in month								
	2003	2004	2005	2006	2007	2008	2009	2010
Germany	60	68	k.A.	80	80	78	82	k.A.
NRW	65	85	77	84	85	86	80	92

Fig. 4: Comparison of average detention (in months) in the Federal State of Northrhine-Westfalia and in Germany at large (k.A. = keine Angabe = no data available).

It seems very likely that the requirement to have regular external expert evaluations of the patients every three years, introduced in Northrhine-Westfalia, in 1985, has actually had an effect on duration of detention.

In terms of duration of detention, it appears that the initially positive effect of having independent psychiatric expert reviews of detention (as exemplified in the case of Mr. Stone and demonstrated by the two waves of discharge in the mid-1980s) has now turned into the opposite after these independent psychiatric expert reviews have become a regular periodic routine. This holds true especially when looking at offenders who initially got a long prison sentence in addition to their psychiatric detention. As, at the beginning of their detention, there is a psychiatric opinion declaring that they pose a high risk of relapse, they will be directly committed to high secure psychiatric hospitals. After the first three years nothing much may have changed, and thus the next evaluation corroborates the unfavorable prognosis. Every additional external psychiatric expert may be influenced by the negative views of their predecessors; and such confirmatory bias is then repeated after six, nine and twelve years. The patients have no chance to be discharged before they have served the time of their prison sentence, or at least two thirds of it, resulting in extended detention.

In 2007, a new law came into force, valid for all federal states of Germany, ruling that every forensic psychiatric detainee has to be evaluated every five years by an independent external psychiatric expert. Based on the available data, it seems possible and even likely that this will result in even longer durations of detentions all over the country.

The business of psychiatric experts is booming. In Northrhine-Westfalia, there are more than 100 registered psychiatric experts, 77 of whom work in an institution; 38 are free lance practitioners whose private practice is only the provision of expert opinions i.e. they do not or no longer work clinically with patients in secure settings. Of course, as medically or psychologically qualified practitioners, they are required to consider the interests of the patient they are accessing as well as the interests of public safety. But experts with no ongoing experience of working clinically or therapeutically with mentally disordered offenders are likely to focus on risk rather than recovery

and positive change; and will therefore be biased towards opinion and evidence that promotes the status quo. It is safer and easier for them not to challenge any previous negative expert opinions. This is despite the fact that good quality risk assessments need to include attention to positive factors that indicate risk reduction as well as negative factors (Hart, 1998; Logan, 2003).

Over the last 30 years, a very large number of standardized prognostic instruments have become available. Many of these (e.g. the Static-99, the SORAG, the HCR-20, the SCR-20) focus either exclusively or predominantly on actuarial statistical parameters, i.e. static and historical factors that cannot change no matter how long the patient is detained. The author has read psychiatric expert opinions that included the application of up to 16 different standardized psychological tests and up to four rating scales even though they quantified mainly the same aspects of risk and lacked data as regards their prognostic value for the specific criminal history of the offender who was assessed. The crude use of such instruments makes it easy for experts to claim that the offender has not changed. It is only recently, that the new generation of such instruments takes the present behavior of the patient and his perspectives for a life in freedom into account. Although it always has been common knowledge in Forensic Psychiatry that such standardized instruments should only be used in conjunction with structured clinical judgments of the patient's present behavior (Andrews et al. 2006), very often the courts will be more impressed by the results of such an armada of seemingly objective instruments.

A particular problem is the formulation of the link between offending and diagnosis, especially when there is an absence of an evidence base to assist. The case below indicates the complexity of formulating risk, and the widely different interpretations of the risk implications of a personality disorder diagnosis.

(4) Case example

The patient was sentenced for attempted rape in 1991 to five years imprisonment. In addition, he was also sentenced ('committed') to treatment in a high secure forensic psychiatric hospital. The initial diagnosis by the expert was Narcissistic Neurosis. After the trial he came directly to the hospital.

In 1995, the first external expert opinion was provided. This was more than 200 pages long, and the diagnoses had changed to (1) Sadomasochism, ICD-10, F65.5, and (2) Combined Personality Disorder ICD-10, F60.8 with narcissistic, histrionic, emotional instable and immature traits. It is noteworthy that his condition had apparently got worse after admission, insofar as the diagnoses were more severe (As an aside: A Combined Personality Disorder should be coded as ICD-10, F.61).

The second external expert opinion was completed in 1997. The diagnosis changed again (Narcissistic Personality Disorder ICD-10, F60) and the prognosis was evaluated as still very risky.

In 1999, the third psychiatric expert opinion avoided any diagnosis at all. It had a rather poetic structure and made a cautious recommendation to start to allow the patient some controlled experience outside the walls of the institution.

The fourth opinion followed in 2002. The report was 116 pages long and made the same diagnoses as in 1995 and 1997 but using DSM-IV criteria rather than ICD-10 (Narcissistic Personality Disorder DSM-IV 301.81; and Sadism DSM-IV 302.84). Despite these diagnoses, this expert opinion commented that the patient's symptoms were no longer as severe as initially. It encouraged the staff of the hospital to be more flexible with the patient and, stepwise, to grant him more freedom.

In 2005, the fifth external expert opinion was provided. This was 148 pages long and made the same diagnoses as 1995, 1997 and 2002 (Narcissistic Personality Disorder and Sadism). However, unlike the 2002 expert, the 2005 expert argued that the patient posed an extremely high risk of relapse and reoffending. This new expert opinion resulted in the patient having to withdraw from the training program outside of the hospital that he had been successfully engaged in for some time prior to this evaluation. Not surprisingly, the patient was upset by this and stopped his cooperation with the therapeutic team.

In 2008, the sixth external expert voiced her opinion. Her report was only 76 pages long and had to rely exclusively on court and hospital files plus interviews with the hospital staff because the patient refused to talk to her. She made the same diagnoses and her prognosis was even more gloomy than the previous assessment.

The patient was evaluated by the author of this paper in 2011 for his seventh external evaluation. He talked freely, demonstrating an impressive ability to mentalize and reflect on his situation. My view was that the risk was reduced sufficiently for him to have the same status in terms of leave as he had prior to the cancellation of all his freedoms after the 5th external evaluation six years ago. At the hearing of the court, the representatives of the hospital opposed this view and the court decided to prolong the detention.

What is striking about this case is the different interpretation of the available data; and the tendency of the reports to focus on negative factors in the patient's presentation and history. There was no requirement that all assessors use the same quality and method of risk assessment. It appears that any positive opinion had to be justified, and was subject to challenge, in ways that negative opinions were not. Such an approach to expert opinion is worrying from an empirical point of view because of the risk of bias that confirms rather than explores risk.

(5) Conclusion and Recommendation

I suggest that the data I have presented here is evidence that there are significant concerns about the quality and use of expert psychiatric testimony in relation to detention in secure psychiatric care in Germany. I conclude that the periodic routine evaluation of risk of relapse and reoffending in mentally disordered offenders leads to increasing length of stay in secure care, without any evidence of benefit to detained patients or benefit to the public in terms of security. This detention causes harm to detained patients (in the form of hopelessness and despair) and does them wrong in the form of injustice. The people who principally benefit are the experts who receive high levels of remuneration for opinions that may be of uneven quality and often lack empirical rigor. In my view, there is evidence that the requirement of periodical expert opinions - first introduced in the Federal State of Northrhine-Westfalia in 1985 in intervals of three years, and in 2007 for all German Federal States in intervals of five years - presently contribute unfairly to the prolongation of detentions, and do not pay equal attention to the possibility of their abbreviation. They benefit the experts and the hospitals, but they are of no benefit for the patients or for public safety.

The recommendation of this paper is therefore that the requirement of periodical evaluations of all detainees in a high secure forensic psychiatric hospital by an independent external psychiatric expert should be repealed. Of course, external independent expert opinions can and should be completed on request of the patient or his lawyer, or even on request of the hospital, if there is a special situation or argument why this may be helpful. There is a risk that (as in the 1970s) lack of regular external review will result in longer detention (as described in Mr. Stone's case above). However, I claim that there is evidence that, presently, the routine psychiatric evaluations are only

contributing to the extension of the duration of detentions. They are also counterproductive in terms of cost.

I will close with another somewhat provocative recommendation: that the duration of detention should be reduced by a 30-percent relation to the average time presently served by patient with comparable diagnoses and offences. Half of the money thus saved on inpatient care should be given to the detainees as a starting capital for them to establish themselves in a relapse-free life in freedom. The other half of the monies saved should be shared between the hospital and the state, so that all parties involved have an incentive for successful treatment in a shorter time than is now the case.

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