Attitudes towards sex offenders and their risk in the Netherlands

W. Smid
Van der Hoeven Kliniek, Utrecht

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Abstract

This paper aims to give an overview of the way sex offenders are treated in the Netherlands. The Dutch law regarding sex offenses and the judicial process are described, as are habits and methods regarding risk assessment, treatment and risk management. Not every possible detail is included for the sake of length and readability, but the reader will get a fairly good impression of the way Dutch society deals with its sex offenders. Overall, prison sentences in the Netherlands are relatively short and the main emphasis in is on treatment and supervision, which can be long and even infinite. Dutch practice has taken some careful steps towards a more evidence based practice, but there is ample room for further improvement, specifically regarding actuarial risk assessment, treatment allocation and treatment content.

Keywords: sex offenders, Netherlands, risk assessment, treatment, risk management

The law on contact offenses

The Dutch law penalizes sexual offenses in about a dozen different codes. Contact offenses are classified based on three characteristics: a) use of force/violence, b) penetration of the body and c) victim age (See table 1). The age of consent in the Netherlands is 16 and all sexual interactions with someone under the age of 16 are punishable, however, consensual sex between teenagers will rarely, if ever, be prosecuted. Sexual abuse of victims under the age of 12 will lead to higher sentences as will penetration of the victim. Penetration used to be interpreted strictly as insertion of the perpetrators penis into the vagina of the victim. But over the years it has come to include many types of penetration (digitial, object, etc.) of any bodily orifice. If the abuse of a male victim includes penetration of the offender, this also qualifies as penetration in the indictment of the offender. In 2011 a forced french kiss was qualified as penetration and thus lead to a rape-conviction for the perpetrator. However, this decision has been reversed in 2013 (Associated Press, 2013).

Table 1: Brief overview of penalties for sexual contact offenses in the Netherlands

(Threats of) physical force: *sexual assault*
no penetration, maximum sentence: 8 years
penetration, maximum sentence: 12 years
No physical force, victim <16 or otherwise incapable of informed consent: *sexual abuse*
no penetration, victim >12, maximum sentence: 6 years
penetration, victim >12, maximum sentence: 8 years

penetration, victim <12, maximum sentence: 12 years

The Dutch law has a separate code for sexual abuse committed from a position of authority, such as a (step)parent, doctor, teacher or any position in which the victim was "entrusted to the care" of the perpetrator. In this case age is irrelevant, sexual interactions from a position of authority are always punishable, if a victim files charges.

The law on Child Pornography (CP) offenses

While the production of CP has always been punishable in the Netherlands, laws regarding the possession of this material are of more recent date (See table 2). The distribution of CP material only became punishable in 1986 and possession in 1996. In 2002 the age limit of children depicted in pornographic material was raised from 16 to 18. This resulted in the situation that having sex with a 17 year old is legal, but looking at sexual pictures of a 17 year old is illegal. This discrepancy occurs in various places in the world, for instance North Carolina (US). The higher age-limit originally aimed to facilitate the indictment of people who possessed material depicting victims around the age of 14/15, while claiming they thought the victims to be 16. And indeed, the raising of the age limit led to an enormous increase in CP cases. This is not surprising because the literature suggests that sexual interest in the age group between 15-17 is ubiquitous (e.g. Green, 2010). However, the number of notified CP offenses on the whole has increased substantially over the years, resulting in far more cases than the police are able to investigate. Therefore the focus of the police has returned to cases concerning younger victims. CP-related offenses carry a maximum sentence of 4 years or 8 years for those who make it a habit or a profession.

Table 2: Brief overview of penalization history of CP-related offenses in the Netherlands

1886	production of pornographic material depicting children < 16
1911	showing (any) pornographic material to children < 16
1986	stocking/distributing pornographic material depicting children < 16
1996	possession of pornographic material depicting children < 16
2002	possession of pornographic material depicting children <18
2010	demonstrable deleted files of pornographic material depicting children <18
2011	online sexual acts (webcam), grooming, sexting with children <18 considered contact offenses

The law on other sex offenses

In 2010, a 'grooming' code was added to the Dutch law, making it possible to convict 'online solicitors' for planning a meeting, online or offline, with a child <16 for sexual purposes, even if the meeting has not taken place (yet). This is a somewhat disputed law that, specifically in the case of 'sting-operations', raises questions of entrapment. Therefore, judges require that the groomer's

plans for a sexual rendezvous are concrete and at least some action has been taken towards the realization of that meeting (e.g. exchanging phone numbers). The maximum penalty for grooming is 2 years.

The Dutch law includes an old separate code for indecent exposure that carries a notably low maximum sentence of three months. Lastly, the Dutch law holds no separate codes (yet) for voyeurism, which makes it difficult to tackle 'modern' offenses like the making of secret video-recordings. Recently a number of hidden cameras were found in various Dutch spas and saunas. The recordings of these cameras were shared online, unbeknownst to the visitors (Van Teefflen, 2018). While it is obvious that this is reprehensible behavior and that numerous people were victimized, it is not entirely clear which Dutch penal code will cover this behavior.

The judicial process

Prosecutors in the Netherlands are free to include as many different penal codes in an indictment as they find applicable. However, the law does not allow judges to add up the various sentences for each of the indictments, neither for the number of different offenses, nor for the number of charges for a single offense. In other words, the sentences of the various codes are not added up, but rather it is the most serious code in the indictment that determines the maximum sentence. On the other hand there is a specific code that increases the maximum sentence in case certain characteristics are present, such as specifically vulnerable victims, severe victim injury or victim death. In practice indictments for comparable cases vary widely. Sometimes all applicable codes are included in the indictment and other times prosecutors include only the single most serious one. For instance, sexual murderers are mostly indicted/sentenced for murder, which carries a maximum sentence of 30 years.

Prosecutors in sex offender cases often produce a cumulative indictment, i.e. an indictment that includes primary and subsidiary charges. The subsidiary charges are usually 'lighter' versions of the primary charges, and apply in case the primary charges cannot be proven beyond doubt. Take for instance the case of intra-familial sexual abuse of a girl form the age of 10 till the age of 14. The primary charge may include sexual penetration of the victim before the age of 12, which carries a maximum sentence of 12 years, while the subsidiary charge may include sexual penetration between the age of 12 and 16, with a maximum sentence of 8 years. If the primary charge is not considered proven by the judges, they will automatically switch to the subsidiary charge. This is a way to ensure that the offender receives the strictest punishment possible for their crimes.

Some type of assessment is usually part of the judicial process for sex offenders, but the scope and content of such assessments vary widely. What the assessments have in common is that a single independent party conducts them; there are no separate assessments performed by prosecution and defense. And although second opinions are sometimes requested, they are rare and, again, conducted by independent experts.

The judicial process in the Netherlands does not involve a jury. A team of three judges reviews the evidence and hears the witnesses and subsequently returns their verdict. The verdict answers the questions of guilt, accountability and risk of recidivism, based on which the conviction may include:

- a prison sentence, which may be unconditional or conditional or a combination of both
- probation, either combined with a (conditional) prison sentence or not
- the specific conditions attached to the conditional sentence/probation, such as the requirement to undergo treatment
- damages to be paid to victims or relatives

- so called "measures", such as involuntary admission to inpatient treatment
- a qualification for long-term supervision, following the other imposed sentences

Punishment versus treatment

The Dutch law offers a wide range of possibilities to punish sex offenders. In practice, however, the Netherlands does not have a history of particularly harsh punishment for any kind of offenders, including sex offenders. And although the public has been demanding increasingly tougher punishment of sex offenders over the past decade, prison terms are still minor compared to, for instance, the USA. The maximum imposable sentences for sexual offences are between 3 months for exhibitionism, 4 years for CP possession, and 6-12 years for various forms of contact offending. However, these maximum sentences are rarely imposed. Often times, especially in case of CP possession, prison sentences are conditional. A recent report studied the punishments of a sample of offenders convicted for child sexual abuse (Nationaal Rapporteur Mensenhandel en Seksueel Geweld tegen Kinderen, 2016). Results showed that unconditional prison time was imposed in 57% of the cases. The average length of the prison sentence was 352 days, with a large SD of 383 and a median of 240 days; 15% received prison sentences of 2 years or longer and 5% received sentences of 4 years or longer. Comparable figures for sexual assault cases are unavailable at the moment.

All in all, this means that sex offenders generally do not spend a long time in prison in the Netherlands. There are of course exceptions, such as the recent case of the random rape and murder of the 25-year-old Anne F. In this case, which was extensively covered in the media, the perpetrator was convicted to 28 years of imprisonment. In general, however, there is much more emphasis on the treatment and supervision of sex offenders than on punishment. Popular believe, like in many other countries, is that some form of treatment is necessary for all sex offenders in order to change their behavior. Although Schmucker and Lösel (2015) suggest that many sex offenders refrain from further offending without treatment. In contrast to the prison sentences, all types of treatment and supervision are of relatively long duration in the Netherlands.

For example, first time CP offenders, without any criminal record, may submit to a two-year outpatient treatment period in exchange for having their charges dropped. This is called the INDIGO measure: "Initiatief Niets Doen Is Geen Optie" translated "initiative: doing nothing is not an option" (2016). Although research shows that recidivism rates, especially for contact offenses, are very low in this group of offenders and very little treatment is indicated. Moreover, the Dutch involuntary inpatient treatment (tbs), which is aimed at high-risk offenders, often takes 10 years or longer and may well be the longest treatment in the world. In comparison, in the programs run by the Correctional Service of Canada, treatment for high- risk offenders involves about 300 contact hours (Hanson & Yates, 2013).

But things are shifting. Like in the rest of western society, the Dutch popular opinion has become more and more (harsh) punishment-oriented over the past two decades, especially regarding sex offenders. Like Pinker (2011) describes, violence has decreased throughout the existence of mankind, however, the violence that remains has become more and more the focus of attention. I believe this effect is further reinforced by excessive media attention for cases of violence and especially sexual violence. An interesting Dutch study (Council for Social Development, RMO, 2006) showed that while the number of serious incidents involving tbs-patients did not increase between 2003 and 2005, the number of headlines increased eightfold! It would be worthwhile to revisit this study 15 years later.

Risk assessment in the Netherlands

Risk assessment of sex offenders has been traditionally carried out before or during trial. For "common" offenders, probation officers carry out the assessment. In complicated or high profile cases, or if the suspect may have a psychiatric disorder, the assessment is carried out by a psychiatrist and a psychologist. In both cases this used to be a completely unstructured clinical assessment for decades.

Structured risk assessment was first introduced in the Netherlands in inpatient treatment facilities, tbs. In 2005, following two serious incidents in with recidivating tbs-patients, formal risk assessment became mandatory for tbs-patients to acquire any form of leave. Due to the fact that structured risk assessment was introduced in a treatment setting, it was strong SPJ-oriented. At the time few actuarial instruments were available that included dynamic risk factors and were deemed feasible for use within this treatment setting. The use of structured risk assessment very slowly spread to the (pre) trial assessments, but kept an SPJ character. A Dutch translation of the Static-99 had been available since 2001 (Beek, De Doncker, & De Ruiter, 2001), and probation officers performing the "common" risk assessments started making standard use of it in 2008. Psychiatrists and psychologists performing the specialized risk assessments started using the Static-99 and/or SVR-20 occasionally. Although the actuarial Static-99 was used, the results were always assimilated into an overall clinical risk judgment.

Over the past five years the call for actuarial risk assessment has become stronger. In 2014 the combined Static-99R, Stable-2007 and Acute-2007 became available in a Dutch translation along with a two-day training (Smid, Koch, & Van den Berg, 2014; Van den Berg, Smid, & Koch, 2014; Koch, Van den Berg, & Smid, 2014). These instruments were quickly introduced in treatment facilities and have all but replaced the SVR-20. Over the past and present year, all probation officers, psychiatrists and psychologists providing pre trial assessment have also been trained in the use of the Static/Stable/Acute. However, the scores of these instruments are still being woven into a broader clinical assessment, where risk factors may be weighted and added, resulting in a kind of structured professional judgment SPJ based on actuarial instruments. In my opinion, two factors underlie this enduring phenomenon. First, people are very persistent in their conviction that actuarial risk assessment has little to no meaning in an individual case and that their clinical expertise will add accurate and useful nuance. Second, people find calculation of probability hard to grasp and dread the use of figures and tables. They often worry if they will be able to convey to the judge exactly what the formal results of their risk assessment mean. Based on these factors, they prefer to compose a more coherent and "rich" story that they themselves as well as the judge find easier to understand and which is therefore perceived as more reliable and useful.

Treatment and risk management in the Netherlands

As noted above, there is a strong emphasis on treatment and supervision in the Netherlands. The aim is directed towards re-socialization, although public opinion is moving in the direction of harsher punishment. The decision for a certain type of treatment or supervision is made at the time of conviction by the court and is imposed along with a (conditional) prison sentence. Prison sentences are served first and treatment follows after prison, in a different inpatient facility or as an outpatient. Roughly, there are three options: supervision without treatment, outpatient treatment, usually enforced by a conditional prison sentence, and inpatient treatment (tbs-measure). The tbs-measure is of indefinite length and discharge depends on the progress of the patient. Every two years the court evaluates if the tbs-measure needs to be extended or should be lifted.

Most sex offender treatment programs in the Netherlands consist mainly of cognitive behavioral therapy, although other forms of therapy are also used, such as schema focused therapy, emotion regulation training, and EMDR. Anti-libidinal medication is regularly used, especially in tbs-treatment. Reconditioning of sexual arousal is generally not a part of treatment nor is the use of the polygraph.

The Dutch/Flemish ATSA chapter NL-ATSA made an overview of the available sex offender treatment programs in the Netherlands en Flanders (Jorritsma, Keulen-de Vos, Mohlmann, & van den Berg, 2016). They found 15 different descriptions of sex offenders treatment programs for adults, directed (at least partly) at dynamic risk factors. The theoretical basis of these programs was indicated as the good lives model (GLM) (n=7) (Ward, 2002), the integrated theory of sexual offending (ITSO) (n=5) (Ward & Beech, 2006), the risk need responsivity model (RNR) (n=3) (Bonta & Andrews, 2007), the relapse prevention model (n=2) (Ward & Hudson, 2000) and other- or no specific theoretical basis (n=10). But even if a theoretical basis was indicated, theoretical frameworks were little elaborated on or translated into specific treatment characteristics. The duration of the treatment programs varied widely (16 weeks to 6 years) or was not specified. There was little specification for offender type, psychopathology or risk level and few guidelines were available. None of the programs had been systematically evaluated for treatment effects. All in all this overview shows that there is still a lot to be gained with regard to Dutch sex offender treatment programs. In my opinion, the evidence based RNR principles should be leading in the development of treatment programs, although more systematic research into the effectiveness of the GLM and ITSO models may also reveal evidence for their feasibility. Most importantly, the models need to be translated in clear and practical guidelines for treatment and followed by rigorous evaluation of treatment effectiveness.

The most intensive treatment in the Netherlands, tbs, has been quasi-experimentally evaluated (Smid, Kamphuis, Wever, & Van Beek, 2014) and showed effectiveness only for moderate-high to high-risk offenders. The total treatment duration is long, often 10 years or more. Both the results on treatment effectiveness and the cost of the treatment indicate the importance of an accurate influx of tbs-patients; there is little gain in the inclusion of low-risk offenders in tbs-treatment.

A small percentage of tbs-patients, for whom the risk of recidivism remains unacceptably high, is transferred to a "long stay" facility, where they will not receive any more treatment. The necessity of their long-stay status is reevaluated in court every two years. From time to time, patients return form long stay facilities back into treatment facilities; and from time to time these renewed treatment attempts are successful and the patient is discharged. Usually, these second-chances are promising if an offender has somewhat "aged out" of important risk factors. All patients who are discharged from tbs-treatment remain under supervision of the probation service for a number of years. Recent introduction of new legislation even makes it possible to keep (sex) offenders on lifelong supervision (Ministrie van Jusitie en Viligheid, 2017). If probation and supervision end, sex offenders are not compelled to register in public registration systems or disclose their prior sexual conviction for housing, jobs or education purposes. However, for some jobs a VoG is required. This is a "Declaration on Behavior" (Verklaring omtrent Gedrag, 2018) issued by the justice department, stating "that your behavior in the past is no objection to fulfilling a specific task or function in society". People who have been convicted for serious crimes cannot easily obtain such a VoG, there is a waiting period during which they have to prove themselves by staying out of trouble. For sex offenders with child victims the waiting period for a VoG can be as long as 20 years.

The Good and the Bad

Generally, there are good possibilities for sex offenders to do penance, improve their lives, reduce their risk, and return to society in the Netherlands. Even a serious sex offense does not necessarily end an offender's productive life. However, although prison sentences may be relatively short, treatment duration, especially the duration of inpatient tbs-treatment, is very long. Furthermore, the gap between outpatient treatment and inpatient tbs-treatment is quite wide. There might be room for a shorter/limited inpatient treatment for offenders with moderate to high risk-levels without excessive responsivity problems. My colleagues and I are currently in the process of developing a treatment program of this kind.

Because treatment is imposed by the court and (pre)trial risk assessments are strongly influenced by clinical judgment, many low-risk offenders get referred to (predominantly outpatient) treatment, along with offenders of higher risk levels. Research suggests that there is a possibility that overtreatment of these low-risk offenders may increases their risk (Lowenkamp & Latessa, 2004), especially because they often end up in the same treatment groups as higher risk offenders (Smid, Kamphuis, Wever, & Verbruggen, 2015). A more strict actuarial approach to (pre)trial risk assessment could help reduce that problem. But treatment providers can also contribute tot a better risk/treatment match by creating specific treatment groups or treatment protocols for low-risk offenders. For instance, at least one outpatient treatment facility provides a specific ultra short treatment program for first time CP offenders, referred under the earlier mentioned INDIGO-measure.

The fairly unique Dutch tbs-measure faces its own serious challenges. Problematic increases in treatment duration are an important issue and are at least partly caused by excessive scrutiny from the media, politicians and the justice department. The increased treatment duration has led many suspects to refuse cooperation with (pre)trial assessment. If they do not cooperate with the assessment, no disorders can be formally diagnosed and if there is no formal disorder, no tbs-measure can be imposed, regardless of their recidivism risk. This means that more high-risk offenders return to society without having undergone any form of risk-reducing intervention, sometimes with disastrous consequences. People are increasingly aware that this problem needs to be solved and the government is currently seeking the input of many parties involved: judges, lawyers, (pre)trial assessment providers, treatment providers, forensic researchers, etc. I am hopeful that together we can find a solution that will provide a better match between offender risk and treatment in the Netherlands.

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Author address

W. Smid
Van der Hoeven Kliniek, Utrecht