A Comparison of Mentally Disordered Male Offenders with and without a Sexual Offence: Their Characteristics and Outcome[1]

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Abstract

Aim/Background: *Among sex offenders, those with a co-occurring mental disorder requiring psychiatric hospitalization form a small but important subgroup that has received little empirical investigation in the UK. We compared their characteristics on hospital admission and their course after discharge with mentally disordered offenders without a sexual offence who were discharged from the same medium secure hospital.*
Materials/Method: *All first-time admissions to a medium secure hospital in the UK over a 20 year period were examined. The sample of 502 mentally disordered men were subdivided into those with and without a sexual offence (MDSOs and Non-MDSOs respectively) and their characteristics on 14 admission variables compared. The outcome of these two groups was also investigated in respect to mortality and readmission rates , in addition to their reconviction rates for sexual and other types of offences.*
Results: *The mean length of the follow-up was 9 years. The two groups were broadly similar in their admission characteristics. Both groups were also similar in their rates of mortality (c. 9%) and readmission (c. 60%) during the follow-up. While the rates of reconviction were similar for any offence and for violent offending in both the sex offending and non-sex offending groups (45.7% and 23.5% and 51.1% and 25.1% respectively), the rates for a reconviction of a sexual offence was greater in the former (17.3% and 2.4% respectively).*
Conclusions: *This study confirms that MDSOs behaved in a way that is suggested by the general criminological literature, namely that (a) they were similar in their background characteristics (i.e. an absence of specialisation in their offending) and (b) their pattern of general and violent re-offending was similar to mentally disordered offenders without a sexual offence. In contrast however, the MDSOs were much more likely to re-offend sexually.*

Key words: mental disorder, offenders, sexual & non-sexual offending, characteristics & outcome, recidivism, readmission, mortality

Introduction

Even among those who commit violent crimes, sexual offenders cause particular concern within society because of their effect on their victim and the perceived likelihood of recurrence (Browne & Finkelhor, 1986; Hanson et al., 2001). This is reflected both in their portrayal in the media and in

legislative provisions that allows for intensive supervision and even their preventative detention (Kansas v Hendricks, 1997). Hence the characteristics of sex offenders and their long-term course are of especial interest to clinical investigators.

There is general agreement that sexual offenders have versatile criminal careers; so that their sexual offending is merely a manifestation of generalized offending behaviour (Gelb, 2007; Simon, 2000). Hanson & Bussiere (1998) in a meta analysis of 61 studies with a follow-up of 4-5 years found a rate of 13.4% for sexual recidivism, 12.2% for non-sexual violent recidivism and 36.3% for any recidivism. although they noted considerable variability, with some subgroups having greater rates of sexual recidivism. In a review of sex reconviction in the UK, Craig et al.,(2008) reported figures for incarcerated samples of 7.8% at 4 years and 19.5% for six years or more of follow-up.

Although it is accepted that most sex offenders are not severely mentally disordered (Simon, 2000; Eastman et al. 2012), current data suggests that about 10% of high secure hospital patients in the UK have a history of sexual offending (Taylor et al., 1998; Tennant et al., 1974; Naismith & Coldwell, 1990; rates that are very similar for prisoners (Greenfield, 1997; Gelb, 2007). Nonetheless, those with a combination of a mental disorder and sexual offending (MDSOs) raise further questions. Do they, for instance, demonstrate show the same criminal versatility as mentally disordered offenders without a sexual offence and if so what is their pattern of recidivism? To explore further these two questions, we compared the characteristics on admission and their course after discharge of MDSOs with other mentally disordered offenders without a sexual offence (non-MSDOs) , both of whom were admitted to the same medium secure hospital in the UK.

Method

A full description of the methodology of the study together with characteristics of the sample can be found elsewhere (Davies, Clarke, Hollin & Duggan, 2007). Briefly, the sample comprised all 502 men on their first admission to a medium secure hospital (i.e. Arnold Lodge, Leicester, UK) from July 1983 to the census date on 30th June 2003. All those discharged over the twenty year period were followed up to the census date. As part of its ethical approval, the study was conducted under Section 60 of the Health and Social Care Act 2001 that allowed for the collection of data from all of the patients in the series without their consent. Reconvictions were classified into 'grave' or 'standard list' offences using the Home Office standard method of reporting (Home Office, 2002). Sexual (and other violent/aggressive) incidents that did not lead to a conviction were also collected during the follow-up period. This was taken from psychiatric reports, admission or discharge summaries where reference was made to any sexual or other violent behaviour (which did not lead to prosecution and/or conviction) or any documented inappropriate sexual or violent behaviour in hospital, prison or the community.

To investigate whether those mentally disordered offenders convicted of a sexual offence were similar or different from the mentally disordered non-sexual offenders, we compared both groups on their characteristics on admission and course after discharge. Those with a sexual offence - either at the time of their admission or in the past - were grouped together or constituted the mentally disordered sex offender group (MDSOs); those without any sexual offence were the comparison mentally disordered non-sex offender group (Non-MDSOs).

To compare their characteristics at admission, we used information from a previous study (Gibbon et al, 2012) wherein each patient had been rated on a number of different variables to measure the "severity" of their presentation at admission. Broadly the variables examined comprised three domains that covered their criminal history, psychological disturbance and childhood difficulties (Table 1). These ratings were developed without any reference to the nature of their offence and

hence are independent of this investigation. For their course after discharge, we examined, not only of their reconvictions for sexual (and other violent) offences, but also their mortality and the likelihood of being re-admitted.

Results

(1) Patient Sample

From the total of 502 men admitted during the period covered by the study, 54 patients (10.8%) had been convicted of a sexual offence at the time of their admission and 34 patients (6.8%) had a previous conviction for a sex offence although their index offence was non-sexual. Therefore 88 patients (17.5% of the total) had a current or previous sexual offence (referred to as mentally disordered sexual offenders [MDSO]); these were compared with the 414 without a sexual offence - the non-sex offender group [Non-MDSO). The median length of stay for those who were discharged (i.e. 83 sex offenders and 372 non-sex offenders) was similar for the two groups (i.e. 164 days (range: 18 days to 3872 days and 159 days (range: 2 days to 2527 days) respectively). The MDSO's were older on admission (mean = 31.8 years, SD = 9.1) than the Non-MDSOs (mean = 29.7 years, SD = 9.2) $t(500) = 2.01$, $p < .05$ (two-tailed). From the group of 502 men who were admitted, 459 were discharged (not including those who had died during their first admission). These had a mean length of follow-up of 9 years (SD = 4.8).

(2) Comparison of the characteristics on admission

The two groups were compared on the 14 characteristics described in Table 1.

Over-all, the sex and non sex mentally disordered offenders were broadly similar, differing on only 4 of the 14 variables examined. These were: index offence grave (yes/no - where gravity is defined according to that described in our earlier Davies et al. (2007) paper), self-harm (yes/no), previous inpatient care (yes/no), and at least 4 previous convictions (yes/no) (Table 1).

Table 1: Differences in the admission characteristics of sexual and non-sexual mentally disordered offenders

	MDSO with Index SO or with past SO (n=88)	MDO without SO (n=414)	p-value
Criminological			
Age at first conviction 17 yrs or less	58 (66.7%)	222 (55.0%)	0.056
Grave index offence	74 (84.1%)	253 (61.1%)	0.001
At least 4 previous convictions	69 (78.4%)	266 (64.4%)	0.012
Custodial sentence before 18 yrs	22 (25.0%)	101 (24.4%)	0.892
Psychological difficulties			
History of severe drug misuse	17 (19.3%)	110 (26.6%)	0.178

History of severe alcohol misuse	24 (27.3%)	140 (33.8%)	0.261
Previous attempted suicide	27 (30.7%)	157 (37.9%)	0.224
Previous high or medium secure care	10 (11.8%)	59 (14.5%)	0.608
Previous self-harm	24 (27.3%)	177 (42.8%)	0.008
Previous inpatient care	42 (47.7%)	262 (63.3%)	0.008
Childhood difficulties			
Problematic behaviour at school	43 (48.9%)	232 (56.0%)	0.239
Alleged childhood sexual abuse	19 (21.6%)	62 (15.0%)	0.150
Alleged childhood physical abuse	19 (21.6%)	125 (30.2%)	0.120
Contact with child MH services	26 (29.5%)	129 (31.2%)	0.801

This table suggests that the MDSOs were slightly more criminal (having more and graver convictions) and slightly less psychologically impaired than their comparator. However, the similarities between the two groups outweighed their differences.

Comparison after discharge

(1) Mortality

The mortality rate was very similar in the two groups with rates of death being 9.6% and 8.8% respectively for the sex offenders and non-sex offenders (Table 2). The rate of unnatural deaths (e.g. suicide/open verdict) was high in both groups and slightly higher in the non-sexual offenders (64% vs 50%).

Table 2: Outcomes of those discharged from their first admission

	Sex Offender	Non Sex Offender	Total
Maximum n	**(n = 83)**	**(n = 376)**	**(n = 459)**
Mortality			
Died from any cause	8/83 (9.6)	33/376 (8.8)	41/459 (8.9)
Died from suicide/open verdicts	3/83 (3.6)	16/376 (4.3)	19/459 (4.1)
Readmission			
Any readmission	44/75 (58.7)	225/335 (67.2)	269/410 (65.5)
Reconviction (type of offence)			
Any offence	37/81 (45.7)	190/372 (51.1)	227/453 (50.1)

Sex offence	14/81 (17.3)	9/372 (2.4)	23/453 (5.1)
Sex offence against a child	5/81 (6.2)	3/372 (0.8)	8/453 (1.8)
Sex offence against an adult	12/81 (14.8)	4/372 (1.1)	16/453 (3.5)
Violent	19/81 (23.5)	93/371 (25.1)	112/452 (24.8)
Arson	0/81 (0.0)	11/372 (3.0)	11/453 (2.4)
Acquisitive	16/81 (19.8)	100/371 (27.0)	116/452 (25.7)
Criminal damage	5/81 (6.2)	64/372 (17.2)	69/453 (15.2)
Other	12/81 (14.8)	101/372 (27.2)	113/453 (24.9)
Reconviction (by classification)			
Standard list offence (at 2 years)	17/77 (22.1)	93/338 (27.5)	110/415 (26.5)
Standard list offence (at 5 years)	26/66 (39.4)	138/301(45.8)	164/367 (44.7)
Grave offence (at 2 years)	6/77 (7.8)	22/338 (6.5)	28/415 (6.7)
Grave offence (at 5 years)	12/66 (18.2)	31/301 (10.3)	43/367 (11.7)
Reconviction (of sex offence)			
New sex offence (at 2 years)	4/76 (5.3)	1/333 (0.3)	5/409 (1.2)
New sex offence (at 5 years)	9/63 (14.3)	2/285 (0.7)	11/348 (3.2)
Incidents (not convicted)			
Sexual incidents (at 2 years)	11/61 (18.0)	11/295 (3.7)	22/356 (6.2)
Sexual incidents (at 5 years)	14/51 (27.5)	21/239 (8.8)	35/290 (12.1)
Violence/Aggression (at 2 years)	19/58 (32.8)	96/277 (34.7)	115/335 (34.3)
Violence/Aggression (at 5 years)	25/54 (51.9)	135/243 (55.6)	163/297 (54.9)

(2) Readmission

The rates of readmission to a psychiatric hospital were similar in both the sexual offenders and non-sexual offenders although slightly higher in the latter (Table 2). For instance, in those cases where readmission data were available, 44 of the 75 discharged sex offender patients (58.7%) had been readmitted to a psychiatric hospital at least once after their discharge (it was missing in 8 of the 83 discharged.). In comparison, of the 225 of the 335 discharged non-sex offender patients where data were available (with data being missing for 41), 67.2% had been readmitted to a psychiatric hospital at least once after their discharge. Although a higher percentage of non-sex offenders than sex offenders were readmitted, this was not significantly different, ^{2}(1, N = 410) = 1.96, p>.05.

(3) Reconviction

The reconviction rates for sexual offending during the follow-up were markedly different for the two groups (Table 2). For the MSDOs , the rates for a further sexual conviction were 17.3% for the entire follow-up period (c. mean 9 years) and 14.3% at five years. These rates were significantly higher than the rates in the Non-MDSO (2.4% overall and 0.7% at 5 years). These differences

between the groups were also found in sexual incidents during the follow-up period at both two and five years which did not lead to a prosecution or conviction. Not surprisingly, this implies that that a history of sexual offending on admission confers a much greater risk of committing another sexual offence after discharge in comparison to the Non-MSDOs.

Those in the MSDO group who were reconvicted of a new sex offence (14/81:17.3 %) were compared with those who were not (67/81: 82.7%) in the 14 variables listed in Table 1. The only variable on which the two groups differed was age on admission; those reconvicted were younger on admission (mean = 25.5, SD = 6.2 vs mean = 33.0; SD = 9.0; $t(79) = 2.95$, $p < .01$ (two-tailed) . Those reconvicted also had a longer follow-up period (mean = 13.5, SD = 4.0) than those not convicted (mean = 8.6; SD = 4.4) $t(79) = -3.89$, $p < .01$ (two-tailed).

Despite these differences in the two groups, their rates of other violent offending during the follow-up were very similar 23.5% vs. 25.1%. Again, incidents of violence/aggression that did not lead to a prosecution or conviction were very similar in the two groups at both two and five years of follow-up. However, the rates of conviction of other types of offending (e.g. acquisitive, arson etc) was higher in the non-sexual group.

Discussion

We found that 10.8% of the patients in this series had an index sexual offence - a figure that is similar to the 10% reported in secure hospital and prison populations (Taylor et al., 1998; Tennant et al., 1974; Naismith & Coldwell, 1990 and Greenfield, 1997; Gelb, 2007, respectively).The aim of this study was to examine the contribution of a history of sexual offending to both their characteristics on admission and course after discharge in this group of mentally disordered offenders. Broadly, we found that the characteristics of both groups were similar on admission and that the outcome was also similar except that those with a sexual history were more likely to commit further sexual offences during the follow-up period. The MDSOs were older on admission which echoes the findings on sex offenders from the general criminological literature (Gelb, 2007). On the other hand, the MDSOs did not demonstrate an increased prevalence of childhood sexual abuse - once, but no longer, considered to be aetiologically important.

As regards the follow-up, we found that while the MDSOs displayed the same degree of versatility in their offending after discharge as the Non-MDSOs , they also exhibited much higher rates of sexual recidivism on discharge. Thus, while MDSOs are as likely to commit other offences as Non-MDSOs ,the latter are unlikely to commit sexual offences. This underscores the maxim that although sex offenders are likely to commit other types of crinimal offences, other types of offenders rarely commit sex offences.

The only comparable study on recurrence of sex offending from a UK sample of hospitalised patients after discharge to our knowledge is that of Milton (2004). He examined the outcome of 104 sex offenders discharged from high secure hospitals with a mean length of follow-up of 9.8 years discharged to the community (and hence 'at risk'). He found that 59% were convicted of an offence of some kind, 25% being convicted of a violent offence and 23% of a sexual offence - figures that are comparable our findings allowing for the different lengths of follow-up. This comparison also highlights another point in the follow-up of sex offenders - whether mentally disorder or not: sexual offenders have a more persisting re-offense risk in comparison to non-sexual offenders. . In a 25 year follow-up by Langevin et al.(2004) (of non-mentally disordered sex offenders), for instance, they found that 80% had reoffended sexually over the 25 years but that the majority had reoffended within the first 10 years suggesting that they require supervision and input particularly over that period (see also Hanson, Steffy and Gauthier, 1993).

This study had some significant limitations. First, this was a naturalistic study that depended on the quality of the case notes to provide the necessary data. Thus, detailed diagnostic information on specific mental health categories was lacking so that we are unable to comment on the relationship between specific diagnoses (e.g. schizophrenia) and sexual offending recidivism. In addition, those in the sexual offender group were defined by their conviction rather than by the sexual psychopathology. Second, the data also came from a single unit with its own admission/treatment and discharge policies; consequently, our findings require replication before the findings can be generalised.

The study, however, had some major advantages over other similar investigations. The sample comprised first hospitalisation admissions thereby avoiding the inclusion of the same patient being repeatedly admitted. The length of follow-up (c. 9 years) was reasonably long and the Section 60 provision allowed the investigators to follow-up all the cases which was a considerable advantage as attrition is a major problem in such a population. It also recorded sexual and other violent incidents during the follow-up that did not lead to a prosecution or conviction - this comprising important and rarely recorded data as the Crown Prosecution Service in the UK is reluctant to charge mentally disordered offenders after their discharge because of the presence of the disorder. The study was also able to report on a number of outcomes of importance - other than offending - thereby broadening the scope of the inquiry.

Finally, it should be recognised that the primary reason for admitting these individuals to hospital was the presence of a mental disorder that was considered treatable, rather than the presence of a sexual or other criminal offence. For instance, 53 (63.9%) of the MSDO group were admitted for treatment of their mental illness.

For many, their sojourn in hospital would have ended once the treatment of their mental disorder was completed and they would have been returned to prison without, necessarily, having their criminality addressed. This practice has now largely changed, with secure hospital services in the UK seeing it as important to address both a patient's mental disorder and his/her criminality before transfer from hospital.

Conclusions

There is a limited published literature on mentally disordered sex offenders despite their important hold on public consciousness. The broad conclusion from this investigation is that psychiatrically hospitalized mentally disordered sex offenders are similar to other mentally disordered non-sex offenders in (a) their admission characteristics and (b) their criminal versatility but are more likely to be re-convicted of another sexual offence. Nonetheless, their rate of sexual re-offending appears to be less than that reported from those released from prison. These findings also have important clinical implications as it suggests that mentally disordered sex offenders require access to specialised interventions in order to reduce the likelihood of both generalised and sexual re-offending.

References

1. Browne, A. & Finkelhor, D. (1986). Impact of Child Sexual Abuse. Psychological Bulletin, 99, 66-77.
2. Craig, L.A., Browne, K.D., Stringer, I. & Hogue, T.E. (2008). Sexual reconviction rates in the United Kingdom and actuarial risk estimates. Child Abuse & Neglect, 32, 121-138.

3. Davies, S., Clarke, M., Hollin, C. & Duggan, C. (2007) Long-term outcomes after discharge from medium secure care: a cause for concern. British Journal of Psychiatry, 191, 70-74.
4. Eastman, N., Adshead, G., Fox, S., Latham, R. & Whyte, S. (2012). Forensic Psychiatry. Oxford University Press.
5. Gelb, K. (2007). Recidivism of Sex Offenders: Research Paper. Sentencing Advisory Council. Melbourne, Australia.
6. Gibbon, S., Huband, N., Bujkiewicz, S., Hollin, C.R., Clarke, M., Davies, S. & Duggan C. The influence of admission characteristics on outcome: evidence from a medium secure cohort. Personality and Mental Health. (Wileyonlinelibrary.com.DOI 10.1002/PMH.1191).
7. Greenfeld, L.A. (1997). Sex Offences and Offenders: An Analysis of Data on Rape and Sexual Assault. Minnesota Centre Against Violence and Abuse. http://www.mincava.umn.edu/documents/sexoff.htm/#id504751
8. Hanson, R.K., Steffy, R.A. & Gauthier, R. (1993). Long-term recidivism of child molesters. Journal of Consulting and Criminal Psychology, 61(4), 646-652.
9. Hanson, R.K. & Bussiere, M.T (1998). Predicting relapse: a meta-analysis of sexual offender recidivism studies. Journal of Consulting and Clinical Psychology, 66, 348-362.
10. Hanson, R.F., Saunders, B., Kilpatrick, D., Resnick, H., Crouch, J.A. & Duncan, R (2001). Impact of childhood rape and aggravated assault on adult mental health. American Journal of Orthopsychiatry, 71(1), 108-119.
11. Home Office (2002). Criminal Statistics, England and Wales 2001. Cm 5696. TSO (The Stationary Office).
12. Kansas v Hendricks (1997). 95 1649 and 95 9075 Supreme Court of the United States. June 23, 1997.
13. Langevin, R., Curnoe, S., Fedoroff, P., Bennett, R., Langevin, M., Peever, C. & Pittica, R. (2004). Lifetime Sex Offender Recidivism: A 25-Year Follow-up Study. Canadian journal of Criminology and Criminal Justice, 46, 531-552.
14. Milton, J. (2004). Care Pathways and Outcome of Mentally Disordered Sex Offenders referred to High Secure Psychiatric Hospitals. Thesis submitted for the degree of Doctor of Medicine, University of Nottingham.
15. Naismith, L.J. & Coldwell, J.B. (1990). A comparison of male admissions to a special hospital 1970-71 and 1987-88. Medicine Science and the Law, 30, 301-308.
16. Simon, L.M.J. (2000). An Examination of the Assumptions of Specialization, Mental Disorder, and Dangerousness in Sex Offenders. Behavioral Sciences and the Law, 18, 275-308.
17. Taylor, P.J., Leese, M., Williams, D., Butwell, M., Daly, R. & Larkin, E (1998). Mental disorder and violence. A special (high security) hospital study. British Journal of Psychiatry, 172(3), 218-226.
18. Tennant, G., Loucas, K., Fenton, G. & Fenwick, P. (1974). Male admissions to Broadmoor Hospital. British Journal of Psychiatry 125, 44-50.

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