Psychopathy in the treatment of forensic psychiatric patients: assessment, prevalence, predictive validity, and clinical implications
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Citation for published version (APA):

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CHAPTER 2

TREATMENT

UNDER THE DUTCH TBS-ORDER

1 Parts of this chapter are based on:
SUMMARY

In this chapter, we briefly describe a special provision in the Dutch criminal code that allows for a period of mandatory treatment following a prison sentence for mentally disordered offenders: *Terbeschikkingstelling* (TBS-order). The purpose of TBS is to protect society from unacceptably high risks of recidivism, directly through involuntary admission to a forensic psychiatric hospital, and indirectly through the treatment provided there. Theoretically, treatment under the TBS-order is of indefinite duration if the offender continues to pose a risk to society. Every one or two years the court re-evaluates the patient in order to determine whether the risk of (violent) recidivism is still too high and treatment needs to be continued. The legal criteria of the TBS-order are described, the important issue of violent risk assessment/management is touched upon, and treatment effectiveness research is reported. Finally, some strengths and weaknesses of forensic psychiatric practice under the TBS-order in the Netherlands are discussed.
INTRODUCTION

Mentally disordered or personality disordered offenders are often envisioned as individuals who violently, unexpectedly, and without reason attack innocent victims. Moreover, the system supposedly treating them is seen as neither reducing the likelihood of future danger nor as protecting society from it. For others, however, mentally/personality disordered offenders trigger sympathy as victims of impulses over which they have little control and as caught in a system they do not understand, which fails to respond to their unique needs. When a (released) forensic psychiatric patient commits a violent crime, the public becomes strongly polarized against the forensic mental health system. To facilitate understanding the movement of this category of offenders through the (Dutch) criminal justice system to the forensic hospital system, the Dutch situation for making decisions regarding mentally disordered or personality disordered offenders is described in a nutshell.2

LEGAL REGULATION

According to the Dutch Code of Criminal Procedure (CCP; Wetboek van Strafprocedure, Sv., Article 352, Section 2) and the Dutch Code of Criminal Law (CCL; Wetboek van Strafrecht, Sr., Article 39), as a general rule, in cases where the criminal act is proven but the offender cannot be held responsible, because of a mental disorder or defect, the offender will not be sentenced but discharged.3 The question whether the defendant has committed the offense precedes and is distinguished from the question whether he4 is punishable, which depends (among other things) on whether the defendant is to be held responsible for the crime he committed (see Article 350 Sv.)

Dutch criminal law recognizes two measures that can be applied to mentally disturbed offenders. First, the law offers the possibility for a defendant who is found not responsible for the crime, to be admitted to a psychiatric hospital, but only if he is a danger to himself or to others or to the general safety of persons or property (Art. 37, section 1

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2 For more detailed descriptions on the assessment and treatment of mentally disordered offenders in the Netherlands, see Malsch and Hielkema (1999), van Marle (2002), de Ruijter and Hildebrand (2003).
3 In Dutch terminology: ontslagen van alle rechtsvervolging.
4 The male pronoun is used in this and the following chapters for referring to either gender.
CCL). Second, Article 37a of the Dutch CCL states that a defendant who, at the time of the alleged crime, suffered from a mental defect or disorder may receive what is called a 'disposal to be involuntarily admitted to a forensic psychiatric hospital on behalf of the state' (maatregel van terbeschikkingstelling, TBS-order). The Dutch Ministry of Justice states that the legitimacy of the TBS order lies in the right for society to protect itself against unacceptable risks of (severe) criminal behavior. The nature of the order is not intended as retribution or to cause suffering but to provide custodial care aimed at motivating the offender to undergo treatment.

The law requires that at least two experts from different disciplines report on the defendant before the trial court can decide to impose a TBS-order. One of the experts must be a psychiatrist (Art. 37a, Section 3 and Art. 37, Section 2 Sr.). A TBS-order can be imposed by the court if the following three conditions apply (Art. 37a Sr.):

1. The defendant must suffer from a mental disorder, which means that his responsibility for the alleged crime is (severely) diminished or absent. The basic assumption is that each defendant is fully responsible for all of his acts. In case of a disorder, the court will decide on the basis of reports by behavioral experts to what extent this disorder has influenced the behavior of the defendant at the moment of the alleged crime;
2. The crime carries a prison sentence of at least four years, or the offense belongs to a category of offenses specifically mentioned in the law, although carrying a lesser sentence;
3. There is a risk for the safety of persons or for the general safety of persons or goods.\(^5\)

Article 37a of the (old) Dutch Code of Criminal Law created the possibility of diminished responsibility. On the basis of this, more refined 'levels' of criminal responsibility were introduced in the Dutch jurisprudence, and eventually a five-point

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\(^5\) Thus, diminished responsibility does not always result in the recommendation and the imposition of involuntarily admission to a forensic hospital under the TBS-order. Only in cases where, in addition to a mental disorder being established, it is judged that the person is at risk to commit another serious (sexually) violent crime in the future, an involuntary admission to a forensic psychiatric hospital will be imposed.
sliding scale emerged, indicating the degree of criminal responsibility: full, slightly diminished, diminished, severely diminished, and total absence of responsibility. In case of diminished responsibility, the judge may sentence a prison term for that part of his psychological functioning for which the defendant had freedom of choice (i.e., the choice not to commit the offense). Consequently, offenders considered to have diminished responsibility for the crimes they committed can (and most of the time will) also be sentenced to imprisonment. The decision by the court to direct both a sentence and involuntary admission is based on the consideration that a combination of the two is a more effective instrument in achieving protection than involuntary admission to a forensic hospital on its own. If a person is sentenced to a long penal sanction in conjunction with involuntary admission to a forensic hospital, the prison sentence is executed first; after the offender has served his sentence he will be transferred to a forensic hospital.

The combination of imprisonment and involuntary admission to a forensic psychiatric hospital poses significant ethical questions. The TBS is ordered to allow treatment of the psychiatric disorder of the offender and therefore there is an ethical obligation to admit the patient to a hospital as soon as possible. From a medical point of view, one can argue that it is ethically unjust to postpone the treatment the patient needs, i.e., by executing the prison sentence first. On the other hand, it seems also ethically unjust to treat the patient first, and execute the prison sentence after he is successfully treated and no longer considered a danger to society.

Theoretically, a TBS-order is of indefinite duration (Art. 38e, Section 2 Sr.). Initially imposed for two years (Art. 38d, Section 1 Sr.), it may be extended for one or two year periods of time as the court re-evaluates the patient to determine whether the risk for the safety of (other) people or for the general safety of persons or goods is still too high (Art. 38d, Section 2 Sr.). Most of the time, TBS involves involuntary admission to a specialized maximum security forensic psychiatric hospital (Art. 37d, Section 1 Sr.) aimed at motivating the patient to participate in the treatment programs offered by the hospital. The implication for clinical practice is that it is legally permitted to place a patient in a living group with fellow patients and to structure his daily life in such a way that it is almost impossible for him to avoid contact with members of the hospital staff (e.g., sociotherapists). Neither on ethical nor on legal grounds can there be an escape from the obligation to participate in a therapeutic milieu in order to facilitate social contacts aimed
at motivating the patient for treatment. However, patients are free to refuse, for example, pharmacotherapy and to avoid participating in specific therapeutic activities such as psychotherapy. As a rule, compulsory treatment is only possible if patients are a threat to themselves or other people. Although there are differences in the treatment models the Dutch forensic psychiatric hospitals adhere to, the treatment provided within the legal framework of the TBS generally strives to effect structural behavioral change that leads to a reduction in violence risk.

Every forensic psychiatric hospital has a legal obligation to provide (1) security to society; (2) treatment for the offender-patient, and (3) to protect the civil rights of the latter. These components need to be balanced in the forensic psychiatric setting, and each hospital makes its own choices in this regard, in conjunction with its therapeutic framework and security level. Although the treatment models of the forensic psychiatric institutions in the Netherlands vary, they all involve a composite of education, work training, individual and group psychotherapy, creative arts and sports activities.

A relatively new development is transmuralization: An intensive resocialization program whereby patients are supported by a special ambulatory team of group leaders, who supervise them during this resocialization phase (see also Chapter 1). They monitor and assist patients in their own living environment. Patients can be re-admitted to the hospital in case there are signs of becoming a risk to society.

**VIOLENCE RISK ASSESSMENT AND MANAGEMENT**

Risk assessment/management is an ongoing task of the staff of forensic psychiatric hospitals where TBS patients stay. All proposals for extensions of leave have to be announced to the Ministry of Justice, who carries the ultimate responsibility for the execution of the TBS order. The Ministry has the right to raise objections to the leave proposals submitted by the hospitals, and withholds permission in some cases. Leave decisions that have to be approved include: the first time the TBS patient is allowed outside the physical security of the institution, still under staff supervision; travel without staff supervision; leave on probation.

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6 Because of the fact that the TBS-order can be extended as long as the TBS-patient poses a risk, refusal of treatment generally implies a prolonged stay in the hospital.
Every one or two years, the court (Art. 38d, Section 1 Sr.) reviews the patient’s case, and decides whether the TBS needs to be extended or can be terminated. The hospital has to submit a report to the court providing information on the mental disorder of the patient, treatment progress, assessment of recidivism risk, and advice on the extension or termination of the TBS. The court does not always follow the hospital’s advice. In a long-term (> 5 years) follow-up of 40 patients who had been treated at the Dr. Henri van der Hoeven Kliniek, recidivism rates of patients who had been released by the judge, against the hospital’s advice, were notably higher than recidivism rates of patients released on the hospital’s advice (25% vs. 55% for serious recidivism that resulted in unconditional imprisonment and/or TBS; Niemantsverdriet, 1993). Similar findings are reported by Van Emmerik (1989) and Leuw (1999).

After a patient has been detained under the TBS order for six years, the law (Art. 509, Section 4 Sv.) requires two independent behavioral experts, a psychologist and a psychiatrist, to submit an independent forensic report to inform the court about the mental disorder and the risk of recidivism of the patient. The court then decides about extension or termination of the TBS order on the basis of the report provided by the hospital where the patient is being treated and those of the two independent experts. This so-called 6-years procedure is to safeguard the patient from the well-known biases that treatment staff are liable to when they have to assess future violence risk in their own patients (Dernevik, 1999).

**TREATMENT EFFECTIVENESS RESEARCH**

Although the TBS order was introduced in the criminal justice system in 1928, research into the effectiveness of the treatments offered in the Dutch forensic psychiatric hospitals is rather scarce. Unfortunately, there are no adequate outcome studies of the TBS system, so it is difficult to know whether it works or not (Mclnerny, 2000). A number of follow-up studies of different patient cohorts from 1974 through 1993, have documented serious violent recidivism rates between 15 and 20% over follow-up periods of three to eight years for patients for whom the TBS order was terminated (van Emmerik, 1985, 1989; Leuw, 1995, 1999). Unfortunately, there is currently no research evidence showing that (reduced) recidivism is related to treatment process and/or outcome. A 2-year cross-
sectional follow-up study of 59 personality disordered patients, during their inpatient treatment in the Dr. Henri van der Hoeven Kliniek, demonstrated that 25% of these patients changed reliably and to a clinically significant degree on a number of self-report measures of personality and psychopathology (Greeven, 1997). The overall personality structure of the patients, however, remained essentially the same, and it remains to be seen how these patients will fare after they have been released into society.

**STRENGTHS AND WEAKNESSES**

The Dutch criminal justice system provides a number of legal procedures that offer possibilities for a unique way of risk assessment, management and treatment for mentally disordered offenders. The TBS order, with its focus on therapeutic milieu treatment and opportunities for education and work training, offers mentally disordered offenders an opportunity towards resocialization and rehabilitation, which is in sharp contrast to the way North American criminal justice systems deal with this group of offenders.

Still, there are a number of shortcomings in current forensic psychiatric practice in the Netherlands that need improvement in the coming years. First, the treatments provided under the TBS order are not evidence-based (see de Ruiter, 2003), and treatment methods have failed to keep pace with those of general psychiatry (van Marle, 2002). In the words of McNerny (2000), “treatment (...) appeared to be on an ad hoc basis, with little adherence to the principles of evidence-based medicine. Consequently, TBS patients are not, in my view, receiving adequate assessment and treatment” (p. 226).

There have not been any studies that examine the relation between treatment outcome and recidivism, which is a prerequisite for determining the effectiveness of the TBS measure. Moreover, there is no information on the differential effectiveness of the treatments provided, i.e., whether treatment is successful with some types of patients but not with others. Also, there is insufficient knowledge about the decision making process for termination of the TBS-order with acceptable risk for society. To date, the most widely used method in forensic practice, at least in the Netherlands, is the unstructured clinical judgment approach that is exclusively based on the professional expertise of the clinicians. Research, however, has revealed several limitations of the unstructured clinical judgment
approach, such as poor reliability and validity (Monahan, 1981). For this reason, several scholars have recommended to employ structured risk assessment procedures in order to optimize accuracy and validity (e.g., Borum, 1996; Webster, Douglas, Eaves, & Hart, 1997). However, risk assessments conducted in the Dutch forensic psychiatric hospitals are generally based on (behavioral) observations by treatment staff in different roles and from different professions (nurses, teachers, work supervisors, psychotherapists, etc.). The psychologist or psychiatrist who carries the ultimate treatment responsibility for an individual patient integrates these observations and provides the court with a description and evaluation of the patients' treatment and states the opinion of the hospital staff about the risk of recidivism. Standardized risk assessments, based on psychological testing procedures (e.g., the PCL-R; Hare, 1991) and structured clinical guidelines for risk assessment (e.g., the HCR-20; Webster et al., 1997), conducted by independent assessors, are, unfortunately, not yet general practice in Dutch forensic psychiatric hospitals.

Second, growing criticism by politicians, the media and the lay public on the expensive 'TBS system' serves to foster long overdue reconsideration of current practices. Few forensic behavioral experts make use of structured risk assessment instruments, which have been proven to be more reliable and valid than unstructured clinical judgment (Grove & Meehl, 1996; Webster et al., 1997).

To conclude, empirically grounded research is needed to improve assessment and prediction of the risk of recidivism and to provide an evidence-base for treatment programs so hopefully in the future recidivism rates will be brought further down. The studies presented in this thesis are an attempt to contribute to this empirical research base.

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7 For a discussion of these limitations, see Quinsey, Harris, Rice, and Cormier (1998). For a detailed discussion about the clinical-actuarial approach controversy, the reader is referred to Douglas, Cox, and Webster (1999) and Litwack (2001).