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The Dual Nature of Forensic Psychiatric Practice

Risk Assessment and Management under the Dutch TBS-Order[1]

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In this chapter the dual nature of forensic psychiatry as a medical profession on the one hand and a juridical specialism on the other will be the frame of reference from which several aspects of the treatment and risk management of mentally disordered offenders in the Netherlands will be discussed. First, we will focus on the legal provisions that apply in cases in which forensic assessment is conducted. Special attention is paid to the concept of diminished responsibility, which plays a central role in the penal system in the Netherlands. We then turn our focus to the treatment and risk management of mentally disordered offenders in one of the forensic psychiatric hospitals in the Netherlands, the Dr. Henri van der Hoeven Kliniek. Finally, the strengths and weaknesses of forensic psychiatric practice in the Netherlands are discussed.

[1] The opinions expressed in this chapter are those of the authors and do not necessarily represent those of other staff or officials of the Dr. Henri van der Hoeven Kliniek. The authors wish to thank J.R. Niemantsverdriet, Ph.D., for helpful comments on an earlier version of the chapter.

JURIDICAL FRAMEWORK

According to the Dutch Code of Criminal Procedure (*Wetboek van Strafvordering*, Sv., Article 352, Section 2) and the Dutch Code of Criminal Law (*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 for his deed, because of a mental defect or disorder, the offender will not be considered punishable. Therefore, the non-punishable offender will not be sentenced but discharged.[2] The question whether the defendant has committed the offense precedes and is distinguished from the question whether he or she[3] 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.).[4]

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 (Article 37, Section 1 Sr.). Second, Article 37a of the Dutch Code of Criminal Law 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 involuntary admitted to a forensic psychiatric hospital on behalf of the state" (*maatregel van terbeschikkingstelling, TBS*). In the remainder of this chapter, we will refer to this penal measure as a "TBS-order."

Most of the time, a TBS-order is combined with an order of mandatory treatment when the safety of persons or the general safety of persons or goods are in danger (Article 37b, Section 1 Sr.). 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 (Article 37a, Section 3 and Article 37, Section 2 Sr.). A TBS-order can be imposed by the court if the following conditions apply (Article 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;[5]

[2] In Dutch terminology: *ontslagen van alle rechtsvervolging*.
[3] In the following, the male pronoun is used for referring to either gender.
[4] Thus, Dutch law distinguishes punishability of the acts from punishability of the defendant. Both types of punishability are a precondition for a conviction.
[5] In the following, we will elaborate on the degrees of criminal responsibility in the Dutch legal system.

2. The crime carries a prison sentence of at least four years, or the offense belongs to a category of offenses carrying a lesser sentence specifically mentioned in the law;
3. There is a risk for the safety of other people or for the general safety of persons or goods.

In theory, a TBS-order is of indefinite duration (Article 38e, Section 2 Sr.). Initially imposed for two years (Article 38d, Section 1 Sr.), it may be extended for one or two year periods 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 (Article 38d, Section 2 Sr.). TBS involves involuntary admission to a specialized maximum-security forensic psychiatric hospital (Article 37d, Section 1 Sr.) aimed at motivating the patient to participate voluntarily 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.[6] Although there are (rather large) differences in the treatment models the nine 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.

In the Dutch criminal law system, which is mainly inquisitorial in nature (as opposed to the adversarial legal systems in most common law systems), forensic reporting on the responsibility of a defendant generally takes place on the initiative of the investigating judge or the court.[7] According to Articles 227–228 Sv., the investigating judge, while conducting a pre-trial investigation, has the competence to appoint behavioral experts, either in his official capacity, or on request of the defense or the public prosecutor. It is this "judicial framework" that serves to guarantee the independence of the expert's contribution, and to avoid a possible

[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.

[7] Article 317 CCP recognizes the authority of the trial court to order an investigation into the mental capacities of the defendant. For this purpose, the court may summon that the accused shall be brought to a particular psychiatric hospital or a forensic mental health assessment center.

"mix up" with the interest of the prosecution or the defense. This procedure is in rather extreme contrast to, for example, forensic experts' daily practice in the United States, where "selection and calling in of the experts, and their payment, largely belong to the domain [...] of the defense and the prosecution" (Malsch & Hielkema, 1999, p. 224),[8] which may compromise the impartiality of the report of the expert; defense lawyers are known to sometimes "shop" for an expert who will support their case. On the other hand, professional standards such as the *Daubert* standard (*Daubert et ux. v. Merrell Dow Pharmaceuticals Inc.*, 1993) on the admissibility of scientific evidence, provide some safeguards against low quality reporting and "reading into the test results what one wants to find."[9] Psychological assessments under *Daubert* have to be based on psychological tests that are reliable and valid and psychological interpretations have to be related to specific test results.

In the Netherlands, the investigating judge or the court generally requests answers to the following questions:

1. What is the personality of the defendant?
2. Did the defendant, at the time of the alleged crime, suffer from any pathological disturbance and/or defective development?
3. If so, what is the relationship between the pathological disturbance/defective development and the committing of the crime?
4. As a result of this relation, to what extent can the defendant be held responsible for committing the crime, if proven.
5. To what extent is the defendant likely to recidivate?
6. What is the best treatment for the defendant?

In general, there are two ways in which the forensic assessments of defendants with suspected mental disorders are conducted: (1) non-residential forensic mental health evaluation and (2) residential observation and assessment at the Pieter Baan Centrum.[10] The choice for a certain type of assessment depends on the nature of the suspected mental disorder and the seriousness of the crime of which the defendant is accused. In general, residential, multidisciplinary observation in the Pieter Baan Centrum is requested when a very serious or bizarre crime has been committed that

[8] Although behavioral experts are generally appointed by the investigating judge in the Netherlands, it does occur that the defense lawyer asks for a second opinion by another expert.

[9] Not everyone would agree on this. See, for example, Hagen (1997), especially pp. 298–299 for a completely different opinion.

[10] For an extensive discussion of the reporting procedure in the Pieter Baan Centrum, see Mooij, Koenraadt and Lommen-van Alphen (1991).

substantially violated the legal order and non-residential observation is not considered to be an adequate assessment procedure.

The majority of the forensic assessments of the defendant's accountability are conducted on an ambulatory basis. In these cases, in general, both a psychiatrist and a psychologist will answer the forensic questions mentioned above. The Pieter Baan Centrum (PBC) is the Psychiatric Observation Hospital of the Ministry of Justice that conducts multidisciplinary evaluations of defendants as to possible mental defects or disorders and advises on treatment. For about seven weeks, a social worker, a sociotherapist, a psychologist, a legal advisor, and a psychiatrist work together to (1) assess the defendant's accountability for the alleged crime, (2) estimate the risk of recidivism, and (3) formulate recommendations about treatment. The conclusion and recommendation are discussed in a final staff-meeting, which is not only attended by the reporting team, but also by a legal advisor (who does not report but has studied the case), a member of the board of directors and the local probation officer, who is, of course, not responsible for the conclusion and recommendation of the reporting team. The legal advisor has as primary task to ascertain that the final report does not contain any (new) information that is relevant to the legal aspects of the case.

COMPETENCE TO STAND TRIAL

In the United States, but also in some other countries, at the very beginning of a potential court case, before the issue of the insanity defense even arises, the defendant may be examined to determine competency to stand trial. According to Melton, Petrila, Poythress, and Slobogin (1997), competency to stand trial is by far the most frequently adjudicated competency issue in the United States. It generally means that the defendant is capable of assisting in his own defense (*Dusky v. United States*, 1960), that is, the defendant needs to have the capacity to understand the criminal process, including the role of the participants in that process, and he needs to have the ability to function in that process, primarily through consulting with counsel in the preparation of a defense.

Competency focuses on the defendant's *present* ability to consult with counsel and to understand the proceedings. It therefore differs fundamentally from the test of criminal responsibility, which is a retrospective inquiry focusing on the defendant's state of mind at the time of the alleged crime (Melton et al., 1997). If the court finds the defendant incompetent, the trial is suspended. In some cases, in particular if the defendant is charged with a nonserious offense, a case will not be further prosecuted

in exchange for the defendant seeking treatment as a civil psychiatric patient. In other cases, in particular if the alleged crime is a more serious one, the accused is often committed to the public mental system for treatment. The stated purpose of treating the person found incompetent to stand trial is to restore competency so that trial may resume (*Jackson v. Indiana*, 1972).

Contrary to legal practice in the United States any defendant can, in principle, be summoned to stand trial in the Netherlands. The question whether someone is "fit for trial" is seldom asked, and therefore not an issue about which forensic mental health experts have to report. Article 16, Section 1 Sv., however, states that the trial court has the authority to adjourn the trial if the accused suffers from such a serious mental disorder that he is not capable of understanding the charges. The defendant's legal counsel serves to defend his interests (Article 331, Section 1 Sv.).

THE DIMINISHED RESPONSIBILITY DOCTRINE

There is a clear distinction between punishment and treatment in the Netherlands. By providing treatment an attempt is made to alter the disturbance in the personality of the offender to such a degree that he will pose less risk and will not commit another serious crime. This so-called dualistic sanctioning system of punishment and coercive measures considers the safeguarding of society to be the main reason for coercive measures; the principle reason for punishment is a certain degree of culpability. The basic principle is that only those who can be held responsible for their behavior will be punished. The choice between punishment and coercive measures is determined by the judge, based on the *degree* of responsibility of the defendant. The basic assumption is that the defendant is fully responsible. In case of a disorder, the court will decide on the basis of reports of behavioral experts *to what extent* this disorder has influenced the behavior of the defendant at the moment of the alleged crime.

Article 37a of the (old) Code of Criminal Law created the possibility of diminished responsibility. On the basis of this, more refined "qualities" of criminal responsibility were introduced in Dutch case law, and eventually a five-point sliding scale (between full responsibility on the one hand, and complete absence of responsibility on the other), emerged, indicating the degree of criminal responsibility: full responsibility, slightly diminished responsibility, diminished responsibility, severely diminished responsibility, and total absence of responsibility. In case of slight or severe diminished responsibility (i.e., the offense is to some extent determined by a mental disorder but cannot be explained in its entirety by this disorder),

the judge may sentence a prison term for that part of psychological functioning 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 (i.e., those suffering from a serious mental disorder) can (and most of the time will) also be sentenced to imprisonment. On the one hand there is the principle of "no punishment without guilt." On the other hand, however, following decisions of the Dutch Supreme Court, there is *no* such thing as "punishment to the extent of guilt." This is because in determining the sentence the court not only takes into account the degree of guilt of the offender, but also includes among others to what extent society is shocked by the offense, and the deterrent effect of the punishment. This means, for example, that if a person committed a first degree murder under the influence of a mental disorder and the trial court consequently considers this person to have diminished responsibility for the offense, the court can sentence him to a long (e.g., 10 years, which is considered long in the Netherlands) prison sentence in combination with a TBS-order.[11] In theory, and sometimes also in practice, a person found guilty but with diminished capacity can serve the same prison term as a fully-responsible defendant and also faces an additional period of involuntary hospitalization on top of the prison term.

The combination of imprisonment and involuntary admission to a forensic hospital leads to significant ethical questions. As stated before, 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 to be a danger for society.

Contrary to the situation in the Netherlands, American legal practice does not allow much room for degrees of responsibility. In the United States, the diminished or partial responsibility doctrine is considered to be a "mini-insanity" defense, which gives mitigating effect to the presence of a

[11] It should be noted that (severely) diminished responsibility does not always result in the recommendation and the imposition of involuntary 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 again, a involuntary admission to a forensic psychiatric hospital will be imposed. If a person is sentenced to a long penal sanction in conjunction with the measure of TBS (involuntary admission to a forensic hospital), the prison sentence is executed first; after the offender has served his sentence he wil be transferred to a forensic hospital.

mental disorder that causes cognitive or volitional impairment but produces neither insanity nor an inability to form the *mens rea* for the alleged crime.[12] The doctrine of diminished responsibility has rarely enjoyed support in the U.S. courts, if only because it is thought to be very difficult to implement: how does one, for instance, sensibly define partial responsibility and of what crime is the defendant guilty if he is "only" partially responsible?

PSYCHIATRIC DISORDERS IN TBS PATIENTS

A little over 1000 TBS-patients are treated in nine forensic psychiatric hospitals in the Netherlands. They form 7.4% of the total prison population (Dienst Justitiële Inrichtingen, 1999). The Dr. Henri van der Hoeven Kliniek is one of the nine hospitals. Ninety-five percent of patients are male and 28% are nonnative (mostly Antillian, Surinamese, Indonesian, Turkish, and Moroccan). Eighty-three percent have only elementary school or lower vocational training. The offenses for which they are sentenced are, for instance, (attempted) murder or manslaughter, rape, indecent assault, arson, pedosexual offences, robbery and extortion (Van Emmerik, 1997). The mean treatment duration for patients who were released from the Van der Hoeven Kliniek in 1997 and 1998 was 4.2 years.

Research has shown that 25% of TBS-patients suffer from a psychotic disorder (18% schizophrenia, 2% organic psychosis, and 5% other psychotic disorders) and approximately 80% fulfill diagnostic criteria for one or more DSM-III-R or DSM-IV personality disorders (American Psychiatric Association, 1994; Van Emmerik, 1997; Greeven, 1997). Thus, a personality disorder (i.e., independent of Axis I disorders or mental retardation) can be grounds for a TBS sentence, and thus also for a degree of diminished responsibility. This is in contrast to the North American criminal justice systems where personality disorders are considered mental disorders but not a reason for diminished responsibility because for the latter the defendant "must then show that a disease of the mind rendered him incapable either of appreciating the nature and quality of the (criminal) act or of knowing that the act was wrong" (Zinger & Forth, 1999). For instance, psychopathic personality disorder has been found to be "a disease of the mind," but to date the presence of psychopathy alone has

[12] Diminished responsibility needs to be distinguished from the diminished capacity doctrine. The latter doctrine, in its broadest sense, permits the defendant to introduce clinical testimony focusing directly on the mens rea for the alleged crime, without having to assert an insanity defense. In contrast to the disposition when insanity is the defense, when the mens rea for a crime is negated by clinical testimony the defendant is acquitted only of that particular charge.

never fulfilled the legislative criterion of not knowing that the act was wrong. Consequently, a diagnosis of psychopathic personality disorder in a defendant in a North American criminal court usually leads to detention in a correctional facility rather than commitment to a psychiatric hospital. In the majority of cases, the diagnosis of psychopathy leads to longer sentences by the court (Zinger & Forth, 1999). In the Netherlands, a diagnosis of psychopathy does not rule out the possibility of a TBS sentence with treatment in a forensic psychiatric hospital. In fact, about 15% of 62 patients committed to one of the Dutch forensic psychiatric hospitals received a diagnosis of psychopathy, based on the Hare Psychopathy Checklist-Revised (PCL-R, see Hare, Vertommen, Verheul, & De Ruiter, 2000; Hildebrand & De Ruiter, 2000).

TREATMENT UNDER THE TBS ORDER

Every forensic psychiatric hospital has a legal obligation to provide security to society, treatment for the offender-patient, and to protect the civil rights of the latter. These three 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 ideology and level of security. Although the treatment models of the hospitals vary, they all involve a composite of education, work training, individual and group psychotherapy, creative arts and sports activities. The general treatment aim is a reduction in future violence risk by means of a positive change in those factors that are associated with (sexual) violence for the individual patient. For instance, at the Van der Hoeven Kliniek in cases of schizophrenia treatment is focused on psycho-education about psychosis and its precursors, on medication adherence and daily living skills. Patients with personality disorders participate in various group therapy programs, such as social skills training, aggression and impulsivity management and sex education. There are special programs for substance abusers and sex offenders. Almost all patients receive individual psychotherapy, which focuses on their individual risk factors for reoffending by means of the so-called offense script and relapse prevention (Van Beek, 1999). Education and job training are an important aspect of treatment, because many patients are lacking the skills they need to be successful on the job market (De Ruiter, 2000).

To give the reader an impression of the treatment process and its different stages, the procedures in the Dr. Henri van der Hoeven Kliniek, one of the Dutch forensic psychiatric hospitals, will be described in some detail here. In this way readers will be able to compare "the Dutch approach to treatment of mentally disordered offenders" to the way this

group of offenders is dealt with in other jurisdictions. A central concept in the treatment ideology of the Van der Hoeven Kliniek is the stimulation of the patient's awareness that he is responsible for his own life, including his offenses and his progress in treatment. This premise is basic to the way the hospital is organized and to all treatment activities. Only when the patient takes responsibility the road towards freedom can be set in.

Observation and Assessment

Prior to admission to the hospital, the prospective patient is visited twice while he is still in prison: once by a supervising psychologist of the hospital, and once by a group leader and a patient. These visits are meant to provide the new patient with some basic information about the hospital and to get to know him. The first two months of his actual stay at the hospital are used for extensive observation, assessment and preparation for treatment. From the first day on, the patient has a program of daily activities, including work, education, creative arts and sports. Work supervisors and teachers observe patients during their activities and report on their observations. The patient also spends time at his living group (see below), where group leaders make observations during structured and unstructured activities. During this period, psychologists see the patient for personality and educational assessment. When there are doubts about a patient's cognitive functioning, additional intelligence and/or neuropsychological testing is performed. The objective of personality assessment is to obtain insight into the factors that are related to the patient's risk of violence. To this end, semi-structured interviews (for DSM-IV Axis II disorders and the Psychopathy Checklist-Revised interview), self-report personality inventories (e.g., the Minnesota Multiphasic Personality Inventory-2, MMPI-2, Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) and anger, impulsivity and interpersonal behavior scales and indirect tests (e.g., the Rorschach Inkblot Method, Exner, 1993) are administered. Also, structured clinical guidelines for the assessment of violence risk (HCR-20, Webster, Douglas, Eaves, & Hart, 1997; Dutch translation: Philipse, De Ruiter, Hildebrand, & Bouman, 2000) and sexual violence risk (SVR-20, Boer, Hart, Kropp, & Webster, 1997; Dutch translation: Hildebrand, De Ruiter, & Van Beek, 2001) have been implemented recently. Personality assessment results are used to help formulate treatment goals and a treatment plan, and to provide standardized information for empirical research. The findings from the educational assessment result in a plan for work and education.

During the first weeks, the patient also meets with one of the psychotherapists and with the social worker who is assigned to his living

group. These sessions are scheduled to determine what function the patient's social network and psychotherapy could have in his treatment. The observation and assessment period ends with the so-called "treatment indication meeting," a staff meeting where all hospital staff is invited to discuss the core issues of the patient and his treatment plan. In the meeting room, an inner circle and an outer circle are created. In the inner circle, the patient and a fellow-patient, two group leaders, the patient's work supervisor, his sports teacher, his creative arts teacher, his social worker, one of the psychotherapists and one of the school teachers, and the supervising psychologist take place, as the latter directs the conversation. All other staff members sit in the outer circle. They listen to the conversation among the inner circle members, but do not participate in it. The first half-hour of the meeting is spent discussing the patient's core problems in relation to the offense(s) for which he was sentenced to TBS. During a ten-minute pause, the patients and the group leaders leave the room so that staff members from the inner and outer circles can exchange their views on what has been discussed so far. After the pause, the (provisional) treatment program as it has been determined by the treatment team, is discussed with the patient.

The Central Role of the Living Group

Most patients stay in a living group, where they live with fellow-patients in a kind of "house." Every living group consists of 8 to 10 patients, who are supervised by 5 group leaders. The living groups manage their own household. The money needed for that comes from the hospital's budget and is spent by the groups, because the hospital emphasizes the importance of handling money in a way that is comparable to that in society at large (Wiertsema, Feldbrugge, & Derks, 1995). The hospital provides patients with a hot meal daily, but living groups are allowed to cook for themselves. Daily life in the group provides patients with experiences that have to do with shared responsibility, social skills and spending leisure time. Each patient has his own room.

The treatment team consists of a supervising psychologist, a social worker and the group leaders and is responsible for the planning, progress and evaluation of the patient's treatment. The group leaders have a diversity of tasks: they are present at meals and at group discussions; they supervise the structure of daily life; they write treatment plans and daily logs of their experiences with patients.

The hospital has a special ward for individual treatment, where patients who are unsuitable for placement in a regular living group are admitted. In general, the goal is to place patients in a regular living group after a period of intensive individual treatment, but this objective is not

always met. Since the beginning of the 1990s there is a special living group for patients with psychotic disorders. This group is more highly structured and medication adherence and psycho-education are the most important aspects of the treatment here.

Treatment Evaluation

Treatment progress is evaluated every three months, both orally and in writing. The patient's progress is discussed with fellow patients during a meeting with the living group and during a meeting with the persons (teachers, therapists, etc.) who are involved in the patient's treatment. After 18 months of treatment, the patient is retested with a number of the personality tests that were also administered upon admission to the hospital. In this way, objective instruments provide information on the patient's progress. Important phases in the treatment process, such as extended leave, are discussed at evaluations. Subsequently, the patient may be invited to submit a proposal for extension of leave, which needs to include arguments why he thinks he has changed so that extended leave is warranted. Such a proposal is discussed within the patient's living group, in the treatment team and in the so-called Hospital Council, which consists of staff members and patient representatives from all living groups. The Hospital Council meets every day and serves to maintain a safe and viable therapeutic milieu through cooperation between staff members and patients. After the patient's proposal has been discussed in all these organs, the final decision about extension of leave is made in the general staff meeting.

The Resocialization Phase

The staff at the Van der Hoeven Kliniek aims to limit the duration of the inpatient treatment phase for each patient, of course without losing sight of society's safety. When feasible, a patient is placed in a so-called "transmural setting." These patients are supported by a special team of group leaders of the hospital, who supervise them during this resocialization phase. Supervision is sometimes conducted in collaboration with other mental health institutions.

There are several types of transmural settings. *(1) Supervised living in apartments owned by the hospital or in rental apartments.* Characteristic for this type of forensic supervised living is regular contact between the patient and staff members of the hospital, but there is no 24-hour supervision. The patient's daily life mainly takes place outside the walls of the hospital, although in some cases he may visit the hospital almost daily, for example to see his psychotherapist or to go to work training. *(2) Collaboration with a*

sheltered home organization in the city of Utrecht (SBWU). Since 1991, a contract with SBWU allows the hospital to place patients with limited social and cognitive capacities who realize sufficiently that they will need supervision for an extended period of time, in a sheltered home. Most of these patients follow a treatment program in the hospital during the day. After a certain period their activities in the hospital are often replaced by activities in society, such as volunteer work or a paid job in a welfare facility. *(3) Clinical admission in a general psychiatric hospital.* For patients who have insufficient capacities to maintain themselves in a sheltered home, the Van der Hoeven Kliniek has places in a general psychiatric hospital. These patients may suffer from psychoses that cannot be managed adequately with medication or they may be unable to adhere to their medication regimen without intensive external supervision. They need long term, continued clinical treatment to prevent psychotic decompensation.

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 sorely lacking. 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 3 to 8 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 recidivism rates are related to treatment process and outcome. A two-year cross-sectional follow-up study of 59 personality disorder patients, during their inpatient treatment in the 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). However, the overall personality structure of the patients remained essentially the same, and it remains to be seen how these patients will fare after they have been released into society. These 59 patients were tested last in 1995, and will be traced and tested again in 2001. Recidivism rates can then be examined in relation to objective treatment measures for the first time.

VIOLENCE RISK ASSESSMENT AND MANAGEMENT UNDER THE TBS ORDER

Risk assessment and management are ongoing tasks 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 or question the leave proposals submitted by the hospitals, and withholds permission in some cases. Leave decisions that have to be approved include, for instance, the first time the TBS patient is allowed outside the physical security of the institution, still under staff supervision, travel without staff supervision and leave on probation.

Every one or two years, the patient's case has to be reviewed by the court (Article 38d, Section 1 Sr.), which decides whether the TBS needs to be extended or can be terminated in the individual case. The forensic hospital has to submit a report to the court that gives information on the mental disorder of the patient, treatment progress, the assessment of recidivism risk and advice on the extension or termination of the TBS. Judges do not always follow the hospital's advice; in one in five cases they opt for termination of the TBS against the latter's advice. Several studies have shown that forensic hospital staff are better at predicting recidivism in their patients than judges. In a long-term follow-up (>5 years) of 40 patients who had been treated at the 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).

Risk assessments conducted in the forensic psychiatric hospitals are generally based on (behavioral) observations by treatment staff from different roles and professions (nurses, teachers, work supervisors, psychotherapists, etc.). The psychologist or psychiatrist who carries the final treatment responsibility for an individual patient integrates these observations into the report for the court and provides an advice on the patient on the basis of it. Standardized risk assessments, based on psychological testing procedures (e.g., the Psychopathy Checklist-Revised, Hare, 1991) and structured clinical guidelines for conducting risk assessments (e.g., the HCR-20, Webster et al., 1997), conducted by independent assessors, are not yet general practice in Dutch forensic psychiatric hospitals. However, we expect that this will change in the coming years, because Dutch translations of a number of important risk assessment instruments have recently become available (Hare et al., 2000; Hildebrand, De Ruiter, & Van Beek, 2001; Philipse et al., 2000) and the Ministry of Justice has recently appointed a task force that will formulate general guidelines for standardized risk assessment under the TBS order (Ministry of Justice, 2000).

After a patient has been detained under the TBS order for six years, the law (Article 509, Section 4 Sv.) requires two independent behavioral

experts, a psychologist and a psychiatrist, to submit a 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 reports 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 against the well-known biases that treatment staff are liable to when they have to assess future violence risk in their own patients (Dernevik, 1999).

STRENGTHS AND WEAKNESSES

The Dutch criminal justice system provides a number of procedures that offer possibilities for a unique way of risk assessment, management and treatment of mentally disordered offenders under the TBS order. A number of follow-up studies have documented a 20% violent recidivism rate in former TBS patients (e.g., Leuw, 1995, 1999). Although the TBS population is not completely comparable to a prison population, recidivism rates after long-term prison sentences for similar offenses tend to be higher. The TBS order, with its focus on therapeutic milieu treatment and opportunities for education and work training offers mentally disordered offenders a much valued opportunity towards resocialization and rehabilitation, which is in sharp contrast to the way in which North American criminal justice systems handle this group of offenders.

Still, there are a number of shortcomings in current forensic psychiatric practice in the Netherlands that need to be improved in the coming years. Criticism by politicians and the lay public on the expensive "TBS system" is growing and serves to foster long overdue reconsideration of the current practice. First, there is as yet no official training or certification program for forensic psychologists or psychiatrists in the Netherlands. Psychologists and psychiatrists generally learn their forensic assessment skills more or less "on the job," and in the absence of quality standards and/or a register of certified forensic professionals, the quality of their reports is highly variable (De Ruiter, 2000). 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 (Webster et al., 1997). Second, the treatments provided under the TBS order are not "evidence-based." 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 the treatment is successful with some

types of patients but not with others. Studies that examine changes in violence risk factors during treatment and the predictive validity of different factors with regard to treatment outcome and recidivism are underway in the Van der Hoeven Kliniek.

From the 1950s on, a general optimism about the treatment amenability of mentally disordered offenders has been part of the influential Utrecht school in Dutch penal law (Moedikdo, 1976). The TBS order and the diminished responsibility doctrine provided venues for this optimism. Recently, however, the optimism of the 1950s has been replaced by the realism of the new millennium. A 20% violent recidivism rate looks good on the surface, but looked at more realistically, it means that every one in five ex-TBS patients is arrested for another serious offense that often caused great personal harm and shocked society. We need empirical research to help us to better assess and predict the risk of recidivism and to improve our treatment programs so we may hopefully at some time in the future bring down that "every one in five" figure.