Prevalence and Treatment of Personality Disorders in Dutch Forensic Mental Health Services

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Offenders with serious personality disorders challenge forensic systems throughout the world. In this article, the authors describe the legal system that shapes the forensic treatment of personality-disordered offenders in the Dutch psychiatric and correctional systems. The evolution of laws and regulations are addressed, as is the bifurcation of treatment between forensic hospitals and correctional settings. Prevalence data of personality disorders in the Dutch systems are presented, and comparisons between the Dutch and American systems are delineated. Current treatment modalities are described. Research initiatives and future directions for the system are presented.

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During the past decade, the number of beds in forensic hospitals in The Netherlands has shown a steady increase from 650 in 1995 to around 1650 in 2006 (Fig. 1). The number of prison cells and the number of beds in youth forensic treatment centers are showing a similar increase. This dramatic development is paralleled by an increase in the crime rate—in particular, the rate of violent crime.[1] There is a growing societal and political awareness in The Netherlands that the current, still largely repressive crime policy is ineffective in reducing the rate of criminal offending. In the Spring of 2005, the Dutch Ministry of Justice presented the results of a study revealing that reoffense rates six years following release from adult imprisonment and youth detention were 73 and 78 percent, respectively.[2,3] Dutch Minister of Justice Donner admitted that these high recidivism rates showed that punishment and imprisonment alone do not help in preventing relapse into crime. He made a comparison with the "tough on crime" policy in the United States, which also failed to result in decreasing (violent) crime rates.[4]

There is a growing uneasiness about crime and public safety and awareness that alternative strategies are needed. This awareness is demonstrated by the fact that the Dutch Parliament and the Ministries of Health and Justice have recently asked for advisory reports on (1) the state of the art of treatment for mentally disturbed offenders in Dutch forensic hospitals, and (2) on the prevention and treatment of antisocial personality disorder, respectively. Both reports appeared at the beginning of May 2006[5,6] and made a strong case for more evidence-based treatment in the forensic mental health field. We will return to some of the specific recommendations made in these reports at the conclusion of the article.

First, we provide a brief overview of the legal context in which the treatment of personality-disordered offenders takes place in The Netherlands and compare this to the provisions regarding such offenders in the U.S. legal system. Subsequently, we will review the findings from recent studies on the prevalence of personality disorders in different forensic settings in The Netherlands. Current treatment practices will be described, with a special emphasis on recently

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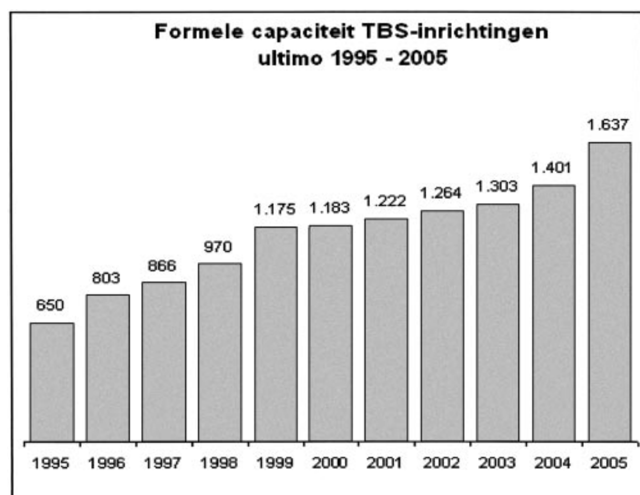

Figure 1. Formal capacity in number of beds in Dutch forensic psychiatric hospitals (1995–2005). Reprinted by permission of Service of Correctional Institutions, 2006. Available at www.dji.nl.

started innovative projects. Finally, future developments will be pointed up, with attention to research, practice, and legal policy.

Legal Issues: Context and Comparison to the United States

According to the Dutch Code of Criminal Procedure (CCP, Art. 352, section 2)[7] and the Dutch Code of Criminal Law (CCL, Art. 39),[8] in cases where the criminal act is proven but the offender cannot be held responsible for his or her act due to a mental defect or disorder, the offender will not be considered punishable. (De Ruiter and Hildebrand have provided a more extensive discussion of Dutch criminal law in relation to mentally disordered offenders.[19]) The question of whether the defendant has committed the offense precedes and is distinguished from the question of whether he or she (he, henceforth, for simplicity) is punishable, which depends, among other things, on whether the defendant is to be held responsible with regard to the crime committed (see CCP, Art. 350). Thus, Dutch law distinguishes both punishability of the acts and punishability of the defendant. Both types of punishability are a precondition for a conviction.

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 if he is a danger to himself or to others or to the general safety of persons or property (CCL, Art. 37, § 1). Second, Article 37a of the Dutch CCL states that a defendant who, at the time of the alleged crime, was affected by 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*, or TBS). In the remainder of this article, we will refer to this judicial measure as a "TBS-order."

The court can impose a TBS-order if all of the following conditions apply (CCL Art. 37a):

1. The defendant must have a mental disorder, which means that his responsibility for the alleged crime is (severely) diminished or absent;

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 as carrying a lesser sentence;

3. There is a risk to the safety of other people or to the general safety of persons or goods.

Theoretically, a TBS-order is of indefinite duration (CCL, Art. 38e, § 2). Initially imposed for two years (CCL, Art. 38d, § 1), it may be extended for one- or two-year periods as the court re-evaluates the patient to determine whether the risk to the safety of society is still too high (CCL, Art. 38d, § 2). TBS involves involuntary admission to a specialized maximum-security forensic psychiatric hospital (CCL, Art. 37d, § 1), which is aimed at motivating the patient to participate voluntarily in the treatment programs offered by the hospital. Although there are significant differences in the treatment models to which the 13 Dutch forensic psychiatric institutions adhere, 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.

Competency to Stand Trial and Criminal Responsibility

At the very beginning of a potential court case in the United States, before the issue of criminal responsibility even arises, the defendant may be examined to determine competency to stand trial. According to Melton *et al.*,[10] competency to stand trial is by far the most frequently adjudicated competency issue in the United States. Competency focuses on the defendant's present ability to consult with counsel and to understand the proceedings. It 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.

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

In The Netherlands, the 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 choice between punishment and coercive measures is determined by the judge, based on the assessed degree of responsibility of the defendant. Article 37a of the CCL created the possibility of diminished responsibility. On the basis of this, more refined degrees of criminal responsibility were introduced in the Dutch jurisprudence, and a five-point sliding scale emerged, indicating the degree of criminal responsibility: full responsibility, slightly diminished responsibility, diminished responsibility, severely diminished responsibility, and total absence of responsibility. In intermediate cases of slightly or severely diminished responsibility (i.e., when the offense is to some extent determined by a mental disorder, but cannot be explained in its entirety by this disorder), the judge may impose a prison term corresponding to the portion of psychological functioning that allowed the defendant freedom of choice (i.e., the choice not to commit the offense). As discussed in the following section, this legal refinement results in the inclusion of a rather substantial number of offenders with a primary diagnosis of personality disorder.

The combination of imprisonment and involuntary admission to a forensic hospital leads to significant questions of ethics. As stated before, a TBS is ordered to allow treatment of the mental disorder of the offender, and therefore there is an ethics 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 by executing the prison sentence first. On the other hand, it also seems 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. This dilemma is as yet unresolved.

Contrary to the situation in The Netherlands, American legal practice does not allow much room for degrees of responsibility. 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 sensibly define partial responsibility, for example, and of what crime is the defendant guilty if he or she is only partially responsible?

Forensic Mental Health Services

Forensic Hospitals

The diminished-responsibility doctrine has important implications for the type of mental disorders found among patients in Dutch forensic psychiatric hospitals. In sharp contrast to the situation in the United States, a large proportion of patients in Dutch forensic hospitals have a personality disorder (PD) without a concomitant major mental disorder. Hildebrand and de Ruiter[11] found in a sample of 94 TBS patients from the Dr. Henri van der Hoeven Kliniek (using the Dutch version of the Structured Interview for DSM-IV Personality Disorders [SIDP[12]]) that 66 percent fulfilled diagnostic criteria for a cluster B personality disorder. For cluster A, 29 percent fulfilled criteria and for cluster C, 22 percent. The most frequently diagnosed cluster B disorders were: antisocial (45%), borderline (24%), and narcissistic (26%). Paranoid personality disorder also had a relatively high prevalence rate (18%); the remaining PDs had prevalence rates between 4 and 11 percent. Lifetime comorbidity between Axis I and Axis II disorders was 72 percent; 48 percent met criteria for at least one substance-related disorder.[11] Seventeen percent of the sample met criteria for schizophrenia or another psychotic disorder. Timmerman and Emmelkamp[13] studied the prevalence of DSM-III-R Axis I and Axis II disorders with standardized semistructured interviews in a sample of 39 TBS patients from Forensic Psychiatric Center Veldzicht. They found that 87 percent received a diagnosis of personality disorder, most often from

cluster B. Only three of the 39 patients had a diagnosis of a major mental disorder (schizophrenia, bipolar disorder).

Outpatient Forensic Clinics

Since the beginning of the 1990s, Dutch forensic psychiatric hospitals have started to operate outpatient forensic clinics in major cities spread over the entire country. In contrast to the inpatient forensic hospitals, which are financed by the Ministry of Justice, these outpatient centers are placed under the Ministry of Health. One of the reasons for this development was the need for community aftercare for TBS patients. Also, since 1996, new legislation made it possible for the criminal court to convict a person to a conditional TBS: the conditions can include mandatory supervision by the probation service and outpatient forensic treatment, but do not include admission to a secure forensic psychiatric hospital. The outpatient forensic centers offer a wide range of ambulatory and day treatment programs for different offender groups: sex offenders, violent offenders, spousal assaulters, mentally retarded offenders, and adolescent offenders. Treatments are offered in different formats: individual, group, and system. Thus far, however, there has been no systematic research into the effectiveness of the outpatient programs offered.[14] Also, research into the epidemiology of mental disorders in the outpatient forensic population is scarce. Derks, *et al.*[15] used a self-report questionnaire, the Personality Disorder Questionnaire-Revised (PDQ-R),[16] to study the prevalence of PDs in the De Waag outpatient forensic clinic. They found that 83 percent of the clients fulfilled DSM-III-R criteria for at least one PD; paranoid (47%), antisocial (41%), and borderline (37%) PDs were the most prevalent. It should be noted, however, that the use of self-report measures to diagnose PDs, in particular in forensic populations, has serious drawbacks.[17]

Correctional Facilities

The capacity in Dutch prisons was 16,000 in 2004: one prison bed per 1000 general population. In general, the offering of offender treatment programs in Dutch prisons is limited. There is a special sanction for repeat drug-addicted offenders, which entails a 2-year substance abuse treatment program in prison, but its effectiveness is unproven.[18] The Ministry of Justice launched a policy program Preventing Recidivism (TR: *Terugdringen Recidive*) in 2002 to introduce the so-called What Works approach[19] into the Dutch prison and probation system. This program has resulted in the introduction of a cognitive skills training program, the installation of an accreditation committee that reviews existing interventions against evidence-based criteria, and a renewed emphasis on aftercare and reintegration. It should be noted, however, that only two years after the launch of TR, the same Ministry of Justice forced rather large budget cuts on the prison and probation service, which imposed severe limits on educational programs and on the amount of daily time a prisoner can spend outside his cell.

Current Forensic Treatments for Personality Disorders

The Dutch forensic mental health field is increasingly aware that forensic treatment should be evidence-based. The recent introduction of structured risk assessment instruments, such as the Dutch-language HCR-20[20] and the SVR-20,[21] has resulted in a focus on treatment of dynamic risk factors for new offenses, of which personality disorder is one. Most forensic hospitals offer cognitive-behavioral treatments, but thus far, no controlled studies of outcome have been reported. Timmerman and Emmelkamp[22] conducted a naturalistic follow-up study with 39 forensic inpatients across a 3-year follow-up period. They reported a significant decrease on self-report measures of distrust and anger, and a significant decrease in oppositional behavior on staff ratings, but no effect on pro-social behavior. Most significant effects were moderate in terms of Cohen's effect size *d*. Greeven and de Ruiter[23] obtained somewhat more favorable findings with their naturalistic study design in a sample of 59 personality-disordered offenders. After two years of inpatient forensic treatment, the Personality Disorder Questionnaire-Revised showed significant improvement on all personality disorder dimensions, except for histrionic PD. Thirty-nine percent of the sample improved reliably (by more than two standard deviations[24]) and 27 percent also fulfilled criteria for clinically significant change on self-reported personality disorder symptoms.

Current Research

In recent years, several cognitive-behavioral treatments that were initially developed for other popu-

lations have been introduced in the forensic field. Among these are Dialectical Behavior Therapy,[25] Aggression Replacement Training,[26] and Schema Focused Therapy (SFT).[27] The original treatment protocols had to be adapted for use with forensic patients, and these implementation projects included intensive training and supervisory programs. For example, SFT is now being used with TBS patients with a diagnosis of antisocial personality disorder. All projects are joined by quasi-experimental research designs—in most cases, the experimental treatment is compared with treatment as usual. A new feature of these projects, consistent with a growing international clinical research trend, is their multicenter nature. In two of the studies, three or more forensic hospitals participated. This is an effective way of obtaining a large enough sample, and it increases the generalizability of the findings.

Future Expectations

As mentioned at the beginning of the article, Dutch forensic psychiatry is currently under close scrutiny. Both the Parliamentary Committee TBS and the Health Council have recommended, in their respective reports, that serious investments are needed in research and development in the forensic field. Studies into the effectiveness of treatments offered in the forensic field, including the prison and youth forensic systems, are a priority. Furthermore, the Dutch higher education system is being directed to develop Master's and post-Master's level programs in forensic mental health sciences to produce professionals with knowledge and expertise tailored to this demanding field.[6] At present, no such programs exist within The Netherlands.

The renowned Dutch soccer player Johan Cruijff is often quoted for his proverbial statements, of which the most famous is: "Every disadvantage has its advantage." This is rather true for the present state of affairs in Dutch forensic psychiatry: the awareness of its weak points has created the momentum for serious investments and improvements in the future.

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