

Summary

Psychological and physical pathology in a sample of ‘persistently dangerous’ forensic psychiatric patients

This report supplements the report on persistently dangerous offenders – empirical estimates and conceptual clarification [*Blijvend delictgevaarlijk – empirische schattingen and conceptuele verheldering*], which describes the population of ‘persistently dangerous’ patients within both the TBS and mental healthcare sectors. The original report focused on ‘persistently dangerous’ patients in whom schizophrenia or personality disorders is/are prominent.

According to DSM-IV, schizophrenia can be diagnosed when two or more of the following symptoms apply for a minimum of six months: hallucinations, delusions, disturbances in perception, thought disorders, affective disorders, incoherent and confused language use, general confusion or catatonia, negative symptoms and failures at a social and professional level. Amongst other things, schizophrenia is characterised by hallucinations, confused language use and incoherent speech that are often the result of thought disorders. Catatonic behaviours are, for example, pointless repetitive movements. Finally, in the case of disorganised behaviour, individuals are usually no longer able to carry out functional, day-to-day activities. There are various theories about the causes of schizophrenia. One of these is the dopamine theory, according to which the dopamine system (dopamine is one of the neurotransmitters in the brains; dopamine transmits impulses from one nerve cell to another) is primarily disrupted. Other researchers argue that schizophrenia is hereditary, or in any event that there is an increased psychological sensitivity. However, to date, no generally accepted explanation exists as to why one patient develops schizophrenia and another does not.

According to DSM-IV, a personality disorder is described as an aggregate of behaviours (which are characteristic of present and long-term functioning) that cause important shortcomings in an individual’s social performance or subjective suffering.

Pathological traits, behaviour and perceptions apply that deviate from the standard norm, but which are not experienced as such by the patient himself. These traits originate in the patient’s youth or early adolescence. If a patient meets a number of criteria for different personality disorders, he or she will also be given a number of different diagnoses on Axis II. There are three personality-disorder clusters, i.e. cluster A, B and C. Cluster A comprises the paranoid, schizoid and schizotypal personality disorders. Cluster B contains the antisocial, borderline, theatrical and narcissistic personality disorders. Cluster C contains the avoidant, dependent and obsessive-compulsive personality disorders.

A personality disorder may arise as a result of a combination of social, psychological, organic and biogenetic factors. For example, social factors include functioning within the family, the quality of relationships with others and the intensity of these interactions. Psychological factors pertain to a patient's actions, thoughts and feelings. Organic factors refer to brain syndromes, skull fractures and epilepsy. These factors are deemed to cause personality disorders.

Much empirical research has been done on the presence of both diagnoses at Axis I and at Axis II of DSM-IV (this is referred to as co-morbidity).

Studies show a connection between cannabis use, alcohol use and the occurrence of personality disorders. Cannabis use and/or alcohol use in combination with schizophrenia also occurs frequently.

As regards disorders that are linked to a persistent danger of offending in some individuals, it appears that personality disorders in particular are connected with violence more closely than schizophrenia is. In many studies, antisocial, narcissistic and borderline personality disorders, particularly in combination with psychopathy, are linked to a permanent risk of recidivism.

In the empirical study, the sample of (n=209) 'persistently dangerous' patients was broken down per admission sector and the disorder diagnosed. Within the TBS sector (individuals who were categorised as 'persistently dangerous' patients in TBS institutions on the reference date), 41 patients were said to have schizophrenia or a related disorder as a first diagnosis and 67 a personality disorder. Within the mental healthcare sector (patients in forensic psychiatric clinics (FPKs), forensic psychiatric units (FPAs), intensive treatment clinics (KIBs), Hoeve Boschoord and two units for chronic psychiatric patients on the reference date), 75 patients were said to be suffering from schizophrenia or a related disorder as the first diagnosis and 26 of a personality disorder. Since all of the subgroups are relatively small, the results obtained are used as an indication of the need for care and security for the various patient groups and in order to gain an idea of the situation at hand.

Looking at the age structure, it is found that within the TBS sector in particular, the majority of patients are older than fifty. Almost all persistently dangerous patients are male. Co-morbidity (disorders on more than one axis of DSM-IV) is relatively common in all subgroups. In addition, many of the patients have a substance dependence. More than one-third of patients from the TBS sector have been diagnosed on Axis III, while the same diagnosis applies for approximately one-fifth of patients from the mental healthcare sector. The majority of patients have normal intelligence. Slightly more patients from the mental healthcare sector have a low-average intelligence, and patients from the TBS sector are more frequently considered retarded.

All patients that fall within the TBS sector had been detained under a TBS hospital order, and a relatively large number of patients were admitted to the mental healthcare sector on the grounds of a TBS hospital order. The offences for which the present legal measure has been imposed are characterised by the presence of a violence component. Sexual violence is relatively frequent amongst personality-disorder patients from the TBS sector.

According to those responsible for treatment, the latency time for a new offence is between several months and one year. There are no differences between the

subgroups, although the latency time cannot be calculated for a considerable number of patients within the mental healthcare sector.

The escape risk for all groups is also estimated as almost identical. Approximately one-fifth of all patients have attempted suicide at some time. More than half of the personality-disorder patients from the mental healthcare sector are reported to have attempted suicide, but the numbers are very small.

The most decisive aspects that have resulted in the assessment of a patient as a persistently dangerous patient are the presence of co-morbidity, continual externalising behaviour, a lack of insight into the illness and lack of problem awareness and the absence of possibilities for self-reflection.

The circumstances causing an increase in the likelihood that an individual will offend are: the use of alcohol or drugs at the time of the offence, an individual's inability to cope with feelings of unease and a lack of structure.

A factor that proves to be a particular impediment in cases of schizophrenic patients is the unreliability of medication use. Regarding individuals from the mental healthcare sector with personality disorders, the fact that the individuals in charge of their cases are 'worn out' by the patient is reported to be a factor, and as regards patients from the TBS sector, a patient's limited learning capacity is said to impede the reduction of the likelihood that he will offend.

Individuals who are responsible for treatment have estimated the degree of supervision that patients will need in the future in order to ensure that the risk of offending is kept in check.

The most intense level of supervision would be the level provided within a (closed unit in a) TBS institution, while the least intense form would be the supervision provided within sheltered accommodation (at least daily). Patients admitted in the TBS sector in particular were said to need permanent supervision, similar to that provided within a TBS institution. For some TBS-sector patients suffering from schizophrenia, the level of supervision provided within a forensic psychiatric unit would be sufficient. Patients admitted within the mental healthcare sector need the level of supervision provided within a forensic psychiatric institution or unit. Some schizophrenia patients would, it was reported, be able to function within sheltered accommodation. However, again, these data apply for very small numbers, as a result of which no generalised observations can be made on the basis of these outcomes.

All patients were asked to take part in a HoNOS assessment, an instrument that is designed to analyse a patient's psychiatric and social functioning.

In both sectors, patients suffering from schizophrenia score reasonably high on the 'symptomatology', 'limitations' and 'social problems' subscales, while patients suffering from personality disorders score slightly higher on the 'behavioural-problems' subscale.

If persistently dangerous patients are compared with other patients groups, the patients suffering from schizophrenia in particular are generally found to score higher or the same as the comparison groups, on the HoNOS subscales.

When the question is whether the patients have serious problems in their psychiatric and social functioning, it appears that all patients generally achieve a low to moderate score. According to those responsible for treatment, the majority of patients would be able to function within a small or large group.

As regards the level of independence at which a patient would be able to function, it is found that the majority of patients require institutional care. TBS-sector personality-disorder patients in particular could function under supervision or completely independently. Again very small numbers apply here.

According to those responsible for treatment, the need for care from a psychiatrist and/or psychologist is considerable (the consultation required varies from daily to monthly). In addition, for TBS-sector patients in particular, there is a great need for the care provided by social therapists. Approximately half of all patients from the mental healthcare sector are said to need daily contact with a social therapist.

On the reference date, patients falling within the TBS sector had primarily been placed in TBS institutions, while patients falling within the mental healthcare sector had primarily been placed in the institutions corresponding to this sector (forensic psychiatric clinics, forensic psychiatric units, intensive treatment clinics and chronic psychiatry units). The individuals responsible for treatment also estimated which facilities would be the most suitable for their patients in the future.

Long-stay facilities in particular would be most suitable for personality-disorder patients from the TBS sector. Schizophrenic patients from the TBS sector could also be placed in normal units or forensic psychiatric units.

It is reported that patients from the mental healthcare sector could chiefly be placed in forensic psychiatric institutions and units, particularly in so-called long-stay units or long-stay psychiatric units. In addition, it is said that a considerable number of schizophrenia patients from the mental healthcare sector could function in sheltered accommodation.

Conclusions

For a large proportion of individuals from the persistently-dangerous-patients population, the likelihood of an offence increases when alcohol or drugs are used. Studies into persistently dangerous patients also show that recidivism is linked to (serious) substance addiction and behavioural disorders, amongst other things.

For the rest, it is striking that there are barely any clear differences between personality-disorder patients and schizophrenic patients within either the TBS or mental healthcare sectors.

It had been expected that there would be a difference in terms of the facilities most suitable for patients, which would suggest that personality-disorder patients would be able to function relatively more independently than patients suffering from schizophrenia. This expectation is not clearly confirmed. This may be because of a lack of detail in the measurements taken. In the case studies, for example, particularly those in relation to Mr B. and Mr G., a detailed description is given of the extent of care and security that would reportedly be applicable for these patients.