Summary

“The biggest puzzle is with migrant patients.” An exploratory study of cultural diversity in the TBS system

Introduction
Non-western immigrants are overrepresented in TBS institutions. Whereas only 6% of the total Dutch population was born in a non-western country, the corresponding figure for the population of these institutions is at least 20%. Ethnic differences are found both in psychiatry and the criminal justice system. Dutch as well as international research shows that non-western immigrants have a higher risk of developing psychotic disorders than native Dutch. They are likely to be held more often and for longer periods in a police cell, as well as being more likely to be compulsorily admitted for psychiatric treatment. Several reports have stressed the need to provide appropriate, well-matched care for ethnic minorities (Raad voor Volksgezondheid en Zorg, 2000; Commissie Visser, 2006). However, it is not clear what this involves. The research project reported here has therefore been undertaken to provide a first exploratory study of the role of culture in TBS institutions. It sets out to provide insight into cross-cultural dilemmas in diagnosis, treatment and risk assessment among forensic psychiatric patients.

Theoretical framework
The theoretical framework relates to a number of topics arising at different moments in the TBS process: cultural issues in criminal law, diagnosis and risk in cross-cultural perspective, and the cultural competence of those involved in treatment. First, different definitions of culture will be discussed.

Concepts of culture
No agreed definition of ‘culture’ exists: the term is used in a variety of ways. Traditional approaches emphasize the static aspects of culture, resulting in the view of culture as a straitjacket that determines the behaviour and experience of human beings. In contemporary cultural anthropology, by contrast, culture is interpreted as fundamentally dynamic: a process of interpretation that is constantly shifting, with outcomes that are difficult to predict.

Culture and criminal justice
Cultural beliefs play a role in the criminal justice system. This system encapsulates what a given society regards as right and wrong, just as the DSM-IV-TR (APA, 2000) and other diagnostic systems incorporate norms concerning mental health or illness. These two dimensions of culture intersect in the TBS system. Judges are permitted to take into account the cultural background of the defendant (for example, by accepting a ‘cultural defence’); the extent to which this happens in practice is partly dependent on the climate of social opinion.

Diagnosis
Opinions concerning the cross-cultural validity of current diagnostic instruments in psychiatry remain divided. Psychiatrists specialised in transcultural psychiatry point to the high degree of cultural variability in the concepts used to refer to psychological problems, as well as the ways in which symptoms are expressed. Others maintain that
these differences do not seriously impact on the utility of instruments such as the DSM-IV-TR. At the present time there is insufficient research which could settle this issue. However, since erroneous diagnoses in forensic psychiatry can have far-reaching consequences both for patients and for society at large, it is imperative to take account of the possible dangers of cultural bias and to devote extra care to diagnostic procedures with persons whose cultural background differs from that of the majority.

**Risk assessment**
There are different methods of risk assessment: unstructured professional assessment, the actuarial method, and structured professional assessment. In the international literature few studies have been found in which the validity of these methods in different ethnic groups has been studied. In the Netherlands, there are no studies of cross-cultural validity relating to any of the methods in use.

**Cultural competence of therapists**
In order to provide appropriate care it is necessary to be ‘culturally competent’. Opinions regarding the nature of ‘cultural competence’ have undergone a process of evolution in recent decades, just as the concept of ‘culture’ has. Whereas previously the service provider was mainly required to acquire information about the characteristics of different groups, much broader conceptions of ‘cultural competence’, involving skills and attitudes as well as knowledge, are dominant today. Moreover, interculturalisation has come to be seen as not just a task for the individual therapist, but for the institution as a whole.

**Method**
The central question of this research is: what role do cultural factors play in the implementation of the TBS measure with compulsory treatment? To answer this question, implementation is divided into three main phases, each consisting of a number of sub-phases:

1. **Preparation** (in which the TBS measure with compulsory treatment is recommended by the expert advisors or ‘pro justitia reporters’, requested by the prosecutor and imposed by the court);
2. **Treatment** (implementation of the measure by forensic psychiatric clinics and its extension by the court on the basis of advice from the clinic, and every six years on the basis of advice from, among others, expert advisors);
3. **Termination** of the measure (conditional ending of the compulsory treatment, probation, or termination of the court order).

We used three different methods to examine the ways in which cultural factors played a role in these phases: analysis of dossiers (case records) on individual patients, interviews and focus group discussions. A total of 39 dossiers were analysed (10 in phase one, 19 in phase two and 10 in phase three). Twenty-eight interviews were carried out with both professionals and patients, and 5 focus group discussions took place. Data analysis was carried out using a grounded theory approach. This is a cyclical procedure in which the categories used to organize information are developed on the basis of the data itself. Passages within the dossiers, interviews and focus group discussions were classified according to their content, using keywords developed in this way. The keywords were also used to structure the chapters of the final report.
Results

General: views on culture
Respondents treated ‘culture’ as a broad concept – a common denominator that both connects people and distinguishes groups from each other. Some respondents viewed culture as providing social groups with taken-for-granted ‘common ground’. Others stressed the layered nature of culture and the different attributes (not just ethnicity) that it may be linked to.

General: differences between patients with a migrant background and native Dutch patients
From the interviews and focus groups it emerged that respondents experience differences in working with these two groups of patients. In the first place, language barriers play a role in all phases of the TBS measure. Sometimes inadequate attention is paid to these problems. In addition, respondents observe that patients with a migrant background have different ways of dealing with guilt and shame, have more difficulty in being open, and have different ideas about gender and authority relations. These are particularly relevant issues in a forensic setting. Another observation was that these patients are more inclined to deny committing an offence. Judges indicated that an attitude of denial can influence sentencing.

In general, the interviews, focus group discussions and dossier analyses complemented each other. It was striking, however, that problems related to migration and acculturation were regularly mentioned in the dossiers, but seldom explicitly referred to in the interviews.

Phase one: expert reports
To advise the judge about a suspect’s degree of criminal responsibility, it is necessary to have knowledge of the socio-cultural background of the individual in question. Only in this context can the behaviour of the accused, including its possible pathological and criminal nature, be properly assessed and interpreted. The Pieter Baan Centre offers various facilities for this purpose. Their use depends on the involvement of individuals and is not yet structurally embedded in the organization. Regarding the individual as the starting-point is necessary in order to avoid the pitfalls of generalisation and to give cultural factors the right amount of weight.

Phase one: prosecutors
In three dossiers some form of justification was given by the prosecutor for the charges laid. In two of these, reference was made to cultural issues. In one case, a belief in winti was referred to as an additional factor likely to impede voluntary treatment; in another, the prosecutor argued against the use of a cultural defence.

Phase one: judges
The judges interviewed stated that in matters concerning the degree of criminal responsibility of the accused, they usually defer to the opinion of the expert advisors. Culture-related offences are judged according to Dutch law. Public opinion is not taken into account when reaching judgements.

Phase two: diagnosis and risk assessment in the clinic
Biological, psychological and socio-cultural factors are taken into account when assessing patients. Although it is recognised that in different societies, different views
are held concerning good and evil or sickness and health, assessments are based on Dutch norms. The bottom line is that the behaviour of the patient has led to a serious crime: treatment of the behaviour is necessary in order to prevent a repetition. The view of those concerned with diagnosis is that is mainly in the treatment setting that different views concerning illness or violence need to be considered. They mention, however, that this is difficult, because it is hard to separate culture from other relevant factors including psychological problems, low intelligence and addiction.

**Phase two: treatment**

Both judges and diagnosticians stated that the Dutch discourse on psychopathology and criminality is dominant. In the treatment of patients, however, it is essential to be aware of their intrinsic motivation and to take into account their perspectives on their own lives. General treatment methods and organizational factors (such as the ‘What Works’ principles and having a multidisciplinary and diverse workforce) contribute to this. There are also special initiatives such as the cultural interview. These are mainly appreciated because they make people constantly aware of the possible influence of ethnic differences. Therapists as well as expert advisors attach great value to the principle that the individual is the starting-point and care should be matched to individual needs and propensities.

**Phase three: termination**

On the basis of an analysis of ten dossiers, no far-reaching judgments about the role of cultural factors in this phase could be made. Nevertheless, even in this small sample it was noteworthy that two patients were released despite continuing to deny their offence.

**Conclusions**

This section compares theory with practice, examines the strong and weak points of the investigation, and makes recommendations concerning follow-up studies.

Knowledge about culture is needed to understand individual behaviour. In this process, ‘culture’ should be viewed as a dynamic and fluid phenomenon. This is not only important in criminal justice, but also in diagnosis and risk assessment. The literature shows that the principles of criminal justice allow room for taking cultural differences into account. The judges interviewed stated that their judgements were mainly informed by Dutch norms, while they relied chiefly on the opinion of forensic experts when determining the degree of criminal responsibility. However, the cross-cultural reliability of the instruments on which diagnosticians base their decisions has never been scientifically established. Doubts about the role of culture in diagnosis concern mainly the preparatory phase.

In the treatment phase a pragmatic approach seems to dominate, informed by the principle that any behaviour which can lead to potentially dangerous situations must be treated. However, for the treatment to be successful it is essential to take account of the experience of the patient, which in turn is related to his or her culture. By taking the individual as starting-point (‘patient-centred care’) and emphasising the importance of the social context, respondents demonstrated a nuanced understanding of diversity. This fits well with recent insights into the dynamic aspects of culture and the nature of ‘cultural competence’.

Other issues related to cultural competence need to be further explored in practice.
This concerns in particular the problem of language barriers, the importance of a diverse workforce and the need for a ‘whole organisation approach’.

Discussion
The aim of this research was to gain insight into cross-cultural dilemmas in the diagnosis and treatment of patients in forensic care with a migrant background. To this end, interviews and focus group discussions have been carried out and patient dossiers analysed. There was clearly added value in this broadly-based approach. Through the interviews it became clear which issues are important to professionals and patients. Focus group discussions deepened this understanding. Analysis of dossiers made it possible to compare the findings from interviews and focus group discussions with the content of documents concerning diagnosis and treatment. In general, the themes from the interviews could be recognised in the dossiers, even though the themes (e.g. different approaches to gender or authority) were not always associated with culture or ethnicity. References to culture or ethnicity in the dossiers were mostly in general rather than concrete terms. Although the combination of research methods has improved the results, it remains a shortcoming of the research that it was only carried out in two institutions.

Further research is necessary to investigate the extent to which the results of this study are representative for the forensic sector in general. On the basis of this study it is not clear to what extent the effectiveness of the TBS measure is undermined by problems arising from cultural diversity. However, the professionals and patients we interviewed were explicit in their opinion that more specific and structural attention should be paid to interculturalisation in forensic care. In spite of this, there is to our knowledge no (current) research on standardised and validated instruments in practice and policy which aim at interculturalisation. The following lines of action deserve attention:

1. Analysis of the cross-cultural validity of instruments used for diagnosis and risk assessment with patients who have a migrant background, with a view to adapting these instruments where necessary.
2. On the basis of this, the formulation of more culture-specific treatment plans for these patients, in which special attention is paid to the need to overcome language barriers;
3. Investigation of the levels of recidivism among such patients, comparing these with levels in the rest of the TBS population.

Finally
“The biggest puzzle is with migrant patients.” This was how one of the respondents described his experiences of providing forensic care to a culturally diverse patient population. A TBS treatment is always a puzzle consisting of several parts. In the view of the researchers, the cultural background of the accused or the patient should not be considered as an additional piece of the puzzle – rather, it is an aspect of all the other pieces. Culture, after all, is not an isolated reality: it gives meaning to reality and therefore influences all aspects of the TBS measure. Through this research project, we have attempted to elucidate some of this complexity.