Wetenschappelijk Onderzoek- en Documentatiecentrum

Cahier 2021-29

Artikel 2.3 Wet forensische zorg in de praktijk

Toepassing en ervaringen van ketenpartners in de eerste anderhalf jaar na inwerkingtreding

Summary

Wetenschappelijk onderzoek- en kennisinstituut voor het ministerie van Justitie en Veiligheid

Cahier
De reeks Cahier omvat de rapporten van onderzoek dat door en in opdracht van het Wetenschappelijk Onderzoek- en Documentatiecentrum is verricht. Opname in de reeks betekent niet dat de inhoud van de rapporten het standpunt van de Minister van Justitie en Veiligheid weergeeft.

Summary

Section 2.3 of the Dutch Forensic care act in practice

Application and experiences of professionals during the first one and a half year the section was in effect

Background

Section 2.3 of the Forensic care act (Dutch: *Wet forensische zorg* or Wfz, hereafter called Section 2.3 Wfz) came into force on January 1st 2020, one year after the other sections of the Wfz were implemented, and simultaneously with the implementation of the Compulsory mental healthcare act (Dutch: *Wet verplichte geestelijke gezondheidszorg* or Wvggz) and the Care and compulsion act (Dutch: *Wet zorg en dwang* or Wzd). The intention of section 2.3 Wfz is to improve the link between the forensic and civil mental healthcare system, with the goal of improving the continuity of mental health care during and after patients' trajectories within the criminal justice system.

Section 2.3 Wfz provides the criminal court judge with the opportunity to issue a care authorization for compulsory mental healthcare as outlined in the Wvggz, or a court authorization as outlined in the Wzd. The criminal court judge can do so either at the request of the public prosecutor or ex officio. Section 2.3 Wfz can be applied by the criminal court judge at several moments throughout the criminal proceedings: at sentencing, when the judge decides not to extend a hospital order (Dutch: *terbeschikkingstelling* or tbs or PIJ; *Plaatsing in inrichting jeugdigen* [Dutch]), or at the request of the public prosecutor. With the implementation of section 2.3 Wfz, section 37 of the Dutch Criminal Code (Dutch: *Wetboek van Strafrecht*) is no longer in force. This section enabled the criminal court judge to involuntarily admit a person to a psychiatric hospital for a maximum duration of one year when that person was considered not accountable for a crime he or she committed due to a psychiatric condition.

Aim and research questions

The aim of this study is to map the use of section 2.3 Wfz in the first year and a half after the section was implemented. To that end, we studied the application of section 2.3 and the experiences of professionals who are involved in the application of section 2.3 Wfz.

The research questions are:

1 How often was section 2.3 Wfz applied during the first year and a half after it was implemented?

  We focus on the following subtopics and sub questions:
  a Number of authorizations. How often has a care authorization or a court authorization via section 2.3 Wfz been requested by the public prosecutor? How often are these care and court authorizations via section 2.3 Wfz issued by the

criminal court judge? Which regional patterns are noticeable concerning the issuing of care and court authorizations through section 2.3 Wfz by criminal courts?

b Personal characteristics. What are the characteristics of the people for whom a care authorization via section 2.3 Wfz was requested?

c The role of professionals. Who takes the initiative for a care or court authorization via section 2.3 Wfz?

d Authorizations over time. How many care or court authorizations are issued each month? How long does it take from the initial request to the decision? For how many care authorizations via section 2.3 Wfz has a subsequent care authorization been issued by a civil court judge?

2 What experiences did professionals involved in the application of section 2.3 Wfz have with section 2.3 Wfz during the first year and a half after its implementation?

We focus on the following themes during the interviews concerning the experiences with the practical execution of section 2.3 Wfz:

a Which patient characteristics and other factors are relevant, according to respondents, in determining whether or not section 2.3 Wfz is appropriate in specific cases.

b Which facilitative and obstructive factors respondents experience with respect to the preparation and execution of a care or court authorization via section 2.3 Wfz.

c Which facilitative and obstructive factors respondents experience with respect to the division of roles and information exchange between professionals involved.

d Which helping and obstructive factors respondents experience with respect to the prerequisite conditions (like finances, capacity of beds and personnel).

e The opportunities that respondents experience for transition of patients from a criminal justice framework to general compulsory care after the implementation of section 2.3 Wfz.

Methods

For the quantitative part of this study, we analyzed data from a database of the Public Prosecution Service (database: OMZIS). Experiences of professionals who are involved with the application of section 2.3 Wfz were obtained by means of semi-structured interviews. A total of 41 interviews were held with criminal justice and mental health care professionals, the latter including both forensic and general mental healthcare institutions.

Scope

This first evaluation study on section 2.3 Wfz took place shortly after the section was implemented. An early evaluation which focuses on the implementation process and the first experiences with the legislation can give an idea about the influence of foreseen and unforeseen factors on the practical execution. Furthermore, indicators can be used to map whether the execution of the legislation is moving in the right direction towards the intended goals.

This study offers a rich picture of the various experiences, but for practical reasons the number of professionals that were interviewed is limited. Based on the sample size, the experiences of the interviewed professionals cannot be generalized to the experiences of all professionals who work with section 2.3 Wfz.

Results

Section 2.3 Wfz in numbers

Based on the data obtained from OMZIS, a total number of 102 care authorizations and 14 court authorizations were issued in the first year and a half after section 2.3 Wfz was implemented. About 93% of the care authorizations and about 83% of the court authorizations that were submitted to the criminal court judge were actually issued. The 102 care authorizations issued via section 2.3 Wfz make up less than 1% of the total number of care authorizations that also include the care authorizations issued by civil court judges. The percentage of court authorizations that were issued by section 2.3 Wfz as part of the total number of court authorizations is even smaller, about 0,21%. More than a third of the authorizations the prosecutor starts to prepare, are ended prematurely, before submission to the criminal court. In half of the cases this happens because of a negative medical statement, in the other half of the cases the prosecutor finds that criteria for compulsive care are not met. Of the 284 unique persons for whom an application for a care or court authorization was registered, about 89% were male; the average age was almost 40 years.

The public prosecutor takes the initiative for an application for a care authorization in more than 72% of all applications. This percentage lies round 68% when it comes to applications for court authorizations. In almost 60% of the hearings concerning care or court authorizations it was registered whether the public prosecutor was present. In all these cases the prosecutor was present. Judges are able to make a decision within three weeks in two third of the applications for court authorizations. The entire procedure (from request to decision) takes almost 51 days on average when it concerns a care authorization and almost 70 days when it concerns a court authorization.

During the first year and a half in which section 2.3 Wfz was implemented, five persons withdrew themselves from compulsory care. At the same time, no temporary suspensions from compulsory care were registered, and only once was the decision made to end the compulsory care. No leave or release was registered for people with court authorizations. Finally, 75 applications for subsequent care authorizations were registered, of with 60 were issued at the time of writing. Five persons were issued a second subsequent care authorization.

Target population of section 2.3 Wfz

Responding to the question whether or not a care authorization via section 2.3 Wfz was suitable, respondents believe that different patient characteristics are important, but more importantly they think that a psychiatric disorder should be the focus of attention. Respondents from forensic or general mental healthcare institutions emphasize that the target population of section 2.3 Wfz is limited when taking the Wvggz criteria into account: having a psychiatric disorder that is treatable (with medication) within a short time frame, having little to no risk of criminal behavior, having committed only a small offense, and being manageable within a general mental

healthcare setting at low security levels. Other respondents see possibilities for the use of section 2.3 Wfz to facilitate care for a broader target population, who may also need medium or higher levels of security.

Respondents are under the impression that most of the section 2.3 Wfz patients are admitted to forensic mental healthcare institutions like forensic psychiatric wards (Dutch: *forensisch psychiatrische afdelingen; FPA*), forensic psychiatric hospitals (Dutch: *forensisch psychiatrische klinieken; FPK*) and ambulatory forensic teams. General mental healthcare institutions have admitted relatively few section 2.3 Wfz patients. According to respondents, section 2.3 Wfz is not appropriate for people with a serious crime risk, severe (antisocial) personality disorders or other disorders that are difficult to treat, a high degree of comorbidity, and/or a need for long term treatment.

Respondents, including criminal court judges, mention a group of patients who do not seem to fit into any of the available options for court ordered compulsory care. Section 2.3 Wfz seems to fall short for this group as most facilities are unable to offer the appropriate combination of care and security. This group concerns people with psychiatric disorders, often multiple diagnoses and behavior that poses a risk to others. These patients are considered to pose too much risk for compulsory mental health care, but are seen as too 'light' for tbs. Respondents therefore experience a gap between tbs and a care authorization that is too large.

Respondents run into many execution problems when people without a valid residence permit qualify for an authorization via section 2.3 Wfz. They deem it important to deploy a specialized institution in these cases.Section 2.3 Wfz offers more possibilities than there were before for customization in transfer of patients from a criminal justice framework to general (mandatory) mental healthcare, according to respondents. These possibilities originated because a person does not longer have to be considered legally unaccountable due to a mental disorder in order to be transferred to general mandatory mental healthcare, in contrast to the old section 37 Sr. Also, with section 2.3 Wfz new combinations are possible between a (conditional) sentence or measure and a care authorization. However, due to the execution problems respondents question to what extend this broader applicability is also reflected in practice.

Respondents have the impression that, in general, the transition from a criminal justice framework to general compulsory mental health care has either remained unchanged, became more complicated or even deteriorated since section 2.3 Wfz was implemented. The deterioration may be due to new problems like laborious preparation procedures for a care authorization via section 2.3 Wfz, but also may be due to structural problems that already existed like a lack of capacity, financing problems and mental healthcare institutions' reservations towards patients with a judicial history.

Respondents mention that, on the other hand, section 2.3 Wfz offers more possibilities in the transition to general mandatory care for specific groups. These specific groups consist of people whose tbs-measure or PIJ-measure is not prolonged, people who are not considered to be fully legally unaccountable due to a mental disorder, and people who are psychologically vulnerable and who would before have left detention without any form of aftercare.

Preparation of a care authorization via section 2.3 Wfz

The knowledge and experience of professionals concerning section 2.3 Wfz have increased in the first year and a half after its implementation. However, respondents also state that there is still much to gain in this respect. Section 2.3 Wfz is a difficult piece of legislation for those who have to work with it. This is especially the case when professionals are not frequently exposed to working with it, which is the case for many criminal court judges.

The preparation of a care authorization is experienced as time consuming because of the procedure's complexity, due to the high number of involved parties, the considerable administrative load and many messages going back and forth. Medical directors see it as a positive thing when the institution where a patient will be receiving care from and its psychiatric expertise are involved early in the preparation process to discuss possibilities and limitations of a care authorization. Not enough attention is payed to the crime risk and need for security in the process of the preparation of a care authorization via section 2.3 Wfz, according to some respondents. In these cases, the presence of a report from a recent investigation by the Netherlands Institute of Forensic Psychiatry and Psychology (Dutch: *Nederlands instituut for forensische psychiatrie en psychologie*; NIFP), which was conducted for the connecting criminal justice case, could be of use. These reports are very helpful in the assessment of the needed level of security, according to respondents.

The criminal case and the preparation procedure of a care authorization via section 2.3 Wfz are regularly misaligned in time according to respondents, as the criminal case can take considerably longer. When a care authorization procedure runs simultaneously with a criminal case, medical information required for the care authorization can become outdated by the time the criminal case is completed. Furthermore, patients have to stay longer in detention or temporary custody pending the issue of a care authorization, and the question is whether a patient receives the mental health care needed during that time. On the other hand, a practical improvement concerns the possibility for a criminal court judge to issue a care authorization for compulsory medical care after tbs or PIJ in one hearing, which arose by the implementation of section 2.3 Wfz.

The mandatory regional meeting of professionals who work within the Wvggz is received positively by respondents. The working relationship between public prosecutors and mental healthcare providers has improved considerably partly due to this gathering. Professionals from penitentiaries, penitentiary psychiatric centers, the probation service, and criminal court judges could be more actively involved.

Barriers exist in the exchange of patient-information between judicial institutions and healthcare institutions (when the patient does not consent to the exchange). These barriers exist, among others, between penitentiaries and (former or future) healthcare providers, between the NIFP and mental healthcare providers, and between mental healthcare providers and the probation service. Another limitation with respect to information exchange lies in the civil procedure for a care authorization by section 2.3 Wfz that is performed within a criminal case. Due to this entanglement of civil and criminal law, a problem is experienced because medical information may become public through the criminal case file and through discussing the care authorization in a public hearing. Respondents indicate that, in practice, agreements are made on how to deal with this.

Execution of a care authorization by section 2.3 Wfz

Respondents indicate that general mental healthcare institutions are hesitant to admit section 2.3 Wfz patients in their facilities. This hesitation is based on the experience that general mental healthcare institutions can offer only limited security-facilities and that they do not have expertise with respect to risk management. The execution of a care authorization for section 2.3 Wfz patients who leave detention can be especially challenging, as provisions like housing, work or daytime activities may have been discontinued. Medical directors or care coordinators from general mental healthcare institutions sometimes feel pressured in taking on a section 2.3 Wfz patient even though they believe that the patient does not fit within their institution. Professionals from specialized mental health care facilities in prisons find it helping that, the public prosecutor's office in principle designates a receiving institution, because it is otherwise challenging to find a mental healthcare facility that is willing to admit their patients. In specific cases, uncertainty can arise about who is responsible for finding a facility that will admit a patient with a care authorization via section 2.3 Wfz, such as when a designated institution gives out a negative advice or when a care authorization is issued ex officio by a criminal court judge and no receiving institution has been designated.

Many respondents criticize the mix of civil and criminal law that arises with section 2.3 Wfz. An important example of the influence of the criminal justice framework on section 2.3 Wfz is that a consent of the Minister of Justice and Security is required prior to a temporary suspension or the expiration of compulsory medical care. Respondents have fundamental objections to the consent requirement because of this unwanted 'interference' of criminal law, where responsibility in line with civil law, is granted to the medical director. A limiting factor here is also that the procedure of application for consent takes a long time in their experience, which is seen as negative for the patient's legal position. Consent for temporary suspension or expiration of compulsory medical care is in fact rarely requested, and healthcare providers feel that the criteria for when and how they should request this consent are unclear.

The mix of civil and criminal law that arises with section 2.3 Wfz can also have other detrimental consequences for a patient's legal position, according to respondents. For example, it is unclear for people who work with section 2.3 Wfz on what grounds patients can file a complaint when they are staying in a forensic psychiatric center (FPC; *forensisch psychiatrisch centrum*). Additionally, not enough is arranged with respect to involving next of kin through means of a patient-, client-, or family confidant for people who are staying in a judicial institution based on a care authorization via section 2.3 Wfz.

Respondents experience a lack of capacity, and with that admission issues. Only relatively few secured beds are available. Section 2.3 Wfz, civil care authorization and forensic care placements compete for these scarce secured beds. According to some participants, these secured beds are also claimed for patients from general mental healthcare institutions who show riskful behavior. The *dashboard secured beds* helps to gain more insight in the availability of secured beds, but has no placement authority.

There is a call for a forensic version of section 2.3 Wfz. A forensic version would solve several issues, according to respondents: such a measure could fill the gap that is now experienced between tbs with mandatory hospitalization and the care authorization.

Such a 'forensic authorization' could, according to respondents, help to make a clearer distinction between patients for who crime prevention is important and for who it is not. The general mental healthcare institutions could then focus on those patients who do not need crime prevention, while the forensic mental healthcare institutions can take care of those patients for whom a focus on crime prevention is needed.

Court authorization by section 2.3

Section 2.3 links not only to the Wvggz, but also to the Wzd. There seem to be some structural flaws in the procedure to prepare a section 2.3 Wfz court authorization according to respondents. As a result several parts of the procedure get stuck, which makes it difficult for the public prosecutor, in the role of applicant for the court order, to obtain the information needed. There are, for instance, currently no partnerships between the public prosecutor's office and knowledgeable medical doctors, and it can be difficult for the public prosecutor's office to find a knowledgeable medical doctor to prepare a medical statement. Furthermore, expert meetings that were organized by the ministries of Justice and Security and Health, Welfare and Sports showed that the field needs more clarity about the legal grounds to share patient confidential information when needed.

Many preparations get stuck on the medical statement, for which information about the accommodation is needed that is often unknown at that point. Independent doctors therefore often issue a negative medical statement, or none at all. This results in a standstill, as applications cannot be submitted without a medical statement. Independent doctors also refuse to issue a medical statement when their work is not financially compensated. The appointment of a legal representative also takes a lot of time, resulting in a delay in the procedure.

The financing of a court authorization can happen by issuing a care needs assessment through the long-term care act (Dutch: *Wet langdurige zorg; Wlz*). This Wlz-assessment is often not yet issued at the time when the court authorization is issued because there is too little information for the Centre for Care Assessment (Dutch: *Centrum Indicatiestelling Zorg; CIZ*) to issue a Wlz-assessment. There is only limited time to find a suitable place when a court authorization is issued, before it expires. An underlying cause for the stalling of the preparation and placement process is that there is no care coordinator who is responsible for the placement of clients. Furthermore, Wzd-accommodations are hesitant to take clients with a criminal history, according to several chain partners.

Capacity problems also exists within Wzd-accommodations. These problems exist because there is little to no transit or outflow from these accommodations. There are only a few secured beds available for clients with a court authorization, which makes it difficult to admit people who need such a secured bed. When clients are admitted, a difference in legal position can arise between section 2.3 Wfz-clients and those who received a civil court authorization to stay in the same Wzd-accommodation: before a client with a court authorization via section 2.3 Wfz can go on temporary leave or can be discharged from the accommodation, the Minister of Justice and Security has to give consent.

Conclusions

Section 2.3 Wfz is being used despite the execution problems that are experienced. The contribution of section 2.3 Wfz to the transition from a criminal justice framework to general compulsory mental health care is small, with around one hundred issued authorizations in the first year and a half after implementation.

Placement of section 2.3 Wfz patients in general mental healthcare institutions does not seem to get into gear yet, based on the qualitative information from the interviews. Forensic mental healthcare institutions like FPAs and FPKs are less hesitant towards patients with a criminal history. However, placement in these facilities is not always straightforward either. Prerequisite conditions like financing and capacity seem to be a root cause for this. But it may also be difficult to place patients with multiple diagnoses in combination with riskful behavior here. An important side note is that in order to draw conclusions with respect to the placement of section 2.3 Wfz clients, one needs quantitative data on the actual patient flow.

Alternatively to section 2.3 Wfz, people can also be led away from criminal justice trajectories towards general compulsory care by means of a care or court authorization issued by a civil judge. This study does not provide quantitative information on how often this route is being used. However, there are indications based on the interviews that this route is regularly applied.

Section 2.3 Wfz has been limitedly used during the first year and a half after the implementation of the section in comparison to the number of issued care and court authorizations by civil courts. Multiple explanations for this have been suggested in the interviews. On the one hand there seem to be reservations among general mental healthcare institutions towards patients with a so-called forensic profile. On the other hand, multiple limitations have been perceived that make the preparation and execution of section 2.3 Wfz difficult, including a limited knowledge of section 2.3 Wfz among professionals, ambiguous parts in the legislation and execution, the time consuming preparation procedure for a care authorization by section 2.3 Wfz, barriers in the information exchange between mental healthcare providers and judicial institutions, the role of confidants and rights of complaint, practical and principle objections against the consent requirement needed from the Minister of Justice and Security, and structural flaws in the section 2.3 Wfz procedure with respect to the Wzd.

Prerequisite conditions are also of great importance in the transition of patients from criminal justice trajectories to (compulsory) general mental health care. The adequate financing of secured beds and sufficient capacity of both forensic and general mental healthcare institutions are important conditions for the execution of section 2.3 Wfz. As a result of years of reducing bed capacity in both forensics and general mental health care, and dismantling long-term and complex care in favor of outpatient facilities in general mental health care, it seems that the condition of providing the necessary capacity cannot be met.

At the same time, respondents also mention factors that are beneficial for the application of section 2.3 Wfz: a broader range of options and potential populations, the improved cooperation between professionals due to the mandatory regional Wvggz meeting, and the development of the secured beds dashboard. In the current study, several recommendations are made that can help remedy the aforementioned limitations and improve the beneficial factors.

Future

Continuity of care from a criminal trajectory towards general (compulsory) mental health care has been an issue for decades. Section 2.3 Wfz was developed to improve the continuity of care. Section 2.3 Wfz is innovative in combining criminal law and civil law. Despite there being a few aspects of section 2.3 Wfz that are perceived positively or as an improvement, there are many practical issues and various principal objections as well. These issues limit the application of section 2.3 Wfz, and lead to resistance to section 2.3 in its current form. A recent proposal from the field of mental healthcare to introduce a forensic version of section 2.3 Wfz does not automatically contribute to the goal of the section, which is to promote the transition from a criminal justice trajectory to general compulsory mental health care. Investigating such a variant cannot be viewed separately from a more fundamental discussion about how general mental health care and forensic mental health care should relate to each other and what the 'care landscape' as a whole should look like in terms of care provision and facilities. An important theme remains how continuity of care from a criminal law framework to regular (compulsory) care can be shaped in practice. Several initiatives have been developed that are meant to connect forensic and general mental health care more closely, such as the ‘transforensic method’ and the ‘Ketenveldnorm’. These initiatives could be beneficial for the continuity of care.

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