Wetenschappelijk Onderzoek- en Documentatiecentrum

Cahier 2022-13

Toepassing van artikel 2.3 Wet forensische zorg

Verkennend jurisprudentieonderzoek januari 2020 tot juli 2021

Summary

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

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Summary

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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

Application of Section 2.3 of the Forensic Care Act

Exploratory case law investigation January 2020 to July 2021

Background

Section 2.3 of the Forensic Care Act (Dutch: *Wet forensische zorg* or Wfz, hereafter called Section 2.3 Wfz) came into effect on January 1st 2020, one year after the other parts of the Wfz came into effect and simultaneously with the implementation of the Compulsory Mental Health Care Act (Dutch: *Wet verplichte geestelijke* gezondheids-zorg or Wvggz) and the Care and Compulsion Act (Dutch: *Wet zorg en dwang* or Wzd). The aim of section 2.3 Wfz is to improve the connection between the criminal justice system and the 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 with the opportunity to issue a care authorization for compulsory mental health care as outlined in the Wvggz, or a court authorization as outlined in the Wzd. These authorizations authorize mental healthcare providers to administer compulsory care to the person concerned. With the implementation of section 2.3 Wfz, section 37 of the Dutch Criminal Code (Dutch: *Wetboek van Strafrecht* or Sr) is no longer in force. This section enabled the criminal court 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 mental disorder. The requirement that the person needs to be considered unaccountable for their crimes due to their mental disorder no longer applies in the case of section 2.3 Wfz. The criminal court 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 at several moments throughout the criminal proceedings: at sentencing, when the court decides not to extend a detention under a hospital order (Dutch: *terbeschikkingstelling* or tbs or PIJ; *Plaatsing in inrichting jeugdigen* [Dutch]), or at the request of the public prosecutor.

Research questions

The aim of this study is to provide an overview of the considerations and applications of section 2.3 Wfz in the first eighteen months after it came into effect. To this end, we have examined the available case law of section 2.3 Wfz.

The main research question of this study is as follows: How was section 2.3 Wfz applied, based on the available case law?

The following sub-questions were formulated for this study:

1 What characteristics can be identified of the people for whom an authorization under section 2.3 Wfz had been considered and had or had not been issued, respectively?
2 What characteristics can be identified of the cases in which an authorization under section 2.3 Wfz had been considered and had or had not been issued, respectively?
3 Which considerations of the criminal courts played a role in the decision whether or not to grant an authorization under section 2.3 Wfz?

Methods

Case law was sought within the e-archives of the Council for the Judiciary (for more information about the e-archive, see Van Opijnen, 2014) and, for practical reasons, also in the publicly accessible Rechtspraak.nl, which contains part of the case law from the e-archive. This was done on the basis of the (Dutch) search term 'section 2.3 Wfz' in combination with 'care authorization' and 'court authorization' respectively.

The following types of case law are included in the investigation (in all cases, this concerns court decisions made between 1 January 2020 and 1 July 2021):

- Judgments in criminal cases and appeal cases in which a care authorization or court authorization under section 2.3 Wfz had been considered by the criminal court;
- judgments in extension cases and on appeal in extension cases in which a care authorization or court authorization under section 2.3 Wfz had been considered by the criminal court;
- orders in which a care authorization or judicial authorization had or had not been issued under section 2.3 Wfz in relation to a criminal case or an extension case.

Characteristics of individuals

The age and gender distribution of those for whom a care authorization under section 2.3 Wfz was considered in a criminal case corresponded to that of the general population of people who had been put on trial in a criminal case – this mainly concerns men in the age category between 24-45 years.

Many of the persons for whom a care authorization was in a criminal case at first instance had a diagnosis of psychotic disorder and/or substance use disorder, as indicated by the medical statement from the Medical Director. Comorbidity is common in the group for whom a health care authorization was considered. In the cases where there was a pro Justitia report in the related criminal case, this provides a comparable picture for both the group for which a care authorization was issued and the group for which a care authorization has been considered but not issued. Psychotic disorders and substance use disorders were also most common among those involved for whom a care authorization was considered in a tbs extension, and more than half of those involved had comorbidity.

In comparison with the general population of those on trial, (attempted) manslaughter or homicide, violent crimes and threats were more common among persons in the study group for whom a care authorization had been issued, while property crimes

were less common. Physical acts of violence and threats were also most common among those who did not receive a care authorization.

Characteristics of care authorization cases

In more than half of the cases where a care authorization was issued, the judge had ruled that the individual was not punishable (not accountable) as a consequence of their mental disorder. They were therefore dismissed from further prosecution (in Dutch: *ontslag van alle rechtsvervolging or OVAR*). This indicates that there is a partial overlap between the section 2.3 Wfz-group and the group that was previously placed in a psychiatric hospital under the old section 37 Sr. In addition to OVAR, (suspended) prison sentences and acquittals were also applied, which indicates that section 2.3 Wfz has a broader area of application than the old Section 37 Sr, as was intended by the legislator.

In the majority of cases, the criminal court followed the advice of the medical director and the public prosecutor in choosing whether or not to issue a healthcare authorization – only in 5% of the first instance cases and in none of the extension cases did the criminal court not follow the advice. Additionally, when it comes to the forms of compulsory care that were provided within a care authorization, it is clear that in the majority of cases the requested forms of compulsory care from the application of the public prosecutor were followed. There was a discrepancy between what forms of compulsory care were requested and which were issued in only 2% of tbs extension cases, and 6% of criminal cases at first instance courts. All possible forms of compulsory care (so-called 'carte blanche') were authorized for only 9 of the issued care authorizations.

In both criminal cases at first instance and tbs extension cases, the most requested and provided forms of compulsory care were admission to an accommodation, administering medication and restricting freedom of movement. In all cases, admission to an accommodation was requested and issued with care authorizations in criminal cases at first instance courts and almost all tbs extension cases. The fact that admission to an accommodation was authorized in almost all cases can possibly be explained by the seriousness of the disorders and the risky behavior of the person concerned. Admission to an accommodation may be immediately necessary or may offer protection if the situation of the person deteriorates. It should be noted here that authorizing the performance of compulsory care does not always mean that it is actually performed, the care provider is responsible for monitoring the person and application of the compulsory care needed.

Considerations of criminal courts

Considerations when issuing a care authorization

The legal criterion of 'serious harm' was predominantly described as a 'danger to the person involved or to another person' or 'general safety of persons or property'. Aspects of danger to the person or others that were most frequently mentioned are 'serious bodily harm' and 'social decline', followed by 'danger to life' and 'serious neglect'. In the cases studied, 'avoiding serious harm' and 'stabilizing mental health' and 'restoring mental health in such a way that the person concerned regains his/her

autonomy as much as possible' were most often described as the goals of compulsory care by the criminal court.

In addition, in the examined cases the criminal courts included aspects to further substantiate the need for compulsory care and to further specify the objectives of mandatory care. With regard to characteristics of the person concerned, a lack of insight into illness or lack of problem awareness, lack of motivation for treatment or care, and care-avoiding behavior emerged most prominently as substantiation of the need for mandatory care. Safeguarding medication use was the most common goal as a specific care goal, but monitoring the patient's condition to prevent relapse (in substance use or psychosis) was also regularly mentioned. In several cases, the court indicated that reducing the risk of criminal recidivism was one of the goals when granting the care authorization. Ensuring continuity of care was mentioned in several cases as a reason for granting a care authorization.

Considerations when not issuing a care authorization

When a care authorization was considered but not issued, the criminal court explicitly stated the criteria, conditions or goals of mandatory care in only a few cases. In various cases the criminal court did, however, provide legal-procedural reasons for not issuing a care authorization, including the discontinued preparation of an application by the public prosecutor or a negative assessment by the medical director.

The criminal court also named substantive aspects to further support their position that the care authorization was not a suitable option for the case in question. With regard to characteristics of the person concerned, the most frequent mention was that the risk of recidivism was too great. Previous unsuccessful criminal or civil care trajectories were also mentioned as a reason why a care authorization was not a suitable option. Furthermore, lack of insight in their mental disorder, lack of motivation for treatment or care as well as care avoidance in the past were mentioned in some cases as arguments for the need for a mandatory framework.

In several cases, however, it was argued that although the care authorization would provide a framework for mandatory health care, this framework would be insufficiently robust for healthcare, monitoring and the security of society. The short duration and uncertainty about extension after the initial six months were most often mentioned as reasons for this. In several cases it was indicated that regular mental healthcare was not suitable for the person concerned because of insufficient possibilities to limit the risk of criminal recidivism, for example because no suitable treatment was possible or the security level was too low. In a number of cases, the criminal court explicitly stated that a forensic framework was necessary. In most of these cases this concerned tbs, but ISD and PIJ or a suspended sentence with special conditions also occurred.

In some of the cases, the criminal court identified risks to continuity of care. More specifically, in some of the cases, problems would arise in terms of compatibility with juridical titles or care locations when a care authorization was issued. In other cases, the criminal court expressed concern about the lack of a suitable alternative.

Court authorizations

Only 15 cases were found in which a court authorization via section 2.3 Wfz had been considered in the first eighteen months after this section came into force. Previous research suggests that serious procedural bottlenecks in the preparatory procedure underlie the limited application of court authorizations via section 2.3 Wfz. Violent offenses and threats were the most common offenses among the persons concerned for whom a judicial authorization under section 2.3 Wfz was issued. The majority of the subjects had a (mild) intellectual disability and only a small proportion had a psychogeriatric disorder. Most of them also reported one or more comorbid psychiatric conditions.

Conclusion

A societal point of concern that was raised when section 2.3 Wfz came into force, related to an increase in the number of people with high-risk behavior being placed in regular healthcare facilities and that these facilities would be insufficiently equipped for this. The question whether this fear is justified cannot yet be answered with the data from the present study. However, one aspect of the aforementioned social concern that more persons with high-risk behavior would end up in regular mental healthcare because of section 2.3 Wfz, was related to the way in which criminal courts would consider whether or not to grant an authorization under section 2.3 Wfz. In the judgments and orders of criminal courts that were studied for the present study, it became apparent that criminal courts consciously weighed up the risky behavior when considering whether or not a care authorization was appropriate.

The main goal of section 2.3 Wfz is to ameliorate the continuity of care. From a quantitative point of view, the contribution of section 2.3 Wfz to the continuity of care was limited, because its application in the first eighteen months after its entry into force, was quite limited. This applies to the care authorization but even more so to the court authorization. It is too early to draw definitive conclusions on the effect of section 2.3 Wfz on this basis. From a qualitative standpoint however, we see that the way in which criminal courts have motivated whether or not to grant a care authorization during this period was indeed in line with the goal of promoting continuity of care. In cases in which a care authorization via section 2.3 Wfz was considered, criminal courts applied customization to the care authorizations to help design a suitable (sequential) patient trajectory, which could contain both clinical and ambulatory components and included legal guarantees for temporary scaling up of mental health care, if necessary. With respect to this process, the criminal court was informed by the application of the public prosecutor containing the advice of the medical director and in several cases the pro-Justitia reporting from the criminal case also played a role. Follow-up research should show how the trajectories of those involved will actually take shape. In the present study, case law from shortly after the entry into force of section 2.3 Wfz has been studied. This means that the application is still under development, it concerns a still limited number of cases and a limited number of criminal courts. It can be concluded, however, that there are early but concrete indications that the application by criminal courts of section 2.3 Wfz is in line with the aims of the legislator with respect to the design of continuity of care. We are curious how this will develop further.

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