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Cahier 2024-6

Evaluation of the approach to reduce the problem of defendants refusing pre-trial forensic psychiatric assessment

Prevalence rates of assessment refusal, the extent to which the courts' questions about mental health issues can be answered and sentences imposed

Summary

Kennisinstituut voor de rechtsstaat

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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 Datacentrum is verricht. Opname in de reeks betekent niet dat de inhoud van de rapporten het standpunt van de Minister van Justitie en Veiligheid weergeeft.

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Introduction

If a suspect of a criminal offence is suspected of having a mental disorder, a behavioural assessment may be requested. This assessment, a pre-trial forensic psychiatric assessment, is conducted to determine whether treatment should take place in a judicial setting. Some suspects of a criminal offence refuse to cooperate with this assessment. In some of these cases, this assessment does not provide enough information about the defendant's mental state. In other cases, enough information is already available about possible disorders from previous and/or other sources. If it remains unknown whether there are any disorders, the undesirable situation may arise of not being able to impose mandatory treatment on the defendant, even though this is necessary to reduce the likelihood of recidivism and increase the safety of society. The most well-known form of such mandatory treatment is a judicial measure that entails mandatory hospitalization and treatment in a forensic psychiatric hospital (art. 37a.1 Dutch Criminal Code), hereinafter 'tbs-order' (in Dutch: *terbeschikkingstelling*). In order to reduce the problem of defendants refusing to participate in pre-trial forensic psychiatric assessment, certain measures have been implemented by the Dutch government, referred to here as the 'refusal approach'. This refusal approach was evaluated in this report.

The current refusal approach has three goals:

1 To increase the safety of society in respect to defendants who refuse pre-trial forensic psychiatric assessment;
2 To reduce the number of defendants who refuse pre-trial forensic psychiatric assessment;
3 To reduce the effects of refusing pre-trial forensic psychiatric assessment;
   a to gather more information about the mental state of the offender;
   b to make it easier for the judge to impose an appropriate sentence and/or mandatory treatment order, such as a tbs-order or otherwise.

This also assumes that imposing an appropriate sentence and/or order and/or treatment on the offender helps reduce the risk of their recidivism.

In the pre-trial forensic psychiatric assessment process, information is gathered about possible mental disorders. With this information, standardized questions of the Netherlands Institute of Forensic Psychology and Psychiatry are answered. These questions refer to the presence of mental disorders, the simultaneous occurrence of a mental disorder at the time the crime was committed, the effect the disorder has on

the crime that was committed, the amount of accountability for the crime, the assessment of the risk of recidivism and the treatment advice.

Methods

To answer most of the research questions, data were obtained from the Pieter Baan Centre (PBC). This concerns information on the number of refusing defendants and the extent to which the courts' questions about them could be answered. In addition, judgments on refusing defendants were accessed through the Council for the Judiciary (*Raad voor de Rechtspraak*) and characteristics of those judgments were recorded in a dataset in a structured manner. Finally, some interviews with PBC staff were conducted.

Answers to the research questions

With regards to research questions 1-3, first the main results on the refusal approach are presented. Afterwards, these results are put into perspective by also presenting results about the years surrounding the refusal approach. From April 2017 to April 2018, a pilot study was set up in the PBC with the main goal to gather more information on refusing defendants. These pilot years were excluded from the control period of the present study, as this was a considerable alteration from the normal procedures. An important part of the pilot was the placement of refusing defendants on a separate ward of the PBC. Besides the main effects of the refusal approach, the last five years were also examined.

1 *How many refusing defendants (absolute and relative) were there before the refusal approach came into effect and how many refusing defendants (absolute and relative) were there after the current refusal approach came into effect?*

Refusal approach

The impact of only the current refusal approach was examined by comparing defendants observed in 2020-2022 with defendants observed in 2014-2016. In 2020 up to and including 2022, the average complete refusal rate was 39%. In 2014 up to and including 2016, the average refusal rate was 44% (a difference of 5 percentage points). These average rates do not differ significantly from each other, although a trend was found in the data, indicating a possible effect. In absolute numbers, the number of refusers in the research group (2020 up to and including 2022) is also lower than in the control group (2014 up to and including 2016), this difference consists of 59 people.

Pilot Unit 3

Looking at the impact of the Unit 3 pilot, 2017 up to and including 2019, the average percentage of complete refusers was 42%. In 2014 up to and including 2016, the previous three years, the average percentage of refusing defendants was 44%. These average rates do not differ significantly from each other. This means that no significant decrease in the number of refusers has been found since the Unit 3 pilot.

Past five years

If all newly examined defendants are considered, those examined in 2018 up to and including 2022, the average percentage of complete refusers is 39% (378 refusers). In 2013 up to and including 2017, the previous five years, the average percentage of complete refusers was 47% (484 refusers). The difference between these two groups is significant: in the last five years, refusals were less frequent. The effect size is small.

The prevalence of partial refusal was examined in the same three ways as above, but shows no significant differences in any of the three comparisons.

Although viewed separately, both factors (the refusal approach and the Unit 3 pilot) had no significant effect, the results do show a decrease in the prevalence of refusal. It is possible that the combined effect of the refusal approach and the Unit 3 pilot and possibly other matters that came up in the forensic psychiatric sector brought about this change in prevalence.

2 *What is the research output of refusing defendants in the PBC after the refusal approach came into effect and how does it compare to the period prior to the coming into effect of the refusal approach?*

In the PBC, the term 'research output' is used to indicate the extent to which the pre-trial forensic psychiatric assessment research questions can be answered. For the judge who must determine whether a disorder exists in a legal sense, it is necessary to have indications about it. These may follow from the current PBC research, but other documents may also be used for this purpose, such as information from previous pre-trial assessment reports or reports on treatments (forensic or otherwise). Not all the courts' questions need to be answered in order to make a legal determination of the disorder. In the current research, the research output, the extent to which the courts' questions could be answered, was determined by the PBC.

Refusal approach

The impact of only the current refusal approach was studied by comparing defendants observed in 2020-2022 with defendants observed in 2014 up to and including 2016). To determine the effects of recent years, we looked at all newly examined defendants, those who were examined in 2017 up to and including 2022, versus the defendants who were examined in 2011 up to and including 2016, the five years before. The results of both analyses are similar, hence only the figures on the refusal approach have been cited.

The figures for all years clearly show that for a large number of refusing defendants, the courts' questions can still be answered. This is especially the case when looking at hypotheses about disorders, the follow-up questions were answered less frequently. One can also observe that the courts' questions are easier to answer when there is more cooperation. For example, among the partial refusers, a hypothesis about a disorder was given more often than among the complete refusers, and among the refusing defendants who cooperate, the percentage of hypotheses increases even further.

Furthermore, it appears that in 2020-2022, the question about disorders was answered approximately as often as in 2014-2016, but that the questions about hypotheses about disorders and the simultaneous occurrence of a mental disorder at the time the crime was committed (simultaneity among refusing defendants were answered much more often in 2020-2022 than in 2014-2016 (differences of 47 percentage points and 24 percentage points, respectively)). The question on legal accountability was also answered more often in 2020-2022 than in 2014-2016, but this difference is smaller: 7 percentage points. The same patterns were found among partially refusing and cooperating defendants, and the questions were answered much more frequently in 2020-2022.

These analyses also show that all defendants from 2020-2022 were given treatment advice more often than those from 2014-2016, whether they refused or not: for the refusing defendants, the difference is 10 percentage points, for the partially refusing defendants, the difference is 13 percentage points, and for the cooperating defendants, the difference is 9 percentage points. Finally, it appears that the advice to impose a tbs-order was given more often in respect of all defendants from 2020-2022, whether they refused or not: for the refusing defendants, the difference is 9 percentage points, for the partially refusing defendants, the difference is 19 percentage points, and for the cooperating defendants, the difference is 14 percentage points.

3 What sanctions, sentences and orders are imposed on the refusing defendants?

The current research made a three-way classification of the sanctions imposed: a tbs-order, a different treatment obligation and other forms of disposition, mostly an unconditional prison sentence. Different treatment obligations include the imposition of the Measure on behavioural influence and limitation of freedom (MBI; in Dutch: g*edragsbeïnvloedende en vrijheidsbeperkende maatregel,* Section 38z of the Dutch Criminal Code), the custodial order for repeat offenders (in Dutch: *ISD-maatregel*), placement in an institution for juvenile offenders (in Dutch: *PIJ-maatregel*), treatment in a conditional part of the sentence, placement in a psychiatric hospital (former Section 37 of the Dutch Criminal Code) and the measure to restrict a person's freedom (Section 38v of the Dutch Criminal Code). The results of the final sanctions are shown below, where the sanctions are combined: if there was an appeal, this sanction was considered final, otherwise this was the judgment at first instance.

Refusal approach

The impact of only the current refusal approach on sanctions imposed was examined by comparing sanctions imposed in 2020-2021 to sanctions imposed in 2015-2016. In 2020-2021, a tbs-order was imposed on average in 43% of the cases. In 2015-2016, a tbs-order was imposed on average in 21% of the cases. These average percentages deviate significantly from each other, the effect size is small.

Pilot Unit 3

To examine the influence of the Unit 3 pilot on the imposed sanctions, the years before and after the Unit 3 pilot were examined. In the research group, 2017 up to and including 2019, the three years of and following the pilot and prior to the refusal approach, the average rate of tbs-orders imposed was 36%. In the control group, 2014 up to and including 2016, a tbs-order was imposed in 13% of the cases (a

difference of 23 percentage points). These average percentages also differ significantly from each other, the effect size is small.

Past five years

In the most recent years, 2017 up to and including 2021, a tbs-order was imposed on average in 42% of the cases. In previous years, 2012 up to and including 2016, a tbs-order was imposed on average in 18% of the cases. In more recent years, tbs-orders were thus imposed much more often (significantly), the effect size is small.

Sanctions were also compared to the type of offender and to the demand by the public prosecutor/advocate general. This shows that in many cases with refusing defendants, homicides were committed (43% in 2017-2021, 44% in 2012-2016), followed by other violent offences (36% in 2017-2021, 36% in 2012-2016) and sexual offences (15% in 2017-2021, 16% in 2012-2016). Both groups show few differences in this regard. There is, however, a difference in types of offences when looking at the three-way classification of sanctions. In 2017-2021, the rate of homicides for which a different treatment was imposed increased to 46%, up from 26% in 2012-2016. This represents a significant increase of 20 percentage points. Furthermore, it appears that in 2017-2021, significantly fewer demands for a tbs-order by the judges resulted in the imposition of the tbs-order than in 2012-2016 (73% versus 87%, a difference of 14 percentage points). The number of refusing defendants for whom the public prosecutor demanded a tbs-order and who received a form of treatment imposed by the judge was also lower in 2017-2021 than in 2012-2016 (a difference of 10 percentage points).

4 *Do the refusing defendants who have been subject to the imposition of a prison sentence also receive some form of treatment, and if so, what kind?*

The current research made a three-way classification of the sanctions imposed: a tbs-order, a different treatment obligation and other forms of disposition, mostly an unconditional prison sentence. For this last group of refusing defendants, it is not known whether they receive treatment in detention or in the reintegration phase. After all, that concerns the execution phase of the sentence and the current research concerns the imposition phase. Possible interventions in a penal institution or penitentiary psychiatric centre (PPC), during a penitentiary programme or conditional release, through the Dutch Forensic Care Act or through the Dutch Mandatory Mental Healthcare Act have not become known in the process. However, the results from two other WODC research programmes have been examined, which show that the MBI and the care authorisation, both aimed at reducing the problem of defendants refusing pre-trial forensic psychiatric assessment (among other purposes), have so far been imposed so infrequently that they can currently contribute little to reducing this problem.

5 *How has the number of cases in which the pre-trial assessment reporters were unable to determine a disorder due to refusal to cooperate, but the judge determined a disorder in a legal sense, developed since the legislative change?*

If the PBC is unable to formulate a hypothesis about a disorder, determine a disorder, or answer the courts' remaining questions due to refusal, the judge may still impose a tbs-order. This requires that the judge be convinced that there is a disorder, that he

comes to the lawful determination of it. For this comparison, all recent years were compared to earlier years.

Courts' questions not answered

If the PBC was *not* able to answer the courts' questions, it usually turns out that the judge imposed a tbs-order more often in 2017-2021 than in 2012-2016. In the absence of determined disorders, the judges (district court or court of appeal or confirmed by the Supreme Court) still imposed a tbs-order in 15% of the cases (7% in 2012-2016), on 25% refusing defendants in respect of whom no opinion on accountability was given, a tbs-order was imposed (15% in 2012-2016) and in 17% of the cases in which a treatment recommendation was issued, a tbs-order was imposed (12% in 2017-2021). In the absence of hypotheses about disorders, a tbs-order was imposed in 2% of the cases in both groups. On the contrary, in the absence of an opinion on simultaneity, a tbs-order was imposed slightly less often in 2017-2021: on 12% of the refusing defendants in respect of whom no simultaneity was established (14% in 2017-2021). The largest increase in impositions of the tbs-order is seen where no opinion on accountability was given, this difference is 10 percentage points.

Courts' questions answered

The analyses also show that in 2017-2021, if the courts' questions were answered, a tbs-order was imposed more often than in 2012-2016. This shows that in 2017-2021, if the courts' questions were answered, a tbs-order was sometimes imposed more often and sometimes much more often than in 2012-2016. This can be seen in the following numbers: in 39% of the cases in which the PBC provided a diagnostic hypothesis, the judges (district court or court of appeal or confirmed by the Supreme Court) imposed a tbs-order (16% in 2012-2016), just as in 26% of the cases in which the PBC determined a disorder, a tbs-order was imposed (19% in 2012-2016). If subsequent questions were answered, the percentage of tbs-orders decreases: 29% if the question on simultaneity was answered (12% in 2012-2016), 16% if the question on accountability was answered (11% in 2012-2016) and 24% if the question on treatment advice was answered (14% in 2012-2016). The largest increase in the imposition of the tbs-order can be seen where hypotheses have been imposed, this difference is 23 percentage points.

6 *How often has the observation period been extended, for both refusing defendants and defendants cooperating with the pre-trial forensic psychiatric assessment in the PBC?*

Although the first statutory period of admission to the PBC is a maximum of seven weeks, a stay of six weeks is standard practice in the PBC. This is also reflected in the figures on all defendants admitted in 2018 up to and including 2022: most defendants stay for six weeks (76%), some for seven weeks (13%), and a few for shorter than six weeks (8%) or even longer than seven weeks (3%; percentages of all defendants in the PBC; the latter group consists of 25 people). Although an extension of the length of admission with a second statutory period of seven weeks is possible, the numbers show that this rarely occurs (the 3% that was mentioned earlier), which means that this measure from the refusal approach has hardly been used.

When dividing the length of stay by the degree of cooperation, it appears that most of the 'long-term stayers' (longer than seven weeks) are defendants who cooperate (5% of all defendants from 2018 up to and including 2022, 76% of the total number of long-stayers). Among refusing defendants just as among partially refusing defendants, the length of stay was extended in only 1% of all cases from 2018 up to and including 2022 (both 12% of the long-stayers).

7 Has the extension of the observation period in both refusing defendants and defendants cooperating in the pre-trial forensic psychiatric assessment resulted in additional research output?

Due to the small number of refusing defendants whose duration of stay was extended, it was not considered useful to further examine the reasons for extension, to split the group by year of stay or to determine whether the research output had increased. This research question can therefore not be answered.

8 How did the refusal policy in the PBC continue after the Unit 3 pilot ended?

Six months after the Unit 3 pilot ended, the PBC moved to a new building in Almere. Several insights from the pilot have been incorporated into the design of the 'new' PBC, which has involved a switch from a *ward* for refusing defendants to a (proposed or enacted) *policy* on refusing defendants. This means that the PBC at the time of the interviews (Fall of 2023) intends to close the separate ward for refusing defendants and to apply the policy on refusing defendants to all wards. This is based on three main reasons.

Firstly, after moving to Almere, several features of Unit 3 were implemented in all wards in the new PBC, not just in the ward for refusing defendants (three of the seven parts of Unit 3): the ward climate of a therapeutic environment, including the availability of the observation coordinator, a day programme with a flexible and attractive range of activities (cooking together, the iPad, musical instruments, an open cell (as much as possible), the availability of the patio), and the multidisciplinary expansion of the pre-trial forensic psychiatric assessment in the sense of more contact moments with the psychologist and psychiatrist.

Secondly, for a while, a lot of time and attention in the PBC was paid to the problem of defendants refusing pre-trial forensic psychiatric assessment, as a result of which a lot of knowledge and expertise about them has been built up and developed and a change in mentality has taken place. This knowledge does not necessarily have to be applied to a separate ward, but can be used with the refusers, regardless of the ward where they are located.

Thirdly, the ward for refusing defendants in Almere has not always been filled with only defendants who refused to cooperate, but also with defendants who did cooperate. This is because the number of refusers has decreased because planning and capacity did not allow otherwise, and because of a changed procedural position of some defendants during admission to the PBC. This has led to the insight that, according to some respondents, it is best to observe the defendants in mixed groups. This eliminates the need for a ward for refusing defendants, according to most respondents. A few respondents also mentioned disadvantages of the (possible) closing of the ward for refusing defendants. For example, vulnerable defendants regularly require a lot of attention on the ward. Refusing defendants, on the contrary,

usually require little attention on the ward and thus can disappear 'under the radar' more easily than others on the ward who require a lot of attention, for example because of psychotic problems, addiction problems, aggression or a mild mental impairment (in Dutch: LVB; *licht verstandelijke beperking*). The advantage of a separate ward for refusing defendants is that everyone remains clearly visible, and therefore the problem of defendants refusing pre-trial forensic psychiatric assessment remains clearly visible, and that these defendants can also be encouraged to show themselves more, according to these respondents.

The interviews also show that several features of the Unit 3 pilot have not remained (four out of seven): the use of additional forensic expertise, few options for withdrawal, extra focus on a subgroup of defendants and extension of the admission period.

Conclusions

The following conclusions are drawn from the evaluation of the current refusal approach.

1 The goal of making society safer cannot yet be determined.

Although the number of refusing defendants has decreased significantly, it is not known, at this stage, who of the refusing defendants will or will not reoffend. A reliable analysis on recidivism rates cannot be performed until 2031. The results do show that the courts' questions in respect of refusing defendants have been answered more often in more recent years, which has provided insight into disorders more often and also more often insight on the need for treatment. If the judge has sufficient information, treatment, a tbs-order or another measure can be imposed, thereby reducing the likelihood of recidivism.

2 The goal of reducing the number of refusers has been achieved.

The prevalence of refusal decreased significantly by 8 percentage points between 2018 up to and including 2022 and 2013 up to and including 2017. However, further analyses show that neither the refusal approach alone nor the Unit 3 pilot alone resulted in this decrease, as no significant differences in the prevalence of refusal can be seen in the years surrounding these changes. It is conceivable that the combined effect of the refusal approach and the Unit 3 pilot and possibly other matters that came up in the forensic psychiatric sector in these years, brought about this decrease in prevalence. These results suggest that the refusal approach may have contributed to the decrease in the prevalence of refusal, but is unlikely to be the only factor.

3 The goal of reducing the potential effects of refusing pre-trial forensic psychiatric assessment has been achieved:
   a Gathering more information about the mental state of the offender has been achieved.

The figures for all years clearly show that with a large number of refusing defendants, the courts' questions can still be answered. This is especially the case when looking at hypotheses about disorders, the follow-up questions were answered less frequently. One can also observe that the courts' questions are easier to answer when there is more cooperation.

The figures further show that the courts' questions were generally answered more often after the refusal approach, in 2020-2022. For example, the question on disorders was answered about equally often in 2020-2022 and in 2014-2016 (prior to the refusal approach), but the questions on hypotheses about disorders, simultaneity, and treatment advice for refusing defendants were answered much more often in 2020-2022 than in 2014-2016 (differences of 47 percentage points, 24 percentage points and 10 percentage points, respectively). The question on legal accountability was also answered more often in 2020-2022 than in 2014-2016, but this difference is smaller: 7 percentage points. The results on the research output in the past five years paint a comparable picture. These results suggest that the increase in research output is at least partly due to the refusal approach.

b Making it easier for the judge to impose an appropriate sentence and/or order, such as a tbs-order or otherwise, has been achieved.

For the judge who must determine whether a disorder exists in a legal sense, it is most important to have some information about possible disorders. Hypotheses about disorders may be sufficient for this. As more courts' questions are answered, it becomes easier for the judge to impose an appropriate sentence or measure. Conclusion 3a shows that there were indeed more frequent answers to the courts' questions in recent years, with the number of hypotheses increasing the most. This makes it easier for the judge to impose an appropriate sentence and/or measure.

The results further show that judges imposed a tbs-order significantly more often in more recent years, if the years in which the refusing defendants were observed are taken into account. This occurs both in cases with refusing defendants in which the courts' questions were answered and in cases with refusing defendants in which the courts' questions were not answered. In 2020-2021, a tbs-order was imposed on average in 43% of the cases. In 2015-2016, a tbs-order was imposed on average in 21% of the cases. These average percentages deviate significantly from each other, the effect size is small.

These results suggest that the increase in the number of tbs-orders is at least partly due to the refusal approach.

4 The perpetuation of the policy on refusing defendants in the PBC shows that a conversion from a ward for refusing defendants to a policy on refusing defendants is now taking place.

The evaluation of the continuation of the pilot shows that three of seven Unit 3 components have been continued and four of the seven components have not. In the process, several insights from the pilot have been incorporated into the design of the 'new' PBC, involving a (proposed or enacted) switch from a *ward* for refusing defendants to a *policy* on refusing defendants. This means that the PBC currently (at the time of the interviews, in the Fall of 2023) intends to close the separate ward for refusing defendants and to apply the policy on refusing defendants to all wards. This is based on three main reasons, namely that several components of the refusal approach have been implemented throughout the PBC and not just in the ward for refusing defendants, that there has been a change in mentality among the pre-trial assessment reporters, and that practice has shown that even in groups in which refusing defendants and cooperating defendants are observed together, good insight can be gained into refusing defendants. The advantage of a separate department for refusing

defendants is that they cannot hide behind other defendants. A possible risk with the discontinuation of the separate ward for refusing defendants and a reduction in focus on this issue may well be that some or all of the refusing defendants will drop out of the picture.

5 *Extending the observation period did not happen often and could therefore hardly have had any effect. It cannot be ruled out that in some cases it did have a positive influence.*

The length of stay of 1% of the refusing defendants is longer than seven weeks. This is equal to the number of extensions longer than seven weeks of partial refusers (1%), but less than that of defendants who cooperate (5%, percentages of the number of defendants admitted in 2018 up to and including 2022). Due to this small number, it was not considered useful to further examine the reasons for extension, to split the group by year of stay or to determine whether the research output had increased.

6 *The Advisory Committee on the Disclosure of Information on Refusing Defendants could not be evaluated, as only one case has been heard to date. No conclusion can therefore be drawn about its possible effect. However, it can be concluded that this measure (so far) has not affected the results found.*

7 *Care during and after detention could not be evaluated within the scope of the current research. No conclusion can therefore be drawn about its possible effect.*

8 *Other factors at play in the forensic psychiatric sector, including the enormous attention brought about by the Michael P. case, may also have contributed to the effects found.*

During the study period (mostly 2014 up to and including 2022), simultaneously with the refusal approach, at least the following changes in laws and regulations and a number of serious cases surrounding refusing defendants also took place, which may have had an impact on the results found in this study. These are the ECHR's ruling in the Hoogerheide case in 2015; the Unit 3 pilot, the abandonment of the maximum term of the conditional termination of the tbs-order with mandatory hospitalization and treatment in a forensic psychiatric hospital and the crime committed by Michael P. in 2017; the introduction of the MBI in 2018; the judgment on appeal of Michael P. in 2019; and the care authorisation (*zorgmachtiging*) from the Dutch Forensic Care Act in 2020.

Recommendations for the refusal approach

With the decrease in the prevalence of pre-trial forensic psychiatric assessment refusal and the increase in the number of tbs-orders imposed on refusing defendants for whom this is necessary, 'the problem of the refusing defendant' has been reduced. The question is whether it is possible and or necessary to reduce it further. Nevertheless, some recommendations for follow-up research and for addressing the problem of defendants refusing pre-trial forensic psychiatric assessment have been given.

1 It is recommended that the pre-trial assessment reporters write down as much information as possible about refusing defendants. Hypotheses about disorders, but

certainly also the answers to the courts' other questions, help the judge determine the disorder in a legal sense.

2 Maintain the change in mentality of the researchers in the PBC towards the refusing defendants, so that there is a greater chance that the problem of defendants refusing pre-trial forensic psychiatric assessment will not arise or increase again.

3 Maintain the expertise of judges, so that they remain informed of the fact that lawfully determining the disorder is a different exercise than its behavioural determination and that they can use all available information, including hypotheses about disorders, for that purpose and for imposing a tbs-order or a different treatment obligation.

4 Investigate the reasons behind the limited use of the Regulation on defendants refusing pre-trial forensic assessment, so that any adjustments to the Regulation can potentially increase its use and potentially further reduce the impact of the problem of defendants refusing pre-trial forensic psychiatric assessment.

5 Investigate the reasons behind the low deployment of the possibility to extend the observation period, so that any adjustments thereto can possibly increase the effort and possibly further reduce the influence of the problem of defendants refusing pre-trial forensic psychiatric assessment.

Research limitations

Since many of the analyses concern all or almost all refusing defendants from the PBC and not a sample, most results have a high degree of reliability. This is true to a lesser extent for the judgments on appeal for refusing defendants from 2017-2021. For 28% of that group, a judgment on appeal has been found, and more are expected to be added as time goes by, because it takes some time for all appeal cases to be settled. This means that the sanctions imposed on this group of defendants may change on appeal.

The current research examines the first years after the implementation of the new legislation. It is well known that new legislation requires time for all parties involved to become aware of the changes therein. It is therefore possible that some effects will linger for a while.

Some of the courts' questions answered contain missing information (missing values). It is possible that insight into these missing variables influences the results found.

It cannot be ruled out that events prior to the current refusal approach have also had an impact on the decrease in the prevalence of refusals and the increase in the number of tbs-orders imposed on refusing defendants. However, by only including in the analyses the years surrounding the refusal approach on the one hand and the Unit 3 pilot on the other hand as much as possible, an attempt has been made to exclude this possible effect as much as possible.