The Dutch perspective

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Chapter 9

A Dutch perspective

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9.1 Introduction

9.1.1 The legal system

To understand the subtleties of the Dutch penal law system related to forensic assessment, a few interrelated procedural characteristics are of great importance in shaping its context. These are addressed in this paragraph. Of course, more substantive characteristics related to sentencing, such as criminal responsibility and the nature of sentences may be of equal impact on the contents of the assessment, but these will be addressed more thoroughly in the remainder of this chapter.

As in most continental European jurisdictions, the criminal process may be best characterised as an inquisitorial system, in which the judge is the driving force in fact-finding, in contrast with adversarial justice systems, generally stemming from the Anglo-American common law tradition, in which parties play that role. As a consequence, in inquisitorial systems the judge is not merely the referee but the independent and 'incorruptible' inquirer, while in adversarial systems there is a greater emphasis on playing fair through equality of arms and an active defense by the accused.[1] The Dutch jurisdiction has been described in the past as the most inquisitorial jurisdiction in Western Europe.[2] However, especially under the influence of the European Convention on the Protection of Human Rights and Fundamental Freedoms (since 1950) and the jurisprudence of the European Court of Human Rights (ECHR) in Strasbourg (France), more and more adversarial elements are being added to the system.[3] Even though the Court does not judge legal systems, individual cases may give rise to changes within a system.[4] For example, both in practice and legislative reforms the issue of fitness to stand trial is increasingly under the attention. This evidently also has relevance to forensic assessment; at least it is of great influence in adversarial justice, while absent in some inquisitorial systems. It is already remarkable that the Dutch system even has such a doctrine in place since 1926, but originally this had a more pragmatic background related to the responsibility doctrine and the (im)possibility for commitment to a psychiatric hospital if the offender became disordered after committing the crime. However, since a few decades, fairness is recognised as its main legitimation.[5] For the subject of this chapter the most important consequence of the inquisitorial system is that forensic evaluators (as expert witnesses) are officially doing the assessment on behalf of the court instead of the parties.

A basic trust in authorities and pragmatic efficiency are two fundamentals of the Dutch welfare state. They explain why the principle of immediacy – which requires that all evidence is presented in court in its most original form – plays a limited role in practice. Witness testimony, including expert-witness testimony, is generally dealt with through paper reports – for eye witnesses, for example, reports of their statements to the police –, and are not voiced by the

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(expert-)witness in the courtroom.[6] Trust and pragmatism are also part of the explanation for the fact that the criminal trial consists of one phase, in which both fact-finding and sentencing take place. In order for forensic assessment to be ready before the trial, very early in the criminal process case selection has to take place, and defendants are being evaluated without the establishment of fact (and consequent culpability). As an important part of the assessment is criminal responsibility based on the mental status at the time of the offense, this feature of the system could be problematic for defendants who dispute the charges.[7]

That the percentage of the population's trust in judges is still highest of all authorities, and also higher than in many other jurisdictions, explains why – outside of academia – no need seems to be felt for further democratic legitimation of judicial decision-making, for example through juries or other lay-judges. The high level of trust seems to be associated with the perceived level of procedural justice.[8] As a consequence of all the characteristics above, admissibility of expert evidence is not a major issue. The professional judges are expected to be able to assess the quality of the evidence and weigh its conclusions accordingly. The division of legislative, judicial, and executive powers, however, hands decisions concerning the execution of sentences to the Ministry of Justice and Security and the Public prosecutors office. Some other decision-making bodies within the execution of sentences are more judicial, but consist also of other professionals (i.e. psychiatrists and psychologists), like the Council for the Administration of Criminal Justice and Protection of Juveniles, the body that for example deals with appeals against decisions of the Ministry concerning the execution of sentences in individual cases.

Again pragmatism and trust play their part as grounds for a large discretionary competence of the prosecutor to not prosecute criminal offences. For example, the widely known policy of tolerance, which is used to 'legitimize' the use of marijuana or a diligently planned and performed euthanasia, is based on this competence.[9] But it is also grounds for the possibility to not prosecute a mentally disordered offender to favour civil commitment, as a kind of diversion.[10] Empirical research shows that this is generally only done in case of less severe offences.[11] Using this competence conditionally may also be used as an out-of-court settlement, with in- or outpatient treatment among the possible conditions. Other out-of-court settlements with the Prosecution exist, both consensual and non-consensual, but they differ from plea-bargaining as no guilty plea is required.[12]

9.1.2 The related tradition of forensic assessment

The historic developments concerning forensic assessment mentioned in Chapter 2 are also identifiable in the Netherlands. Whereas insanity used to be regarded as something also a lay person could see, in the late Middle Ages cases are known in which law practitioners would use medical books to assess insanity themselves, like that of Volker Westwoud from 1674.[13] When psychiatry became a more specialised discipline, including more rigorous scientific evaluation, its influence on criminal law grew. The development of treatment and assessment for forensic patients went hand in hand, and in a sense has been interrelated for almost 150 years. In 1884 new legislation on coercive treatment of mentally disordered people was introduced (the 'insanity law', the first edition was from 1841) while in 1886 the new Criminal code was enacted as the follow-up of the Code Pénal (1811) from the Napoleontic times.[14] The connection between those new laws was the person of Johannes Nicolaas Ramaer (1817–1887), a medical doctor and from 1842 medical superintendent of different asylums for the insane.[15] He was the adviser of the Ministry of Justice in the development of both laws and as a doctor he introduced a better health care and legal protection in the asylums and prisons. It became common for courts to ask doctors, working in those institutions, for advice on legal matters. This was also triggered by the fact that as the psychiatric discipline evolved, more subtle

disorders were recognised, which were not as easily recognisable for judges. Especially the category of 'monomania' became popular, a form of partial insanity conceived as single pathological preoccupation in an otherwise sound mind, as these patients acted rational, but for one psychological function. It was no coincidence that the oldest case traceable in which a psychiatrist testified in court, was that of a pyromaniac girl in 1839. She was acquitted for setting fire to a haystack.

From the case of Volker Westwoud onwards, who was convicted for manslaughter, insanity did not necessarily mean acquittal, but could also lead to a form of preventive detention. When the modern criminal law school emerged at the end of the nineteenth century – which emphasised causes of crime based on advancements in biological, psychological, and sociological knowledge – preventive sentencing became more popular and justified. A pivotal moment in the history of forensic assessment in the Netherlands was the introduction in 1928 of the entrustment order called the TBR (from 1988 onwards: TBS), by which offenders could be sentenced to a commitment in a high-security psychiatric hospital when they were a 'danger for the public order and/or security', due to a mental disorder which diminished the responsibility for the offense. The disorder and diminished responsibility were necessary to reach a compromise with the classical school in criminal law, which was based on proportionate retribution to the extent of guilt. It only allowed for such a safety measure next to incapacitation in penitentiary institutions, because diminished responsible offenders kept getting lower sentences even though they were more likely to reoffend.[16] As this safety measure was basically indeterminate, but had to be prolonged every two years by the court, more assessment was required, in this case from the psychiatrist of the TBR-asylum, later called 'clinic' and since the turning of the twenty-first century 'center'.

When after World War II the attitude towards psychiatric patients became more therapeutically optimistic – group therapy and relevant psychotropic drugs were discovered in the meantime – and humane, the TBR became more frequently used. Its criteria turned into the dominant questions for pre-trial assessment, and an observation clinic to support this assessment was instituted in 1949 as well as a selection clinic in 1952. Selection was necessary because similar to criminal law, forensic psychiatry 'schools' also emerged with their own frame of reference on treatment and assessment, among which a psychodynamic school, a phenomenological school, and a behavioural school could be distinguished.[17] Clinics were differentiated accordingly, and private clinics invested in by the Ministries of both Justice and Health. When towards the end of the twentieth century the treatment model shifted from cure to control, TBS-clinics became more eclectic. The necessity of efficiency was also related to a large increase in the number of patients, leading also to an increase of psychologists within forensic treatment. This backdrop explains why the TBS-clinics became early adapters of risk assessment instruments for back-end decisions: prolongation or termination of the order. Since 2008, the Forensic Care Act (FCA) supports the movement to a broader mental health field for forensic treatment, paid for solely by the Ministry of Justice and Security (which is a telling addition in 2010!), ranging from outpatient treatment as a condition for non-prosecution to inpatient treatment in a high-security TBS-facility, and everything in between.

Likewise, the pre-trial assessment has undergone several quality-enhancing changes over the years. After World War II, the forensic assessment was detached from the treatment clinics, through the establishing of local institutions named Forensic Psychiatric Services for every judicial district and the abovementioned observational clinic. These institutions and the observational clinic were merged in 2008, so that assessment is now governed by a centralised organisation: the Netherlands Institute for Forensic Psychiatry and Psychology (NIFP). The centralised NIFP was established by the Dutch Government to provide more unity in the quality of the assessments for the courts. How this is done, will be elaborated in the next

paragraphs. Of course, standardisation is important in unifying. This development was already visible at the end of the twentieth century, when for example a first standard set of questions for the assessment was introduced as well as a Likert scale for the assessment of criminal responsibility, instead of everyone formulating their own questions or using their own words to describe the strength of the causal relationship between disorder and offence.[18] Maybe also because risk assessment research has had more focus on back-end sentencing decisions, structured assessment was introduced fairly late to pre-trial assessment. Up until today discussions on scientific reasoning, nomothetic versus idiographic, for example, can become quite emotional among evaluators, especially when it comes to risk assessment.

Another important governmental body for safeguarding the quality of forensic assessment is the Netherlands Register of Court Experts (NRGD), which was introduced by the Experts in Criminal Cases Act in 2010. Even though the act had a background in miscarriages of Justice related to fact-finding, it also applies to behavioural scientific experts making evaluations for sentencing.[19] *A fortiori*, Forensic Psychiatry and Psychology is by far the largest discipline represented in the register, within 2019 508 out of 604 court experts in total, i.e. 84% of the total number of registered court experts.[20] It underlines the quantity of forensic assessment, and thereby the relevance of its quality.

9.2 Short overview of the role of assessment in sentencing offenders

9.2.1 Sentences and execution

9.2.1.1 The Dutch sentencing system

The Dutch sentencing system may be characterised as a twin-track of retrospective, retributive penalties, on the one hand, and prospective, preventive measures, on the other hand. The penalties and measures however differ mainly in theory. In recent decades, the objectives of custodial penalties and safety measures have grown closer together.[21] This is partly because of the compromises between classical and modern theory, of which the TBS-order itself is an example, but also because one of the main arguments for the distinction – intentional versus unintentional suffering – is rather unsatisfactory from both a pragmatic and a moral point of view.[22] More important is the fact that in the 1950s when the TBS-order was executed with a lot of liberties for the patients, it was not regarded as sufficient for public protection, and instead lengthy prison sentences were imposed on dangerous offenders. The Supreme Court allowed this practice, so that the severity of punishment is no longer only tailored to the extent of guilt, but may also be tailored to the extent of dangerousness.[23] This discretionary competence for judges is understandable, as it is almost total in sentencing. There are only maximum sentences in place per offence and there are no mandatory sentences. The recently enacted prohibition of community service for severe violent or sexual offences (or in case of recidivism) seems to keep judges from sentencing too mild but is also often avoided by giving a prison sentence for the duration of the pretrial detention already served.[24] Recidivism in general may be an aggravating factor for raising the maximum sentence, as well as confluence of multiple offences tried together, for which only one penalty may be imposed. Again it is pragmatics over principle that excludes the option of a back-to-back-sentence conviction. From the side of the judges themselves, judicial 'points of reference' for sentencing have been formulated for the most common offences, as the word 'guidelines' was considered to be too much in friction with their discretionary competence.[25] The prosecution does have guidelines in place for both their prosecutorial decisions and their sentence demands.[26] The discretionary competence includes the choice of penological goals

of the penalty in a single case, as long as these (especially restriction of liberty) are well motivated, and – even after conviction – no sentence may be applied for example if due to personal circumstances penological goals can no longer be reached.[27]

The twin-track system was originally very much related to the concept of criminal responsibility, but this dogmatic stronghold has similarly weakened under the influence of pragmatics. Non-responsible offenders may still not be given a penalty, but they may be given a safety measure. Ever since the first Dutch Criminal Code (CC) from 1886, a safety measure of placement in a psychiatric hospital (not the same as the imposition of a TBS-order) existed, especially for the non-responsible. It has been replaced in 2020 by the possibility for the criminal court to warrant coerced civil care in any stage of criminal proceedings for whomever meets the criteria laid down in the civil (in name, but administrative in function) mental health laws. Non-responsible offenders may be sentenced to a TBS-order if they meet the criteria of having committed a severe offence and being considered (very) dangerous. Diminished responsible offenders may be sentenced to a combination of a penalty, generally a prison sentence, for the part they are responsible, and a TBS-order, for the part that they are (biopsychologically) determined to be dangerous. Since a supervision order was enacted in 2018, the combination of a prison sentence and a supervision order is also possible for offenders considered fully responsible. Furthermore, it depends on the contents of the sentences at hand whether they can or may be combined.[28]

Another relevant feature of the Dutch sentencing system is that for juveniles between the ages of 12 (the age of criminal accountability) and 18, specific sentences are in place. The rationale is primarily determined by the pedagogical/educational aim of sentencing and has to be least restrictive to allow the minor to make a new start in life after serving the sentence. However, for two groups exceptions may be made. Adult sentences may be applied to 16–17 year olds, if they meet aggravating criteria. Vice versa, juvenile sentences may be applied to 18–23 year olds ('adolescents'). This latter exception is called 'adolescent criminal law', was introduced in 2014, and was based on the dual rational of accountability (neuroscientific evidence that the brain is maturing until around the age of 24) and prevention. The central notion was to provide an effective and offender-oriented manner of sentencing which does justice to the committed offense and which takes into account the personal circumstances of the offender, including his/her developmental phase. Although Dutch law recognised the relationship between incomplete (biopsychosocial) development of adolescents and young adults, and recognised the superior effectiveness of the offender-oriented and pedagogical juvenile justice system in terms of better reintegration into society and prevention of reoffending, juvenile criminal sentencing is still only rarely applied to young adults.[29]

In sum, the Dutch sentencing system has evolved away from its former dogmatic rigidity to a highly flexible system in many aspects. The upcoming wish (or demand) in recent decades to further reduce reoffending, to fill all the gaps that may allow for risk to peep through – the pursuit of absolute certainty – has led to an increase in sentencing options, especially through new safety measures, many of which target specific groups of offenders. Since measures are much less bound to dogmatic restrictions than penalties, and are founded in the wish to counter 'undesirable situations',[30] they are prone to be used and created in risk society politics. To be able to follow such developments, for some recently added sentences the years of enactment are provided as additional information in the next paragraph.

9.2.1.2 Relevant sentences

Examples of penalties are the prison sentence, the community service, and the fine. A prison sentence may be a life sentence for a very selective set of offences (including murder), while

the maximum period of a temporary prison sentence is 30 years. Sentences may (in part) be imposed conditionally, so that the execution is being suspended as long as conditions are met for a certain timeframe (probation period). In suspended sentences, special conditions may be imposed, such as inpatient or outpatient treatment, not necessarily *de iure* but indeed *de facto* only as long as the offender agrees to the conditions. Even though no forensic assessment is required for imposing a (partially conditional) penalty, such a special condition of a suspended prison sentence, is actually the most frequently recommended legal framework for forensic psychiatric treatment.[31] Partially conditional penalties cannot be used for the most severe offences, as a complete suspension is possible for prison sentences up to two years and a partly suspension is possible for prison sentences between two and four years.[32] In practice, in 90% of the cases of suspended penalties in which special conditions are being imposed, some kind of assessment, possibly also by probation, is in place.[33] If the condition entails inpatient treatment, the judge has to decide upon imposition on its maximum length. This decision cannot be delegated to the probation services.

Similar to penalties, measures can be both monetary and liberty restricting. The monetary measures include compensation of damage, confiscation of illegally obtained benefits or extraction of dangerous objects. Other measures target dangerous people and are called safety measures in literature.

The before mentioned TBS-order can be imposed in case of severe offences, dangerousness, and no or diminished criminal responsibility, and can be prolonged infinitely every two years by the court of imposition.[34] In case of diminished responsibility, TBS may be imposed in combination with a penalty. The order can also be imposed conditionally (instead of coerced commitment). In case of conditional TBS, the possible additional sentence is restricted to five years imprisonment and the total duration of the TBS-order is capped to nine years. A conditional TBS-order can however be changed into an unconditional TBS-order if conditions are breached or if '*the safety of others, or the general safety of persons or goods demands it*'. The unconditional TBS-order has a variant of limited duration of four years when it is imposed for offences which are not directed at or cause risk for the inviolability of the human body – a term which covers violent and hands-on sexual offences. For the imposition of all the variants of the TBS-order, a recent and multidisciplinary (of which at least a psychiatrist) forensic assessment has to be in place. Specific rules regarding defendants who refuse to cooperate in the evaluation exist to avoid as much as possible that the formal criterion of assessment would be considered unmet.

A safety measure targeting repetitive (petty crime) offenders was enacted in 2003. This 'ISD measure' permits the placement in a custodial treatment facility (e.g. for drug addicts) for two years *'if the safety of persons or goods demands it*'. The imposition of this safety measure formally requires a forensic assessment, but – other than for the TBS-order – this does not have to be provided by a psychiatrist and/or clinical psychologist as establishment of a mental disorder is not required. In practice, probation officers advise about utility, necessity and feasibility of the ISD measure. In case of diagnostic questions, a specific ISD-trajectory consultation or diagnostic investigation can be provided by any independent psychologist or psychiatrist, not required to be registered as a court expert. This is similar to the possibility for a suspended ISD measure can be imposed, as well as for the option for the court to provide itself with an intermediate check of the continuation of the order.[35]

Since 2012, liberty of offenders can be restricted with location and/or contact bans for a maximum of five years, for *'protection of society or to prevent criminal offences'*. No forensic or behavioural assessment is needed for such imposition. Since 2018, an indeterminate supervision order exists called the 'Measure of Influencing Behavior or Restricting Liberty' (GVM), which can be imposed in case of violent or sexual offences in combination with a

prison sentence or a TBS-order. After TBS the order is most logical in combination with one of the two modalities of the TBS with a maximised duration, i.e. the conditional TBS (max. nine years) and the unconditional capped TBS for non-violent offences (max. four years). The criterion of dangerousness as meant in the GVM-measure resembles that of the TBS-order, although no (relation to a) mental disorder is required. The order needs to be imposed during sentencing, but another judicial decision is needed for the execution of the order at the end of the combined sentence. In this second judicial decision, the initial duration is set, up to five years, after which prolongations for periods up to five years are possible. For execution and prolongation a different dangerousness criterion is in place (see paragraph 9.2.3). For imposition, execution, and prolongation, forensic assessment by the probation service is required.[36]

Up to 2020, non-criminally responsible offenders could be placed in a psychiatric hospital, not necessarily a secured facility, for the maximum duration of one year. In a legislative change, this safety measure has been replaced by its successor (art. 2.3 of the Forensic Care Act, FCA). The new regulation provides the criminal court the opportunity to warrant coerced psychiatric, psychogeriatric, or intellectual disability care, when the criteria of the civil mental health laws (also new since 2020) are met, in any stage of the criminal process – prosecution, trial/sentencing, and execution of sentences. As it is no longer limited to the trial phase, or restricted to non-criminally-responsible offenders, the option of confluence with other sentences – in practice mainly suspended prison sentences – or legal frameworks is created, as well as the combination with an acquittal. Since the new civil mental health laws, it has become possible to only warrant, for example, coerced medication, instead of only coerced admission in a mental health institution. The maximum duration of the warrant is six months but can be prolonged if the criteria are still met. The criterion of dangerousness differs from before, and now includes 'serious disadvantage' for others and self. Other differences include formal criteria of the medical expert advice. Before 2020, a multidisciplinary forensic evaluation by at least one psychiatrist used to suffice, but for imposition of coerced civil care a medical declaration and treatment plan from the receiving facility are necessary. Whereas placement in a psychiatric hospital before 2020 could be imposed under criminal law also in the case of limited treatability of the underlying mental condition, the new legislation created new barriers. Coerced treatment is not only required to be proportionate but should also be effective, including expected improvement of the psychiatric condition. Therefore, if a receiving mental health facility – usually not equipped for reduction of the risk of reoffending, but merely for the treatment of the psychiatric condition – concludes that coerced treatment will probably be ineffective, it usually refuses to offer a treatment (plan) and/or refer the patient to another (secured) centre.

For juveniles (and, as mentioned, some adolescents/young adults), the Criminal Code provides separate sanctions. The most common sentences for adults have their equivalent for juveniles, albeit with a (much) lower maximum. Prison sentences for juveniles below the age of 16, can be at maximum one year, for 16–17-year-olds at maximum two years. The equivalent of the TBS-order, known by the public as 'youth-TBS', is called 'placement in an institution for juveniles' (PIJ). This PIJ measure is carried out in special wards in the same facilities as the juvenile prison sentence but can have a longer duration. The safety measure is imposed for a minimum of two years and can be prolonged up to a maximum of seven years. A maximum duration is in line with the aims of the juvenile criminal justice system, which is to provide education and give the convict a real second chance by avoiding lengthy detention. Life sentences are therefore not possible for minors convicted under juvenile criminal law. Other sanction modalities of rehabilitation and restriction of liberty in the community exist in the juvenile sentence arsenal, including a 'Measure of influencing behaviour'. Placement in

psychiatric hospitals via 2.3 WFZ is not possible, although civil mental health laws also include minors from the age of 12 years onwards. On the other hand, opportunities under civil youth law, such as supervision orders and coerced placement in youth care institutions, are often combined with sanction modalities. The aims of education and rehabilitation ensure that in juvenile justice there is always some sort of forensic assessment in place. The NRGD acknowledges separated registration for court experts reporting about juveniles. Probation services and the Council for Child Protection are always involved.[37]

9.2.1.3 The execution of these sentences[38]

The described sentences are executed in four 'systems' or 'pathways' with specific legislative frameworks for the internal legal position: 1. the penitentiary system, governed by the Penitentiary Principles Act (PPA), 2. the TBS system, governed by the TBS-care Principles Act (TPA), 3. the (forensic) mental health system, governed by civil (mental) health laws, different for voluntary care, coerced care for persons with mental disorders, and coerced care for persons with psychogeriatric conditions or intellectual disabilities, 4. the community. Even detainees may be treated within all three intramural systems, for example through transfer. In the execution phase of offenders in these three systems, the Ministry of Justice and Security is the most common decision-maker. Treatment is also being paid for by this ministry during execution. The Forensic Care Act (FCA) is merely an 'organizational' act, labelling which care is being paid for by the Ministry of Justice and Security. The act now covers almost thirty legal frameworks within the criminal law sphere, which can be divided roughly in care related to the TBS-status, care as a condition in a conditional legal framework, and care for both provisional and prison detainees. Especially the last two categories cover multiple phases within the criminal process: the prosecution (including provisional detention), the trial (sentences imposed which involve care), and the execution of sentences (including safety measures). As a consequence several actors may decide on forensic care, like the prosecutor, the court, and the Minister, as competencies are divided over the course of the criminal process. Community reintegration, under supervision of the probation services, is generally within a conditional legal framework, like conditional release, in which the ex-detainee needs to adhere to certain conditions in order to not be placed (back) into detention.

In all systems, special facilities exist for treatment. Within the penitentiary system, the most notable institutions for forensic care are the so-called Penitentiary Psychiatric Centers (PPC's), of which there are at present four locations within penitentiary institutions throughout the country. The TBS-system consists of seven Forensic Psychiatric Centers (FPC's), of which two are governmental institutions and five private institutions. Within the forensic mental health system, the facilities with the highest security – albeit one level less secure than FPC's – are Forensic Psychiatric Clinics (FPK's), five in total. There are also a number of Forensic Psychiatric Departments in psychiatric hospitals (FPA's). Within the realm of addiction care, there are separate clinics and departments in place with similar levels of security. Furthermore, any mental health facility that meets the criteria may have a contract with the Ministry of Justice and Security for delivering forensic care. For treatment and care within the community, forensic outpatient clinics exist, as well as many homes for assisted living designated for forensic care.

So again, flexibility is a core characteristic of the execution of sentences, especially when it comes to administering forensic care, which is recognised in policy as the way to reduce reoffending. Even if such care or treatment is not automatically part of the sentence, it may still be provided through transfers between systems. Treatment aims and possibilities however differ between systems. Treatment in penitentiary institutions should cover general mental

health care based on the WHO standard of equivalence of care compared to the community, basically including crisis intervention, stabilisation, and motivational treatment to provide a starting point for more in-depth psychotherapy after the prison sentence. In FPC's the treatment is of high intensity, including a long-term trajectory of slow but steady re-integration, and aimed at reducing risk. The aim of risk reduction is similar throughout the forensic mental health system although with less security and possibly less intensity, while treatment in the general mental health system treatment is primarily aimed at (recovering from) the mental disorder.

9.2.2 Decisions within sentencing and execution

9.2.2.1 Front-end sentencing decisions as part of the trial

The first type of front-end sentencing decisions that comes to mind is of course the imposition of sentences by the court. The relevant sentences are described in paragraph 9.2.1.2, including if any type of forensic assessment is required for such imposition. Preliminary to this decision, however, a decision has to be made about the culpability of the offender, as for example, the absence of culpability on the basis of a mental disorder (non-criminal-responsibility) renders penalties out of reach. Dogmatically related is the decision, for defendants of a certain young age (as described in paragraph 9.2.1.1), on the application of adult or juvenile sentences. As mentioned before as well, the criminal court may, either alternatively or additionally to a (minor) sentence, choose to warrant civil commitment. In sentencing, first of all a decision has to be made about the type of sentence, or the combination of sentences.

With regard to penalties, a decision has to be made about the height of the sentence within the maximum established by law. As mentioned earlier, diminished responsibility (based on a mental disorder) may be used as a mitigating factor, while dangerousness (either or not based on a mental disorder) or recidivism may be used as aggravating factors. Behavioural advise on these concepts is generally received by the forensic assessment(s) for the trial.

When a suspended/conditional sentence (including safety measures) is chosen, a decision has to be made about the type of conditions. The probation services generally advice on these issues and courts rely heavily upon these reports (as part of the quintessential practical enforceability). If one of the conditions is forensic care, a department within the NIFP is in charge of indicating the required level of security and treatment intensity. Of course if relevant, the evaluators doing the forensic assessment for the trial may advice on these matters, as they will also advice on the necessity and feasibility of the type of treatment and the legal framework. Many suspended/conditional sentences or liberty restricting safety measures may be declared immediately executable, meaning that appealing the verdict does not suspend the execution. These decisions often require sanction-specific, and different, criteria for dangerousness. Electronic monitoring may be ordered to control location bans as a restrictive condition in many sanction modalities.[39] A final decision for suspended penalties is the choice of the probation period. In general, it can have a maximum of three years, but in case of high risk for reoffending with a violent or hands-on sexual offence, or in case of high risk for an offence against the wellbeing of animals, it can be up to 10 years.[40]

9.2.2.2 Mid-way sentencing decisions within execution

After the judicial sentence, the executive branch or administration – prosecution, Ministry, directors of institutions, probation services – becomes the authority. First, it has to decide on

placement within custodial sentences. Placement in forensic care institutions requires some psycho-legal information on risk and treatment needs which is gathered internally (by the NIFP). At present, there is no general risk screening for detainees, although a recent pilot with a newly created instrument was successful.[41] Decisions on transfer from prison to external institutions are made by the director of the penitentiary institution, on advise of a multidisciplinary prison team meeting, in which a psychiatrist (provided by the NIFP), psychologist, medical doctor, nurses, and social workers. So-called selection officers from the Ministry are able to transfer detainees within the penitentiary system, for example from a regular ward to a PPC, and transfer to either the TBS-system or the (forensic) mental health system.[42] A transfer from the TBS-system to the (forensic) mental health system is possible as well.

Within the TBS-system, transfers to other TBS-facilities are quite common, via the general route for placement in forensic care. Differentiated wards exist for offenders who need extreme risk management (including the risk for escape), or long-term forensic psychiatric care (LFPZ), formerly known as 'longstay' wards. These former 'longstay' wards are infamous, because the TBS-treatment is no longer aimed at rehabilitation through reduction of risk. Even though at the moment in practice there is more flow through the facility than its public stigma of 'life sentence in disguise' suggests, there are additional legal safeguards in place concerning placement and continuation of placement, which has to be reviewed every two years. There is a special multidisciplinary advisory committee for placement on long-term wards, which checks the application by the TBS-facility, while placement and continued placement also require independent multidisciplinary forensic assessment. In the end, however, the Minister decides. This decision may be appealed to the 'Council for the administration of criminal justice and protection of juveniles' (RSJ), which deals with appeals to many decisions by the Minister in the execution of sentences, as well as appeals to decisions of complaints committees in individual institutions, or certain decisions on coerced medication. Other important decisions in the execution of the TBS-order are those on leave. Over the decades an extensive system of leave has developed which is used as a treatment instrument in an individual case and ideally gradually becomes less restrictive. Phases include accompanied leave, unaccompanied leave, and 'transmural' leave, with which someone can live outside the institution but still follows treatment inside. Every new phase in the leave system has to be warranted by the Minister. Again, an independent multidisciplinary advisory committee judges the application for leave by the TBS-institution. On that advice, the Minister decides. Only the decision to revoke a warrant for leave is eligible for appeal, a general negative decision on an application is not. In a way, all these decisions are a product of a sequence of forensic assessments, as already the application of the institution, as well as the advice of the committee, may be regarded as such.

Some decisions during the execution are in the competence of the judiciary. These are first of all decisions related to deprivation of liberty, such as prolongation of the TBS-order, the intermediate check on the ISD-order, and decisions on changing conditional sentences into unconditional sentences (for example prison, TBS, PIJ, or ISD). Many of these decisions can be appealed by a specialised judicial body called the Penitentiary Chamber, in which three judicial members are accompanied by two behavioural scientific members. For the prolongation of the unconditional TBS-order at least an advice from the clinic is required, and every four years an independent multidisciplinary assessment. For prolongation of the conditional order an advice from the probation services and a psychiatrist are required.[43] Even though the law does not require establishing a mental disorder for prolongation, in legal practice this is used as a criterion nonetheless as a basis for risk and treatment. For the PIJ-order, comparable requirements are in place. Some decisions for which a judicial decision is

necessary are related to restriction of liberty, such as the execution and prolongation of the GVM, as well as many back-end decisions.

9.2.2.3 Back-end sentencing decisions regarding execution[44]

At the end of sentences involving deprivation of liberty, frameworks involving restriction of liberty exist for a gradual community reintegration. Such frameworks of supervision often consist of conditions, under which someone is allowed (back) into the community, and which are being supervised by the probation services. Of course all conditional frameworks require consent to the conditions, even though the conditions could even mean inpatient treatment in a forensic mental health facility. The most obvious framework related to prison is conditional release.[45] Since July 2021 the eligibility for parole is no longer after serving two-thirds of the (long) prison sentence, but only two years before fully serving the sentence. The possibility for parole was pushed back to better communicate the retributive aspect of the sentence to victims and society. It is expected that judges will counter this development by imposing lower sentences.[46] As this was also the moment for transfer to a TBS-institution in case of a combination sentence with prison, this will mean longer detention before the treatment can start. In 2018, another hole in the dike was closed by enabling prolongation of the probation period for conditional release, again and again for two years, in case of high risk for violent or hands-on sexual offences or burdensome behaviour towards victims or witnesses.[47] This indeterminacy within the track of penalties is dogmatically a novelty. Life sentence in the Netherlands is in principle indeed 'for life', even though this is determinate in a way. There is no tariff system in the law, but to adhere to the European Court of Human Rights' requirement of perspective, a legal safeguard was enacted in 2017, in which a committee will advice the Minister about rehabilitative options for a lifer after 25 years of imprisonment. In this advice, risk is also a factor. Any potential rehabilitative efforts would then have to be fit in a general, but rarely used, legal framework of a (conditional) pardon, which is officially a decision by the Crown.[48]

Conditional release is also a possibility with regards to the TBS-order.[49] The GVM supervision order may be used as a back-end decision after a prison sentence or TBS, but only if it is already imposed at the trial. It is the only framework of restriction of liberty that does not require consent. All conditional release possibilities may be revoked by a court, as not adhering to conditions of the GVM may also lead to deprivation of liberty as a sort of punishment.

Even if all the criminal justice frameworks are to expire, art. 2.3 FCA civil commitment may be used to keep someone off the streets, of course only when the individual meets the criteria from civil mental health law, which may be problematic if the framework is only used to avoid reoffending (see paragraph 9.2.1.2). It is more frequently used in case of termination of the TBS-order, than after a prison sentence, but can also be used for individuals detained in a PPC at the end of their sentence, who need further coercive treatment after their imprisonment in the general mental health system.

Within youth sentences, also conditional release options exist. For the sentence of 'youth detention' a judge can even order it at any time during the execution of the sentence. As indeterminacy is not in line with the principles of youth justice, such frameworks are all limited in time. Only one back-end decision in this case is the exception. If, after seven years of PIJ *'the safety of others, or the general safety of persons or goods demands',* the PIJ measure may be changed by a court into a TBS-order for adults. For this decision, in terms of assessment, only an advice by the youth institution is required.[50]

9.2.3 Concepts to be assessed

9.2.3.1 Relevant psycho-legal concepts

As the possibility of a TBS-order was traditionally the dominant reason for forensic assessment, it is no coincidence that the formulated standard set of questions for forensic assessment in service of the trial are very much in line with the criteria for imposition of the order. The questions are on:

1 The current presence of a disorder
2 The presence of that mental state during the offence
3 The influence of the disorder on behaviour and choice-making during the offence
4 The corresponding (level of) criminal responsibility for the offence
5 The risk for re-offending
6 The required treatment in behavioural terms and in terms of the legal framework

The questions evidently show that translations are required from psychodiagnostics to psycho-legal diagnostics. Even though the TBS-order is no longer the dominant outcome of the evaluation, and for most other frameworks there is no legal requirement of having a disorder, it still remains the point of reference for the forensic diagnostic evaluation by psychiatrists and psychologists. A pilot with a set of questions without diagnosing a disorder has recently been conducted. Assessments by the probation services in service of the trial focus much less on psychodiagnostics. In case of adolescent/young adult defendants, a question is added on the eligibility for juvenile justice. The standard set of questions for juvenile defendants is comparable, with more emphasis on developmental and educational or pedagogical aspects.

During the execution of sentences, especially risk and need for treatment remain important concepts, for example for decisions on leave or transfer respectively. For placement on an LFPZ ward, treatment prognostics come into play. For back-end sentencing decisions, again risk is the most important concept.

9.2.3.2 Mental disorder

Until 2020, the criterion for mental disorder in both criminal and civil law was 'a defective development or pathological disorder of the mental capacities'. Except for some minor editorial changes this criterion did not change since the first Dutch Criminal Code in 1886. Apparently, it sufficed for a long time, due to the fact that it was broad – acknowledging both a developmental and pathological cause for mental dysfunctioning -, not phrased in language of medical and/or behavioural disciplines and therefore could adapt to all changes and fashions within those disciplines. In case law it has been ruled that the criterion is not restricted to DSM-classifications, and could include a wider range of mental dysfunctioning.[51] Forensic assessors phrased their conclusions in both clinical diagnostical terms and in a classification.

This adaptability was particularly important because in Dutch law the criterion is a legal criterion, which has to be established by the court, possibly based on the answer to the relevant question in the forensic assessment, but it is not bound by this 'advice' and may substitute its own view on the matter. This does not often happen, but is more common in cases in which defendants refuse to cooperate with the evaluation and evaluators are unable, or hesitant, to diagnose a mental disorder. As refusal to cooperate is often prompted by the

wish to avoid a TBS-order, for which a disorder has to be established, the old criterion has only been kept in place for the imposition of that order (and the equivalent in juvenile justice, PIJ). In doing that the legislator wanted to avoid that no such safety measure could be imposed, even though the protection of society would demand it. This legislation was triggered by an infamous case of re-offending of a dangerous offender (Michael P.) who was able to avoid a TBS-order by refusing to cooperate with the forensic evaluation. Even more legislative changes were enacted, such as the possibility to request old medical records. A special multidisciplinary committee was installed to assess the relevance of these records for forensic evaluation, but it has not yet had any cases in practice.[52] The ECHR has acknowledged the possibility of establishing the legal criterion by the court in cases of refusing defendants as grounds for imposition of the TBS-order.[53] The evaluator is asked to explain what the attitude of the defendant was towards the evaluation, and if he refused to cooperate, to what extend, and in what way this impacted the answering of the questions.

However, as in new civil mental health laws the criterion for mental disorder was changed into more 'modern' language, also in all other provisions of criminal law, the new criterion is now 'mental disorder, psychogeriatric condition or intellectual disability'. This enumeration is explained by the fact that in 2020 separate civil mental health laws were created for coercion within the psychiatric side of the mental health system and within the institutions for psychogeriatric and mental disability care, and is therefore solely pragmatic and without too much contents. In practice, however, the distinction is quite hard as a lot of disorders that do not literally fall under these categories have to be added in lower provisions, while comorbidity between disorders (which is highly frequent within individuals) makes the distinction even more difficult. Although the intention was to not alter the principle in criminal law that it is the court that has to establish the criterion, the new terminology, more in line with the DSM-classification system, seems to shift the competence for establishment more to the behavioural disciplines.

9.2.3.3 Criminal responsibility[54]

The literal translation of the Dutch term for criminal responsibility *'toerekeningsvatbaarheid'* is something like 'susceptibility for attribution'. Attribution has a broader meaning within criminal law in light of the question whether offence behaviour can be attributed to the accused. It underlines the legal competence in deciding on the matter. Nevertheless, there has been elaborate discussion about the competence of forensic assessors to give advice to the court on this concept, as susceptibility seems to suggest a rather fixed capacity of the personality. Of course, non-responsibility is strictly related to the particular offence and not a permanent trait. In practice, the division of competences is not that rigid that the evaluator may give no advice about criminal responsibility. The only provision related to the concept is on non-responsibility: '*A person who commits an offense for which he cannot be held responsible due to a mental disorder, psychogeriatric condition or mental disability shall not be punishable.*'[55] It lacks any specific test as to which specific abilities should be impaired, as there was no consensus to be reached on the subject. Therefore the Dutch concept is an example of requiring a general (not specified) relation between the disorder and the offence. As such an open criterion allows for almost all sorts of causal relations between the disorder and the offence, which have been formed in legal doctrine, case law, and assessment practice, including internationally known criteria on cognition and volition.

This general causal criterion leaves room for (gradations of) diminished responsibility. The Dutch legislator however chose, in order to ensure consensus between classical and modern theorists, not to mention diminished responsibility in the criminal code, but in practice it

plays an important role. The gradual or dimensional approach to responsibility may indeed have more 'face validity', but automatically adopts problems in the reliability of assessment. Indeed the Dutch experience has shown that even something like 'percentage responsibility' can be developed in practice, but there are far too many gradations than can scientifically be distinguished.[56] At present the debate has focused for almost a decade on five versus three gradations, ever since the guideline from the Dutch Association of Psychiatry in 2013 seemed to suggest that five gradations (including severely and somewhat diminished) cannot reliably be distinguished.[57] Non-responsibility is generally reserved for cases of psychotic motivations, in which the offence may solely be explained by the disorder without any circumstantial factors. Many personality disordered or sexually deviant offenders are considered to have (somewhat) diminished responsibility.

In the execution of sentences criminal responsibility does not play a role. Of course other capacity issues may arise, for example, related to coerced medication, but these are not specific for sentencing law.

9.2.3.4 Dangerousness

In the Dutch Criminal Code, dangerousness is not defined by a fixed definition. A lot of criteria have already been mentioned in paragraphs 9.2.1 and 9.2.2, as there are risk-criteria in place for all kinds of decisions in sentencing. They differ in contents and strength, both in aim and in required likelihood. But these cannot consistently be related to the severity of the consequences of certain decisions. The highest bar, both in aim and in contents, for example, seems to be for extending the probation period of a conditional sentence to 10 years: '*if it must be seriously taken into account*' (likelihood) that reoffending will take place of an '*offence which is directed at or cause risk for the inviolability of the human body*' (aim). It would be more understandable if this were the criterion for the TBS-order, in fact, why wouldn't such a person receive a TBS-order? However, the bar for receiving a TBS-order is, in terms of dangerousness, lower, defined as *'if the safety of others, or the general safety of persons or goods demands the imposition of the measure'*. Even stranger is the fact that another criterion for that same decision on the probation period is '*if it must be seriously taken into account that the convicted person will again commit an offence that harms the health or welfare of one or more animals*'. Here a political – or electoral – agenda, of a few political parties that have made animal welfare their issue, peeps through into the criminal law. Similarly, in the recent civil mental health laws the agenda of patient interest groups is visible in avoidance of the stigmatising word – and its broad definition – dangerousness, in favour of 'a significant risk for serious disadvantage'. In civil law disadvantaging oneself is an additional criterion to those of others and society in criminal law. Of course, the diverse and inconsistent use of risk criteria is a result of the expanding sentencing arsenal with the impossible aspiration of controlling any risky situation.[58] Creating a logical and consistent system would require a complete revision of the sentencing provisions in the CC.

In the CC no provisions are in place for how the establishment of these criteria should be carried out, apart from requiring it to be multidisciplinary. Only for imposition of the TBS-order, the provisions state that other reports regarding the personality of the defendant, the seriousness of the offence, and the frequency and seriousness of former offences are taken into account by the court.[59] This is the remainder of a discussion in Parliament on whether or not to require relating the assessment of risk to these factors. As also a mental disorder is required, there is a debate in case law whether there should be a relation between the disorder and the dangerousness. This debate is also topical amongst evaluators, as traditionally the dangerousness is derived from the established relation between disorder and offence, while risk assessment research suggests that disorders in general are not a strong predictor for recidivism.[60] For civil

commitment the risk has to be related to the disorder, meaning that a general risk for (re-) offending does not suffice. In the standard questions for criminal pre-trial evaluation a compromise may be seen, in which the risk should also be described in terms of known risk and protective factors, other than arising from the disorder. Risk assessment in the Netherlands has traditionally been developed in relation to decisions in the execution of the TBS-order and back-end decisions. Those are situations in which there is a lot more clinical information present to draw from, than in case of pre-trial evaluation. There is still a lack of validated instruments for risk assessment that match the specific criteria during the trial phase.

9.2.3.5 Other relevant concepts

In relation to the last question of the pre-trial evaluation, concerning need for treatment, concepts such as treatability and responsivity are implicitly taken into account. Regarding civil commitment, also if warranted by a criminal court, effectiveness of the coerced care is an additional legal criterion. In the execution of a prison sentence (or provisional detention), need for treatment is relevant for decisions on internal or external transfer to a treatment facility. Traditionally, the criterion for external transfer was 'unfitness for detention' on a regular ward. In practice, this is still important, as the need for care or treatment is less noticed if a detainee easily manages his/her stay in the prison unit.

Finally, for 18–23 year-old-defendants, an additional question is added to the standard set of questions for pre-trial assessment on the eligibility for the application of juvenile sentences. Vice versa, for 16–17-year-olds, forensic assessors are asked to advise about the application of adult sentences. In practice, behavioural experts almost never find any reason to explicitly advise a juvenile to be convicted as an adult, and the severity of the offence is the most prominent reason for criminal courts to apply adult criminal law in the case of a 16- or 17-year old offender. The other way around, the advise to convict a young adult as a juvenile, is more frequently given by forensic behavioural experts. As the central notion behind 'adolescent criminal law' was to provide an effective and offender-oriented manner of sentencing, which does justice to the committed offence and which takes into account – as the law mentions – the personal circumstances of the offender, including his/her developmental phase, this may be considered a psycho-legal concept. Even though the legislator recognised the relationship between incomplete (biopsychosocial) development of adolescents and young adults, and recognised the superior effectiveness of the offender-oriented and pedagogical juvenile justice system in terms of better reintegration into society and prevention of re-offending, juvenile sentencing is still only rarely applied to young adults.[61] This is partly due to the lack of clear guidelines, both for behavioural experts as for legal practitioners in the criminal law system. Public prosecutors have developed a list of indicators that can be used as a basis for the decision to request the application of juvenile criminal law for young adults, including still living at home, still going to school, needing support because of mild intellectual disabilities and openness to educational support. Contraindications are the severity of the (alleged) offence and the criminal record of the young adult. Still, many public prosecutors (and judges) rely on intuition and experience. Social workers from the probation organisations often advise in an early stage, and recommend on applying juvenile criminal law, including (preventive) detention of the young offender in a juvenile institution instead of adult jail. Most behavioural experts use a standard weighing list as developed by the NIFP, thereby weighing concepts such as cognitive and adaptive skills of the adolescent and the (expected) responsivity of the adolescent to pedagogical interventions. Contraindications include the criminal record of the offender, a 'criminal lifestyle', psychopathic traits, and pedagogical impossibilities. Nevertheless, the concepts and dimensions to conclude with

regards to developmental delays in the young offender are still being discussed. Furthermore, the need to review contraindications as well as the starting point in the application of the law (adult criminal law for 18 years and older unless, instead of juvenile criminal law unless) is still debated, as no young adult under the age of 25 is fully or completely developed, neither biologically (brain maturation) nor psychologically.

9.2.4 Forensic assessment and procedure

With regards to forensic assessment in service of the trial, it is often the public prosecutor who decides whether forensic assessment is needed, and if so, by which behavioural discipline(s). As soon as a defendant is taken into custody, police officers, probation workers, and, for juveniles, the Council for Child Protection, can signal any mental problems, and advise the public prosecutor to ask for a comprehensive forensic behavioural evaluation. After three days, all (alleged) offenders are arraigned to an examining magistrate. At this point in time, psychiatrists or psychologists working for the NIFP are often consulted to do a short reviewing evaluation and provide a behavioural advise for further forensic assessment. The nature and severity of expected psychiatric disorders, nature and severity of the (alleged) offence, as well as the expectancy regarding a possible verdict of TBS or PIJ, guide the necessity and multidisciplinarity of the assessment.

The kind of the assessment will eventually be chosen by the public prosecutor, or, in case any questions on mental state or personality of the offender remain during the ongoing criminal process, by the examining magistrate or trial court, possibly on request of the defense counsel. If a sentence that requires multidisciplinary evaluation is not to be expected, a monodisciplinary evaluation suffices. In such a case, the nature of both the mental state and the offence points towards which discipline should be chosen. For example, one may expect a different examination of an individual with primarily psychotic or bipolar disorder than with a person with a personality disorder, or with interpersonal violence at home compared to violence within street gangs. Finally, the intensity of the examination decides between an examination in a cell in the remand prison or at an office of the NIFP (the so-called ambulatory examination) or a clinical observation in the Pieter Baan Centre (PBC) or the juvenile counterpart, to be ordered by a judge. An observation will last for six weeks in general, which time can be doubled whenever needed, for example, in the case of those persons who refuse to cooperate. Possibly, in case of group offences, as the interactions between the members of the group seem to be decisive for the aggressive outcome, a group observation may be organised. Observation within the PBC also includes a comprehensive survey of the social network of the defendant, by a trained social worker.[62] Rather new is the possibility of such a 'triple' variant, in combination with a multidisciplinary ambulatory examination, to prevent a clinical observation (because of pragmatic reasons such as a waiting list and the costs). As such the views of three behavioural experts (psychiatrist, psychologist, and social worker) will come together for a consensus meeting, comparable to a final observation meeting within the PBC. All biopsychosocial aspects of the defendant and the situational aspects of the offense will play a role in the decision about place, time, and involved experts. Methodologically it is important that both judges and behavioural experts know what the influence of the setting of the examination is on the outcome of its results. Clinical observations as well as ambulatory examinations may include further specialist diagnostics and reports from a neurologist, neuropsychologist, or other specialties, for example, in case of (suspected) psychogeriatric disorders or acquired brain injuries.

All evaluations lead to one or more written reports, which are discussed in court, but usually not with the authors themselves. Naturally, either one of the parties or the court itself

can ask the expert to further testify verbally in court, if there are any questions. In general, about 90% of the conclusions of the PBC evaluations are followed by the courts.[63] This percentage is lower for ambulatory evaluations, which is partly explained by the fact that these are cases with less severe offences or problems, creating more sentencing alternatives.[64] In about 20% of adult cases brought before a criminal court, forensic assessment by NIFP evaluators was performed. For juvenile cases, this is about 11%, which can also be explained by the fact that the Council for Child Protection writes reports as well.[65]

Within the execution of the TBS-order the prosecution is also competent in requiring forensic assessment as it has to be submitted to the court along with their request for prolongation. This is similar for both an evaluation from the TBS-facility or probation service, and a four-year report from independent NIFP evaluators.[66] For decisions on leave or transfer (to an LFPZ ward), the initiative is taken by the TBS-facility as they make an application to the Ministry. The screening being done for transfers within the correctional system is already explained in paragraph 9.2.2.2.

9.3 Safeguards for the quality of forensic assessment

9.3.1 Requirements in law and policy

The requirements that exist in law and policy can be divided in (a) general requirements for expert evidence for all forensic expertise in the CCP, (b) requirements for what type of forensic assessment should be done for a few impactful decisions within sentencing (mainly in the CC, already mentioned in paragraph 9.2), and (c) requirements in policy about what instruments to assess risk with for a few decisions within the execution of sentences.

Regarding the general requirements for experts, at the end of paragraph 9.1.2, it was already mentioned that since 2010 more extensive regulations for expert evidence can be found in the CCP.[67] The most fundamental change was the introduction of a register for experts (NRGD). As its rationale is mainly to safeguard the quality of the expert, its procedure will be discussed in paragraph 9.3.3. Some other requirement on the quality of the expertise can be found in the CCP. An examination needs to be in an area on which the expert possesses specific or particular knowledge. A written report is required – except when a judge specifically asks for an oral report –, which is truthful, complete, and to the best of the expert's knowledge. The report should be reasoned and '*if possible, the expert will indicate which method he has used, to what extent this method and its result can be considered reliable and what skills he has in applying the method*'.[68] Most behavioural scientific forensic evaluators, however, do not specifically comment on the reliability of their general diagnostic method, other than describing reliability and validity of one or more standardised assessment instruments or mentioning reliability issues in auto- or heteroanamnesis.

As mentioned in paragraph 9.2, for a few decisions a multidisciplinary forensic assessment is required. Even though the order existed since 1928, this requirement for the imposition of the TBS-order came into force in 1988. In that same legislative change many legal safeguards against disproportionate deprivation of liberty were introduced, for example, the appeal possibility to the decision on prolongation, and the independent multidisciplinary evaluation after six (now four) years (more on those in paragraph 9.4.2). The multidisciplinarity requirement for imposition was also very much rooted in the wish for more legal protection (initiated in the 1970s), but was specifically motivated to ensure 'maximum scientificity and due diligence'.[69] The option of requiring assessment in an observation clinic for all defendants was even discussed, but that was deemed unpractical. The demand that one of the examining disciplines is a psychiatrist may be viewed in light of the status of the medical

profession (at that time). Later, this requirement was similarly applied to conditional TBS, PIJ, and the transfer of a prisoner to a TBS-facility. In the text of the provision, it is stated that the report should be done by the experts 'together or each separately'. No specific motivation was given for these wordings, leading to a discussion whether multidisciplinarity was meant as having expertise and counter-expertise together. In practice it is almost often 'together', as there is generally a deliberation between the two experts, sometimes also together with experts from the NIFP and probation officers. Experts generally strive for consensus, but dissensus is possible and should be discussed in detail in the written reports. Arguably both a team assessment and a counter-expertise may count as safeguards for the quality of an assessment. A final safeguard for quality is that the assessment may not be older than one year before the trial, unless all parties agree.[70] In practice, assessments are generally finished shortly before the trial, so this provision is mostly relevant for a possible appeal.

In policy regulations, some requirements exist for the use of standardised risk assessment instruments. Since 2008, in the aftermath of the parliamentary inquiry report after incidents with TBS-patients on leave, it is required for TBS-leave applications to use instruments of standardised clinical judgement.[71] Later, this became also required in the prolongation advice format or LFPZ-application format for example. In the aftermath of an infamous case, Michael P., similar requirements would be demanded for the placement of a detainee in a (forensic) mental health facility. Since 2019, offenders of severe violent or sexual offences need a formal risk assessment and offence analysis before their potential transfer to a mental health facility during the prison sentence. The risk assessment instrument has to be tailored to the offence at hand, and the assessment cannot be older than six months.[72]

9.3.2 Disciplinary and ethical requirements

Under this heading, first the efforts of the NIFP to ensure the quality of forensic evaluations are addressed. Thereafter, relevant guidelines from scientific associations and the code of conduct from the NRGD are discussed. These are all mostly applicable to the evaluation in service of the trial. However, many aspects will also be applicable to assessment within the execution of sentences, although differences will be mentioned if relevant.

The NIFP may be involved in case selection. Even though it is the duty of the prosecution to decide which cases require forensic assessment, efforts are underway to discuss cases together with behavioural or legal experts from the NIFP. After an attempt to use a standardised instrument for case selection,[73] which was never completely adopted in practice, these deliberations seem to be an efficient way to already involve expertise into the decision. If a case is selected, the NIFP matches the case with a suitable evaluator. Since (especially psychiatric) evaluators are scarce at present, there are practical limits to the matching process. Juvenile and adult evaluations require specialised knowledge as well as registrations, while young adults (18–23-year-olds) may be examined by both specialties. With regard to specific cases, such as sex offenders, evaluators who are trained in using tailored risk assessment instruments are preferred.

Another important instrument for safeguarding the quality of an individual report is a so-called 'feedback' procedure. All forensic reports are, before they are sent out to the legal parties, reviewed by a colleague behavioural expert and a legal expert working at the NIFP. These reviewers provide the forensic assessor with constructive criticism on the traceability and readability of the report, and the feasibility and applicability of the advices. It remains however the responsibility of the assessor whether s/he processes and adapts the comments, thus guaranteeing independence as an important ethical requirement – and in line with

his/her own liability under disciplinary law. In the PBC the whole evaluation, including the conclusions, is being discussed with a peer and a legal expert in team meetings.

A more general safeguard which is already mentioned is the standard set of questions. The NIFP makes sure that with every change in legislation, this frame of questions is updated via expert meetings, including members of the public prosecution offices and courts. Moreover, there are regular deliberations with judges to test whether the set of questions is adequate for legal practice. In that sense, the NIFP is like a spider in a web, deliberating also with the disciplinary associations, NRGD (see next paragraph), the Prosecution and Ministry, for example about hours and financial compensation. The standard number of hours was recently updated to 23 hours for the psychiatrist and 27 hours for the psychologist (who is using more standardised instruments, questionnaires, tests). As an important part of the quality, as in usefulness for legal practice, is to have the report finished in time (before the trial), the NIFP keeps track of processing time as well. Finally, the NIFP provides education and supervision to become a registered expert, refresh courses, further training, assistance to and tools for evaluators, as for example a 'format' for the report (for all types of evaluations), which is being recommended but not obliged. After description of the diagnostic data collection and interpretation, including the conversation about the analysis of the offence, the format ends with forensic considerations and answers to the questions.

Although forensic psychiatry has been well connected to general psychiatry, it took until 2012 for the Dutch Psychiatric Society (NVvP) to set out disciplinary guidelines for forensic examination and reporting (a second version is now under construction, in which the NIFP is also involved).[74] For psychological evaluation, the Dutch Institute for Psychology (NIP) at present does not have a guideline, but the governmental NIFP has formulated some disciplinary recommendations, written down in a guideline in 2018.[75] Both the psychiatric and psychological guidelines build on existing guidelines for methodology in general psychodiagnostics, and add recommendations on (the translation to) the forensic context. Both cover adult and juvenile justice. An important aspect related to quality that is covered in both guidelines is the differential diagnostic considerations. It is stressed that the disorder may not be based on the indictment. Furthermore, methodology on how to assess criminal responsibility and risk is covered extensively, as well as some ethical issues.

Some relevant aspects of health law are not applicable to reporting to the court. For example, confidentiality does not exist in the relation between forensic expert and examinee, which differs essentially from the usual patient-doctor relationship in society. Whereas a pretrial evaluator is not allowed to have such a relationship, in the current nor in the past, the advisor from the TBS-facility on prolongation of the order generally does have a treatment relationship. The examinee, as a part of his legal position, should be pointed at this difference and also at the fact that he cannot stop the report from being transferred to the court. Although the examinee does not have the right to block the report, s/he has the right to read it at first hand, by which the examinee can point to some factual inaccuracies (such as date of birth or number of siblings) or may respond verbally or in writing to the contents of the report. The examinee's response to the content of the report is added to the report. Evaluators are required to provide clear information about the examination, their role in the trial process, the rights of the examinee, and the issued report, after which the examinee is able to provide informed consent for the examination.

As mentioned before, in the case consent has been refused, the expert witness still has to write a report to the court, not only informing about the refusal but also about the reasons (if available) for that, and all the attitudes and behaviours s/he has witnessed from the examinee. The examining psychiatrist and psychologist remain as professionals subordinate to the disciplinary law and behavioural codes of their profession, even though they act on behalf of the

court. Expert witnesses should be independent, impartial, and competent professionals. Other obligations for the expert, as mentioned in the Code of conduct of the NRGD,[76] include: remain within the limits of your assignment and your expertise, report every significant (attempt to) influence the execution of your assignment, ensure the required quality of the evaluation, keep the gathered information available for counter-expertise, ensure a comprehensible, properly reasoned, verifiable and timely report (be prepared to submit your report to fellow professionals for assessment), supplement a provided report as far as necessary on the basis of further information, maintain and develop your professional competence.

9.3.3 Requirements for the evaluator

Requirements that are in place to safeguard the quality of the evaluator in general are training and registration. However, these are more or less connected, as accomplishing the forensic training by e.g. the NIFP leads to an initial registration in the NRGD. The total duration of theoretical training courses is nine months for one day a week, during or after which at least five different forensic reports are written under supervision of a trained and registered supervising colleague. Registration takes place after a written and oral exam in which three reviewers, including a representative from the NRGD, assess the applicant on at least three of the applicant's forensic reports. Prior or partly during the training to become a forensic expert, applicants should have completed training and registration as a psychiatrist or as a health care psychologist (which takes a total of at least 10.5 or 6 years respectively).

Assessors who act as an expert in a criminal case should be registered in the NRGD. Only in exceptional cases, non-registered experts can be appointed to report by an examining magistrate, usually in the case of special expertise for example on the type of disorder. Every five years a registered expert is required to re-register, during which the applicant should report on further training and followed conferences and the number of hours of intervision with other behavioural experts. There is also an association for forensic evaluators, which aids in reaching these goals, just like the NIFP. During re-evaluation, representatives of the NRGD again evaluate at least two (anonymous) forensic reports written by the applicant. In the Resolution Register Expert in Criminal Cases,[77] the criteria for a positive decision on the application are mentioned. They include: sufficient knowledge and experience in both the own discipline and the legal context, able to write an understandable report, again timely, and once more independent, impartial, diligent, skilled, and honest. These requirements are preceded by a criterion for the discipline itself. It should be: a well-defined area of expertise of which it is plausible that meaningful, objective, and reliable information can be provided on that basis and that, in the opinion of the Board, has been developed in a such a way that the findings can be tested and justified on the basis of shared standards. Interestingly, most disciplines acknowledged by the NRGD have substantive additional standards in place, including legal psychology, while the extra standards of the clinical behavioural disciplines are mostly procedural.[78] It underscores the exceptional position of these disciplines, both in terms of difficulty to be judged like (other) empirical disciplines, and in terms of its traditional value for the practice of criminal law.

9.3.4 Enforcement of requirements

The requirements for the quality of the evaluator under 3.3 are of course enforced by the (re-) registration procedure of the NRGD itself. Experts may loose their registration, or receive a conditional registration, if the standards are not yet completely met. However, being a registered expert, does not automatically mean that all your reports are of sufficient quality (if only

because re-registration is done on cases that someone can select him/herself). For every individual evaluation, even when registered, an expert is appointed by a magistrate. If a court is not satisfied that the quality of the evaluation is sufficient, it will for example leave the report out of consideration, as it did in a case of someone who claimed to be an expert in non-verbal communication and micro-expressions, but draw conclusions outside that area of expertise.[79] When more reports are present in a case, the court may use arguments on quality of the report, to dismiss its conclusions in favour of those of a report which is deemed of higher quality.

Disciplinary 'malpractice' cases, based on health law, regarding forensic assessment are scarce. Only disciplines that fall under the Professions in Individual Health Care (BIG) can be liable. Therefore, assessments by probation services for example cannot be challenged through this way. Some case law exists on cases in which the evaluation was completely done on file information and the examinee was never seen. However, in cases of defendants refusing to cooperate, the attempt to talk to someone can qualify as 'seen' already, after which conclusions may be drawn for example on information from files, observation or conversations with network members.[80] Also some case law exists on the right to correct information. If a complaint is filed against an evaluator, the norm applied is generally whether this was an act or omission contrary to the care that the healthcare practitioner should exercise in that capacity.[81] To judge how an evaluator should act will probably be based on the guidelines as mentioned earlier in paragraph 9.3. A concern is that disciplinary committees often do not have enough 'feeling' for the forensic population, among which are also a few frequent complainers.[82] Even though complaints are generally not considered well-founded, the procedural hassle for the evaluator is enormous, while a founded complaint may lead to serious consequences from a fine or (a warning to) being removed from the BIG-register.

9.4 Safeguards 'against' the limited quality of forensic assessment

9.4.1 Questioning the assessment by the defense

In the Dutch inquisitorial trial procedure, expert witnesses are called by the court itself. However, the parties may apply to the court for calling the expert witness. If the expert has also written a report, this is generally granted. First the court questions the expert, but after that the prosecution and defense counsel are allowed to ask questions as well. Regarding forensic assessment the counsel can also take other initiatives. Counsel can apply for forensic evaluation to the prosecution, the examining magistrate, or later the trial court.[83] Moreover, the defense can take the initiative to suggest a particular (registered) expert already for the initial assessment, for example, if the defendant trusts this expert.[84] This may also aid not refusing to cooperate with the assessment. These provisions apply for both an initial assessment, as well as a counter-expertise. Of course, if there already is an initial report, the court will judge an application for a second report differently. The criterion used in case law is whether the court considers itself sufficiently informed.[85] It proves to be quite hard for the defense to motivate why counter-expertise is necessary, especially if the report comes from the highly esteemed PBC. The questioning in the trial may also be used for this argument.

Two other options that exist in the CCP to test the quality of an expert evaluation are not often used for behavioural scientific assessment. First of all, a controlling expert may be appointed by the defense, also to be present during interactions with the defendant.[86] This accompaniment is less imaginable in case of a diagnostic interview than in case of DNA-analysis for example. The alternative of audio(visually) recording such interviews, is also uncommon. Another option is to have the report evaluated by another expert.[87] It has been argued that these options should be explored more, for example in having an observing

expert present during a meeting between the evaluating experts, or in the PBC, in which the conclusions are discussed, to monitor the process.[88]

Another possibility the defense may use, commissioning an assessment itself, is not provided for by law. In practice, a few difficulties have to be overcome regarding this adversarial initiative. First of all, via this route there is no option to have the defendant placed in the PBC. This has led to complaints from the perspective of equality of arms, which in this inquisitorial system is not completely applicable. Moreover, the costs of the evaluation have to be advanced by the defense (or defendant). If a report is eventually used in court, counsel can motivate afterwards that the costs have to be reimbursed by the State.[89] However, counsel generally wants to have the opportunity not to submit the report in the proceedings, for example, if the conclusions are not in line with the desired strategy, rendering reimbursement of the costs unsure. Especially this strategic use, and the uncertainty whether the report will be used in court, is one of the reasons that most experts are reluctant to evaluate individuals commissioned by the defense. For example, the idea that an assessment of high risk for violent reoffending will not reach the court, weighs on their conscience, apart from concerns about influencing attempts by the defense or to be viewed as a 'party-expert', or not having the quality safeguards from the NIFP in place.[90] Most of these concerns are or may be remedied. The NIFP has circled the policy that feedback will be provided also for reports commissioned by the defense, while a 'quick scan' of the initial report by an expert on request of the defense, whether other outcomes by a plausible outcome of a second evaluation, is being used by certain experts to mitigate the costs.

Of course, if there is an option for appealing the court decision, this would be a possibility to have another court look at the evaluation, or have a new evaluation in place. Most of these regulations apply, *mutatis mutandis*, to court decisions within the execution of sentences, such as prolongation of the TBS. The difference is that in such a proceeding the initial assessment is being done by the TBS-facility in charge of treating the offender. A placement on an LFPZ-ward may be for example appealed by the RSJ. But in general, from the perspective of the counsel there are very few options to effectively challenge the course of treatment.[91] The TBS-provisions allow for applying for transfers (also for second opinions) or for an observation in the PBC, for the necessity of which the Ministry has to be persuaded. In general, in contesting forensic assessment much depends on the initiative and specialist knowledge of the defense counsel. There is an association for TBS-lawyers to promote such knowledge, but not all TBS-patients have a lawyer that is part of that association, while it is legally the responsibility of the patient to have a good lawyer.

9.4.2 Questioning the assessment by the court

Indeed in this inquisitorial process, the court is leading in questioning the assessment, even if calling the expert to court was applied for by one of the parties. For the decision on calling the witness, a timely finish of the report is essential. As mentioned, it is not self-evident to call experts to court. Efficiency deliberations often lead to decisions based on written reports. Procedures for judicial bodies within the execution of sentences are also inquisitorial in nature. Since many questions already have been answered, questioning by the parties does not really have the nature of a cross-examination. As mentioned in paragraph 9.2 (especially 9.2.4) courts often follow the conclusions of the assessment, even though they have the competency to substitute their own conclusions. In paragraph 9.5 it will be discussed how courts could decide in case of differences of opinion. If the court does not consider itself sufficiently informed, it may commission expertise or counter-expertise itself.

The conclusions of the forensic evaluation are considered an advice. This means that it is only

a part of the other facts and circumstances which the judges use in their sentencing decision. As the education of the expert witnesses tells them how to put their reports into words the judges can understand, as such the judges and public persecutors have their own options for training to understand forensic reporting at their education centre (SSR). There is also a knowledge circle for TBS and warranted care within the judiciary, in which relevant knowledge is shared and which also organises conferences. Membership of this circle is however not obligatory. Some larger courts have special teams in place for TBS-decisions, but courts with fewer judges have not. Although there have always been debates about strengthening the behavioural expertise within judicial bodies, even the court deciding on prolongation of TBS consists of three members from the judiciary. Only in the Penitentiary chamber, dealing with all sorts of appeals to court decisions within sentencing, two behavioural expert members are added to 'strengthen the expert element' in the decision. However, the fact that their influence in the secret deliberations for decision-making may not be (con)tested, has been criticised.[92]

9.4.3 Other questioning of the assessment

The Dutch legal system does not know a 'friend of the court' (*amicus curiae*), nor a possibility for intervention in a single case concerning the quality of forensic assessment by any others, including bodies mentioned earlier, like the NIFP.

Only regarding the execution of the TBS-order, the legislator has provided for obligatory counter-expertise, for example for prolongation and for (continued) placement on an LFPZ-ward. This is understandable, as the initial advice is being given (or application is being made) by the treating TBS-facility. In addition, the continuation of the order is considered a very severe infringement on the right to liberty, solely based on forensic assessment, and LFPZ-placement is considered a loss of perspective on liberty. The independent multidisciplinary advice for prolongation used to be after every six years, but on the grounds of the wish to reduce the mean duration of the intramural TBS-treatment, is now every four years. The decision on continuation of stay on an LFPZ-ward, including independent assessment, used to be every three years, and is now every two years (also to be in line with the timing of decisions on prolongation of the order itself).

The presence of behavioural experts in some decision-making bodies, like the RSJ (for appeals concerning decisions on the internal legal position, including transfers) and the Penitentiary Chamber (for decisions on the external legal position, the framework for deprivation of liberty), serves in a sense as a (peer) review on the expert assessment. The same applies to many advisory bodies (for example for TBS-leave, for pardoning a life sentence, et cetera).

9.5 Safeguarding the quality of decision-making when confronted with disagreement between experts

9.5.1 Dealing with disagreement

In a multidisciplinary evaluation, it may occur that the psychiatrist and co-reporting behavioural expert (mostly a psychologist) disagree on the conclusions. As mentioned in paragraph 9.3.1, they generally discuss the outcomes of their separate evaluations, and strive to consensus. However, if they cannot find agreement on (some of) the conclusions, the guidelines require them to both discuss and explain their differences in their respective reports. For the obligatory counter-expertise on the advice of the TBS-facility for prolongation or application for LFPZ-placement described in paragraph 9.4.3, the standard set of questions is already phrased in terms of agreement and explanation of any disagreement.

Even though disagreement may occur in any case, especially in exceptional cases of scientifically more uncertain matters, disagreement occurs more often. It is no surprise that a famous case in which about six evaluations were being done by several instances, was a case of double homicide by an asylum seeker after a change in his antidepressant medication. Complicating factors here were the intercultural and pharmacodynamic aspects. It led to very different conclusions on the presence of a mental disorder at the time of the offence and the level of criminal responsibility.[93] The case has also led to a complaint from pharmacological experts against one of the evaluators to the university he works for, however without any consequences.[94] As this obviously showed that the state of the discipline on the issue was one of uncertainty, the Court of Appeal was explicitly critical about the fact that even the PBC-report did not mention this.

> *After all, it is of great importance […] to find out whether there are differences of opinion between the reporting experts themselves, and with other members of the interdisciplinary consultation, about the quality of the evaluation conducted and the conclusions drawn from that evaluation. Only such openness enables the court to assess the reliability and the traceability of the expert's report for the decisions to be taken. Whether a report stating differences of opinion between experts is useful for those decisions is at the discretion of the court, not of the experts.*[95]

That last remark is related to the idea among experts that judges are not helped with differences of opinion. With regard to the required openness of the experts about the state of scientific evidence, the appellate court also referred to the NRGD Code of Conduct in which it is stated that: 'If the findings within the relevant area of expertise can reasonably lead to differing interpretations or conclusions, the expert shall report this when providing information or when issuing that report.'[96] Again, it shows that the NRGD standards are tailored more to (natural) empirical sciences, because this standard may have to lead to a general disclaimer for behavioural forensic assessment. And in defense of the experts, little research is being done on difference of opinion.[97]

A first option for a decision-maker when confronted with conflicting conclusions is just to make a decision. An analysis of case law[98] suggests that most often one of the reports is being followed, with no particular favour for an initial or counter-expertise,[99] motivated by the fact that this report seems more reasoned and understandable. For example, when it is a report from the PBC, which is generally more elaborated as a team effort, this argument is used. In fewer instances the court substitutes its own, third, position on the matter. In cases of the obligatory counter-expertise of TBS-prolongation, in about half of the cases there is some disagreement. It is apparent that the independent experts reported more in favour of the individual. In about two-thirds of the cases, the court follows the independent expertise. This is partly explained by the difference in advising a prolongation of one or two years, which is quite a 'safe' decision. When it comes to disagreement on conditional release, the court follows the initial experts in about 50%. Even though courts seem prone to speed things up, arguments may then be that the TBS-facility knows the individual better because they see him everyday instead of in two meetings.

In literature, there is some support for courts' ability to break through the 'expert-paradox', which means that the court has to judge the quality of the expertise without having the expertise. The court may ask questions on the methods (and level) of acquiring knowledge and the state of the discipline.[100] However, when the decision-maker finds it too difficult to reason which advice to follow – the criterion of not considering to be sufficiently informed seems similarly applicable – it could ask for a third opinion, or more (as we saw in the discussed case).

9.5.2 Best practices

In literature, an expert meeting is suggested in case of differences of opinion, with a debate on the timing of this meeting, either prior to the trial or in front of the court – lawyers prefer the latter.[101] Such a meeting may show some similarities with the best practice that has come up within the execution of the TBS-order, in case treatment takes a very long time (it started out as a pilot for 15+ years) for example because of an impasse in the treatment. The Ministry introduced a so-called 'care conference', which is a case conference, with all the parties involved: Ministry, clinic, patient, lawyer, third experts, probation service, possible follow up facilities, et cetera. Quite often, disagreement about the diagnosis or the course of treatment is such an impasse. It shows to be a highly valued instrument and quite effective in reaching its goals: out of the box brainstorming, shared problem ownership, and taking trajectories responsibly forward.[102] Lawyers may request such a conference, just as they may also request an official meeting with the clinic, which often already helps in aligning the patient and the clinic.

9.6 Critical reflections

In the body of this chapter some critical reflections have already been made, which are briefly summarised here. From the positive side, it should be mentioned in advance that the Dutch tradition of forensic assessment is deeply rooted in the practice of criminal law, is frequently used, and has quite an impact on decision-making. Forensic care is and has been extensively used, in a highly flexible sentencing system, creating a lot of decision-making in which expertise is requested. Many parties are involved in trying to safeguard the quality of this expertise.

Critical comments have been made concerning the ever-growing sentencing arsenal, with the impossible aspiration of reducing all re-offending risk. The consequential sprawl of different dangerousness criteria is, both in terms of substantive and procedural requirements, inconsistent with the severity of the consequences. It also does not easily match the existing instruments for (standardised) risk assessment, while in many cases psycho-legal concepts do not have to be established with the aid of behavioural expertise at all. Many discussions on relevant concepts, especially regarding criminal responsibility, are typical for the Dutch context. Similarly, the inquisitorial justice system and the strive for consensus, may overestimate the reliability of the expertise (underestimate difference of opinions) and render the assessment less scrutinised. The strongest safeguard for the quality of assessment, the register and its procedure, do not necessarily ensure the quality of assessment in a single case. The instruments in the CCP for that, as well as the standards of the NRGD, are tailored more to the (natural) empirical sciences and are not always applicable for clinical behavioural expertise. Even though this has had a positive effect in opening up the tradition of too little transparency about the state of the discipline, there is more to gain and tailor. Obvious recommendations are: more research on the quality of forensic assessment and reporting, further interdisciplinary training of all the parties involved in sentencing, and a continued debate involving all these parties on how to further safeguard the quality of forensic assessment within the particular disciplines at stake, in all its elements, both in service of the trial and within the execution of sentences.

Notes

1 Van Koppen and Penrod, 2003.
2 Nijboer, 2000.
3 See Mevis and Van der Wolf, 2021.
4 Schwikkard, 2008.
5 Van der Wolf et al., 2010.

6 Groenhuijsen and Selçuk, 2014.
7 Outside the issue of assessment, this feature is also under debate when it comes to victim impact statements, which also only influence the sentencing decision, but may have psychological consequences for both victim and offender if the defendant is afterwards found not guilty of committing the crime and as a result no decision on sentencing is made. Keulen et al., 2013, with a Summary in English.
8 Grootelaar and Van den Bos, 2018.
9 Mevis, 2015.
10 Van Marle et al., 2012.
11 Gremmen, 2018, with a Summary in English.
12 Jacobs and Van Kampen, 2014.
13 Parts of this paragraph are based on Van der Wolf, 2013 (in Dutch).
14 Strange as it may sound, this legislation introduced by the occupier remained in force after regaining sovereignty.
15 J.N. Ramaer was, with colleagues, also co-founder of the Dutch Society of Medicine (KNMG; in 1849) and the Dutch Psychiatric Association (NVvP; in 1871).
16 See for more background on the origins of the TBS-order: Van der Wolf and Herzog-Evans, 2014.
17 See Koenraadt, 1987, who refers to the Groningen school and Utrecht school.
18 See Van der Wolf and Van Marle, 2018.
19 See Hoving, 2017, with a Summary in English.
20 Nauta, Abraham and Pieters, 2020, in Dutch.
21 Van der Wolf and Herzog-Evans, 2014.
22 De Keijser, 2011.
23 SC 10-09-1957, *NJ* 1958, 5. See Van der Wolf and Herzog-Evans, 2014.
24 De Ridder et al., 2018, with a Summary in English.
25 See, also for this terminology Tak, 2008, p. 137.
26 Van Wingerden and Drápal, 2018.
27 Art. 9a CC.
28 See Van der Wolf and Mevis, 2021.
29 See Schmidt, Rap and Liefaard, 2020.
30 Kooijmans, 2002, with a Summary in English.
31 Van Kordelaar, 2018, in Dutch.
32 Art. 14a CC.
33 Jacobs, Van Kalmthout, and Von Bergh 2006, with a Summary in English.
34 Art. 37a-38j CC.
35 Art. 38m-38p CC. See also Struijk, 2015.
36 Art. 38z CC. See also Struijk and Mevis, 2016.
37 See art. 77a–77gg CC.
38 Parts of this paragraph are based on Van der Wolf and Mevis, 2021.
39 See Hucklesby et al., 2016.
40 Art. 14b CC.
41 De Vries Robbé, Van den End and Kempes, 2021, in Dutch.
42 For a complete description of the possibilities, see Van der Wolf and Mevis, 2021.
43 Art. 6:6:12 CCP (Code of Criminal Procedure).
44 Parts of this paragraph are based on Van der Wolf and Mevis, 2021.
45 Art. 6:2:10 CCP.
46 Uit Beijerse et al., 2018, with a Summary in English.
47 Art. 6:1:18 CCP.
48 Van Hattum and Meijer, 2016.
49 Art. 38 g CC.
50 Art. 6:6:33 CCP.
51 CA Den Bosch 11-10-2011, *LJN* BT7167.
52 See art. 37a under 6–9 CC.
53 See Kooijmans and Meynen, 2017.
54 Parts of this paragraph are based on Van Marle and Van der Wolf, 2018.
55 Article 39 CC, own translation.
56 See Zeegers, 1981.
57 NVvP, 2013, in Dutch. A new guideline is in the making, so the discussion continues.
58 See Struijk and Van der Wolf, 2018, in Dutch.

59 Art. 37a under 5 CC.
60 See Bijlsma et al., 2019.
61 Schmidt, Rap, and Liefaard, 2020.
62 See Koenraadt, Mooij, and Van Mulbregt, 2007.
63 Boonekamp et al., 2008, in Dutch.
64 Canton, 2004, with a Summary in English.
65 Van Kordelaar, 2020, in Dutch. For cases in front of a three judges court, as for less severe cases one judge may suffice.
66 Art. 6:6:12 CCP.
67 See art. 51i-51m CCP.
68 Art. 51 l under 1 CCP.
69 See Van der Wolf, 2012, with a Summary in English.
70 Art. 37a under 3 CC.
71 Next to the HCR-20 an instrument was created specifically for the TBS-context, called HKT-30. Werkgroep Risicotaxatie Forensische Psychiatrie, 2002, in Dutch.
72 Artikel 5.2 van het Besluit forensische zorg.
73 Van Kordelaar, 2002, with a Summary in English.
74 NVvP, 2013, in Dutch.
75 NIFP, 2018, in Dutch.
76 NRGD, 2016.
77 Art. 12 Resolution Register Experts in Criminal Cases.
78 NRGD, 2018, in Dutch.
79 DC Zeeland-West-Brabant 27-01-2021, ECLI:NL:RBZWB:2021:280.
80 See Kempes and Van der Wolf, 2018, in Dutch.
81 Art. 47 under 1, a, Wet BIG.
82 Prinsen and Groothuizen, 2019, in Dutch.
83 Art. 150, art. 176, art. 315 under 3 CCP respectively.
84 Art. 227, under 2 CCP.
85 E.g. CA Arnhem 9-07-2011, ECLI:NL:GHARN:2011:BQ7584.
86 Art. 228 under 4 CCP.
87 Art. 230 under 2 CCP.
88 Hummelen, 2018, in Dutch.
89 Art. 591 CCP.
90 Drees et al., 2020, in Dutch.
91 See Van der Wolf et al., 2016, with a Summary in English.
92 See Van der Wolf, 2010, in Dutch.
93 See SC 12-12-2016, ECLI:NL:HR:2016:2838 and SC 14-3-2017, ECLI:NL:HR2017:417.
94 Van Wijngaarden, 2016, in Dutch.
95 CA Arnhem-Leeuwarden 11 December 2014, ECLI:NL:GHARL:2014:9618.
96 See III Ad II.5 NRGD Code of Conduct.
97 See Drees et al., 2020, in Dutch, for an analysis of case law, and Kempes and Van der Wolf, 2018, in Dutch, for a vignette study, supported by the NIFP.
98 See Drees et al., 2020, in Dutch.
99 Even though in the case law it could not be distinguished who initiated these counter reports.
100 See Giard and Merckelbach, 2018, in Dutch; and Hoving, 2017, with a Summary in English.
101 See Drees et al., 2020, in Dutch.
102 Oosterom et al., 2019, in Dutch.

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