Summary

Length of stay in forensic psychiatric hospitals

Numbers and possible explanations

Background and research goals

The number of individuals with a mental disorder who have committed serious violent or sexual offences (forensic psychiatric patients) in the Netherlands has increased strongly in the last 20 years (from 405 individuals in 1990 to over 2100 in 2010). The increase was caused by an increase in the number of new patients, a lack of patients finishing their treatment and moving out of the forensic psychiatric centra (fpc) and an increase in the length of stay necessary to complete the treatment successfully. Due to the strong increase of new patients in a relatively short period of time, beds to treat these people in special hospitals became scarce and long waiting lists developed. Until recently, these problems have played a dominant role in forensic psychiatric practice in the Netherlands. Several studies have looked at ways to decrease the shortage of beds, the waiting lists and related problems. The most recent large scale study was conducted by a Parliamentary Committee, who published their report in 2006. Despite the fact that these studies led to new rules and regulations in the forensic psychiatric sector, the lack of hospital beds and waiting lists continue to be a problem.

Research into the length of stay in the hospital is important for a number of reasons. For one thing, as is mentioned above, it is one of the reasons there is a lack of hospital beds. Also, some lawyers advise their clients not to participate anymore in psychological and psychiatric assessment that is necessary for getting mandatory treatment in a forensic psychiatric hospital, called a ‘tbs-order’ (disposal at the state due to a mental disorder; art. 37a, b Dutch Criminal Code), because the length of stay in such a hospital has increased in the past years. This causes clients to refuse to participate in the assessment which makes it more difficult to impose a tbs-order. As a consequence, individuals no longer receive the best treatment for their mental disorders. A third reason research into the length of stay in forensic psychiatric hospitals is necessary is that several policies of the Dutch Ministry of Justice are based on an average length of treatment of six years, whereas it is unknown if this is still accurate. The Dutch Ministry of Justice asked their Research and Documentation Centre (Wetenschappelijk Onderzoek- en Documentatie Centrum; WODC) to conduct a study into the increase of the length of treatment in the fpc and reasons behind this increase. The results of this study are described in the present report.
The main goals of the study were:
1 to provide insight into the length of stay in forensic psychiatric hospitals in the period 1990-2009
2 to provide insight into the reasons behind the developments found in the length of stay in the period 1990-2009

The developments in the length of stay were examined first, followed by an examination of reasons behind these developments. To meet the second goal of the study, possible explanations in four main domains were examined. These themes were policy measures, risk assessment and risk management, the system of going on leave of absence out of the hospital, and the supervision and aftercare system. The present study consisted of studying the available literature, conducting two expert meetings, and analysing several datasets. The datasets that were used were the Monitor Information System Tbs-patients (Monitor Informatiesysteem Tbs; MITS) and the Research and Policy Database for Judicial Documentation (Onderzoeks en Beleidsdatabase Justitiële Documentatie; OBJD).

Due to the short time frame in which the study had to be conducted (January to October 2010) and the complex research topic, it was not possible to examine all possible explanations for the increase in length of stay. Therefore, the focus of the present study was on policy measures and not so much on developments inside the forensic psychiatric hospitals. In Chapter 1, the method section, the research questions that we could not answer within the studies’ time frame, are listed.

Results

Developments in the length of stay of tbs-patients

Length of stay in an fpc in the present study was defined as: ‘the total length of stay, starting at the first day of the admission to the first forensic psychiatric hospital and ending at the day the stay in the hospital ends. The time spent in prison waiting for a bed in the hospital for mandatory treatment is not included. Periods of special leave (proefverlof), conditional release (voorwaardelijke beëindiging), time spent in a remand centre and periods of absence without leave are subtracted from the length of stay. In the present report results of analyses of time spent waiting for treatment in prison, periods of special leave and conditional release are presented separately. For so-called longstay tbs-patients (those who will probably never leave the secure hospital), the length of stay was calculated separately. For reasons of legibility, the length of stay in a forensic psychiatric hospital is referred to as shortly ‘length of stay’.
There are three statistical methods to determine the length of stay: a method based on influx cohorts, a method based on outflow cohorts and a method based on examining the length of stay on a set day. Length of stay for influx cohorts was determined by examining the average length of stay of all patients that were admitted in the first forensic psychiatric hospital in a certain year. Length of stay for outflow cohorts was calculated by examining the average length of stay for patients that left the forensic hospital in a certain year. The three statistical methods each have their advantages and disadvantages. The main disadvantage of the last two methods is that the length of stay is underestimated. Since calculations of length of stay based on influx cohorts are most reliable, the analyses in the present study were based on this method. The main disadvantage of numbers based on influx cohorts however, is that it takes some time before the length of stay can be calculated reliably, since patients need time to undergo treatment. For this reason, throughout the report, when necessary, the results are completed by adding information based on the other two methods.

The results showed that the length of stay increased gradually in the last twenty years, with the exception of the length of stay in 1995 compared to 1994 (influx cohorts) in which a relatively strong increase was seen. The gradual increase was shown univocally by the three statistical methods. The length of the increase differs depending on the statistical method that was used to calculate the increase. The increase is 2.8 years in a period of nine years (influx cohorts 1990-2009), 4.2 years in a period of 19 years (outflow cohorts) and 0.9 years in a period of seven years (1 January 2004-1 January 2010). The present length of stay is 9.8 years (most recent influx cohort – 1998). Based on the other two methods, the most recent length of stay that can be calculated is 8.4 years (outflow cohorts) and 5.4 years (set day 1st January 2010).

The increase of length of stay was substantiated by several other findings. The number of tbs-patients leaving the hospital has declined and in the period 1981-2000 fewer patients leave the hospital each year. The percentage tbs-patients that leave the hospital within six years of treatment has declined from 60.3% (oldest influx cohort, 1981) to 18.9% (most recent influx cohort, 2000). This is a decline of more than 41%-points. Several policy measures are based on an average length of treatment of six years. These results suggest that this is not an empirically correct number.

We then looked at subgroups within the tbs-population, to determine whether the increase in length of stay could be attributed to an increase in length of stay in one or more specific subgroups. Within the scope of the present study, we were able to look at the subgroup of sex offenders, of longstay tbs-patients and of those patients who go through treatment relatively fast.
(there was no information available on other criminal history or type of psychological and psychiatric disorder). The results showed that the outflow of tbs-patients who have committed sex offences has also decreased: the amount of sex offenders who leave the forensic psychiatric hospital within six years has declined from 20% (influx cohort 1990) to 11.6% (influx cohort 2000). This means that the length of stay for sex offenders has also increased. The results show further that sex offenders among tbs-patients stay longer in the forensic psychiatric hospitals than patients who have committed other offences: after six years of stay 11.6% of sex offenders leave the hospital, as compared to 18.9% of the total group of offenders (influx cohorts 2000).

For the longstay tbs-patients an average length of stay of 14.1% was found at 1 January 2010. This is an increase of seven years as compared to the length of stay at 1 January 2004 (when length of stay for longstay tbs-patients was 9.7 years). The increase in length of stay of longstay tbs-patients is inherent to the characteristics of this subgroup; they are put in a separate facility for longstay tbs-patients due to the lack of possibilities of reintegration into society. Because of the fact that the length of stay for this subgroup was reported separately, there are no consequences of this increase for the total group of tbs-patients.

The tbs-patients with the shortest length of stay, the first 25% of the outflow of a certain influx cohort, was the last subgroup we looked at separately. Also for this subgroup, an increase in length of stay was found. For influx cohorts 1990 to 1999, the length of stay increases from 5.1 years to 7.1 years. The increase was rather sudden between the influx cohorts 1994 to 1995.

To determine whether the increase in length of stay could be explained by a decrease in length of stay in other phases of the tbs-order, the duration of time spent in prison waiting for mandatory treatment, special leave and conditional release were calculated. The average length of time spent in prison waiting for treatment and the period of special leave increased in the researched period (influx cohort 1998 compared to influx cohorts 1990). The time spent waiting in prison increased from 135 days to 292 days and the period of special leave increased from 296 days to 445 days. The average length of stay under conditional release did not change much (326 days in 1990 and 351 days in 1998). These results suggest that the increase in length of stay inside the forensic hospital is a robust finding, which is not compensated by a decrease in length of stay in other phases of the tbs-order. The total length of stay in the other phases of the tbs-order also increased and is for the most recent influx cohort almost three years. Within the scope of the present study, it did not become clear how many tbs-patients spend time in these three phases and how much time each individual should add to the length of stay.
Policy by the Dutch Ministry of Justice

From the analyses of changes in legislation and issuing of rules, it was shown that the main problem in the tbs-sector was a lack of beds in forensic psychiatric hospitals. Due to the lack of beds, waiting lists evolved and tbs-patients had to wait a long time in prison before they could start their treatment in the forensic psychiatric hospital. The lack of beds was a result of an increase in the number of impositions of the tbs-order, an increase in the length of stay and a congestion in outflow. By taking measures in these three areas, it was attempted to tackle the shortage of beds and waiting time in prison. Most measures also had the safety of society as a short-term or long-term goal. From 2000 onwards, this became a more prominent goal. The policy measures further had controlling the increasing costs of the tbs-order as a sub goal.

There was some overlap in the goals behind the different policy measures. For instance, for the problem of the long waiting lists, treatment modules were started up in the prison system (such as preclinical treatment and preclinical intervention modules). However, of these treatment facilities it was also expected that they could decrease the time necessary for treatment in the forensic hospital, since treatment was started up sooner. Below is a short review of the main policy measures that could have influenced the length of stay in the forensic hospital. Due to the fact that the length of stay increases gradually, without any main peaks or drops, determining the influence of individual policy measures is difficult.

To determine the possible influence of changes in policy for longstay tbs-patients, the length of stay for this subgroup was determined and compared to the length of stay of the other tbs-patients. Further, changes in policy for longstay tbs-patients were examined for possible influence on this subgroup. In 1998 the first criteria for placement on a longstay ward were articulated. A tbs-patient who had stayed in two separate forensic hospitals over a period of six years (six year-criterion) and whose risk level had not decreased to an acceptable level, was eligible for placement on a longstay ward. In 2005 this six year-criterion was replaced by a criterion in which the untreatability of a patient was more important, independent of the length of stay (risk-criterion). In this manner it has become possible to put a tbs-patient on a longstay ward when it becomes clear that his risk level will not go down further. After 2005, an increase in longstay tbs-patients is seen. It is not clear if their average length of stay is shorter or longer than six years of treatment. The results do show that the average length of stay after introduction of the crime-criterion increased, which implies that the influx of longstay tbs-patients after 2005 involves mainly tbs-patients that stayed at least six years.

The random allocation procedure that sends tbs-patients to a random forensic hospital was introduced in 1999 as a way to decrease length of stay. From
that moment onwards tbs-patients were no longer first admitted to a selection institute where psychological and psychiatric diagnostics took place, but they were sent immediately to one of twelve forensic hospitals for treatment. This change in allocation procedure was introduced after a change in the payment system. The Dutch Ministry of Justice pays the forensic hospitals for the treatment they deliver to the tbs-patients. They decided to introduce a financial stimulus in their payment system, to shorten time spent in treatment. This stimulus entailed less money for patients who had to be treated longer than six years (see further). The financial stimulus would only make sense if the fpc’s were comparable when it comes to the patients they treat and this was not the case before the random allocation procedure was set up (some fpc’s were specialized for treating patients with certain mental problems et cetera). However, after the random allocation procedures started, it was still possible to exchange patients from one hospital to the next and also some patients were sent to another fpc at the final stage of their treatment program to reintegrate into society in a region that was familiar to them. When patients are exchanged, delay can occur, since the new fpc and the patient have to get to know each other and trust each other and build up a productive treatment relationship.

Further, as mentioned above, changes in the payment system of the Dutch Ministry of Justice were introduced. Instead of paying the same amount of money for each patient for as long as his or her treatment lasted, two tariffs were set up: until six years of treatment a larger amount of money was paid then after six years of treatment (from 2000 onwards). By introducing this financial stimulus, it was expected that fpc’s would try harder to get the patients to finish their treatment within six years.

By trying to improve the quality of treatment (from 2002 onwards), among others by conducting research and by setting up standardized treatment protocols, it was expected that the length of stay could be reduced. In 2010 four national standardized treatment protocols have been set up, but we were not able to determine if these programs are also implemented in all fpc’s.

By developing preclinical interventions and preclinical treatment programs to those patients who were still in prison waiting for their treatment to start, it was assumed that the deterioration of psychiatric complaints would be minimized (from 1997 the first pilot phase started). Indirectly, from these interventions it was expected that it could shorten the length of stay in the forensic hospitals. As far as we could find out, these interventions no longer take place in the prison system. From studies it was shown that the influence on length of stay was negligible.
In 1988 the possibility was created to impose a tbs-order of a maximized duration of four years. This type of tbs-order is only possible when the crime that has been committed is a non-violent crime. It was expected that when more patients would get a maximized tbs-order, the average length of stay would be decreased, since the maximized tbs-order may last only four years.

By diminishing the influx of those patients who do not have a valid permit to stay in the Netherlands (around 2000), who by means of this status cannot be reintegrated back in society, expensive and scarce beds became free for patients who did have perspective to reintegrate back in society. Because these patients often stayed quite long in fpc’s, due to the lack of reintegration possibilities, it was expected that the length of stay would decrease as soon as they were moved to other, separate facilities.

All in all, it can be said that in the past twenty years, many different policy measures were taken to decrease the length of stay and to solve the problem of the shortage of beds. Often, there was hardly any time taken to have these measures take their effect. By implementing several new policies at the same time, it was hard to examine the influence of the measures separately. We also came across these problems in the present study. Furthermore, there were hardly any evaluation studies done at the time the measures were introduced.

Structured risk assessment and risk management and length of stay

In the present study, risk assessment was defined as assessing the risk of violent delinquent behaviour. Risk management was considered to be the strategies put up to control the assessed risks. The assessment of risks is an important task for forensic psychiatry, since it plays a dominant role during decision making in important phases of the treatment, such as decision-making regarding (supervised) leave and decision-making regarding whether or not a tbs-order can be cancelled. While these decisions are based on risk assessment, risk assessments indirectly influence the length of stay.

In the past ten years more attention has been focused on diminishing risks to society. This increase in risk management can also been seen in forensic psychiatry. Professionals in the forensic field identified the societal unease/com- motion as the most important explanation for the increase in length of stay in expert meetings that were held for the present study. These professionals meant that there is fear to take risks in all parties concerned: society, politicians, fp’s, responsible treatment personnel and probation services. The representatives that were present in our expert meetings indicated to be sensitive for the aversion for risks in society and politics, and said they were influenced by this and made their decision more carefully.
There were also some other developments in the risk assessment and risk management domain that indicate an increased focus on the risk a tbs-patients poses. These developments may have influenced the way risk assessment and risk management are conducted and thereby may have influenced the length of stay.

First, risk assessment and risk management in the forensic psychiatric sector has developed strongly in the past ten years and several risk assessment methods have been implemented in the Dutch forensic system, however, risk assessment is not without limitations. The most important limitation is that the instruments that are used to assess the risk of recidivism are not always validated for this situation, but are validated for the situation after finishing treatment. A second shortcoming is that the assessment of the risk is not always correct. There appears to be a particularly high level of false positive predictions (as opposed to the level of false negative predictions), which means that the risk is estimated to be too high (between 56% and 72% of false positive predictions). The third shortcoming is that repeated training of professionals who make risk assessments is necessary, but does not always occur. The fourth shortcoming is that risk factors that may predict risk at group-level, not always also predict risk at the individual level. The fifth shortcoming is that recent research suggests that risk assessment methods may not be able to predict the risk well for all subgroups in forensic psychiatry.

Second, risk factors and risk management have become more important in forensic policies, mainly in procedures for leave. In the subsequent leave policies, there is more and more focus on risk assessment and risk management procedures. From 2000 onwards, more explicit risk factors have to be taken into consideration while making a request for leave and it has to be shown how risk management is put in place. More people both within the fpc’s as well as at the Ministry of Justice have become involved in the decision-making regarding leave. Furthermore, more so-called ‘risk groups’ have been identified, for whom more demands regarding leave are put in place and for whom extra expert opinions on the level of risks are obligated.

Third, the focus on preventing risks has probably influenced the risk assessment of professionals in the forensic sector. As mentioned before, they indicated during the WODC expert meetings that they see an increase on safety and controlling risks. They identified the societal unease/commotion as the most important explanation for the increase in length of stay and mentioned the following arguments: unease in politics and society, the extensive media attention and coverage of an incident involving tbs-patients, the ‘toughening on crime’ in society and the pressure to guarantee public safety. These arguments also possibly play a role in the risk assessment that professionals con-
duct, that is, that the risks are overestimated. This can be deducted from, among others, the fact that risk assessment and risk management have been professionalized. It is likely that the process of making protocols, of professionalizing the risk assessment process and of structuring the risk assessment process, has contributed to a greater emphasis on the risks that are present.

The results further show that the severity of crimes that were committed by these patients at the time of influx into the fpc has increased in recent years. This finding can be substantiated by the following results, in which the outflow cohort 1989-1993 and the outflow cohort 2004-2006 are compared. The index crime of tbs-patients (the criminal act that they were convicted of and got them the tbs-order) more often has a violent component in recent years. This increase was found when examining only the most serious crime (an increase of 5%-points) but also, and more strongly, when examining all crimes of the index case (an increase of 10.6%-points). Also, the percentage of index crimes with a minimum sentence of eight years or more has increased for the more recent tbs-patients (an increase of 9.8%-points). Furthermore, the base rate of general recidivism (that means all formal contacts with the justice department) has increased slightly (an increase of 7.7%-points). These results suggest that one of the reasons that the length of stay has increased, is because of an increase in the criminal behaviour.

Based on these results regarding an increase in the severity of the criminal behaviour, it would be likely to expect an increase in the amount of incidents or recidivism rates. However, the results showed that incidents during and after the tbs-order have decreased. This is shown from a decrease in the number of patient with unauthorized leave. Also, the recidivism rate of the most recent outflow cohort compared to the outflow cohort of twenty years ago has decreased strongly: the percentage of serious recidivism (a new crime with a minimum sentence of four years or more) after two years has decreased from 29.5% to 17.7%. When comparing the most recent outflow cohort with the second most recent outflow cohort, a smaller effect was found: the percentage of serious recidivism after two years decreased from 19.5% to 17.7%.

The practice of leave and length of stay

With leave in the tbs-sector we mean authorized freedom to move outside the safe zone of the fpc. Leave is an intrinsic aspect of treatment. With leave outside the fpc it is possible to guide the patient gradually in his reintegration process back into society. By granting leave the return to society is prepared, by studying if the accomplished advances in treatment hold up in the less protected environment of society and by examining if the patient can handle this increase in freedom and responsibility.
In 2010 there are four separate phases in the leave system of the tbs-sector in which reintegration is the explicit goal. Next to these four phases there is incidental leave. This type of leave is granted for special occasions such as attending a funeral.

Leave practice historically
In the studied period (1990-2009), the leave practice has changed several times. Over all, the practice of leave has become stricter. We have identified at least five ways in which the practice of leave has become stricter. First of all more rules have been set up for the way an application for leave has to be written. Second, procedural changes have been set up in the way an application for leave is tested. Third, the party making the decision about granting leave has changed; the decision-making process has become more strict and slower. Fourth, a leave permit is now valid for a shorter period of time than before: it is valid for a year, after which it automatically loses its validity. Fifth, there are more groups indicated for who special rules apply or who are not allowed to go on leave. These are tbs-patients who are moved to another fpc, risk groups (patients who have recidivated) and tbs-patients who have a combined prison sentence and tbs-order. The special rules apply since 2005 and have become stricter in recent years.

Data patients on leave
To get more insight on the way leave policies may have influenced the length of stay, we analysed data on tbs-patients on leave. For these analyses it was showed that the total amount of tbs-patients with possibilities for leave has decreased during the years 2000-2008 (from 58.3% in 2000 to 43.7% in 2008, a decrease of 14.6%-points. This is not caused by an increase in the number of revoked leave permits (an average of 1% a year, with the exception of 2005), but is caused by the fact that relatively less new leave permits are granted each year: in 2008 26.9% of tbs-patients received their first leave permit as compared to 45.6% of tbs-patients in 2000 (a decrease of 18.7%-points). This involves mainly new permits for unguided and transmural leave together (34.6% in 2000 to 26.3% in 2008) and not so much new permits for guided leave (22.5% in 2000 and 20% in 2008). A possible explanation could be that fpc’s have applied less leave application, but we did not study this, so we cannot say this for sure.

It also takes longer before tbs-patients are granted leave: leave permits for guided leave as well as for unguided together with transmural leave, are granted after a longer time in treatment in more recent years. For guided leave, mainly the percentage of tbs-patients who receive a grant to go on guided leave within one year (12% in 1996; 1.4% in 2007) and within two years (29% influx cohort 1996; 13.4% influx cohort 2007) has decreased. For unguided and transmural leave, the percentage of tbs-patients that gets this type of
leave within three years have decreased (53% influx cohort 1996; 25% influx cohort 2004). For the most recent influx cohort (2005), the majority of tbs-patients go on leave within four years of treatment (60.1%).

Advisory committee applications for leave (AVT)
The AVT strives to send their advice on a leave application to the Ministry of Justice (leave unit) within three weeks. This goal was not completely reached in 2009: 38% of the advices were sent within three weeks, 62% lasted longer. The majority of advices were sent to the Ministry within four weeks. In the period before the AVT was operational (before 2008), it was common that the decision about a leave application was taken within three of four weeks. The time the AVT needs to send their advice is therefore not much different from the time before the AVT was operational. However, since 2008 when the AVT became operational, the total amount of time necessary to make a decision about leave takes an average of 60 days, whereas this process lasted only three to four weeks in total before 2008. The extra time that is necessary is taken up by the Ministry of Justice who needs an average of 28 days to complete a procedural step. It can be expected that, ceteris paribus, the length of stay from 2008 onwards will increase more, since a tbs-patients can not go on leave while the decision-making process is still going on.

The majority of the advices that the AVT sends are positive: 86% in 2008 (1158 leave applications) and 87% in 2009 (1293 leave applications). The increase in length of stay does not appear to be connected to the nature of the advices on leave applications of the AVT. In 2008 7.1% of leave applications was sent back with a request for more information (95 leave applications) and in 2009 6.5% of leave applications were sent back for this reason (96 leave applications). This percentage is relatively high, when it is taken into consideration that the Ministry of Justice already performed a check on all leave applications that they receive at the moment the applications are sent to them by the fpc.

Groups of tbs-patients with special considerations for leave
There are several subgroups for who special rules and regulations are in place when it comes to granting leave. Due to the fact that these subgroups do not go on leave or are granted permission at a later point in time, they have an effect on the length of stay of the total group of tbs-patients (this is increased). These groups are persons with a long combined prison sentence and tbs-order, who have been placed under the so-called Fokkens-terms (a maximum of 8.8% of tbs-patients), tbs-patients who do not have a legal status/permit to stay in the Netherlands (maximum 8% of tbs-patients), and tbs-patients who have been transferred to another fpc (number unknown).
Supervision and aftercare and the length of stay of tbs-patients

Supervision and aftercare are defined as controlling (aspects of) the behaviour of the person involved, with or without guidance, treatment and care, with the goal of preventing new crimes. In the present study the programs that were examined fall mainly in the aftercare tradition. In aftercare programs, intensive supervision programs are combined with treatment, therapy, care and societal guidance in living, working, education, leisure activities, and finances. The way in which supervision and aftercare are organized can decrease the length of stay. That is, when supervision and aftercare are well organized, tbs-patients can move faster from the fpc to institutions with less high levels of security.

Supervision and aftercare are arranged differently according to the different phases of the tbs-order. In the intramural phase, when this becomes an option, guided and unguided leave may be granted. All responsibilities and supervision lie with the fpc at this time. In the transmural phase, the transit period between the stay in the fpc and moving back to society, transmural leave can be granted. All responsibilities still lie at with the fpc, however, the patient can be staying elsewhere. In the extramural phase special leave and conditional discharge may be options. For special leave a cooperation is set up between probation services and the fpc and they set up a treatment plan together. The legal responsibility is still with the fpc, however, they no longer actually supervise the patient. This is done by the probation services. In conditional discharge the tbs-order is still at place, however, the judge had ruled that the mandatory treatment is no longer necessary. Instead, he formulates conditions for discharge. The legal responsibility lies with the District Attorney and not with the fpc.

Supervision and aftercare in historical perspective

Policy measures in the supervision and aftercare phase of the tbs-order have been set up to decrease the shortage of beds and to increase the promptness of moving to the extramural phase. The large number of policy measures included: better cooperation between fpc’s and aftercare institutions, setting up financial stimuli, introducing the possibility to conditional discharge and later improving the regulations under which this may take place, trying to improve circuits of care, expanding the number of available beds (in fpc’s and aftercare facilities), creating a new form of aftercare that is ‘forensic psychiatric supervision’, enlarging the aftercare offer of aftercare facilities, developing Diagnosis Treatment and Security Combinations (DBBC’s) and adjustment of the flow of information to regional administrators. Despite all of these efforts, the lack of outflow possibilities is still seen as one of the main
reasons the length of stay keeps increasing (second most named explanation in our expert meetings).

**Recent measures**

Two recent measures in the final phase of the tbs-order are the increase of the maximum duration of the period of conditional discharge from maximum three to maximum nine years (from 1 January 2008 onwards) and the introduction of forensic psychiatric supervision (May 2008). Of increasing the maximum duration of the conditional discharge it is expected that different parties involved are prepared to discharge conditionally sooner than before. Of forensic psychiatric supervision it is expected that it leads to an increase in the preparedness of fpc’s to special leave, conditional discharge, and outflow in a broader sense, with which length of stay may be decreased. It is also expected that the regular psychiatric health care system is prepared to sooner take ex-tbs-patients into their care. This would create possibilities to decrease the length of stay.

Because both these measures have been introduced recently it is not possible to determine the effect of the measures yet. Considering fpt in a pilot phase there were some limitations as to the effect it had on outflow of fpc’s and inflow of regular mental health care systems. Also the system of going through all phases of leave in fpt may be a factor that slows down outflow instead of increases outflow. In time, we will know the effect of these measures.