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Research Paper

Bottlenecks in the Belgian forensic care system: A qualitative study on residual patients

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ABSTRACT

This study aimed to explore the difficulties encountered in admitting Not Guilty by Reason of Insanity (NGRI) patients in Belgium, as well as identifying bottlenecks and potential improvements within the Belgian forensic care trajectory. Expert insights were gathered through focus groups involving professionals from both the Justice and Mental Health Care sectors. A total of 87 participants engaged in 14 focus groups, 43 from Flanders and 44 from Wallonia, representing diverse professions and facilities associated with NGRI care. The focus group data were analysed using inductive thematic analysis to identify recurring themes. Participants emphasized that admissions are particularly challenging for patients presenting with a high risk of violence, substance abuse issues, sex offenders and people with dual diagnosis. Participants also underscored systemic issues, including the imperative for standardisation in the conceptualization of forensic psychiatric care, the necessity for a common language, and the urgency to streamline the forensic care system. Additionally, the sharing of forensic knowledge and expertise was proposed as a solution to mitigate stigma and foster collaboration between forensic institutions but also between forensic and general psychiatry. This study sheds light on crucial aspects of NGRI patient care and underscores the urgency of systemic improvements to ensure better outcomes for all stakeholders involved.

1. Introduction

Forensic mental health systems aim to balance societal protection with the provision of appropriate treatment in the least restrictive setting possible. In practice, however, Not Guilty by Reason of Insanity (NGRI) patients encounter significant barriers in accessing or progressing through care pathways. They may remain in prison while awaiting psychiatric placement, experience prolonged stays in higher-security settings than clinically indicated, or face repeated admission refusals from treatment providers. These situations raise legal, ethical, and organizational concerns. While legal frameworks differ across countries, these challenges are not unique to Belgium. The Belgian context, characterized by an indeterminate NGRI safety measure and a fragmented governance structure, provides a relevant setting in which to examine these issues in depth.

1.1. Legal nature of the NGRI measure

Under Belgian law, a safety measure can be imposed on an NGRI offender.[2] This measure is not a punishment; its purpose is to protect society while providing treatment and rehabilitation for the person concerned. The legal rationale is therefore preventive and therapeutic rather than retributive. In Belgium, approximately 300 to 400 individuals are placed under this safety measure each year, and this

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[2] (Internment act of 5 May 2014, adapted by the Potpourri III-act of 4 May 2016, Belgisch Staatsblad 13 May 2016). https://www.ejustice.just.fgov.be/eli/wet/2014/05/05/2014009316/staatsblad

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number has been rising over the last few years (Seynnaeve et al., 2023). The measure is of indeterminate duration: its continuation depends on ongoing assessments of risk and treatment needs rather than on a fixed sentence length. This indeterminacy reinforces its protective character but also creates structural vulnerabilities when appropriate treatment settings are unavailable.

1.2. Institutional landscape

In the past, dedicated forensic beds were not available in Flanders until 2001, and the first Flemish high-security forensic hospital (Forensic Psychiatric Centre; FPC Ghent) opened only a decade ago. As a result, many NGRI patients resided in prison settings where access to appropriate therapeutic interventions is limited (De Clercq & Vander Laenen, 2017; Jeandarme, 2016a; Moens & Pauwelyn, 2012), and Belgium was repeatedly censured by the European Court of Human Rights (ECHR).[3] The opening of new forensic care facilities and the creation of additional forensic beds were not sufficient to significantly reduce the number of NGRI patients in prison. To date, roughly one quarter of the NGRI population still resides in prison (De Spiegeleir et al., 2025), with some spending several years incarcerated (Netwerk zorg aan geïnterneerden, 2020). This situation persists partly because requests for admission to healthcare facilities are refused, or from the absence of appropriate treatment settings for individuals with complex comorbidities and security needs (Seynnaeve et al., 2018).

1.3. Post-NGRI decision pathways and decision-making authorities

Once declared NGRI, decisions regarding the person's place of treatment, transfers between levels of security and unconditional release are made by a multidisciplinary court (Chambers for the Protection of Society).[4] This court includes legal and clinical expertise and retains authority throughout the measure. Transitions between security levels depend on risk assessment, treatment progress, and treatment capacity. In practice, individuals may move across several settings (see Fig. 1). When an NGRI patient is treated outside the prison system, the NGRI patient is 'conditionally released' under the authority of this court or placed involuntary for treatment. As soon as the security needs have diminished, the NGRI patient will either be referred 'conditionally' to a lower level of security (inpatient) or into the community with outpatient care. This can be in forensic treatment facilities or in general psychiatry. All treatment options are coupled with a judicial mandate to receive treatment and to follow all specified rules. In other words, individuals under conditional release remain under judicial supervision.

1.4. Allocation of responsibilities: justice and health care

The Belgian system is characterized by a structural interdependence between the justice and health care sectors. The judiciary (through the Chambers for the Protection of Society) determines legal status, transfer decisions, and conditions of release. The health care system (both forensic and general psychiatric services) provides assessment and treatment and can only give advice to the court regarding step-down or step-up transfers. This dual structure can create tension. Admission into health care facilities requires acceptance by providers operating within the broader psychiatric system. General psychiatric or forensic services may refuse admission based on perceived security risks, lack of expertise, or resource constraints. Consequently, individuals who legally require treatment may remain in prison because no health care provider is willing or able to admit them. One exception concerns the high-security forensic hospitals in Belgium. These institutions cannot refuse patients once the court has ordered placement, nor can patients decline admission. In such cases, the court directly mandates compulsory placement within a secure forensic hospital setting.

1.5. Revocation, refusal, and de facto detention

If NGRI patients violate the conditions of their release (e.g., by failing to attend treatment or by breaching residence requirements) they can be revocated and returned to prison.[5] Under the previous internment act,[6] revocation rates among medium-security patients were as high as 40% (Jeandarme, Wittouck, et al., 2017). Although the new law has made such revocations more restrictive, a return to prison remains possible. In 2022, this occurred in about 10% of the total population under conditional release (Seynnaeve et al., 2023). This mechanism contrasts with systems in other European jurisdictions, where breaches of treatment conditions typically lead to a return to a (higher) secure hospital or treatment unit rather than to prison. In England, for example, recalls after conditional release generally occur within the health system, often for reasons of increased risk or non-compliance (Jewell et al., 2018). Similar procedures exist in the Netherlands (Nagtegaal et al., 2017), where clinical reassessment and transfer between security levels are preferred over re-incarceration. In Finland and the United States, too, violations tend to be managed within the treatment framework (Manguno-Mire et al., 2014; Seppänen et al., 2020).

Admission refusal, delayed transfers, or the absence of suitable treatment possibilities have important practical and legal consequences. In such cases, individuals may be held in prison while awaiting admission to a forensic or psychiatric facility. Legally, they remain subject to the NGRI safety measure; practically, however, they experience incarceration in settings not designed to provide specialised forensic psychiatric treatment. In Belgium, the waiting time in prison for NGRI patients prior to forensic psychiatric admission into high and medium security settings has been very long averaging 4.8 years and 4.6 years respectively (Jeandarme, 2016a; Jeandarme et al., 2022). In contrast, in countries such as the Netherlands or Ireland, early diversion from the criminal justice system towards forensic mental health services is more common. For a detailed overview of cross-national differences in NGRI evaluation and procedures see Pouls et al. (2022).

Finding institutions willing to admit these NGRI patients can be challenging. The reasons why NGRI patients are denied access to care facilities are multiple, complex, and remain understudied. These reasons might relate to specific characteristics of the NGRI patients but also to dysfunctions in the social, judiciary, and care systems. For instance, studies have shown that some patients remain in a particular setting for too long, possibly in higher security levels than necessary (Jeandarme, Habets, & Kennedy, 2019; Shah et al., 2011), with substantial variation between countries (Jeandarme et al., 2022). Internationally, an expanding literature on length of stay (LoS) shows that extended institutionalization in forensic settings is associated with certain clinical and offence-related variables. For example, the systematic review by Dima et al. (2024) found that committing (attempted) homicide, having a criminal legal status with restrictions, and a diagnosis of schizophrenia-spectrum disorders were all associated with longer stays in forensic psychiatric hospitals; higher Global Assessment of Functioning (GAF) scores were associated with shorter stays. More recently, the study by Fekete et al. (2025) reported that the type and method of the index offence, the community residential setting into which the patient was released, age and gender significantly predicted LoS. Their regression model only explained 34% of the variance, indicating many unexplored factors. Another study identified wide inter-hospital variation in LoS

[3] Pilot judgement, 6 September 2016, W.D. v. Belgique. https://hudoc.echr.coe.int/eng?i=002-11327 for an overview see https://www.echr.coe.int/documents/d/echr/FS_Detention_mental_health_ENG

[4] Article 19 Internment act of 5 May 2014

[5] Article 59 Internment act of 5 May 2014

[6] Act of 1 July 1964 on the protection of society against persons of unsound mind and habitual offenders (BS 17 July 1964)

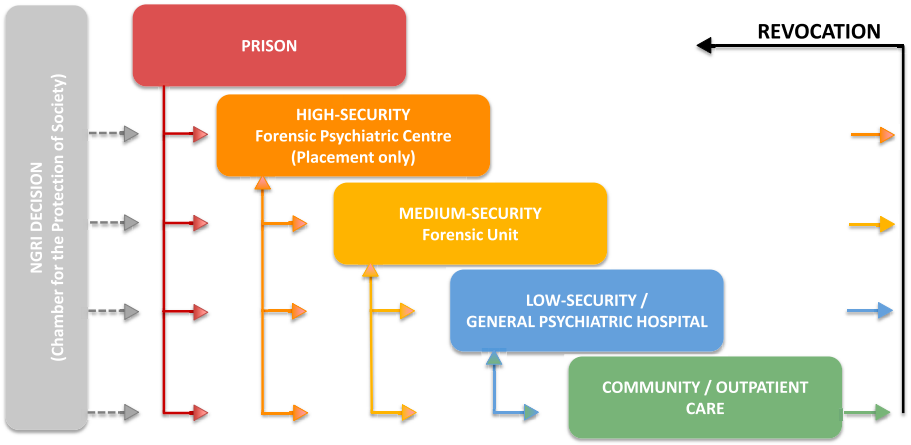

Fig. 1. Following an NGRI decision, the Chamber for the Protection of Society retains authority over placement and transitions at all levels of treatment. Individuals may enter treatment at different levels of security depending on their assessed risk and clinical needs; initial admission does not necessarily occur in prison or in a high-security forensic hospital. Although the trajectory commonly follows a step-down process: from higher to lower levels of security and eventually to community-based conditional release, the court may also decide to scale individuals up to a higher level of security when required. In cases of breach of conditional release or non-compliance with imposed conditions, the court may revoke the release and order a return to prison.

among forensic inpatients and flagged that institutional and treatment-programme differences may play a role (Páv et al., 2025).

In Belgium, long-term stays are often linked to a shortage of step-down facilities and the slow progression between security levels (Jeandarme et al., 2022). This aligns with the international literature suggesting that non-clinical, system- and institutional-level factors are also likely to be relevant, even though they are less frequently measured or reported. To our knowledge, there are no studies on NGRI patients who experience difficulties accessing care and remain detained for prolonged periods. Existing research primarily focuses on long-stay patients. According to the literature, the profile of these long-stay patients includes severe psychopathology, a history of violence, drug abuse, severe offences, lack of cooperation with treatment, and a shortage of appropriate step-down facilities (Chester et al., 2018; Fekete et al., 2025; Völlm et al., 2017, 2018). However, these studies are limited in number and predominantly originate from the United Kingdom, focusing on a selection of secure facilities and patients who are ready for discharge but are not discharged. They did not examine patients who fail to be admitted to treatment facilities in the first place.

Also, it is important to distinguish between long-stay and long-term patients, as these terms refer to different situations within the forensic mental health system. In Belgium, long-stay refers to a specific type of facility and patient group: individuals for whom resocialization is not feasible in the short or medium term. Long-stay units provide a secure and structured living environment focused on stability, safety, and quality of life rather than active treatment or rehabilitation. These units are intended for patients whose risks are enduring and whose prospects for reintegration are currently limited, though periodic reassessment remains possible. By contrast, long-term patients are those who remain in a forensic or prison setting for an extended time because of systemic obstacles, such as a shortage of appropriate facilities, slow transfer processes, or institutional reluctance to admit complex cases. These patients are often clinically ready to move on to a lower level of security or to community-based treatment but cannot do so. In this study we refer to them as *residual* patients: individuals who "fall between the cracks" of the forensic care system. Residual patients primarily refer to individuals who remain trapped within the system for prolonged periods due to the absence of suitable transition points or those who are actively rejected by institutions. Their situations raise significant ethical and practical concerns: residential forensic care is costly, and ethically, patients should receive care in the least restrictive environment that is safely possible. Moreover, research suggests that placement in an inappropriate security level can lead to treatment disengagement or drop-out (Jeandarme, Habets, O'Reilly, & Kennedy, 2021). Therefore, ensuring smooth and timely transitions between institutions to provide treatment at the correct level of security is crucial. Clarifying this difference is essential, as the needs and policy responses for both groups diverge: long-stay care focuses on sustained support and quality of life for patients with chronic risks, whereas reducing unnecessarily long-term stays requires addressing bottlenecks and inefficiencies in the care trajectory.

To better understand the concept of the so-called residual patient within forensic care, we formulated a broad research question aimed at minimizing potential blind spots: What are the characteristics of NGRI patients who experience difficulties accessing appropriate forensic care? To explore this question, we conducted focus groups with experts in the field (working within Justice or Mental health care). Our objectives were threefold: (1) to identify the characteristics of NGRI patients who have problems finding institutions willing to admit them, (2) to examine problems within the care trajectories and its supporting institutions, and (3) to uncover potential solutions to these problems.

2. Method

This study used a qualitative design to explore barriers and facilitators in the care trajectories of NGRI patients across Belgium. Fourteen online focus groups were conducted with 87 professionals from forensic and general mental health, justice services, and related facilities in Flanders and Wallonia. The following subsections describe the research team, participant selection, data collection procedures, and analytic process in accordance with COREQ guidelines (Tong et al., 2007).

2.1. Research team and reflexivity

The Flemish focus groups were facilitated by PH (PhD, female researcher in forensic psychiatry), and the Walloon sessions by HB (PhD, male researcher in socio-cognitive clinical psychology). At the time of the study, both facilitators were employed as academic researchers with expertise in qualitative methods and forensic care systems. Both had prior experience conducting focus groups and qualitative interviews in mental health settings. A second researcher attended each session to assist with logistics and take field notes. No prior relationship was established between the researchers and participants. Participants were informed about the researchers' academic background and the study's objectives prior to the sessions. The facilitators' interest in the topic stemmed from their involvement in national forensic care policy and

research on NGRI patients.

2.2. Study design

2.2.1. Theoretical framework

The study was underpinned by an inductive thematic analysis approach, following Braun and Clarke (2006), without a predefined theoretical orientation.

2.2.2. Participant selection

The coordinators of the mental health and justice networks[7] contacted their network (all Belgian care and justice facilities that work with NGRI patients) with a request to participate in focus groups. The focus groups were organized separately for Flemish and Walloon participants, due to the differences in language between the two parts of Belgium (Flanders: Dutch, Wallonia: French). A purposive sampling strategy was not used; instead, a self-selection sampling approach was employed whereby participation was open to individuals who expressed interest in joining the study. Participants were approached via email and invited to join region-specific focus groups.

A total of 87 people participated in the 14 focus groups (43 in Flanders and 44 in Wallonia). Participants were grouped according to their professional setting to facilitate context-specific discussions. These settings included: forensic hospitals and sex offender units; general psychiatric hospitals; outpatient services; sheltered housing facilities and psychiatric nursing homes; prison services; justice-related services (e.g., justice houses, inreach teams, and ABAGG[8]); and units for individuals with intellectual disabilities. Table 1 presents an overview of the participants' job titles, organized by focus group. No additional demographic data was collected. A diverse range of professions participated from varied facilities that are related to NGRI care including both justice institutions and healthcare services. All participants provided informed consent prior to the sessions. Confidentiality was maintained by anonymizing the transcripts and ensuring that no identifiable information was included in the analysis or reporting.

2.2.3. Setting

Due to the COVID-19 regulations at the time of the study, the focus groups were conducted online via Whereby or Teams. Research has shown that virtual focus groups are comparable to face-to-face focus groups (Stewart & Shamdasani, 2017). The online format also reduced participants' time investment by eliminating travel time, potentially increasing participation. There is no clear agreement on the ideal focus group size, but they typically tend to be between 4 and 12 participants (Masadeh, 2012). Each focus group was limited to eight participants to ensure an in-depth yet manageable discussion.

2.2.4. Data collection

The participants of the focus groups received the questions by email beforehand, allowing them to reflect on the questions in advance and consult with their team. The focus groups were structured around three central questions:

1. Which categories of NGRI patients are often refused or do not find a facility that is willing to admit them?
2. What problems are there in the care trajectories of these NGRI patients?
3. Suppose you get a bag of money to spend on further expanding care for NGRI patients. How would you use that money? Which type of care is most in need for additional funding?

Sub-questions were prepared to facilitate discussion if needed. No pilot testing of the interview guide was conducted. All sessions were audio-recorded and transcribed verbatim by PH and HB. Field notes were also taken to capture non-verbal cues and the overall dynamics of the discussions. Each transcript was reviewed by a second researcher and supplemented where necessary. Focus groups lasted approximately 90 min. No repeat interviews were conducted. According to COREQ criteria, data saturation was assessed within each focus group rather than across groups: discussions on each topic continued until no new information or perspectives emerged, at which point the facilitator proceeded to the next question. Transcripts were not returned to participants for comment.

2.3. Data analysis and reporting

Although the primary aim of this study was to examine barriers and facilitators in forensic care pathways under NGRI measures overall, the analysis was conducted separately for Flanders and Wallonia. This approach was not an a priori objective but was necessitated by Belgium's federal structure, linguistic divisions, and differences in procedural and administrative practices between the regions. Separate analyses enabled a meaningful interpretation of regional variations in service delivery and patient experiences. As a result, data were analysed separately for the Dutch and Walloon groups using an inductive thematic analysis approach inspired by Braun and Clarke (2006). Each transcript was read multiple times to achieve familiarization with the data. Meaningful units of text were then systematically highlighted and coded according to their relevance to the research questions. Codes were initially colour-coded at the sentence level, and similar codes were grouped together to form preliminary categories. These categories were then clustered in Excel to identify overarching themes and subthemes.

The process was iterative and comparative: codes and themes were continuously refined through discussion between the researchers until consensus was reached. No formal coding tree was developed, and themes were generated inductively from the data rather than from pre-existing theoretical concepts. Data saturation was verified during analysis when no new codes or patterns emerged from the final transcripts. NVivo or other software was not used. In accordance with COREQ criteria for ensuring rigour and credibility, the frequency of each theme's occurrence and the number of focus groups in which it appeared were recorded to provide a descriptive overview of their relative prominence. Participant quotations were included in the findings to illustrate key themes. Minor themes and divergent views were also described to reflect the diversity of perspectives.

3. Results

Tables 2 to 4 provide an overview of the most frequently mentioned themes for 1) patient characteristics, 2) obstacles that prevent admission and 3) proposed solutions to the problems raised earlier. The themes identified in the focus groups often show interrelationships: one theme may be the consequence of another, or one theme may serve as a solution to a problem highlighted in another theme.

3.1. Characteristics

Based on the analyses of the responses of the 87 field experts, the most frequently reported diagnoses that make it more difficult for NGRI patients to get admitted are: substance misuse problems, dual/multiple diagnoses, acquired brain injury (ABI), autism, antisocial personality disorder, and psychopathy. In terms of offences, only offenders with sex offences histories were mentioned. It was also indicated that the perceived degree of dangerousness plays a role: persons with high risk levels for violent reoffending or who appear to be too dangerous are more often refused (see Table 2). Furthermore, a lack of motivation from the patient can lead to refusal. Patients with illegal residence status are

[7] They function as facilitators within their regional network between different institutions and organizations within health and justice departments.

[8] ABAGG provides support for people with a disability within the prison by an external party.

Table 1
Overview of job title of the participants per type of service ($n = 87$).

	Focus groups							
	Forensic hospitals + sex offenders units	General psychiatric hospital	Outpatient services	Sheltered housing + psychiatric nursing homes	Prison services	Justice houses + inreach + ABAGG	Units for people with disabilities	Total *n*
Job title[1]								
Coordinator	●	●○	●●●	●●○○	●●●●○○	●	●●	19
Social worker	○○○	○○○○	○○	○		●○○	●●	15
Psychologist	●○	●●	●○○○	○	○	○		11
(Head) nurse	●○○	●○○○		●○				9
Care worker	●		●●●○			○	●●●	9
Justice assistant		●			●	●○○○○		8
Psychiatrist	●●○	○○			○○			7
(Care)Manager	●●			●●			●	5
Criminologist	●●	●	○					4
Psychologist assistant	●							1
Remedial educationalist		●						1
Occupational therapist				○				1

ABAGG = support for people with a disability within the prison by an external party
● = Flemish participant
○ = Walloon participant
n = number of people with that job title
[1] some persons had two job titles

Table 2
Characteristics of patients who experience difficulty getting admitted.

	Focus groups							
	Forensic hospitals + sex offenders units	Psychiatric hospital	Outpatient services	Sheltered housing + psychiatric nursing homes	Prison services	Justice houses + inreach + ABAGG	Units for people with disabilities	Total *n* (%)
Substance abuse	○○○	●●●●●○○○○○○	●○	●●○○○	○○○	○○○		29 (33%)
Sex offenders	●●●●●○	●●●○○○○	●●	●●	●●○○	●○○		26 (30%)
Double diagnosis	●●●●○○○	●●○○○○	●●○○		●○○	●○○		23 (26%)
Danger/ reoffending	●●●●●	●●●●●	●●		●●●	●●	●●	19 (22%)
High risk	●●●●○	●●●○○○	●○	●	●			16 (18%)
ABI	●●●	●●●○○○○	●		●○○	●●		16 (18%)
No motivation	○○	○○○○○	●○○	●○	●○	●	●	16 (18%)
Undocumented immigrants	●●○○○	○	○		●●○○	●●	●	14 (16%)
High psychopathic traits	●●○○	○		○	●○○			9 (10%)
High somatic need/ elderly	●●●●	○			○○			7 (8%)
Antisocial personality disorder	○○	●○○			○	○		7 (8%)
Severe/ mild intellectual disability		○○○○○			○			6 (7%)
Autism			●			●●	●●	5 (6%)
Conduct disorder (Violence)		○○		○○				4 (5%)
Women (mainly arsonist)	○	○			○			3 (3%)
Borderline personality disorder	○○		○					3 (3%)

ABAGG = support for people with a disability within the prison by an external party
ABI = acquired brain injury
● = Flemish participant
○ = Walloon participant
Total *n* (%) = Number of participants who mentioned the topic, with percentage calculated within the total sample.

Table 3
Obstacles that prevent admission.

	Focus group							
	Forensic hospitals + sex offenders units	Psychiatric hospital	Outpatient services	Sheltered housing + psychiatric nursing homes	Prison services	Justice houses + inreach + ABAGG	Units for people with disabilities	Total *n* (%)
Difficult transition between institutions	●●●●●	●●●●○○	●●●○○	●●●	●●●●	●●●○○○	●	30 (34%)
Delay because of the number of procedures that need to be followed	○○○	●○○○○	●●●●●○○○	●○○	●	●●○○	●●	26 (30%)
VAPH (application, stay, procedures)	●●	●●●● ○	●●○○	●●●●	●●●	●●	●●●●●	25 (29%)
Lack of intermediate institutions (mainly for people with addiction problems)		○○○○○○○	○○○○○○	○○○○○○○○	○○	○○		25 (29%)
Image of the forensic patient		●○○○	●●○	●●	●	●●○○	●●●●●	19 (22%)
Insufficient staff for effective treatment	○○	○○○○○	○○	○○○	○○○○○			17 (20%)
Lack of cooperation between services	○○○	○○○○	○○○○		○	○○○○		16 (18%)
Re-integration not always possible / long stay	●●●●●●○○	○○			●●	●	●	14 (16%)
More difficult to send someone back	●●●○○○	○ ○ ○	○○	●	●●			14 (16%)
Strange decisions of the court	○○	○○○○○	●○○		○○	●		13 (15%)
Lack of psychiatrists		○			○○	○○○		6 (7%)
Delay due to lack of social housing		○○		○○○○				6 (7%)
Lack of crisis agreement / relapse beds / crisis beds			○○			○○		4 (5%)
Lack of security triage / decisions on where a person should receive treatment					○○			2 (2%)
Delay because the safer ward is at capacity		○○						2 (2%)
Lack of research		○						1 (1%)

ABAGG = treatment for people with a disability within the prison by an external party
VAPH = Vlaams Agentschap voor Personen met een Handicap (Flemish Agency for People with a Disability)
● = Flemish participant
○ = Walloon participant

also refused because of legal and health insurance issues. Finally, people with significant somatic care needs are refused because institutions lack the necessary resources to provide adequate care.

3.2. Obstacles

Table 3 presents an overview of the obstacles, categorized by frequency of mention. Notably, there were differences in responses between Flemish and Walloon participants, with some themes exclusively mentioned by Walloon participants. The issue that most people mentioned was a poor transition between facilities (34%). According to the participants, this is partly due to the lack of standardised procedures for the transition between facilities. However, the second most mentioned issue (30%) was the fact that the procedures that are in place cause unnecessary delays. This is mainly the case for people with an intellectual disability and is not specific to forensic care. For example, it was mentioned that the funding resources for people with an intellectual disability (within the VAPH[9]) are different for people with or without a NGRI status and that it can take a very long time before the VAPH application is approved. The participants suggested aligning available budget systems so that it becomes a more flexible system. For example, budgets could be automatically continued when somebody comes of age. Other problems mentioned with the VAPH included the long waiting lists and the uneven geographical distribution of the forensic VAPH departments.

The Walloon participants consistently emphasized a need for more intermediate structures between institutions. One respondent indicated that, on the one hand, they are reproached for keeping certain patients in treatment for too long so that a lower level of security says that they can no longer do anything for the NGRI patient. On the other hand, if they want to transfer NGRI patients towards a non-forensic setting, these services often consider the step too large. It was mentioned that they would prefer a type of intermediate structure between the prison and the medium security that is not a high security hospital and between a mental health setting (no autonomy) and sheltered living or community housing (semi-full autonomy).[10]

Furthermore, 22% of the participants mentioned that when referring to general psychiatry, the stereotypical image associated with forensic patients leads to resistance from both staff and other patients. One participant mentioned that: *"Unknown is unloved"*. It was also indicated that the focus is too much on successful reintegration into society, while this is not possible for everyone. Flemish participants said that there is a shortage of long-stay beds in Flanders. While the Walloon participants did not mention this as a problem, they did indicate increasing the

[9] Vlaams Agentschap voor Personen met een Handicap (Flemish Agency for People with a Disability).

[10] Since the completion of this study, forensic transition houses were implemented in Flanders, to (partly) solve this issue.

Table 4
Suggested solutions.

	Focus groups							
	Forensic hospitals + sex offenders units	Psychiatric hospital	Outpatient services	Sheltered housing + psychiatric nursing homes	Prison services	Justice houses + inreach + ABAGG	Units for people with disabilities	Total *n* (%)
Better cooperation between services	●●●●○○○	●●●○○○○	●●●○○○○	●●		●●○○○○	●●	31 (36%)
Alternative residential facilities	●	○○○○○	●○○○	○○○○○○○		●○○	●	21 (24%)
Intermediate institutions		○○○	●○○○	●●○○○○○	●●●○○	●		20 (23%)
A shared vision/ language/method	●●●●	●●●	●●●●	●	●●	●	●●●	18 (21%)
More staff	○○	○○○○○	○○	○○○	○○○○○			17 (20%)
Trajectory formation	●●●●●●	●	●●	●●	●	●	●●●	16 (18%)
Crisis agreement/relapse bed/time-out crisis bed	●●●	●	●●○○	●	●●●	○○	●	15 (17%)
Assessment of risk and needs before admission	●	●	●●	●	●●	●●●	●	11 (13%)
More uniformity (what is forensic care)	●●●●●●		●	●	●		●	10 (11%)
More psychiatrists		●●○			○○	●○○○		9 (10%)
More research	●	●	●	●	●		●	6 (7%)
More long stay beds	○○	○○						4 (5%)

ABAGG = treatment for people with a disability within the prison by an external party
● = Flemish participant
○ = Walloon participant

number of long-stay beds as a solution.

According to the participants, the new law reform (making it more difficult to send people back to prison) has led to more cautious admission strategies. They explained that when assessing a person's suitability for admission, any uncertainty can lead to a refusal. This is primarily due to the lack of referral options once a person is transferred from prison.

3.3. Possible solutions

Table 4 presents an overview of the possible solutions mentioned in the focus groups. A frequently mentioned solution was improving cooperation between institutions (36%). Related to this was a clear need for a shared vision, where people use the same methods and the same terminology (21%):

> "Actually, we have to make a table together and everyone is responsible for his table leg, where everyone takes their responsibility. It is important to make a plan together and not to wait for someone else."

> "The problem is that we discuss whether it is a table or a chair. There is a lack of a shared vision. We do not agree and ideas about treatment are not aligned. Everyone puts their own house in order first, follows their own principles. A shared trajectory is needed."

Related to this, the participants indicated that determining a care trajectory in advance and for each patient would improve transitions between institutions. According to the participants, some people are being treated in inappropriate security levels. Participants expressed support for a tiered or stepped-care system (from higher to lower security). They suggested that disagreements between institutions could be avoided through better cooperation, or providing guarantees of a fallback/crisis/time-out bed if difficulties arise, especially since referrals back to prison are no longer approved so easily.

> "A structural solution is a crisis ward specialised in forensic beds for the entire country."

Another theme that was mentioned was the need for uniformity: What is meant by forensic care? What treatment methods are ideally used? Participants indicated that this should begin with a thorough assessment resulting in a care trajectory plan. One participant suggested that this trajectory plan should be binding for institutions rather than functioning merely as guidance.

> An observation centre is needed for this, where the diagnosis can be made, and the plan worked out: what is the highest achievable outcome for this person? This avoids discussion between institutions."

Participants pointed out a significant disparity in the level of supervision and security across institutions. Related to this, participants mentioned a need for more security levels: they wanted facilities that serve as an intermediate stage between different security levels such as transition houses for NGRI patients, an observation house / crisis house, a setting that is intermediate between prison and medium security. When developing new initiatives, the availability of experienced staff was identified as a major challenge. Furthermore, both the Flemish and the Walloon participants indicated a great need for psychiatrists. To reduce stigma and correct misconceptions about NGRI patients, participants suggested organizing introductory visits to the receiving facility together with the patient and presenting the patient at team meetings, where the referring institution can share experiences and practical recommendations.

4. Discussion

The Belgian Internment Act, enacted on 5 May 2014, marked a significant advancement in the rights to care for NGRI patients. Despite these legislative changes over the past decade, NGRI patients continue to be detained in Belgian prisons, some of whom spend several years there (Netwerk zorg aan Geïnterneerden, 2020; Seynnaeve et al., 2018). This

highlights a subgroup of NGRI patients for whom current provisions are inadequate: the so-called "residual" patient. The present study aimed to delineate the characteristics of these patients' encountering challenges in getting admitted to (forensic) institutions, together with current bottlenecks in care trajectories and potential solutions to these issues. Some of these have been longstanding topics of discussion (e.g., observation centre and needs assessment). Several initiatives have already been implemented to address part of these challenges, including the development of medium security beds for people with intellectual disabilities, the high security hospitals in Flanders, and InReach programmes.

4.1. Characteristics

During the focus groups, numerous patient characteristics were identified, primarily based on diagnostic categories, with only one mention of the type of offence (sex offences). This discussion will focus on three specific characteristics: high risk, comorbidity, and acquired brain injury, as these represent current challenges in psychiatric ward admissions. The decision to highlight high-risk characteristics stems from the fact that risk assessment and risk management are core functions of forensic psychiatric care. While substance use was discussed more frequently, we focus on comorbidity as it also includes the substance use theme. Although ABI was not the most frequent mentioned topic, its inclusion in the discussion is justified by other considerations. ABI emerged as a relatively new and under-recognised issue in the context of NGRI care (de Geus et al., 2024) and participants who raised it emphasized the lack of appropriate knowledge and care pathways. The remaining topics, while important, are not discussed due to space constraints.

4.1.1. High risk

Risk assessment is essential for guiding both the treatment plan and decisions regarding transfer to other services. Adherence to the Risk-Need-Responsivity (RNR) principles enhances forensic psychiatric treatment effectiveness (Andrews & Bonta, 2010). However, participants mentioned that institutional preferences for risk assessment tools hinder communication and comparison between scores. For example, the Flemish high security units work with the Historische, Klinische en Toekomstige – Revisie (HKT-R; Spreen et al., 2013) (a Dutch structured professional judgement risk assessment tool) whereas the Flemish medium security units more often use the Historical, Clinical, Risk Management (Version 3) (HCR-20:V3; Douglas et al., 2013; Dutch translation: de Vogel et al., 2013). Communication regarding risk assessment results could benefit from a standardised and uniform approach ensuring that people share the same view on what 'high risk' entails. Recent initiatives have focused on standardizing risk categories to enhance decision-making in risk management (de Vogel et al., 2019; Eher et al., 2019; Smid & Uzieblo, 2020) but are not yet implemented into practice.

Participants indicated that transitioning to non-forensic psychiatric care often shifts focus away from monitoring recidivism risk, reflecting differences in perspectives between forensic and general psychiatry. Forensic partners reported that their counterparts in general psychiatry do not place sufficient emphasis on risk assessment and management. Also, communicating about risk may lead to refusals for admission, leading to some advocating for a parallel forensic system alongside to general psychiatry, thereby circumventing the lack of forensic treatment perspective.

4.1.2. Comorbidity

Research indicates a high prevalence of comorbidity among Belgian NGRI patients, with a majority having diagnoses on both Axis-I (clinical disorders such as mood, psychotic, or substance use disorders) and Axis-II (personality and developmental disorders), based on DSM-IV criteria[11] (Jeandarme et al., 2020; Jeandarme, Pouls, et al., 2017). Patients with comorbid diagnoses, known as 'dual' or 'triple diagnoses', pose significant challenges in (forensic) psychiatric care. Studies show that patients with comorbid disorders often have a history of violent offences, substance use, and more serious criminal behaviour (Cosyns et al., 2007; Deckers et al., 2014; Jeandarme, 2016a; Ogloff et al., 2015). In the Walloon focus groups, it was mentioned that patients with addiction problems can disrupt the therapeutic environment, either by bringing drugs into the clinical settings, by stealing, or by extorting others to obtain substances. Participants stated that individuals with both alcohol misuse and psychotic disorders may face difficulties in finding appropriate treatment due to these complex needs. According to the Risk principle of the RNR model, these patients require more intensive treatment. The other RNR principle, responsivity, is also an important factor in this group of patients. Studies in general psychiatry have shown that responsivity is an issue for people who present with an addiction in combination with a personality disorder as they appear to respond less well to treatment (Brooner et al., 1997) and are also more likely to drop out (Kokkevi et al., 1998). Forensic treatment should focus on an integrated treatment format (Van Wamel et al., 2015) where both disorders are treated simultaneously (Miles et al., 2007; Oddie & Davies, 2009; Ritchie et al., 2011). In (Belgian) practice, however, treatment efforts are often focused on one disorder. The medium security institutions include people with a psychotic or a personality disorder possibly in combination with another problem, but do not have specific dual-diagnosis beds or care pathways. In contrast, the Flemish high-security hospitals organise persons with a dual diagnosis into different care pathways modules. In the last few years, additional medium security departments for people with intellectual disabilities (and additional psychological problems) have been set up.[12] The Flemish institutions that currently provide treatment for people with a dual diagnosis are all low security units or outpatients facilities. Participants suggested that the creation of similar medium security beds specifically for dual diagnosis addiction could fill a gap. Guidelines on integrated care in forensic psychiatry should be developed. The problem of dual diagnosis is not only specific to forensic psychiatry, as in general psychiatry it appears that people with a double diagnosis often also face difficulties to be admitted in an institution (Hoge Gezondheidsraad, 2015).

4.1.3. Acquired brain injury (ABI)

People with an ABI are another group that experience difficulties getting admitted. In the focus groups, it was indicated that the necessary expertise is lacking in both the diagnosis of ABI and knowledge about the most appropriate referral pathways. This is challenging as specialised knowledge is needed regarding cognitive disorders, (neuro)psychiatric disorders, and the severity and location of the brain injury. The literature review by de Geus et al. (2021) found that despite the high prevalence of ABI in offender populations, interventions in forensic settings are rarely targeted at individuals with an ABI. There is a possibility that ABI is under-diagnosed in the forensic population. International studies report prevalence rates in prison populations of approximately 50% (de Geus et al., 2021) and 23% in forensic psychiatric populations (Colantonio et al., 2007), whereas Belgian data reported a prevalence of 8% in high security patients (Jeandarme et al.,

[11] Although this classification system has been replaced by DSM-5, it remains in use for clinical records and research contexts in Belgium.

[12] Since the completion of this study, several small-scale initiatives have been launched in Belgium to address care gaps for NGRI patients with comorbidity issues related to substance use. These include new projects at UPC Duffel (Atlas unit for dual diagnosis), PC Sint-Jan-Baptist Zelzate (Ligarsa day clinic), and the Hemera unit for elderly care.

2024). This under-diagnosis can complicate treatment adherence, particularly in relation to the responsivity principle. These low prevalence rates might indicate not only under-diagnosis but also a higher likelihood of refusal for admission, underscoring the systemic barriers faced by individuals with ABI.

4.2. Obstacles

4.2.1. Lack of specialised knowledge

The lack of knowledge was not limited to ABI; the focus groups also indicated that there is a general need for knowledge sharing and training in which forensic themes are integrated within general psychiatric themes. According to the participants, care institutions receive many requests from other care institutions for expertise sharing but do not have the time and financial resources to do so.[13] Furthermore, both inter- and supervision within forensic psychiatric settings are considered very important, with particular attention to the prevention of work-related stress, dealing with negative feelings (because of some crimes committed), 'splitting' by patients, support in interpersonal conflicts between caregivers and support in setting (personal) boundaries (Pouls & Jeandarme, 2020). The participants indicated that more attention should be given to forensic psychiatry within higher-education programmes (e.g., psychology, nursing school, medical school). The use of experts by experience as guest speakers at various courses was suggested. This could also potentially help reduce the stigma that NGRI patients experience and create a better understanding of the forensic patient.

The importance of training is evident from several studies (Beryl & Völlm, 2018; Isaak et al., 2017, 2018; Kuosmanen et al., 2019; Redhead et al., 2011). The report on the quality criteria for forensic mental health care provides an overview of the training/education needs within forensic care, such as conflict management/aggression management, culturally sensitive care, training for specific target groups (e.g., personality disorders), recovery-oriented care, family interventions, and education on evidence-based working (Pouls & Jeandarme, 2020). In Flanders, limited training opportunities exist in forensic psychiatry, with only two long-term postgraduate courses available for specialization while in Wallonia the Université Libre de Bruxelles provides a one-year postgraduate. There is *certificate d'expertise in psycho-légale* at the University of Liège and a joint post-graduate on the evaluation and the treatment of sexual aggressors (Faculties of Medicine of UMons and Paris-Descartes). Conversely, the Netherlands offers specific master programmes in forensic psychology.

4.2.2. Motivation

Participants mentioned that challenges arise not only within the institutional framework of the care process, but also at the patient level (e.g., lack of motivation). This issue aligns with the responsivity principle of the RNR model, which emphasizes the importance of reducing barriers to participation (Andrews & Bonta, 2010). Motivation is a critical factor in treatment adherence and outcomes (Völlm et al., 2018). High drop-out rates (32% drop-out within the Flemish medium security units; Jeandarme, 2016b) may reflect both motivational issues and mismatches in security level needs (Jeandarme, Habets, O'Reilly, & Kennedy, 2021). Papapietro (2019) states that therapy should never be forced; change can only be achieved when the patient takes individual responsibility for their situation. To support this process, they recommend assigning one care provider who meets regularly with the patient to explore treatment goals and barriers to engagement. This individualized approach may take several months to produce meaningful progress (Long et al., 2012; Papapietro, 2019). A similar endeavour focused on expediting admissions from prisons was initiated in Flanders in 2014, known as the InReach project (Stassen et al., 2014), which has garnered positive feedback from staff members (Habets et al., 2023). However, quantitative findings did not demonstrate a favourable impact of the InReach project on the rate of referrals back to prison.

4.2.3. Stigma/image of the forensic patient

NGRI patients face a dual stigma as both psychiatric patients and offenders (Margetić et al., 2008; West et al., 2014, 2015; Williams et al., 2011), with some experiencing a triple stigma when substance abuse is involved (Hartwell, 2004). Participants mentioned that the image society holds of NGRI patients adds another layer of complexity to the care process, particularly when attempting to refer patients to lower levels of security or general psychiatry. Resistance from mental health care teams, organizations, and even other patients' families may occur due to stigma. Stigma can lead to feelings of inferiority, social exclusion, and decreased therapy adherence, impacting various aspects of life such as work, education, and home (Crocker et al., 2017). The Not in My Backyard (NIMBY)[14] effect further complicates the situation, with people supporting treatment, work, and housing for NGRI patients but not within their own communities. Informing and involving the community has been shown to lower this threshold, as evidenced by research in general psychiatry (Corrigan et al., 2003). Studies have found that individuals with training or professional experience in mental health and forensic psychiatry tend to have more positive opinions regarding NGRI patients, highlighting the importance of education and familiarity in reducing stigma and promoting understanding (Kavak et al., 2019; Van Roy, 2020).

4.2.4. Pathways of care

Care pathways for forensic patients in general are highly variable and therefore difficult to predict or structure. One main topic emerged in the focus groups: the need for a systematic assessment of the needs of forensic patients both at the start of their treatment (i.e., during the stay in an observational centre) and during treatment. There is also a need for a common language and standardised use of assessment tools together with better cooperation between centres. This point directly contributes to the improvement of continuity of care. The participants have suggested that achieving this continuity can be accomplished through conducting a working visit, wherein admission and exclusion criteria become evident. They also indicated that the Dangerousness, Understanding, Recovery and Urgency (DUNDRUM) toolkit (Kennedy et al., 2016; Dutch translation: Jeandarme, Habets, & Pouls, 2021) could serve as a useful framework to achieve greater standardisation.[15]

4.3. From individual profiles to systemic responsibility

Although the patient characteristics identified in this study are consistent with the forensic literature, there is a risk that describing these profiles may inadvertently reinforce a "difficult patient" narrative. Our findings suggest, however, that the core issue does not lie solely in the inherent nature of specific patient groups, but in the limited capacity of the system to provide flexible, continuous, and adequately resourced care pathways tailored to complex and fluctuating needs. When forensic and general mental health services operate with narrowly defined admission criteria, insufficient step-down options, or unclear cross-

[13] Since the completion of this study, as part of ongoing efforts to promote cross-sector collaboration in forensic care, the Belgian forensic care networks have started the "Vreemdgaan-Wisselleren" exchange initiative. In the first phase, host organizations are invited to open their doors to professionals from other institutions.

[14] "Not in My Backyard" (NIMBY) refers to opposition by residents or institutions to the placement of certain facilities or individuals (such as forensic psychiatric patients) in their local area, despite recognizing the general need for such services.

[15] After the completion of this study, The DUNDRUM-toolkit has since been implemented across justice and health institutions in Flanders.

sector responsibilities, individuals with combined complex clinical and security needs are more likely to fall between institutional boundaries. What appears as patient "unmanageability" often reflects systemic inflexibility and governance gaps. Addressing these bottlenecks is essential to uphold both the therapeutic rationale and the human rights foundations of the NGRI framework.

4.4. Solutions

One solution suggested by the participants in relation to facilitating good care pathways was the creation of a psychiatric observation centre.[16] In this observation centre behavioural experts can assess the different needs of the patients as well as the need for specialist forensic care. Participants stated that, in addition to the 'not guilty by reason of insanity' assessment, a comprehensive evaluation of the patient's security and psychiatric needs should be conducted. This evaluation should inform the development of an individualized care trajectory, including a corresponding treatment and reintegration plan. Participants indicated that there is a clear need for more staff in general (especially psychiatrists) and a need for staff with specialised knowledge about forensic psychiatry. We suggest that enhancing specialised knowledge could be achieved by establishing an (*E*-learning) platform dedicated to the dissemination of knowledge, research findings, as well as tools and methodologies. Establishing a centralized hub for accessing and exchanging information is the first step in meeting this need. We propose improving collaboration between settings through a forensic networking conference organized by the government where knowledge sharing and learning from each other is the key focus. Additionally, it has been mentioned multiple times that scientific research is essential to support and substantiate the necessary steps, which has been internationally voiced recently (Tully et al., 2024).

Also, it was mentioned that not all forensic facilities share the same views on what forensic psychiatry should be. Furthermore, participants stated that general psychiatric services do not have the knowledge or the tools to continue with the specialised care the patients received in the forensic faculties or have a different view on how to manage risk. Participants indicated that a general policy defining forensic care is needed. In Flanders there are now official standards regarding residential forensic care that stipulate the quality criteria for the care process, such as the intake procedure, observation, and diagnostics, as well as the evaluation of treatment progression and drop-out. In addition, more attention is given on the internal legal position of the forensic patient, the collaboration with family, and infrastructures (e.g., individual rooms), … (Pouls & Jeandarme, 2020; Zorg en Gezondheid, 2019). Standards in Wallonia are not available yet, but each institution does have its own position papers/vision texts.

A transformative approach to enhancing the care pathway involves restructuring forensic hospitals to encompass all security levels within their facilities, akin to the model observed in institutions such as the Central Mental Hospital in Ireland and forensic hospitals in Germany (Edworthy et al., 2016). Consequently, consolidating care within a hospital at varying security levels offers the treatment team a clear view into the care pathway, thereby improving continuity of care. Moreover, by providing care across multiple security levels within one facility, the evaluation of step-down progress can be conducted internally, thereby minimizing waiting lists.

Participants stated that clear agreements should be made between facilities regarding the admission criteria and transfer criteria. Interaction between non-forensic psychiatric services and forensic psychiatry is essential and unavoidable: most patients in forensic units have had previous contact with general psychiatric services (Jeandarme, 2016b). Also, a number will progress to general psychiatry at some point. However, participants indicate that general psychiatric services are still reluctant to admit forensic patients. There are already some local initiatives mentioned by the participants to reduce the forensic stigma. For example, there is a facility where the forensic ward staff accompanies the forensic patient to a non-forensic treatment centre to get acquainted with each other before admission (i.e., a warm hand-off). Involving and informing the community is also a means to reduce stigma.

4.5. Regional differences

Because of the fragmentation between ministries and level of powers, it is difficult to have a unified view and standards for high-quality forensic practices (McLaughlin et al., 2023). Fragmentation exists not only between ministries but also between the two regions of Belgium: Flanders (the northern Dutch-speaking region) and Wallonia (the southern French-speaking region). This fragmentation was also visible in the results from the focus groups. For example, the level of dangerousness or risk of reoffending was mentioned frequently in the Flemish groups but not in the Walloon groups. Regarding diagnoses, only the Flemish groups identified autism as a problem, while the Walloon groups exclusively mentioned intellectual disability, conduct disorder, or borderline personality disorder. Additionally, the obstacles mentioned varied between regions: Walloon participants highlighted a lack of intermediate structures, staff shortages, and a lack of cooperation as significant issues. Interestingly, some topics were framed differently between regions; for example, the Walloon participants viewed the lack of research as an obstacle, whereas Flemish participants suggested more research as a potential solution. These differences highlight the regional disparities in perceptions and approaches to psychiatric care challenges in Belgium and can be explained by the diversity of working methods and available institutions between Wallonia and Flanders in the forensic field (Cartuyvels et al., 2010; Cosyns et al., 2007; Pham et al., 2019). For example, forensic units for people with disabilities or sex offenders, and forensic outpatient services exist in Flanders but not in Wallonia (Jeandarme, Saloppé, et al., 2019). It is possible that in the north there is a culture of attempting to transfer patients more rapidly by applying simultaneously to multiple institutions. This idea is supported by the fact that the length of stay in a high security in Wallonia (3080 days; Jeandarme, Saloppé, et al., 2019) is much longer than in Flanders (1013 days; Jeandarme et al., 2020) and by the fact that the experts in the south also mention serious issues with a lack of transfers between settings for patients.

Furthermore, regional diagnostic differences were identified. The frequency distribution of primary diagnostic characteristics among NGRI patients in the north was personality disorders, substance abuse and psychotic disorders. Whereas in the south this was: substance abuse, psychotic disorders, and personality disorders. De Page and Goethals (2019) also outlined these regional differences, with Walloon colleagues diagnosing more psychotic disorders and Flemish colleagues diagnosing more personality disorders. Studies have also shown disparities in risk profiles between Walloon and Flemish NGRI patients (Pham et al., 2019).

These regional disparities underscore the need for greater standardisation and coordination across Belgium's forensic mental health system. However, Belgium's complex forensic care landscape, with differences in infrastructure and available institutions between regions, complicates the development of unified standards. Any effort to harmonize forensic practices must therefore be sensitive to these structural realities and involve coordinated dialogue across regions and the ministries. The use of the new federal observation centre could play a pivotal role in addressing these differences by providing a uniform framework for evaluating patients and guiding placement decisions. Assessing the feasibility and budgetary impact of these solutions is challenging and falls outside the scope of this article. Furthermore, the Belgian forensic care system is funded at federal, regional, and community levels, which complicates implementation and cost estimation. Moreover, empirical evidence on optimal staffing ratios and psychiatric

[16] This observation centre has been opened after completion of this study.

bed capacity is limited, and international guidelines offer little clarity due to legislative differences, differences in security levels and team composition.

4.6. Limitations / strengths

This study has several limitations that should be considered when interpreting its findings. First, there are significant variations in the legal frameworks governing forensic psychiatric patients across different countries (Edworthy et al., 2016; Pouls et al., 2022). The NGRI statute and the associated terminology in Belgium differ from those in other countries. For example, some countries exclude diagnoses like personality disorder from their NGRI criteria. In the Netherlands, three levels of NGRI are recognised, while Sweden does not use the concept of NGRI at all. These legal differences result in diverse patient characteristics, complicating direct comparisons. Therefore, conclusions drawn from this study, as well as from studies conducted abroad, should be interpreted with these variations in mind.

Second, this study relied on input from professionals experienced in working with NGRI patients. While this approach allowed for diverse perspectives to be considered, viewpoints can vary widely among professionals within different institutional settings and roles, including those in ambulatory and residential mental health care, as well as the judiciary system. Recognizing that one opinion does not necessarily represent all or apply universally is crucial. For example, the lack of crisis agreements was mentioned as an obstacle; however, such agreements are possible in practice. High-security hospitals constitute an exception, as their only recourse in crisis situations is to transfer the patient back to prison. While diversity in professional roles can introduce variability in smaller samples, the relatively large number of participants in this study (particularly within the Belgian context) provided adequate data depth and diversity to capture the main recurring themes.

A third limitation of this study is that it exclusively reflects the perspectives of professionals. This was a deliberate choice given their central role in admission decisions. The experiences of NGRI patients and their families remain underrepresented, despite being directly affected by these procedures. Complementary insights can be found in the study by De Pau et al. (2020), which gathered narratives from 23 NGRI patients through semi-structured interviews. Participants described how factors such as psychiatric condition, offence type, and prior incidents in mental health services, could influence admission outcomes. Conversely, good behaviour, motivation for treatment, and support from prison psychosocial services were seen as facilitators. These insights overlap with the perspectives of professionals in this study. Despite these limitations, a major strength of this study is the comprehensive input from a diverse group of professionals across different regions and institutional settings. This diversity enhances the richness of the data and provides a well-rounded understanding of the challenges in admitting forensic psychiatric patients. Additionally, the focus groups themselves appeared to facilitate exchange between stakeholders, as several participants identified new partners and shared practical insights. Finally, surveying the actors across all stages, from detention to society, provides a holistic or even mechanistic understanding of the obstacles and bottlenecks.

4.7. Recent developments

The Belgian forensic mental health field is continuously evolving in efforts to improve the conditions of NGRI patients and to address the above-mentioned longstanding structural bottlenecks. Since the completion of this study, several changes have been implemented, while additional initiatives are planned to further strengthen capacity and coordination. For example, the DUNDRUM toolkit has now been implemented across justice and health institutions in Flanders to enhance standardisation in security needs and transfer decisions. To promote cross-sector collaboration, the Belgian forensic care networks have launched a cross-institution exchange and learning Initiative, in which host organizations open their services to professionals from other institutions to stimulate mutual learning and cooperation. Several small-scale initiatives have also been introduced to address care gaps for NGRI patients with for instance comorbid substance use problems and elderly forensic care. Furthermore, in 2026, the opening of forensic transition houses is planned. These units will provide alternative resocialisation pathways for individuals under an internment measure, facilitating their transition from, for example, prisons or high- and medium-security psychiatric facilities. The units offer short-term stays of up to one year, with the goal of promoting further integration into the community. In Wallonia, since 2023, a partnership between the *Walloon Agency for a Quality Life* and the *Care Pathways for Patients* has aimed to increase the availability of suitable accommodation and to promote the inclusion of conditionally released patients, particularly those with dual diagnoses or elderly individuals, within these services. In 2025, a federal taskforce was established to address prison overcrowding and the related presence of NGRI patients in correctional settings. These changes reflect the continued policy attention to structural pressures within the system.

5. Conclusion

Belgium has faced repeated censure from the ECHR for detaining NGRI patients in prison settings without adequate access to treatment. Despite successive legislative reforms and the expansion of specialised forensic care facilities, our findings indicate that systemic bottlenecks, such as institutional refusals, a shortage of intermediate structures, and fragmented funding mechanisms, continue to delay or prevent timely access to appropriate care. In contrast to several other European jurisdictions, where breaches of treatment conditions typically trigger a process of clinical reassessment, Belgian law still allows for reincarceration, raising ethical concerns regarding proportionality and therapeutic intent. The persistence of lengthy stays in high-security environments and the scarcity of step-down options further challenge the principle of providing care in the least restrictive setting. Addressing these structural obstacles is therefore essential not only to improve clinical trajectories but also to bring Belgian forensic psychiatric practice into closer alignment with international human rights standards.

Ensuring the successful completion of a care trajectory for forensic patients demands considerable resources in terms of infrastructure, staffing, consultation, and service quality, all of which incur significant costs. These challenges not only perpetuate the high costs of the system but also contribute to secondary costs such as despair, demotivation, non-cooperation, and deterioration of patient health. Investments aimed at enhancing the forensic system have the potential to mitigate these challenges. This, in turn, can reduce the ongoing need for extensive staffing and infrastructure, thus offering potential long-term cost savings. Currently, the forensic network in Belgium remains fragmented, lacking cohesive guidelines and coordination among stakeholders. Establishing a federal forensic platform to facilitate information sharing across stakeholders, organizing training sessions, and distilling research output for practical application in forensic practice are necessary steps. Addressing these deficiencies through strategic investments now appears to be more cost-effective in the medium term than maintaining the status quo with its current financial burdens and its recurring inefficiencies. Strengthening inter-institutional collaboration, standardizing assessment frameworks, and investing in staff expertise are key to improving continuity of care and upholding patients' rights. Greater coordination between regional and federal levels is essential to align forensic psychiatric practice with ethical and human rights standards, ensuring a more coherent and humane system. By prioritizing these investments, Belgium can move towards a more integrated, efficient, and ethically grounded forensic care system that better serves the needs of NGRI patients while optimizing resource allocation and improving outcomes.

Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work the author(s) used ChatGPT in order to improve language clarity, as authors are not native English speakers. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

CRediT authorship contribution statement

P. Habets: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **H. Bukowski:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **C. Pouls:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis. **A. Vinckier:** Writing – review & editing, Writing – original draft, Methodology, Data curation. **T. Pham:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Funding acquisition, Conceptualization. **I. Jeandarme:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Funding acquisition, Conceptualization.

Declaration of competing interest

None.

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