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A theoretical framework for goal directed care within the prison system

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Abstract

When it comes to mental health care and treatment in prison, several ‘stakeholders’ are of importance in defining the availability, the aims and the quality of care and treatment. This group of stakeholders consists of prisoners, the providers of care, the prison system, the government and society. As a consequence, the goals involved in care are divergent. There is no sound theoretical framework comprised of well-defined concepts and that also accounts for the complexity of care in prison. Although prevention and the transfer of inmates to more specialized facilities are necessary, the focus in this article is on describing the processes involved in seeking and providing care within the prison system. We discuss a broad theory and its conceptual framework, in which we differentiate between prisoners with emotional suffering versus those without, the need for care from an objective point of view as opposed to a subjective one, need for care related to mental health problems versus need for care related to limiting recidivism, and the process of care seeking under the influence of approach in contrast to avoidance factors. The equivalency principle should have a substantial impact on the processes involved in this type of mental health care.

In the Netherlands, there is great interest in the issue of mental health care during detention. Politicians, the government and professionals all contribute to this increasing interest. The quality of care is also an issue, especially in regard to the standards of equivalence, which impose similar services in both correctional and non correctional settings. In addition, there is a partly contradicting tendency toward being tougher on crime, tougher in sentencing and being more strict during detention. Protecting society from dangerous and violent offenders is also an important issue in the Netherlands, just as in other countries. Treating prisoners (mentally ill or not) during their detention to reduce recidivism has become one of the main points of debate in Dutch policy.

When it comes to mental health care and treatment in prison, several 'stakeholders' are of importance in defining the availability, the aims and the quality of care and treatment. This group of stakeholders is comprised of prisoners, the providers of care, the prison system, the government and society. In this article¹, we will present a framework to clarify the complex process of care and treatment during imprisonment in general, and for the Dutch situation in particular. First, the actual care and treatment in Dutch prison will be described. Then we will focus on need for care from two different perspectives: mental health and reducing recidivism. The discussion of different concepts, treatment goals, motivation and the 'approach-avoidance' like process of care seeking will lead to the construction of a framework. This framework will be applied to the situation in Dutch prisons.

Care and treatment in Dutch prisons

Within Dutch prisons, there are different levels of care (Van Marle, 2007). In addition to basic health care, specialized mental health care is provided by a multidisciplinary team consisting of psychologists, forensic psychiatrists, medical services and sometimes social workers. The main task of this team is to coordinate individual health care. These professionals provide individual care and advise on creating specific circumstances within the prison to support the individual treatment

¹ This article is based on two Dutch manuscripts: 1- Bulten, B. & Schoenmakers, M. (2003) Toenadering en vermijding. *Proces* 82 (1) 32-41. 2- Bulten, B., Schoenmakers, M. & Oei, T. (2008) Subjective and normative care requirements of prison inmates In. T. Oei & Kaiser, L. (eds.) *Forensische psychiatrie onderweg* pp 145-160. Nijmegen: WLP.

of prisoners. Prisoners are referred to this care by the prison staff or by inmates themselves. When a mentally ill prisoner cannot be managed and treated properly within a regular prison, transfer to other correctional facilities, forensic hospitals or community psychiatric hospitals is required. Within the Dutch prison system, special units provide this more specialized mental health care. In the near future, five so-called institutions for “special care” will provide this care for 700 prisoners on a total population of about 14000 detainees.

The main focus of the special care units is to promote mental health. Treatment during detention aimed at reducing recidivism is mainly ‘training-oriented’ and is provided by probation officers, mental health service for drug abusers and, in some cases, therapist from (forensic) institutions for outpatient care and treatment.

Both mental health care and treatment aimed at reducing recidivism are subject to the influence of the traditional “custody-care” dilemma (Cloyes, 2007). The correctional staff and providers of care are faced with the ambiguity of pursuing both the original aims and demands of ‘security’ and the correctional tendency towards an “one size fits all” approach on one hand, and a more therapeutic, individualized orientation on the other hand.

However, in Dutch law there is a difference between regular imprisonment and the so-called TBS-order. Dangerous, mentally disordered, offenders can be sentenced under the Dutch Penal Law to involuntary admission to a special (TBS) hospital (12 hospitals with a total capacity of about 1800 beds). In those cases, the crime committed must have been serious and severe. In addition, the offender must have been suffering from a psychiatric or developmental disorder at the time of the offence, leading to reduced accountability (Drost, 2006). In most cases, a prison sentence precedes the beginning of treatment under this TBS-order. In the Dutch prison system, several of these offenders are doing their time before the start of the treatment in these special forensic hospitals.

This article focuses on ‘regular’ detainees without involuntary admission to a special hospital under the TBS order.

Mentally disordered prisoners

The rapid increase of inmates with serious mental health problems since the 1990s constituted the initial stimulus for a stronger emphasis on mental health care during detention. Just as in many other 'Western' countries, the inmate population in the Netherlands has become increasingly psychotic, depressive, and drug addicted (Bulten, 1998; Fazel & Danesh 2002; Anderson, 2004; James & Glaze 2005; Black et al. 2007; Butler et al. 2007; Bulten et al. n.d.). Mental and addictive disorders are common in both male and female prisoners (Gunter et al. 2008).

The prevalence of these kinds of mental disturbances in the prisoners is higher compared to the prevalence in the general population (Brinded et. al., 2001; Fazel et al., 2002; Andersen, 2004; Butler et al. 2006). For instance, in a large prison survey the prevalence of psychoses was over 10 times greater than in the general population (Brugha, et al., 2005). As a consequence, this high prevalence raises questions regarding the necessity of care for these inmates with mental health problems.

From the professional's perspective, these prevalence figures represent a potential high need for care. However, research has revealed a significant contrast between the prevalence of psychiatric disturbances and health care received (Gunn, et al., 1991; Birmingham, et al., 1996; Bulten, 1998; Schoemaker & Van Zessen, 1997, Blaauw et al., 2000; Andersen, 2004). This 'underconsumption' of care seems also to be true for the period before detention. Mentally disordered offenders in the community (before their incarceration) have high rates of need and low levels of treatment and care, the so-called 'inverse care law' (Harty et al., 2003).

Dutch research into young adult prison inmates also showed that mental health-oriented need for care (determined with standardized research instruments) was considerably greater than was provided. This varied per diagnosis; inmates with anxiety problems, in particular, make little use of the Dutch penal mental health care (Bulten, 1998). Teplin (1984) showed that in a US jail for remanded prisoners 62% of the severe mentally ill inmates remained undetected by standard procedures. Diverse European studies indicate that the need for immediate, essential and urgent psychiatric care is estimated at 6% to 12%, of which current care covers only a

portion (Blaauw, 2000). These percentages vary according to illness, prison type, period of detention and nation.

A North American study conducted under approximately 3600 inmates revealed that 45% of those with significant psychiatric or psychological problems were not treated by penal mental health services. Gender, ethnicity, education, and potential stigmatization are evidently associated with seeking mental health care. Male inmates were especially reluctant to ask for help (Steadman et al. 1991).

In many of these studies, the need for essential psychiatric care is established via structured and standardized research instruments. Yet, needs determined by professionals -not by means of standardized research instruments- generate different percentages. Dutch penal psychologists were asked whether there was a need for psychiatric or psychological help for inmates (Schoemaker & Van Zessen, 1997). For roughly one in every eight inmates, this question was answered affirmatively (12%) whereas the prevalence of mental disorder was much higher. Birmingham et al. (1996) established that professionals believe that 30% of the prison population requires mental health care, while Brooke (1996) found this to be 55% in a similar population. The exact definition of essential care varied in these studies.

Treatment and recidivism

Although mental health problems have become a characteristic of prison populations, the issue of need for treatment or care in relation to re-offending is also very important. Almost six out of ten prisoners re-offend within two years (Wartna et al. 2006). About 75% of the Dutch ex-prisoners commit another registered crime within the period of eight years, underpinning the necessity of the focus on reducing recidivism.

Furthermore, the effectiveness of treatments aimed at reducing recidivism, perceived rather pessimistically in the 1990s, began to be seen in a more optimistic light. The 'What works' perspective provided a conceptual and theoretical framework for reducing recidivism (McGuire, 1996). Society's welfare and safety are of central concern; factors conducing to crime dominate, as do the expected results in terms of lowering recidivism rates. In contrast to issues of treatment within the framework of mental health care, social concerns are the point of reference in this case. Rather than

mental illness, the 'social unsuitability' of the inmate is the prime focus in the 'What Works' orientation.

In England, the Offender Assessment System (OASys) was developed in order to assess those deficiencies which lead to crime (criminogenic needs). In the Netherlands (based on the Dutch version of the OASys: RISC) a prevalence of 40-60% minor to severe criminogenic needs was reported (Vogelvang et al., 2003). Psychological problems, working career problems, friends and activities related to offending behavior, financial problems, but also drug abuse and moderate to severe problems regarding thinking patterns were reported frequently. This is in line with conclusions that, in general, prison populations show a wide range of so-called criminogenic needs (Loza & Simourd, 1994; Hollin et al., 2003). From a societal perspective, this is an important conclusion.

The prevalence of criminogenic needs, assessed and established by research or professionals, does not inform us whether the inmate perceives this need as well, as the high prevalence of mental disorder in prison population doesn't automatically mean that the prisoner also perceives a need for mental health care. This raises the question whether inmates themselves feel the need for care or help.

Need for care

In general, we know very little about this subjective need for care or help. This is not only true with health care problems, but also in the case of recidivism. However, there is some information about the subjective general health care needs of inmates in the Netherlands (Schoemaker & Van Zessen, 1997). A quarter of a group of inmates that were interviewed required a physician or other health professional during their incarceration, though they did not actively seek help. Inmates reported that the most important reasons for not seeking help were their preference for solving the problem themselves, the believe that no one could help them, and that they 'had little faith in the available help.' Fear of being stigmatized was hardly mentioned at all. This data is based on a small group of inmates (n=32).

Also, Morgan et al. (2004) did not present exact figures on specific needs, but pointed out that the subjects in their study presented a variety of issues or problems, with a preference for individual counseling, provided by a well-trained professional.

In a small qualitative interview study, male respondents of a prison in England reported that in general they would not seek help from a general practitioner or other health care professional if they were experiencing mental distress. They feared the stigma of being labeled due to the diagnosis of a formal mental disorder. Lack of trust towards the 'system' and authority figures and distrust directed at healthcare professionals was often expressed (Howerton et al. 2007). In general there is little information about the way inmates perceive need for care.

What about the process of seeking help? Apart from this research, the empirical data on this matter are scarce as well. Deane et al. (1999) conducted one of the few studies addressing the relationship between the intentions of male inmates to seek help and their attitudes toward help professionals, fear of being helped, and emotional complaints. Thus, Deane (1999) did not conduct his work as part of treatments aimed at reducing recidivism. Attitudes towards mental health assistance were the only significant predictors of whether inmates really intended to ask for help. A positive attitude toward treatment increased the chance of seeking help. Inmates who had received assistance earlier and found it to be helpful had a more positive attitude toward treatment. Strikingly, fear of treatment and the degree of perceived psychic illness were not significant in this regard. This study reported a low response and a relatively small sample. Yet these investigators felt that the research material and the analyses provided sufficient reason to conclude that it was reasonably representative for male prisoners.

In a much larger sample Skogstad et al. (2006) also assessed the intentions to seek help for personal-emotional problems. The general attitude towards seeking professional psychological help influenced the intentions to seek help, as did interpersonal factors like social pressure. Intentions to seek help were also higher among older prisoners and those who had previous contact with a psychologist outside the prison.

Most of the research (e.g. Deane et al. 1999; Skogstad et al., 2006; Howerton et al. 2007) has been focussed on male detainees. However, gender or sexual identity probably has some influence in help-seeking behavior of detainees. In addition to the strong impression that men have a more negative attitude towards asking for assistance (Biddle et al. 2004) and keep more to themselves, along with evidence

indicating a greater tendency of masking personal vulnerabilities the influence of general prison culture is emphasized. This culture consists primarily of competition, aggression, and limited emotional sincerity. In a prison's hard environment, seeking help is likely to be seen as weak, a sign of vulnerability, and inappropriate (Deane et al., 1999; Morgan et al., 2004). Kupers (2005) refers to these barriers surrounding mental health treatment in prison as 'toxic masculinity'.

In conclusion, there is great variance in the conceptual definition of care. Also, the way prevalence of need for care is assessed depends on various viewpoints: the subject's, the professional's, or society's. The overall conclusion is that the goals involved in care definitely differ and that there is no sound framework that contains well-defined concepts and that accounts for the complexity of care in prison. In the next part of this article we will focus on the definition of some concepts.

Definition of concepts

What is the need for help; what is care; what is the difference between care and treatment; and what are care requirements? Who defines the term care and from what perspective; what is care's goal? Does the welfare of the inmate, the prison environment, or society take precedence?

First of all, the term care could be defined as an intervention or set of interventions aimed at the prevention of -or recovery from- mental illness, limiting the consequences of the illness, as well as making chronic illnesses or ailments bearable (Donker & De Wilde, 1999). Care can be provided through treatment, counseling, nursing, and the protection and promotion or maintenance of general health. This comprehensive definition of care covers all kinds of mental health activities and also covers penal mental health care, naturally with important differences in accents and sometimes limitations. In a penal institution, the maintenance and promotion of mental health, for example, should be heavily emphasized. In this article, we shall employ this specific, but also broad, definition of care.

The literature offers multiple ideas and definitions for the concept 'need for care' (Wiersma et al., 1999). Bradshaw (1972) differentiates between subjective and normative need. The subjective (or 'patient-assessed') need addresses needs as

presented by the patient or inmate, while normative ('provider-assessed') need is determined by the clinician or care provider.

Bradshaw also divides the concept into subjective categories, such as need that is merely felt (and not acted upon) and need that the patient asks for. At the moment that care is requested, the availability of care becomes important and, in particular, whether the available care is appropriate (Phelps, 1993). This refers to the suitability of a specific approach for a patient with certain clinical symptoms. An appropriate treatment is one which, in the end, provides a net increase in health, as compared to any other possible course of action, including no treatment at all. The most appropriate treatment is 'evidence based'. But there is also the difference between treatment that is 'clinically' appropriate (preferably 'evidence based') and treatment that is appropriate for ethical or juridical reasons (Van Kordelaar & Bulten, 2005). It is necessary to be aware of this difference, especially in a forensic context. For instance, a certain type of compulsory treatment can be 'clinically' appropriate but not 'legally' appropriate and vice versa.

Motivation, approach and avoidance

As previously noted, psychological complaints and psychiatric morbidity do not automatically result in the application of care. In the general Dutch population, approximately one out of seven people with psychological problems actually check themselves into a mental health institute (Wiersma, et al., 1999). There are many contributing factors, such as the nature and seriousness of the disturbance, gender, demographic variables, health care availability, earlier experiences with mental health care professionals, socio-economic status, but also motivation. Some of these factors are more or less static and historical factors, others like care availability and motivation are more dynamic and susceptible to change. We will focus on some important dynamic factors. The availability of mental health care will be addressed later along with the principle of 'Equivalence', wherein the quality and quantity of care equalizes the care in the community (Lines, 2006; Lines, 2007; Vlach et al. 2007). We will now focus our attention on a crucial factor, which is motivation.

The concept of (treatment) motivation is often linked to an individual need for help or care and the process of seeking help. Although motivation is an important concept

in this matter, several researchers underline the conceptual ambiguity of the concept of motivation (Drieschner et al. 2004). In an effort to overcome this ambiguity, Drieschner et al. (2004) developed an interesting model in which internal determinants of treatment motivation (level of suffering, outcome expectancy, problem recognition, perceived suitability of the treatment, external pressure and perceived costs of the treatment) contribute to motivation to engage in treatment. Besides intrinsic factors, motivation is also influenced by external factors like events in the patient's life, available resources, external pressure, etc.

The model of Drieschner et al. (2004) on motivation shows the complexity of the concept of motivation and the 'struggle' between determinants to engage in treatment and determinants to avoid such an engagement, and seems to be in line with another theoretical framework known as the approach-avoidance model. This conceptualization of help-seeking was introduced by Kushner and Sher (1989). Because of the need to identify the factors that causes people to approach and avoid seeking professional help at the same time, Kusher and Sher (1989) defined this tension as a classic approach-avoidance conflict (Miller, 1944). It appears that the decision to reach out for help is determined in part by the ongoing conflict between tendencies toward approach and avoidance. This tension can be seen as a process in which the tendency to seek out care (approach) appears to increase as psychological problems and subjective feelings of disturbance grow. However, avoidance tendencies grow even stronger during this process. The factors that produce avoidance (e.g., stigma, fear of care, cost) weigh more as one approaches the 'feared' or 'hoped for' goal. Some avoidance factors deserve a closer look (Vogel et al. 2007), such as social stigma, treatment fears, fear of emotion, anticipated utility and risks, self-disclosure, social norms and self-esteem.

Kusher and Sher (1989, 1991) had a "non"-criminal population in mind when they developed their model. Nevertheless, there is no reason to assume that the approach-avoidance model is not applicable to prison inmates. This population too has motives to seek out help (emotional disturbance, mental suffering, danger of recidivism, family pressure, or other stresses, etc.) and at the same time strong reasons to avoid assistance (e.g. fear of care, fear of being labeled mentally ill, fear of emotion, social

norms, self disclosure, self-esteem, distrust, cost, etc. ; Mathias & Sindberg, 1985; Mobley, 1999; Kupers, 2001; Morgan et al., 2004; Vogel et al. 2007).

An integrative model

In the previous part of this article we differentiated between prisoners with emotional suffering or ego-dystonic symptoms versus those who don't, the need for care from an objective versus a subjective point of view, need for care related to mental health problems versus need for care related to limiting recidivism, and the process of care seeking under the influence of approach versus avoidance factors. All these different aspects are integrated in a model (see figure 1). This figure is an illustration of the model describing process of care seeking.

The entire process begins with the question as to whether there is mental suffering or not. Is the prisoner suffering emotionally, does he have a mental disorder with ego-dystonic symptoms? Is he aware of the risk of reoffending and of the fact that without care the possibility of recidivism is substantial²? Different types of behavior and symptoms can deviate from the prevailing norm. However, one of the issues is whether the inmate experiences these as ego-dystonic. In case suffering and ego-syntonic forms of maladaptive behavior or symptoms are absent, the inmate will probably not experience a need to seek help.

Yet, even when they do have complaints and experience suffering, inmates do not necessarily feel the need to seek help. When they do feel some need for care, the approach-avoidance conflict influences the decision of whether help is actually sought or not. Such a subjective need for care can subsequently be transformed into behavior aimed at actually getting help. The motivation to engage this subjective need for care is in these cases followed by actually seeking it.

However, a subjectively determined need (subjective need for care: SNC) does not necessarily imply that there is a normative determined need for care (normative need for care: NNC), as does a normative determined need for care not necessarily imply a

² The so-called "What Works" literature demonstrates that proper care and treatment based on the risk-need-responsivity principles can contribute to reducing recidivism (see McGuire, 1996). For care in corrections a fourth principle seems to be of complementary importance: a human service delivery (Dowden & Andrews, 2000). Apart from that 'treatment-integrity' is another relevant principle.

subjective need for care. For example, a psychotic inmate may not feel any need for treatment or health care whereas professionals may consider psychiatric-medical treatment in this situation to be imperative. In treatments designed to reduce recidivism, it is also not improbable that inmates assess risks and recidivistic tendencies differently than do professionals. All these different options are delineated by this model. Likewise, Figure 1 points out the difference between whether the goal of mental health care treatment is primarily designed to improve mental health (in which case the mental disorder and its treatment are central; Mental Health Care (MHC)) or primarily to limit recidivism (in which case societal safety is a central concern). This is indicated as Reducing Recidivism (RR). However, these two goals are not mutually exclusive.

In order to avoid confusion when discussing desirability, necessity, effectiveness, and the goal of treatment in prison, it is of importance to clearly define the relevant concepts, to make the entire process transparent, and to carefully differentiate between the goals of various treatments. The chart below (see figure 1) displays these in a way designed to facilitate comprehension.

Figure 1

In the next part of this article we focus on the Dutch situation as an example, using this model and further analyzing the complexity of providing care in prison.

The Dutch Prison Service

The chart presented should serve as a guideline for the following discussion. With the assistance of this chart we now move to a discussion of the different combinations of subjective and normative care and the patterns of seeking care. These combinations represent different subgroups of prisoners.

A: Subjective and normative care requirements and patterns of seeking care

The most ideal situation is the one in which an inmate formulates a request for care when his subjective need coincides with the normatively established need (see A, figure 1). In this subgroup the ‘struggle’ of the inmates between avoidance and approach tendencies results in actually seeking help. In this subgroup health care provider and recipient are in agreement about the objectives and terms of treatment.

To be more specific, in Dutch prisons, about 26% of the detainees in general, non-special wards (in these non-special, regular wards about 90% of the total prison population is detained, the other 10% are transferred to special care and/of control units) receive some kind of mental health care for psychiatric problems and/or their drug abuse, mostly voluntary (Bulten et al., n.d.). About 16% of the prison population in those regular wards receive care from a special multidisciplinary team consisting of psychologists, forensic psychiatrists, medical services and sometimes social workers (see also ‘care and treatment in Dutch prisons’). In most of those cases there is agreement between this specialists team of care providers and the detainee.

So far for care from a mental health perspective in this subgroup. Based on a relatively new Dutch program on reducing recidivism (‘Terugdringing Recidive’), care and treatment aimed at the prevention of reoffending is increasing. With this type of care, agreement between the detainee and the professional on treatment goals is necessary.

In the process of determining the goals of care, one must be clear as to what is more important: the common good (prevention of recidivism), or the psychiatric issue and mental illness. In practice, this differentiation cannot always be made distinctly, particularly when normative and subjective needs match, or are strongly intertwined. It is, nonetheless, expedient to accentuate these differences, keeping the primary goal in sight, while also discussing it with the inmate.

However, even when specific health care goals are formulated and agreed upon, another important question still remains: whether effective, appropriate (evidence based) care is available, feasible and suitable for the specific conditions in prison.

B: Subjective need for care including seeking help, no normative need

An inmate can experience the subjective need for health care or help, while the professional health care provider has a different view. The reasons driving the inmate to seek care outweigh those of not doing so. In this subgroup, the health care provider is reluctant to give this care on professional grounds. This constitutes a lack of normative need (see B, figure 1). This can be the case for both mental health care and the reduction of recidivism.

There are several possible reasons for the reluctance of providing help. Although the inmate wants help, it could be the case that the professional does not see evidence indicating illness or does not consider treatment or care as a possible answer to the subjective needs. Naturally, intensive and careful contact must take place between the inmate and the professional. The professional has to explain and clarify his reluctance, but it is not out of the question to think that a difference in opinion can remain. In contrast to non-prison populations, Dutch inmates' options to ask for help at a different location, from other professionals, are rather limited. However, internal legal procedures give the detainee the opportunity to formally complain.

C+D: Subjective need for care without seeking help, with or without a normative need

Figure 1 illustrates the difference between experiencing a need for help, asking for help, and actively searching for help (help-seeking behavior). This is a relevant difference. A subjective need for care can exist which is never expressed (see C and D, figure 1). Filters within the penal care system and inmates themselves cause this difference. In this subgroup, the balance between internal and external determinants to express a need and seek help results in hiding this need some way. Do the expected benefits (e.g. reduction of suffering) outweigh the expected costs (e.g. effort, (self)image, costs) for the individual? Are the prisoners aware of all the possibilities the penal care system has to offer?

It is plausible that a safe, humane and positive psychosocial penitentiary climate is of influence on these filters. In practice, environmental influences on patterns of seeking care can indeed be quite complex, however. Thus, on the one hand, we can expect that in an optimal situation in prison, some basic health care questions are answered on the 'work floor' by members of the staff. On the other hand, it is

obvious that in such a situation inmates also have more confidence to voice their subjective need for help to professional care providers like psychologists, psychiatrists, nurses or social workers. In contrast, a poor psychosocial climate may generate health questions, yet paradoxically such an environment would discourage their expression. We still lack specific knowledge of these mechanisms. However, it is obvious that the staff members have a large role in creating and maintaining a proactive, protective, preventive and positive climate in which inmates feel more or less free to express their subjective needs (Dvoskin & Spiers, 2004).

This group of inmates (subjective need for care without seeking help, with or without a normative need) also raises questions concerning quality of counseling, available information about care, accessibility to care, the quality and quantity of care providers, observation and the policy of case finding and screening within the prison. After all, within this group there is mental suffering and a need for care. This is certainly so when a normative need is expected (for instance based on the observations by the staff), and the health professional finds that there is probable indication for treatment. Care has to be 'outreached' in these cases. Screening can be the first step in effectively and properly addressing the mental health care problems of those mentally ill prisoners (Lurgigio & Swartz, 2006; Swartz 2008).

From the mental health perspective, the 'poignant, languishing, care needy' patients are of prime concern. From the perspective of curbing recidivism, this group is important because these inmates have an unexpressed need for care in this terrain – a need which is also confirmed normatively if it would have been expressed. The challenge is in how to find, stimulate, and motivate these people to actually need care, want care, but also to put forward this need.

E: No subjective need for care and no help sought, with a definite normative need

The chart (fig.1) indicates clearly that there is a possibility that an inmate makes no complaint, while in fact a strong normative need for care exists (see E, chart 1). In penal health care, this is frequently the case with seriously mentally disturbed inmates. For example, an inmate's ability to realize he is sick may be absent,

physical complaints may be experienced egosyntonicly, or their origins may be sought in the environment.

In the most troubling and acute cases, inmates in the Netherlands are sent to special psychiatric wards where, when needed, forced medication is administered under strict conditions. The staff's role in these special facilities is crucial. They contribute strongly to the reduction of human suffering, to the maintenance of order and security, reduction of prison-like stressors, thorough observation, referral and supporting psychological and psychiatric treatment (Dvoskin et al., 2004).

In extraordinary situations, this can also take place outside of these sections. Transfer to a psychiatric hospital can be considered as well, although this is extremely difficult in practice until now (Reed, 2003; Zwemstra et al., 2003).

So far, with regard to severe mental health problems, under the aegis of reducing recidivism, the health care professional can estimate the normative need (criminogenic needs like antisocial attitudes, antisocial behavior, antisocial/criminal thinking, lack of cognitive, social skills, drug abuse etc.) to such an extent that care seems desirable. This presumes that this care (e.g. treatment or training) can positively influence recidivism. In these cases, normative need concentrates on the reduction of recidivism.

The implementation of a normatively established need in the absence of a subjective need, concerning the reduction of recidivism within the penal system, needs special attention. In quite a few situations, inmates experience their criminogenic needs as egosyntonic. They do not see themselves as 'socially ill' and (still) resist to treatment. In those situations it remains crucial to examine the method of motivating inmates, to determine the circumstances in which motivation can best be developed, in what way and with what kind of method the motivation development must take place. Care interventions must be carefully tailored to the learning style and skills (responsivity) of the detainee. The role of the executive personnel in this process is indispensable.

Under the TBS-law, offenders can be admitted involuntarily to special hospitals when the risk of re-offending is high, in combination with diminished accountability of the individual. In this context of regular imprisonment, treatment aimed at limiting recidivism, must be of a voluntary character.

F: Neither subjective nor normative need for care

The previous examples refer to situations in which inmates either have or do not have a need for mental health care and either do or do not express it by seeking assistance. However, we must not forget that there are also inmates who feel no need for treatment (which naturally generates no request for assistance), and for whom there is no reason to encourage treatment from a normative perspective (see F, chart 1). Not for mental health reasons, nor for the reduction of recidivism.

Prevention, transfer and diversion

The focus in this article is on the description of the processes involved in seeking care or not within the prison system. However, some remarks on prevention and the transfer of inmates to more specialized facilities are necessary.

Being in prison can have a strong impact on individuals. Dvoskin et al. (2004) mention five major stressors in correctional settings: anger, fear, loss of autonomy, uncomfortable physical limitation and humiliation, and their sometimes insidious impact on the psychological well being of all members of the prison community. Reducing the effect of these stressors will probably have a positive effect on the mental health of prison inmates and can be preventive for mental health disorders. On the other hand, it seems that some characteristics of the prison environment, like structure, can have a beneficial effect on the course of psychosis within a prison population for instance (Blaauw et al. 2007).

Mental health service in prison should include three distinct phases: 1- comprehensive assessment, monitoring, mediation, 2- intensive treatment, and 3- release, reintegration and preparation phase (Welsh & Ogloff, 2003). In all three phases, transfer to special units within the correctional system or (forensic) psychiatric hospitals outside the prison service may be inevitable.

Diverting mentally ill individuals into community-based care instead of jail and prison can improve health outcomes and prevent unnecessary criminalization of

mentally disturbed patients. Though not the core of this article, nevertheless a very important part of the penal system

Conclusion

Inmate care is indispensable, and they have a right to it. The equivalency principle is in effect regarding this health care: care within prison walls must strive to match that outside those walls. Within this principle, sound mental health for inmates is a fundamental component (Wilson, 2004; Lines, 2006, 2008). People in prison have the right to a standard of mental health care equivalent to that available outside of prisons

Of course, we cannot lose sight of the societal interests in a penal context. The design and implementation of treatments to limit recidivism are desirable, but most certainly cannot act as substitutes for vital health care.

For the development of both mental health care and of treatment aimed at reducing reoffending, it is important that individual, subjective care needs are clear and well known, and that they are compared to normative needs. The formulation of goals, type of need, 'clinically', ethical and juridical appropriateness of the care, etc. must all take place within a clearly defined framework. This article is designed to get this process going.

It is important to influence the process of expressing subjective needs and prisoners' motivation to seek help (if necessary). It is equally important to develop and maintain a psychosocial climate within the prison; a climate in which good surveillance and screening procedures function to detect prisoners with severe problems (normative need for help).

There is need for a broader theory and a conceptual framework. The approach-avoidance model can be a helpful part of such a framework, and, if related to a sound concept of motivation, be part of a broader theory about the subjective and normative need requirements of inmates.

Solving mental health problems and reducing recidivism are not mutually exclusive. However, it is important to carefully differentiate between these goals; for the

inmate, for the health care system, for care providers aimed at reducing recidivism, for professional ethics, and for research in general.

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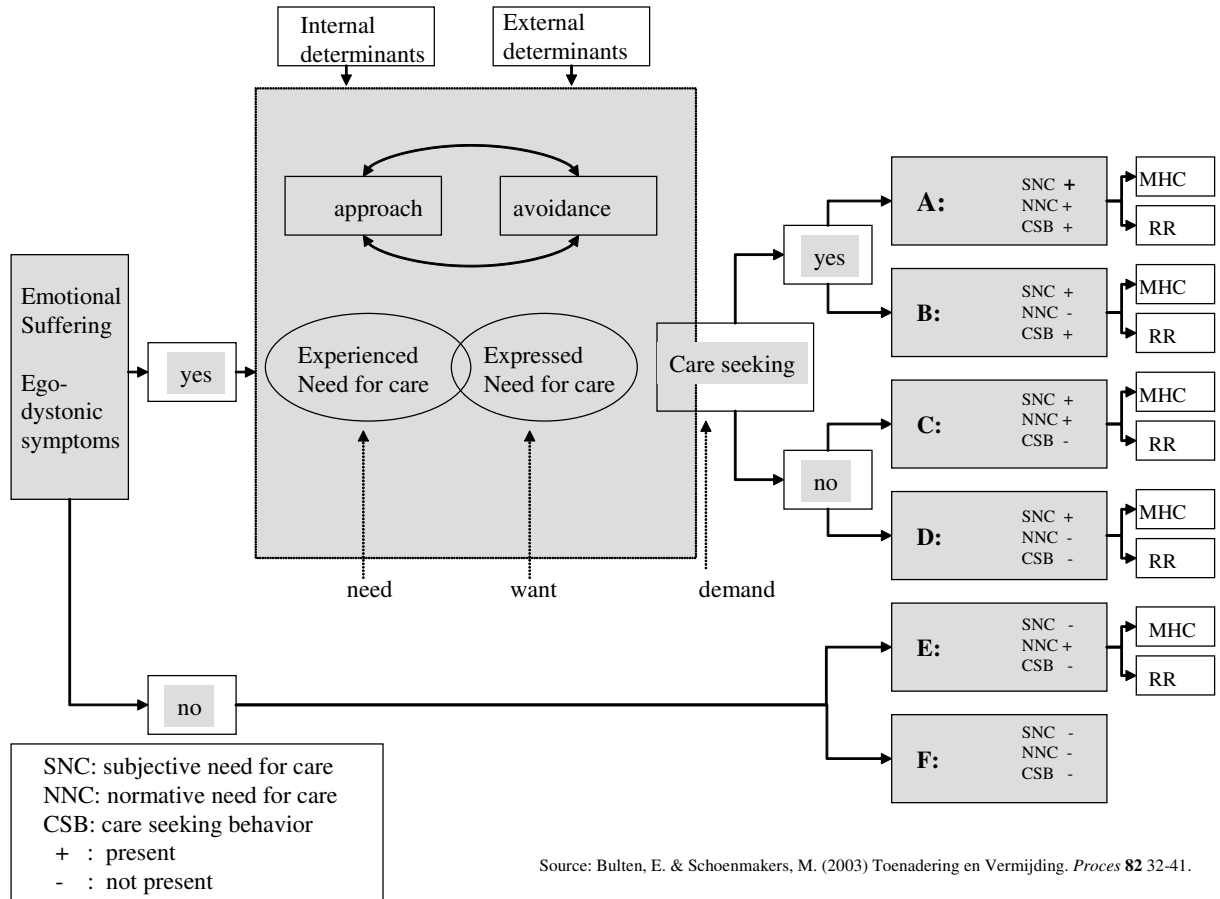
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Figure 1: Process of care seeking for goal directed care



Source: Bulten, E. & Schoenmakers, M. (2003) Toenadering en Vermijding. *Proces* 82 32-41.