

Summary of forensic care programmes in the prison system

Study carried out at six penal institutions into signalling, care indication and placement

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Reason for and aim of the study

There are many prisoners in custody who have mental problems: psychiatric symptoms, addiction, a (mild) intellectual disability ((M)ID) or a combination of these problems. In 2014 over 1,600 prisoners, out of an intake of 41,400 prisoners, were referred for clinical care; over 1,000 of these were placed in a Penitentiary Psychiatric Centre (PPC) and 500 in a general mental health institution (GGZ) (www.dji.nl). It is believed that the provision of timely, suitable, high-quality forensic care contributes to a reduction in recidivism, so care programmes have been developed in an attempt to provide care and continuity of care for these prisoners during and after custody. If the Ministry of Security and Justice (VenJ) is to be able to provide better forensic care within the prison system and optimise the placement process, it needs to know how decisions are made about prisoners with psychological en psychiatric (mental health) problems. DSP-groep was commissioned by the Scientific Research and Documentation Centre (WODC) of the Ministry of Security and Justice (VenJ) to carry out a qualitative study into how decisions are made about the (forensic) care programmes of prisoners in six penal institutions and the progress of these programmes.

Scope of the study

The study focuses on the forensic care and the basic mental health care provided for prisoners (pre-trial detainees, convicted persons and repeat offenders (ISD)) from the time that they arrive at the penal institution (PI) until the time that they leave the PI. Forensic care is defined as mental health care, care for drug addicts or care for individuals with a mental disability that is part of a (conditional) punishment or measure or the implementation thereof, or another criminal punishment. There is also basic mental care provided in every PI. This care is provided by a multidisciplinary team – the Psycho-Medical Team (PMO) – consisting of a prison psychologist, the psychiatrist from the Dutch Institution for Psychiatry and Psychology (NIFP) and the medical service. Prisoners with psychological problems, psychiatric symptoms, addiction and/or a mild intellectual disability are discussed in the PMO. The PMO then decides whether there is a need for a referral to basic mental care or forensic care. The study is restricted to the perspective and the experiences of the PMO professionals and the case managers in the PIs studied and to the care programme from the time that the prisoners arrive at the PI to the time that they leave the PI.

Research questions and approach

The study provides answers to four central research questions:

- 1 What form does the decision-making take in the PMO?
- 2 Are placements carried out in accordance with the procedures set up concerning this?
- 3 What happens to prisoners who do not join a care programme but for whom this is desirable?
- 4 What form does the care programme for prisoners take?

The study was carried out in six PIs. The study, carried out at these six PIs, involved four remand centre departments, five prisons, a PPC and three repeat offenders units. The following qualitative research methods were used for answering the research questions:

- Desk research.

- Group interviews with representatives of the PMOs in the six PIs (22 respondents).
- Case study of 79 anonymised cases (27 prisoners in preventive detention (pre-trial detainees), 23 convicted persons, 26 repeat offenders and 3 detainees) consisting of a digital questionnaire carried out among psychologists and a telephone interview with case managers or psychologists. The cases were selected with a view to obtaining a diversity of types of care programs and referrals.
- Feedback interviews with representatives of the PMOs in the six PIs.
- Group interview with the regional psychologists with the aim of assessing whether the findings in the six PIs were recognisable for other PIs.

Scope and limitations of the study

The study is a qualitative study and provides insight into patterns, factors and bottlenecks that play a role in the referral, care assessment and placement of prisoners in forensic care. The study does not provide a quantitative representative picture of the degree of success achieved in providing timely, suitable care for prisoners with mental problems. Nor does the study provide a quantitative picture of the effect of the bottlenecks. A quantitative study needs to be carried out for this that involves a representative sample of all PIs.

The findings presented in this report are based on interviews with the professionals from the prison system who implement the care programmes within the forensic system. The findings primarily reflect the experiences and opinions of these professionals in a general sense and more specifically with regard to the cases studied. This study did not look at the perspective of the mental health care institutions (GGZ) and other chain partners, such as probation officers. As some bottlenecks and improvement points relate to (collaboration with) these chain partners, it is recommended that their perspective be studied in further detail.

Simply by listing the bottlenecks and improvement points that were mentioned by several PMOs and that were also recognised by all the regional psychologists we are providing a basis for the policy and for a further quantitative study. The study was carried out in six PIs with various purposes. This was a conscious choice aimed at including as much diversity as possible in the case studies. We succeeded in including diversity in the case studies, with the exception of the short-sentenced prisoners. These cases were not adequately covered in the study. The results relating to prisoners are therefore mainly about long-sentenced prisoners. We note that the number of cases looked at in this study is not representative of the total population of prisoners. The results should therefore be used only as an illustration of how forensic care programmes are designed and the possible bottlenecks therein.

This study was carried out during a period in which a lot of new developments were taking place in forensic care. As it was not possible to carry out the field work in the various PIs simultaneously, implementation of the new developments had progressed further in some PIs than in other PIs. Moreover, some findings are currently no longer relevant as there is now a solution to these. This was taken into account as much as possible in the interpretation of the findings.

Referral to and decision-making in the PMO

Tasks and responsibilities of the PMO

In accordance with the procedure for psychomedical care in the prison system, in all the PIs one or more PMOs were set up that hold weekly meetings about the *prisoners* who have been referred to the PMO. Each PMO discusses 15 - 40 prisoners each week depending on the capacity of the PI. The study revealed that the emphasis in the PMO, according to the respondents, is strongly on drawing up indications and there is insufficient time for multidisciplinary discussions of complex cases. The (administrative) workload is regarded as being great. If the psychologists were relieved of some of their administrative tasks, more time could be freed up for basic mental care. Moreover, there is uncertainty among the respondents about the tasks and responsibilities of the PMO with regard to the indication and referral to mental health care in the last phase of custody.

Repeat offenders are discussed in two of the three repeat offender units studied in a separate PMO specifically for repeat offenders; in the third repeat offender unit repeat offenders are discussed in the general PMO (for all detainees in the PI). In each PMO 10 - 20 repeat offenders are discussed. The case load of the psychologists in the repeat offender units studied is great as repeat offenders are regularly returned to the PI after out-placement in mental health care either definitively or for a time-out. As a result of this it is not always possible to carry out additional diagnostic research in some of the repeat offender units in the first phase, which is what should happen. Sometimes there is too little time for basic mental care in the form of motivational and supportive interviews with the psychologist. We believe that this latter can have consequences for the further progress of a care programme.

Referral to the PMO

Prisoners are referred to the PMO in all the custody phases. This often happens in the first ten days of the Intake Screening and Selection phase (ISS phase). However, this is not always possible and necessary according to the respondents. Not all problems are immediately obvious or they do not manifest themselves in such a way that there is a reason to take action. Also, the (main) care requirements of a prisoner can change – because of comorbidity – during the custody period or there could be some destabilisation. The study shows that problems that are missed in the ISS phase are often depression or a mild intellectual disability problem.

All the repeat offenders are discussed several times in the PMO. So in the case of this target group there is no referral to the PMO. Problems or signals during the intramural phase of the repeat offender measure are reported immediately to the PMO according to the respondents.

Decision-making in the PMO

Decisions about prisoners in the PMO studied are made on the basis of the information collected by the medical service about medical details from outside custody, legal details from JD online, details from the DJI (Custodial Institutions Agency) internal systems (MicroHis, ISP, DUWAR), observations from the department and meetings with the psychologist and/or psychiatrist with the prisoners. It is sometimes difficult for the medical service to request medical information from outside custody according to the respondents. The internal systems are unevenly filled in. In the case of acute problems with prisoners in preventive detention who are admitted shortly before the weekend the information is missing, because the systems cannot be accessed until after a prisoner has been enrolled in the prison (after the weekend). The medical service is then dependent on the information that prisoners themselves provide. In the case of arrested detainees the lack of medical

information from outside the prison system is regarded as a bottleneck. They stay for such a short time in the PI that it is important that the information is received quickly. This often does not happen. The lack of medical information on arrival can have consequences for the speed with which a prisoner is referred to the PMO and the most suitable care that can be provided.

All repeat offenders arrive with a probation report. The extent to which the information in the probation report is sufficient to determine what care is needed depends, according to respondents, on the scope, the quality and the date of the report. In the first phase of the repeat offender measure the idea is that the psychologists carry out an additional diagnostic examination. The extent to which this is possible varies in the repeat offender units studied and depends on the case load of the psychologists. According to psychologists a lack of time is the main reason that they do not carry out an additional diagnostic research themselves. The requirement for additional research then lies with the mental health clinic where the repeat offender is placed. The outcome of this is that in the case of a referral to a clinic for diagnosis it is not always clear whether this clinic is also the right place for the treatment and there is therefore less time left during the repeat offender measure for the treatment in the clinic. In view of the waiting times at some clinics this can have consequences for the completion of the treatment during the period of the measure.

The study shows that the principle *mental health care unless* – i.e. that prisoners with psychiatric problems, addiction problems or a mild intellectual disability are placed in a mental health institution unless there are contraindications – is not feasible for all prisoners according to respondents. In the case of pre-trial detainees there is a lack of clarity as to whether placement in general clinical care is legally permitted. The agreements and guidelines relating to this have not (yet) been well implemented, as a result of which this principle is not applied in the PIs studied in the case of pre-trial detainees. In addition, in the case of pre-trial detainees it is also relevant that it is not yet clear whether and for how long they will stay in custody (punishment not yet known). The waiting lists for clinical care are often too long to be able to place the prisoner for treatment within the duration of the pre-trial detention. Here it should also be taken into account that a PPC is a better framework for a patient for the assessment of their motivation and willingness, for diagnosis of the psychological and psychiatric problems and for providing the desired clarity for the patient.

Nor is the *mental health care unless* principle applied as standard in the case of convicted persons. Here too the remainder of the sentence plays a role. If there is too little time left of the sentence, there is insufficient time to carry out the treatment, especially in view of the waiting times in the mental health institution (GGZ). In the case of both pre-trial detainees and short-sentenced prisoners ongoing care in the form of basic mental care can provide a solution according to psychologists.

Supportive, stabilising meetings can work on the motivation for care, the aim being to improve the connection between the care before custody and that after custody.

Long-sentenced prisoners can often not be transferred if there is no clear idea of when the prisoner will be eligible for possible leave, according to respondents. Clinics work towards greater freedom and want to have an idea of the timescales in which this is possible with the clients. Moreover, we note that there is an impression that clinics regularly refuse prisoners after indication and refer to NIFP/IFZ, for example because they are afraid that they cannot handle the prisoners' problems. It is

not clear how often this happens and to what extent this is reported to the placement desk of the Forensic Care Department (DforZo).

Indications not totally in accordance with care needs

It appears that – in the case of both prisoners and repeat offenders – the indication and referral to care in the PIs studied also take into account the care available and the waiting times. So the indication report is not fully focused on the need for care, as it is intended to be. As, in those cases, no indication report is requested by the PMO for the most suitable care, these needs for care are not recorded anywhere. So there is not a representative (quantitative) picture of the need for care of prisoners at DforZo (and PIs).

At the moment the Stepped Care model is being implemented in the PIs. The idea behind Stepped Care is that there is as little treatment or care as possible but as much as is necessary. However, we note that in the PIs studied a choice is not always made for basic mental care if this is sufficient. If there is insufficient capacity among the psychologists to provide basic mental care, the care is scaled up to ambulatory care provided by external mental health care providers.

Placement in accordance with procedures

In the PIs studied the placement of the prisoners and the repeat offenders takes place according to the procedures. These have to be followed to make the financing of the forensic care possible. The procedures are regarded as complex by the psychologists. The IFZO digital system is regarded as being user-unfriendly and time-consuming. A lot of information has to be entered. The administrative burden is regarded as being too great. During the time that the study was being carried out a solution was found to the bottleneck that consisted of all the details having to be re-entered on reassessment. In the new version of IFZO fields can be copied from an earlier assessment. This will remove part of the administrative burden.

We also conclude that, according to psychologists, the partners in some regions do not comply with the roles within the procedures and/or there is a lack of clarity about the roles and procedures. The agreements at national level are still insufficiently implemented in the PI and the regional collaboration.

On the basis of the findings of the study the question can be asked as to whether the complexity of the procedures and the digital system support the care indication and placement process.

The idea that there should be independent care indication and placement is endorsed by most of the psychologists interviewed. However, this works well only if the type of care offered by the care providers in IFZO corresponds to the type of care that they can actually provide. The experience of the psychologists is that this is not always the case: the listed or registered care is not available and is not up to date and referrals are refused. There is no good record of the number of refusals or of the returns or of the extent to which second-best care is provided, as a result of which these experiences cannot be quantitatively supported. The study shows that there is a need among the PMO professionals for research into the extent to which the care providers provide the contracted care and the quality of the care provided. As this does not exist, proper indications are not

stipulated or requested, and care indication reports are focused on the care that is offered by providers. This means that the principle of independent care indication and placement is breached.

Care advisable but not provided

All prisoners who need care usually receive some form of care, but this is not always the most suitable care and this care is not always provided on time. Basic mental care, placement in an Extended Care Facility (EZV), placement in a PPC and additional ambulatory care are possible in most cases. In all cases this is care that can be prescribed by the PMO itself. However in some PIs the EZVs are very full and prisoners are put on a waiting list. A decision is then taken as to which prisoner needs a placement in the EZV the most.

If a placement in the EZV, in the PPC or in ambulatory care is not immediately possible, the PMO members provide interim care (to bridge the period until placement in the indicated care) as much as possible. Lack of capacity does not allow this in some PIs. If it is not possible to place a prisoner in clinical care, in the case of acute and serious problems a choice is made for placement in the PPC or a decision is taken as to whether additional ambulatory care or basic mental care will suffice as second-best care.

Care programs are regularly interrupted in the case of the repeat offenders studied. In several of these cases it is, on the whole, not possible to achieve the extramural phase. i.e. realizing placement in a mental health clinic. At the end of the repeat offender measure these offenders are still waiting for the indicated care. In the case of this group the last phase is then mainly used to organise a daytime activity, accommodation, etc. In the case of this group too the waiting time has a negative effect on the treatment motivation of the prisoner.

Placement and outline of the care programmes

The study shows that there is a lot of diversity in the forensic prisoners' care programmes. This is in keeping with the individual approach advocated by DJI. The programmes are customised.

A successful placement means that the prisoner is placed in suitable care in good time. This seems to depend on the prisoner's motivation for treatment, the care available and the waiting lists, the psychologist's network (the extent to which there are short informal lines between the psychologist and the external mental health care providers), and the communication and feedback between the external care providers and the PI. Successful placements can be boosted through investment in the promotion and facilitating of collaboration between the PI and the mental health institutions (GGZ) and the implementation of the collaboration agreements concluded between GV, DforZo and the mental health institutions.

Although attempts are made to obtain a placement in clinical care or in assisted-living and sheltered units for all repeat offenders in the PI studied in the extramural phase, this is not always successful for all repeat offenders. The route to the placement is highly varied. There are sometimes long waiting times for repeat offenders for clinical care and above all for assisted-living and sheltered units. However, this differs a great deal from region to region as well as within regions and also from institution to institution. The long waiting times can have consequences for the repeat offender

care programmes and the extent to which it is possible to use the extramural phase in accordance with the repeat offender procedure. In the case of repeat offenders feedback and communication with the external care providers appear to be important factors in whether or not the placement succeeds.

The psychologists indicate that there is a shortage of earmarked, suitable places for forensic care patients in sheltered-living and assisted-living units and in some municipalities for clinical mental care. On a national scale there are also insufficient suitable places for female prisoners and repeat offenders.

Type of care provided

There is often comorbidity in the case of the prisoners and repeat offenders for whom forensic care is indicated. The type of care which is initially prescribed depends on the problem that is dominant at that time and that needs to be tackled first, according to the psychologists. The prisoner's motivation for treatment – and this is more emphatically the case with repeat offenders – plays a role in the decision as to what type of care will be first provided. As a result of this the starting point that the most suitable care should be prescribed is not always adhered to.

Time-outs and definitive returns in forensic care programmes

There are a lot of time-outs in clinical placements according to psychologists. This is the case with repeat offenders in particular. Definitive returns to the PI also happen on a regular basis. Care or treatment programmes are often interrupted, particularly in the case of prisoners who have addiction problems. The study shows that experiences with interrupted placements also play a role in prisoners not (or no longer) being referred to clinical care by the psychologists interviewed. This cannot be supported by figures. There is no clear picture of the number of placements in the mental health institution (GGZ) that are interrupted. Nor is there a clear picture of how many prisoners ultimately successfully complete the clinical treatment in the mental health institution (GGZ). Quantitative research can provide a picture of this and can support or refute impressions.

Match with care after custody

The different financing streams and a lack of clarity about the responsibilities of the various indication partners form an obstacle to subsequent care after the custody period. The findings of the study advocate earlier and timely consultation between PMO and case managers and probation about the required care. We believe this is also necessary for a good match between the care given during custody, the care requirements after custody and the care imposed as part of the sentence.

The coordination of follow-up care for prisoners who have no conditional framework after the end of their custody is mentioned as a point of attention. The prisoner him/herself or a support organisation itself has to then request that the prisoner be prescribed voluntary care. According to respondents it is important that during custody some work be done on prisoners' motivation for this treatment. At the moment the PIs studied have no standard time or capacity to provide this ongoing care in the form of motivating, supportive meetings. A bottleneck in the case of detainees is the fact that a lot of detainees are not insured.

With regard to repeat offenders this study focused mainly on the care indication and placement of repeat offenders in forensic care during the extramural phase. The study shows that in several

cases repeat offenders have to leave the clinic or unit if the measure and therefore the forensic criminal punishment ends. Whether the repeat offender may continue to live in the clinic or in assisted-living units after the measure depends on the agreements concluded by the care providers with the municipality and the region.

Collaboration between PI and the mental health institutions, care for addicted persons and mentally disabled persons

According to the psychologists interviewed there is good collaboration between the PI and external mental health care providers of ambulatory care with whom there has already been collaboration (for a long time). Clear agreements have been concluded with these providers about information transfer in accordance with professional rules, the psychologists are kept well informed, there are short lines, the external psychologists have experience in providing treatment within the custody framework, and there is a clear vision of how many clients they can treat. It is often difficult to make agreements with external new partners and it takes time to conclude good agreements. External mental health care providers who are new do not fully realise what it means to provide treatment within the walls of a prison. It is not feasible to bring in a specific treatment from an external provider for a prisoner. But this is the starting point for the purchase of ambulatory care by DForZo. However, this is difficult to achieve in practice.

The study shows that the collaboration between PI and clinical care institutions is highly individual. How well transfer and regular feedback work depends mainly on whether psychologists and therapists of the clinic know each other. Agreements and frameworks have been established for collaboration and feedback at policy level but these are not yet being equally well implemented overall in practice. In addition, the study revealed a need for greater checks on and control of the agreements.

Overall conclusion

The purpose of this study was to gain insight into how decisions are taken about prisoners with mental problems and how the forensic care programme within custody is then designed. We conclude that the psychologists and the PMO in the PI go to a lot of trouble to indicate and provide care for prisoners with mental problems. In most cases they succeed in providing (some form of) care – even if this is not always the most suitable care. The type of care that is best at any particular time in custody differs from person to person and is in keeping with the individual approach advocated by DJI. 'Most suitable care' does not necessarily mean that the prisoner is transferred immediately to the mental health institution (GGZ). This study shows that that the PIs comply with the principles of Stepped Care that were being implemented at the time of the study: as little intervention as possible but as much as necessary. Not only is good basic mental care important in leading on to forensic care; it also plays an important role in ongoing care and interim care. The bottlenecks and improvement points referred to in this study provide a basis for providing even more prisoners with the most suitable care.



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