Recommendation from the Council for the Administration of Criminal Justice and Protection of Juveniles
- Summary -

Forensic Care during Detention

Recommendation to the Dutch State Secretary for Security and Justice, dated 27 September 2012

The Council issued a recommendation on its own initiative about care during detention for detainees with psychological disorders, mental impairments or addiction problems.

The following recent developments prompted the Council to issue this recommendation:
- The transfer of the relevant budget from the Ministry of Health, Welfare and Sport to that of the Ministry of Security and Justice (2008);
- The introduction of an 'additional care facility' in each penal institution.
- The introduction of five custodial psychiatric centres;
- The measures in the context of the Prison System Modernisation Programme; and
- The implementation of the Forensic Care Act (expected in 2013).

The central question is whether the forensic care provided to detainees is currently in order, both qualitatively and quantitatively.
The Council has concluded that, in particular, the introduction of the custodial psychiatric centres is a positive development. Since the transfer of the care budget from the Ministry of Health, Welfare and Sport to the Ministry of Security and Justice, the Minister of Security and Justice has been responsible for the mental healthcare facilities for offenders. With this structural change, the Netherlands has taken a different course from what is generally recommended and pursued internationally. So far, the practical results have not been negative. This course may therefore be continued, provided that the quality of the care is guaranteed.
However, there are still a number of major bottlenecks that exceed the level of start-up problems.

The psychological problems among detainees are serious and extensive. Approximately half of the detainees have personality disorders, 40% experience addiction problems, and circa 15% are mentally impaired. The detainees often have multiple problems. Only a very limited proportion of them receive specialised care during detention. The Council has estimated that approximately 10% of the detainees are designated as needing specialised care. Not more than 8% of the detention capacity (i.e. the custodial psychiatric centres and the Institutions for Habitual Offenders) can be classified as care facilities. This is not in proportion to the scope of the observed problems.

The Council has observed the following:
- Bottlenecks in the screening of detainees, as a result of which psychological disorders are not recognised as such;
- A shortage and overburdening of psychologists, and interrelated to this, the limited functioning of the psychological and medical consultation committees; and
- Long bureaucratic procedures for needs assessment and the placement or transfer of detainees, which show little confidence in the care professionals who are dealing with the relevant detainees.

As a result of all this, the required care is sometimes provided late or not at all.

The Council finds that there is too great a difference in the level of care between the

custodial psychiatric centres and the other detention places. The level of care provided in the additional care facilities is not different from the standard wards.

According to the Council, the custodial psychiatric centres have developed in the right direction, but they still fail to provide sufficient specialised care to persons held in long-stay detention. The Council supports the desire to give the custodial psychiatric centres a coordinating function to improve the care in the penal institutions.
The treatment of 'habitual offenders' (often addicts) is often seriously delayed by the prolonged needs assessment and placement procedures. As a result of this, the treatment in an addiction clinic often starts much later than necessary, and the time that is left within the judicial framework is often too limited.

The central principle in the care for detainees who suffer from psychological disorders is 'mental healthcare unless': this care is provided *by* and possibly also *in* the mental healthcare facilities. This principle has been supported government-wide for a long time, and will be given legal status in the Bill on forensic care, but has had insufficient implementation in practice. In order to be more successful in achieving this aim, the judicial authorities and the mental healthcare institutions should strive to achieve common objectives, starting points, quality requirements, and integrated working processes. By setting up regional networks, the custodial psychiatric centres will also be able to play an important role in building a bridge between the judicial authorities and the mental healthcare institutions.

From a social point of view, the reduction of recidivism is an important objective of forensic care. It is therefore important to obtain insight into the effects of treatment and to consequently improve the treatment results, and to increase the support for forensic care. At the same time, the Council is of the opinion that the reduction of recidivism should not be the most important objective of forensic care. The Council considers the provision of responsible care, also in the context of resocialisation, equally important.

In order to increase the positive developments set in motion in forensic care during detention, the Council considers it necessary to make improvements (i) at the start of forensic care upon placement in detention, (ii) in the range of forensic care options during detention, and (iii) to the detainees discharged from forensic care during detention. This has resulted in the following recommendations:

Recommendations with regard to the start of forensic care upon placement in detention:

1. Improve the screening of detainees with regard to psychological problems, and increase the warders' knowledge about psychological disorders.
2. Simplify the needs assessment by reducing the number of parties involved and by assigning the decision-making power at a lower level in the organisation.
3. Make one care professional responsible for the coordination at case level (preferably the professional doing the intake) and provide support to this end.

Recommendations with regard to the range of forensic care options:

4. Designate the additional care facilities for psychologically vulnerable detainees and strengthen the position of the additional care facilities in the forensic care pathway by organising them in such a way that these facilities will *actually* be able to provide additional care.
5. Improve the treatment options in the custodial psychiatric centres, in particular for persons held in long-stay detention, without, however, abandoning the principle of 'mental healthcare unless'.
6. Reserve sufficient capacity for the needs assessment with regard to habitual offenders, addicted or otherwise.

Recommendations with regard to the detainees discharged from forensic care:

7. Give each custodial psychiatric centre in its region a coordinating function for the surrounding penal institutions, and support the custodial psychiatric centres as network organisation within the range of care options provided regionally.
8. Do not allow a relapse in substance abuse to discontinue a transfer to an addiction clinic that has already been set in motion.

Overarching recommendation:

9. Strengthen the forensic care pathway during detention with regard to the detainees arriving in the penal institution, the range of forensic care options, and the detainees discharged from forensic care, and examine whether the custodial psychiatric centres could be strengthened further in assuming a more directive function as coordinating organisations.

The recommendation can be obtained from the secretariat of the Council
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