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# The subjective and normative care requirements of prison inmates\*

B.H. Bulten, M.P.L. Schoenmakers en T.I. Oei

## *Introduction*

In the Netherlands, there is great interest in the issue of care during detention. Politicians, the government and professionals all contribute to this increasing interest. In addition, but also in part opposed to this development, is the tendency toward being tougher on crime and tougher in sentencing.

The rapid increase of inmates with serious psycho-medical 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<sup>1</sup>. It is logical, then, that this high prevalence raises questions regarding necessary care of these inmates with mental health problems. The professionalization of health care within the penal system added extra impetus to these questions. These issues did not take into account the question as to whether these inmates themselves actually feel a need for care or treatment. Lack of insight concerning their illness, suspicions or bad experience with health providers, for example, may influence this need. Out of necessity, as an *ultimo refugium*, the prison system has adapted itself as best it could to these circumstances. Basic prison mental health care programs and facilities were

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B.H. Bulten & M.P.L. Schoenmakers, 'Toenadering en vermijding. Over mogelijkheden en beperkingen van penitentiaire geestelijke gezondheidszorg', *Proces*, 2003, p. 32-42.

<sup>1</sup> Bulten 1998; Fazel & Danesh 2002; Andersen 2004.

developed. Linking this mental health prison service with the non-penal mental health care system remains particularly problematic, however.<sup>2</sup>

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' program provides a conceptual and theoretical framework for this. Many policy initiatives designed to reduce recidivism were presented.<sup>3</sup> Society's welfare and safety are of central concern; factors conducive 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 here. Rather than mental illness, the 'social unsuitability' of the inmate has become the prime focus.

Both developments support the policy of treating inmates. Health care professionals have taken the lead in mental health care, while questions from a society that does not feel safe play an important role in treatments designed to reduce recidivism. What do inmates think about these developments, however? Which kind of needs do they experience and express? Empirical data on the type of need are rather scarce. In this article we try to integrate some existing empirical data, the inmate's and the professional's perspective, issues on mental health care, and the reduction of recidivism in a more comprehensive model, taking into account the complexity of the prison situation. But first of all, we will discuss the literature about prisoners' need for care.

### *Need for care*

Many inmates complain that they do not feel well and that they suffer from psychological problems. This kind of complaint can just as well be caused by factors relating to an inmate's characteristics, including (temporary) adjustment problems and the effects of imprisonment.<sup>4</sup> A significant proportion of these inmates suffer from emotional disturbances or psychiatric conditions. The prevalence of these kinds

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<sup>2</sup> Zwemstra et al., 2003.

<sup>3</sup> McGuire, 1996.

<sup>4</sup> Harding, 1989; Blaauw et al., 1997; Bulten, 1998; Andersen, 2004; Bulten et al., (under construction).

of mental disturbances is high.<sup>5</sup> For instance, in a large prison survey the prevalence of psychoses was over 10 times greater than in the community.<sup>6</sup>

From the professional's perspective, these prevalence figures represent a potential high need for care. Research, however, has revealed a significant contrast between the prevalence of psychiatric disturbances and health care received.<sup>7</sup>

Dutch research into young adult prison inmates showed that mental health-oriented care requirements (determined with standardized research instruments) were considerably greater than was provided. This varied per diagnosis with inmates with anxiety problems, in particular, who make little use of the Dutch penal mental health care.<sup>8</sup> Excepting the possible inability to recognize the problem, the reasons not to seek care appear to be stronger than motives for getting it. Teplin showed that in a US jail for remand prisoners 62% of the severe mentally ill inmates remained undetected by standard procedures.<sup>9</sup> 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 part.<sup>10</sup> These percentages vary according to illness and nation.

A North American study of some 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 unlikely to ask for help.<sup>11</sup>

In many of these studies, the need for essential psychiatric care is established via structured and standardized research instruments. Yet normative needs determined by professionals -not by means of standardized research instruments- generate different percentages. Dutch penal psychologists were asked whether there was need for psychiatric or psychological help for inmates.<sup>12</sup> In case of roughly one in every

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<sup>5</sup> Brinded et. al., 2001; Fazel et al., 2002; Andersen, 2004.

<sup>6</sup> Brugha, et al., 2005.

<sup>7</sup> Gunn, et al., 1991; Birmingham, et al., 1996; Bulten, 1998; Schoemaker & Van Zessen, 1997, Blaauw et al., 2000; Andersen, 2004.

<sup>8</sup> Bulten, 1998.

<sup>9</sup> Teplin, 1984.

<sup>10</sup> Blaauw, 2000.

<sup>11</sup> Steadman et al., 1991.

<sup>12</sup> Schoemaker & Van Zessen, 1997.

eight inmates this question was answered affirmatively (12%). Birmingham et al.<sup>13</sup> established that professionals believe that 30% of prison populations require mental health care, while Brooke<sup>14</sup> found this to be 55% in a similar population. The exact definition of essential care varied in these studies.

The focus in the former research was on mental health. Although mental health problems have become characteristic for prison population, the issue of need for treatment or care in relation to re-offending is also very important. In England, the Offender Assessment System (OASys Two) was developed in order to assess those personality deficiencies which lead to crime. In the Netherlands, based on the OASys, a prevalence of 40-60% minor to severe criminogenic needs was reported.<sup>15</sup> 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 were reported frequently. This is in line with conclusions that, in general, prison populations show a wide range of so called criminogenic needs.<sup>16</sup> From a societal perspective, this is an important conclusion. Partially as a consequence of this, about 75% of the Dutch ex-prisoners commit another registered crime within the period of eight years, underpinning the necessity of this focus on reducing recidivism. It is beyond the scope of this paper to discuss exhaustively the way factors that contribute to crime amongst inmates were determined.

The prevalence of criminogenic needs, assessed and established by research or professionals, does not tell us if the inmate perceives similar kinds of need. We thus come to the question whether inmates themselves feel the need for care or help.

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 on the subjective general health care needs of inmates in the Netherlands.<sup>17</sup> A quarter of a group of inmates that were interviewed required a physician or other health professional during their incarceration, though they did not

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<sup>13</sup> Birmingham et al., 1996.

<sup>14</sup> Brooke, 1996.

<sup>15</sup> Vogelvang et al., 2003.

<sup>16</sup> Loza & Simourd, 1994; Hollin et al., 2003.

<sup>17</sup> Schoemaker & Van Zessen, 1997.

actively seek help. Inmates reported that the most important reasons for not seeking help were that they preferred to solve the problem themselves, that they did not believe anyone 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). Morgan et al. did also 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.<sup>18</sup> So, in general there is little information about the way inmates perceive need for care.

What about the process of seeking help? The empirical data in this matter are scarce as well. Deane et al. conducted one of the few studies of the intentions of inmates to seek help in relation to their attitudes toward help professionals, fear of being helped, and emotional complaints.<sup>19</sup> Deane thus did not conduct his work as part of treatments aimed at reducing recidivism. A sample of 111 male inmates in a New Zealand prison was divided between those with personal-emotional problems and those with suicidal thoughts. Statistical analysis revealed that attitudes regarding mental health assistance were the only significant predictor of whether inmates really intended to ask for help. A positive attitude increased the chance of seeking help. Inmates who had received assistance earlier and found it 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. It is also notable that inmates with personal-emotional problems were more likely to report for treatment than those with suicidal tendencies. 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. also assessed the intentions to seek help for personal-emotional problems.<sup>20</sup> The general attitude to seeking professional psychological help influenced the intentions to seek help, as did interpersonal factors like social pressure. Intentions to seek help were also higher with older prisoners and

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<sup>18</sup> Morgan et. al., 2004.

<sup>19</sup> Deane et al., 1999.

<sup>20</sup> Skogstad et al., 2006.

those who had previous contact with a psychologist outside the prison. Most of the research focuses on male detainees.

In addition to the strong impression that men in general have a more negative attitude toward asking for assistance, that they keep more to themselves, and evidence of greater tendency to mask 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.<sup>21</sup>

Some conclusions can be drawn from this research. First, definitions of care differ a great deal. Secondly, the way prevalence of need for care is administered 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 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; 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 whose goal is the prevention of -or recovery from- mental illness, limiting the consequences of the illness, as well as making chronic illnesses or ailments bearable.<sup>22</sup> Care can be provided through treatment, counseling, nursing, and the protection and promotion or maintenance of general health. This definition also covers penal mental health care,<sup>23</sup> naturally with important differences in accents and limitations. In a penal institution, the maintenance and promotion of mental health,

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<sup>21</sup> Deane et al., 1999; Morgan et al., 2004.

<sup>22</sup> Donker & De Wilde, 1999.

<sup>23</sup> In addition to basic health care, specialized mental health care is special care differentiations within prison and the *Psychomedisch overleg* (PMO), the penal consultative structure between penal psychologists, forensic psychiatrists, medical services and sometimes social workers aimed at coordinating individual health care.

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 of the need for care.<sup>24</sup> Bradshaw differentiates between subjective and normative need.<sup>25</sup> 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 subjective category in need that is merely felt (and not acted upon) and need that the patient asks for. At the moment that care is requested, the question becomes important whether care is available and, in particular, whether it is appropriate.<sup>26</sup> This refers to the suitability of a specific approach for a patient with certain clinical symptoms.<sup>27</sup> 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 also, there is the difference between treatment that is ‘clinically’ appropriate (‘evidence based’) and treatment that is suitable for ethical or juridical reasons (‘normative based’).<sup>28</sup> And it is necessary to be aware of this difference, especially in a forensic context.

#### *Motivation, approach and avoidance*

As previously noted, psychological complaints and psychiatric morbidity do not automatically result in the application of medical care. In the general Dutch population, approximately one in seven people with psychological problems actually check themselves into a mental health institute.<sup>29</sup> Many factors play a role in this, including the nature and seriousness of the disturbance, gender, demographic variables, health care availability, earlier experiences with mental care professionals, socio-economic status, but also motivation.

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

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<sup>24</sup> Wiersma et al., 1999.

<sup>25</sup> Bradshaw, 1972.

<sup>26</sup> Phelps, 1993.

<sup>27</sup> Willemsse et al., 2000.

<sup>28</sup> Van Kordelaar & Bulten, 2005.

<sup>29</sup> Wiersma, et al., 1999.



in this matter, several researchers underline the conceptual ambiguity of the concept of motivation.<sup>30</sup> In an effort to overcome this ambiguity, Drieschner et al. 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 a motivation in treatment engagement.<sup>31</sup> Apart from this, motivation is also influenced by external factors like events in the patient's life, available resources, external pressure, etc.

The Transtheoretical Model matches different types of interventions with different stages of change and different levels of problems. It identifies five typical stages in a change process: precontemplation, contemplation, preparation, action and maintenance.<sup>32</sup> Although the empirical evidence for this model is limited this model seems to be useful to describe some aspects of the change process.<sup>33</sup> However in this contribution we will focus on different theoretical perspectives.

The model of Drieschner et al. 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: the approach-avoidance model.

It appears very likely that the decision to reach out for help is determined in part by the conflict between tendencies toward approach and avoidance. This tension can be seen as a classic approach-avoidance conflict, in which the tendency to seek out care (approach) appears to increase as psychological problems and subjective feelings of ill-health grow.<sup>34</sup> However, avoidance tendencies, grow even stronger during this process. The factors that produce avoidance (e.g., stigma, fear of care, cost) weigh more heavily as one approaches the 'feared' or 'hoped for' goal.

Kusher and Sher had a non-criminal population in mind when they developed their model. Nevertheless, there is no reason to presume that this approach-avoidance as such is not applicable to prison inmates.<sup>35</sup> This population, too, has motives to seek

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<sup>30</sup> Drieschner et al., 2004.

<sup>31</sup> Drieschner et al., 2004.

<sup>32</sup> Prochaska & DiClemente, 1982.

<sup>33</sup> Sutton, 2001.

<sup>34</sup> Miller, 1944; Kusher & Sher, 1989, 1991.

<sup>35</sup> Kusher & Sher, 1989, 1991.

out help (emotional disturbance, mental suffering, danger of recidivism, family pressure, or other stresses, etc.) and equally strong reasons to avoid assistance (e.g. fear of care, fear of being labeled mentally ill, distrust, cost, etc.).<sup>36</sup>

### *An integrative model*

The approach-avoidance conflict, the difference between care for mental health problems, care or help provided to reduce recidivism, and expected effects are integrated in a model (see figure 1).

The entire process begins with the question as to whether there is mental suffering and/or the awareness that without care the possibility of recidivism is substantial. However, is the inmate suffering? Does he have emotional complaints and/or difficulty admitting them? Is he aware of the risk of reoffending, if no help is accepted? All kinds of behavior and symptoms can deviate from the prevailing norm; one of the issues is whether the inmate experiences these as egodystonic. Absent suffering and missing, egodystonic forms of behavior or symptoms, 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 seek help.

When they do feel this need, the approach-avoidance conflict influences the decision of whether help is actually sought. Questions about care can subsequently be transformed into behavior aimed at getting help. The motivation to engage care is followed by actually seeking it.

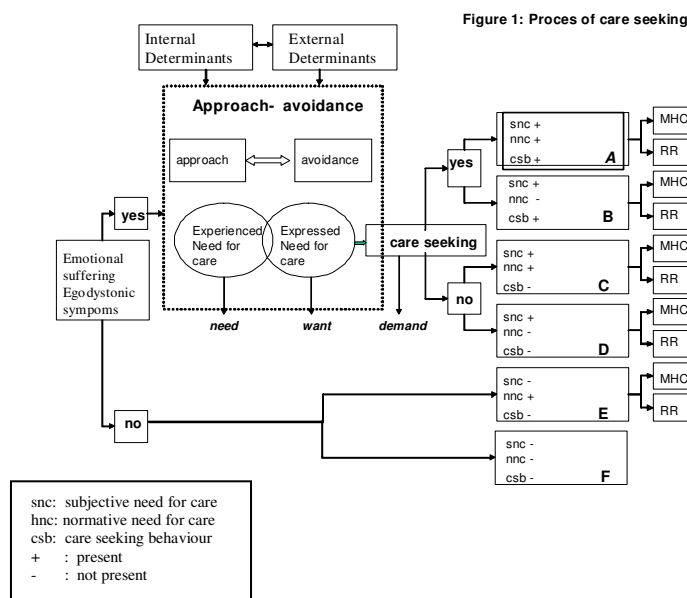
A normatively determined need does not necessarily imply that, likewise, there is a subjectively determined need for care. But even if a psychotic inmate may not feel any need for treatment, health care professionals may well judge psychiatric-medical treatment to be imperative. In treatments designed to reduce recidivism, it is also not implausible that inmates assess risks and recidivistic tendencies differently than do professionals. All these different options are shown by this model.

Likewise, Figure 1 indicates the difference between whether the goal of mental health care treatment is designed to improve mental health (in which case the disturbance and its treatment are central; Mental Health Care (MHC)) or to limit

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<sup>36</sup> Mathias & Sindberg, 1985; Mobley, 1999; Kupers, 2001; Morgan et al., 2004.

recidivism (in which case societal safety is a central concern). This is indicated as Reducing Recidivism (RR). These two goals are not, however, 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 concepts, to make the entire process transparent, and to carefully differentiate between various treatments' goals. The chart below (see figure 1) displays these in a way designed to facilitate comprehension.



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 forensic setting*

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

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

The most ideal situation in which an inmate can formulate a health care request is when the subjective need coincides with the normatively established need (see A, chart 1). The ‘struggle’ of the inmate between avoidance and approach tendencies resulted in actually seeking help. In that case, health care provider and recipient are in agreement about the terms of treatment. The specific health care goal must then be formulated, so an important question still remains: whether effective, appropriate (evidence based) care is available and feasible. In Dutch prisons, about 26% of the detainees in general, non-special wards receive some kind of mental health care for psychiatric problems and/or their drug abuse, mostly voluntary.<sup>37</sup> In most of those cases there is agreement between the care provider and the detainee.

In this formulation of the ultimate health care goal (agreement), 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 goal in sight, while also discussing it with the inmate.

*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 of the inmate to seek care outweigh those of not doing so. On professional grounds, the health care provider is reluctant to give this care. This constitutes a lack of normative need (see B, figure 1). This can take place with mental health care as well as with the reduction of recidivism. The inmate wants help, but the professional does not see evidence of illness or does not see treatment as a possible answer to the subjective need. Naturally, intensive and careful contact must take place between the inmate and the professional, but it is not out of the question to think that a difference can remain nonetheless. In contrast to non-prison populations, Dutch inmates’ options to ask for help at a different location, from other professionals, are rather limited.

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<sup>37</sup> Bulten et al. (under construction).

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

The chart differentiates between experiencing the need for help, asking for help, and actively searching for help. This is a relevant difference. A subjective need for care can exist which is never expressed (see C and D, chart 1). Filters within the penal system, care and treatment operations, and inmates themselves cause this difference (filter theory). The balance between internal and external determinants to express a need and seek help, results in some way in hiding this need. Do the expected benefits (e.g. reduction of suffering) outweigh the expected costs (e.g. effort, (self)image, costs)?

It is plausible that a safe, humane and positive psychosocial penitentiary climate is an influence on these filters. In practice, environmental influence on patterns of seeking care can indeed be quite complex, however. Thus, on the one hand, we can expect that, in an optimal situation, 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 need.<sup>38</sup>

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 systems 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 normative need is expected (for instance based on the observations

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<sup>38</sup> Dvoskin & Spiers, 2004.

by the staff), and the health professional finds that there is probable indication for treatment. Care has to be 'outreached' in these cases.

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 a not expressed need for care in this terrain – a need which is also confirmed normatively. The challenge is in how to find, stimulate, and motivate these people to actually need care, want care, but also to express this need.

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

The chart makes clear that the possibility exists that an inmate makes no complaint, while in fact a strong normative need for care exists (see E, chart 1). In penal health care, one finds this situation occurring frequently 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.<sup>39</sup>

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.<sup>40</sup>

So far, concerning 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

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<sup>39</sup> Dvoskin et al., 2004.

<sup>40</sup> Zwemstra et al., 2003; Reed, 2003.

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 this context, treatments, and in particular treatment aimed at limiting recidivism, must be of a voluntary character. 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 way to motivate 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 (responsitivity) of the detainee. The role of the executive personnel in this process is large.

#### *F: Neither subjective nor normative need for care*

The previous examples are of 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. We must not forget, however, that there are also inmates who feel no need for treatment (which naturally generates no request for assistance), and that from the normative perspective there may be no reason to encourage treatment either (see F, chart 1), not for mental health reasons, nor for the reduction of recidivism. The current size of this group in the Netherlands is not known.

#### *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.

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, appropriate (evidence based) and suitable (normative based) treatment, 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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