The State of the Prisons

Medical care in the Dutch penal system

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Dr E Meulenbeld, an ex-resistance fighter and now medical inspector of prisons for the Dutch Ministry of Justice, has no doubt that he does not want any doctors working full time in Dutch prisons. He has two reasons for this conviction: firstly, a doctor working full time with what, in the main, are healthy young men will cease to be a good doctor; and, secondly, he believes that a full time doctor would become institutionalised and hazy whether his commitment was to the prison or the prisoner. The Dutch have in the past had full time prison doctors, but they have been phased out. Dr Meulenbeld himself, although he works full time in the building of the Ministry of Justice, is employed by another ministry.

This issue of divided loyalties is a thorny one for prison doctors and prison authorities all over the world. The Dutch doctors like to think that their commitment is entirely to the patient and that security is no concern of theirs. The doctors who provide daily general practitioner care do not have to write reports on the prisoners, but they do have to see prisoners in the punishment block every day that they are there. The doctor whom I spoke to in Amsterdam prison also said that he had once or twice in his four years as a prison doctor given an injection to sedate a difficult patient in the patient's own interest although without his consent.

Only rarely then do Dutch prison doctors stray into an arena where it might seem that their actions are benefiting the prison authorities as much as the patients. In federal prisons in the United States, in contrast, the entire prison staff, including the doctors, have impressed on them that the first aim of imprisonment is to keep the prisoners inside the prison: everything else is secondary. Security problems arise, for instance, with prisoners smuggling drugs into the prison in their rectums. Should the doctor agree to do a rectal examination? Such an examination is clearly in the interest of the authorities not the prisoner. The American doctors working in Federal prisons would undertake such an examination; the Dutch doctors would not; doctors in Melbourne are arguing about it; and the British do not tell us because of the Official Secrets Act.

Organisation of Dutch services

Every Dutch prison has a part time general practitioner who does regular surgeries and provides 24 hour cover. There is the equivalent of one full time doctor to every 300 prisoners, and there are 50 general practitioners working part time for the Ministry of Justice. They are salaried and all also work in their private practices. A few years ago there were problems with

recruitment, but not any longer—even in outlying areas (not that anywhere is very outlying in a small country like Holland).

The work of the prison doctors is straightforward general practice. They see all the prisoners within 24 hours of them being admitted to prison and take a full history, do an examination, and take blood and urine tests. The consultation is very unhurried by the standards of local and remand prisons in Britain. At Brixton prison, for instance, some 300 prisoners are seen each day as they come in (some of these are not new prisoners but ones returning from court appearances), and many of the Brixton prisoners come off the streets in a dreadful state. Many are alcoholics, addicts, or mentally disordered; many have been living rough; and many are uncooperative. In Holland, in contrast, most of those admitted into remand prisons have already been in police cells for up to five days and are thus "sorted out" by the time they arrive in the prison.

The prison doctors then see patients as they want to be seen, which is often. The consultation rate is very high by the standards of the community just as it is in Britain. Yet the aim of the Dutch is to make the process as much like that in the outside community as possible. The prisoners cannot, however, choose their doctor, but they can ask for a consultation with an outside doctor. The doctor from outside cannot treat the prisoner but he can give him an opinion and he can discuss his treatment with the prison doctor. In practice this right seems rarely to be exercised, which provides some evidence to support Dr Meulenbeld's statement that he is running the best general practitioner service in Holland. Most prisoners, he points out, can get a doctor more quickly than somebody in the community.

The use of drugs in Dutch prisons is not controversial as it is here in Britain. Most European doctors prescribe more drugs than British doctors, but the trend in Dutch prisons, as most prison doctors insist it is in Britain, is for the doctor to be resisting prisoners' demands for tranquillisers and hypnotics. One doctor told me that very occasionally he has to use an injection to quieten a prisoner against his will, but this does not seem to cause the same controversy as in Britain. One reason for this is that the Dutch popular press does not take such a prurient interest in prisons and prisoners as the British. The absence of an exaggeratedly hostile press allows the prison authorities to be much more relaxed and experimental in their approach to prisoners. They do not, like the British and Australian authorities, have to live in fear of the sensational headline that will bring chaos if something goes wrong—as it will, almost by definition, in most experiments.

Apart from their general practitioner duties, the doctors do not have many extra responsibilities. They must see prisoners who are being punished but, crucially in Dr Meulenbeld's mind, they see the prisoners after the punishment has been started. They are not declaring prisoners fit for punishment; they are making sure that the punishment is not harming the prisoner medically. They are not part of the management of the prison, and Dr Meulenbeld is quite clear that it is no part of

his doctors' duties to treat criminality in any way. He recognises that prison medicine calls for special skills, but these can be picked up easily on the job and do not include any grand schemes for reforming the prisoner. Furthermore, he is pessimistic about any attempts to treat alcoholics, addicts, or sex offenders within the prison system.

Nursing services

The nurses in the Dutch prisons work full time. Neither the medical inspector nor any of the doctors I spoke to saw any difficulty in this because the nurses, they say, are responsible to the doctor. Those many people in Britain who see nurses as professionally quite independent of doctors might be less happy that it is thought important that doctors should not be full time but that it does not matter for nurses. The Dutch doctors see the nurses being full time as an advantage—it improves the communication among doctors, prisoners, and authorities. The nurses whom I spoke to agreed.

Dutch prison nurses, in contrast to the British (18 February, p 554), are fully trained—indeed, they must have done at least three years in the community before they are eligible for employment in the prison. They receive the same pay as in the community, and there seems to be some problem in recruitment. The fact that the nurses are fully trained is probably just as well because in prisons where the doctor comes only a few times a week the nurses hold their own surgeries and are able to prescribe drugs such as tranquillisers and hypnotics.

Hospital services

Just as in the community the prison doctors can refer prisoners to any hospital specialist they want. In practice, however, most prisoners needing non-urgent hospital treatment are referred to the prison hospital in the Hague, which is on the same site as Holland's highest security prison. Prisoners needing emergency treatment are sent immediately to the local hospital, but there are sometimes problems in deciding what is an emergency. A prisoner might seem quite stable when put into an ambulance for the Hague, but by the time he arrives three hours later he may be critically ill. Dr A Kraajeveld, who is director of the prison hospital and a part time general practitioner, has had this experience a couple of times but he does not think it is a serious problem. Nobody has died, and with any system mistakes will inevitably occur.

Dr Kraajeveld is very proud of his well equipped hospital. He points out that he has seven beds for each 1000 detainees, whereas in the community there are only five beds for each 1000 citizens (and the prison hospital does not take mentally ill prisoners). Most kinds of general surgery and medicine can be undertaken in the hospital, and all the patients are under the care of specialists from a private hospital that is about a mile away (apart from one famous war criminal who is 84—he is under the care of Dr Kraajeveld). There are no doctors on the premises, and if specialised surgery or intensive care is needed then the patients are treated in the private hospital. Occasionally for even more specialised treatment the prisoners are treated in academic centres. Because of this careful selection policy and because terminally ill prisoners are pardoned and released, Dr Kraajeveld has had only one death in the last six years—a prisoner with lung cancer who had nowhere to go.

The advantage of this system is that it is more secure and cheaper than sending prisoners needing hospital care to outside hospitals accompanied by prison officers. The main disadvantage is that prisoners, some of them unwell, have to be transported all over Holland. Such a system could work in Britain only with several hospitals. It would also require very close links between a hospital in the community and the prison, and this may be difficult when hospitals are part of the NHS and prisons fall under the Home Office.

Suicide in Dutch prisons

In 1980, 22 prisoners in England and Wales killed themselves (16 did so in 1981, and 17 in 1982). This high incidence of suicide has caused much public, media, and parliamentary concern, and the Medical Inspector of Prisons is now conducting a special inquiry into preventing suicide in prisons (21 January, p 208). I was thus interested to hear that in 1980 seven Dutch prisoners killed themselves. Given that on any one day the Dutch have roughly a tenth as many people in prison as England and Wales (although the annual throughput is not proportionately so small), this figure of seven deaths seems disturbing. It may be that because the Dutch imprison fewer people they imprison a higher proportion who are mentally abnormal, which may partly explain the high numbers. But, some of the mentally abnormal are diverted to the TBR clinics (TBR is an abbreviation for the Dutch words meaning detained for an indefinite period), and the prison suicide figure does not include the clinics. But either way nobody in the Netherlands, including the medical inspector, seemed much concerned.

The Dutch have similar systems to the British for managing those who seem suicidal: they are kept under very close observation. But, again just as in Britain, many of those who succeed in killing themselves are prisoners whom nobody thought likely to kill themselves. Of the seven Dutch prisoners who died in 1980 three hanged themselves and one jumped from a great height. The Dutch authorities keep figures on attempts as well as on successful suicides, and in 1980 there were 231 attempts. Defining what constitutes an attempted suicide is, of course, difficult, but for what it is worth there were 315 attempts in 1981.

It seems to me that the Dutch should be worried about the number of prisoners killing themselves. A higher incidence of suicide is probably to be expected in prison but not a rate that is several times that in the community. The high rate may reflect a failure of doctors to pick up that prisoners may be contemplating suicide or a failure of security officers to stop them. Only detailed inquiry can determine the causes, and the British authorities are undertaking such an inquiry—albeit diplomatically into preventing future suicides rather than finding out what went wrong in the past. Perhaps the Dutch need such an inquiry as well.

Mentally abnormal offenders in the Dutch prison system

The Dutch have some of the same problems as the British with mentally ill offenders becoming unsuitably stuck in the prison system, but they also have a uniquely intense and well funded system run by the Ministry of Justice for trying to treat violent, dangerous offenders who hover in the hinterland between bad and mad.

The mentally ill who commit an offence can in Holland be diverted from the prison system before they are charged. During the five days allowed in police custody, police doctors and the public prosecutor may decide that the offender might be better managed in a mental hospital. This decision, as in Britain, seems to be based on the seriousness of the offence, the extent of the mental illness, and the dangerousness of the offender. Those who have committed only minor offences, who are not dangerous, and who are quite clearly mentally ill are the easiest to divert. The next stage at which offenders can be diverted is when they are brought to court, and again they may be diverted while on remand. The longer that they are in the penal system the more difficult it becomes to divert them.

The places for diversion are ordinary mental hospitals or the one state mental hospital. The state mental hospital will take the psychotic, and the ordinary mental hospitals will take those who are mentally ill but not dangerous. Just as in Britain, the mental hospitals are cautious about whom they will take as they have unlocked wards and little or no security. Again as in Britain, the

Dutch are creating medium secure units; one has actually been opened.

Once the offenders have been sentenced other options open up. Firstly, they can be treated as outpatients on the court's recommendation with the understanding that if they lapse from treatment they will receive another sentence—possibly prison. This option might be used for sex offenders against children who have not been violent in any way. The second option is that the court can sentence an offender to the special clinics run by the Ministry of Justice—the TBR clinics. Strangely, if it is thought that the offender needs to be punished for a serious offence as well as treated he can be sent to prison for a number of years before being sent to the TBR clinic. The logic of this is hard to understand because it must create difficulties for the prison authorities looking after somebody who is mentally abnormal and will not help the prisoner at all, and if the courts believe, as they seem to, that TBR clinics can treat dangerousness then it would seem much more sensible to send the offenders to the clinics first and then to prison if it is still thought necessary.

Despite all these places of referral a number of mentally ill people end up in Dutch prisons—Dr Meulenbeld estimated that at any one time there are about 100. Some end up on what Dr Maler, clinical director of the Mesdag Clinic, one of the biggest of the TBR clinics, called a circuit that takes them through the state mental hospital, TBR clinics, mental hospitals, and prisons. Each prison has access to a social psychiatrist, all of whom work only part time in the prisons, and a forensic psychiatrist. The forensic psychiatrists have to produce reports for the courts, but the social psychiatrists are concerned purely with treating and preventing mental illness. The Ministry of Justice has unfilled vacancies for both kinds of psychiatrists, however, because forensic psychiatrists are in short supply and many social psychiatrists are not attracted to working in prisons.

The Amsterdam prison complex also contains a special unit for dealing with mentally ill prisoners, but the policy of the Dutch is to try to get the mentally ill out of prisons. The psychiatrists are in the prisons not to treat the mentally ill who should really be in hospitals but rather to help the courts with psychiatric reports and deal with the psychiatric problems that inevitably arise in any community but particularly in people deprived of their freedom.

The TBR clinics

The second main reason for the Dutch penal system attracting so much international attention, in addition to its having so few people in prison, is its method of treating violent offenders who are deemed too mentally abnormal for a prison sentence but not so mentally ill that they should be in the state mental hospital. This group of offenders, which is necessarily not clearly defined, is sentenced to TBR clinics. Holland has seven of these; the two largest are run by the Ministry of Justice, and the five smaller ones are private clinics. I visited the Mesdag Clinic, which is the largest and best known of the clinics and which is psychoanalytically orientated. The other large government clinic runs much more on behavioural lines, and each of the other five clinics has its own therapeutic philosophy.

TBR was introduced in 1929 and reached its heyday in the 'fifties and 'sixties—just at the same time as the rehabilitation philosophy in most other countries. In 1955 a third of all offenders sentenced to more than a year and a third of the daily population of offenders in institutions were in TBR clinics. Since those days the judges have refined their thinking on what kind of offenders are best suited to TBR, and the Mesdag clinic is finding that its patients are becoming younger, more psychotic, and most of them now have committed serious violent offences. On the day that I was in Holland there were 409 people in TBR clinics and 62 in the Mesdag Clinic. Dangerousness and treatability are two of the main criteria determining a sentence to TBR, according to Dr Maler, the clinical director of the clinic,

and he emphasised that the Mesdag is neither a prison nor a mental hospital.

It had, however, as strong security as any prison that I visited in Holland. Heavy doors are open and shut electronically; cameras follow people throughout the clinic; and ultraviolet beams, which when broken set off alarms, run along the outside of all windows. Inmates do occasionally escape, but not very often. The clinic has a staff of 200, only 44 of whom are security officers. There are eight full time psychiatrists, and in addition a therapeutic, recreational, and educational staff of 92. Enormous resources are thus sunk into the clinic. Indeed, until recently the clinic had a staff of 240, but economic cuts have cut it back. The doctors fear that if further cuts have to be made the clinic will cease to be a therapeutic community and become a prison with a little psychiatry tacked on. Grendon Underwood, the British psychiatric prison, which is perhaps the closest British equivalent to the TBR clinics, has never really had enough resources to lift it beyond being a prison with a psychiatric bias.

The philosophy of the Mesdag

The therapeutic regimen of the Mesdag is based on the object relations school of psychotherapy: the clinic's staff believe that the offenders have been arrested in their development. They try to treat this by creating a "family" within which the inmates can begin to grow again. The inmates are either in groups of 10 to 12 in "intensive care wards" or in groups of no more than four in "very intensive care wards." In addition to living, learning, and working in their "families" the inmates all have individual programmes. About 40% receive individual psychotherapy (as much as five hours each a week), and about a third are taking antipsychotic drugs—usually just at night. Dr Maler points out that the custody but not the treatment is forced.

The offenders stay in the clinic for about four and a half to five years on average. They are seen by a judge every year, when it is decided whether the inmate is ready for release. Dangerousness is the crucial factor in this decision. Some four or five of the inmates would probably, Dr Maler thought, have to stay forever.

Does the treatment work? When I asked this question to Dr Maler, he replied that this was the one question that politicians always asked. When you consider the resources that must be consumed by TBR clinics, it is no surprise that the politicians always ask that question. Dr Maler, however, is never able to give them a straight answer: How do you decide what constitutes "working?" Has the clinic worked if ex-inmates are happy and well adjusted, or has it worked simply if recidivism rates are low? How do you decide whether recidivism rates are low? Control groups are not possible; the population of the clinic is changing rapidly with time; time and money are short for research; and there are formidable ethical difficulties in following up inmates—most do not want to be reminded of that phase in their lives.

Despite all these difficulties the clinic does do research and does have figures available on recidivism rates. About half of the inmates reoffend within two years and three months of release; about 30% commit crimes as or more serious than the ones for which they were originally sentenced; and about 15% murder after discharge. These figures might seem dreadful, but, remembering that about two thirds of offenders from ordinary penal institutions reoffend and that the Mesdag has a selected population of highly dangerous and unstable offenders, the psychiatrists are quite pleased with these results.

The Mesdag clinic was a fascinating place to visit, and the Dutch authorities must believe in the value of the clinics to keep funding them so generously, but it is hard to see that they have much relevance to Britain, where resources are much tighter and psychoanalysis is not held in such high regard. Maybe if there comes a day when British prisons contain far fewer prisoners and the prison department has better resources then we can look closely at the Dutch system and learn better ways of dealing with these both sad and dangerous people.