Incarceration of Women with Mental Health Needs in the Netherlands as Compared to the United States: A Comparative Analysis of Trauma Responsiveness

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Abstract

This honors thesis highlights the lack of efficient mental health services within United States women’s county jails. Addressing mental health concerns among incarcerated women is crucial for the individuals overall health and the improvement of the criminal justice system as a collective. This thesis will include a comparison between the United States and the Netherlands mental health services in women’s jails, in order to explore where our country is lacking in these services. Comparing and contrasting the current mental health services in the United States with those provided in the Netherlands, including their responsiveness to trauma, will allow for an assessment of alignment with positive outcomes between a rehabilitative approach and a punitive approach for mental health concerns. A comparative analysis as well as a gap analysis are methods to identify recommendations for the United States to replicate the policies, practices, and systems utilized by the Netherlands including comprehensive social-emotional services, support services, trauma responsive services, and intervention services for women either currently incarcerated or those transitioning out of incarceration. Overall, by analyzing a country that has more efficient mental health approaches within their jails, I will conclude with services that the United States could implement to efficiently address mental health challenges among women who are incarcerated.
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I. Section One

a) Introduction

The lack of mental health services in women’s jails is an issue that requires more focus within the United States. The Bureau of Justice has reported that the nation’s jail population has increased more than 40% since 1990, with these incarceration rates increasing more among women than among men (Green et al., 2005). In contrast, between 1997 and 2004 the prison rate increased 50%, but after the year 2005, the imprisonment rate decreased progressively (Masthoff & Bulten, 2013). There is a striking estimation that about one third to one-half of the 2.3 million women and men in the United States jails and prisons have a mental illness, compared to 18.3% of the general population (Kolodziejczak & Sinclair, 2018). On the contrary, the Netherlands prison population has decreased by 44% between 2005 and 2015 (Boone et al., 2020). Research reveals the Netherlands prison rate, or in simpler terms, the number of prisoners, was at an average of 54.4 individuals in 2018 (Boone et al., 2018). The Netherlands per capita rate of incarceration is also significantly lower than that of the United States.

Upon reviewing related research surrounding the United States, people with mental health conditions from all gender identities make up 64% of those incarcerated, as stated by the Federal Bureau of Prison Statistics (Johnson, 2014). According to research, by 2019, there were 114,500 women in jails, 95,626 women in state prison, and 12,329 women in federal prison (Carson, 2020). These numbers in the United States also encompass a racial disparity of women incarcerated. In addition to the substantial increase in women becoming incarcerated, African American women are disproportionately represented in the criminal justice system. To substantiate these claims, there were approximately 42,281,890 women of color in the United States general population between the years of 2010-2014 (Williams-Baron & Shaw, 2016). In
continuation, the rates of African American women incarcerated include 115 per 100,000 women overall, compared to a rate of 49 per 100,000 for White women (Oser et al., 2017). Comparably, for Hispanic women, there are 64 per 100,000 women overall (Oser et al., 2017). Mental health challenges are not only more prominent but also more intensive among incarcerated women, especially due to traumatic experiences. Debra Houry and James Mercy, from the Center for Disease Control (CDC) explain that Adverse Childhood Experiences, or ACEs, are traumatic experiences that occur in one’s childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home; and or having a family member attempt or lose their life to suicide (2019). It has been said that exposure to traumatic experiences is universal among incarcerated women, with these numbers ranging from 77% to 90% (Green et al., 2005). The United States Department of Justice Bureau of Justice Assistance explains that female offenders report greater incidence of mental health challenges and serious mental illness compared to male offenders (O’Donnell, 2013). Trauma and victimization experiences significantly contribute to the increased intensiveness of the mental health needs of women of color that have been, or currently are, incarcerated. For instance, these two factors tend to relate to women’s involvement in the criminal justice system. A research study from 2012, which looks at the linkage between these two risks found that exposure to numerous forms of interpersonal violence, such as childhood abuse or neglect, over a lifetime is a substantial risk factor for “depression, posttraumatic stress disorder (PTSD), suicide, and substance use problems” (Lynch et al., 2012, p.382).

There is a growing need for more efficient mental health treatment services in American women’s jails. The number of women in small county jails has increased by 31% from 1970 to 2014 (Swavola et al., 2016). With this increasing number also comes the lack of mental health
treatment. For instance, there are possible challenges that come along with delivering treatment in a punitive institution with individuals who are mandated to be there (Kolodziejczak & Sinclair, 2018). Of these challenges includes the lack of quality mental health professionals, with the role of responding to mental health being left to correctional staff (Kolodziejczak & Sinclair, 2018). If individuals are mandated to be in these punitive settings, and are not receiving the quality of care needed for their mental health, there is a greater chance for non-compliance to the small-scale amount of services they would be receiving. In contrast, the Netherlands prison system have defined within their primary goals to provide mental health services of equivalent quality to treatment options in society, and pursuing a reduction in the rate of recidivism by improving forensic psychiatric care (Masthoff, 2013).

Along with the many challenges related to mental health care within the United States criminal justice system, comes the high turnover rate of all staff in correctional facilities, which in turn negatively affects the facility’s services (Kolodziejczak & Sinclair, 2018). There is chronic understaffing for mental health programs within U.S. jails and prisons. This makes it more difficult to achieve adequate mental health services in these facilities (Levesque, 2010). In addition to the lack of services is the underfunding for psychiatric care. The resource allocation for mental health supports has not risen with the increase in criminal justice system populations nor the higher level of needs (Levesque, 2010). Turnover for mental health service staff is at an ultimate high, due to the fact that the work is difficult, the pay is low, and the need for mental health counselors is so abundant, which makes it difficult to serve this population due to lack of training and skills (Levesque, 2010). While the United States has witnessed staff trained to effectively respond to the mental health needs of those incarcerated, the Dutch prison system has been working to train ALL staff in the detection and handling of psychiatric disorders among
inmates (Mastoff, 2013). The difference between approaches in the Netherlands and the United States sheds light on the crucial importance for the United States to take on a more quality-based approach. Without clear benchmarks of success and or holistic wellness at universal, secondary, and tertiary levels both in the general population as well as within women currently incarcerated, it becomes impossible to identify what is effective and what is missing (gap analysis) towards continuous improvement. Further, it becomes even more difficult to establish the quality of what is in place without specific consistent approaches to build the capacity of all criminal justice staff to efficiently identify and respond to mental health needs within the United States.

Specifically, among treatment needs is a lack of effective universal screening tools. If correctional facilities incorporate mental status assessment into the intake process, this would create a mechanism for identifying needs before crisis occurs. In addition, research has proven the use of reliable universal mental health screening tools bring to light both intrinsic and extrinsic needs. In comparison, reacting to external behavioral concerns without effective multi-tiered systems of support has little to no positive benefit related to behavioral change. The trauma women face unless the symptoms are noticeable at that time (Swavola et al., 2016). Without evidence based mental health screening tools, jail intake staff are left deprived of concrete information to identify and effectively respond to women’s mental health challenges, unless the symptoms are externally apparent (Swavola et al., 2016). Previous research findings have revealed that not only is data involving the overlap or intersectionality of women with mental health challenges and victimization insufficient, but also further reveals that incarcerated women have significantly greater exposure to mental health challenges and trauma than incarcerated men (Karlsson & Zielinski, 2020). In addition, the findings from eight previous independent studies suggest substantially higher lifetime and current prevalence rates of mental
health challenges within incarcerated women as compared to non-incarcerated women (Karlsson & Zielinski, 2020). This substantiates that there is a need for additional credible research related to this topic. In addition, this proves there are insufficient mental health services in United States women’s jails. Many believe that jailing those with mental illnesses is protecting public safety, but this is not the case. Instead, those with mental health challenges are more often the victims of violence rather than the perpetrators. There is a need to investigate not only the lack of mental health services, but also improve the provision of universal training of ALL correctional staff to be able to identify who needs further assessment and support (i.e. refer for accurately assessing mental health needs and evaluate the effectiveness of the psychological services that are received (Kolodziejczak & Sinclair, 2018). Next, the availability of sufficient qualified mental health professionals (QMHPs) in proportion to the needs of this population must be ascertained and met. This has the potential to improve incarcerated women’s overall health, as well as reduce economic risk—socially, financially, and emotionally. This emphasizes that this topic MUST be of prime concern to United States policy makers, the public, and health professionals (Kolodziejczak & Sinclair, 2018).

If the complex treatment needs of incarcerated women are not properly addressed, their mental health can worsen. The assessment tools that are used among arrival are biased, in that they primarily have been evaluated for effectiveness in relation to men involved with the criminal justice system (Swavola et al., 2016). Research states that “assessing women with a gender neutral or male-focused assessment tool—often using current charges and criminal history as determinative factors, ignores research showing that women, even those deemed high-risk, generally pose less risk than men” (Swavola et al., 2016, p.13). With biased assessment tools comes an underrepresented population within existing research. This is especially true for
the reactive services women will then receive in jail. If women are inaccurately classified among arrival, they will not receive the social, emotional development and mental health services to meet their needs. Throughout this thesis, the need for the United States to apply rehabilitative and restorative strategies, that have been proven to be effective in the Netherlands to sufficiently respond to women’s mental health challenges, as well as lower recidivism, and increase positive life outcomes among this population.
II. Section Two

b) Background

History of Services within Women County Jails

In the early 1900s, just about 145,000 individuals were protected within state mental institutions (Blevins & Soderstrom, 2015). From here, this number grew onto almost one million individuals receiving services within state mental institutions during the 1950s (Blevins & Soderstrom, 2015). Although the early 1900s were a date in time where mental health challenges were prioritized in related facilities, the treatment received was not what was to be expected. Although mental institutions embarked to assist those in need of effective services, the conditions of treatment were not ideal. For instance, many patients were subjected to abuse, instead of receiving the treatment they intended to for their needs. Once the cruelty behind treatment services at mental institutions were discovered, the Civil Rights movement began during the 1960s, with the aim to create positive changes for different groups of individuals in our society (Blevins & Soderstrom, 2015). Soon after the Civil Rights movement, which intended to help those in need, began the closing and decreased housing of state psychiatric hospitals, better known as, deinstitutionalization (White et al., 2006). The emergence of deinstitutionalization caused for a shift in individuals receiving particular care for their specific mental health needs, and instead resorted those with mental illnesses back into their communities. Deinstitutionalization pushed for individuals with mental health needs to seek treatment in community-based treatment facilities, such as local clinics, halfway houses, and community residential treatment centers (Blevins & Soderstrom, 2015). It was then in the mid-1970s that thousands of individuals were deinstitutionalized, or removed from mental hospitals,
with hopes to gain treatment in their surrounding communities (Blevins & Soderstrom, 2015). The reality of the deinstitutionalization movement was that striking numbers of individuals who needed assistance with their mental health were left without treatment, because community-based services were not entirely accomplished in the way they were hoped to be at the time. The history of deinstitutionalization in the United States can also be compared to the Netherlands and their practice with this approach. It has been noted that deinstitutionalization has been less drastic in the Netherlands than in the United States (Kamperman, 2014). With this shift of individuals with mental health concerns in the community in the United States, then pushed for the justice system to correspond in the complex needs of those in need of mental health care. The complex number of those incarcerated with mental health concerns is partially due to deinstitutionalization.

The Bureau of Justice Statistics suggested in a 1999 survey that about 238,000 individuals with mental health concerns were incarcerated in United States facilities in 1988, which represented 16% of all state prison and local jail inmates and 7% of federal prisoners (White et al., 2006). What is important to note upon is how these numbers began to increase and why so many individuals were left without efficient treatment in the justice system. Research presents that deinstitutionalization is a leading factor as to why the number of psychiatric beds has decreased dramatically over the last 40 years, while the number of beds housing those with mental illness has increased throughout the same span of time (Blevins & Soderstrom, 2015). Historically, mental health problems among those involved in the criminal justice system began prominently in mental institutions, but then began to shift to criminal justice settings in the late 1900s to early 2000s.
Background of Women with Mental Health Challenges

In order to understand the scope of the issue, it is important to examine the risk factors impacting women overall and further of those incarcerated. As the number of males in the criminal justice system has decreased, the number of females has steadily increased. Precisely, 66% of females incarcerated within the United States had a history of a mental health diagnosis compared to 35% of males incarcerated (Bronson & Berzofsky, 2017). For the purposes of this analysis, serious mental illness (SMI) includes major depression, bipolar disorder, and schizophrenia (Swavola et al., 2016, p.10). In the United States, it is increasingly important to focus on county jails due to the rates within them and the opportunity to divert away from stricter, higher level incarceration. Researchers from the Vera Institute of Justice describe that since the year of 2000, jail incarceration rates for women in smaller counties has increased from 79 per 100,000 women to 140 per 100,000 women (Swavola et al., 2016, p.6). It has further been noted that small county jails have been the main engine of the growth of women in jails. Compared to the United States, the Netherlands has had a decline in number of prisoners as a collective. For instance, between 2005 and 2015, the Netherlands prison population decreased by a shocking 44 percent (Boone et al., 2020). Through this comparative analysis, the stark differences between the increases in incarceration within the United States, as opposed to the decrease in incarceration in Dutch prisons, it is clear there is a contrast between our justice system and that of the Dutch.

When considering that comparison, there is a need to narrow the focus of this analysis to statistics surrounding women with mental health challenges, without comparing the numbers to men. The Bureau of Justice Statistics includes that based upon their previous research, “75 percent of women in jails reported having had symptoms of a mental health disorder in the past
12 months” (Swavola et al., 2016, p.10). In addition, although many women meet criteria for having multiple mental health challenges, one in five have experienced serious mental illness (SMI), post-traumatic stress disorder (PTSD) and substance abuse disorder in their lifetime (Swavola et al., 2016). A research study of the prevalence of mental health concerns among 491 women found that mental health was widespread, with the findings concluding that 91% (N=446) met lifetime criteria, and 70% (N=343) qualified for 12-month or current criteria for at least one mental health condition (Lynch et al., 2014). Additionally, the lifetime prevalence of posttraumatic stress disorder is 9.7% of females in the general population, compared with 53% of women in this study undergoing lifetime posttraumatic stress (Lynch et al., 2014). The women included in this study included 51% of pre-conviction participants and 49% of post-conviction participants, from jails in Colorado, Idaho, metropolitan Washington, D.C. (Maryland and Virginia), and South Carolina, who participated in diagnostic interviews (Lynch et al., 2014). The prevalence of mental health concerns found in this study suggest the critical need for assessment of mental health concerns upon women’s entry into criminal justice facilities and the need to address female offenders treatment needs (Lynch et al., 2014). Research states the reasoning for these growing numbers is the appearance of past physical and sexual abuse among women, and the high rates of interpersonal trauma and associated symptoms of posttraumatic stress disorder among female offenders (Lynch et al., 2014). Furthermore, there is a higher likelihood of individuals with major depressive disorder and psychotic disorders to engage in activities relating in violent or nonviolent infractions (Lynch et al., 2014). Including the numbers surrounding women without a comparison to men provides insight on behalf of women and the prevalence of mental health concerns among this population.
Many women in jails have also been victims of violence, which can play a significant role in the mental health issues they may face. Researchers from the Vera Institute explain that 86% of women report having undergone sexual violence in their lifetime, followed by 77% reporting partner violence, 60% undergoing caregiver violence” (Swavola et al., 2016, p.11). A study of 1,272 female arrestees awaiting trial at Cook County Department of Corrections in Chicago, Illinois exposed that 22% of women met criteria for post-traumatic stress disorder, and a review in 2005 suggests that exposure to traumatic events is nearly universal among incarcerated women with trauma exposure ranging between 77% and 90% (Green et al., 2005). These startling numbers reveal the extent that a lack of access to mental health treatment affects women in jails.

**Racial Disparity: Women Incarcerated**

The issue of mental health services surrounding women in jails also disproportionately affects women of color in the United States. A researcher through the American Psychological Association found that in American jails, African American women are twice as likely to be incarcerated as white women, as also previously stated by the Treatment Advocacy Center (Cowan, 2019). Statistics reveal that 96 per 10,000 African American women are incarcerated compared to 49 per 10,000 of their white female counterparts (Conwan, 2019). The data supporting the high rates of women of color found in the criminal justice system conveys the disproportionality in the female incarceration rate. Racial dynamics within the criminal justice system remains a prolonged issue, but research has noted that between 2000 and 2009,
imprisonment rates for black women dropped a total of 31% from “205 per 100,000 to 142 per 100,000” (Nellis, 2016). Furthermore, the ratio of black women compared to white women declined from 6:0:1 to 2:8:1 between 2000 and 2009 (Nellis, 2016). These statistics exhibit a change in racial disparities within the system, but the change is not progressed enough. With racial disparity among women in the justice system comes the increasing need for justice reform which incorporates racial justice.

Although there seems to be a slight decrease in women of color compared to white women incarcerated, research continues to reveal disproportionate numbers surrounding race. Individuals from racial minorities who have a mental health condition are consistently directed to the criminal justice system (Johnson, 2014). People of color as a collective, those of all gender identities, make up 64% of individuals in jail with mental health concerns (Johnson, 2014). Some mental health conditions black individuals’ face in jail include schizophrenia, psychoses conditions, and bi-polar disorders (Johnson, 2014). Black individuals who undergo these three mental health concerns are more likely to be incarcerated than people from other racial identities (Johnson 2014). To give some insight into the disparity we see occurring with people of color incarcerated, 35% of the total female jail population in Los Angeles includes black women (Johnson, 2014). The reason why the Los Angeles jail population is referenced in this portion of the paper if because LA County Jails are thought to be the nation’s largest mental health holding sites in effect, with approximately 19,000 pre-sentenced and sentenced individuals housed in their facilities (Johnson, 2014). By looking into the unjust rates of those of color with mental illnesses who are incarcerated, it can help support the issue at hand, the need for more efficient mental health treatment.
Studies not only expose the disproportionate rates of black and brown individuals incarcerated with a mental illness, they also exhibit the cycle of black individual’s limited ability to acquire mental health treatment. Supporting these claims is the finding through a study of a national sample of state and federal inmates, where it revealed that 26% were diagnosed with a mental health condition in their lifetime but only 18% of this total received medication for their diagnosis during their sentence (Mahaffey et al., 2017). Of the total sample of people in this study, 40.6% and 43.4 were black (Mahaffey et al., 2017). Without effective treatment needs creates a great divide within the criminal justice system, especially for those of color.

**Most Prominent Mental Health Concerns that Women Face**

The types of mental health issues most often experienced by women need to be reviewed in order to understand best approaches to intervene. For one, “serious mental illness (SMI)—including major depression, bipolar disorder, and schizophrenia—affects an estimated 32 percent of women in jails, a rate more than double that of jailed men and more than six times that of women in the general public” (Swavola et al., 2016, p.10). According to the Treatment Advocacy Center, women with mental health concerns, including schizophrenia, schizoaffective disorder, bipolar disorder and major depression are more likely to undergo re-incarceration compared to their male counterparts with the same conditions, with the time they spend in the community being half as long as it is for men (Cloyes et al., 2010). What can be seen by this statement is that women are more susceptible to other conditions or unfair treatment once incarcerated with a mental illness. With their mental health comes the rate of re-incarceration, self-harm rates, and suicidal behaviors. The Treatment Advocacy Center provides research on these rates, explaining that women make up more than half the at-risk group of adults in nearly
every suicide risk, including suicidal thoughts at 53%, suicidal plan at 58%, and attempting suicide at 60% (Stanley et al., 2015). When looking at women with serious mental illnesses and their re-incarceration rates, women are seen to spend half the amount of time in their communities after release compared to men (Cloyes et al., 2010). With a serious mental illness comes other external factors that can affect women. Included is the rates at which they lose custody of their children, which is seen to be increased among incarcerated women with mental illness, and a co-occurring condition. For instance, women with schizophrenia and substance abuse are six times more likely to be incarcerated than women with schizophrenia alone and women with bipolar disorder and substance abuse are three times more likely to be involved with the system than women with bipolar disorder alone (Roberstson et al., 2014). A multisite random sample study of 491 women found that fifty-three met criteria for having post-traumatic stress disorder in their lifetime, followed by forty-three perfect of participants meeting criteria for a serious mental illness (Lynch et al., 2014). Consequently, this same study found that the prevalence rate for depressive disorder, bipolar disorder, and schizophrenia and other psychotic disorders was 31% for women compared to 15% men (Lynch et al., 2014). The multitude of data supporting the need for efficient mental health treatment among women in county jails helps to better understand the need for significant change of treatment approaches within these facilities.

**Current Mental Health Assessment Tools in Women County Jails**

An in-depth analysis of the current mental health services provided to women in county jails allows for an assessment of the downfall of these services. This section will first entail
services provided upon women’s arrival to facilities, in order to determine their mental health challenges. Studies reveal that the approach that facilities take once women arrive at intake are male focused, and are not geared towards women specifically. This means that many women receive services that are not geared towards their gender identity. Many jails used assessment tools in order to identify where and how individuals will be housed within facilities, while also pinpointing the other services they are eligible for (Swavola et al., 2016). These assessment tools are geared towards the needs of men, and many times use current charges and criminal history in the conclusive factors (Swavola et al., 2016). By using a tool that is more determinative of the risk factors of men, it makes for an unreliable assessment of women upon their intake.

Research suggests that the risk of deterioration while incarcerated proves the importance of conducting mental health screening at the time of admission and the need to provide continued services during these individual’s sentences (Nicholls et al., 2012). Most research to date on these screening tools shows that quintessential jail booking procedures are not effective and the current tools are not considered accurate (Nicholls et al., 2012). With that being said, research does not exhibit an instrument that is validated in its efforts to evaluate incoming inmate’s mental health status in a productive manner and their need for specific placement and service needs (Nicholls et al., 2012). Through a multitude of research findings, there seems to be more research aimed at creating a validated screening tool for women who arrive at correctional facilities, so that it is ensured they are receiving the best level of care and protection while incarcerated. The lack of substantial screening tools aimed towards female needs causes women with mental health concerns, who are viewed to commit less violent crimes than men with mental health concerns, to be viewed as a threat and or/a risk. Not only is there a lack of screening tools, there if further a lack of research supporting any treatment services that follow
the screening. This lack of research displays a lack of investigation into the actual services that are currently in place. In conclusion, a failure to properly distribute mental health screening leaves for the lack of attention towards services for the mental health jail population.

The Netherlands have a much different approach with their current mental health screening services, compared to the United States. This section will specifically include assessment screening services the Dutch implement in their justice system, to compare their screening tools with the United States screening tools. Although research of Dutch screening tools does not speak of women compared to their male counterparts, their tools take into consideration the needs of all individuals, unlike the United States tools. With the screening tools, research reveals that of only Dutch prisons, while there is no known research regarding jail screening tools in their country. In comparison to the United States, the Netherland prison system includes psycho-medical consultation in every prison, where the practitioners who conduct this consultation include a forensic psychologist, a forensic psychiatrist, a general practitioner, and a nurse (Kamperman, 2014). Research suggests that the United States have a lack of effective screening tools, while the Netherland have worked in effort to modernize their system and services. Alongside the Dutch’s efforts to modernize their justice system, they have similarly worked to implement a screening instrument for incarcerated individuals of all backgrounds, to identify psycho-medical, better known as an individual’s mental or psychological state, and other social concerns, to further provide efficient care for all who are in need within their system (Kamperman, 2014). In comparison to the United States, the Netherlands assessment tools are much more modernized, and they continue to improve upon their mental health services.

This section, speaking of the current mental health approaches in the United States, is incorporated so that viewers can see where this country is lacking. However, data from the
Netherlands helps provide evidence for much more mental health focused services in this country. Data includes that most Dutch individuals, or those residing in the Netherlands, are no longer in protective care including 24-hour hospital services, but instead about 90% of serious mental health patients receive outpatient care or are living in supportive housing facilities (Kamperman, 2014). Although, there is limited research of mental health services specifically in local jails in the Netherlands, their numbers about prisons still give a look at their restorative nature of services. To back up these claims, the Netherlands have a mixed nature of their internal and external organization of prison mental health care, with their internal services dominating their external (Salize et al., 2007). Within 1998-2006, research showed that the Netherlands prison system implemented a reducing recidivism program and from there they continued to restructure the prison system (Salize et al., 2007). Section three of this thesis will go into more detail about the Netherlands specific services and their success with restructuring their criminal justice approaches, while incorporating how the United States can take on a similar approach to improve their services going forward.
III. Section Three

c) Mental Health Services to be implemented in Women’s Jails

Multi-Tiered System of Supports (MTSS)-A Response to Intervention (RTI) Framework

This writer is writing from a professional social work perspective as guided by the National Association of Social Workers (NASW) comparing the medical model to a continuum of supports. This could include universal development of social emotional skills through explicit instruction and reinforcement, and implementing evidence-based approaches such as Mental Health First Aid (El-Den et al., 2018). Next, layering secondary level of services, including trauma-responsive approaches and skills-based group therapy and support groups (citation). Finally, if universal and secondary interventions are not effective, and it is determined that some women need additional intensive levels of tertiary support including wraparound services and individual counseling to heal trauma through holistic supports. These different levels of services reflect the Multi-Tiered System of Supports Framework (MTSS) (McCance & Lynch, 2019).

MTSS is a system often used in schools, but also reflects the tiered public health model to efficiently use resources to address needs. This approach can also be applied to women who are incarcerated in the United States. MTSS is an approach designed to respond to the needs of all members within a system that incorporates, but is not limited to, tiered behavioral and academic supports (McCance & Lynch, 2019). This system of supports is a comprehensive–based framework for improving outcomes through a hierarchical trajectory of evidence-based practices and systems (McCance & Lynch, 2019). MTSS uses data to identify needed assistance through specific benchmarks or thresholds. This thesis explores which methods could be included in tier one approaches, including universal skills taught to all individuals within a criminal justice
facility. Tier two allows for early intervention or targeted support for women incarcerated (McCance & Lynch, 2019). Let it be noted that tier three services include those which are more individualized interventions to address an individual’s identified condition, but this thesis focuses more on universal services for women’s mental health rather than individual services. A multi-tiered system of supports is an approach that not only is beneficial to the education system and the students within it, but would further benefit the criminal justice system and those involved within it undergoing mental health challenges.

Within a multi-tiered system of supports is the need for recognizing those who are incarcerated as a ‘whole person.’ What this highlights is the need for a whole person approach to be incorporated into all services for women in correctional facilities. A whole person approach is a concept of care which can be drawn on holistic theory (Baum, 2020). The term holistic refers to the mind, body, emotions, and spirit, and their interconnection (Baum, 2020). A whole person approach supports that an individual is not limited to their physical health, they also have their wellness as a whole person. It focuses on an individual’s own perception of self, and the many different avenues that contribute to one’s wellness. This can include, but is not limited to, psychological wellness, emotional wellness, social wellness, physical wellness, and spiritual wellness. It is essential that a whole person approach, or a focus on all aspects of a person, is incorporated into the practice methods which need further implementation into women’s facilities.

For the purpose of this thesis, this writer will be focusing on a phase down approach for the Multi-Tiered System of Supports Framework. What this entails is a framework which works from learning skills, to group support and strategic supports for individualized needs, to
increased benefits and independence. This is an approach which starts with a highly structured approach, to phasing down to more individuality in mental health services.

**Figure 1**

This graph is focused on student’s needs, but it can also be translated to the needs of women who are incarcerated in the United States.

![Multi-Tiered System of Supports](image)

(Branching Minds, 2020)
i. **Tier 1 Services**

**Social-Emotional Learning or Development for Women**

Social-emotional learning is an approach that needs further implementation within women’s mental health treatment services. This form of learning is essential to provide universally for all women incarcerated. Managing one’s emotions is a key aspect of social-emotional development. Emotional regulation includes amplifying, attenuating, or maintaining affective responses to situations where emotions are heightened (Axelrod et al., 2011). A study of women in prison explains that respondents described the prison environment as being more emotionally intense than life on the street (Greer, 2002). This same study also revealed that the participants in the study experienced an increased intensity of feelings right before their release from the system into their communities (Greer, 2002). These findings provide insight for why it is essential for women to have the tools to manage their emotions.

Furthermore, the trauma many of these women have faced placed them at an emotional disadvantage once incarcerated (Greer, 2002). Many times, past traumatic experiences cause many incarcerated women to face challenges when it comes to building relationships with their peers. This is because once many women undergo trauma, they lose the ability to trust other individuals around them, in fear that their past experiences can become their current reality. It is essential that social-emotional services take into consideration that “individual-based deficits in emotional resources influence the type of emotion management technique selected” (Greer, 2002, p.136).

In addition, there are current studies of programs supporting the need for social emotional services, and the positive impact they have on incarcerated women. One such program coupled
survivors of intimate partner violence with law students who provided legal advice and informal help in preparing for court, provided emotional support, and referred victims to community agencies. Women who received advocacy services as part of the program reported lower levels of re-victimization and improvements in the level of emotional support (Parsons & Bergin, 2010). In addition, there is a current program in place named the Path to Freedom Program, which was adapted from the Integral Peacemaker Training, a leadership training program created by Kate Crisp and Fleet Maull for the Peacemaker Institute (Ferszt et al., 2015). This particular program is a mindfulness-based emotional intelligence (MBEI) training for those incarcerated, which employs key elements of social emotional learning and mindfulness-based cognitive behavioral training. The Path to Freedom Program is a prime example of a Tier One service within the multi-tiered system of supports, since it is a universal training to teach social emotional skills to those incarcerated. The training is a model of public health support which further focuses on increasing participants’ resources, capacities and skills for self-awareness, mindfulness, presence in the here and now, and maintaining focus and attention in daily living (Ferszt et al., 2015). Additionally, it emphasizes women’s need for emotion management, resilience, listening, empathic communication, problem-solving and conflict management, forgiveness, and reconciliation in the domain of personal and work relationships (Ferszt et al., 2015). The practices brought forth through the program encourage the shift away from fear-based criminal strategies to pro-social strategies grounded in uplifting incarcerated individuals and working to emerge their confidence (Ferszt et al., 2015). This would allow for a shift away from punitive approaches in the U.S. criminal justice system and the further implementation of more reactive and rehabilitative resources. Based upon research, The Prison Mindfulness Institute (PMI), a nonprofit organization within the State of Massachusetts, originally offered the
program, while it is now beginning to be taught in prisons throughout the U.S., Canada, Sweden, Finland, Australia, Chile, and the United Kingdom (Ferszt et al., 2015). Research supports the increased application of this program, but there is limited research supporting its implementation within women facilities so far.

In continuation, the growing body of research on the Path to Freedom Program supports the benefits of the training this program offers. For instance, the benefits include mindfulness of physical and psychological outcomes, and a reduction of depression and anxiety (Ferszt et al., 2015). Women are subjected to becoming emotionally vulnerable once incarcerated due to the challenges that come along with incarceration. These could include the constraints, strip searches, lack of privacy, nutritional constraints, limited visitation from their loved ones, and the need to continually submit applications for health visits (Ferszt et al., 2015). Additionally, many women have children who they are being separated from when incarcerated, which creates another burden (Ferszt et al., 2015). This could increase an incarcerated women’s stress levels and levels of emotions, which could further affect their mental health. Having services that teach women how to manage their emotions can better set them up for success when managing their mental health challenges.

**The Need for Further Implementation of Mental Health First Aid (MHFA)**

Mental health first aid (MHFA) is a form of training with the goal to detect mental health concerns. This form of training is defined as the assistance provided to a person who is developing a mental health challenge, experiencing the worsening of an existing mental health problem, or in a mental health crisis (El-Den et al., 2018). Mental health first aid allows for
community members to receive proper training to detect a mental health crises. Training staff personnel in the criminal justice system to identify a mental health situation would further benefit women incarcerated, due to the underlying trauma they may face.

Between 2008 and 2016, 47,660 Mental Health First Aid courses were offered in the U.S. (El-main et al., 2018). These trainings trained approximately 777,000 individuals nationwide (El-main et al., 2018). Mental Health First Aid was originally created in Australia in 2001. The U.S. implemented this form of training years later, to help address gaps in understanding mental health among adults in the community by teaching needed skills to identify and help individuals experiencing emotional distress (El-main et al., 2018). The United States implemented The Mental Health first Aid Act of 2016, in an attempt to authorize 20 million annually for Mental Health First Aid training and received wide bipartisan support (El-main et al., 2018). Although it gained much support, this act was not passed in the Senate during the 2015 sessions (El-main et al., 2018). There is currently no federal policy in place for funding these programs, while states are left to appropriate state funds to provide Mental Health First Aid training (El-main et al., 2018).

Furthermore, there is a need to implement Mental Health First Aid in the criminal justice system. Not only could this form of training be implemented, it could also be required for all staff who assist women incarcerated, to ensure there is a general knowledge of steps needed to take in crises situations. Although there is substantial research supporting the increased usage of Mental Health First Aid in rural and urban areas between the years of 2008 to 2016, there is limited research to support the use of this training in the criminal justice system. On the contrary, current research helps to support how training staff personnel in jails and prisons would benefit those incarcerated undergoing mental health challenges. Mental Health First Aid is most
commonly taught through an 8-hour session or over the course of 2 days in two 4-hour sessions (El-main et al., 2018). These courses include (a) assessing the risk of suicide or harm, (b) listening nonjudgmentally, (c) giving reassurance and information, (d) encouraging the individual to get appropriate professional help, and (e) encouraging self-help strategies (El-main et al., 2018). These steps are most commonly referred to as “ALGEE” where they also teach basic information about different mental health challenges people face (El-main et al., 2018). Research proves through a 2014 meta-analysis of 15 international Mental Health First Aid research studies that this form of training increased trainees’ knowledge of mental health, decreased any negative connotations of mental health, and increased their supportive behaviors towards those with mental health concerns (El-main et al., 2018). When looking at the United States, a research study of 36,263 participants found that participants reported an increased knowledge and confidence in their ability to apply skills due to the training (El-main et al., 2018). Previous research supports the effectiveness of Mental Health First Aid training, but the purpose of this thesis is to focus on incarcerated women’s mental health needs and how services such as Mental Health First Aid could benefit their mental health.

Most criminal justice agencies are poorly equipped to address mental health concerns of victims and police and courts staff members rarely receive training to recognize or address mental health concerns (Parsons & Bergin, 2010). This lack of training leads to exacerbating the trauma of the original crime or that of an incarcerated individual (Parsons & Bergin, 2010). Women especially receive inadequate care which leads to undetected mental health challenges, but if all staff were prepared through Mental Health Aid to do so, women could begin to receive appropriate treatment upon arrival. In addition, research reveals that women who are trauma survivors are likely to undergo the often invasive nature of many daily correctional procedures,
and the close quarters in which incarcerated women reside, as profoundly threatening, activate the distress that both underlies and accompanies trauma (Swavola et al., 2016). Standard correctional procedures lack an understanding of mental health and how women who undergo mental health challenges and trauma should be addressed by staff. To back up these claims, research has noted that access to effective treatment services is an especially critical part of a woman’s recovery (Swavola et al., 2016). Research explains that there is limited detection for women who have a mental health concern, while without this detection they cannot be referred to treatment that can support them. If there is an increase in Mental Health First Aid implementation among jurisdictions, staff could begin to detect and refer women to the appropriate care for their mental health needs.

ii. Tier Two Services

**Trauma-Responsive Services for Women**

The United States does not render their focus on psychotrauma while the Netherlands has shifted their focus on psychotrauma substantially during the last three decades (Kazlauskas et al., 2016). The United States is in dire need of services which focus on gender based needs. Women specifically need services which are more trauma responsive, or in simpler terms, take into consideration an individual’s treatment needs while also being conscious of past traumatic experiences. Research explains that histories of sexual abuse interfere with female inmates’ capacity to benefit from needed services or programs, due to the disconnection that trauma can cause (Miller & Najavits, 2012). Gender-responsive interventions are especially efficient due to
their focus on “empowerment and improving problem-solving, self-image, and self-efficacy” based on grasping the pathways that lead to crime among women and affect their high rates of victimization, mental health distress, and substance use disorders (Fedock et al., 2019, p.257). The data that research exhibits exposes the need for more trauma informed care, especially among women incarcerated.

A form of care that takes into account the trauma one has faced is Trauma-Informed Correctional Care. It has been noted that some women’s correctional facilities have begun to use trauma-informed care, although not all facilities have incorporated this in their services. This is why there is a need to extend this type of care nationwide for all women’s correctional facilities. There are many guidelines that would need to be followed in order to implement this form of care in a safe and successful manner. Let it first be noted that the term trauma-informed includes the modification to operational practices that can cause more prolonged trauma among women (Benedict, 2010). Staff would first need to learn and understand trauma’s effect on the brain and body. In addition to this understanding of trauma, programs would need to integrate education for women on the negative effects of trauma, teach effective coping mechanisms, and operational practices would need to help assist women in managing the symptoms of trauma, in order to safely engage in these trauma informed services (Benedict, 2010). Not only could a lack of services affect women with trauma and mental health challenges, but also typical routines in the corrections system could heighten the negative impacts that trauma can cause.

A researcher from the Bureau of Justice Assistance suggests that even when the concepts of empowerment, safety, and trust are present, they are usually only used in one-on-one counseling, group services, or case management (Benedict, 2010). This same researcher suggests that we need to broaden the scope of trauma-informed practices to “the larger institutional
culture” for incarcerated women (Benedict, 2010, p.4). The use of trauma-informed care among mental health services for women helps to promote trauma recovery. Trauma-informed interventions in women’s facilities should be strength-based and work to promote recovery and resilience (King, 2017). It would also be efficient to allow for trauma-informed treatment to be in a warm, welcoming environment within the facility, because the environment plays a major role on mental health treatment (King, 2017). In addition, enforcing a “time-out” option for women when receiving these services would be very beneficial, as it is known that past traumatic experiences could be brought to light once receiving treatment. The professionals facilitating the trauma-informed treatment should understand the implications and effects of the form of treatment, in that it can re-traumatize a women if the practitioner is authoritative or coercive in their intervention methods (King, 2017). This is of key importance when facilitating trauma-informed treatment because with a negative treatment approach can come triggers of trauma.

There are eight specific steps that can be taken for a more trauma-informed category of care, as explained by the Bureau of Justice Assistance. These steps include making a commitment to the trauma-informed practice, supporting and training staff in their efforts to be more informed on the topic of trauma, adopting trauma-informed language/communication and terms, creating a trauma-informed physical plant rehabilitation project, making existing institutional procedures more trauma-informed, implementing new trauma-informed operational practices, introducing strategies to help women incarcerated manage difficult trauma and symptoms, and building a trauma safe community with those incarcerated (Benedict, 2010). If trauma-informed services were mandated to be incorporated in women’s mental healthcare services, there could begin to be a decrease in the negative impacts that other services can have on trauma.
Benefits of Skills-based Group Therapy for Incarcerated Women

While group therapy is seen to be a very effective approach for women with mental health concerns, it is not known how many facilities currently implement these services. Group therapy generally teaches self-regulation and change skills, and skills for self-acceptance and the acceptance of others (Verheul et al., 2003). There is a lack of extensive research on the impact of group therapy on incarcerated women in American facilities, but there are a few researchers to date who have addressed this topic. One study described a 16-week treatment model of incarcerated women who have been physically or sexually abused (Goldman, 2000). As a result of the 12-week support group and a 4-week period of education on the topic of abuse, these women reported increased self-esteem, increased perceived control over their lives, and a decrease in isolation from others, and an increased trust in other individuals (Goldman, 2000). The positive results reported from this extensive form of group therapy support its need for further implementation. Group therapy is a form of treatment which would allow for women to work towards their goals while incarcerated, so that once they are released, there is less of a chance for recidivism.

Many times, women with mental health challenges have difficulty building relationships with their peers when incarcerated. This can be due to the trauma they have faced, an inability to trust others, feelings of anxiety, and low-self-esteem. Research on group therapy found that women who participated in this form of therapy when incarcerated felt better about themselves and were able to better build bonds with inmates who attended the group because they had the opportunity to escape any conflict, boredom, or deprivation they felt in the general living units (Goldman, 2000). Another study revealed that when women in jail participated in support groups, the participants’ had positive outcomes with their self-adjustment (Goldman, 2000).
Among the forms of self-adjustment included improved social and emotional adjustment and fewer physical concerns among the women who participated in the group, compared to women who did not participate (Goldman, 2000).

Research notes that group therapy not only can help stabilize a woman’s mental health challenges, but it can contribute to the process of offender rehabilitation by offering therapy groups focused on cognitive restricting of criminal thinking and attitudes (Morgan et al., 2006). A specific form of group therapy that’s has be identified as being beneficial to women incarcerated is group art therapy. Art therapy is defined as “the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma, or challenges in living” (Gussak, 2007). Researchers state that group art therapy is a way of stimulating introspection, building self-esteem and self-awareness, and allowing insights to come to the surface (Erickson & Young, 2010). It is indicated that incarcerated women are ideal candidates for group art therapy because their ability to express emotions is often limited due to the criminal justice setting they are confined to (Erickson & Young, 2010). Especially for women, vulnerability is seen to be viewed as a weakness. Group art therapy allow allows for women to express themselves and their emotions through their creativity.

In addition, art therapy in groups promotes group members to express themselves through illustrations and then create a supportive environment to express these feelings verbally to their peers (Erickson & Young, 2010). Many art therapy programs are referred to as Arts-in-Corrections programs. As measured over a 6-month and a 2-year period of time, these programs have determined a decreased number of disciplinary reports written on inmates who participated in the arts and a decreased rate of recidivism for these individuals (Gussak, 2007). Further, art can help to diminish pathological symptoms, provide necessary diversion and emotional escape
for participants, promotes disclosure, even while the inmate is not compelled to share feelings and ideas that might bring up feelings of vulnerability (Gussak, 2007). There is growing research on the use of art therapy among criminal justice facilities, although this research does not display all facilities that have implemented it to date. Without knowing how many facilities have begun to use these services, it can only be assumed that there are still many facilities lacking this effective form of therapy.

Group therapy is beneficial to implement among other services as well. For instance, interpersonal process-oriented psychotherapy groups, or a group which focuses on making personal improvements over time, is seen to be beneficial for incarcerated individuals learning to uphold responsibility for their own progress in treatment programs (Morgan et al., 2006). Interpersonal process-oriented psychotherapy groups can be beneficial for women because many times, women have trouble trusting their peers due to the trauma they have undergone. These groups allow for women to explore relationships with other group members, while becoming responsible for how their behaviors could affect their fellow group members (Morgan et al., 2006). Group therapy allows for women to build bonds with other incarcerated women, in a healthy and safe environment. All in all, research on group therapy has proven that it has been implemented in many facilities, while it is unknown how many women have the means to receive this type of therapy while incarcerated.
iii. Tier Three Services

Specialized Mental Health Units

Women who have more individualized mental health needs could benefit from the creation of specialized mental health units within all female facilities. These units would serve as a safe space for women who are unable to cope with participating in everyday activities within the general population (Hills et al., 2004). Implementing these units would allow for women to receive assistance in a safe environment. Research has shown that these units have been demonstrated in numerous prison systems (Hills et al., 2004).

New York State has created many efforts to respond to mental health within the system. Specifically, New York has created “alternative to incarceration” programs, including mental health courts and diverting low-level offenders from jail to probation style treatment (Pope & Eide, 2018). This demonstrates an increase in alternative programs but also a lack of research addressing services while incarcerated. Many individuals who are incarcerated do not always have the luxury of gaining access to these alternative programs. On the contrary, based upon Mayor Bill de Blasio’s Action Plan of 2014, New York State planned to implement specialized mental health care units. This plan included the conversion of four existing Mental Observation Units into units that provide intensive and frequent mental health care for those with more acute needs (de Blasio, 2014). These would specifically be known as Program for Accelerated Clinical Effectiveness (PACE) units (de Blasio, 2014). These programs or units would especially be beneficial for women in need of more intensive care, by providing more persistent guidance. Although this Action Plan describes that these units would be converted, it also stated that it would only convert four current existing units. This statement discloses the lack of current
mental health units specifically in New York State. Research does not reveal how many units have been converted in New York since this Action Plan, but it can be interpreted that there needs to be further creation of specialized mental health units for women’s facilities in the United States as a whole.

**Intermediate Care Programs**

Intermediate care programs are a mental health approach provided within specialized mental health units. They provide those incarcerated with an alternative level of clinical and rehabilitative supports (Hills et al., 2004). These programs are not considered “intensive” as tier three demonstrates, but they can be considered more individualized services. This is because they provide services for those who need more than outpatient services, but do not require intensive inpatient services offered by the state’s forensic psychiatric center. These programs within mental health units provide those with mental health concerns the opportunity to be separated from possible harassment in the general population (Hills et al., 2004). This separation is especially influential for women and their needs, since studies show that correctional facilities exacerbate the vulnerabilities that women undergo (Cowan, 2019). There are many specific services that are provided within intermediate care programs, but for the purpose of tier three services, this writer will be discussing individual-based therapy.

When looking at individual-based therapy, the contribution of the therapist is just as valid as manualized treatments of physiotherapy methods (Scott, 2008). Psychotherapy, a specific form of individual-based therapy, is seen to be more intensive for those it serves. Psychotherapy is referred as a therapeutic intervention which is client-centered, psychoanalytic and/or reflective
of unconscious feelings, and confined to private practice therapists who work one on one with a client (Scott, 2008). Research shows that for those incarcerated, treatment needs are defined by outside sources and systems outside of the treatment process (Scott, 2008). This is because while incarcerated, any individualized treatment method relies on a partnership with referral sources, such as probation (Scott, 2008). Women would be positively affected by these partnerships. They could begin to feel a sense of collaboration and management, while receiving support for their mental health. Psychotherapy should also link clients to resources that could assist in their rehabilitation and intervene in any criminogenic factors identified by outside partners (Scott, 2008). These criminogenic factors could include anti-social thinking and behaviors, anti-social peers, and impulsive behaviors (Scott, 2008). Addressing factors that could further lead to incarceration would better set women up for success.

**Intensive Case Management**

Intensive case management allows for women incarcerated to have a developed care plan alongside a trained professional (Walsh et al., 2001). These specialized approaches include a case worker providing direct care and organizing the delivery of a range of services tailored to each individual’s needs (Walsh et al., 2001). Especially since intensive case management emphasizes small caseloads (10-15 patients per case manager), women would have the opportunity to feel like the worker is involved in their case and individualized needs. As research states, without trust and healthy self-esteem, women are less likely to use the support systems available to them (Richie et al., 2000). Evidently, having an intensive case manager alongside
women with mental health needs would allow for women to build rapport and trust with a trained professional while incarcerated.

There are five sequential activities included in case management, as described by the National Institute of Justice include (1) assessing the clients specialized needs; (2) creating a service plan; (3) connecting the individual to appropriate services; and (5) advocating for the individual’s needs (Healy, 1999). It can be understood that there is a gap in research based upon how many women receive intensive case management while incarcerated. For instance, research explains that in a few systems in the United States, every probationer and parolee receives some form of case management, but this statement does not include those who are currently incarcerated (Healy, 1999).

One specific intensive case management approach which needs further implementation into all women’s facilities includes “strength-based” case management. Strength-based intensive case management emphasizes the individual’s strengths and builds upon them in the service plan (Healy, 1999). This form of case management is especially influential for women undergoing mental health challenges. It would help them identify their strengths, to increase their ability to self-reflect, and formulate goals (Healy, 1999). Many women who are incarcerated have undergone some form of trauma which likely contributes to any feelings of self-doubt, vulnerability, or distress. Especially for women with mental health concerns, the climate of violence and dysfunction and preexisting vulnerabilities places them at a greater risk of destabilization and distress (Cowan, 2019). A strength-based approach for intensive case management is seen to help those incarcerated to understand they have inner strengths and resources (Healy, 1999). For this method of case management, the case manager must also show disapproval for the individual’s antisocial behaviors, in order to help them stay on a positive path
Intensive case management for women with mental health challenges would help them maintain a structured form of care and monitor their progress.

d) Mental Health Services in the Netherlands Criminal Justice Facilities

The Forensic Observation and Guidance Department

The Netherlands justice system set up the Forensic Observation and Guidance Department in 1981, in hopes to assist detainees undergoing mental health crises. This Department was set up in order to address psychiatric hospitals failure to respond affirmatively to take in detainees (Koenraadt, 2010). Originally implemented in the Amsterdam prison system, the Forensic Observation and Guidance Department worked as a facility for crisis intervention with detainees undergoing serious mental illness who need psychiatric treatment and cannot be properly treated at a penitentiary (Koenraadt, 2010). These departments in Amsterdam, a city in the Netherlands, address the need to offer beds to detainees who are not able to reside in penitentiaries. Although this department does not directly care for detainees within a prison facility, it acts as an alternative placement for those who are unsuitable for detention. The point of this thesis is to focus on services within criminal justice facilities, yet it is important to highlight services that the Netherlands has put in place and how they compare or contrast to the United States efforts.
TBS (Terbeschikkingtelling) Instrument

TBS, standing for Terbeschikkingtelling, is a judicial instrument “embedded in the Criminal Code” which works simultaneously with a prison sentence in the Netherlands (Marle, 2002, p.83). This approach is specifically implemented for individuals with mental health concerns in the system to reach rehabilitation. TBS includes clinical mental health care combined with detention, usually taking place in a secured mental health treatment setting (Santegoeds, 2013). TBS strives to protect society in the short term by detention, and in the long term, by treatment that reduces risk from a mental health challenge (Marle, 2002). This tool in in place for individuals who could be at risk for being dangerous based on their mental health diagnosis.

With the assessment of risk for TBS also comes the certainty that the act was committed based upon an individual’s mental health diagnosis. There are two specific forms of TBS, TBS with conditions and TBS-Treatment. TBS with conditions includes certain conditions applying to the individual who committed an illegal act, where they stay at a regular psychiatric center to receive treatment for their mental health concern (Santegoeds, 2013). On the contrary, TBS-Treatment includes a mandatory stay in a Forensic Psychiatric Clinic (Santegoeds, 2013).

In the Netherlands, there were provisions for sentencing on September 26, 1997, where only 1/3 of the prison sentence needs to be served, while this can even be shortened due to unsuitability for detention or serious medical need for treatment (Marle, 2002). The provisions to TBS in 1997 also makes it possible to put pressure on an offender to undergo certain treatment without having to become incarcerated (Marle, 2002). TBS as an approach for treatment allows for an individual who commits an illegal act to consult with their probation officer, in order to track progress. This tracking of progress allows for an inmate with a mental health concern to receive supervision and/or support while receiving needed services. TBS is in place not to
change personality but to stabilize a mental health challenge in an optimal setting to live whereby the personnel provide and control all activities of patient (Marle, 2002). Although research states that personnel can control patients, this is an approach that could benefit women in the United States who are involved with the justice system. It can become clear through research that revisions would need to be made if implemented, due to the control personnel could hold over a patient, but it is an approach that would help to prevent recidivism for women incarcerated with mental health concerns. Compared to the United States, which has not implemented a tool such as TBS, it is important to consider the Netherlands approaches with mental health challenges, especially for women who are incarcerated and in need of more efficient services.

- Netherlands Penitentiary Psychiatric Centre’s (PPC)

The Netherlands criminal justice system has created ample mental health services within their facilities. In 2009, five particular centre’s for incarcerated individuals with mental health concerns were implemented within the prison system, these centres all being penitentiary psychiatric centres. The Netherlands’ Prisons began to implement an approach where those who refuse treatment can be sent to Penitentiary Psychiatric Centre’s, or for short PPCs, where they can receive extensive care outside the general prison population (Masthoff, 2013). Let it be noted, inmates who are sent to PPCs are in the midst of serving their sentence, and are able to arrive at these extracurricular facilities upon serving time. These centres’ serve as a separate unit in Dutch jails, where inmates with more severe mental health needs can receive more structure upon receiving services. In these PPCs psychologists, psychiatrists, general practitioners, psychiatric nurses, social workers, expressive therapists, music therapists, psychomotor
therapists, and drama therapists provide incarcerated patients with efficient care (Masthoff, 2013). Having this range allows for incarcerated individuals to receive appropriate services with trained professionals.

Within Penitentiary Psychiatric Centre’s, the mental healthcare is of higher worth compared to the basic care available within the general prison system (Masthoff, 2013). Although research on PPCs in the Netherlands does not specifically focus on women, the benefits of these centres elucidate how they could benefit women in American jails. Women are more susceptible to disparate social and legal status in multiple jurisdictions, and may have a decrease in access to capital, social goods, and other legal means to protect themselves against being victimized or victims of crises (Aolain, 2011). When it comes to emergency situations, including mental health crises, women are increasingly put on the sideline to receiving treatment (Aolain, 2011). Implementing Penitentiary Psychiatric Centre’s for women in American facilities would moreover allow for structured services for this population. Penitentiary Psychiatric Centre’s would take into consideration the specific needs that women inhabit while incarcerated, and emphasize the idea that women’s vulnerability is “to be primarily cultural and organizational rather than biological or physiological” (Aolain, 2011, p.5). Not only do Penitentiary Psychiatric Centre’s allow for more structure, they also include an array of service providers, which can aid women with a wide variety of mental health needs, social-emotional needs, and trauma-informed care. If the United States criminal justice system were to implement PPCs into their facility services, women would have the opportunity to both benefit from a form of care that best suits their needs, and receive more than one form of care, if prompted.

The guards in these Psychiatric Centre’s are not “regular” prison guards, they are called ‘care and treatment facility workers’ (Masthoff, 2013). These guards are trained in taking care of
psychiatric patients (Masthoff, 2013). In contrast to the United States, the Netherlands has guards in these units who are specifically trained to assist incarcerated individuals with mental health challenges. Research about the United States does not give insight into guards being trained as ‘care and treatment facility workers.’ Penitentiary Psychiatric Centre’s in the Netherlands further include specific units for females and for those with sexual deviances (Masthoff, 2013). By incorporating female only units, women could begin to feel safer and more stable in the environment they are receiving these services.

**Motivational Treatment in the Netherlands Prisons**

The Netherlands prison system has worked to Modernize the Prison System, or in Dutch, Moderniseri ng Gevangeniswezen (MGW) (Masthoff, 2013). Within this modernization has evolved their focus on motivational treatment. Motivational treatment includes the enhancement in communication skills of all staff pursing the goal of uplifting prisoners in developing self-motivation and implementing self-accountability among their own rehabilitation (Masthoff, 2013). The approach of motivational treatment allows for a more humane approach within the treatment of inmates who undergo severe mental health concerns. The Dutch have developed approaches which provide a balance between support, safety, and rehabilitation within their mental health treatment in prisons. This form of treatment supports the key role that staff play in the success of an incarcerated individual.

With motivational treatment, it is argued that the way staff treat inmates directly relates to the reliability of treatment. The use of motivational treatment includes the helpful attitudes of prison staff, where they encourage inmates to participate in differing activities, assist them in making
plans for post-release, and educate them on self-reflection (Molleman & Broek, 2014).

Motivational treatment derives from the importance of motivational interviewing, where all staff, no matter which branch of the prison system they work for, has to follow a basic educational training to motivate incarcerated individuals upon interviewing or intervening with them (Molleman & Broek, 2014). This is especially an effective approach for women, since women are in dire need of more social-emotional care approaches once incarcerated. The use of motivational interviewing in United States women’s facilities would allow for women to feel motivated to change, instead of being led to failure, just as they currently are within the American justice system. The use of motivational treatment in the Netherlands justice system stresses the importance of staff receiving basic educational training in the rehabilitative process to create a more uplifting environment.
IV. **Section Four**

**Summary of Findings**

The comparative analysis conducted within this thesis reveals a multitude of findings which require further review. By comparing and/or contrasting the services in the Netherlands to the United States, it can be seen that there is not only a lack of research on this topic, but also a gap in research. As stated in Section One within the Introduction, without clear benchmarks of success and/or holistic wellness at universal, secondary, and tertiary levels both in the general population as well as within women currently incarcerated, it becomes impossible to identify what is effective and what is missing (gap analysis) towards continuous improvement. A lack of research on differing levels of women’s mental health care reveals a need for additional investigation into this matter. As previously stated within Section Three, research supports that educational services for women would be very beneficial, but on the contrary, research does not reveal how many women’s facilities have implemented these services. Specifically, research on these services supports the benefits of social-emotional learning, Mental Health First Aid, trauma-informed services, and group therapy and/or support groups. Further, it supports the positive outcomes of intermediate care programs, specialized mental health units, and intensive case management, but it does not prove how many facilities utilize these services for women with mental health challenges. These findings reveal a gap in research on mental health services for women incarcerated.

Current research speaking on behalf of the issue at hand is mostly geared towards men. This highlights the need for more research surrounding the mental health and overall wellness of women who are currently incarcerated and transitioning out of incarceration. For instance, as described in Section Two, studies reveal that the approach facilities take once women arrive at
intake are male focused, and are not geared towards women specifically. Also, the assessment tools that many criminal justice facilities use to house those in their facilities, are geared towards the needs of men. (Swavola et al., 2016). As stated in Section Three under the Multi-Tiered System of Supports section, there is a need for a determiner of success for women incarcerated. The multi-tiered system of supports is currently only used within schools. This system is designed to improve learning outcomes for students, by structuring behavioral and academic supports into a hierarchal ranking to measure improvement. Research obtained through this comparative analysis reveals that this system would greatly benefit the criminal justice system, in order to determine the benefits of mental health services which fit into the universal, secondary, and tertiary levels of the multi-tiered system of supports.

Further Recommendations

Pilot Initiative

In order to build on the mental health services within women’s correctional facilities, there are quite a few further recommendations which could be brought forth. In order to investigate services for women incarcerated and the gap in current research, a pilot initiative could be effective, by creating a preliminary study for mental health services among women. An example could include creating an initiative in New York State which focuses on subgroups within different New York Counties. These subgroups would include women who are incarcerated, who identify as having a mental health challenge. In addition, conducting a pilot
An initiative on women’s mental health could include the assessment, intervention, and evaluation of mental health among women and the services which best suit them. If New York State conducted a pilot initiative, where they implemented the mental health services described in Section Three of this thesis, it would give a more detailed look at how these services could benefit women within New York. Within this pilot initiative, it would be beneficial for the New York State Department of Justice, Criminal Justice Reform branch, to partner with the Office of Mental Health, in order to create a study which combines both departments needed for this initiative. A small-scale study on this issue would allow for researchers to conduct a preliminary study and then scale up, or in other words, build upon these findings by conducting further studies in other states.

**Partnership between Departments of Criminal Justice and Mental Health**

Another recommendation includes creating an intentional partnership among the New York State Department of Justice, Criminal Justice Reform Department, and the Office of Mental Health to document this model. Overtime, specific efforts would be needed to scale-up this model within multiple states at the federal level. This could be achieved by distributing national resources through the Substance Abuse Mental Health Services Administration (SAMHSA). This model is used to capture innovative practices to build systems of care (Hardee et al., 2012). It also works to establish an affinity group of states to scale-up this work (Hardee et al., 2012). The concept of scaling up has been used in implementation science, which is the implementation of evidence-based findings into practice systematically (Schultes et al., 2020). It
is crucial for women’s incarceration facilities who appreciate the importance of building MTSS to efficiently respond to the unique needs of the population they serve.

**Policy Recommendations**

Policies are needed to address both the lack of mental health services within United States women’s criminal justice facilities as well as structuring these services within a hierarchy of supports, to use resources effectively. Just as there are specific policies implemented within certain organizations for topics such as visitation, discharge, and reporting a complaint, there also must be policies regarding the types of services across a continuum of response. Specific policy guidance is needed for those who wish to replicate this responsive model within all women’s prison facilities. One such example is The New York State Office of Mental Health’s Treatment Plan Policy. This requires that every person receiving a mental health treatment plan includes opportunities for gathering the input of close family (Smith & Parish, 2010). In addition to this policy, the Office of Mental Health explains that the policies they have in place are carried out differently across the criminal justice system, so advocacy is essential to provide effective assistance (Smith & Parish, 2010). What this implies is that the Office of Mental Health has a handful of policies addressing different avenues within the criminal justice system, but that does not mean these policies are carried out effectively and the same in every facility. Based on research, what the Office of Mental Health does not address is a policy which makes it mandatory for certain types of services within all facilities. It would be essential that a policy was created, and put into action, in order for an accurate change to be made within women’s
facilities in addressing their mental health needs. In order to create and implement a policy such as this one, community members would need to begin advocating for the creation of such a policy and partner the Office of Mental health in this process.

**Models of Support**

It is further recommended that models of support are used when advocating for the implementation of women’s mental health services. There are models of support which could help to better identify the needs of females incarcerated. For instance, the Sequential Intercept Model (SIM) is a model of intervention for communities to use when considering the interface between the criminal justice system and mental health systems as they address concerns about the criminalization of individuals with mental health challenges (Munetz and Griffin 2006). This model of support helps to guide reform within the criminal justice system, and could be used to advocate for more mental health services for women. The Sequential Intercept Model was created in the early 2000s by Mark Munetz, Patricia A. Griffin, and Henry J. Steadman to assist communities in addressing those with mental health concerns in the criminal justice system (Willson et al., 2018). This model of advocating for change also relates to policy recommendations for the issue at hand. This is because the Sequential Intercept Mode identifies which criminal justice decision makers are responsible for each intercept within this framework (Willson et al., 2018). These intercepts are in place to practice early intervention with those in the system. First includes Intercept 0 which addresses community services and interventions for those with mental health concerns before they come in contact with the system (Willson et al., 2018). Next, Intercept 1 includes law enforcement, and the influence they have in addressing an individual in crisis (Willson et al., 2018). Following Intercept 1 is Intercept 2, which includes
initial detention of an individual, their post arrest diversion options for treatment, and their initial court hearings (Willson et al., 2018). Lastly, there is Intercept 3, 4, and 5, which address those being held in pretrial detention and the importance of specialty treatment courts, reentry and the importance of transition planning, and community corrections among those with mental health needs (Willson et al., 2018). It would be recommended that models such as the Sequential Intercept Model (SIM) be further used in the process of reforming how the criminal justice system addresses mental health.

**Database to Track Mental Health Care**

A database could help with tracking the services that women are currently receiving and where the services could be lacking in regard to their needs. For instance, in 2008, the New York State and New York City Mental Health and Criminal Justice panel convened to discuss cases of serious mental health challenges among those incarcerated. They came to the conclusion that there is poor coordination and lack of accountability in the mental health treatment system among incarcerated individuals (Hogan et al., 2008). With this, they also recommended creating a database to track the mental health care provided to adults in need (Hogan et al., 2008). This recommendation is applicable to the issue discussed in this thesis. If the Office of Mental Health and the Department of Health Mental Hygiene came together to create a database accessible to both agencies addressing the encounters of women with mental health needs, it would allow for the Care Monitoring Teams to track services of care. This would help providers understand any interruptions in needed methods of care (Hogan et al., 2008). This database would make for a great tool to track the types of services women are receiving, where services are lacking, and which services are further needed.


**Funding**

Services for women would need significant levels of funding. Just as many programs within the criminal justice system, implementing more mental health services would need funding in order to create and implement more programs. For instance, women’s criminal justice facilities could receive funding from different departments focused on mental health, to go towards bettering the mental health services among this population. Federal funding from departments could help and create more needed services to reach the needs of criminal justice-involved individuals. Based upon research focusing on 180 funded research grants by the National Institute of Health, 11% were based on mental health (Ahalt et al., 2015). In addition, only 4% of grants were for healthcare delivery research in correctional or transitional settings of care (Ahalt et al., 2015). Research reveals that there is a clear divide in the amount of grants focusing on mental health needs. In addition, the same study found that funding research for criminal justice healthcare is very limited, compared to the increasing number of individuals affected (Ahalt et al., 2015). Research findings reveal the need to fund more mental health services and further fund research aimed at the mental health needs of women in United States criminal justice facilities.
Conclusion

As a result of the comparative analysis conducted in this thesis, it can be concluded that research helps to substantiate the topic at hand. The claims made within this thesis, including the lack of mental health services in women’s criminal justice facilities, the lack of measuring success of these services, and the idea that the Netherlands has more efficient and restorative practices within their facilities, are all supported and confirmed through current research. With this, the United States women’s facilities could benefit from applying an approach such as the Netherlands, and begin to implement their services which have been proven to be effective. In addition, research supports that there are services implemented for women, but there is a gap in research about how many facilities use these services. With needed services comes the need for a tier of support, in order to measure the success of women’s mental health services. As this thesis states in Section Four, a Multi-tiered System of Supports could be implemented within the criminal justice system, in order to effectively respond to the mental health needs among women who are incarcerated. As stated within the Further Recommendations section of this thesis, it can be concluded that recommending a pilot initiative, a partnership between the departments of criminal justice and the Office of Mental Health, effective policies, reviewing support models for services, creating a database, and further funding mental health services, could all play a part in improving women’s mental health services. As a result of this comparative analysis, there is criteria to support the need for more mental health services for women incarcerated due to the specialized needs of this population, but there is a need for further research to conclude how many facilities in the United States use effective services. By advocating for next steps to be taken, there is increased optimism for a positive change in mental health services for women within the United States criminal justice system.
References


Munetz, Mark R., and Patricia A. Griffin. 2006. Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. Psychiatric Services 57(4), 544–49


