BUILDING FOR THE INSANE CRIMINAL
ARCHITECTURE FOR THE FORENSIC PSYCHIATRIC PATIENT

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The 1 in 4 Dutch people will have a psychiatric problem. In 2009 more than a million people in the Netherlands will be treated in psychological health care. The treatments seem effective since three quarters of the patients have been 'healed' within a year. (GGZ Nederland, 2011). 1700 patients are admitted to psychiatric institutions, ... in forensic psychiatric care. Because of an psychological disorder combined with a conviction of a severe crime. These last are the ‘insane criminals’ of the Netherlands.

During my Bachelor in Build Environment at Avans Hogeschool Tilburg I was interested in healing and sickenning environments. I had already visited a forensic institution to see how those work. I was fascinated by the contrast within the building, being locked down and being treated. The chance of being treated and the possibility of not committing an other crime. In the media forensic psychiatric care is a big issue. Every time a former forensic psychiatric patient falls back into old habits and commits a new offence the media is all over it. Politicians are to debate the process and would seem everyone has an opinion about the fate of these insane criminals.

Though, for some reason, there is little known about the building and architecture for this special group. This in contrast to prisons and psychiatric institutions, which seem to have attracted the interest of architects ever since Nicolas Le doux and his panopticum.

I am interested in the way forensic psychiatric works, what kind of special needs those patients have, how the building facilitates re-socialization and how and if architectural means could enhance the re-socialization process. It might be utopian to think of a healing building to cure all criminals, but one could try to take the effort if it is partly possible.

Within my graduation studio at the Faculty of Architecture at the TU Delft it was possible for me to explore my own fascination. ExploreLab 12 gave me a platform to research my interests in building for forensic psychiatry and find acknowledgements for future forensic psychiatry design projects.

Elke Miedema, February 2011, Delft
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1. PREAMBLE
1.1 MOTIVATION

My goal is to find architectural means to improve the re-socialization process of forensic psychiatric care. Where will the inmates go top when they have served their punishment? There is a need on research on what kind of home these people need. A research on the process of forensic psychiatric care, the forensic psychiatric patient and it's building. Before this research there was little know about the architecture for forensic psychiatric care while media and politicians seem to have it on their agenda several times a year. Architects have find their way researching prisons and health care, but the forensic psychiatric institution is still to be discovered.

1.2 AIM

The research will give answer to the following questions:

**FORENSIC PSYCHIATRIC CARE**
- What is forensic psychiatric care?
- What is re-socialization?

**THE FORENSIC PSYCHIATRIC PATIENT**
- What is a forensic psychiatric patient?
- What are his specific needs?

**FORENSIC PSYCHIATRIC BUILDING**
- What types of buildings house forensic psychiatric care?
- What are the requirements of a forensic care institution?
- How can architecture contribute to the re-socialization process of forensic psychiatric patient?

These answers together will result into guidelines for future designs of forensic psychiatric care.

The answers found by literature research, interviews and case studies. To find out more about the (forensic) psychiatric patient, the process of re-socialization in forensic psychiatric care and architectural means to improve their living and treatment environment. The research will be limited to the living facilities in forensic psychiatric care. The focus will be on the architectural translation of the re-socialization process.

1.3 STRUCTURE

The structure of the research is as follows. The thesis is build up in 3 parts; Forensic Psychiatric Care (FPC), The Forensic Psychiatric Patients (FPP) and the Forensic Psychiatric Institution (FPI).

Forensic Psychiatric Care will set the basic knowledge of the subject. The historical, the legal and social context are described to give a basic knowledge of Forensic Psychiatric Care and the process of re-socialization.

To understand whom to design for an understanding of the main users of the Forensic Psychiatric Institution is needed. What kind of people end up to live here? What are their disorders and how are they effected them.

While the first two parts are create a basic understanding the third part is the linking the process, the patient and it’s architecture. This part concludes to be the program of requirements for any new forensic care institution. The design research will implement an example on how to implement those regulations, needs and qualities into a new forensic care institution.
2. PRECURSORS OF FORENSIC PSYCHIATRIC CARE

Insanity and psychology is probably as old as humanity. Archeologists have found 7000 year old skulls where, with the use of firestone, holes had been drilled. Those archeologists thereby concluded that this could be some kind of care to get rid of demons in ones mind. Forensic psychiatry on the other hand is quite young and a combination of different branches we still know now: that of the mental hospital and a branch of the prison. The evolution of mental hospitals, or psychiatric institutions, are to be found in the history of hospitals. Therefore the origin of the forensic psychiatric institution is to be found in the rise of care building for both poor, sick and criminals.

2.1 RELIGIOUS BUILDINGS.

Even before the Greek (oudheid) there was a sense of insanity. It was said to be caused by spirits, magic, evil demons and the contribution in taboos. The insanity would have been the punishment similar like physical illnesses during those times. There was not even a real distinction between psychological and physical disorders and illnesses yet (Porter, R.S. (2003) Waanzin; een korte geschiedenis).

Greek Ancient history describes those (psychological) illnesses in their myths and epopes. While own will and reason are of no influence, Homerus (a poet and singer whom lived from ca. 800 v.Chr. – ca. 750 v.Chr. in Ancient Greek History) describes life, behavior, normal and abnormal as a result of randomness of supernatural forces (Porter, R.S. (2003) Waanzin; een korte geschiedenis).

During that time an Asclemepeia housed the poor and ill. Asclemepeia is derived from the Greek god Asclepios of medicine and healing. The temple would facilitate resting, meditation and healing for the sick and poor. They where allowed to beg when given a sacrifice to Asclepios. The ill where to be healed by with prayers, sacrifices and magic spells. They believed to be visited by Asclepios and his daughters in their sleep, healing them from their illnesses. Reconsideration might say the health had improved by the improver hygiene of the ill by taking a bath and resting. But Asclemepeia are still seen as the origin of hospitals and modern health care.

Religious people have been concerned about the care of poor and sick people. Insane people were not to be locked down but taken into custody to prevent them to be a risk to society or them selves. Questioning the thoughts of the early Greeks they thought epileptics would derive form being possessed by ghosts or demons. The attract would be the fight of the demon with the body and mind of the ‘victim’.

From the birth of Jesus Christ, the believe in gods, angels and saints contributed to the thought that madness was something people had little influence on. The Christian theology describes the conflict of the soul by devil and holy spirit. At this point there is only difference in normal and abnormal people, meaning those who believe and those who do not believe. One who lets in the devil or losses faith would be insane, with symptoms like fear and desperation.

Till the 8th century there was little change in the opinion on insanity. With the rise of Xenodochia a new kind of building came to be. Xenodochia are places for strangers derived from Xenos (strangers) and Docheion (place). Those Xenodochia where empty residences of ‘clerics’ who stood of their houses when passed away. They would give them to the less fortunate to live in, some as part of a monastery some as independent houses. Those less fortunate could either be the poor, mentally or physically ill since there was no clear difference between them.

2.2 HIDDEN AT HOME

During the early middle ages there was a change in how to take care of the ill, psychological of physical. When an illness had consequences for society those who were insane would be place under care by relatives. In most cases this would mean the ill was placed in cellars or with the pigs. Those circumstances where no different from those of dungeons which housed the criminals of that time. When there was no threat to society any longer the ‘patients’ were being released. In most cases, the release would result in relapse and as a result recurrence of imprisonment. In exceptional circumstances a cleric would inter fear with lunatics wellbeing. The care and healing of a madman was perceived as a religious act.
2.3 DUNGEONS OR MONASTARY

Much later the insane were seen as unlucky beings which were not accounted for their own actions or disabilities. From that moment on those insane where secluded from society. This seclusion would be imprisonment in towers or dungeons with other insane and criminals.

This separation from society

In 1621 was het Richard Burton wie negatieve ervaringen van geesteszieken aanschreef als duivels en veroorzaakt door satan, waarbij de slachtoffers ziekten waren. Onreine geesten moesten dan ook met geestelijke middelen worden aangepakt. Kerken speelde een belangrijke rol in de zin van het bezoeken van missen, duivels uitzetten. Maar ook het graf van een heilige zou kunnen helpen bij het verdrijven of genezen van krankzinnigheid. Een voorbeeld van een dergelijk graf was dat van Dimpna van Geel. Maar hier werd niet gebouwd voor de geesteszieken, alleen een plek waar ze konden verblijven.

2.4 (KLOOSTER)ZIEKENHUIZEN OF GEVANGENIS

Aan het einde van de 14e eeuw werden gebouwen in gebruik genomen voor het opvangen van krankzinnigen. Zo werd het klooster van H. Maria van Bethlem in gebruik genomen. In de omgeving van Geel bij het graf van St. Dimpna wat inmiddels al een bedevaarder oord is voor krankzinnigen ontstaat een centrum voor genezing van geestelijk gestoord.

In Spanje in de 15e eeuw werden gestichten gebouwd onder leiding van kerkelijke initiatieven. De verzuiling draaide eveneens er aan bij dat er verschillende instellingen omm de verspreidheid over het land met een verschillende achtergrond maar een gelijk doel.

1 De Heilige Dimpna is de patrones van de bezetenen en geesteszieken en de beschermheilige tegen epilepsie en krankzinnigheid.

2 Later bekend als het Bethlam ofwel Bedlam.

Onder de leiding van de regering van Lodewijk de XIV werd in 1653 in Parijs het Hospital General opgericht waar een grote diversiteit aan mensen werd ondergebracht.

Het hospital general welke in eerste instantie was bedoeld voor het opvangen van armen, ontwikkelde zich in de 18e eeuw zicht tot een instituut van staatcontrole. Staatscontrole in de zin dat eigenlijk iedereen welke niet optimaal aan het arbeidsproces kon deelnemen daarmee niet deel kon zijn van de maatschappij. Dat wil zeggen dat de groep welke niet kon werken door ofwel ziekten ofwel gekte werden opgesloten. Er werd hierin geen verschil gemaakt tussen zieken, krankzinnigen of criminelen. Alle omstandigheden waren zeer slecht en amoebig. Iedereen die een andere mening had dan de staat kon opgesloten worden. De 18e eeuw wordt dan ook veelal gezien als de eeuw van de opsluiting zoo ook in de woorden van Foucault.

Uiteindelijke leidde dit initiatief tot een eis van de Franse regering nog geen 20 jaar later in om dergelijke instellingen in elke grote stad te huisvesten. Lodewijk de XIV was daarin de grote aanstuurder.

2.5 PSYCHIATRISCHE INRICHTINGEN;

3 M. Foucault e.a. Les Machines à guérir (aux origines de l’hôpital moderne), Bruxelles, Liège 1979, p13 (Menk, 2003)
VERZORGEN EN GENEZEN.

De kwalen zoals Histeria, insania en andere psychische ziekten bleken te behandelen te zijn.

Rond 1800 verandert de plaatst van een psychiatrisch patiënt in de samenleving sterk; de krankzinnigen werden niet langer weggestopt maar men besloot dat de patiënten misschien wel te genezen zijn. Hoewel het in eerste instantie geen effect heeft op de gebouwen of patiënten verandert hiermee wel de denkwijze waarmee een begin wordt gemaakt van een gedachtegoed zoals we dit nu kennen.


De effecten welke de moderne stad heeft op de inwoners lijkt ook een reden te zijn meer aandacht te besteden aan de plek van de psychiatrische inrichting. Daarnaast wordt de behandeling ook humanischer waar architectuur ook wordt gezien als een factor welke een belangrijke rol speelt in het genezings proces.

De natuurlijke context (die natuurlijke sociale verhoudingen insloot) zou het ideale kader vormen voor een gelukkig leven zonder ziekte, gekte en criminaliteit. Dat zou kunnen op zeer kleine schaal binnen de muren van een gebouw of op zeer grote schaal.4

Het gehele maatschappelijke gedachtegoed over de krankzinning verandert in die periode en men denkt dat de bewondering van het bestel de beste remedie is tegen fysieke en psychische kwalen van die tijd. Op die manier kunnen ze ook meer invloed uitoefenen op de patiënten en beter controleren.

Het is de tijd van de categorisatie en de opkomst van de wetenschap daarmee wordt vanaf deze tijd ook verschil inzichtelijk tussen type ziekten; het verschil in lichamelijk en geest ziekten. Daarnaast wordt er onder de geestesziekten onderscheid gemaakt tussen rustige, half rustige en onrustige. En ook de afdelingen van gebouwen werden hierop aangepast. De verschillende afdelingen verschillen niet per type geesteszieken, maar het verschillende type patiënten worden niet meer gemengd geplaatst.

2.6 1841: KRANKZINNIGHEIDWET


Natuur had behalve natuurwetenschappelijke betekenis ook een ethische en emotionele waarde. Er werden nog meer accenten gelegd op de buiten ruimtes; de toewaarheid van de Chinese tuinen werden toegepast om ongerepte natuur na te bootsen. Ook mede door de inrichting van de tuinen bleef de omheining uit het zicht van de patiënten. Hierbij werden tuin en gebouw samen. Daarnaast kwam met het naar ‘buiten’ plaatsten van de gebouwen nog een voordeel mee; er was veel ruimte voor de arbeid therapiën welke op dat moment een belangrijk onderdeel zijn van de behandeling. Daarnaast moesten patiënten kunnen wandelen in de natuur. Vooral de drukke en opgewonden patiënten zouden op die manier rust komen en door beweging een deel van de onrustigheid kwijt raken.

2.7 VAN OPPASSERS NAAR PSYCHIATERS

Tijdens de verlichting ontwikkelt men ook de wetenschap van medicijnen en de psyche van de mens. Door deze ontwikkeling veranderen ziekhuisen in behandelt centra met medicijnen en geneesheeren. De behandeling bestaat niet langer uit het verzorgen van basale behoeften zoals eten, drinken, veiligheid en hygiëne, en het aanleren van normen en waarden, maar door de opkomst van medicijnen kunnen ook ziektes en bacteriën bestreden worden.

Echter werd hier ook duidelijk dat de genezing van sommige ziekten zoals geestesziektes nog niet te behandelen zijn door medicatie. Hoewel ze wel de aller onrustigste geestesziekten beter onder bedwang kunnen houden kunnen ze deze patiënten niet genezen van hun waanideeën en krankszijnheid.

Vrijwillige patiënten (zenuwijlders)

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De architectuur wordt door twee elementen gekenmerkt; de trek naar buiten en de introductie van het paviljoen type.

In de tweede krankzinnigenwet werden verschillende randvoorwaarden aan gestichten scherp gesteld. De woning van de patiënt moet gezond zijn met voldoende gelegenheid tot beweging in de openlucht. Uiteindelijk kwam het paviljoen type hieruit; een reeks van verschillende gebouwen welke verspreid in een landschappelijke omgeving zijn geplaatst. De voordelen hiervan zijn de optimale inpassing in de natuur, fysieke scheiding tussen de verschillende categorieën en klassen patiënten en een grote mate van overzichtelijkheid binnen elk paviljoen.

In hetzelfde jaar wordt ook de vereniging tot Christelijke Verzorging van Kankzinningen en Zenuwlijders in Nederland (VvvKz) opgericht. Dit is een initiative van Lucas Lindeberg.

2.8 1886: WETBOEK VAN STRAFRECHT

De gevangenen moesten daarom worden aangepast aan de eisen van het nieuwe Wetboek van Strafrecht, dat in 1886 werd ingevoerd. Een architectonisch resultaat van de nieuwe regelgeving was bijvoorbeeld de koepelgevangenis van Haarlem, die in 1901 werd gebouwd.

Voor 1886 werden criminelen en delinquenten opgesloten in gevangenissen onafhankelijk van hun geestelijke toestand. Met de invoering van het wetboek van strafrecht kon iemand die leed aan een gebrekkige ontwikkeling of ziekelijke stoornis hiervan worden vrijgesteld. De betreffende persoon kon dan niet het delict worden toegerekend. Met behulp van de deskundigheid van een psychiater werd toen vastgesteld of de dader dan wel niet toerekeningsvatbaar was tijdens zijn daad. De keuze voor de rechter bestond dan uit het plaatsen in een psychiatrische inrichting of een justitienige inrichting afhankelijk van gevangenis.

Hierdoor ontstond een verschil tussen geestelijk gezonde criminelen en geestelijk zieken criminelen waarvan de eerste thuis hoorde in een gevangenis en de tweede plaats kreeg in de psychiatrische inrichtingen.

Welke plek je terecht kwam was sterk afhankelijk van welke partijin invloed probeerde uit te oefenen. “De scheidslijn tussen beide groepen blijkt in de praktijk vaak samen te vallen met de wisselende invloed van de verschillende partijen die zich op dit gebied begeven, met name de instellingen die onder het departement van Justitie vallen, de krankzinningen zorg ...” (Mens, 2003, p. 272)

Wat in ieder geval wel duidelijk was dat de veroordeelde psychiatrische patiënt niet op zijn plek was in een gevangenis waar ze niet konden functioneren en daarmee het voor de andere gevangenen onmogelijk maken. Bovendien is was daar ook geen mogelijkheid tot behandelen terwijl dit toch nodig bleek. Daarnaast is de psychiatrische instelling niet geschikt om deze patiënten te handhaven. Om dat moment werden veel problemen gevallen opgesloten in psychiatrische inrichtingen en daar waren deze helemaal niet op berekend.

Omdat geestelijk zieken niet een daad toegerekend kon worden werd iedereen welke ook maar een beetje geestelijke problemen had in een psychiatrische inrichting opgesloten om na één jaar weer te worden vrijgelaten. Daarnaast vormden ze een gevaar voor de andere patiënten. Er moest dus een nieuwe plek komen voor deze veroordeelde patiënten.

Onder het besef dat afzondering alleen een misdadiger niet kon verbeteren, deed de term resocialisatie zijn intrede. Gevangenen moest je leren om zich te verbeteren: een taak waar de reclasering zich mee ging bezighouden. Verder begon men er over te denken hoe de gevangen na hun straf te hebben gezeten weer in de maatschappij konden laten terugkeren.

Eind negentiende eeuw begon men anders te denken over misdaad en straf. De gevangene moest niet meer met andere gevangenen in een ruimte worden opgesloten, maar in zijn eentje in een cel. Eenzamen tot inkeer komen, in volledige afzondering van alle verderfelijke invloeden: dat was de achterliggende filosofie waarmee de strafrechtvormers dachten de criminaliteit te kunnen uitbannen.
3. THE (LEGAL) HISTORY OF CARE FOR THE INSANE CRIMINAL.

3. The History of Care for the Insane Criminal

De gevangen was al lang geen plek meer voor de ‘normale’ psychiatrische patiënt, maar in het begin van de moderne tijd werden gewelddadige en criminele mensen met psychologische stoornissen nog steeds in gevangenissen geplaatst. Deze mensen hadden per eenmaal een delict gepleegd en moesten hun straf uit zitten. Men was geneigd deze types zo lang mogelijk van straat weg te houden en op te sluiten. Indien ze hun straf hadden uitgezet, en weer op staat stonden, vielen deze veroordeelden veelal in herhaling. Pioniers zagen het effect van krankzinnigheid op criminaliteit en probeerden de krankzinnigen en criminele uit de gevangenis te halen en te plaatsen in psychiatrische instellingen.

3.1 Het Gebouw voor de Krankzinnige Crimineel

J.G. Schnitzler beschrijft in zijn boek [5] dat personen welke door de psychiatrie worden erkend als geesteszieken niet vallen onder justitie. De kern van deze wet was gericht op het scheiden van de geestelijk zieke gevangenen en de normale gevangenen. Hier werd echter nog geen onderscheid gemaakt tussen de criminele en de normale psychiatrische patiënt. Daarmee was wel duidelijk dat deze nieuwe patiënten problemen zouden opleveren voor de psychiatrische inrichtingen van dat moment. Niet veel later zouden gekke criminelen niet langer worden getrakt als gewone criminelen.

3.2 1928 Psychopaten Wet

In 1928 kwam de mogelijkheid om de geestelijk gestoorde crimineel onteerkeningsvastblijvend te verklaren. Dit gaf een naam aan de groep criminelen welke hun delict in een vorm van instabiele psychiatrische toestand hadden begaan. Ofwel een crimineel welke (tijdelijk) niet geestelijk gezond was ten tijde van het delict.

Het gebouw is niet gebouwd specifiek voor de psychopaten. Het was oorspronkelijk gebouwd als pesthuis in 1655 hoewel het eigenlijk nooit als zodanig in gebruik is genomen. Het Pesthuis is ooit ontworpen door stadstimmerman Huybert Cornelisz. van Duynvulvacht. Het carre model is ook eerder gezien in het pesthuis van Amsterdam en de gracht binnen over het plein is bedoeld om de mannen en vrouwen te schijnen. Het gebouw heeft later ook wel functies gehad zoals een militair ziekenhuis en gevangenis. Door de carre vorm bedoeld voor het binnen houden van de pest en haar slachtoffers was het ook zeer geschikt voor de criminelen en gekken van die tijd.

In 1929 werd de nieuwe instelling Oldenkotte voor mannen geopend bij Rekken aan de Duitse grens. Dit is het eerste gebouw gemaakt specifiek voor de opvang van psychopaten. Het initiatief kwam in 1910; toen hadden dominee Slot en koopman René van Ouwenaller al het idee om “de noden van zwakzinnige en geestelijk gestoorde mensen die niet thuisschrap in een gevangenis, maar in een zorgzame
omgeving opgevangen moesten worden.” Uiteindelijk wordt de instelling in 1929 geopend. (zie ook case studies).

Het gebouw ontworpen door de Hilversumse architect C. de Groot bevat vele paviljoens. Het gebruikte materiaal, rode baksteen, komt uit de omgeving en is geïnspireerd op de Japanse architectuur en jugendstil details.

Vanaf dat moment worden er op korte termijn meerder gelijke inrichtingen gebouwd voor psychopaten. Dit heeft ook veel te maken met de verzuiling in die periode. Elke zuil zorgde op haar eigen manier voor de psychopaten. Maar ook in de nieuwe gebouwen blijft het zorgen bepaart tot het appart opsluiten.

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Tussen 1928 en 1940 is de inrichting van het Willibrordus-terrein fasegewijs uitgevoerd naar het ontwerp van de Haagse architecten H.J.W. Thumissen en J.H. Hendriks in een aan de Delftse school verwante traditionalistische vormgeving. De hoofdopzet was kenmerkend voor de jaren ’30 en bestond uit een paviljoensysteem, waarbij patiënten naar ziektecategorie werden ondergebracht. De plaats, de ligging en de verbinding tussen de gebouwen was essentieel, evenals de ligging van de wegen en de stand ten opzichte van de zon. De gebouwen moesten vriendelijk ogen en hygiënisch zijn. Een duidelijke structuur was noodzakelijk maar een volledige symmetrie, de rechthoekige grondvorm als het idee van wiskundige volmaaktheid, vond men te mathematisch en te star. De belangrijkste gebouwen zijn de rechthoekige grondvorm als het idee van wiskundige volmaaktheid, duidelijke structuur was noodzakelijk maar een volledige symmetrie, zon. De gebouwen moesten vriendelijk ogen en hygiënisch zijn. Een evenals de ligging van de wegen en de stand ten opzichte van de plaats, de ligging en de verbinding tussen de gebouwen was essentieel, waarbij patiënten naar ziektecategorie werden ondergebracht. De plaats, de ligging en de verbinding tussen de gebouwen was essentieel, evenals de ligging van de wegen en de stand ten opzichte van de zon. De gebouwen moesten vriendelijk ogen en hygiënisch zijn. Een duidelijke structuur was noodzakelijk maar een volledige symmetrie, de rechthoekige grondvorm als het idee van wiskundige volmaaktheid, vond men te mathematisch en te star. De belangrijkste gebouwen zijn de rechthoekige grondvorm als het idee van wiskundige volmaaktheid, duidelijke structuur was noodzakelijk maar een volledige symmetrie, zon. De gebouwen moesten vriendelijk ogen en hygiënisch zijn. Een evenals de ligging van de wegen en de stand ten opzichte van de

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Na de oorlog werd de stopwet opgeheven. Mede doordat vele Nederlanders zelf hadden ondervonden hoe het was om opgesloten te zitten door de Duitse bezettingen werd een stop gezet op de slechte omstandigheden waarin de ter beschikking gestelde behandeld zouden worden. Hoewel nog steeds niet duidelijk was hoe dit vorm moest gaan krijgen is hier wel een belangrijke stap geweest ook voor de gebouwen voor de penitentiaire psychiatrische patiënten. Men werd opnieuw bewust van het effect van een goede omgeving en dat het opsluiten als straf al erg genoeg is. Daar niet ook nog een behandeling als dieren bij hoeft te kpomen. Ook kwam het besef dat het vrijlaten van de TBR-gestelden zonder echte behandeling toch niet een goed effect had. Vaak vielen de deliquenten weer terug in hun normale patroon en pleegden weer een delict. Pieter Baan stelde zelfs dat behandeling het gevaar voor de maatschappij verminderde door dat het recidiv, ofwel een delict, werd verminderd.

Om een goede behandeling te kunnen geven was het van belang dat de behandelaren goed wisten aan welke soorten de deliquent leed. Vanaf dat moment zijn er heel veel experimenten geweest op en

3.3 1933 DE STOPWET

De vraag naar plaats voor deze patiënten groeide steeds meer en hoewel ook het aanbod groeide moest de psychopaten noodwijk in 1933 moest de toestroom van Ter beschikking gestelde tot een halt roepen. De zogenoemde stopwet stelde strengere beperkingen aan het opleggen van terbeschikkingstelling; in het geval van een zeer ernstig delict en indien groot gevaar bestond dat de dader in herhaling zou treden. Helaas was de behandeling van dergelijke terbeschikkinggestelden nog steeds zeer beperkt, maar werd vooraf de bescherming van de maatschappij voorop gesteld.

Op dit moment is de leefsituatie voor de patiënten vergelijkbaar met die van de middeleeuwen. In het geval van de Rekkense inrichting werden omliggende oude varkens stallen geboukt als overnachtingsplaats voor de TBR-gestelden. Het nieuwe Rijksasyl in Avervoet moest de omgebouwde initiatieven vervangen en werd alleen gebouwd voor het groeiende aantal TBR-gestelden. Daarmee worden wel de afdelingen in Leiden en Woensel gesloten.

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voor de penitentiaire psychiatrische patiënt, maar deze hadden niet een duidelijk effect op de ontwikkeling van het gebouw. Wel leefde de penitentiaire psychiatrische kliniek op en werd er steeds meer aandacht besteed aan de psychiatrisch gestoorde crimineel.

Pas in de jaren 50 kwam het beseft dat een groot deel van de patiënten in hun jeugd was verwaarloosd. Door hoogleraren als Willem Pompe en Pieter Baan dat het nodig was onderzoek te doen naar individuele delinquenten om de behandeling van hun ziekte aan te passen aan hun geestelijke toestand. Op die manier zou de behandeling ook kunnen bijdragen aan de veiligheid van de maatschappij. Observatie klinieken ontstonden waar men de psychopaat kon analyseren.

Op dat moment wordt ook in Groningse gevangenis een afdeling in gebruik genomen voor de forensische psychiatrie. Dit is een voorbode van vele afdelingen en verbouwingen van gevangenissen ten behoeve van de forensisch psychiatrisch patiënt.

3.4 1953: BEGINSELENWET

De rechten en plichten van de gevangenen en terbeschikkinggestelden werden in 1953 vastgelegd in de beginselenwet. Daarin werd geacht dat gevangenen in gemeenschap met elkaar moesten werken om hen op die manier voor te bereiden op de maatschappij. Bovendien van de behandeling niet meer dan een cel, wat eten en beetje werk. Geen goed gesprek met een begeleider of psycholoog was mogelijk. Toch was het een begin van de ontwikkeling van behandeling van de forensische psychiatrisch patiënt.

Daarnaast waren de leefomstandigheden voor de forensische psychiatrisch patiënt sterk verbeterd; zo hadden de gevangenen midden jaren zeventig radio, televisie en een enorme privé-bibliothek. Ze hadden wel ieder een eigen cel, maar de mochten een groot deel van de dag bij elkaar in en uitlopen. Daarnaast hadden ze een gezamenlijke ruimte, waar ze zonder gestoord te worden door meeluisterende bewakers hun proces mochten voorbereiden.

3.5 1988: NIEUWE PSYCHOPATEN WET

Er waren veel discussies over de werking van TBR. Het zou erger zijn dan levenslange gevangenisstraffen en deed daarnaast weening aan het straffen van de deliquent. Het TBR systeem zou niet hard genoeg zijn. Die tegestrijdigheid en de discussie lijde tot een grondige verandering van de psychopaten wet. De maatregel van Ter beschikking van de Regering (TBR) werd omgezet naar Ter beschikking Stelling (TBS) waardoor ook een aantal nieuwe eisen werden gesteld aan de aard van het delict en de dader. Er zijn twee vormen van TBS ontstaan; met bevel tot verpleging waarbij de veroordeelde opgenomen wordt in een penitentiaire psychiatrische kliniek. Met voorwaarden betekende dat iemand buiten de penitentiaire psychiatrische kliniek werd behandeld aan zijn kwalen. Dit kan zijn in een polikliniek of in een psychiatrische instelling.

De minimale detentie was verandert naar 4 jaar. Daarmee zou het aantal TBS-ers moeten afnemen en bovendien het straffen van de deliquent al voor een deel in de gevangenis plaats vinden. Daarnaast werd deze maatregel maximaal voor 4 jaar opgelegd, waardoor levenslange opsluiting onmogelijk zou worden.

3.6 1997: BEGINSELENWET VERPLEGING TERBESCHIKKINGGESTELDEN.
3.7 FROM ILL TO CRIMINALLY INSANE

The history of forensic psychiatric care has its origin in care; all ordinary where ill during in ancient Greece. Later there became division between the criminal and the ill. The middle ages made the division between sick and criminal and little later the poor and ill.

During the rise of psychology the care for ill was divided by physically ill and the mentally ill. Nowadays there the types of people could be divides in 5 categories making criminally insane, the combination of criminals and insanity, the new kind of illnesses.
4. FORENSIC PSYCHIATRIC CARE NOW

Since 1997 much has changed in forensic psychiatric care. Even within forensic psychiatric care there have been divisions. And the theoretical frame has been changed of time. What is forensic care nowadays?

4.1 THEORETICAL

After being locked away for at least 4 years one is de-socialized from society. During the forensic psychotic care process this alienation has to come to re-socialization and socialization at some point.

As a focus on the project I want to find out whether healing and sickening effects can contribute not only to physical illness, but also to psychological illnesses. The way a mentally ill person experiences a space can be interesting. They may have the most advantage of a ‘healing environment’.

My interest focuses on the living space for the people in all steps of re-socialization. They now often live in institutions where they have a small personal room and a larger common room. Often those personal rooms are prison cell like and don’t contribute to the individuality of the patient. How can those rooms be more adaptable and more personal to make it a better healing environment?

And after a long period of their live in an enclosed environment how do they get back in society? How can architecture contribute to those different steps back in ‘normal’ live. Can there be a place where those people can live on their own but can communal function nearby? Similar like sheltered accommodation for elderly people those homes can be part of a bigger complex.

Maybe it would be interesting to work with a couple of different rooms in the treatment where the patients stay. The problem here can be though that the ‘feeling at home’ is more difficult when they stay in there less than a couple of months.

The question is also if they should feel home. Society might feel that the patients should be punished for their crime while psychologist might think a more therapeutic environment contributes to the treatment and re-socialization.

It must be mentioned that here is assumed that mental illness and psychiatry a reality and not a myth of human brokers. As obvious as this may sound, in 1961 and 1971, a book written by Thomas Szasz professor in psychiatry at the University of Syracuse (NY), which denied the existence of mental disorders:

Psychiatry is usually defined as a medical specialty that deals with the diagnosis and treatment of mental illness. My view is that this definition, still widely accepted, psychiatry in the company of the
Alchemy and astrology, and end up doing it classifies the pseudo-sciences. (Thomas Szasz, 1961)

Historically, crime and insanity have common ground. In the middle ages there was no difference in the handling of criminals or lunatics. Nowadays a large amount of the delinquents who come in to contact with the justice system have some kind of mental disorder. Probably causing them to commit the crime. In most countries those kind of criminals will end up in a prison or a mental hospital. In Brazil, for instance, a murderer can be detained in a prison or, in case of an mental disorder, in a psychiatric hospital. The last option exempts them from a prison sentence since they are not full responsible for their act, because of their mental problems, but they are not better off. When the criminal is declared ‘non compus mentalis’ or ‘to be of unsound mind’ they will have to proof to the institution which has locked them down they are ‘normal’. In Brazil this ultimately results in a live sentence in a mental hospital.

In the Netherlands there is a third option. There is a unique trail in the legal system for criminals with psychiatric disorders. Although in many countries make a distinction between criminals which are (temporary) insane, or were just completely sane, in the Netherlands is provided with an intermediate, less accountable. These offenders are mentally disturbed. They cannot be fully taken responsible for their act, because of a psychological disorder, but are also not entirely mentally ill. They did not, or only partly, knew what they were doing when committing the crime. The disability is taken into account during the trial.

This crossing point between mental health and the justice system is forensic psychiatry. In the Netherlands this forensic psychiatry deals with delinquents who are sentenced with a ‘measure restricted freedom’ in combination with a plea for psychiatric care, the so called TBS-restriction (1).

This is the confinement in the Penitentiary focused on the short term while protecting the TBS measure is intended to cure the offender of his psychiatric disorder and thus prevent recurrences. In this forensic psychiatric care where convicts are to be ‘cured’ for their psychiatric disorder. Curing meaning learning how to live with a certain kind of disorder or multiple disorder.

The reason why there is a third option in the Netherlands is founded in security of the patient and society. An ordinary psychiatric institution is not secure enough for such patients and in prison there is too little focus on treatment and therefore not suitable for this group of delinquents. This has resulted in a new function; the forensic psychiatric institution where psychiatric patients are ‘cured’ after a prison sentence.

The purpose of these clinics is safe return of these patients into society with a low risk of recidivism. Therefore there are phases to test whether they are able to handle those steps. Institutions are therefore composed of different components of treatment and there are several types of buildings facilitating the types of care. They all turn its own wishes and requirements for the building.

Rehabilitation is the re-occurrence in society or the re-education of a psychiatric patient. The delinquent is being called a patients when leaving prison and is being treated for his psychological disorder(s). To know how the building for re-socialization works the process of re-socialization has to be researched and simplified to a couple of phases. I want to know what those phases mean in terms of public/Private, own will, social interaction and the kind of problems they will run in to. The ultimate goal of re-socialization would be the admittance of a insane criminal into society without reoccurrence.

4.2 LEGAL FRAME WORK

The TBS-mesure or ‘to be detained under a hospital order’ is in drie wetten vastgelegd:

De TBS-maatregel is in drie wetten vastgelegd:

Het Wetboek van Strafrechten het Wetboek van Straf ordering regelen de externe rechtspositie, zoals de oplegging van de maatregel, hetgevangenstijdstip van de behandeling en de verlengingsregeling. Als iemand is veroordeeld tot een gevangenisstraf en TBS, begint hij in principe na een derde van de straftijd aan zijn TBS. Op 1 oktober 1997 is de Beginselenwet verpleging ter beschikking gesteld en Reglement in werking getreden. De Beginselenwet regelt de rechten en de plichten van de ter beschikking gestelde binnen de kliniek: de externe rechtspositie Deze wet is opgenomen in het “Handboek Rechtspositie Tbs-gestelden”. Voorst zijn in het handboek het “Ministeriële regelingen en besluiten” opgenomen.

4.3 ITS GOAL

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4.4 THE PROCESS

Forensic psychiatric care is mostly a process of different steps. The process is not at all the same for all delinquents, but is to be divided in steps. Those steps or phases of re-socialization can be skipped when necessary or possible. The scheme (figuur x) visualizes all the steps possible and the route one delinquent may take in this process.

CRIME
The process of forensic care start with the crime obviously. Before a crime there is no forensic care, there might be psychological care. There are different types of crimes and only the serious crimes with severe injuries, consequences and the risk of repetition could be resulting to forensic psychiatric care. Suspects who with offences like murder, sexual or physical abuse and other crimes like abduction are considered for forensic psychiatric care. They will be asked to undertake observation.

OBSERVATION
The observation of the delinquent is meant for the first ‘fast’ diagnosis. This is focused on weather the delinquent has a psychiatric disorder which lead to committing a crime. The delinquent will stay in an observation clinic for 4 to 6 weeks. He will have talks with an observation team like the psychiatrist, psychologist, sociotherapists and his lawyer. The team will try to find out weather the delinquent is (partly) accountable for his acts. This will help the judge to make a decision on the sentence, prison, psychiatric institution or forensic psychiatric care.

COURT
In court the judge will be advised by the lawyers and the forensic psychiatry team about the sentence most fitted for the crime and delinquent. At this point will be decided whether the delinquent is accountable for his acts. The outcome will decide weather he will go to a psychiatric institution or prison with or without a forensic care.

PRISON
The prison sentence has to be at least 4 years. During this prison sentence there is no treatment for the delinquent. In prison there is no place and money for treatment. This is purely meant for punishment and of course protecting society for this kind of people and the crimes they have committed.

STABILIZATION
Stabilization is meant for patients who are disturbing, disruptive and dangerous. The are is focus on the individual since they need more attention at this unstable phase. At this point only individual treatment is possible since the patients are not stable, secure for other patients, their selves and the practitioners.

Stabilization is also meant for patients who, due to extreme confusion, have committed a severe crime. Those patients can be dangerous since the acute confusion makes them unreliable. This department is focused on the stabilization of the psychical condition. Within this treatment is finding the right medication for the problems and taking over personal care when necessary. The team of practitioners will try to find a program suitable for the patients with the disability. When the patient is more stable he will be ready to go to the next phase.

ADMISSION / DIAGNOSIS
Admission is for most patients the first step of re-socialization. While in prison there was no room for treatment and not all patients are being send to the stabilization department the treatment will start here. The treatment will focus on research and diagnostics of the psychiatric disorder. The treatment plan is being discussed and the treatment team will advise for the following steps.

MOTIVATION
Forensic care is never forced upon the patients although the patients is restricted in his freedom when not participating in treatment. The first step in the re-socialization process would be to motivate the patient to participate in therapy and treatment. Those patients have a high risk on escalating. As part of the treatment and motivation the patient should be able to take account for the offence before they are able to take the next step.

SETTING THE GOALS
The next step in re-socialization is meant for patients who are easily out of balance and sensitive for their surroundings. When out of balance the symptoms of the disorder, like for instance aggression, may come reoccur. The main focus for this step is setting out the goal for treatment. What would be the ideal situation possible to live in? A analysis of the crime is needed to find out what triggers the patient to certain acts.

TREATMENT
The next steps are focused on learning how to live with a psychiatric disorder. From this point patients are allowed to take place in education and even work outside the clinic. First possibilities for leaves are in order as part of learning how to live with a disorder.
The leaves are being controlled and in a step-by-step order with more freedom when earned.

Re-Habilitation

The final phase of treatment, patients spend with accompaniment by the rehabilitation department. The patients in this department no longer have the extreme security needs of the institute, but they still need help in preparing for life and live outside the clinic. This live outside the clinic is divided in three ways: in a house outside the gates of the clinic setting, in a continuation of the overall mental health facility or in a house rented by the forensic psychiatric institution. In each of these three methods of rehabilitation counseling will be done by the staff of the former forensic care institution or in a poly clinic.

When fully re-socialized the patients do not have to be in contact with its care team. He is allowed to participate in daily activities to prevent him from wandering on the streets. There is at this point no need for extra care since the former insane criminal is not able to handle his own live.

4.5 Changes in Forensic Care

Still 20 percent of the ‘released’ clients commit an offense. The media is all over it and cannot understand how such a person may leave forensic facilities. Politics will involve and new rules are made for leaves. The problem with this group is that the offences are severe and speak to one’s personal live. Who would want their child to be living next to a pedophile, even when there is guidance around? If a forensic psychiatric patient falls back in old habits, the results are huge. Still, 80 percent of released prisoners of a justice institution is a whole different number. So there a good results from the forensic care clinics.

More often delinquents choose to go to prison rather than going to a forensic psychiatric institution where they will have to stay until they are declared ‘healed’. From 2000 till 2005 the length of stay in a FPC has doubled from 5 to 10 years. This is after they have been to prison. Prison can be longer, though there is a set limit which gives a better prospect on freedom. Since the recidivism of delinquents who go to prison is 60% higher there is a trend right now that the judge gives a higher sentence since the delinquent is not open to treatment. There is also a trend on creating psychiatric departments or ward in prison or penitentiary institutions where those delinquents can be treated for their psychiatric disorders. This would lower the recidivism rate of the penitentiary institution.

The forensic psychiatric system as we know it in the Netherlands needs a change; while the Netherlands were at first progressive in its system for ‘the insane criminal’ the systems does not work properly anymore. The re-socialization process or treatment of forensic patients has grew from 5 years till an average of 8 till 10 years resulting in the question if the Dutch TBS-system is not an disguised form of a lifelong sentence.

Suspects are increasingly opting for the prison rather than a forensic psychiatric treatment because it can be extended until the patient is declared cured. There is no set limit for the duration of the treatment and they do not want to take the risk of being locked down for the rest of their live. The idea alone of not being able to look ahead the prison sentence since their is no set date for freedom. The consequence is that lawyers advised the delinquents to refuse psychological investigation. In the Dutch law they are not able to force people to go to the observation clinic, therefor observation can be avoided and there is no possibility of finding out whether the delinquent has an psychological disorder and is virtually impossible for judges to impose treatment on a suspect. While the delinquents get prison sentences which seem as a good problem solver, the possible psychological disorder is untreated.

This change is reflected in the figures. Where previously two hundred patients annually where admitted in forensic hospitals, there are now only fifty a year. This may seem as a reduction of the delinquents with a psychological disorder, but in this case the numbers are not thorough. The 150 patients who might have gone to forensic care are, according to Van Binsbergen, untreated and return after their prison sentence back into society. The treated criminals have a lower recidivism rate (20%) than the criminals who only where punished by a sentence in jail (80%).
5. THE PSYCHOLOGICAL PROBLEMS OF A FORENSIC PSYCHIATRIC PATIENT.

The research will focus on building for the forensic psychiatric patient, but what is he? What is there to know about the insane criminal?

The forensic psychiatric patient is a psychiatric patient who has committed a crime (partly) due to a psychological disorder. This could either be a patient who was sentenced with the Dutch TBS-measure or a delinquent in a penitentiary institution who seems to have psychiatric problems which came to the surface during detention. A TBS patient is a prisoner detained under hospital care.

Typically for the patients in forensic care are the number of patients who are traumatised and have maturation problems or/and are behind on their development in several grounds. As a result the patients are less likely to have constructive and respectful relations with fellow man. The patients are being controlled by fear and their behavior can be very aggressive and unacceptable. Usually there is not enough reality testing, lack of empathy and guidance by conscience.

5.1 DISORDERS

Research shows that among forensic psychiatric patients cluster B personality disorders are the most common (66%). The cluster B personality disorders are the anti-social, the borderline, narcissistic, and histrionic personality disorders. Within this cluster, the antisocial personality disorder most frequently (45%), followed by the narcissistic (26%), borderline (24%) and paranoid personality disorder (18%).

Cluster A and cluster C personality disorders are respectively 29% and 22% of forensic psychiatric patients (Source: Hildebrand & de Ruiter, 2004)

ANTI-SOCIAL PERSONALITY DISORDER (ASP)

Central feature of personality disorders in the instability of thought, feeling, behavior and selfishness. This can lead to significant changes in mood, unstable relationships, impulsivity and the pursuit of short term gratification. These people often have a disruptive effect to their social environment (external isere issue).

They live by a motto similar like “Be sure to target someone else before he will target you.” This makes them unreliable and unfair.

The psychopath is easily bored, making them tend to thrilling and risky things like extreme sports, alcohol and drugs misuse. The extreme patients with anti social personality disorders who are in forensic care are not afraid of committing crimes like rape, murder or extortion. They can not handle frustration and act impulsive without caring for the effects. They even feel that they are allowed to since they are a victim of a terrible childhood or unfair society.

Research show that the psychopath does not have as much fear as
normal’ people. (7)

There is in some cases a distinction between an anti-social personality disorder with or without physical aggression towards people or animals. The disorder is probably the ratio male to female who has an ASP is four or five to one and especially in the age group of 25 till 44 years.

**Borderline Personality Disorder (PBS)**

According to the diagnostic criteria of the DSM-VI-TR, the diagnosis of borderline personality disorder (PBS) made when there is a pervasive pattern of instability of interpersonal relationships, self-image and emotions and clear impulsivity, beginning by early adulthood and present in a variety of criteria:

These patients have a convulsively need of preventing people from leaving them. They have a fear to be left alone, realistic or not. They often have very unstable and intensive relationships with others which are characterized by extremes of idealization and disparaging (black and white thinking). Patients with PBS have an identity disorder; a strong varying self-image or self-awareness. They have several impulses with dangerous results for them and their direct social environment. They spend too much money; have multiple sex partners, use of narcotics, and reckless driving or have excessive indulgence of food.

A patient with PBS has a high risk on hurting or killing oneself, and threatening on doing so. Their emotions rapidly changes in response to incidents. This may lead to phases of extreme grimness, irritability and fear. This lasts for a couple of hours of at most a few days.

They are inadequate to control extreme rage which results to outburst of anger and they will repeatedly be in fights when not controlled.

The patients with PBS have an ongoing feeling of emptiness. Due to stress the PBS patient gets paranoid and has severe dissociative symptoms; the patient will, in certain mental activities, become detached from the rest of his personality.

Borderline falls within the so-called B-cluster of the dramatic personality disorders. Like the anti-social personality disorder. This group of patients is very manipulative, capricious and poorly in maintaining social relationships. In their behavior, often impulsive, sometimes violent, they do not consider their own safety or that of others.

Most patients with PBS have at least one other disorder. Approximately one third of all patients with PBS have a minimum of one personality disorder.

**Narcissistic Personality Disorder**

A patient with a narcissistic personality disorder has an extreme love for himself. This term originates from the Greek mythology about Narcissus, son of the river god and an extraordinary beauty. He was in love with himself and could not get away from his reflection in a small river. His tragic fate was that he finally literally pined away from unfulfilled desire. On the spot he died the flower appeared which is called after him: Narcissus.

The narcissistic patient is preoccupied with mightiness, status and success. To be seen and admired is their goal and fantasy. They want to be special, extraordinary but cannot handle criticism well.

A patient with a narcissistic personality disorder is easily hurt and this may result to unexpected extreme anger. This anger can end in an anger attack with a consequence of serious criminal offense. The patients are restless and suspicious and will think that normal laws and rules do not apply to him. They are often described as being cool, calculated and distant. They are not willing or able to take others in account. And they do not see their behavior as part of their problems.

**Schizophrenia**

One on three of all patients in forensic psychiatric care is schizophrenic. This schizophrenia effects all psychological functions like perception, thinking, speech, will and feelings. The symptoms are paranoia, hallucinations, confused thinking, the lack of energy and tension. They are not capable of handling stress and psychoses can lead to extreme fears. They are easily socially isolated.

Because of their paranoia they will not trust their family, friends or colleagues. They will think people are planning a conspiracy theory against them and their will find evidence for. They are waiting for them to strike and therefore are always alert. This results in isolation and distanced patients.

**Light Mentally Disabled**

Within forensic care there is a small group with a (slight) mental disability. Those patients have aside to their mental disability a strong personality disorder or psychiatric problems. These patients often are confronted with multiple problems; a low intelligence level, psychiatric or personality disorders and high risk behavior. This risky
behavior has led to an offence and conviction. In this case the care is more focused of finding a way to live with the disability like the other disorders, but unlike other forensic psychiatric patients this group will probably never fully take place in society. The care is focused on the competencies which they are able to do and enlarging those skills to improve possibilities for independent living.

**ADDITIONAL PROBLEMS**

Typical of a large part of the patient population is that it is often traumatized people with defects or developmental disorders and/or developmental delay in several areas. An important consequence is that the insufficient ability of patients to a constructive, respecting way of dealing with fellow people. It often results in conflicting relationships of various kinds. Often they are led by fear and aggression in their behavior and border exceeding to see. Usually there is enough reality testing, lack of empathy and guidance by conscience. What are the characteristic or symptoms? What kind of psychological illnesses do they have and what kinds of problems occur in the treatment?

**5.2 CO MORBIDITY**

Many forensic psychiatric patients suffer from multiple disorders at the same time, it is also called co morbidity. Research shows that the co morbidity of AS I to AS II disorders is very high. Emmerich and Brewer (2001) found in their research forensic psychiatric patients under that 59% of these patients both As I and an As II disorder had. An examination of Hildebrand and de Ruiter (2004) showed an inter fpp life time co-morbidity of As I and As II disorders of 72%. If substance abuse is included, this is 50%. (http://www.efp.nl/forensische-psychiatrie/stoornissen) Most patients have a personality disorder and a minority is suffering from a psychotic disorder. Many patients also have an addiction problem.

When patients have an anti social disorder and are narcissistic they are called psychopaths. They don’t have
5.3 LIVING TOGETHER?

Within the institution the patients differ from male to female, from psychopaths to szitsofrenics and from pedofiles to murders. How do they all live together? Can they live in one department?

FEMALE PATIENTS

Since 1995 there are 65 women in the Netherlands which are placed under TBS or forced treatment in forensic psychiatric care. In the same time more than 915 men receive a similar sentence for their crimes, while 'normal' psychiatric care consists for the larger part out of female patients. "Aggressive women target themselves while men target others." The small percentage of those women who do end up in forensic psychiatric care are most likely an arsenic or an impostor.

The women in FPC who have compulsory (psychiatric) treatment are placed in female departments the forensic psychiatric centre in Oldenkotte and in 'Van der Hoeve'. In other forensic situations they may be placed in departments like the forensic department of the Gelderse Roos in Wolfheze. This is a psychiatric institution where the forensic department is for both male and female. Also the poli clinic in Tegelen does not have a specific gender group.

It seems that there is no specific difference between the forensic psychiatric care for male of female patients. It could be interesting to find out if there is a difference in approach of the male and female patient.

DIFFERENT DELICTS OR DIAGNOSIS

Opposite to normal psychiatric care, forensic psychiatric care is not divided by disorder or treatment intensity but mainly by the degree of security needed.

LONG STAY

Some patients do not see the necessity of therapy and do not want to participate in treatment or therapy. Since therapy cannot be forced in the Netherlands none of the patients can be obliged to enter in therapy. If they refuse to participate in their treatment they will probably have problems in the process of re-socialization. In most cases the treat-er or treatment team will decide that such a patient is advised not to be not allowed to leave the institution on leave or release. In most cases the lawyer will advise the patient to participate in therapy and treatment to have all the more reason for the patient to be released during the case on the extension of their stay in the institution.

There is also a small group who has found their home in a forensic psychiatric institution. They feel safe in the institution and don’t have to be afraid of acting on their psychiatric disorder. They often do not participate in treatment any longer. Most of those patients will stay in so called log stay institutions. Those institutions don’t have much place for treatment but all the more place for humane imprisonment.
To find out how architecture contributes to a better healing environment, it is important to figure out if the experience of space for a psychiatric patient is any different than that for a 'normal' person. I assume that all people experience a space differently, due to cultural differences and association, but are there differences which are specific to psychiatric patients? For this, the specification of the patient is very important. And will they experience space differently during the treatment process? Will they have other requirements in the different steps of the treatment?

6.1 BASIC NEEDS

Maslow’s triangle describes the needs of people, the basic needs in the bottom and the higher one gets in the triangle the more involved people will be. Those needs are similar to those of the psychiatric patient, but unlike the average human being in the Netherlands most forensic psychiatric patients can not fill their needs of safety. Some even can not provide the physiological need for them selves because of their psychological disorder. To consider the specific needs for the patient there is a description of the basic needs for people.

The origin of humanistic psychology lays in Maslow’s theory and his triangle. With his triangle he describes the need of a mentally healthy person. This triangle also includes motivation, if satisfied one would want and need more for himself and would go up on the triangle. The most basic needs are the physiological needs like food, water shelter and warmth. These are the minimum to be able to survive. Once these needs are being filled people desire more from those needs. They don’t just want food, but are likely to want good food since they have a choice. For the patients those needs are also in order but are not as The safety need is about the security, stability and freedom of fear. Those needs are also motivation to find a home which can provide this need.

With this theory, he is the founder of humanistic psychology. It emphasizes the needs of the healthy-minded man. The universal needs that follow from here have a relationship with a very different approach, combining psychology and evolutionary biology Vroon (1990). In this the environment controls the basic needs that control and support the behavior. These laws are to be compared with the lower needs of Maslow as Vroon says, the physiological and safety needs.

Comparison can also be made with Kaplan and Kaplan (1982, 1987) and their model on behavioral preferences. They assume like Vroon that those behavioral preferences have an evolutionary history.

According to Kaplan all needs are to be brought back to two basic needs; These “laws”, showing agreement with the above lower Maslov needs, physiological needs and safety. There is also an interface model for behavior and preferences van Kaplan Kaplan (1982,1987). Vroon (1989) assumes that a behavioral preferences evolutionary history. According to Kaplan (1987) people have preferences for certain environments to be traced to two needs: the environment, a sensible meaning and also a curiosity. Meaning requires an environment that conveys a consistent message (not confusing) and therefore readable. Interest in the environment is generated by any complexity and mystery. Makes needs a more dynamic character. Man has his skills challenges need to keep training, or as the Veenhoven stated: “Paradise is not viable” (2000). A sustainable liveable environment thus gives the possibility needs and has a dynamic quality. A liveable environment is so changeable as the leven. Het recognize the complexity of urban life requires some care to give design recommendations for a sustainable liveable neighborhood. The patients within forensic psychiatric care have the same needs, though some of them are not being fore fulled when living in the care institutions.

Vroon (1990) describes the basic needs in basic rules. There rues are similar to those of maslov’s basic needs like safety and the physiological needs.

NEED FOR OWN SPACE

According to Kaplan & Kaplan all people have a need for own space. A place they can relate to and retreat. Here would be a possibility to express themselves and have some privacy. When living in an closed environment with limited choice in where to live the need for own space is even more crucial. In most cases the patients have their own
6.2 HEALING ENVIRONMENTS AND ENVIRONMENTAL PSYCHOLOGY

The term healing environment describes the positive effects of living environment on the inhabitant in this case the patient and the staff working in the institution. Environment psychology is the psychology regarding the physical and social living environment.

The focus of the healing environment in this thesis lays on the physical environment more than the social living environment.

6.3 NATURAL ENVIRONMENT

In previous chapters the effects of nature where described; a natural environment calms people and especially psychiatric patients down. In the design process of a forensic psychiatric institution the sight on or toward nature plays a central role. Nature or a natural environment could be a field, a forest, the countryside, a park or water. But even small natural elements like trees, or natural materials like wood or stone can stimulate relaxation.

Within all the departments there should be excess to some kind of natural environment. Artificial or real. The patient should be able to see it all times and are allowed to be part of it at least ones a day. Therefore all the individual rooms should have a view on the natural environment. The living room should also give a view to natural elements like trees, bushes or grass fields.

When a patients needs to go outside before going to therapy both patient and staff will be more relaxed. The design should enable patients to go outside when going to therapy. This natural environment can function as a filter between those two main functions.

6.4 DIFFERENTIATION

**NEED FOR CHANGE.**

"More alternatives results to less aggression."

(Minke Simonis, head of treatment, de gelderse roos, wolfheze)

Because all people’s needs are diverse there exist a certain differentiation in normal life. Whit in a closed living environment differentiation for all inhabitants is even more important. Since most of the inhabitants are not allowed to leave the terrain or even their department differentiation with in the department is necessary.

- Differentiation in spaces, think of public, private, collective, individual, high, low, light vs. dark.
- Differentiation is function

Because there are o many types of people and patients the placement of the building would be best to differentiate. Patients are send to one of the institutions and may not have a choice where to be placed, but they are allowed to request replacement. Therefor the differentiation in the different institutions would be advisable. Patients can choose whether they want to be near a city, near the country side or on an island in a lake. When making a diverse range of locations the patients can find his own requirements.

**UNDERSTANDABILITY**

Because most patients are psychological disrupted the need for order in their direct environment is vital for the treatment process. This order can be reduced on the terrain of the building since the patients need to learn how to handle disorder. In this case order can be realized by clear, readable structure and views.

- The department and the individual room need to be orderly. All patients and personnel should be able to understand the department at once.
- The compilation of the buildings on the site should differ from orderly without surprises (the maximum secured living building) to less orderly and more interesting towards the re-socialization department.
CONTROL VS. FREEDOM

Within a closed institution the freedom and own choice are limited. Though the feeling of being out of control does not improve the treatment process, it might even obstruct it. While control is also a large factor for safety it is not easy to give possibility to control or freedom. The different departments divide the limitation of control and freedom:

- Level I. No control of freedom
- Level II. Limited control and freedom
- Level III. Control and freedom during the day. (9u to 21u)

Although a forensic psychiatric care is a controlled environment privacy is is important in a living environment. Public and private space should be implemented in the design on different scales and the different security levels.

6.5 SPECIFIC NEEDS FOR THE DIFFERENT PHASES.

All the different phases of re-socialization from stabilization to rehabilitation have different needs and activities. The scheme describes which functions are most likely to happen in what scale.

These activities and functions can be used for the differentiation between the different departments.

Structure is important for most patients. Learning how to live with disabilities in most cases is a large deal in living structured. The Rooyse Wissel for example has tight schedules for the patients. All weekdays and a different one in the weekends.

A typical weekday for a forensic psychiatric patients could be as following:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.00</td>
<td>Wake up call.</td>
</tr>
<tr>
<td>8.30</td>
<td>Breakfast</td>
</tr>
<tr>
<td>9.00</td>
<td>Session 1</td>
</tr>
<tr>
<td>10.00</td>
<td>Coffee break</td>
</tr>
<tr>
<td>10.30</td>
<td>Session 2</td>
</tr>
<tr>
<td>12.00</td>
<td>Lunch and going for some fresh air.</td>
</tr>
<tr>
<td>12.30</td>
<td>Session 3</td>
</tr>
<tr>
<td>15.00</td>
<td>Tea break</td>
</tr>
<tr>
<td>15.30</td>
<td>Session 4</td>
</tr>
<tr>
<td>17.00</td>
<td>Preparing diner</td>
</tr>
<tr>
<td>18.00</td>
<td>Diner</td>
</tr>
<tr>
<td>19.30</td>
<td>Free time</td>
</tr>
<tr>
<td>22.00</td>
<td>To individual rooms</td>
</tr>
</tbody>
</table>

During the weekends less staff is available and therefor less activities and structure. In the Rooyse Wissel they only have air time and lunch at 12.00 and diner time at 18.00. Patients can fill in the rest.

The interpretation of the sessions differ from patients and treatment step. This could be either free time, therapy, work, education sessions or sports. Depending on the department or treatment step one is in he is allowed to leave their room or department.

STABILIZATION

Living in the clinic, treatment in own department. The patient lives in the clinic and follow the day program. There is a very intensive form of supervision. The guidance, for example, the form of guidance or hand in hand there is often stay in the separation area.

FROM MOTIVATION TO SETTING THE GOALS

Living inside, day program inside (individual focus) The patient lives in the clinic and follow as the day program, the guidance is highly individual.

TREATMENT

Living inside, day program inside (group focus) The patient residence stay in the clinic and there follows the daily program, the guidance is primarily focused groups.
BUILDING FOR FORENSIC PSYCHIATRIC CARE
The forensic care system is complex and so are the different building types. Most of them have own functions in the care process with own requirements in cohesion with the degree of security or treatment. In this chapter different buildings are placed in a diagram of treatment intensity and level of security. Some buildings overlap; others are only one step in the re-socialization process.

7.1 FUNCTIONS

**Observation Clinic: Pieter Baan Centrum**
The observation clinic is in most case the first building the offended will see. In this case the delinquent is still an offended, he is not a patient jet or an inmate. The observation clinic is officially a house of detention with a specific task to give advice for justice system. Behavioral experts of an observation center will examine the defendant which is suspected of a severe crime. Every year 200 defendants are being observed in observation clinics. The behavioral experts will advise the judge or the ministry of justice about the accountability, the risk of recurrence and a possible treatment of the suspect.

**Forensic Psychiatric Clinic (FPC)**
A forensic psychiatric institution is the formally know institution we know in the Netherlands as TBS-inrichting. There is a high level of security and a high intensity of treatment.

**Forensic Psychiatric Department (FPD)**
Within a forensic psychiatric department patients are being treated with psychiatric of psychological disorders and have been in contact with or a likely to get in contact with the justice system. This type is a function in between forensic psychiatric care and normal psychiatric care. In most cases as part of a Mental Health centre linked to the department for long psychiatric care.

The difference with a forensic psychiatric centre is the admission. The patients can be treated on voluntary basics or as a forced treatment due to juridical basics. This could be for delinquents who had a prison sentence from less than 4 years. They can serve the last year of their sentence in a forensic care department. This is relatively ne and is a result of the high receive from delinquents released out of prison.
without psychological help.

**FACILITIES FOR THE CARE AND TREATMENT OF ADDICTS**

Many of the patients in forensic psychiatric care have addiction problems. In 2009 the first initiative for forensic addiction care has started in Almere. The clinic is a part of the penitentiary institution or prison and is focused on delinquents with complex, chronic and combined problems on the three main field of criminality, addiction and psychiatry. This actually resolves into a new division of the forensic criminal. In most cases for forensic psychiatric care this is a part of other building types for forensic psychiatric care.

**THE POLYCLINIC**

Outpatient care or ambulant care is psychiatric care on appointment in a polyclinic. While the patient lives at home or in RIBW he will have to visit a polyclinic nearby. This can differ from a couple of times a week to ones every two months. Whith in this kind of care there is a difference between forensic ambulant care, activating and supporting care. Where the forensic psychiatric care is focused on the treatment of the disorder, the activating and supporting care is focusing on helping the patient to live with a disorder with in society. The main elements of this way of treatment are support in living, daily activities and coaching.

In this kind of building the treatment intensity for one patient is low and the security of the patients is not as important anymore. But this kind of therapy can also be possible in an penitentiary or house of detention for inmates.

The main goal of the polyclinic is helping patients to be responsible and the care of themselves. As a result the patients will have stability in situation where they are not restricted and in a supportive environment.

**REGIONAL INSTITUTION OF SECURED LIVING (RISL)**

Regional institution of secured living is which stands for “. This is a type of housing and living which also accomodates stimulating and supportive counseling. The counseling focuses on the potential of patients by their dayly rithms and social relations. Responsibility and
independence are vital in the care of these patients. Not all patients living in similar houses have a criminal background. Some have been in contact with the justice system and are placed in RISL by court order, some inhabitants are the former inhabitants of FPC or those who are allowed to have a leave fro such an institution.

(RIBW is Regionaal Instituut beschermd Wonen) Most of the RISL houses are build in small scale and are located within urban situations. The patients are regarded as normal citizens and are working, studying and have social relations.

**PENITENTIARY PSYCHIATRIC CENTRE (PPC)**

Some inmates who were not sentenced with an forensic psychiatric care have such major psychiatric problems they are not able to function within a normal penitentiary institution, or prison. This specific group of inmates is placed in a penitentiary psychiatric centre to improve the quality with the limitations of detention.

**LONG TERM FORENSIC PSYCHIATRIC CARE CENTRE**

There is one type of clinic where the treatment is less important and the security of society the primary goal: the long term forensic psychiatric care centre or the long-stay clinic. These clinics house the patients who are no longer in need of treatment. Those patients are still a dangerous to society and there seems to be no future for them outside the enclosed facility. These patients do have visitors but are not allowed outside of the department or clinic.

### 7.2 DEVELOPERS

Responsibility for the patients in forensic care lies with the Department of Forensic Care (DForzo) DJJ (Ministry of Justice, 2010). There are several types of organizations that offer forensic care in the Netherlands. Some fall under the Ministry of Justice, but more often are private establishments and mainstream mental health services where the Department of Forensic Care Custodial Institutions Service (DJJ) buys or subsidizes health care. TBS patients are treated in a Forensic Psychiatric Center (FPC). This is the new name for a hospital clinic. Then there are the Forensic Psychiatric Clinic (FPK) and the Forensic Psychiatric Department (FPA). (Ministry of Justice)

Since there are different kinds of buildings for forensic care the case studies are a diverse collection of buildings for (forensic) psychiatric patients. They are all analyzed for the urban context, functions, the routing within the building and around it, safety issues and the individual rooms are looked at. The buildings are either for normal or forensic psychiatric care since there are differences and similarities within those buildings.
Case studies are analysis of buildings which house either forensic psychiatric patients or normal psychiatric patients. The goal was to find similarities, differences and element to use in a new forensic psychiatric institution.

The institutions which are chosen are diverse selection; different locations, different functions and scales. The cases are not limited to forensic psychiatric institutions since the interest lays primarily on feeling at home within a (partly) closed environment.
1. FPC de Rooyse Wissel by dJG Architects
2. Long Stay, Zeeland by Rijksgebouwendienst Advies en Architecten
3. Van Gogh instituut by Greiner van Goor Architecten
4. Tiengemeten renovated by GBS Architecten Baskoop
The Rooyse Wissel houses only for male forensic psychiatric patients. It is a private institution which work together with the Ministry of Justice about the number of TB5-patients they will take in and how much the clinic will be compensated for the costs.

In 2000 the first patients arrived and at this point the Rooyse Wissel facilitates more than 108 beds for forensic psychiatric care. Next to the FPC centre the Rooyse Wissel has 30 beds for re-socialization outside of the terrain.

LOCATION
The Rooyse Wissel is situated in a rural area between Wanssum and Oostrum near Veray in Limburg. Adjacent to the terrain is a provincial road connecting Venray and Venlo. There is a buss top on the side of the road near the terrain.

TERRAIN
On the terrain of the rooyse Wissel there are several buildings situated. Next to Forensic Psychiatric Care there is also an addiction clinic. At this point they have just finished a new building complex for forensic psychiatric patients who are mentally disabled as well.

THE BUILDING (FUNCTION AND LAYERS)
The facility is to be entered on the long edge of the building. That is for personnel and visitors. Besides the facilities at the residential units the Rooyse Wissel has within the institute a number of other facilities in the field of sport, leisure and care. Examples include the shop, sports hall, sports field and gym, snack bar, the quiet room where every week a church service is held, the library and rooms where the dentist and the hairdresser weekly consultation to keep.

DEPARTMENTS / FUNCTIONS (SIGHT)
Patients stay in departments, usually 10 patients a department. The housing department is their daily living environment. They eat and drink in the common living room and kitchen and spend a large part of their free time here. Cooking and cleaning of the department to do together. At the department is constantly support, there are always two or three supervisors, sociotherapists called present.
The hallways connecting the lining zone to the treatment zone is made by glass bricks which show little from the surroundings. The colors have a play full effect, but it may only enhance the length of the hallway.

THE ROOM
Additionally, they all have a private bedroom with a shower and toilet. This room is they may, in consultation with the guidance, in principle, free setup.

ENTRANCE
The entrance of the building serves as a filter and security centre. The entrance houses the access for the staff, the admittance of the patients and the reception of visitors. In the scheme you can see that the entrance has a view on outside and the visitors waiting room. There are lockers located for visitors in the first zone. The second zone houses lockers for the staff members.

THE MAIN SQUARE
The main square is located in the middle of the building. Most hallways end at the square and in facilitates the dining for staff members and patients who are allowed out of their department. The square of the Rooyse Wissel is meant as a social space for leisure and public functions. The square is mainly white and empty since most patients are only allowed out of their department limited time.

Since the square is a space to connect all the hallways there should be a lot of movement though when being there outside of lunch hours almost no one is there. There is not a difference in the staff and patients eating space and while there visitors may have a hard time to see the difference between the treaters and to be treated.

NATURAL ENVIRONMENT
The immediate surroundings of the terrain are trees which hide the building from sight. The terrain has one entrance on the provincial road. From the side road leading towards the terrain the side road leads to the Forensic Psychiatric Institution (FPI). The building itself lays in an open grass area surrounded by trees. From half of the rooms there is sight on the surrounding green, though the other half
only has sight on the inner courtyard which are not all green.

Since they have build a new department for the mentally disabled, (zwakzinnigen) as a separate building, the staff and patients who have to go there need there coats in winter time since they need to actually go outside. Even when the weather is bad. "I have never felt it to be a problem and it can never be an excuse for the patients not to go to their therapy, education of work. They know they will be addressed when they will not go." (dr. A.G. Miedema, 2011)

WAY FINDING / IDENTITY
When entering the terrain of Rooyse Wissel it is clear where to go by signs. The entrance of the building can be recognized by the protruding parts from the high fence. Once inside the building it is quite difficult to orientate. Although the patients and staff are regular users the building could have been more clear. Because of the similar departments there is no differentiation and there for it is difficult to orientate. The closed hallways which do provide privacy contribute to that difficulty.

AUTONOMY
The possibility to make your own choices is difficult within this building. There is always one route towards the main square, the individual rooms are all alike and only the interior of the communal room at the department is to be chosen by the inhabitants. This would be a choice of the group living there. The individual room is for own interpretation, but this privilege is only meant for those patients who have deserved it. The treatment team can (re)gain control over the group in this way.

SAFETY
The building can only be exceed by two locked chambers controlled by personnel. One meant for personnel, visitor and patients, the other for transport of goods and sometimes patients. Both locked chambers or sluices are directly adjacent to the control room and main entrance.

Once people have entered the building personnel and patients have passes or badges which limit or control the departments, rooms and buildings the patients have access to. Since this system is vulnerable to abuse this is only used within the terrain and does not give access to the exit or the living departments.

The living departments are all guarded by locked chambers which are controlled by the control room and camera’s. This prohibits the patients to entire the department of others without permission. The staff passes do not even give access to the departments since one patient could trick out one of the passes from a staff member.

All the department gardens are surrounded by a low fence. These fences are merely to remind people it is not theirs. They will have to live up to the expectations of their treatment team that they will not cross those lines. This is part of there treatment to be tested on security layers.

SEPARATION ROOMS
The separation rooms of the Rooyse Wissel are located in between 4 departments. The rooms are meant for punishment also as stabilization. The patients in most cases was aggressive or psychotic and is placed in these rooms to stabilize again. The rooms are very ‘clean’ and there is little place for autonomy or expression. The materials are all hard and it is not able to hurt oneself. Due to the hard materials the acoustics are terrible, the reverberation time is long.

Each room has access to a courtyard providing fresh air. Though the patients in here have no autonomy and are not allowed outside unless
security allows them to. They will be allowed a leased once a day.

The lighting in these rooms are form above. There is no view which could disturb them. But this means there is no view on nature. The inner court yards materials are also harsh, grey and uninspiring. This results also in an stimulus less room. The only way the patient can express himself is the blackboard wall where he can write and draw.

The walls are rounded off and the small gutter just outside the room which makes it easy to clean.
8.2 DE CORRIDOR

The Corridor is a long stay facility in Zeeland Brabant and has been in the media several times. It is an institution only for the long stay patients who have no longer treatment meant for healing but are denying treatment or are not able to be part of ‘normal’ society. These patients are living in these types of institutions for most of their lives.

TERRAIN

In between Uden and Zeeland in Branbant here is a old terrain of a former juvenile detention center ‘De Corridor’. The old buildings are used for treatment facilities, living and offices, while the new building is meant for living of the long term patients. The so called Long Stay department. The buildings are situated in a rural area with forest and fields around it.

On the level of the terrain the building for long stay lays in between the trees hidden from sight. Around the terrain is a green belt with bushes. From the provincial road near by the terrain and the buildings can be seen but are hidden in the back. The terrain is only to be reached by car, bike or by foot. The nearest bus stop is in Zeeland a ten minute walk. From the nearest train station (Central Station Oss) it will take a little less than an hour by bus.

You enter the terrain by foot, bike or by car. The entrance from the small road onto the main road of the terrain. As to be seen on the photos and diagrams the buildings are surrounded by trees and green fields.

THE BUILDING

This building is meant for the long stay department of ‘de Corridor’ The building facilitates for the most part living. Supporting functions for this specific group of forensic psychiatric patient like a small therapy or common room is situated in the court yard. Administrative functions, entrance and security are located in the heads of the building.

These are also the entrances where one would enter the building either visitor, patient or caretaker.
The building can be accessed by the two entrances on the side. Those entrances will give entrance to the court yard and the different circulation spaces. The separation of the staff, visitor and patients start here. Only the staff is allowed in the prominent head and tail of the building.

From the court yard and the circulation spaces one can enter the living departments. Since the inhabitants are not allowed to go from one department to another the departments are all divide by circulation spaces. The patients can only enter their own treatment department while the staff are allowed to go to all departments.

The building consists out of 2 building levels, which houses 4 departments per level. The garden is used by all the inhabitants. There is little room for treatment since these patients are no longer effected by therapy.

**THE ROOM**

One room facilitates a living space for one patient. The room can be reached from the department hallway. All individual room have their own sanitary facilities and a balcony. This balcony gives the patients their own outside space where they can smoke, get some fresh air or relax. This also improves the air quality inside their own room since the patients are not allowed to smoke anymore. While the balconies are secured by bars the possibility of actually opening a window is in itself a new quality for similar buildings. Since the patient now...
has a choice of opening or closing a window, going outside or not the autonomy is quite good even though there are many limitations to their freedom.

**DETAIL**
This specific building has a less institution like identity. Because the patients staying here are not being treated any longer and they have a small chance of getting out this building is focused on a secured 'home' feeling.

The hallways are a result of the different approach. How normally the hallways are closed, with on both sides closed doors, the hall ways in 'de Corridor' are open on one side. This results to views outside and daylight. Form the hallway you can see the exit and the courtyard. And also the organization of the building.

Due to the set back in the individual rooms the hallway also has variation in the width. Which also contributes to the decrease of the institute feeling.

The courtyard is being used by all the departments and has to be secured. Because there are no blind walls surrounding the courtyard it should feel less like imprisonment, but the level of security improves since all departments can look at the courtyard.

The materials used for the walls are smooth, they don’t allow patients to climb on them to escape. The overhanging roofs make it even more difficult to escape by climbing the walls.

**NATURAL ENVIRONMENT**
The building for the long-stay patients is located within a natural environment. It is surrounded by a tree ‘fence’ and lays in the county side. The terrain itself is also mainly green, grass, trees and water. The buildings are places like pavilions and are surrounded by green. The long stay building also has it's own courtyard. At the pictures there is no green jet, but they have planted trees and grass. Since the hallways are located adjacent to the courtyard all of the departments
have a direct link to the green in the courtyard. Also, the living areas are linked to the courtyard and are provided with light and sight on green. The individual rooms have a direct link to the green trees and bushes around the building.

**WAY FINDING / IDENTITY**

Since most patients or in this case maybe inhabitants, since they no longer have therapy, live in this building for a long time way finding is less important. Though because of the symmetry it is more difficult to orientate. This can only be done by external factors like the sun and surrounding trees which can be seen from the inner courtyard. The departments do not have their own identity. Though the inhabitants are allowed to create and own identity in their room and balcony. The balconies are a way of identification and way finding which works for the outside of the building. Most inhabitants use that space to express themselves. Or at least they use that space to personalize their direct living environment.

**AUTONOMY**

The autonomy within this building is difficult since the inhabitants have chosen not to contribute in treatment any longer. They are still a threat to society therefore not able to leave the building or go on leave. The autonomy within this building is limited. Though with introducing the balcony a new level of autonomy appears. The inhabitants are now able to open a door and go outside whenever they want to. This may seem normal for anyone else but this specific group has not allowed to have open windows let alone to decide for themselves to go outside. The degree of autonomy therefor is quite high even though these inhabitants are not even allowed to go out of there department without guidance or guards.

**SAFETY AND PROTECTION**

The long-stay patient is one of the patients which is most dangerous and therefore has to be highly secured. The protection of the inhabitants is mainly done by the green trees fence. The building is located out of sight near a small road, people are not likely to go there when it is not necessary. This creates some kind of protection and improves their sense of safety. Though the bars around the balconies make it clear that these people are dangerous and need to be locked down. For some reason the ability to express themselves with plants and decorative eases the effect of the bars. It seems to make them more human.

The bars provide a security layer. The patients are only allowed to go outside but are not able to leave the department without permission. When having left the department they will be in the courtyard which also functions as a security layer. The materials used make it impossible for the inhabitants to climb the facades and the overhanging roof makes these attempts even more difficult. Since this all happens in the courtyard on which all patients and staff have sight on from the hallways these attempts will not be inviting.

When staff wants to leave the building they can only leave by a locked chamber which is operated by personnel only.
8.3 F.P.D. VAN GOGH INSTITUTION
The van Gogh Institution is a general psychiatric institution in Venlo. It is a collaboration between the penitentiary and psychiatric care since this houses not people who are sentenced with TBS but only people who are found to have psychiatric problems when in prison. Those ‘patients’ are here because they choose to be here. Those patients will serve the last part of their sentence in this institution where they will have counseling with their psychiatric problems as well as rehabilitation.

**TERRAIN**
In Venray is a larger psychiatric institution situated in the middle of the city. The forensic department is located within the terrain of the institution.

The terrain itself is just outside the old centre and has always been meant for care institutions.

The terrain has its own infrastructure system, but does fit within the surrounding system of Venray. Next to the psychological care there are also some normal houses and functions integrated on the terrain. This is an example of reversed integration. On the terrain of the psychiatric institution it is possible to live as a regular family or as part of the institutional families. This would encourage the therapeutic community, a community simplified for special needs of special inhabitants but also able to house normal families.

**THE BUILDING**
The building houses 24 beds for forensic psychiatric patients. The building can be divided in different departments. The average occupation is 8 patients at each time. It exist out of two parts connected by one centred hallway ax. The first for treatment the other for living functions. When the patients need to go to treatment they do not have to leave the building. The building is flexible in its use since the department can differ for different demands.

**THE DEPARTMENT**
The department is L-shaped. At the end of the L-shape one larger common room for relaxation and a kitchen to prepare food. There is
also a smoking area adjacent to the living room; an is situated outside area where the patients are allowed to smoke without irritating other patients.

**THE ROOM**

One room facilitates a living space for one patient. The room can be reached from the department hallway. All individual rooms have their own sanitary facilities and a balcony. This balcony gives the patients their own outside space where they can smoke.

The nice quality about these rooms is the possibility to open the door to ‘outside’. While the balconies are secured by bars the possibility of actually opening a window is in itself a new quality for similar buildings.

**THE HALLWAYS**

Hallways to connect the departments or the different rooms have a similar width and set up. All the hallways are at some point linked to the courtyard. One of them has glass brick work towards the inner court of the separation department the other one is only open towards one side. The left one has also an adoption; the foil prevents people from looking at the courtyard and back. This provides a little bit more privacy for both inside as outside. Both hallways of these hallways are very light. The other hallways are very closed. There is mostly artificial light, though all of them have some type of natural lighting.

**DETAIL**

This specific building has a less institution like identity. Because the patients staying here are not being treated any longer and they have a small chance of getting out this building is focused on a secured ‘home’ feeling.

The courtyard is being used by all the departments and has to be secured. Because there are no blind walls surrounding the courtyard it should feel less like imprisonment, but the level of security improves since all departments can look at the courtyard.

The materials used for the walls are smooth, they don’t allow patients to climb on them to escape. The overhanging roofs make it even more
difficult to escape by climbing the walls.

**NATURAL ENVIRONMENT**

The Van Gogh Forensic Psychiatric Departments is located within the terrain of the Van Gogh Institution which is located in a urban situation. Though the terrain has a lot of old trees and grass fields and is surrounded by a long row of trees. The building itself is surrounded by grass zone and other buildings. The natural environment is limited to the build environment. The courtyard do not have grass, but wooden decking. The facade materials on the inside of the courtyards are also wooden planks which could be described as being natural. The courtyard also hold planters which contribute to the quality of the courtyard when the plants have grown.

**WAY FINDING / IDENTITY**

The entrance of the building is very clear since a ramp lead to it and an overhanging roof accentuates it. One inside the building there is a clear view on how the building ‘works’. The first part is for treatment functions and offices. The larger block houses the living functions. Due to the courtyards an understanding of the building is easier. The hallways are at least partly of the length linked to those courtyards which makes the hallways not only light but also check points.

The four sides does make it somewhat difficult to see where the hallway lays in relation to the entrance. Though the building is clear.

**AUTONOMY**

Within the FPD the patients have little autonomy. The furniture is all the same and there is only little place for own input. This may have to do with the fact that this is actually a extension of the prison sentence where they will only live for several months in stead of years.

Due to the small size of the building the inhabitants are not really allowed to wonder on the terrain, there is nothing that they might do there and therefor unnecessary.

It could be that since the building is new all the furniture is bought at once. In the future the new furniture could be selected by the inhabitants. The inhabitants are allowed to interfere in the placement
of the furniture. And are allowed to go outside to the courtyard even when not allowed to get of the department.

**SECURITY**

The security within a forensic psychiatric department is quite different than that of an institution. The patients who live here have applied for psychological guidance themselves. Mostly in cooperation with their probation officer who concluded that psychological help would be best. The last months of one's sentence can be served within these departments. The fences as seen adjacent to the courtyard are meant to keep them inside, but not high enough to prevent inhabitants from escaping. The inhabitants should be able to deal with those regulations and should not want to climb out. The individual rooms can not be opened, but they are not made with unbreakable glass. When an inhabitant wants to leave they can with the risk of an other prison sentence.

All people who want to entire the building will enter through a locked chamber. You cannot see personnel but it is being watch by the control room. Ones in the building also the departments can be accessed by passes all with different limitations or privileges.

**SEPARATION DEPARTMENT**

The separation department is were most patients arrive with the ambulance. At least two staff members will be escorting the patient through the separation garden of to the separation department. The goal is to have a conversation there with the patients and ambulance personnel or psychiatrist. After the conversation most patient will be stabilized in one of the three stimulus poor room. All rooms have a door directly connecting the garden. They all have a clock to keep track of time.

In most cases the patients will arrive through the normal entrance but can be brought in the separation department when not comply by the rules of the institution. When I was there only one room was in use like in most cases.

In front of the door (like below) are drainage strips to be able to clean the separation room easily when a patient is no longer in control of his actions. Those separations rooms will only facilitate the basic needs and nothing more.
1. Photo courtyard with security layer
2. Photo of the side of the FPD;
3. View from window of one of the individual rooms
4. Drawings separation department incl. outside space, the rooms linkage and the individual room.
5. Photo courtyard for separation department.
6. Photo of the separation room with expression black board and toilet.
7. Photo of the separation departments with entrance door to one of the rooms and some discussion seats.
8. Photo of the separation room with sight on inner courtyard, a clock for time reference and regulations.
In Tiengemeten is a small farm with 25 apartments for patients with chronic psychotic disorder and for patients with non-congenital brain damage. In the future they will try to place forensic patients as well. Only those patients who are probably never able to live without any form of psychological guidance. These patients are not able to live in chaos or an urban situation like other may. Some need this environment just to get used to the freedom to transfer to a later stadium in an urban setting.

It seems like a utopian scene for psychiatric patients and in particular the dangerous ones. just put them on their own island.

**URBAN SITUATION**

The farm is to be found on a small island in Zuid Holland, the Netherlands. On the island lives a small community and the inhabitants of the psychiatric department.

**FIRST IMPRESSIONS SURROUNDINGS**

The first impression about the building in Tiengemeten is clearly different than the other institutions visited. It start by getting there; you will need a pond to go to the small island and that is already part of the trip there since there is no other way in or out. The natural surroundings, meaning the trees, open fields, water and wind give no indication of stress or hurry like people might encounter in the city or urban areas. This location it seems is empty with nothing else but the institution when going there.
**TERRAIN**
The fact that the patients are part of a real (controlled) environment in this small community has a big advantage. They can work, relax and are allowed to really live on the island.

The surroundings give place to relaxation, while some patients can’t handle the silence others are able to find some peace. The responsibilities and freedom result in confidence in their own doings.

**THE DEPARTMENT**
The whole of one building is one department. It has a small scale therefore the division in different departments is not a necessity.

**THE ROOM**
The individual rooms are more like apartments. They have smaller and bigger rooms and they can cook, eat, sleep and relax there. Those apartments are no longer cells or rooms but are larger. All rooms have window that can be open since non of the patients will have the need to escape from the building.

**NATURAL ENVIRONMENT**
This case had the most wide natural environment. When going there patients, staff and visitor need to walk, cycle or drive a long route towards the building (figure 5) which makes the experience of getting there quite impressive. It is a long walk (20 minutes) and the wind and all elements effect people who will go there.

The building itself actually has a view on a wider range of natural elements like water, fields and a couple of trees. The views are much further than the other cases. From one side of the building from the upper floors the patens can look over the water and over the field. The lower apartments over look the embankments which are covered with grass, bushes and green.
What is most interesting about this case and its natural environment is the use of gardening and animals in treatment. All patients have some kind of role in their small community. Some will take care of the vegetable garden and others take care of the sheep and horses. Taking care of plants and animals could enhance the confidence of the patients since they are able to take care of something. This will contribute to the treatment and this is one of the cases where input of living animals are deployed for treatment and the use for the food needed for the institution. (Miedema, dr. A.G. 2011)

WAY FINDING AND IDENTITY

Since the building has a much smaller scale the orientation and identification is less difficult. One central hall connects all the different apartment doors visually. The hallway also connects the more public front garden to the more private garden in the back. The different rooms all have different doors, some more laid-back. While the doors at the upper level are all in one line.

The doors to the apartments do not differ from those giving access to the installations or cleaning closet. This could be confusing. This can be seen in the picture taken on the site. You can see also that it is not possible for the patients to express themselves at the entrance of their door.

There are some ways for patients to express themselves outside their room like the paintings made by one of the inhabitants above. These are chosen by the staff and inhabitants by democratic means.

AUTONOMY

The patients all have their own apartment and are allowed to decorate them with furniture themselves. All apartments therefor have different identities. The result is a very home like farm building. It could be used for a commune also. As seen on the pictures all patients have different taste and are allowed to act as they want. But they are not allowed to paint or change the floors.

SECURITY

The safety and control has quite different layers than forensic psychiatric institutions. Simply because the people who live here are allowed to live on their own but prefer to live in a in between stage with a controlled environment where there is less chance to fall back in old habits.

At daytime all the patients are able to go out of their room, outside the building and of the terrain. The whole island is part of their practice area. The island is their community like a therapeutic community meant in the seventies. On this island it seems to work since the taxi driver and the bike rent are run by inhabitants.

This means no fences are needed around the building as can be seen
The only barrier is the water surrounding the island. The pond owner is in charge of who is allowed to get off and on the island. Also all the inhabitants of the island know the inhabitants by name so the social control is very high. This makes it safe for patients and normal inhabitants to live close to each other. Though the question would be if it would be safe to place a former pactioning pedophile on an island like this. Because people might know who he is could help him not to make the same mistakes, but it could also call for aggression within the community. This question is not only within this type of building but for all former forensic psychiatric patients returning to normal houses.

In the building is no room for separation. The kind of patients living here should be able to handle the calm society and are able to retreat in their individual rooms. Though the individual rooms are free to decorate therefor in most cases with many impulses. Since the patients are able to go outside in the serene rural environment.
8.5 AN OVERVIEW ON THE CASE STUDIES

The different cases are compared on the different scales and the different subject. Words like home like and institutional are used but not clearly to be defined, but may be found in the comparison of the various cases. When finding something more institutional like or homelike.

FUNCTION
All cases house psychiatric patients who have in most cases been in contact with the justice system. The Rooyse Wissel as an PFC has the highest need of security since it houses the patients with a prison sentence of at least 4 years and a severe psychiatric disorder. The Corridor is a LFPZ, a long stay clinic, only for those patients who will not be able to contribute to normal society.

TERRAIN
The terrain for (forensic) psychiatric care differ from being located within an rural area to an urban area. Though non of the institutions or buildings are build in high density areas. Most of them are hidden by either surrounding trees or surrounding buildings as part of the same institution. The only exception is the one in Tiengemeten. This one lays out in the open but in this case the emptiness which surround the building has the same effect. While in the other cases the surrounding trees give some kind of natural environment within the site this is in Tiengemeten just by the actual natural surroundings.

Tiengemeten therefore has less coverage than the other cases. It could also be that the trees make it possible to hide the high fences which are not necessary in Venray and Tiengemeten.

BUILDING
The buildings are either pavilions within a terrain like Tiengemeten, the Van Gogh institution and the long stay clinic de corridor or one building as a whole. It might have to do with the scale of the projects in which de Rooyse Wissel is much bigger than the other cases. The loose buildings do have a less institution like image than the Rooyse Wissel and seem to be much more readable.

All of the buildings house psychiatric patients not all of them dangerous patients who are a risk to society.

THE DEPARTMENTS
The departments differ from size within the different cases. Though te maximum size of one department is 12 rooms for twelve patients. The Van Gogh Department is more flexible and can house different groups by demand. The size of the departments are depending on the kind of patients who live there and the need for control within those groups. Except for the department of Tiengemeten all departments are on one building layer. In all of the departments survey ability seems important. Though in Venlo the Van Gogh Department due to the corners the survivability is less than in other cases where the hallways are straight.

All departments have difficulty to handle the institutional image. Where de Rooyse Wissel tries to make the departments less institution like by using different colors and wider hallways it seem that the amount of doors next to each other make the it institution like non the less.

In most cases the hallways are dark and have little natural lighting not including the case in Zeeland where one side of the hallway lays next to the inner courtyard. The Van Gogh also has one sided hallways but the ones which do not have them do not have a different possibility for the entering of natural lighting.

THE ROOMS
The rooms of all institutions have own sanitary facilities. This is not distinctive for similar functions but in most new buildings all patients have individual sanitary facilities. Only the apartments of Tiengemeten have the possibility to cook in the individual room.

In all cases the rooms have windows with a view, not all of them to be opened. In the Van Gogh institution inhabitants are not able to open their windows.

THE DETAILS
In all four different cases most colors used are pastel colors except from the Tiengemeten. For some paste colors are used for heir ability to be calming and neutral. Though because the use of pastel colors in hospitals for many years this actually makes it institutional like.
The materials used in the different building are wood, brickwork, marbled linoleum flooring and in stucco. The Corridor seems to have used the last institutional like materials.

**NATURAL ENVIRONMENT**

All cases have natural environments, all of them are surrounded by it and create views. Though not all rooms have such good views as the apartments in Tiengemeten. The Rooyse Wissel creates natural views from the living rooms, not from all the individual rooms. The Van Gogh Institution has the least natural environment laying in the middle of an urban site. The natural environment in this case is more like the use and sight on the inner courts and the grass field and large trees around the building. This case does not allow patients to be part of the natural environment. By using materials like wood there seems to be some natural elements, though this can not really compair to the experience of being in nature.

By being part of nature would be to be able to not only see it but able to touch it and use it in a way. In de Corridor in Zeeland the inner court has a small pond and a grass field. It is not much but they are able to use their natural environment. In comparison to the courtyard where the natural environment may have a minimum built, the views from the rooms are all aimed at the trees and grass fields. While the patient can not be part of this greenery he can have plants on his own balcony. Those plants are under his own care and not of the facility, meaning he will take part in his own natural environment.

**WAY FINDING AND IDENTITY**

The Rooyse Wissel has a clear entrance but once inside the building the structure is very unclear. It is difficult to orientate in the closed hallways. The departments are very much alike and have little own identity.

The Corridor is possibly difficult to orientate, though once in the building the departments are very clear. The small building in the courtyard and the small pond work as landmarks which improve orientation. When comparing to the other cases this seems to be the only building which can be read from the inside courtyard. The structure is very clear.

The corridor seems to be the best example of allowing identity within the facility. The balcony provides space to personalise the individual rooms and reflect this to the outside.

**AUTONOMY**

Autonomy within a closed facility is difficult to accomplish, though most cases have some level of autonomy. The autonomy is often primarily on the scale of the room and department. The freedom of choice lays in the possibility to influence the interior of the living room and the individual room. In most cases the autonomy of types of rooms is not possible because there is little differentiation. The RISL apartments are the best example of good autonomy, although this is also the least secured facility. Therefor autonomy becomes less difficult.

The possibility for patients to open their doors in case of the Corridor improves the autonomy. This gives the patients a choice on going outside, in the public space or in their own individual space. This is a good example of autonomy within a closed facility.

**SECURITY**

Since all the cases house different types of patients the security levels are different. The visibility of those layers is what is interesting. de Corridor is one of the most secured cases, though it is not very visible. The bars on the balcony side are the only clearly visible sign of security. The Rooyse Wissel has the most visible security. The five meter high fences are the first thing anybody will see before entering the building. The Van Gogh institution and the RISL in Tiengemeten have reduced security. The Van Gogh building seem to have no barriers, the only security layers are the buildings the patients live in, though since the patients are not allowed to open their window the absence of bars is deceived freedom. The inhabitants in Tiengemeten are secured by the ferry and social control of the island.

**SPECIAL QUALITIES**

One of the special qualities used by de Rooyse Wissel and in Tiengemeten is deploying the care of plants and animals in the therapy. By taking care of others, first plants and animals the patients feel more secure.
9. THE NEEDS FOR THE FORENSIC PSYCHIATRIC BUILDING(S).
(shape / use / material / urban context)

The functional and practical needs are formed by guidelines from the Dutch governmental justice department. The chapter is an overview on the different requirements for multiple scales.

9.1 REQUIREMENTS FROM ‘DIENST JUSTITIELE INRICHTING’ (DJI)

The department judicial institution for the Dutch Ministry of Justice has composed a document of requirements of a new Dutch TBS clinic, similar to a forensic psychiatric institution. The essence of the document would be to give insight in the spatial, functional and technical desires for this kind of buildings. These are derived from policy frameworks and existing principles joined by Sectordirection TBS into a long-range plan (Meerjarenbeleidsplan Sectordirectie TBS, 2002-2006).

- Humanistic environment by offering a personalized therapy for individual disorders.
- Safety by protecting society from the danger posed by the patient.
- Efficiently to place the patient in a less expensive housing when he is able to.
(Most cost from certain facilities derive from personnel running and securing the facility.)

Institutions for forensic psychiatric care are fully fledged psychiatric clinics. The patient will be treated for his specific individual disorder, fitted for his crime. (DJI, 2006) In addition to the normal requirements for psychiatric care there are security requirements.

The scale of the building is limited to approximate 150 beds for patients. When exceeding this limit the clinic will not work effective and according to the goal of the building. Overview is lost, controllability will be difficult and the need for extra functions is out of number. (DJI, 2006)

9.2 THE SITE

Normally the government is the one to find a place for a new forensic psychiatric institution. Probably for this reason there are no hard regulations on the location of forensic psychiatric care.

ACCESSIBILITY

The main reason to pick a certain location would be accessibility. For visitors, staff and patients to go or leave the building it should be accessible either by public transport or by foot. Thus far resulting in many similar institutions build near train stations. Because of suicidal patients this is not without consequences. Large fences around the train track are needed to make sure those patients are not easily seduces
to take their live.

**TErrAIN SIZE AND GROWTH**
A forensic psychiatric clinic needs a lot of space. The security layers demand distance between the wall and fences to create

When searching for a new location for a forensic psychiatric institutions the decision should take future growth into account. Most institution grow due to time and changing demands. Therefor the terrain should not be to rigid and there should be space enough to add new departments or functions.

**GEOGRAPHICAL CONTEXT**
The qualitative needs for the site could be the direct physical environment of the site. There is a difference in 3 types of locations possible. Either the new building will be integrated within a urban landscape. The patients should in this case be part of normal society and should be able to handle the effects of this environment. An other option would be to place the building in a natural country site where there is no or little contact with society. This would be the best place for patients to live which are very disrupted and unstable. At this point there is also a new theory; patients should live at their own site, but on this site normal people are allowed to live therefor creating a mini society within the site of the psychiatric institution; reversed integration. This would only work for a normal psychiatric institution, not for the forensic type, since normal people would not be safe within this mini society and security of the patients is more difficult. (link requireements DJI)

**9.3 FUNCTIONS**
Within the institutions functions similar to a small town are needed. The institution facilitates clusters of activities and functions like living, sports, work, education, health care, parks, traffic routes and public functions like hotel, restaurant and cafes. To understand the complexity of the building there are clusters to be made.

**LIVING CLUSTER**
Living involves the basic needs of every day life; Sleeping, eating and drinking, sanitary facilities and relaxation. Within the living cluster there is a differentiation in security levels (see 9.4 ) but they included more or less the same basic activities.

**HEALTH CARE**
Psychological health care is a large portion of the health care within an institution like this. The therapy spaces for group and individual therapy are needed. And spaces for staff to discuss treatment procedure and evaluate. Observation of the patients after the first conclusions in an observation clinic can take place in the health care cluster.

**EDUCATION AND WORK**
Education and working is part of the re-socialization process. Patients can participate in courses or should be able to work. This will give them structure and will help them find a job once out of the clinic and will be concerned with the therapy. When the patients are able to leave the institutions during leave they are allowed to follow education or work outside the clinic. The kind of education or clinics which can be offer to the patients can differ from wood craftsman ship, agricultural, writing and art depending on the management of the institution. All patients have individual plans for personal education. The facility should be able to facilitate the varying requirements for these courses. Within work therapy production is minor to systematical reality training in relation to the self, the materials and others. The social aspect is important when designing a workshop. The risk of dangerous tools and machinery will make these spaces important to oversee and control.

Within the mini society ‘normal health care’ is also needed. Think of a dentist, a physiotherapist, a nursery and even education for health care.

The patients in Stabilization and M0tivation are frequently in need of medical care. The living facilities for this phases should be near or part of the medical cluster.
SPORTS

Sport facilities for indoor and outdoor practice will need protection from bad weather and destruction. The sport cluster should provide a wide differentiation in sport for individuals to groups sports to improve the social qualities and self confidence. It will help the patients to improve their physical well-being. The sport cluster should provide for the staff to sport also.

MARKET PLACE

A market place is meant for social interaction. Different function combined will make the market place the connection between therapy and living, staff and patient. This complex centre of interactions is less organized creating a testing ground for the patients. Can they handle many stimulus and social interaction. Patients can evolve their social skills and staff can observe. This will give insight on social skills, behavior and possible foul play by patients. An animated active public place is necessary to analyze the development of the treatment.

This garden or outside area would house social and public functions which allow patients to participate in a controlled society. A church can be for the surrounding neighborhood as well as for the inhabitants of the institution. But there are regulation according to the safety of the visitors, the patients and society.

GARDEN/OUSIDE

Due to the length of stay within those clinics possibility to go outside are important. Beside the outdoor sport facilities patients (and staff) should be able to go outside. This can be combined with daily activities like gardening, a ramble or the care for animals.

GUEST UNIT/

Even in the case of a closed facilities there are visitors. Some patients are allowed to receive visitors over the weekend. The interaction between patient and visitor can give an indication on the social skills of the patient. The social skills shown during visits are an indicator for the treatment team.

SMOKING

Smoking is an important element in a forensic psychiatric institution. Most patients smoke since it one of the only activities they have when they have just entered the institution. When smoking is accommodated in separate rooms there will automatically be a transformation in the groups since they divide the non-smoker from the smoker. This is not desirable, since group interaction is vital to good treatment (Placeholder3).

ENTRANCE

Most forensic psychiatric institutions have different entrances. One for vehicles and one for pedestrians. The entrance has several functions.; Receiving visitors and suppliers. To control what goes in and out the building and to control the whereabouts of all patients inside.

The entrance works as a sluice gate. And is only controlled from the inside. The entrance sluice houses lockers for visitors. The are no entries to the control room to prevent them to be in danger. Once through the sluice there are more lockers for personnel.

9.4 SECURITY LAYERS

The security of the building is the second function. The building should keep all patients inside the building unless they are allowed on a leave. Organization of the buildings, fences and structures can improve the controllability and the security. The goal would be to prevent patients to break out. This by slowing down the patient and an alert system to make sure staff is able to stop them in time. A break in would be stopped in the same manners, by creating barriers to slow them down and stop them in time.

breaking in or out should not be possible without tools. With tools the delay created by barriers will be at least 15 minutes.

During the design process one should take in account the difference of night and day situation.

The security consist out of several elements which only work together:

- security personnel
• Entrance procedure.
• Key system and discipline
• Personal and mental security
• An emergency plan
• The planning of the building
• Dividing responsibilities
• Maintenance

Architectural means which can be used to improve security are:

• Gated sluices / locked doors
• Good lighting. No dark corners and secure use of back lighting
  Facial expressions can be seen.
• Security of windows, doors, roof lights, vents and access to
  crawling spaces.
• Ceilings which are not able to hide tools.
• Compartments
• Terrain enclosures
• Placing sensors on the barriers to signalize out or in breaks.

**INSTALLATIONS**

• observation installations like camera’s and sensors.
• communication installations for personnel on separation cells.
• emergency installations
• Announcement installations.

The cost of the building use will be primarily security and staff wages.
By implementing design solutions for controllable situations will
reduce the costs.

9.5 MOVEMENT

ROUTING & RELATIONS

Routing to the separation rooms has to be a sub route, not the main
route since the other patients will get agitated by other patients being
looked down. (Wind, 2004)

Some patients are not able to read, therefor all way finding should be
preferably done by icons.

**TRAFFIC SPACE**

The traffic spaces in (forensic) psychiatric care should improve
orientation and clarify the building. In most case studies the traffic
spaces are closed hallways which prevent one from orientating.

When the patients have to or can overcome in (multiple) obstacles this
can result in a negative notion. The patient can decide not to go to his
treatment when he has to walk long distances, stairs and when they
can run into people they don’t want to see or talk to.

The problem trough when trying to limit the use of stairs is the feeling
of an institution instead of a home. (Placeholder4)

The long hallways seem to make the feeling of being trapped even
stronger. Maybe because the possibility of retreat are less?
ARCHITECTURE FOR RE-SOCIALIZATION
10. HOW CAN ARCHITECTURE CONTRIBUTE TO THE TREATMENT?

The complexity of building for forensic psychiatric care drives from both the function and activities as the users. The combined functions of the forensic and the psychiatric care demand a long list of requirements related to safety and treatment. Combining this with the inhabitants and users of the building who are in most cases instable and mentally disturbed the design of a new building for forensic psychiatric care. The role the forensic psychiatric patients plays in the media makes it even more sensitive. Why should one take interest in the well-being of these psychopaths and shouldn’t they be locked down for the rest of their lives? Since the Dutch government has introduced the TerBeschikking maatregel” and thereby the forensic psychiatric care it has been proven that people actually can learn how to live with their disorder and are able to re-socialize in normal society. With that point of view it would be best to find out what the best circumstance are for those patients within the limitations of forensic care. One needs to understand what kind of patients live here and how the process of re-socialization works. Should understand what functions are needs or could improve the quality of the facility. This research in meant to bring that information together and find solutions for this design issue.

Like the research itself the acknowledgements are divided in different parts: need for the patient and needs for the forensic psychiatric treatment. The overview shows what kind of activities and functions requirements could be linked to different steps of re-socialization.

The needs for the building are divided in different scales and different domains. This chapter describes the different scales within a forensic psychiatric institution and the domain within that scale. It describes acknowledgements and guidelines for future designs. These guideline could help urban designers when finding a new location for a FPI. Or an architect when given the assignment of making a new FPI or a new department with such similar function. The needs for the building are divided by scales, functions and some key words which can be found in the multiple scales.

The scales used:

- Location
- Site / Terrain
- Building
- Departments
- Room
- Detail

The keywords used:

- Shape / composition / space / form
- Material / climate / structure
- Function / movement / use
- Urban context / Natural environment
- Story / context
- Private / public
- Security
- Differentiation / order / disorder
- Safety
- Control and autonomy

10.1 ARCHITECTURE CAN CONTRIBUTE TO THE TREATMENT

Building for forensic psychiatric care is not just the combination of a prison or penitentiary centre combined with a psychiatric institution. The differences between the imprisonment and treatment is immense since one is focused on punishment while the other is focused on feeling better and treatment. To make one feel safe or at home in an enclosed situation would be the primarily focus in a design process for a certain institution. Treatment will only take place or even fasten the process when the patients feels better and safe.

One can feel unsafe due to his therapist, treatment team, fellow patients or lack of stability of thought. These factors are all vital for the treatment, though these can not be facilitated trough architecture. It would be architecture to influence facilitate the treatment process,
to allow a patient to retreat, to learn or to feel at home. Architecture can play a role in the notion of feeling safe. Also could it help to hide the signs of imprisonment.

In this way there is an architecture to contribute to forensic psychiatric care.

10.2 HOW CAN WE IMBED ARCHITECTURE?

But how can architecture facilitate treatment and let one feel safe? In previous chapters the relevance of different needs found. They are a combination of needs for patients, the treatment and forensic psychiatric care.

They are to be combined in numerous keywords:

- Rewarding by Autonomy
- Identification
- Natural environment
- Clear Arrangement
- Privacy & Protection
- Security & Examining

REWARDING BY AUTONOMY

The building houses many individuals with different needs and preferences. To meet to most users there should be a kind of autonomy possible. While some inhabitants prefer long views and social contact, others might choose a road with back coverige and less people. This would be on the scale of the terrain and the building. The building should meet both. For example there could be a public and a private route from living tot treatment. The level of autonomy differs primarily from the phase one patient is in.

The first two phases don't allow much autonomy. The patients are in one hand not able to make their own choices jet. Also the prospect of being able to earn more autonomy motivates some patients.

The treatment living department can also facilitate autonomy by creating different room types and different hallways. The differences result in ranking of the rooms, varying by patient, which the treatment staff can use as a kind of rewarding system. “If you are able to behave properly for at least a month you can be transferred to that room.”

The patients will feel less obliged to live somewhere when they have a choice. This contributes to the feeling of home and the re-socialization process.

There should always be a something to choose.

IDENTIFICATION

Recognition and identification is important to relate to the building. When there are (architectural) elements which are recognizable for the patients and staff the place and building will be easier to understand.

To be able to recognize there are two different factors; one is the recognition of elements within live in the building and living outside the building. And the recognition of the different buildings within the site. When buildings are recognized they function as landmarks and way finding.

The identification of the individual rooms works quite similar. It should be possible to adapt the rooms according to the patients taste. Though, since most patients tendency to clutter up their rooms, there are regulations for adaptation.

Personalization should be possible at different scales, but mostly at room scale.
**NATURAL ENVIRONMENT**

Natural environment can help the users of the building to relax. It could hide the building from sight creating protection from normal society. The first steps in forensic psychiatric care could use natural element to calm psychotic patients down. By creating less grey and greener refresh spaces the effect will be more relaxing and calming. Patients will require less medication.

From the individual rooms there should always be a view on some kind of nature. By orientation the windows towards trees, parks or field the qualities of the rooms increase.

To be part of nature is even better. By creating gardens and parks one can not only look on nature but be part of it. Therefore vegetable gardens, farm animals and market garden. This proving for work and eduction for the patients.

The use of natural materials will improve the quality of the building. The natural materials have a decreased effect in comparison to the real nature outside but still result in calming the users down.

If possible should all seats should have a possible view on nature. All windows of individual rooms should have a view on some kind of greenery.

**UNDERSTANDABLE**

Due to their abilities the patients are disorientated. They need the building and its routes to be understandable. Orientation is vital in a clear understanding of the building. It should be made possible to orientate at all points in the building. This orientation can be found in a clear arrangement of the buildings, differentiation between buildings for living or treatment.

Long hallways block views and can result in confusion. Landmarks can contribute to the orientation of the patient and staff members. The division of the different functions also leads to a clearer understanding of the building. This also provides the quality of not having therapy in the same building as the patients lives.

Patients in the stabilization and motivation phase can be paranoid and could mistake subtle detailing for conspiracy plots against them. For these patients clear and understandable shapes and structures are necessary.

The building should be understandable and clear in use

**PRIVACY & PROTECTION**

Privacy is something difficult within forensic psychiatric care. Patients are to be looked after and should be ‘secured’ at all time. Though it is inhumane to keep them locked up and checked upon by camera’s. Privacy for the patients contributes to the feeling of home. A patients should be able to retreat and find protection from the outside world.

Privacy within institutions of forensic care is in most cases limited to the individual room. Within these rooms there is no real gradient from public to private. It could be compared to a hotel arrangement, the hallway is public and the room is private. Only one door keeps total strangers in case of the hotel away from your bed. In case of forensic care these are not strangers, but other patients who you are afraid of.

The rooms should give some kind of protection against the ‘outside world’ or external factors. In the first phases, stabilization and motivation this protection is most vital. From the treatment phase less protection is needed, though the patients should always be able to retreat.

At all scales, from site to room, there should be degrees of privacy. The further a patients is in the re-socialization process the less protection is needed or wanted.
To design an better treatment environment for forensic psychiatric care one should try to understand what kind of people live in the closed facility. What functions and activities the facility houses and how unsettled and under construction forensic psychiatric care still is. The next pages visualize and example of requirements for the individual rooms. With every step towards entire re-socialization there are more privileges and the activities within the room, department, terrain or even outside possible. The icons explain what activities patients are concerned with and where these activities could take place.

Low fences and barriers which allow people to cross boundaries, but claim them not permitted are necessary within the ground of forensic psychiatric care. These rules are easily broken, but make a testing terrain for the patients. Can they handle the responsibility living with regulations. When they can they will get more responsibilities. I case they can not resist they are not ready for new steps of responsibility. The cost of the building use will be primarily security and staff wages. By implementing design solutions for controllable situations will reduce the costs.

Next to the normal security needs we know in prisons there is a testing security which is easy to crack.

**SECURITY & TESTING**

Within the forensic psychiatric care there is an distinction within security layers. While the patients should be secured inside to protect society they should also be learning how to handle their disorder in that same society. 5 Meter high fences and 11 meter high wall prevent the patients from leaving the terrain. These are not to be crossed. Lockages, locked doors, lower fences state are possible to trick, but then the patient would violate the rules. This might keep him in the institution longer or even degrade him to an lower phase of the re-socialization process.

**10.3 ARCHITECTURE OF THE RE SOCIALIZATION PROCESS.**

The next pages visualize and example of requirements for the individual rooms. With every step towards entire re-socialization there are more privileges and the activities within the room, department, terrain or even outside possible. The icons explain what activities patients are concerned with and where these activities could take place.

Those rooms are examples on how these requirements can be translated into rooms. The goal is to give some basics which can be used as a starting point. Not an per ce the ideal room for every patient or building.
STABILIZATION

Patients in Stabilization are in need of structure. Patients are in most cases psychotic, disorientated and unstable. They will be medically supervised 24/7 and are probably starting to use calming medication.
Protection in this case is realized by the placement of the doors. The placement allows one part of the room to function as back coverage. Try to minimize the amount of doors. The plinth creates a back coverage when the patient wants to lean against the walls.

SECURITY AND TESTING
Because the patients in here can be suicidal or aggressive the room is violence proof. They should not be able to leave the room without tools. There are two entrances to the room providing for two staff members to take action when necessary. The main entrance is place to be able to oversee the room through a peek hole in the door. The windows are that high that climbing is not possible.

ACOUSTICS
The room is ‘hanging’ in the building. The walls, floor ceiling are disconnected to prevent contact noise to disturb the neighbor. The slightly turned wall prevents an echo. Since patients can be very loud this is essential to these rooms. It would be advisable to have a sound reduction of 25 dB(A) in the walls. The oblige in the wall prevent the noise to reflect on the walls. The echo should be under 0,5 seconds (T).

CLIMATE
Mechanical ventilation is desired since none of the windows can be opened. The floor will provide heating and cooling. This because it is nice for the patients to sit on the floor and they do not wear any shoes. Also since the concrete is violent proof. The climate is centrally organized. Air needs to be refreshed by approximately 15 liter a second.
**MOTIVATION**

The motivation phase is meant for patients who just arrived. They have been in prison for at least 4 years and will start up their resocialization process. Some patients have been in Stabilization first.

The goal of the motivation is to motivate the patients for treatment. Starting by letting them understand what they have done, what their psychological problems are and finding where they went wrong. Motivation is the starting point of the treatment.
**REWARDING BY AUTONOMY**

All of the furniture is fixed except from the chair which is only allowed when the patient does not have a high risk on being aggressive. The wardrobe can be closed or opened by staff creating. This could be a reward for patients who behave well. The patients in motivation phase can handle some kind of autonomy. It would be good to integrate a light switch and ventilation adaptability.

**IDENTIFICATION AND PERSONALIZATION**

Identification is limited to the blackboard on the wall and a notice board in their room. Personalization is limited since patients will live here for a relatively short time. They should be motivated to proceed in re-socialization.

**NATURAL ENVIRONMENT**

The facade openings should provide a view on nature. The patients can handle some human activity in their view but it would be advised to limit this kind of use to several hours a day.

**UNDERSTANDABILITY**

It would be best if patients are able to reduce stimuli when necessary. The problem within these rooms would be the wide range of activities within one room even though dinner and living has been partly moved to the department. The ability to close of the wardrobe is vital. The saloon doors in the bathroom do give more control, but will increase the stimuli.

**PRIVACY/PROTECTION**

Patients in motivation departments have earned more privacy and should be able to handle more responsibilities. The room becomes a place for retreat while a living room facilitates the common place of stay.

**SECURITY AND TESTING**

The saloon doors in the bathroom provide the patients to lock themselves in. The angled wall provide for clear views through the room.

**ACOUSTICS**

Since some patients shout or can be histeric the sound isolation should reduce the sound disturbance to a maximum of 20 db(A) similar like a silent room. Echo will be less of a problem because of the furniture, but would be advised to be less than 0.5s.

**CLIMATE**

The climate of the motivation room is managed centrally and to be adapted individual. The need for fresh air is approximately 16 liter/ second. Floor heating is advised since it is violence proof solution for heating.
TREATMENT

Once a patient is in the treatment phase he is able to handle some responsibilities. But they can still be aggressive or unstable.

Treatment involves therapy, education, social interaction and work activities. Patients spend most of their re-socialization within treatment phase. They will learn how to handle their disabilities and will be tested doing so. They are, in most cases, allowed to leave their department.
**ACOUSTICS**

The acoustics in these rooms should be compared to those of a normal room. The noise from the outside should be reduced to a maximum of 35 dB(A).

**CLIMATE**

The ventilation can be a combination of either natural or mechanical outlet. The supply of fresh air can be either by natural means because of the door and windows. There needs to be an refreshing rate from at least 420 l/s because of the kitchenette.

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**REWARDING BY AUTONOMY**

Furniture in the room is no longer fixed. The patients are allowed, when earned, to move around the furniture according to their wishes.

The patients are also able to open their windows and regulate the installations.

**IDENTIFICATION AND PERSONALIZATION**

The patients will live in these rooms for some time. When they move in the room will be painted accordingly and the patients are allowed to have personal objects. One wall can be designed for expression or easy hanging of posters. Magnet paint or a large notice board would be integrated in the design.

**NATURAL ENVIRONMENT**

The windows will give a view on nature like trees, bushes, fields or other natural elements. The protruding window frames allow patients to sit in the wall and experience the natural environment.

**UNDERSTANDABILITY**

The patients can handle normality. The room is to be compared by an individual room within a normal house. The activities are more divided over the department and the building. The department being the house, the terrain being the city they live in. The room will be for retreat, individual activities, hygiene and sleeping.

**PRIVACY AND PROTECTION**

The privacy in the individual rooms is increased because of the zoning in the room. There are corners in which one can retreat. Though, due to the placement of large windows the shadows will give hiding difficulty.

**SECURITY AND TESTING**

The patients have passes to enter their room and department. They will check whether they are inside or not. Once a day staff will check if they are all right. The ‘testing’ takes place during the day, when they are allowed to leave the building and terrain. Also within the department where they are in contact with other patients and staff.
Re-Socialization

Patients in re-socialization are ready to participate in normal society. They will have a job or education outside the clinic. They will have therapy only once or twice a week in a poly clinic or at the institution.

The goal of re-socialization is the controlled rehabilitation within society. They will still have boundaries like a curfew and are obliged to go to their treatment.

16 M2

4 Patients
VENTILATION
The ventilation can be a combination of either natural or mechanical outlet. The supply of fresh air can be either by natural means because of the door and windows. There needs to be an refreshing rate from at least 420 l/s because of the kitchenette.

REWARDING BY AUTONOMY
Patients in re-habilitation are more or less on their own. Most patients are allowed to leave their room and the building between certain hour. The access to the balcony could be a privilege and also the use of the kitchen in their room.

IDENTIFICATION AND PERSONALIZATION
The rooms are not furniture by staff but by patient. The balconies will give identification to the outside of the department. The patient is able to express not only to the visitors of the room, but also the outside. The arrangement of the rooms can create extra space in front of the room providing space for personalization.

NATURAL ENVIRONMENT
Balconies allow the patients go outside. The planters will take in nature. The view from the rooms should have natural element in sight. Though the planters will provide this also.

UNDERSTANDABILITY
The understandability of the rooms should be comparable to a normal house. The patients should be able to retreat in their room. It would be nice if patients are able to reduce stimuli when necessary.

PRIVACY AND PROTECTION
Privacy is limited to the curfew of the patients and the access to the rooms and building. But once inside the individual rooms they are in private domain. The kitchen and bathroom will create a privacy zone in between the public hallway and the sleeping area.

SECURITY AND TESTING
The patients have passes to enter their room and department. They will check weather the are inside or not. Once a day staff will check weather they are all right. The testing takes place during the day, when they are allowed to leave the building and terrain.

ACOUSTICS
The acoustics in these rooms should be compared to those of a normal room. The noise form the outside should be reduced to a maximum of 35 db(A)
11. DISCUSSION
Since the subject of architecture for the forensic psychiatric patient is very complex and limited was written about it there was much to gain. I have tried to find information through literature, case studies and interviews and put it together to find some guidelines for future design projects concerning the subject.

While finishing the research there was still much information and data left for further research. I found it difficult not to go on reading, talking to involved people and going to cases. Though, at some point I had to stop and put all the information I had together to make the research document for my graduation project.

When I would have more time I would have liked to visit the Oostervaarder kliniek which I have made a case study about. Also I would have loved to talk and interview (forensic) psychiatric patients and ask for their opinion.

At this point there was no time to research more about foreign countries and their opinion about the subject. During my visit to the congress on environmental psychology in Eindhoven I have heard new information about the environmental psychology on psychiatric patients. Again, the same problems which I have seen before, researchers seem to be interested in the faith of the psychiatric patient but do not include the criminal version of these patients. Also most information was not practical or to be used yet.

11.1 HOMELESSNESS:

At the congress I did find some kind of confirmation on my hypotheses. They think that homeliness is very important for the psychiatric patient. Homeliness is a concept used in environmental psychology and underlit in architecture. It is about the physical environment of people. The specifics of this homeliness would be interesting for further research. Especially while transferred from theory toward architecture, to make it applicable. Would I have more time I would like to concretise these factors, not just use them.

11.2 RESTORATION:

At the congress there were researchers curious about the effects of restoration by living environment. Restoration would be the healing or recovery after stress in a certain living environment. The main focus lay in the effects of nature, light (brightness and temperature), noise and fresh air. While much research is done about it the application is still limited. In case of the results which are found they are focus on ‘normal people’. Research claims to calm people down and restore them, but while normal people have to recover from one long day of work the (forensic) psychiatric patients may have to recover from every social interaction.

It would be interesting to compile the different results and adjust them for the forensic patient.
1. GGZ Nederland, 2010
2. (Novum, 2010)
3. (nu.nl, 2010)
4. Director of the Van der Hoeven Kliniek
5. In a conversation with a psychologist (A.G. Miedema) and a socio therapist trauma treatment sociotherapist (W. de Bij) the contradiction came up. Should it be a hotel for better treatment or a penitentiary cell?
6. Falling back to old habits and committing a similar crime.
8. (Schoenmaker, dr. C.; Ruiter, Prof. dr. C de; Trimbos Instituut, 2005, pp. 147-155)
9. P. 150 (Schoenmaker & Ruiter, 2005)
10. Van dale; dis-so-ci-a-tie
11. CBS Penitentiaire inrichtingen: aantal gedetineerden naar kenmerken. (Centraal Bureau van de Statistiek, 2011)
12. Dr. A.G. Miedema Interviews (attachment)
13. Christaan, a former TBS patient (Cornellisse, 2006)
14. (Ministry van Justitie, 2010)
15. A ‘TBS-kliniek’ is best translated to a forensic psychiatric treatment clinic although it does not cover the word entirely.
16. Something that has separate and distinct existence and objective or conceptual reality. (Merriam-webster)
17. From his LinkedIn profile may 2011
18. website Rooyse Wissel pagina populatie (http://www.berooysewissel.nl/page.asp?menu_id=29)
38. Roy, J. l. (1787). Précis d’un ouvrage sur les hôpitaux, dans lequel on expose les principes résultant des observations de physique et de médecine qu’on doit avoir en vue dans la construction de ces édifices, avec un projet d’hôpital disposé d’après ces principes. Parijs, France.
Archief.
LITERATURE


ARTICLES


WEB SITES


DOCUMENTARY

Zie Zorg: de Psychiatrie (2010). [Motion Picture].


ziekenhuis. Amsterdam: Stichting Architectuur en geestelijke gezondheidszorg.


The interviews are all done in Dutch. The original interviews are in the attachment. When used in the thesis the translation is done by me.
Interview: Charlotte Boonstra


**Jeugdige Delinquenten**

Ik werk in een project dat heet Multi system therapie. Ik kan eigenlijk een individu beschrijven aan de hand van verschillende systemen. Als individu, de familie er omheen, de vrienden, de school, de gemeenschap en ga zo maar door. Al die systemen proberen wij bij de therapie te betrekken. En wat wij zeggen, in het project waarin ik zit, gaat het om jongeren tussen de 12 en 18 jaar. En als die een delict plegen of als ze heel agressief thuis zijn of als er volgens de ouders niet meer thuis zijn en gedragsproblemen heeft, hele oppositioneel gedrag vertonen, hij spijbelt, of … , maar ik ben ok verbonden aan jongeren welke zeden delicten plegen. Maar goed het gaat allemaal om jongeren tussen de 12 en 18 jaar waarvan de ouder of verwijzer zegt: het gaat niet goed, eigenlijk zou hij opgenomen moeten worden, maar de andere om hem heen zeggen: opnemen? Is het niet veel beter als we proberen dat hij thuis kan blijven en dat hij dan met name met zijn ouders, met zijn familie en de school probeert thuis aan een gelijk programma te werken. Dat hij niet weg hoeft. En dit is er dus op gericht dat er minder klinieken nodig zijn.

En dat … de jongeren welke bijvoorbeeld in een kliniek zitten dat we zeggen nou we moeten vooral de ouders sterker maken want hij is natuurlijk even geschrokken van de gevangenis, misschien is hij al wel een jaar uit huisgeplaatst geweest in een penitentiaire jeugdinrichting. Maar vroeg of laat komt hij weer thuis. En dan is die therapie, daar ben ik dan supervisor van. Dan heb je een team van therapeuten en die hebben een aantal gezinnen onder zich. Meestal een stuk of 4 a 5.

En dan gaan ze aan de ouders en de jongere vragen om naar een instituut te komen. En vanaf dat moment komt een therapeut 2 a 3 keer per week aan huis. Dan kijken ze samen, nou deze jongen gaat niet naar school toe, hij hangt veel op straat, of misschien verkoopt hij ook drugs of hij is in aanraking geweest met de politie of heeft al een korte gevangenis straf gehad. Dan kan een rechter uitspreken bijvoorbeeld hij krijgt een voorwaardelijke straf, dus als je het nog een keer doet moet je er wel heen. (gevangenis). Maar je bent verplicht is (uitsluitende voorwaarde) dat je Multi systeem therapie krijgt. En al hij dan toch weer in de fout gaat, nou dat weten de jongeren dan ook dat weten ze dat ze hangen en moeten zitten.

Wij proberen met het team door middel van de therapeut te voorkomen dat de jonge delinquent weer in aanraking komt met justitie of terg vol in zijn oude gedrag.

Nou hij heeft nu 5 maanden gezeten in een psychiatrische inrichting, hij gaat zo naar huis toe, maar zeer waarschijnlijk zal hij zodra hij thuis is weer in zijn oude gedrag vervallen. En dan vragen ze ok de therapie vorm aan.


Tussen de 12 en de 18. Meeste hebben gecombineerde stoornissen en gedragsproblemen en een dreiging tot een persoonlijkheid probleem.
Dit zou kunnen uitgroeien tot psychopathen e.d. Ze zijn nog jong en het zijn daarmee nog geen definitieve stoornissen

ROKEN/ALCOL?

De jongeren zijn thuis en moeten aan de eisen voldoen welke de ouders stellen. Als men denkt dat de jongere af en toe prima kan blowen dan mag dat. Hard drugs is natuurlijk wel not-done. Maar als zijn ouders denken dat het zijn negatieve gedrag beïnvloedt dan niet gebruiken. Maar eigenlijk zijn vrienden veel belangrijker. In het geval van een drugkoerier zal het gehele contact moeten worden verbroken met een vorm van drugs.

HET GEBOUW

De therapeuten vinden plaats buiten een instelling, maar in de woning van de jongere. Eigenlijk zijn wij niet zozeer een vijand van de instelling, maar de meeste jongeren daar niet veel beter van worden proberen wij de jongeren in huis de therapie te bieden.

Doordat de therapeuten bij de jongere thuis gehouden worden is er geen gebouw voor de therapie. Daarnaast werken alle therapeuten vanuit huis en daarmee worden kosten voor een gebouw wat veel leeg zou steen bespaard.

Bijkomend voordeel van het afspreken bij de jongeren thuis is dat op die manier de ouders sneller geneigd zijn aanwezig te zijn. Vaak bijkomend voordeel is dat deze mensen, de jongeren zelf en de directe omgeving, vaak al teleurgesteld zijn door het systeem. Ze zitten in de woonkamer of in de etuurmente. Het is een dure therapie, doordat het zeer intensief is, maar er geen gebouw nodig. Daardoor kunnen de kosten toch laag gehouden worden.

De therapeuten

Alle therapeuten werken vaak alleen en rijden met hun auto van huis naar huis. Maar ze gaan ook naar de stageplaats, de werkplek. Soms worden afspraken gemaakt over het loon. Maar je moet ook de leefomgeving van de jongeren bezig. Dit kan ook de school, sprotsschool zijn. Bij boxen wordt ook afgemeld wat er in de leefomgeving van de jongeren bezig. Daar moet je proberen de jongeren in de buurt te vinden. Ze vinden de meeste op de stageplaats, bij school, bij vrienden.

RESOClALiSATiE


Het gaat dus het weg gaan bij het instituut, het vasthouden en dan
weer zonder voorbereiding vrij laten. Die overgang is gewoon vaak minimaal en daardoor gaat het natuurlijk vaak ook heel snel weer slecht. Stel je voor dat een jongen van 14 in een jeugd inrichting terecht komt en een jaar later eruit komt. Je ben groter, ouder en steender geworden en je ouders zijn je daarnaast ook nog ontw, dan is de kans groot dat het weer mis gaat. Die breuk met thuis hoef je in dit geval dus niet te herstellen.

**VERZEKERING/ ZORG WETTEN?**

Deze behandeling duurt niet lager dan 5 maanden want deze is er heel erg op gericht dat de therapeuten een plan maken samen met de ouders. Wat moeten we aanpakken? School, medicijnen, wijkagent? Daardoor kunnen ouders een directe lijn leggen met wijkagent.

Dit ook om te voorkomen dat het traject te lang gaat duren en de ouders, omstanders te afhankelijk worden.

Zij zijn dus niet afhankelijk van de diagnose en de maanden welke staan voor ziekte beelden. Er worden een aantal doelen gesteld en de moeten behaald worden binnen de 5 maanden.

**NIEUW NETWERK OPBouwen?**

Er mag soms wel contact zijn met oude contacten. Vaak kunnen ze met hun nieuwe hobby's ook nieuwe mensen leren kennen. Ook de school kan hierin mee spelen. Vaak maken ze niet snel sterke banden, maar dat kan groeien. Daarnaast kunnen ook oude banden weer worden opgepakt van voor de criminele periode. Er zal dus een verschuiving plaats vinden.

Wij hebben het niet over resocialiseren, maar socialiseren. Je voorkomt op deze manier dat het re socialiseren niet nodig is.

Dit kan ook door jongeren omdat ze ook beschermd gaan wonen doordat de jongeren hun directe familie om hun heen hebben.

**NIEUW BOUW?**

Als je iets nieuws gaat bouwen voor deze groep jongeren dan zou je kunnen kijken dat het nieuwe netwerk een goede plaats kan krijgen binnen de woning(groep). Een gezamenlijke woonkamer of juist een

Vroeger was de therapie leiding voor de vorm/structuur van het gebouw. Daardoor merk je nu ook dat het gebouw niet meer helemaal werkt binnen de nieuwe behandeling vormen.

**GESCHIEDENIS:**

Men ging op gegeven moment ook langs de grenzen van de instelling wonen. Controle kan natuurlijk nu ook met een chip en op die manier komen er hele andere mogelijkheden voor de architectuur.

**LEEF OMGEVING**

Omdat er niet een gebouw is maar dat de therapie thuis plaatsvindt is er niet een omgeving/ stedenbouwkundige situatie waarin het standaard staat. Dit kan dus afwijk in het hartje centrum van een stad zijn. Ofsel op het platteland.
Andre Miedema heeft in Groningen Psychologie gestudeerd en in verschillende TBS inrichtingen gewerkt zoals de Pompe kliniek in Nijmegen en ... Momenteel is hij hoofdbehandeling van de afdeling ... in de Rooyse Wissel in Venray. Daarnaast treedt hij soms op als expert bij rechtzittingen over het aan dan niet verlengen van de TBS maatregel.

**TYPE PATIENTS IN EEN TBS KLINIEK.**
Het meest voorkomende in de TBS in drie groepen van antisociale, borderline, en narcistisch. Maar er zijn ook voor één derde psychotisch kwetsbare (schizofrenen. En daarnaast een groep cognitief beperkt zwakbegaafden, zwakzinnigen'. Momenteel zie je dat het aantal persoonlijkheidsstoornissen sterk afneemt, zeker in percentage.

De andere persoonlijkheidsstoornissen zoals theater komen in de TBS minder voor.


**KOMEN PATIENTS ALTijd NAAR DE BEHANDELING?**

Wanneer mensen ambulante behandeling hebben in een forensische polikliniek (TBS met voorwaarden bijvoorbeeld, maar ook schorsing preventieve hechtenis) kunnen ze niet op komen dagen voor de verplichte behandeling. Ze lopen dan risico weer naar de gevangenis te moeten.

**VROUWEN IN DE TBS.**

Maar: in de gewone geestelijke gezondheidszorg zijn veel meer vrouwen, in gevangenissen en alles wat met justitie te maken heeft zitten meer mannen. Een van de weinige terreinen waar vrouwen nog een achterstand hebben. Tijdens mijn opleiding werd gezegd"vrouwen richten agressie op zichzelf, mannen op anderen”

**WAT IS HET VERSCHIL TUSSEN EEN FORENSISCH PSYCHIATRISCH KLINIEK EN CENTRUM?**
Een FPC (centrum) is wat men vroeger een tbs kliniek noemde. Tegenwoordig noemen ze dat een FPC omdat men vaak meer is dan alleen de kliniek: ook een poli en vaak beschermd woonvorm voor de rescisialisatiefase. Hoewel er klien veranderingen zijn wat betreft de doelgroep zijn het overwegend TBS patients met dwangverpleging. Binnen forensische settings zijn e FPC’s hetmeest beveiligd (High Care noemen ze dat ook wel)

Wat minder beveiligd zijn de FPK’s. Hier zitten patients met verschillende juridische titels, waaronder ook TBS met dwangverpleging maar ook zonder dwangverpleging. Een beetje ingewikkeld maar dat is de voorwaarde bij hun TBS opname in een FPK (je hebt een FPK in
Assen, en je de Meern bij Utrecht als FPK. Vaak zijn ze een onderdeel van een APZ, Algemeen Psychiatrisch Ziekenhuis.


**ZIJN ER INSTELLINGEN WELKE ZEER VEROUDERT ZIJN? MISSCHIEN KAN IK DIE GEBRUIKEN ALS LOCATIE?**

Echt verouderd gebouw kan natuurlijk niet, maar er zijn wel een tweetal in oudere gestichten gebouwd. Zo heb je FPC Veldzicht in Avereest waar ze de voorgevel van het oude gebouw hebben laten staan en qua architectuur mooi over te gaan in nieuwbouw. De Medag in Groningen gebruiken nog wel echt de oude gebouwen uit het begin van de vorige eeuw. De voorgevel lijkt net de poort van een robuuste gevangenis. Het is nu niet meer functioneel.

In Utrecht hebben ze het vroegere Meijers Instituut, dat de selectie van de patients deed, veranderd in een nieuwe TBS kliniek: De Tweelanden. Eigenlijk belachelijk dat deze recent nog geopend is terwijl het aantal TBS ers aan het krimpen is.

Als je een bezoekje kunt brengen aan de Mesdag in Groningen krijg je aardig beeld van de ontwikkelingen van de gebouwen in de loop der t
Op 10 mei heb ik op het kantoor van de Jong Gorremaker Algra Architecten in Rotterdam Jeroen Veth geïnterviewd. De Jong Gorremaker Algra architecten (DJGA) is een bureau met ervaring in zorggebouwen zoals ziekenhuizen, psychiatrische inrichtingen en de forensische psychiatrie. Ze hebben onder andere gewerkt aan De Kooyse Wissel in Venray en Kijvelande in Portugal.

Jeroen Veth is daar een senior architect, leidinggevend aan een team van architecten, interieurarchitecten en bouwkundigen. Eindverantwoordelijk voor gehele ontwerpproces van initiatiiefase tot oplevering. Hij heeft ruime ervaring in diverse projecten in de gezondheidszorg (ziekenhuizen, forensische psychiatrie) en andere utilitaire opdrachten.

**Hoe zijn ze terecht gekomen in het bouwen van de forensiscy psychiatriSche inrichtingen?**

De oorsprong van dergelijke inrichtingen ligt in ziekenhuis architectuur waar ze bij DJGA veel aan werkten. Van een psychiatrische afdeling naar een psychiatrische kliniek. Naar een forensische afdeling naar een TBS kliniek. Op die manier is DJGA er waarschijnlijk gewoon in gedraaid.

**Verschillende groepen**

In een normale psychiatrische instelling worden de patients ingedeeld op type stoornis of de zwaarte hiervan. De afdelingen worden dan gekoppeld aan de onrustige en rustiger patients. In een forensische psychiatrische instelling worden groepen ingedeeld op beveiligingsniveau; van zwaar beveiligd naar gecontroleerd voor delen van de dag.

Verschil met normale psychiatrische instelling.

Het belangrijkste verschil tussen een forensische en een normale psychiatrische inrichting is de beveiliging. De patiënten in een forensisch psychiatrische instelling mogen niet naar ‘buiten’, afwijk buiten de muren van het terrein. Daarmee wordt de beveiliging van de patiënt enorm ingekaderd. Daarnaast zijn er heel veel voorzieningen welke aan de beveiliging mee werken. Zo zijn buiten al een hek, een muur en nog een hek nodig. Daarnaast heb je ook nog een gevel welke afsluit van de buiten wereld, een afdeling en een kamer. Dit zijn 6 (1) beveiligingslagen. In een normale psychiatrische afdeling zijn dat (alleen) twee hekken en de kamer en afdeling.

**Waar komen de richtlijnen voor de instellingen vandaan?**

In de forensische psychiatrische inrichtingen zijn de richtlijnen van justitie leidend. Een TBS kliniek of een forensische afdeling heeft één opdrachtgever; het ministry of justitie. Vaak schrijven ze een tender uit. Een tender is een soort van opdracht voor nieuwe plaatsen bij een instelling. Er kan bijvoorbeeld een tender uitgeschreven worden voor 12 nieuwe bedden / plaatsen. Alle instellingen kunnen dan een plan schrijven waarin wordt beschreven welke kosten ze die nieuwe plaatsen kunnen creëren.

Daarnaast geeft het voormalige College Bouw, tegenwoordig onderdeel van het TNO, een ruimtelijk kader aan de forensische psychiatrie. Centraal in de behandeling van psychiatrische patients in het opbouwen van een dagritme. Daarmee is het van belang deze faciliteren.

**Separeercellen**

Op het moment gaat de behandeling van de patients eigenlijk dusdanig dat sepereer cellen nauwelijks gebruikt worden. Dit komt voornamelijk door de omgang van de behadeloers met de patiënten en het gezamenlijk vaststellen van het behandelplan. Toch blijven sepereercellen een vast onderdeel in forensische en normale psychiatrische inrichtingen. Wat je nu ook steeds meer ziet is dat de patiënt binnen hun eigen kamer worden gesepareerd van de afdeling of van prikkels. Zo heeft DJGA zogenoemde smartrooms ontworpen voor de prijsvraag ‘Humane zorg in een gesloten inrichting’.

(zie afbeelding)

Hierin zijn de individuele kamers zo ontworpen dat de prikkelarm gemaakt kunnen worden indien dit nodig is. Op dat moment worden de keuken, de werkhoek en de sanitaire voorzieningen afgesloten van de kamer en blijft een lege ruimte over.
Ook het architectenbureau het Architectuurplein heeft een ander alternatief gevonden voor separatiecellen. Voor hun deelname aan de prijswaar hebben ze een kamer ontworpen welke met automatisch bedienbare schuifdeuren een grote kamer kan omzetten naar een separatiekamer. De patiënten kunnen nog wel slapen, naar de toilet en naar de eigen buiten ruimte, maar kunnen niet meer bij hun woongedeelte en badkamer.

(zie afbeelding)

**FORENSISCHE ZORG BUITEN NEDERLAND**


Het doel van de klinieken in België ligt iets anders, deze zijn te vergelijken met de psychiatrische afdelingen binnen een gevangenis. Het is bedoeld voor delinquenten welke niet thuis horen in een gevangenis. Waarom blijkt dat ze dusdanig last hebben van hun psychische stoornis dat ze niet kunnen ‘overleven’ in een penitentiaire inrichting. Vaak worden deze groep mensen aan het einde van hun detentie een aantal dagen tot weken overgeplaatst naar een psychiatriese afdeling.

De klinieken worden gebouwd in Gent en Antwerpen. In Gent gaat het om 250 plaatsen daarmee is het een grote kliniek. Ze hebben daar nog geen richtlijnen en de meeste eisen komen uit het gevangen wezen. Dat betekent dan dat ze in een knooppunt van gangen een bewaker willen hebben welke de hele dag de gangen controleert. Dit bevorderd misschien de veiligheid, maar zeker niet de behandeling.

Ook komen de delinquenten binnen en worden meteen naar de isolette...
cel gebracht. Vanuit daar kunnen ze rustig worden en gediagnostiseerd worden. In Nederland worden juist deze ruimten niet meer veel gebruikt. Ook zie je dat de beveiliging daar heel extreem is in vergelijking met Nederland. Ze hebben natuurlijk nog geen ervaring met dergelijke klinieken en daarom zijn er veel beveiligingslagen. Wat wel bijzonder is aan de Belgische instellingen is dat daar je niet alleen het gebouw moet beveiligen tegen uitbraak maar ook tegen inbraak. Ontspanningen via helikopter inbreken komen daar wel degelijk voor en binnen tuinen moeten dan ook hier tegen beveiligd worden.

**BEHANDELEN EN WONEN APPART?**

In de gewone psychiatrische instelling kun je de twee functies van wonen en behandelen gemakkelijk scheiden zelfs met een openbare weg er tussen. In het geval van een forensisch psychiatrische kliniek is dit moeilijk maar wel wenselijk. Het is de bedoeling dat een normaal dagritme wordt gecreëerd en daarmee zal ook werk en behandeling buiten het woongebouw plaats vinden. In de zwaar beveiligde afdelingen is dit moeilijker te verwezenlijken dan in de lichtere beveiligde afdelingen aan het einde van het resocialisatie proces. In het eerste geval kan de behandeling dan toch op de afdeling plaats vinden. Later zal de patiënt naar een ander gebouw(deel) moeten gaan en in het geval van begeleid wonen zal de behandeling plaats vinden in een polikliniek op afstand van de woonfunctie. Dit hoort ook bij de verantwoordelijkheden welke steeds meer uitgebreid gaan worden.

**DIEREN EN BEHANDELING.**

Op het moment is er een trend met het betrekken van dieren in de behandeling. Dat wil zeggen de verantwoordelijkheden krijgen om voor dieren te zorgen en daarmee eigenwaarde te verbeteren, maar ook het leren zorgen voor zichzelf en anderen. In Gent passen ze dit principe ook toe en is er ook een plaats voor een kleine boerderij met konijn, geiten en andere kleine tot middelgrote dieren.

**FORENSISCHE ZORG BIJNEDERLAND.**
