



Background Paper for Trenčín Statement on Prisons and Mental Health

Towards best practices in developing prison mental health systems

Paper drafted as background paper for the WHO International
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The paper on prisons and mental health review the situation on mental health and mental health care in prisons in Europe. It aims to provide evidence for actions to improve the current situation on mental health among prisoners and so reduces the risks to the community and to public health in general. It concentrates on the size of the mental health challenge, the key issues involved in that, and it describes what actions can be taken.

The paper has been produced within the overall objectives of the WHO Health in Prisons Project (HIPP), namely to use a whole-prison approach to protect and promote the health of prisoners, their families and prison staff in the wider interest of public health and was used to draft the Trenčín Statement for Prisons and Mental Health, WHO 2008.

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CONTENTS

Foreword.....	1
Acknowledgements	2
Executive Summary	4
Introduction.....	6
Aims and structure of this paper.....	6
Values and Guiding Principles for ensuring good quality mental health care for prisoners.....	7
Inclusiveness.....	7
Equivalence.....	7
Appropriate care and shelter.....	8
Good governance.....	8
Prisons and Mental Health: Seven Big Issues	8
1. Mental health care for prisoners	8
2. Mental health promotion for prisoners.....	9
3. Prisoner basic needs for good mental health.....	9
4. Defined and implemented good practice and policy on care and confidentiality.....	11
5. Compulsion.....	12
6. Disciplinary punishment in prison, human rights, role of physicians	13
7. Special Prisoner Groups.....	14
Improving mental health in prisons: action areas for policy review and priority action	18
1. Actions by the criminal justice system and Ministries of Justice and Health.....	18
2. Actions by senior prison management.....	20
3. Actions by health care and other professional staff.....	22
4. Actions by all staff.....	26
Mental health care and the prisoner pathway.....	28
1. Reception and first night arrangements.....	28
2. During the prisoner’s sentence	29
3. Resettlement and after-care	31
Summary Key points.....	31
Conclusion	32

Foreword

This paper on prisons and mental health review the situation on mental health and mental health care in prisons in Europe. It aims to provide evidence for actions to improve the current situation on mental health among prisoners and so reduces the risks to the community and to public health in general. It concentrates on the size of the mental health challenge, the key issues involved in that, and it describes what actions can be taken.

The paper has been produced within the overall objectives of the WHO Health in Prisons Project (HIPPP), namely to use a whole-prison approach to protect and promote the health of prisoners, their families and prison staff in the wider interest of public health and was used to draft the Trenčín Statement for Prisons and Mental Health.

The paper is a result of research evidence and expert opinion derived from various expert sources and from the conclusions of the various bodies working in Europe on mental health issues, as indicated in the acknowledgements.

The final editorial group included Gerda van't Hoff, Lars Moller, Brenda van den Bergh, Paul Hayton and Alex Gatherer.

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Executive Summary

International research consistently shows that prisons in Europe hold a very high proportion of prisoners with mental disorders and dependence problems. This is due to the fact that a number of prisoners already have mental health problems before entering prison, but also to the fact that prison environments are by their nature normally detrimental to protecting or maintaining the mental health of those admitted and held there. In addition, diversion schemes prior to and at the point of sentencing are often poorly developed, under-resourced and badly managed. Without urgent and comprehensive action, prisons will move closer to becoming 21st Century asylums for the mentally ill, full of those who most require treatment and care but who are held in unsuitable places with limited help and treatment available.

The global facts are clear and startling: Of the nine million prisoners world-wide, at least one million suffer from a significant mental disorder, and a larger number suffers from common mental health problems such as depression and anxiety. There is often co-morbidity (dual diagnosis) with conditions such as personality disorder, alcoholism and drug dependence. Yet the great majority of prisoners will at some point return to the community. It is therefore in the best interest of society that a prisoner's health needs are addressed, that the prisoner is adequately prepared for resettlement, and that the causes of re-offending are addressed.

Prisons perform a service required by society, and must therefore be seen as an integral part of that society. In the same way, prison health services should be viewed as an integrated part of the society's national health system, but this is rarely the case. It requires the combined efforts of society and its health system to tackle this lack of cohesion. Society, through its political, judicial and social systems, has to address urgently issues such as overcrowding, marginalisation and discrimination of prisoners. If these problems are not dealt with, attempts to provide good health care in prisons, and especially good mental health care, will almost certainly fail.

There are key criteria that can transform the current unsatisfactory level of mental health care in prisons, with their high prevalence of mental illness. These steps require a coordinated effort by all those working in prisons, not just the health care staff. It will also require a concerted effort from policy-makers, the wider public, and the media:

Key criteria for success

1. There must be a clear acceptance that penal institutions are seldom, if ever, able to treat and care for seriously and acutely mentally ill prisoners. Such prisoners should be diverted whenever possible to appropriate mental health services before reaching the prison gate. Those already in prison should be transferred to specialist psychiatric care as soon as possible. For those awaiting transfer, those where diversion is not possible or those with minor mental health problems, adequate psychiatric facilities and support should be made available to address their immediate needs.
2. The vulnerability of newly admitted prisoners must be understood and assessed. The need to plan and provide reception policies which will prepare

prisoners for their life inside prisons is essential. Health and other needs assessments should be conducted by trained staff, working with a caring attitude, and this should be laid down by the governor or director of the prison. In this regard, leadership is essential in ensuring that daily prison life is as little harmful as possible to the (mental) health of those inside. An understanding of the particular needs of vulnerable prisoners, such as those with mental illnesses, learning disabilities/difficulties, women, young prisoners, elderly prisoners and those from ethnic minorities, is crucial.

3. A personal sentence and care plan should be prepared for each individual prisoner, based on both initial and later assessments of needs. Similarly, the needs of those prisoners who are awaiting trial or not yet sentenced need to be met in a care plan. In many cases, this can be simple and straightforward but, if there are mental health problems, the plan should include specific means of help and support. Psychopharmacology offers great potential but medications must be adjuncts to comprehensive psychiatric treatment. Special steps will be needed where there is risk of self-harm or suicide. In addition, screening and enhanced programming are essential to identify and care for those under treated prisoners who run foul of the disciplinary system and end up in segregation, where isolation and idleness cause their condition to worsen.
4. Promoting mental health and well-being should be central to a prison's health care policy. This will address such matters as the general prison environment, prison routines and levels of prisoner activity, education and work opportunities, and staff-prisoner relationships.
5. Prisons should be resourced to take the necessary steps briefly summarized above. Two essentials are effective leadership by the governor or director and adequate resources to provide a sufficient level of staff with proper initial and continuing training.
6. Health care is very important for the general rehabilitation of prisoners: mental health treatment for those with mental illness and mental health promotion for all prisoners are crucial parts of health care in prisons. The level of health care should be based upon assessed need and be as equivalent as possible to that available in the community. Contact between inmates and staff, and with the outside world, should be supported whenever possible.

The current position relating to mental illness and prisons is very unsatisfactory. It fails to meet the needs of vulnerable people, it fails to meet the standards of humane care called for by internationally agreed conditions of human rights, and it fails to make its rightful contribution to the emerging mental health plans of the WHO and the EU. However, much can be done, even in countries with the most limited resources, to make substantial and long-lasting improvements and to contribute significantly to the mental health and well-being of all prisoners.

Introduction

In general it can be said that prisons are frequently detrimental for a prisoner's mental health. The prison environment is often not conducive to protecting or maintaining the mental health of those admitted. Nevertheless, with a positive environment and caring ethos much can be done to improve the care and treatment of the mentally ill in prison. However, specialist care for people who are acutely mentally ill or severely disturbed should not usually occur in prison, but in a suitable facility.

Poor mental health is the common experience of prisoners, and severe mental illness is much more frequent among prisoners than the general population. WHO Europe and the International Committee of the Red Cross report that the disproportionately high rate of mental diseases in prisons may be related to several factors, such as the widespread misconception that all people with mental diseases are a danger to the public; the general intolerance of many societies to difficult or disturbing behaviour; the failure to promote treatment, care and rehabilitation, and, above all, the lack of, or poor access to, mental health services in many countries.¹

It should not be forgotten that prisoners are in prison *as* a punishment, not *for* punishment. It is the deprivation of an individual's liberty that is intended to be the punitive, but also protective, factor. Holding people in inappropriate conditions should not be an adjunct to this punishment. A positive prison regime, attitudes of staff, good relations among prisoners, decent accommodation, and respect for a prisoner's basic needs and rights depend on, and can be improved through, policy changes and the creativity of the staff.

This paper does not cover some of the complexities related to mental health. Examples include: differences in diagnoses of mental illness across Europe; the overlap between mental illness and criminal responsibility; differences in culture and legal systems across. The paper concentrates on the size of the mental health challenge, key issues involved, and what action can be taken.

Aims and structure of this paper

Both overcrowding and the high prevalence of mental illness in prisons have created a challenging situation for prisons throughout Europe, as evidence presented to the WHO Health in Prisons Project has revealed on several occasions. This paper serves as a guide on how prisons can improve mental health care. The goal is to provide practical advices and recommendations suitable for adoption in any prison. The recommendations are meant for all staff in prisons but also for prisoners, their family and visitors.

Dealing with mental health problems is not simply a health issue but also an issue of good prison management. This Paper is therefore particularly aimed at all those who can really make a difference, especially Governors and Directors, prison staff in general and policymakers in the Ministries of Health and Justice.

¹ WHO-ICRC: Mental health and prison. Information sheet

The paper follows the following structure:

- Values and Guiding Principles for ensuring good quality mental health care for prisoners
- The prevalence of mental illness within the prison population
- Improving mental health in prisons: action areas for policy review and priority action
- Mental health and the prisoner pathway
- Summary Key Points
- Conclusions

It is important to keep in mind how many people in prisons suffer from mental illness. From the total of 9 million prisoners worldwide, at least 1 million prisoners suffer from severe mental disorder.² Overall the percentage of prisoners who suffer from a mental health problem and/or drug dependence has been estimated to 60-65%.

Values and Guiding Principles for ensuring good quality mental health care for prisoners

Inclusiveness

Prisons should be seen as part of society. They are created and built by society to fulfil a particular role, commonly and narrowly perceived as to punish serious law-breakers and to contribute to public safety by enforcing sentences of society's courts of law. While security is one of the prison's key functions, isolation from or rejection by society is misguided, leading to additional costly problems which are detrimental to the public good. Community reintegration is crucial for successful rehabilitation and reduced recidivism.³ Additionally, there is a great need for staff in prisons to be respected by the community for the service they provide and a need for continuing contact between prisoners and their home communities as part of protecting and improving health and mental health, are of high importance.

Equivalence

The health care available in a prison should be broadly equivalent to that available in the local community. This is a fundamental requirement of human rights and also has public health importance. Many diseases which are a threat to public health can only be tackled by adopting strategies of prevention, control and continuity of care for all at risk, including the often disadvantaged inmates of prisons.⁴

² Chapter 7: mental health, dr.E.Blaauw , prof H.J.C. van Marle, 2007.

³ See Maruna, S. (2001), *Making Good: How Ex-convicts Reform and Rebuild their Lives*, American Psychological Association

⁴ See Wilson, S. (2004), 'The Principle of equivalence and the future of mental health care in prisons', *British Journal of Psychiatry*, 184, 5-7; Birmingham (et al.) (2006), 'Prison Medicine: Ethics and Equivalence', *British Journal of Psychiatry*, 188, 4-6

Appropriate care and shelter

It is a basic human right that people deprived of their liberty by a court of law should be held in premises which are acceptable in basic terms of shelter, sanitation and warmth, and which are suitable for meeting their particular needs.

Good governance

Prisons need good governance, order and proper accountability in order to deliver appropriate care. Health care in prisons is sometimes viewed as contrary to the main aims of the institution such as security and control. The reality of trying to treat, protect and promote mental health for prison populations has to be seen against very challenging limitations in terms of the prison's political and legal mandate, its environment and in its facilities. Success will need dedicated and well-trained staff, but in their turn they will need support and recognition.

Prisons and Mental Health: Seven Big Issues

1. Mental health care for prisoners

Despite the competing responsibilities of prisons, health care should be seen as a top priority. The level of health care in prison including the medicines and opportunities for prevention should be at least equivalent to that in the outside community⁵⁶. However, prisoners will also require additional services. For example, the majority of prisoners will require a general psychiatric assessment, treatment and care. Many will require full pre-trial assessment and some prisoners will require transfer to secure psychiatric facilities.

It is important to distinguish between individual health care in comparison to the range of forensic treatment being offered.

- *Individual health care covers:*
 - care and treatment (primary and secondary) based on a health needs assessment⁷;
 - the medically and professionally identified demands and needs for care of the individual patient, with the aim of healing and supporting the patient, and easing suffering;
 - The duties of the general physician or psychiatrist in administering general medical and psychiatric care include patient confidentiality as paramount. This should meet the same standards in prison as in the community

⁵ Penal Reform International: Making Standards work. An international handbook on good prison practice. The Hague, March 1995.

⁶ WHO Health in Prisons Project (2003). *Declaration. Prison health as part of public health, Moscow, 24 October 2003*. WHO Health in Prisons Project (http://www.hipp-europe.org/news/moscow_declaration_eng04.pdf, accessed 10 January 2005).

⁷ See Shaw, J. (2002), 'Needs Assessment for Mentally Disordered Offenders is Different', *The Journal of Forensic Psychiatry*, Vol 13: 1: 14-17

- *Forensic health care* concerns the care and treatment (primary and secondary) based on a risk assessment and is imposed by the court in the context of criminal law, focused on reducing criminogenic factors with the aim of reducing the risk of re-offending and the risks to society. It is also important to distinguish the duties of a forensic clinician to the court, i.e. providing independent expert opinion on the mental state of a person to a court of law and this can mean that the patient's medical information may be disclosed to the court; as mentioned above, this differs from the duties of a general physician or psychiatrist for whom the normal ethical standards including confidentiality strictly apply.

2. Mental health promotion for prisoners

Detention in a penal institution, no matter how humane the environment, is normally structured around maintaining control and this includes some greater or lesser degree of repression. This is not an approach conducive to promoting mental health.

Maintaining a positive environment in prisons can promote emotional resilience among prisoners and safeguard against mental health deterioration. For this, adherence to the United Nations' Standard Minimum Rules for the Treatment of prisoners is important. The best safeguard is obtained when all prison personnel is carefully selected and adequately trained in mental health promotion, mental health awareness and harm reduction.

The last consensus statement from the WHO Health in Prisons Project on mental health and prisons was issued in 1998 and was concerned only with *Mental Health Promotion in Prison*. This remains an important and rather neglected subject in prison health. Having recognized the afore-mentioned problems and based on the principle of equivalence, the WHO Health in Prisons Project states: "In order to achieve positive mental health, countries must have in place positive mental health legislation, close integration of health, penal and social policy and effective aftercare following imprisonment. Prisoners remain members of the community; therefore prisons should work in partnership with prisoners, their families and appropriate community agencies to deliver programmes and treatment that engage those in prison with the community at an early stage of any period in custody. Cooperation with community agencies is vital to secure continuity of treatment (for example, treatment of psychiatric illness and substance misuse) and to facilitate the reintegration of the prisoner into the community." (1998 consensus statement on *mental health promotion*)

3. Prisoner basic needs for good mental health

The United Nations Standard Minimum Rules (SMR - see Appendix) outlines the basic principles of how prisoners should be treated. But inspection of the SMR leads to the conclusion that these rules do not fully guard against mental health deterioration and that they mean little for mental health promotion.

But what is understood by good mental health in prisons? Research in different types of prison regimes and different countries has revealed quite consistent patterns of needs among prisoners.⁸ In addition, some research has found that prisoners with mental health problems are also in many ways similar to people in the community with mental health problems. However, one key difference is in terms of co-morbidity (dual diagnosis), and complex multifaceted problems, such as personality disorder, drug use and antisocial behaviour. In addition, it has been noted that 'there are additional dimensions of need to consider in mentally diseased offenders, such as the level of security need and so-called political need (where consideration is given, for instance, to the effect of the index offence or the high profile nature of the case).'⁹

The most important basic needs for prisoners are for reliable assistance from persons and settings, and for services that facilitate self-advancement, self-improvement and autonomy. Specifically:

- Personal development and respect from others;
- A sense of being appreciated and cared for, and a desire for relationships that provide emotional sustenance and empathy;
- Activity and distraction and the need for maximizing the opportunity to be occupied and to fill time;
- Safety, environmental stability and predictability; and
- Privacy and autonomy.

Apart from these, a number of factors have a major impact on a prisoner's mental well-being, and are likely to have a positive influence on emotional resilience. Emotional resilience varies from one person to another; and for every individual it can vary at different times, depending on external and internal factors. Practical ways of enhancing emotional resilience include¹⁰:

- Access to sports and fitness facilities;
- Opportunities to benefit from education and obtain qualifications;
- Vocational training and help in obtaining employment after release;
- Opportunities to participate in the arts;
- Balanced diets;
- Access to health care;
- Reduced substance use or dependence;
- Access to drugs and alcohol detoxification and rehabilitation programmes;
- Access to opiate substitution therapy;
- Practice in social skills;
- Assistance in coping with strong or destructive feelings such as guilt and anger;
- Supportive relationships with, and good role models from, staff;
- Advice and education on relationships including parenting;

⁸ Toch, H. (1977). *Living in prison: The ecology of survival*. New York: The free press. Dijkman, A., & Blaauw, E. (1997). Psychologisch disfunctioneren van gedetineerden. *Sancties*, 6, 317-327.

⁹ Shaw, J. (2002), 'Needs Assessment for Mentally Disordered Offenders is Different', *The Journal of Forensic Psychiatry*, Vol 13: 1: 14-17

¹⁰ See the consensus statement on mental health promotion produced by the WHO (Regional Office for Europe) Health in Prisons Project.

- Opportunities to gain insight into their own offending behaviour;
- Opportunities to reflect and take stock of their lives, with support in making changes;
- Opportunities to practise the constructive, enjoyable and fulfilling use of time, for example in involvement in the arts or exercise; and
- Opportunities for socially useful activity, for example through peer support or community involvement.

4. Defined and implemented good practice and policy on care and confidentiality

Legislation on good quality and reliable care

Good-quality and reliable care is efficient, effective and patient-oriented, and is geared to the patient's actual needs. Systematic monitoring, management and improvement of care are essential. The rights of detainees to protection of their physical and mental health are protected by international human rights law, in particular the International Covenant on Civil and Political Rights (ICCPR) and the Convention Against Torture. Universal standards for the level and quality of health care in correctional institutions have been set down in the United Nations Standard Minimum Rules for the Treatment of Prisoners (United Nations 1984) and the UN Principles of Medical Ethics, and within the countries of the Council of Europe are also governed by regional standards, in particular the European Prison Rules (Council of Europe, 1987, 2006). At the national level there can be a Constitution and countries have criminal and penal law as well as national health care legislation that should protect the mental health of prisoners in conformity with the above international law and standards.

Ethics

Doctors who work in prisons face responsibilities both to their patients, and inevitably to the prison authorities in whose institutions they practice. The prison doctor is thus faced with a so-called "dual loyalty", in that they are bound to provide impartial and independent medical care to their patients, but at the same time must operate in an environment in which the main concern is security. As stated already, in general medical or psychiatric care the prison doctor has the same ethical duties as those who practice in the community, and in particular with regard to autonomy, consent and the confidentiality of medical information. This is a therapeutic role, as in the community. On the other hand, there may be specific situations where the doctor may have to make decisions that are more linked to the security of the institution and to the safety of other prisoners and staff, such as when cases of ill-treatment are noted. (for further discussion on the issue of dual loyalties, see under "Disciplinary Punishment" below).

However, the forensic psychiatrist most often has a duty to the court (a non-therapeutic role, at least in part) in that they are tasked with providing an independent psychiatric opinion on the capacity of the individual, and what elements of a psychiatric disorder may have contributed to the commission of a particular crime. In this case, the psychiatrist must explain clearly to the concerned prisoner

where the limits of the usual medical confidentiality lie, and what he will disclose to the courts or other parties. For these reasons of differing levels of confidentiality, the two functions of prison doctor, and forensic psychiatrist should not be mixed.

In addition, it has been noted that 'prisoners are not routinely informed about the limits of confidentiality on entry to prison. Although many (if not most) prisoners may be highly suspicious of any claims to confidentiality offered by doctors, equally there are some who may assume that doctors can offer total privacy.¹¹

5. Compulsion

Involuntary treatment or treatment without consent

When involuntary treatment is required, this can only be provided within psychiatric care when there is a risk to the patient or to others, and when intervention is necessary because of a worsening of the disorder. Treatment without consent must be controlled by strict administrative and legal/judicial procedures. The patient must retain the right to a judicial review and to an appeal of involuntary treatment.

Compulsory care is therefore implemented only if the patient is under a judicial verdict, because of a former offence, or if he is a danger to himself and to others because of his mental state. According to the civil law and the court's sentence he can be taken into custody. When it comes to involuntary treatment, this is only implied when there is an imminent dangerousness of the patient or the risk of suicide. Compulsory care demands a psychiatric inpatient hospital setting because of the full responsibility of the medical professions. It means that the patient is compelled to receive psychiatric treatment, often in the form of medication and separated housing. Regular inspection and monitoring is necessary and is a legal responsibility.

In order to prevent a situation in which treatment without consent could become necessary, it is better to work on the motivation of the patient. A sliding scale is proposed to start a motivation process for treatment participation.

- **Motivation** is the lightest form of persuasion, in which the staff explain the different forms of treatment and try to make the patient enthusiastic or accepting about treatment.
- **Persuasion** itself means that there is some push or some reward involved; a sliding scale of motivating techniques can only be applied by professionals, and the co-operation of the patient should also be the main aim of this intervention.

There are issues around mental capacity, particularly when treating mentally ill prisoners. It has been noted that 'Capacity to consent or refuse treatment is rarely explored in prison despite there being case law which states that competent refusals of treatment must be respected. If a competent adult prisoner refuses medical treatment, this decision should be respected, even if the consequences could result in their death. When seeking consent the doctor must not knowingly or unwittingly

¹¹ Birmingham (et al.) (2006), 'Prison Medicine: Ethics and Equivalence', *British Journal of Psychiatry*, 188, 4-6

compromise the prisoner's autonomy by pressuring them into accepting treatment...[Yet] the question of consent in custodial settings is a complex one, and it is often argued that valid consent is almost always impossible in prison'.¹²

Management of violent patients

Violent patients are an exception, not the rule. The principles of dealing with violent patients should follow universal human rights and the UN principles and rights for people with mental health disabilities, including proportionality and the subsidiarity of measures:

- restraints are a last resort. Approaches of persuasion and negotiation must be the primary aim;
- the use of restraints must be governed by set procedural safeguards, monitoring and oversight; and
- the use of physical or chemical restraints must be carefully monitored and only used on strict medical criteria and certainly not for the ease of prison management.

Instruments of restraint

It has been noted that 'Control and restraint measures used to maintain discipline should be carried out as a last resort, and for the shortest time possible needed to achieve the purpose and only in accordance with prescribed guidelines (European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment 2002), but never be used as a punishment.'¹³ Certain forms of restraint are forbidden under any circumstance, in particular chains and leg irons (UN Minimum Rule No.33). In general it is clear that minimizing the resort to any form of restraint will help in fostering an environment that is respectful of human rights and which and to promoting a good atmosphere between staff and prisoners.

6. Disciplinary punishment in prison, human rights, role of physicians

It is essential that a medical doctor or other qualified medical personnel should be available to attend to the medical needs of prisoner under any form of punishment *but not* for the purpose of supporting the prisoner's capacity to sustain a punishment. The participation of medical personnel in the administration of punishment in prisons raises considerable ethical problems for medical professionals. Discipline and punishment are security and not health issues, and therefore the physician, whose primary duty is to the patient, has no role in deciding upon the administration of such punishments. This is particularly so in relation to the provisions which require a medical officer to examine and certify that a prisoner is fit to receive punishments like solitary confinement before they are administered¹⁴. This provision of the UN

¹² Birmingham (et al.) (2006), 'Prison Medicine: Ethics and Equivalence', *British Journal of Psychiatry*, 188, 4-6

¹³ Birmingham (et al.) (2006), 'Prison Medicine: Ethics and Equivalence', *British Journal of Psychiatry*, 188, 4-6

¹⁴ Penal Reform International: Making standards work, an international handbook on good prison practice. The Hague, March 1995; Principle 3 Medical Ethics Relevant to the Role of Health Personnel,

Standard Minimum Rules was first elaborated in the 1950's, whereas today, such involvement in punishment is deemed unethical and totally inappropriate to the accepted role of a doctor. The prison administration is responsible for establishing and administering an internal review process. Ordinarily, this would be part of the complaint mechanism. The prison governor has a responsibility for administering and monitoring the process of internal review of disciplinary punishments.¹⁵

Solitary confinement

Of all the forms of punishment, solitary confinement, perhaps more than any other, is the best known. Although the SMR do not expressly prohibit solitary confinement, they clearly make it a form of punishment that should be used infrequently and exceptionally. Principle 7 of the United Nations Basic Principles for the Treatment of Prisoners requires that efforts addressed to the abolition of solitary confinement as a punishment or the restriction of its use should be undertaken and encouraged. For this reason, and as mentioned in the previous section the physician should have no role in certifying that a person is mentally or physically fit to withstand such a punishment. This does not, however, preclude the physician from attending to the health needs of someone who is undergoing any form of punishment.

Solitary confinement should not under any circumstance be imposed on any prisoner for an indeterminate period. Prolonged solitary confinement is unlawful. The Human Rights Committee of the United Nations specifically observe that repeated and prolonged solitary confinement of the prisoner may amount to prohibited acts of torture.¹⁶ Yet very often solitary confinement is perceived and used by prison officials as a handy and effective way of dealing with prisoners who are perceived as disruptive, irrespective of what the prisoner has been accused of in any particular case. Because of potential harmful effects that solitary confinement may have on the physical and mental health of the prisoner, the prison administration has a legal duty to discourage and reverse this tendency.¹⁷ Solitary confinement should not be combined with any other form of punishment.

7. Special Prisoner Groups

Imprisonment can be especially harmful for the mental health of prisoners who are particularly vulnerable. If a prison has a repressive and controlling atmosphere, there are few opportunities for social learning or experimenting with newly learned behaviour techniques. A 'landings' culture based on violence, intimidation, and paranoia means that a prisoner showing weakness is often easily discriminated against and excluded from the prisoner community.

Available evidence suggests that assessments and interventions may require more

particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment ; UN Assembly December 1992.

¹⁵ Penal Reform International. Making standards work, an international handbook of good prison practice. The Hague, March 1995.

¹⁶ Human Rights Committee UN: Case Dave Marais v. Madagascar (communication no 49/1979) Case Larrosa v. Uruguay (communication no 88/1981).

¹⁷ 'Penal Reform International: Making standards work, an international handbook on good prison practice. The Hague, March 1995.

individually tailored approaches if the needs of different groups in prison are to be met effectively. In some circumstances, vulnerable inmates should be separated from the rest of the community. It is not possible here to detail the requirements of each of the following special groups. However it is important that all prison systems should develop policies suitable to meet the needs of the following groups.

Personality disorders

There is evidence¹⁸ that the personality disorders which are most prevalent in prison populations are antisocial personality disorders, paranoid personality disorders and borderline personality disorders. In a survey carried out in the United Kingdom the rate for antisocial personality disorder was the highest. The prevalence was 78% for male remand, and 64% for male sentenced and 50% for female prisoners. In most Eastern European countries the ICD-10 is used in the differentiation in the group of personality disorders, which is slightly different from the DSM-IV, which is used in the West.

Co-morbidity (Dual Diagnosis)

Co-morbidity of multiple mental diseases with drugs and alcohol use is common among prisoners. Dependence problems can be secondary to psychiatric problems or vice versa. Co-morbidity patients are sensitive to depression and anxieties and often have a high incidence of using drugs illegally. A substantial number of co-morbidity patients have a history of emotional, physical and sexual abuse. In most treatment settings patients are treated insufficiently, addressing either the dependence or the psychiatric problems but not both.

Offence types – 'low level' and 'special'

Certain detainees have to be defined as 'vulnerable' even though they are not psychiatric patients with a psychiatric illness. Vulnerability can particularly affect special and low status offenders¹⁹. This means that they may be less able than others to resist the pressure and control that other prisoners put on them and often become victims of bullying, abuse or violence by 'superior' prisoners. These prisoners are prone to a low status. They are the ones who committed sexual offences, murdered a child or a parent or who are imprisoned for fire setting. Some vulnerable detainees have also psychiatric diseases (such as mental illness, learning disabilities and personality disorders).

Female Prisoners

Female prison population share many similar characteristics to the male prison population, e.g. drug and or alcohol dependence, and mental health problems. There are also indications of some important differences. There is often a difference in the offences women commit, compared to men. The majority of women prisoners committed non-violent offences, and a third of women in prison committed offences

¹⁸ Psychiatric morbidity among prisoners: summary report, N.Singlketon, H.Meltzer, R.Gatward e.a., survey by the Social Survey Division Of ONS on behalf of the Department of Health,1997.

¹⁹ Mental health care in prison: How to manage our care. Prof.H.J.C van Marle.

of theft or drugs handling.²⁰ The female psychiatric patient in prison is an underexposed research area, and there are few existing trials of treatment effectiveness^{21,22}. The same conclusion can be drawn for the adolescent female population²³. Incarcerated women are far more likely to have had traumatic experiences in early childhood than incarcerated men, like early sexual, mental and physical abuse. The majority of women in prison are also mothers, and the effect of imprisonment can have massive and detrimental implications for dependent children and families.

Women who are sent to prison bring with them a complex set of problems, needs, anxieties, illnesses and distress. Prison compounds these problems, and therefore serves to increase the vulnerability of most of these women (for example see the Chief inspector of Prisons in England, 'Review of Women in Prison'.²⁴

- Eight out of ten women in prison will suffer from diagnosable mental health problems;
- Two thirds will be drug dependent or use alcohol to dangerous excess;
- Half will have experienced domestic violence;
- One third will have suffered from sexual assault; and
- One in ten will have attempted suicide before being imprisoned.

Young People in custody

The needs of young people in prison are often unmet in important areas such as mental health, education, employment, and social relationships²⁵. In addition, there may be a lack of adequate assessment and of accessibility for services for this group. It is also often difficult to engage young people in treatment. The costs are significantly higher in closed facilities than for those receiving mental health care from the criminal justice system in the community²⁶, and young offenders are more likely to become the adult offenders of the future without early intervention and care. The diversion of young, vulnerable people is therefore particularly important and relevant, both morally and economically.

Elderly prisoners

Elderly prisoners face particular problems. The physical health of elderly prisoners is worse than that of elderly men in the community. The conditions in prisons are more geared to younger men than to elderly prisoners who have mobility problems or who

²⁰ Dockley A. Distressing times: what happens to vulnerable women when they come into custody. *Prison Service Journal*; 2007; 169: 22-27.

²¹ Research issues in forensic psychiatry, Current opinion in Psychiatry, (In Press), prof H.J.C.van Marle, P van der Kroft , 2007.

²² Treating incarcerated women: gender matters. Lewis C, *Psychiatr Clin North Am*, 2006; 29(3); 773-89.

²³ Do we know which interventions are effective for disruptive and delinquent girls, A.E Hipwell, R.Loeber; *Clin Child Fam Psychol Rev*, 2006 Dec; 9(3-4):221-55.

²⁴ Owers A., *Review of Women in Prison*, 2007.

²⁵ Mental health needs of young offenders in custody and in the community. Chitsabesan P, Kroll L, Bailey S., et al. *Br J Psychiatry* 2006; 188:534-540.

²⁶ Barrett B, Byford S, Chitsabesan P, Kenning C. Mental health provision for young offenders: service use and cost. *Br J Psychiatry* 2006; 188:541-546.

may be disabled or debilitated. Work, exercise, the library, and so on can all be physically difficult to reach in a prison. Being imprisoned and elderly, and aware of being in the last period of life, can result in severe psychological damage and emotional distress. For these prisoners medical, psychiatric, and pastoral care are of vital importance²⁷.

Learning disabilities

Within the correctional services there is an overrepresentation of offenders with a learning disability. Recent research shows that seven percent of prisoners have an IQ of less than 70 and a further 25 percent have an IQ of less than 80; 23 percent of the juvenile prisoners have an IQ of less than 70. Furthermore 20 percent of the prison population has some form of 'hidden disability', which 'will affect and undermine their performance in both education and work settings'.²⁸

These groups are at risk of continued offending because of unidentified needs and consequent lack of support and services. The barriers faced by these offenders after release, such as to housing and emotional support, are high. They are unlikely to benefit from conventional programmes designed to address offending behaviour, and frequently are targeted by other prisoners when in custody. Also, they present numerous difficulties for the staff that works with them, especially when staff members lack specialist training or are unfamiliar with the challenges of working with this group.

These vulnerable prisoners face:

- A failure of prisons to identify their needs, and a lack of awareness among staff about the impact these needs have;
- A lack of provision of appropriate services and support;
- Difficulties in coping with prison life and for some a lack of understanding of what was happening to them or even of why they are in prison; and
- Difficulties in communicating with staff and other prisoners; they are being viewed as 'different' and as a result being at risk of being bullied, victimized and isolated.

Effective identification of people with learning disabilities and learning difficulties should be made at the earliest point after they have entered the criminal justice system, namely at the police station.

Other groups

Prisoners with disability face a number of particular problems which can seriously affect their mental health and minority ethnic groups including foreign prisoners can suffer from double discrimination and so special attention could better meet their needs.

²⁷ Fiselier, Jan: Oud (worden) in de gevangenis. Contribution to Dirk Herman de Jong volume, May 2007

²⁸ Talbot J. No one knows, offenders with learning difficulties and learning disabilities. Prison Service Journal;171, 28-34.

Improving mental health in prisons: action areas for policy review and priority action

Concerning policy review, policies are agreed methods within established principles for achieving the aims of an organization and give background guidance on which best practices can be designed. They should be based on evidence of what works in the situation of that country, and should be adopted by senior management for each prison so that they are understood and acceptable to those who work on the ground. They should draw attention to the different needs of different groups and, when necessary, be developed into treatment and care protocols.

Concerning priority action, it is clear from the ‘Seven Big Issues’ outlined above that that the challenges of mental health in prisons will only be adequately addressed if those involved work together in a co-ordinated plan of action. The following headings and their text may be useful as a checklist for policy makers, senior management, health care and other staff, and for all those sharing the aim of making an improvement to the current position.

1. Actions by the criminal justice system and Ministries of Justice and Health

Diversion

The starting point in protecting those with serious and acute mental health problems should be diversion at the earliest point from the Criminal Justice system, long before entering the prison estate, for example at the point of arrest by police or at first attendance at the Courts. Before commencing or continuing with the Court process, evaluation and assessment leading to diversion should be the aim, depending on the seriousness of the crime and the degree of dangerousness. It is not just about alternatives to imprisonment, but about identifying individuals with severe mental health problems and diverting them even from the courts. People with mental health problems should not be sent to prisons as a substitute for appropriate mental health care in the community.

Prison environment

There are two important aspects to consider in the prison environment. First the physical environment: buildings and facilities should be decent, meet minimum standards, and capable of meeting the needs of all prisoners and the staff. Secondly, the prison atmosphere should be characterized by caring attitudes of staff, by an organization which enables staff to know prisoners and report about their needs, and by procedures ensuring that prisoners’ requests and prison officers’ reports (oral and written ones) are taken seriously and dealt with properly. Only in such a situation is it possible to detect prisoners in need of care, and for psychiatric patients to be allocated to treatment and help. A programme in the UK funded by the King’s Fund, *Enhancing the Healing Environment*, will develop new ideas and practice on positive environments, piloting in five London prisons. This project will be evaluated by the Sainsbury Centre for Mental Health.²⁹

²⁹ See <http://www.enhancingthehealingenvironment.org.uk> and <http://www.scmh.org.uk>

Overcrowding

Overcrowding can be considered with two meanings, the spatial density and the social density. ***Spatial density*** is defined as the amount of space (number of square feet) available per person in a particular housing unit. ***Social density*** is defined as the number of individuals sharing a housing unit. The last one is considered the factor which contributes most to the adverse effects of overcrowding. In the prison setting where crowded conditions are chronic, people who are already prone to anti-social behaviour are gathered together, with an absence of personal control and where idleness and boredom can be prevalent. Overcrowding can be described as an interactive variable, which can sometimes cause, result from or exacerbate the impact of other conditions.

Complaints

A system like a prison needs an independent board, committee or group to which inmates can complain about the way they are treated. This board should not be considered as interfering but as a means to improve the prison system. For this purpose it is also useful to establish a participatory system in which prisoners are involved in generating ideas for running their unit. This has the added advantage of enhancing routine communication between staff and prisoners.

It has been noted that in some countries, “human rights violations in such institutions [as prisons] are not uncommon and that there is no mechanism for impartial handling of complaints.”³⁰ A good complaints system is one way of supporting the constant vigilance necessary to ensure a proper human rights approach to prison care and management.

Corruption

Excessive force and corruption can only meet one reaction: strictness and intolerance. Some have noted that ‘no other branch of psychiatry is as open to corruption as forensic psychiatry and it is public knowledge that some powerful criminals buy their way into “non-responsibility”, and hence stay several years in a mental institution rather than being sentenced to long prison sentences’.³¹

In addition, some have suggested that forensic psychiatry in some countries in Europe was closely directed and involved in the systematic use of psychiatry for political purposes by declaring political and religious dissidents mentally ill.³²

Strict attention to human rights by professional managers should be an essential feature of prisons. There is considerable value in a prison visiting service from the local community as well as a national and even international independent monitoring service.

³⁰ Van Voren (2006), ‘Reforming forensic psychiatry and prison mental health in the former Soviet Union’, *Psychiatric Bulletin*, 30, 124-126

³¹ Van Voren (2006), ‘Reforming forensic psychiatry and prison mental health in the former Soviet Union’, *Psychiatric Bulletin*, 30, 124-126

³² Van Voren (2006), ‘Reforming forensic psychiatry and prison mental health in the former Soviet Union’, *Psychiatric Bulletin*, 30, 124-126

2. Actions by senior prison management

The management of any institution determines how staff handles their clients, whether pupils, patients or detainees. Good management often works as a function of good example.

One can only prevent negative tendencies and provide adequate care when the prison management is capable of facilitating necessary changes. A different attitude from staff towards patients has to be supported by a different relationship between management and staff.

In prison the Governor's leadership makes all the difference. A governor, who has positive attitudes, communicates in an open and inspiring way with his staff and inmates, and shows real leadership, will create an atmosphere in which mental health can develop.

Prisons are difficult and demanding working environments for all levels of staff. The presence of prisoners with unrecognized and untreated mental diseases can further complicate and negatively affect the prison environment and place even greater demands. A prison that is responsive to, and promotes the mental health of prisoners, is more likely to be a workplace that promotes the overall morale and mental health of prison staff. Therefore, mental health promotion for all in the prison should be one of the central objectives of good prison management.³³

The process of leading a patient through the different phases of his detention needs a process-oriented management style. In the relationship between prisoners and staff a process of cooperation and negotiation has to develop. The same goes for the relationship between staff and management. To do their job properly, the working staff needs competences and needs to be facilitated by clear agreements with the management about methods, conditions and results.

At the level of prison governor/director, very different dynamics can occur. Bureaucracies and leadership in prisons differ between countries and regions. In many of the countries there is hardly any middle management or tactical level which takes care of a coordinated translation of the directives from the top into an adequate approach on the ground. Officials may be expected to be disciplined and docile towards their boss in the Ministry and strong and authoritarian towards their staff. A director who chooses to change his organization and implements a more process- and patient- oriented approach could put him/her in a treacherous situation. When they change their own attitude they could even experience a loss of respect from the Ministry, their staff and colleagues. As a consequence of this, the workers on the floor often experience a lack of support from their management and are confronted with ideas, rules and regulations they cannot change.

In order to reform prisons and improve the circumstances for staff and prisoners it is essential to support the management of the facility. It is important to relieve the governors of unnecessary bureaucratic pressure and to support them in their difficult task. Higher authority should treat them with clear directions and be prepared to

³³ WHO-ICRC: Mental Health and Prisons. Information sheet.

listen. Structurally organized meetings with colleagues and learning from each others practices can be very supportive³⁴.

Prisoners' contacts with the outside world

Imprisonment often means that the interaction and communication of prisoners with the outside world is seriously reduced. However, contact between inmates and the outside world must be supported as much as possible in order to facilitate good resettlement and rehabilitation. This can be achieved in different ways, such as by good visit and telephone facilities, a library and newspapers. Social workers, doctors and some selected NGO's should also be allowed inside the prison to visit prisoners.

Contact with religious representatives

For many prisoners having contact with a representative of their religion or ethical society is of utmost importance. Religion and belief can mean belonging to a supportive community and give people an identity. Also it can create perspective, give hope and help develop motivation and goals. Prison pastoral care represents the whole of the outside church community and it provides prisoners with a connection to the outside world. So, it has to be seen as an important and meaningful concept³⁵.

Management of change

When changes have to be made, a model has to be used in which the different stages are described. Changes should be made gradually. Such a change process could be based on the model that has been used by the Global Initiative on Psychiatry that starts with³⁶:

- Improving physical circumstances of prisoners;
- Improving care offered to prisoners with mental diseases;
- Improving mental health needs assessment and care delivery; and
- Composing a model for modern psychiatric care in a penitentiary institution, and an implementation plan for duplication of this model in other prisons.

Changing an institution requires some basic assumptions:

- Take a gradual approach: step by step;
- Avoid too ambitious a time span;
- Give a recognized reason for the changes that are made;
- A key factor is that staff has to preserve a critical attitude, they have to notify the management when changes are not practicable and cannot be performed. In turn the board has to notify the staff why certain issues raised by the staff are not being pursued at that time;
- Workload must be taken into account;
- The board of directors have to assist the other directors with guidance; and
- There has to be a dialogue in order to achieve concrete realization of the planned

³⁴ Douw, Frans: Mental health and prison management. Presentation WHO-HIPP, Sinaia, October 2006..

³⁵ Eerbeek, drs. J.D.W.: The connection between pastoral care and aftercare. Conference International Chaplains Association Europe, Tallinn, June 2004.

³⁶ Improvement of care for mentally disturbed prisoners; Kresti prison -St Petersburg, Russian federation, February , Geneva Initiative on Psychiatry, feb 2003; 2.4 Project results.

transformation.

However, the Global Initiative has found that ‘resistance to reform is deeply rooted and often seems insurmountable. This resistance is often caused by a combination of fear of change (‘What will a changed environment do to my career?’) and distrust of the need for change (‘Our system is quite OK and certainly not worse, we know best and who are you to criticize us,’ etc.). This means that a very careful, sensitive approach is needed to build a sense of partnership’.³⁷

3. Actions by health care and other professional staff

Training

One of the most important issues in this regards concerns the training and coaching of staff. Staff members have to attend to inmates in a closed situation and have to try to serve goals which often seem to be opposed: not only to guard but also to care for prisoners in ways that will reduce the damage caused by detention. Nevertheless, staff should learn:

- How to deal with their prison’s particular population, which is frequently addicted and/or mentally ill;
- How to prevent violence and to use compulsion only when absolutely necessary;
- How to write observation-reports; and
- How to make an individual sentence and care plan for each inmate, tailored to personal characteristics.

Staff should get used to taking responsibility, to reporting honestly and to answering questions openly. It is necessary to limit the number of rules and regulations for staff as much as possible and, instead, to put responsibilities as close to the working floor as possible. Physical conditions for staff have to be on an acceptable level. Staff should have space in which to write their reports, to hold a conference with each other and with specialist visitors, and to take a break.

Continuity of care

Prisons, as part of society, deserve a prison health service which is well integrated with the national health care system. Prisoners who arrive in prison but who cannot be diverted (perhaps due to the nature of their crime) and who are already under mental health care should be able to continue their treatment.

Those prisoners who develop mental health problems while in prison should be referred to the community mental health services before release. Strong links between the prison mental health service and the community mental health service are therefore very necessary. Thus, prior to release, the community mental health services should enter the prison, discuss the case with the patient and the prison

³⁷ Van Voren (2006), ‘Reforming forensic psychiatry and prison mental health in the former Soviet Union’, *Psychiatric Bulletin*, 30, 124-126

health staff and agree with the consent of the patient on the management of care after release.

In the Netherlands guidelines have been developed to provide what is called 'intervention care'. Intervention care is individual health care offered to people with serious psychiatric problems which exist over a long period of time. In these cases, waiting until the patient seeks help is not an option. In this kind of care the close cooperation of different health care organizations is very important. The meetings at which personal information is discussed should be undertaken in a way which ensures that the personal data is carefully used. Guidelines include the following directives:

- Patient rights should always be respected. A temporary restriction on any patient rights must remain an exception;
- Clients should receive general information about their rights and in which circumstances exceptions can or must be made;
- A limitation of patient rights can only occur if there is an obvious significance that can justify the restriction of the patient rights;
- Only if there is no option of a less drastic approach, personal information can be given to other professionals without the patients consent;
- The limitations on the patient's rights should be evaluated frequently. The evaluations provide an opportunity to see if there are still enough reasons to justify the restriction/limitation;
- If the personal information is necessary to provide care, only the relevant information should be given;
- The organization that provides patient information without consent must make a note of that in the patients file;
- Reports of meetings between professionals should be encoded as much as possible;
- All the professionals involved should operate under clinical confidentiality towards others outside the circle of the organizations involved; and
- The organizations involved should keep written agreements to improve the care.

Self harm/suicide

Any prisoner may experience thoughts about committing self-harm or suicide. Identifying the symptoms that may accompany these thoughts by staff is crucial. The symptoms include weight loss or gain and sleep disturbances. Suicide mostly happens in the first days after imprisonment, the so-called reception period, or after the verdict has become definite.

Prisoners are placed in a situation which leads directly to anxieties, worries and distress. These feelings can often include suicidal thoughts, despair and guilt feelings, failures in adaptation, worries about being left behind, about finances, about families and insecurity about legal position.

The suicide rate derived from the different countries on the list of deaths in judicial institutions, shows that the average suicide rate is approximately 7 per 10.000 detainees (Council of Europe 2002).

There are a number of best practises that can be taken from the recommendations of the international association for suicide prevention task force on suicide in prisons,

based on the development and documentation of a comprehensive suicide prevention plan. The following should be implemented³⁸:

- A training programme (including refreshers) for correctional staff and care givers to help them recognize suicidal prisoners and appropriately respond to prisoners in suicidal crises.
- Close attention to the general prison environment (levels of activity, safety, culture and staff-prisoner relationships). In particular, the quality of the social climate of prisons is critical in minimizing suicidal behaviours. While prisons can never be stress-free environments, prison administrators must enact effective strategies for minimizing bullying and other violence in their institutions, and for maximizing supportive relationships among prisoners and staff. The quality of staff-prisoner relationships is critical in reducing prisoners' stress levels and maximizing the likelihood that prisoners will trust staff sufficiently to disclose to them when their coping resources are becoming overwhelmed, causing feelings of hopelessness, and suicidal ideation.
- Procedures to systematically screen prisoners upon their arrival at the facility and throughout their stay in order to identify those who may be at high risk.
- A mechanism to maintain communication between staff members regarding high-risk prisoners.
- Written procedures which outline minimum requirements for housing high-risk prisoners; provision of social support; routine visual checks and constant observation for acutely suicidal prisoners; and appropriate use of restraints as a last resort for controlling self-injurious prisoners.
- A procedure where mentally ill prisoners who need psychopharmacological medication, receive them following strict watch-take procedures.
- A development of sufficient internal resources or links to external community-based mental health services to ensure access to mental health personnel when required for further evaluation and treatment.
- A strategy for debriefing when a suicide occurs towards identifying ways of improving suicide detection, monitoring and management in correctional settings.

Although the ability to predict accurately if and when a prisoner will commit suicide is not a science, prison officials and their correctional, health care and mental health personnel are in the best position to identify, assess, and treat potentially suicidal behaviour. And although not all prisoner suicides are preventable, many are, and a systemic reduction of these deaths can occur if comprehensive suicide prevention programming is implemented in correctional facilities throughout the world.

³⁸ Norbert Konrad, Marc S. Daigle, Anasseril E. Daniel, Greg E. Dear et al. (2007) *Preventing Suicide in Prisons Part I Recommendations from the International Association for Suicide Prevention Task Force on Suicide in Prisons*

High alcohol use, drug dependence and co-morbidity (Dual Diagnosis)

There is a growing body of evidence that a high proportion of violent crimes is committed under the influence of alcohol and/or drugs.³⁹⁴⁰⁴¹⁴² Substance related diseases are named as the number one co-morbid problem in psychiatric services and prisons.⁴³⁴⁴⁴⁵⁴⁶⁴⁷ Despite the recognition of the relationship between substance use and crime, little effort has been made to combine substance use treatment with psychiatric treatment. There seems to be uncertainty about the best model of care for co-morbid substance use and links with specialist substance use services are poorly developed.⁴⁸ Since substance use can play a large role in re-offending, more emphasis should be placed on relapse prevention during admission as well as after discharge. Staff members should be willing to educate themselves about substance related problems.⁴⁹ At present, dependence services and psychiatric services are two separate fields of expertise. Both specialisms can benefit from an exchange of knowledge.

Drugs treatment

The frequency of serious problems that arise during the period of withdrawal from substances on admission to prison, including self-harm and violence, strongly support the need for a planned approach to substitution maintenance therapy or other kind of drugs treatment. This should be included as part of a clinical programme for the treatment and care of drug-dependent prisoners. Substitution treatment reduces heroin use and is more effective in retaining drug users in treatment than detoxification. Substitution treatment has many other benefits, including stabilizing drug users, improving the general health status of drug users, reducing the risk of fatal overdoses after release, interrupting chaotic lifestyles and thereby improving the levels of social functioning and employment⁵⁰.

³⁹ Koh KG, Gwee KP, Chan YH. Psychiatric aspects of homicide in Singapore: a five-year review (1997 - 2001). *Singapore Med J* 2006; 47:297-304.

⁴⁰ Mulvey EP, Odgers C, Skeem J et al. Substance abuse and community violence: a test of the relation at the daily level. *J Consult Clin Psychol* 2006; 74:743-54.

⁴¹ Jayaraman A, Frazer J. Arson: a growing inferno. *Med Sci Law* 2006; 46:295-300.

⁴² Bourget D, Gagne P. Fratricide: a forensic psychiatric perspective. *J Am Acad Psychiatry Law* 2006; 34: 529-533.

⁴³ Durand MA, Lelliott P, Coyle N. Availability of treatment for substance misuse in medium secure psychiatric care in England: a national survey. *J For Psychiatr Psychol* 2006; 17:611-625

⁴⁴ Kjelsberg E, Hartvig P, Bowitz H, et al. Mental health consultations in a prison population: a descriptive study. *BMC Psychiatr* 2006; 7:27-35.

⁴⁵ Huchzermeier C, Bruss E, Godt N, Aldenhoff J. Kiel psychotherapy project for violent offenders. Towards empirically based forensic psychotherapy - disturbance profiles and risk of recidivism among incarcerated offenders in a German prison. *J Clin Forensic Med* 2006; 13:72-79.

⁴⁶ Fakhoury WK, Priebe S, PLAO Study Group. An unholy alliance: substance abuse and social exclusion among assertive outreach patients. *Acta Psychiatr Scand* 2006; 114:124-131.

⁴⁷ Gendel MH. Substance misuse and substance-related disorders in forensic psychiatry. *Psychiatr Clin North Am* 2006; 29:649-673.

⁴⁸ Durand MA, Lelliott P, Coyle N. Availability of treatment for substance misuse in medium secure psychiatric care in England: a national survey. *J For Psychiatr Psychol* 2006; 17:611-625

⁴⁹ Gendel MH. Substance misuse and substance-related disorders in forensic psychiatry. *Psychiatr Clin North Am* 2006; 29:649-673.

⁵⁰ WHO-HIPP Status Paper on Prisons, Drugs and Harm Reduction. May 2005.

There are strong reasons for prisons services to consider introducing substitution therapy for opiate users. These include:

- Problems in managing regimes and difficulties for staff that arise during withdrawal, including drug smuggling and acts of violence towards staff and other prisoners;
- The growing problem of suicide and self-harm during the period of withdrawal among imprisoned problematic drug users and drug-dependent people;
- The aim for equivalent health care provision between prisons and communities;
- The risk of a fatal overdose in the first few days following release from prison, especially for short-term prisoners; and
- If 'cure' seems to be impossible, it can be more pragmatic and useful to aim for 'care'. It is important to apply everything possible to limit the damage for the drug dependent prisoner, his family and society at large.

Programmes delivering substitution therapy require that the user accepts some control, supervision and involvement in psychosocial conditions. The aim is to increase the quality of life and improve social functioning and living conditions. In order to be successful, programmes on substitution therapy should be embedded in programmes that address all spheres of life, such as housing, employment, education, family life, medical care and social networks.

4. Actions by all staff

One of the guiding principles of the WHO Health in Prisons Project is a 'whole prison approach', e.g. all kinds of staff may be important in the actions already listed above such as assessing risk of suicide. The following are areas where a wide variety of staff involvement is important.

Marginalisation, stigma, bullying and discrimination

Prisoners have the right not to be bullied, discriminated against, intimidated or abused while in prison. **Bullying** can be either physical or mental. The effects of bullying can be long lasting and serious and can lead to anxiety, depression and feelings of hopelessness, guilt, shame and frustration. All prisons should have an anti-bullying strategy.

Special attention should be paid to the protection of mental health patients and the prevention of **discrimination**. Within most societies people with mental diseases face marginalisation, stigma and discrimination in the social, economic and health spheres, due to widespread misconceptions related to mental diseases. This stigma and discrimination usually continue in prisons, with the person often facing further marginalisation and isolation. Separation of prisoners with mental health problems is often used as an approach to the potential vulnerability of mental health patients within the prison population and the need for protection. By promoting a greater understanding of the problems faced by those with mental diseases, stigma and discrimination can be reduced and the use of isolation can become less frequent.⁵¹

⁵¹ WHO-ICRC: Mental health and prisons. Information sheet; Penal Reform International: Making standards work, an international handbook on good prison practice. The Hague, March 1995.

Multidisciplinary co-ordination of staff interventions

From the experiences in the Dutch prison services a Psycho Medical Consultation has been proposed: A multidisciplinary advisory board with a psychologist as the chair, and the prison doctor, the consulting psychiatrist, the nurses and the social worker as members. Each of them is entitled to bring cases to a weekly consultation. The purpose of the consultation itself is to assign these cases to a certain more or less intense level of care. As in community health every one keeps their own specialization in the allocation depending on the specific needs of each case. The more psychiatric problems are involved, the more the psychiatrist can advise for psychiatric care or treatment. The more somatic or psychosomatic complaints, the more the prison doctor (and often part-time general practitioner outside the prison) indicates and arranges basic health care, eventually with referral towards other general clinical specialists. The other members of the Psycho Medical Consultation team bring in their special indications for health care and psychiatric care. The responsibility for the quality of care rests with the general director of the prison, who is also responsible for the quality of the consultation.

Improving mental health for vulnerable groups

The mentally unwell, women, young, elderly and those with learning disabilities have greater or more specific health needs than the prison population taken as a whole. The numbers of these groups are rising rapidly within the prison population, so it is important to recognize and respond effectively to their health needs. Yet, there are still considerable gaps in knowledge about the health needs of the vulnerable groups. Gaps identified include the general physical health needs of women, young offenders and elderly prisoners. Research that evaluates healthcare interventions is needed, and research seeking the views of prisoners from minority groups would also prove useful in identifying gaps in provision.

All prisons and prison systems should be able to accept the importance of information and understanding about the harmful consequences of inappropriate drug use as a part of an approach based on public health and human rights, even if this means acknowledging the limitations in depending on an official enforcement of total abstinence. The advantages of substitution therapy can be great, as mentioned earlier.

Staff training

Many prison systems lack the necessary numbers of appropriately trained staff, and screening procedures could be improved in most countries. Problems could be decreased in most countries through extra staff, more and better training programmes, improved referral possibilities, and the spreading of good practice and learning from other prison systems.

Next to, and in interaction with the more or less vulnerability of the detainees, the supporting power and the resilience of the staff are vital in its impact on prison atmosphere. Staff should be able to support group cohesion, facilitate education and recreation, and pay respect for the 'man-behind-the-offender'.⁵² When there are

⁵² Mental health care in prison: How to manage our care. Prof.H.J.C van Marle.

‘circles of stress’⁵³ in the relationship between staff and prisoners, the well-being of both parties is likely to get worse. The circle of stress includes various causes of stress, such as reduced staffing levels, prison culture, prison management, and fear of safety. The different causes are frequently described as interacting with each other and increasing overall stress levels. Apparently low morale and staff shortages increases stress levels, which in turn increases staff sickness rates, reducing staffing levels, further lowering the morale of remaining staff and leading to more stress and staff sickness.

Learning from each other, exchange of best practices

Structurally organized meetings with colleagues and learning from each other’s practices can be very useful. Exchanging best practices and bench marking between countries must be actively promoted and supported by national and international bodies. Development of wide ranging management instruments, the translation and supply of guides, books, brochures, teaching methods and educational materials are of utmost importance, as is the monitoring and following of best practices, examining the result and exploring new possibilities for improvement.

Mental health care and the prisoner pathway

Another way of ensuring a whole prison approach and seamless healthcare is to view the prisoner pathway in terms of mental health. This section briefly examines key points in this respect, although inevitably these divisions are not always hard and fast.

1. Reception and first night arrangements

When diversion from prison has not occurred, or was thought inappropriate, there is evidence that formalized first night procedures should be a core part of a prison’s safer custody agenda. These procedures require adequate buildings and space as well as fundamental shift in the culture, ethos and approach of the prison, including specially selected and trained staff and a truly ‘caring approach’.

This translates into recommendations regarding the reception area, the first night arrangements and the induction period:

- Reception areas should be bright, clean and welcoming;
- Sufficient private areas should be created, where they are able to speak in confidence about their needs and vulnerabilities;
- First night procedures should be implemented in all prisons;
- Stays at the first night centre should be for at least 48 hours;
- The aim should be to accept all prisoners; those suffering from drugs or alcohol withdrawal should be maintained until detoxification is commenced;
- During the first night each prisoners should receive a hot meal, a change of clothes, and be able to have a shower;
- First night centres should be comfortably decorated to help create a calming environment;

⁵³ Influence of environmental factors on mental health within prisons: focus group study, Nurse J, Woodcock P, Ormsby J. *BMJ* 2003;327;480.

- Dedicated officers should staff first night centres, they should have Insiders working on the centre; and
- First night arrangements should be part of a longer period of induction; prisons should aim for this to cover a fortnight.

A human rights approach to prison management should protect and promote mental health. Protection and promotion of the human rights of persons with mental health problems should be included in all policies and programmes.

2. During the prisoner's sentence

Health needs analysis

The Committee of Ministers of the Council of Europe stated that respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment and health care equivalent to those provided to the community in general.⁵⁴

It is recommended that each prison, where possible, undertakes a health-needs analysis for the prison population, and that every prisoner receives a health screening on entry to prison. Furthermore many prisons should provide chronic disease management services, immunization programmes for communicable diseases, and health education and promotion for those at risk.

Health Promotion

Developing a whole-prison or settings approach to promoting health, including mental health, is important for improving the chances of intervention succeeding. The vision for a health-promoting prison is based on a balanced approach recognizing that prisons should be safe, secure, reforming and grounded on the concept of decency and respect for human rights.

Human rights and decency are important foundations for promoting mental health, because they underpin all aspects of prison life. Attaining the following measures creates a basis on which to promote mental health:

- Maintaining facilities that are clean and properly equipped;
- Providing prompt attention to prisoners' proper concerns;
- Protecting prisoners from harm;
- Providing prisoners with a regime that makes imprisonment bearable; and
- Fair and consistent treatment by staff.

Improved care offered to prisoners with mental health problems

The prisoners with mental health problems should be treated according to the state of the art of general psychiatry, which may lead to transfer to a special unit. Obviously, prisoners and staff in such units should have easy access to a psychologist

⁵⁴ Recommendation of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prisons (Council of Europe Recommendation No R(98)7).

and psychiatrist. When it is not always possible to prevent a further deterioration of the mental state of prisoners, the transfer to a general psychiatric hospital may be required as medical ethics demands the prevention of irreparable damage to the health status of detainees due to imprisonment.

Specialized psychiatric treatment in prisons may be necessary not only for the prevention of mental health damage, but also for the treatment of psychiatric symptoms. Such forensic psychiatric treatment focuses on the risk factors that are related with recidivism, which is important for both the patient and the wider society. Forensic psychiatric treatment has for many years been provided in special forensic hospitals, but is also becoming more common in prisons where treatment programs are used to utilize the length of stay in prison (such as the Dangerous and Severe Personality Disorder (DSPD) units in England and Wales). The patient though cannot be forced to undergo this treatment. This is another reason that the treatment programme should be responsive towards the needs of the detainee in a way that it creates motivation.

To create equivalence of care it is advisable to establish out-patient clinics. In such clinics not only patients from special hospitals can continue treatment, but also prisoners can after their release. Visits to these out-patient clinics can start initially from the prison on an hourly basis, and then be prolonged to a full stay in the community. In some countries this is called “transmuralization” or “out of prison programmes”. In these cases the patient stays under the control of the prison service with or without the help of the probation services.

Comprehensive health care

Because of the complexity of the psychiatric and psychological problems of prisoners, it is insufficient to confine prison care to medication alone. Multimodal ways of treatment like individual psychotherapy, group psychotherapy, including multi-systems therapy, should be available. A multidisciplinary diagnosis and treatment is necessary to provide quality care to patients who have frequently double or triple diagnoses. A multidisciplinary co-ordination of staff intervention is also recommended.

Pastoral care and voluntary societies

Pastoral care and voluntary societies can support the prisoner in his efforts to restore the ties with family, friends and relatives, to take responsibilities and to get new perspectives in life. Thus it contributes to the acceptance of the punishment and the reintegration process after the release. In many countries voluntary workers from religious communities and non-governmental societies visit prisoners on a regular basis, thus trying to get across that the person, although imprisoned, still is part of society at large. By visiting prisoners, collecting documentation and through contact with prisoners, ex-prisoners and prison staff, they can gain and present valuable information about prison climate, conditions and practice.

3. Resettlement and after-care

It is in the interest of society as a whole that prisoners are reasonably prepared to be able to re-integrate into society. It is now better understood that prisoners will respond to aspects of their prison experience such as decent living conditions and a humane prison climate. As the vast majority of prisoners will sooner or later return to society, it is essential that they can be assisted through treatment and care to improve in health and mental health terms for their own benefit, but also to reduce the risks to public health when they are eventually discharged.

When released prisoners ask for help on their own initiative, the prison system and the probation service should direct them to other organizations outside the criminal justice system, like social or health care services. These services can provide different kinds of help, such as assistance in housing, employment, and debt relief. For the resettlement of released prisoners, aftercare projects should be set up. Volunteers should play an important role in this⁵⁵.

For prisoners with serious mental health problems, transfer to forensic mental health care may be necessary after detention. This referral can be undertaken on a voluntary basis but sometimes legal actions may be appropriate. Civil legislation can sometimes be applied.

Prisoners with a history of drug dependency encounter problems on re-entry to the community. Interventions are needed to engage former prisoners in community treatment after imprisonment to address their treatment needs, improve their retention in treatment, and reduce the likelihood of recidivism. In order to reduce the risk of overdose deaths after release it is important that prisoners receive training on risk factors for overdose deaths especially:

- signs and symptoms of overdose;
- the risk of combining drugs (especially cocaine and heroin (speedball or snowball) but also with alcohol and benzodiazepines; and
- the risk of using “old” doses after a longer break.

All previous drug users should at release be followed by community drug services or local drug agencies to repeat training in risks of drug use, to give psychological support and to give opiate substitution therapy if necessary.

Summary Key points

- Current prison systems are often detrimental to a prisoner’s health, especially their mental health.
- Health care is very important for the general rehabilitation of prisoners, and mental health treatment of those with mental illness and mental health promotion for all prisoners are crucial parts of health care in prison.
- The level of health care in prison should be based upon assessed need and be as

⁵⁵ The Dutch justice system, organization and operation, P.J.P.Tak, second revised edition, WODC, 2003.

- equivalent as possible to that available in the community.
- In prison the Governor's leadership is vital for protecting and promoting health and well-being, especially mental health.
 - There is evidence that the most common form of mental health problem in prisons is personality disorder; a substantial part of the remaining prison population suffers from psychosis-related problems; co-morbidity is very common with multiple mental health problems with drug and/or alcohol dependence.
 - Women, young prisoners, elderly prisoners, those from ethnic minority groups and those with substance misuse problems and co-morbidity problems often have even more complicated health needs than the prison population in general. The greater vulnerability of these groups also needs to be acknowledged to ensure more effective care.
 - A purposeful and humane prison environment, which is promoted and protected by prison authorities, the government and politicians, is vital for the mental health of prisoners and staff alike.
 - Overcrowding, bullying, marginalisation, stigma and discrimination are problems in prisons that must be specifically addressed and actively combated.
 - Every prison must have a comprehensive suicide prevention plan which includes a training programme for correctional staff and care givers.
 - Contact between inmates and staff, and with the outside world, must be supported as much as possible.
 - Detoxification should be included as part of a clinical programme for the treatment and care of drug-dependent prisoners.
 - Substitution treatment reduces heroin use and is more effective in retaining drug users in treatment than detoxification on its own.
 - Substitution treatment has many other benefits, including stabilizing drug users, interrupting chaotic lifestyles, and improving the levels of social functioning and employment. It should be implemented on a widely base.

Conclusion

There are two main conclusions. Firstly, the current challenging situation concerning the mental health of prisoners across Europe is far from satisfactory. Secondly, evidence suggests much more could be done to improve mental health and mental health care in prisons even where resources are limited. What would make a valuable impact would be the political and professional acceptance that something must be done now. A higher priority within the health agendas of every country for a review of what is feasible would show areas where progress can be made. If radical change cannot be funded, then at least some additional training of staff and support for them would be an important step forward.

Appendix: Standard Minimum Rules

The United Nations have formulated Standard Minimum Rules (SMR) for the treatment of prisoners, which provide further safeguards against the deterioration of mental health. The basic principle of the rules is that there shall be no discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. At the same time it is necessary to respect the religious beliefs and moral precepts of the group to which a prisoner belongs (SMR 6). Obviously, adherence to this rule is essential for mental health promotion. With general health in mind, it is also essential to adhere to the following rules: prisoners shall be kept in rooms that are sufficiently large and sufficiently lighted, heated and ventilated (SMR 10); adequate bathing and shower installations must be provided, so that every prisoner may be enabled and required to have a bath or shower [...] at least once a week (SMR 13); prisoners must be provided with water and with such toilet articles as are necessary for health and cleanliness (SMR 15); In order that prisoners may maintain a good appearance compatible with their self-respect. Facilities shall be provided for the proper care of the hair and beard, and men shall be enabled to shave regularly (SMR 16); prisoners shall be provided with a separate bed, and with separate and sufficient bedding which shall be clean when issued, kept in good order and changed often enough to ensure its cleanliness (SMR 19); every prisoner who is not allowed to wear his own clothing must be provided with an outfit of clothing suitable for the climate and adequate to keep him in good health. Such clothing shall in no manner be degrading or humiliating (SMR 17); every prisoner shall be provided at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served, and drinking water shall be available to every prisoner whenever he needs it (SMR 20).

Some United Nations Standard Minimum Rules are in full accordance with the top three needs of prisoners. With regard to self-advancement and self-improvement, prisoners' most important need, the United Nations state that sentenced prisoners must receive treatment that encourages their self-respect and develops their sense of responsibility (SMR 65). To this intention, all appropriate means shall be used, including religious care in the countries where this is possible, education, vocational guidance and training, social casework, employment counselling, physical development and strengthening of moral character, in accordance with the individual needs of each prisoner, taking to account of his social and criminal history, his physical and mental capacities and aptitudes, his personal temperament, the length of his sentence and his prospects after release (SMR 66). In addition, access to a qualified representative of any religion shall not be refused to any prisoner (SMR 41). With regard to prisoners' need for being loved, appreciated and cared for, the United Nations state that prisoners shall be allowed under necessary supervision to communicate with their family and reputable friends at regular intervals, both by correspondence and by receiving visits (SMR 37). The prisoners' need for activity and distraction is addressed with the following rules: Every institution shall have a library for the use of prisoners, adequately stocked with both recreational and instructional books, and prisoners shall be encouraged to make full use of it (SMR.40); Every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air, daily if the weather permits (SMR 21-1); Young prisoners, and others of suitable age and physique, shall receive physical and recreational training

during the period of exercise. For this purpose, installations and equipment should be provided (SMR 21-2).